Nottinghamshire Area Prescribing Committee

Annual Report 2011/12

Figure 1 - Map of Nottinghamshire APC Member Organisations

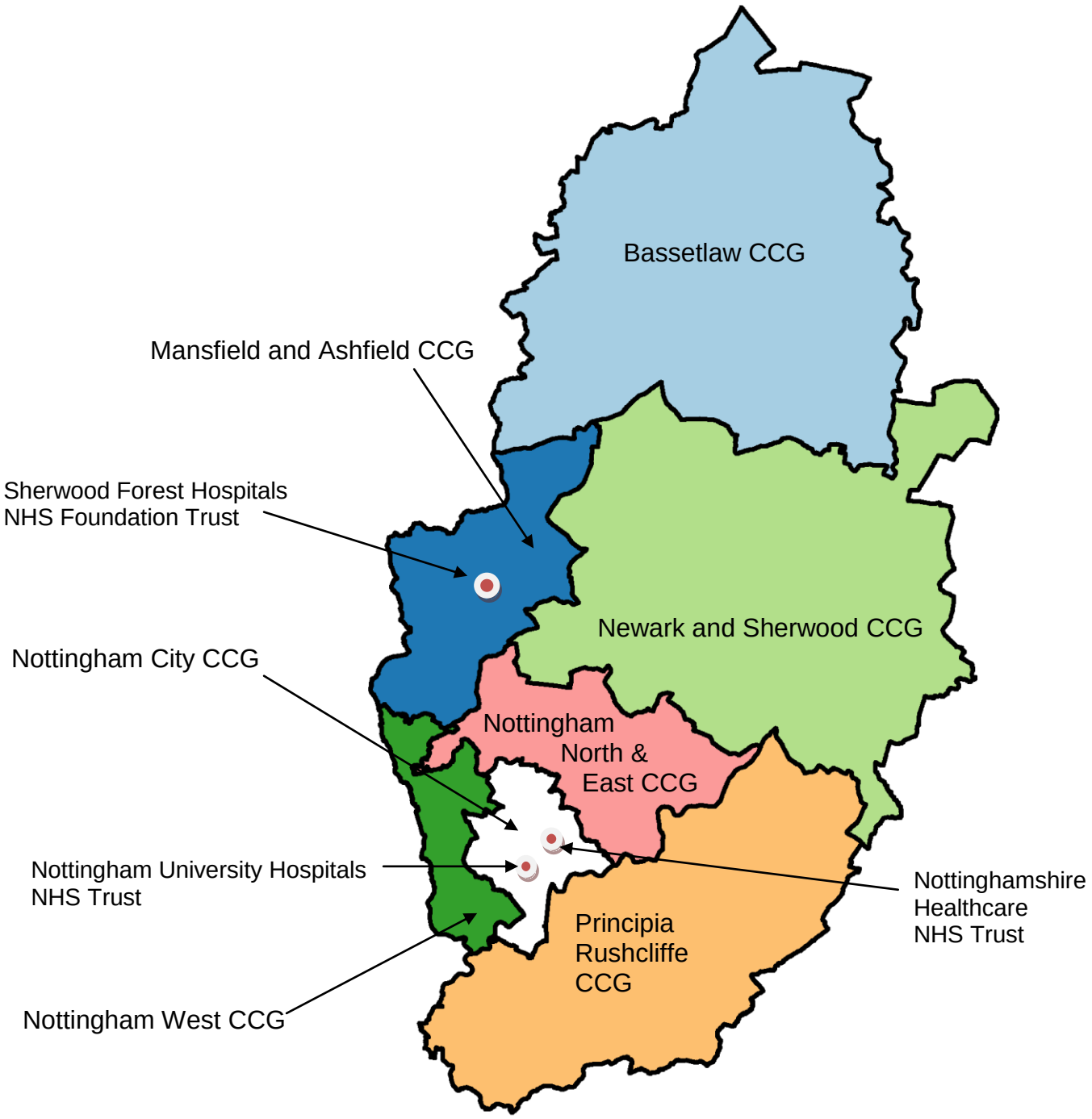


Table of Contents

EXECUTIVE SUMMARY

Key Achievements of the Nottinghamshire Area Prescribing Committee

- External fitness for purpose review by the National Prescribing Centre (NPC) plus.
- Reaffirmed APC mandate with stakeholder organisations.
- Support to QIPP agenda via Productive Notts and horizon scanning.
- Local decision making which supports pathway redesign.
- Development of a Joint Formulary across the Nottinghamshire Health Community including online resource.

Year In Numbers

- 7 committee meetings (including 1 extraordinary meeting)
- 73 medicines were classified on the Nottinghamshire Traffic Light System
- 21 new clinical guidelines, shared care protocols, formularies & policies/position statements were developed and ratified.
- 7 clinical guidelines, shared care protocols & formularies reviewed and re-approved
- Overall the decisions that the APC made throughout 2011-12 with regard to traffic light classification resulted in an estimated saving/cost avoidance of £3.7M drug costs for the Nottinghamshire Health Community

Type of implication	Number of decisions	Cost implication
Savings	13	£482,808 saving
Cost avoidance	28	£3,197,900 avoidance
Cost neutral	25	Neutral
Cost implications	7	£13, 529 in year costs

Future Priorities for 12-13

- Implement the actions identified in the NPC Plus Fitness for purpose review
- Develop financial monitoring of APC decisions
- Improve engagement and consultation with CCGs
- Rivaroxaban/dabigatran/apixaban for Atrial Fibrillation
- The Joint Formulary completion and launch of website

The Year In Numbers

Figure 2: Traffic light classification of medicines in 2011-12

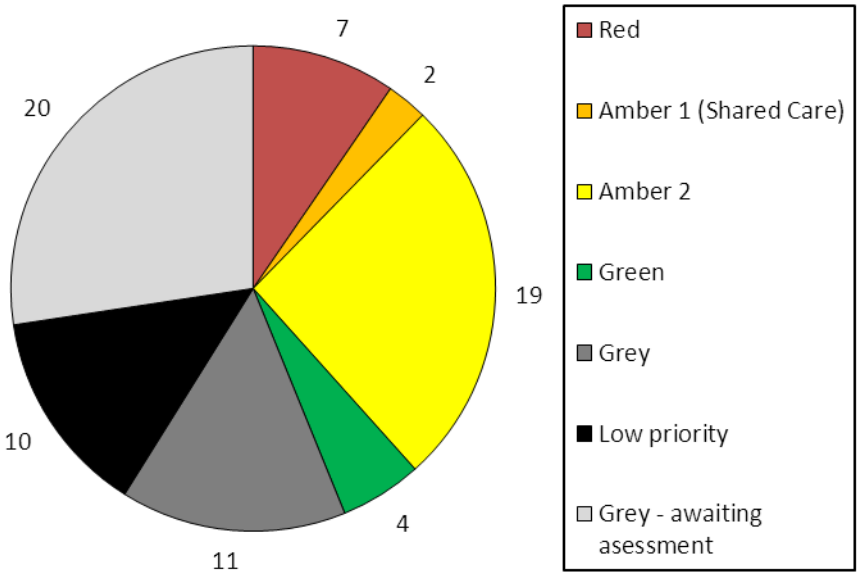


Table 1 – Decision showing implications and traffic light classification

Implication	Red	Amber 1	Amber 2	Green	Grey	Low priority	Grey awaiting assessment	Total
Savings				2	1	10		**13**
Cost avoidance					8		20	**28**
Cost neutral	3	2	17	1	2			**25**
Cost implications	4		2	1				**7**
Total	**7**	**2**	**19**	**4**	**11**	**10**	**20**	**73**

Figure 3: Documents developed/ratified by the APC during 2011-12 **(**See appendix 3 for further details)

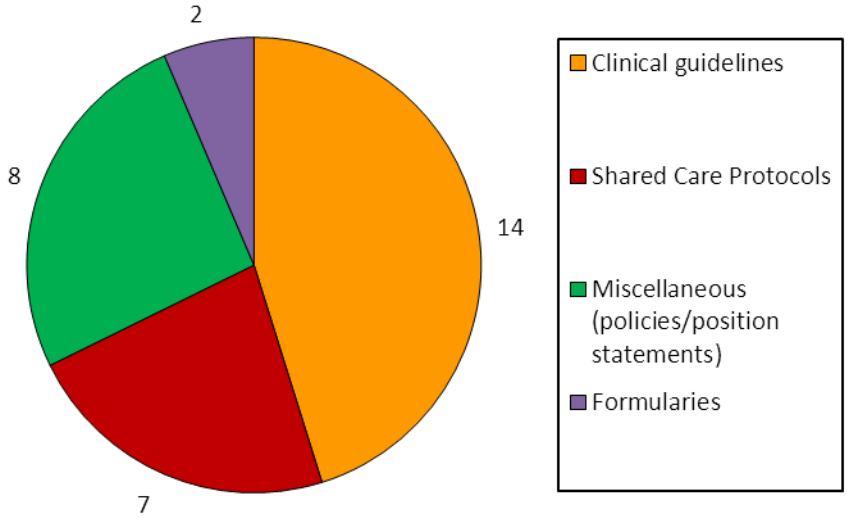
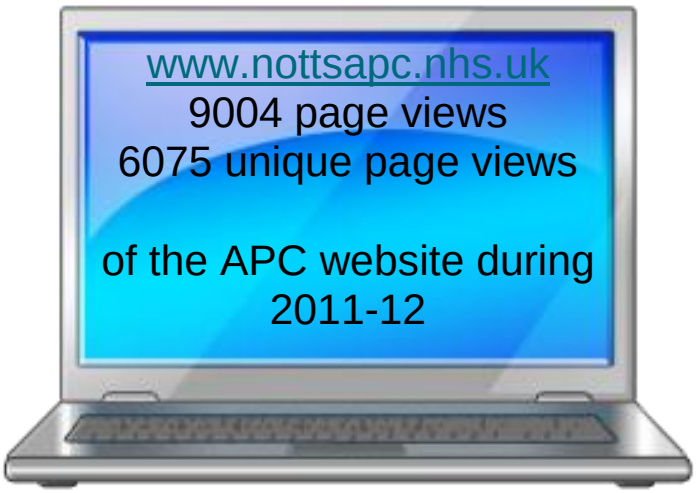


Table 2: Documents managed by the APC

Type of document	Ratified by APC during 2011-12	Previously ratified by APC	Total Number of documents the APC manages
Clinical Guidelines	14	13	27
Shared Care Protocols	7	2	9
Formularies	2	2	4
Miscellaneous documents	8	5	13

Figure 3: Nottinghamshire Area Prescribing Committee Website Statistics



The website was launched in July of 2010 therefore this is the first full financial year that the website has been in operation. Ratified APC documents are published on the website.

Purpose of the Committee

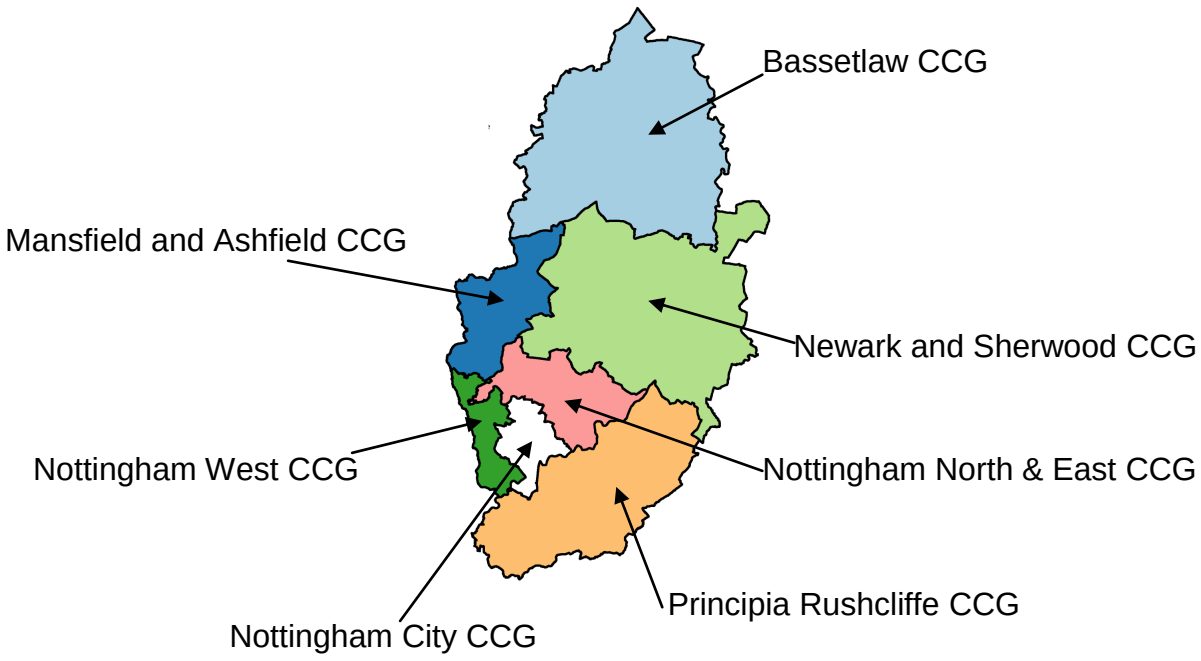
The Nottinghamshire APC has been in operation since 2007. It is a partnership committee across organisations within the Nottinghamshire Health Community. This consists of NHS Nottinghamshire County, NHS Nottingham City, Sherwood Forest Hospitals Foundation Trust, Nottingham University Hospitals, and NHS Bassetlaw & Nottinghamshire Healthcare Trust (in relation to mental health issues only). Independent contractor representative organisations (i.e. the Local Medical Committee; LMC and Local Pharmaceutical Committee; LPC) also form part of the committee's membership. The APC is currently chaired by the Chief Pharmacist/Associate Director of Public Health for NHS Nottinghamshire County.

The main functions of the committee are:

- To establish a collective strategic approach to prescribing & medicines management issues across the Nottinghamshire Health Community, in relation to the safe, clinical and cost effective use of medicines.
- To approve policy on prescribing and medicines management issues at the interface between primary and secondary care and identify associated resource implications for consideration by the commissioning organisations.
- To ensure robust governance arrangements are in place for the effective delivery of medicine policy within a framework of the whole patient care pathway.
- To provide guidance on these issues for commissioners and providers within the healthcare community.

During 2011-12 there were significant changes within the NHS. Clinical Commissioning Groups (CCGs) will be taking over local commissioning responsibility from PCTs in 2013.

NHS Nottinghamshire County is set to become 5 CCGs, NHS Nottinghamshire City and NHS Bassetlaw will each have 1 CCG. There is now a need to review structures, functions and accountability of the existing Area Prescribing Committee (APC) to ensure that the commissioning of medicines within Nottinghamshire continues in a safe, efficient and effective manner.



KEY ACHIEVEMENTS DURING 2011-12

- External fitness for purpose review by the National Prescribing Centre (NPC) plus.
- Reaffirmed APC mandate with stakeholder organisations.
- Support to QIPP agenda via Productive Notts and horizon scanning.
- Local decision making which supports pathway redesign.
- Development of a Joint Formulary across the Nottinghamshire Health Community including online resource.

NPC Plus review

In December 2010, the NPC (in partnership with NPC Plus) invited expressions of interest from Area Prescribing Committees across England wanting to undertake a facilitated fitness for purpose review. The Nottinghamshire APC was one of the APCs selected. (NB the review was supported by an unrestricted educational grant from Sanofi Aventis.)

The main function of the NPC Plus review was to help existing APCs set their future direction and improve the systems and processes that will support the APC moving forward. This is particularly important in light of NHS restructuring which will see GP Clinical Commissioning Groups (CCG) taking on the functions of PCTs in shadow during 2011/12 and fully by April 2013.

The review was undertaken in May 2011 and was well attended by APC committee members and other stakeholders.

Key actions from the review included the committee reaffirming the APC's mandate with member organisations including establishing authority for decision making and identifying a financial threshold for decisions made by the APC.

As part of the mandate, stakeholder organisations were also asked to consider the accountability of the APC. This would ensure that there is;

- effective consultation regarding APC policy (including patient & public involvement)
- formal acknowledgement of the minutes of decisions
- final APC policy/ decisions are ratified within member organisations where required
- an internal process of communication, implementation and monitoring is followed

In order to facilitate this, the APC/JFG now publishes a forward work programme which is widely disseminated to CCGs.

The terms of reference also required updating to reflect changing organisational structures to maintain engagement and a balanced membership. A third action was identified as developing and implementing effectiveness measures for APC decisions and recommendations.

An action plan for the APC was developed as a result of the review (Appendix 2) where work has been carried out throughout the year in addressing these and other areas.

The findings of the review also featured in the national NPC quarterly newsletter; 'Tough Decisions' where the Nottinghamshire APC was presented in a very positive light.

QIPP

Prescribing and Medicines Management was once again high on the QIPP agenda with organisations required to achieve significant savings to their prescribing budgets.

The APC has contributed significantly to the QIPP agenda throughout 2011 -12 via;

1. **Productive Notts**

In November APC members were requested to support prioritisation of productive Notts initiatives into the work programme of the APC, JFG and local DTCs. The committee agreed to this request.

The APC supported the Productive Notts agenda with several pieces of work throughout the year. The work to classify a number of medicines as low priority has contributed a large proportion of the savings achieved.

2. **The Joint Formulary**

A joint medicines formulary has been developed by the Nottinghamshire Joint Formulary Group (NJFG) (sub-group of the Nottinghamshire APC) for use across primary and secondary care organisations throughout Nottinghamshire. This has been a huge undertaking; with consultation and rationalisation of all of the approved chapters. Eleven of the fifteen BNF chapters have been ratified and the remaining 4 are due to be ratified early in 2012 -13.

The joint formulary is a live, online reference source with links to local primary and secondary care guidelines, traffic light status, online BNF, national guidelines, Summary of Product Characteristics (SPC) and other resources.

The main link for the Joint formulary is http://nww.nottsformulary.nhs.uk . It is currently hosted on an NHS website available to NHS computer users or those with N3 access. Issues with access by local pharmacy contractors have been noted but unfortunately this continues to be an ongoing national issue.

See appendix 3 for the Specialist Interface and Formulary Pharmacists report on the achievements of Joint Formulary Group during 2011-12.

3. **Supporting Pathway Redesign**

NHS Nottingham City CCG, Nottingham West, Principia and Nottingham North & East have recently undertaken a review of the pathway for managing patients with prostate cancer. Part of the review included rationalising the choice of gonadorelin analogues to ensure that the most cost effective one, triptorelin, was being used. To support this the APC developed a position statement in conjunction with secondary care specialists. It states that the gonadorelin analogue of lowest acquisition cost (within their licenced indication) should be used irrespective of which analogue had been initiated by secondary care.

NHS Nottingham City, on behalf of the CCGs within Nottinghamshire County and City, requested the reclassification of acetylcholinesterase inhibitors for dementia from Amber 1 (shared care) to Amber 2 (specialist recommendation) to facilitate their prescribing by specialists within primary care as part of the new memory assessment service (MAS) pathway. It was proposed that as part of the new MAS, primary and secondary care

professionals will continue to work in partnership to support patients with dementia. As such under the new proposal it is recommended that acetylcholinesterase inhibitors will continue to be initiated within secondary care with the specialist prescribing the first dose and care then transferred to primary care with GPs becoming responsible for ongoing prescribing and titration.

4. Horizon Scanning

This was introduced during 2010-11 as part of the APC processes in order to highlight upcoming medicines or changes in indication where there is a potential financial risk for the member organisations. Horizon scanning was firmly embedded into APC processes during 2011-12.

Once identified the medicine is classified 'Grey – awaiting assessment' which acts as holding position before local prescribing becomes established. This allows the introduction of new medicines to be managed in a considered and effective way. The medicine will then be assessed for the likely financial impact on prescribing, implications for commissioning and whether there is local interest from clinicians.

One example of this is dabigatran for anticoagulation in Atrial Fibrillation (AF). There are significant financial, clinical and commissioning implications from the introduction of these medicines. Through horizon scanning, a timely position statement was issued from the APC recommending that dabigatran should not be prescribed for this indication until a local strategy had been developed.

Financial Implications of APC decisions 2011-12

Overall the decisions that the APC made throughout 2011-12 with regard to traffic light classification and inclusion in the formulary resulted in a net saving/cost avoidance of £3.7m million drug costs for the Nottinghamshire Health Community.

The APC makes some decisions which result in increased prescribing costs; however it ensures that the evidence to support the decision ensures an overall cost saving (e.g. reduction in admissions or other activity costs).

Table 3: Financial implications of APC decisions during 2011-12

Type of implication	Number of decisions	Cost implication
Savings	13	£482,808 saving
Cost avoidance	28	£3,197,900 avoidance
Cost neutral	25	Neutral
Cost implications	7	£13, 529 in year drug costs

The details of this, including the sources used to calculate this figure, are contained in appendix 1.

Savings
A significant proportion of the £483K saving came from the implementation of the 'low priority' medicines policy which was developed throughout the previous year and ratified at the first APC meeting of 2011-12.

A number of the CCGs have incorporated the low priority medicines list into their QIPP plans for 11-12 where a significant amount of the savings identified have been released.

Fostair was introduced into the adult asthma guidelines and has resulted in savings from patients being switched to this more cost effective product when appropriate. It is too early to tell yet whether the classification of once daily tadalafil as grey will result in savings.

Cost avoidance
Decisions are classed as cost avoidance when a medicine is not accepted on to the formulary or it is given grey/grey awaiting assessment classification. It is calculated using intended patient numbers from submissions/business cases or NICE / New Drugs Online cost calculators.

Cost implications
During 11-12 the APC made decisions which resulted in a £13K cost pressure to the health community. This low figure reflects the robust decision making process that is applied and highlights that QIPP was high on the APC agenda for 11-12.

Review against priorities identified in 2010-11 annual report

1. **NPC plus review of APC**

This has been carried out and significant progress made with the actions.

2. **Monitor the financial impact of APC decisions across the health community**

A model for assessing the financial implications has been incorporated in the annual report for 2011-12. It continues to be a priority for 2012 - 13.

3. **Continue to work with the cardiologists**

Work has continued throughout the year on guidelines for lipid modification medications. It has been challenging at times to obtain a consensus although a position statement for the use of ezetimibe has been developed. Due to atorvastatin coming off patent in May 2012 and a likely significant price reduction, progress on agreeing the place in therapy of the statins has been delayed until future costs are known.

4. **Ensure the QIPP agenda is embedded within APC processes**

This has been achieved throughout the year and continues into 2012-13.

Future Priorities for 12-13

Implement the actions identified in the NPC Plus Fitness for purpose review
Lay engagement was highlighted as a priority in the review. Scoping of lay involvement will be carried out in the first quarter of 2012-13 with the development of a job description and a person specification. The APC will seek to fill the post(s) by the 3rd quarter.

All other actions have been assigned leads and timelines for completion.

Develop financial monitoring of APC decisions
The assessment of the financial impact of APC decisions has become more significant for member organisations and the APC will have to continue to demonstrate the ways in which it contributes to QIPP.

The methods used to monitor the decisions will need to be further refined to assure member organisations.

Improve engagement and consultation with CCGs
The aim is to strengthen the decision making process of the APC by improving engagement with the CCGs and other member organisations. This will be driven by the support team and APC members using well established processes and networks. Communication links will be constantly reviewed and updated in line with NHS structural changes throughout 2012-13.

Rivaroxaban/dabigatran/apixaban for AF
The introduction of these medicines poses a significant financial risk to the Nottinghamshire health community of approximately £2million. There are also clinical and commissioning implications to be considered. A scoping exercise will be carried out in the first quarter of the year to identify the actions to be taken to introduce these medicines in an appropriate manner. NICE Technology Appraisals (TA) are due to be published in 12-13 which will dictate the use of the medicines where further guidance as to implementation will need to be agreed on a local/East Midlands level.

The Joint Formulary (nww.nottsformulary.nhs.uk)

April – September 2012
The four remaining chapters are:

Chapter 8(Malignant disease and immunosuppression)
Chapter 9 (Nutrition and blood)
Chapter 14 (Immunological products and vaccines)
Chapter 15 (Anaesthesia)

These will be completed by the end of the second quarter. There are several IT issues which need to be addressed with regard to access across the county, and these will be a priority for the first half of the year.

October – March 2013
During the second half of the year, work will start on the maintenance phase of managing the formulary with the refinement of the processes to achieve this.

APC Committee Members

Dr Mark Devonald	NUH DTC Chair (from Jan 2012)	Nottingham University Hospitals NHS Trust
Dr Vivienne Weston	NUH DTC Chair (until Dec 2011)	
Prof Malcolm Partridge (Deputy Sarah Pacey)	Chief Pharmacist	
Dr David Kellock	SFHFT DTC Chair	Sherwood Forest Hospitals NHS Foundation Trust
Steve May (Deputy Steve Haigh)	Chief Pharmacist	
Cathy Quinn (Chair; May, Sep, Jan, Mar)	Associate Director of Public Health	NHS Nottinghamshire County & NHS Bassetlaw
Dr Chris Kenny (Acting Chair Oct, Nov)	Director of Public Health	
Nicky Bird	Senior Prescribing Advisor	
Maxine Bunn	Head of Procurement	
Tanya Behrendt	Deputy Head of Medicines Management	NHS Nottingham City Clinical Commissioning Groups
Dr Esther Gladman	GP prescribing lead	
Dr Marcus Bicknell	GP – City CCG (until Sep 2011)	
Dr Khalid Butt	GP -County CCGs (North)	NHS Nottinghamshire County Clinical Commissioning Groups
Dr Alex Macdonald	GP- County CCGs (South)	
Richard Harris	Community Pharmacist -LPC	LPC
Dr Guy Mansford	GP – LMC (until Sep 2011)	LMC
Dr Felicity Armitage	GP –LMC (from Oct 2011)	
John Lawton	Senior Pharmacist (South)	Nottinghamshire Healthcare NHS Trust
Dr Hemant Bagalkote (Deputy Sangeeta Bassi)	NHT DTC Chair	

(Deputies are acknowledged above where they have attended)

Acknowledgements

The Nottinghamshire APC is managed and supported by
Nicky Bird, Senior Prescribing and Interface Advisor, Nottinghamshire Commissioning Support Hub (NCSH)
Amanda Rawlings, Prescribing Interface Advisor, NCSH
Lynne Kennell, Specialist Interface and Formulary Pharmacist, Sherwood Forest Hospitals Foundation NHS Trust
James Sutton, Specialist Interface and Formulary Pharmacist, Nottingham University Hospital NHS Trust
Georgina Brudzinska, Medicines Management Team Secretary, NCSH
Tim Oxley, Senior Data Analyst, NCSH.

Thanks to Dr Guy Mansford (GP/LMC rep), Dr Marcus Bicknell (GP, Notts City CCG) and Dr Viv Weston (Consultant Microbiologist, NUH) as previous members of the APC.

All clinicians who have either worked with us to produce documents or who have taken part in their development via consultation. They are too numerous to mention individually but make a significant contribution to the work of the APC.

Appendix 1

Nottinghamshire Joint Formulary Group Annual Report 2011/2012

Introduction

The Nottinghamshire Joint Formulary Group (NJFG) is a sub-group of the Area Prescribing Committee and has been in operation since April 2009. The main purposes of the group are

- To make evidence-based informed recommendations for the
  - inclusion of medicines, medical devices, wound care products and dietary products on the Nottinghamshire Joint Formulary;
  -classification of these products within the Nottinghamshire Traffic Light system
- To lead on the development of the Nottinghamshire Joint Formulary
- To lead BNF chapter reviews

This group has medical and pharmacy representation from Nottingham University Hospitals NHS trust, Sherwood Forest Hospitals NHS Foundation Trust, Nottinghamshire Healthcare NHS Trust, NHS Nottinghamshire County CCGs and NHS Nottingham City CCG and meets bi-monthly. The group is chaired by the Chief Pharmacist at Sherwood Forest Hospitals NHS Foundation Trust.

Work for the Joint Formulary Group is co-ordinated by two 0.6 WTE Specialist Interface and Formulary Pharmacists. One post is based at Sherwood Forest Hospitals NHS Foundation Trust and the other at Nottingham University Hospitals NHS Trust.

Meetings

There have been five meetings of the NJFG. The October meeting was cancelled due to the arrangement of an extra-ordinary APC meeting.

The NJFG strategy group was established to support the work and establish the priorities of the NJFG. There have been three meetings of this group.

Key Achievements

Development of the Nottinghamshire Joint Formulary

A key achievement of this year has been the development of the Joint Formulary. The formulary provides information on medicines available to prescribers in Nottinghamshire. The main aims of the Joint Formulary are to:

- To promote safe, effective and cost effective prescribing.
- To support the QIPP programme by promoting economical prescribing. This allows better use of limited NHS resources within the Nottinghamshire Health Communities.
- To reach agreement between primary and secondary care regarding which drugs should commonly be prescribed, assisting in the development of closer working relationships between secondary care trusts and primary care.
- To produce greater familiarity with a more limited range of drugs.

Appendix 1

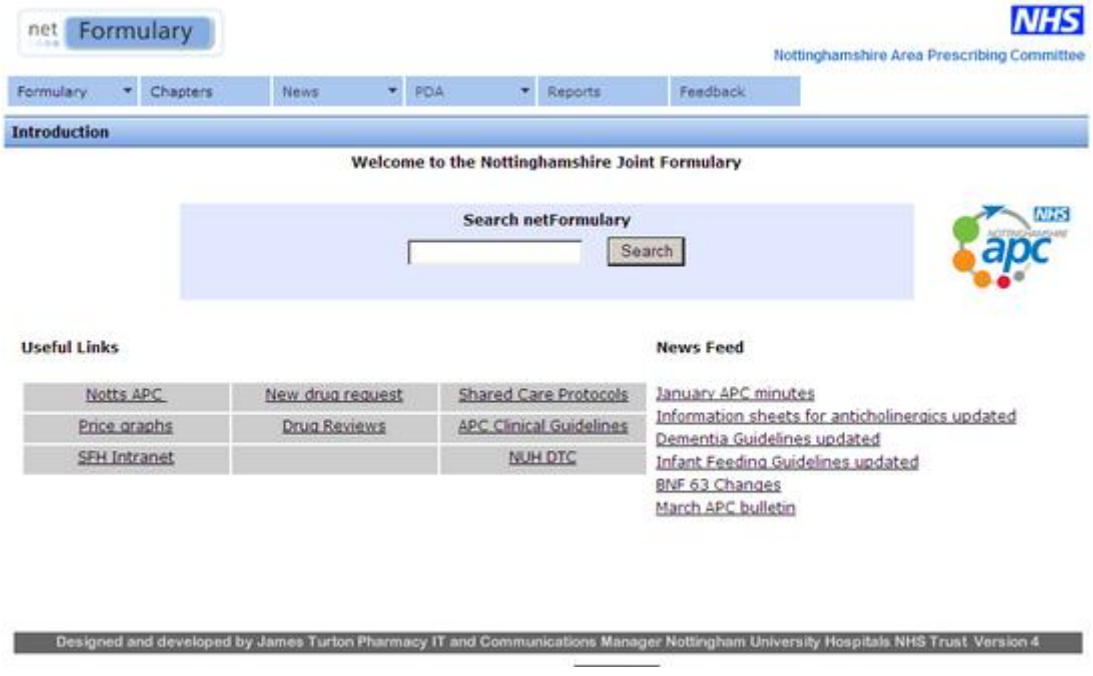
- To promote a seamless approach to medicines, aligning prescribing across the primary/secondary care interface. This should reduce unnecessary medication changes on admission and discharge from hospital, reducing risk issues and patient confusion.
- To encourage generic prescribing where appropriate.

The formulary follows the layout of the BNF and is available via an online searchable database. BNF chapters 1-7 and 10-13 have been through a process of review, consultation and ratification. The Joint Formulary database is intended for use by health professionals in primary and secondary care, across all stakeholder organisations It is hosted via an NHS website at the web address nww.nottsformulary.nhs.uk.

In addition to listing formulary choices, the database is a vast Medicines Information resource and has several other useful features including:

- hyperlinks to the e-BNF, e-BNFc and to the electronic medicines compendium which holds Summaries of product Characteristics
- First and Second choices shown where possible to assist cost-effective prescribing
- Restricted medicines show approved indications and/or prescribers
- Traffic light status displayed
- Links to relevant local and national guidelines
- Links to cost comparison graphs where available.

Fig 1. Front page of the Joint Formulary



Appendix 1

The process of formulary development has also prompted a review of the traffic light list. Traffic light discrepancies have been referred to the APC for consideration and the majority of medicines listed on the formulary have now been assigned a traffic light classification.

Wound care formulary

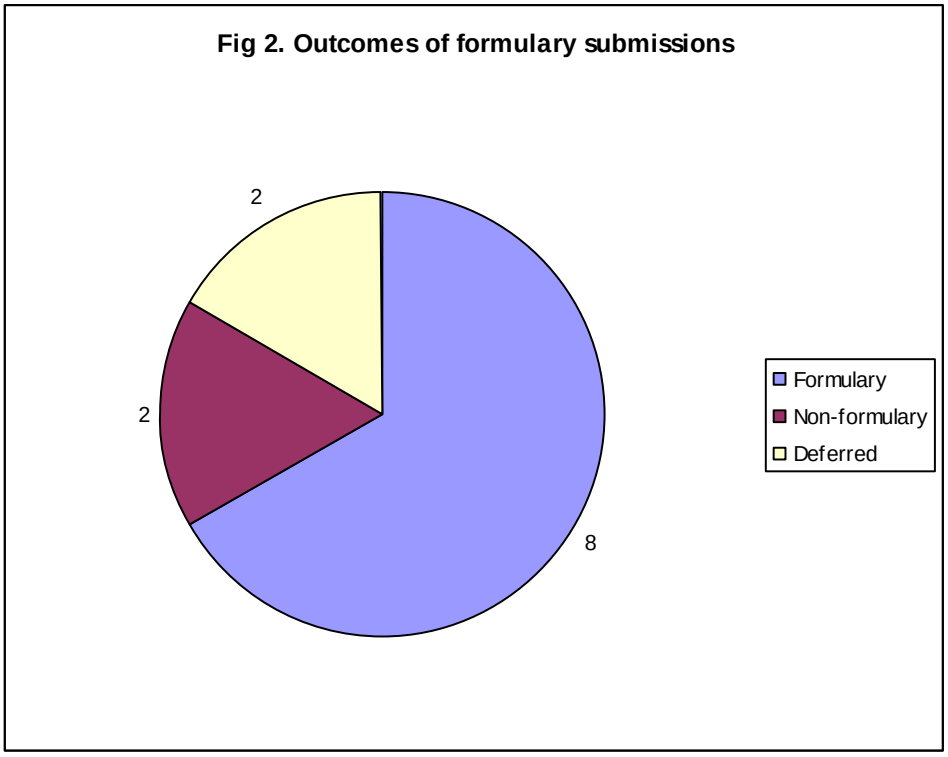
The development of the Nottinghamshire Wound Care Formulary has been a lengthy project overseen by the Nottinghamshire Wound Management Group, with input from the Interface and Formulary Pharmacists. The Wound Care formulary was launched in Primary Care in January 2012. The implementation of the formulary is expected to release considerable cost savings across the health community as well as promoting consistency in wound care product prescribing and ensuring that patients are treated with the most cost-effective wound care products available. Savings from implementation of the formulary are predicted to be in the region of £1 million PA across the health community.

New Medicine Submission Reviews and Recommendations to APC

The NJFG considers all submissions for new medicines submitted by primary or secondary care which are to be prescribed at the interface. A comprehensive independent review of the current evidence is produced for each formulary submission along with consultation with relevant clinicians where appropriate. In some circumstances the requesting prescriber is asked to attend the NJFG meeting at which the submission is discussed. Following the process of formulary consideration, recommendations for traffic light classifications are made.

12 medicines have been reviewed by the NJFG and outcomes are detailed below:

Fig 2. Outcomes of formulary submissions



Appendix 1

Horizon scanning.

All new medicines or indications which may potentially have an impact on prescribing at the interface are reviewed pre-emptively by the NJFG and recommendations made on the appropriate traffic light classification. This helps manage the introduction of new drugs in a considered and effective way, avoiding what otherwise may be an unexpected cost pressure for stakeholder organisations.

Shared Care Protocols

This year has seen the updating and ratification of all outstanding Shared Care Protocols (SCPs). The Interface and Formulary pharmacists have either led or had strong input into their development.

The updated SCPs include:

- Methylphenidate and atomoxetine treatment of Attention Deficit Hyperactivity Disorder in Children and Young People.
- Management of Inflammatory Bowel Disease in adults with azathioprine or 6-mercaptopurine
- Methotrexate for Shared Care in Adults with Severe Psoriasis unresponsive to conventional treatment

Prescribing guidelines and prescribing position statements

A number of prescribing guidelines and prescribing position statements have been developed. These include prescribing guidelines for colistin in non-CF bronchiectasis, asthma in adults, ulipristal, NuvaRing and an opioid guideline to support the safe and effective prescribing of opioids in primary care. Position statements on generic prescribing of lamotrigine and GnRH analogue prescribing in breast and prostate cancer aim to ensure that cost effective prescribing is achieved in these areas.

Future Priorities of the NJFG

The Nottinghamshire Joint Formulary remains a key priority. The formulary is due for launch in primary care on 2nd April 2012 and outstanding BNF chapters are due for completion by the end of summer 2012. The Formulary is a dynamic document and will be updated on a continuous basis. Once the formulary is established, methods of monitoring access and adherence, both in primary and secondary care will be developed.

A number of prescribing areas have been highlighted as requiring further input from the NJFG. These include the use of insulin analogues and the implementation of the use of the newer oral anticoagulants across the health community.

The development of prescribing guidelines will continue. Those currently in progress include guidelines for the use of Vitamin D, a Paediatric Specials Formulary and a supporting prescribing guideline for primary care on enoxaparin.

Appendix 2

Decisions which facilitated savings for the whole health community

Medicine	Date	Indication	Classification	Actual Financial Implications for 2011-12 for the whole health community (if possible to assess at present)	Predicted Financial Implications for 2011-12 for the whole health community	Assumptions
glucosamine	May-11	osteoarthritis	LOW PRIORITY MEDICINE, not be prescribed on the NHS (except via IFR policy)	-£ 459,308.00	-£ 500,000.00	£400K County and £59K from City using ePACT
Herbal medicines	May-11	various				
Homeopathy	May-11	various				
non staple gluten free preps	May-11	various				
chloroquine	May-11	malaria prophylaxis				
mefloquine	May-11	malaria prophylaxis				
proguanil	May-11	malaria prophylaxis				
malarone®	May-11	malaria prophylaxis				
Sativex®	May-11	spasticity in MS				
Tramacet® (tramadol 37.5mg/ paracetamol 325mg)	May-11	Compound analgesic				
Fostair	Jul-11	Asthma	Green	-£ 23,500.00	Patient numbers not outlined in request as will be replacing a more expensive medicine when used.	Based on price difference between fostair and seretide. Spent £121K on Fostair which would have cost £144.5K if it had been seretide.Steep increase in usage following the APC decision to make this green.
Fultium-D3	Mar-12	Treatment and prevention of Vit D3 deficiency	Green	Too early to assess from prescribing data.	Likely to be a saving as there will be less use of specials	
Once Daily Tadalafil	Mar-12	Post radical prostatectomy	Grey	Too early to assess from prescribing data.	-£ 62,000.00	Based on what is currently being prescribed in primary care. Requires implementation by primary and secondary care to be able to assess actual impact.

Decisions which facilitate cost avoidance across the whole health community

Medicine	Date	Indication	Classification	Actual Financial Implications for 2011-12 for the whole health community (if possible to assess at	Predicted Financial Implications for 2011-12 for the whole health community	Assumptions
Episil	Jul-11	Oral mucositis	Grey	Small amount of primary care prescribing (£180 in County)	Unable to quantify. Likely modest cost avoidance	
Agomelatine	Jul-11	Depression	Grey	£38,000 cost avoidance no prescribing	-£ 38,000	NDO cost calculator. Inc*idence 0.4%, 10% requiring second line Tx*
Fingolimod	Jul-11	Multiple Sclerosis	Grey (awaiting assessment)	£194,000 cost avoidance as no prescribing.	-£ 194,000	NDO cost calculator. NICE estimate that there are around 1600 patients in England that have rapidly evolving RRMS. These patients would currently qualify for natilizumab at a cost of around £14,700 per year – fingolimod costs around £19,000 per year although some of this cost differential will be reduced by reduced administration costs. If we assume that 50% of them start treatment with fingolimod of whom 50% switch from natilizumab – this would increase costs by £9.72m which equates to £19,400 per 100,000 population.
Bilastine	Jul-11	Antihistamine	Grey	No prescribing in primary care	-£ 21,500	if 1% of cetirizine & loratadine annual prescribed as bilastine instead.
Hyroxycarbamide (Siklos®)	Sep-11	Sickle Cell anaemia	Grey		Unable to quantify	
Rivaroxaban (Xarelto®)	Jan-12	Prevention of stroke in AF	Grey (awaiting assessment)	In reality primary and secondary care are working collaboratively on this to ensure there is a managed introduction of these medicines across Nottinghamshire.	-£ 2,190,000	(From New Drugs Online) Prevalence AF is 1.4%, 40% patients currently anticoagulated, 40% of patients have an INR in the target rage <65% of the time and would therefore be considered (Cost £146K per 100K population). 20% of patients are not considered suitable for warfarin(cost £73K per 100K population). therefore total cost of £219K per 100K population.
Dabigatran	Sep-11		Grey			
Roflumilast (Daxas▼®) (resubmission)	Oct-11	Severe COPD with frequent exacerbations	Grey	£800 spend in County; £382 spend in City	-£ 250,000	NICE recommended use in clinical trial however we made this decision prior to NICE (Jan 12). Add on therapy therefore any costs will be additional. Cost per annum £452.52. 30-40% COPD classed as severe. 1.6% prevalence COPD. If 40% are severe and 50% of these receive roflumuilast approx £145k per 100,000 population. Based on cost savings between Oct 2011 and Jan 2012 when NICE made their decision.
Olmesartan, amlodipine & hydrochlorothiazide (Sevikar HCT®)	Jan-12	Hypertension	Grey	No prescribing in primary care	likely modest cost avoidance	

Aliskiren, amlodipine & hydrochlorothiazide (Rasitrio®)	Jan-12	Essential hypertension	Grey	No prescribing in primary care	Likely modest cost avoidance	
Nutritional supplements for AMD	Mar-12	Prevention of AMD	Grey awaiting assessment		-£ 5,000	From submission based on current level of primary care prescribing. If made Grey will need implementation to realise savings.
Resperate	Mar-12	BP	Grey awaiting assessment	No prescribing in primary care	Unclear at present. Costs £150 per patient.	Evidence to be reviewed by Joint Formulary Group. Heavy marketing directly to patients and within some community pharmacies.
Mannitol Inhallations (Bronchitol®)	Jan-12	Cystic fibrosis	Grey (awaiting assessment)	No prescribing in primary care	Unable to quantify	NICE TA due August 2012
Apixaban (Eliquis®▼)	Nov-11	Prevention of venous throboembolic events after hip or knee surgery	Grey (awaiting assessment)	No prescribing in primary care	See rivaroxaban above	NICE TA will be published after those for dabigatran and rivaroxaban.
Belatacept (Nulojix▼®)	Nov-11	Prevent graft rejection in renal patients	Grey (awaiting assessment)	No prescribing in primary care	-£ 40,000	Based on business case for 4 patients. (6 months due to when decision was made)
Tramadol Oral Drops	Oct-11	Pain	Grey (awaiting assessment)	No prescribing in primary care	Unable to quantify	Zero prescribing on ePACT
Rifaximin	Oct-11	Travellers diarrhoea	Grey (awaiting assessment)	Small amount of prescribing within primary care.	Likely to be modest savings	
Esomeprazole & Aspirin (Axanum®)	Oct-11	CV event prevention	Grey (awaiting assessment)	No prescribing in primary care	Likely to be modest savings	
Telaprevir (Incivo®)	Jan-12	Hepatitis C	Grey (awaiting assessment)	No prescribing in primary care	-£ 90,000	Additional treatment. Positive NICE TA. Funded by EMSCG prior to 90 day NICE implementation therefore classification since been changed to RED. New drugs online estimates first year costs to be 540K. Figure based on 2months cost avoidance between APC decision and NICE positive TA.
Bocepravir	Oct-11	Hepatitis C, chronic genotype 1	Grey (awaiting assessment)	No prescribing in primary care		
Tobramycin Inhaled (TOBI Podhaler®)	Oct-11	CF chronic pulmonary infection	Grey (awaiting assessment)	No prescribing in primary care	-£ 4,000	Based on 3 courses requested in business case. Difference between this and current Tx. 6 months due to time of year when decision made.
Denosumab	Sep-11	Prevention of skeletal related events in adults with bone metastases from solid tumours (NICE TAG in progress)	Grey (awaiting assessment)	Not possible to assess due to mulitiple indications.	-£ 365,000	50 patients per 100,000 might be considered for this treatment (New drugs online). If 50% switch from bisphosphonate this would be an additional £36,500 per 100,000 population. NB doesn't take into account any activity costs with IV admin of bisphosphonates.
Fampridine	Sep-11	Multiple Sclerosis	Grey (awaiting assessment)	No prescribing in primary care	Unable to quantify	business case to calculate cost avoidance
Midazolam (Buccolam)	Sep-11	Epileptic seizures in children	Grey (awaiting assessment)	Small amount of prescribing within primary care.	N/A	Decision was made on safety grounds to facilitate managed introduction.

Linagliptin	Sep-11	Type 2 Diabetes	Grey (awaiting assessment)	Small amount of prescribing within primary care.	-£ 400	Based on 10 patients being initiated at each Acute Trust (from subsequent submission in May 2012).Slightly more expensive compared to others in it's class but decision based on evidence and safety. Small amount of prescribing in primary care.
Hydrocortisone MR	Mar-12	adrenal insufficiency	Grey awaiting assessment	N/A	N/A yet	Not available yet (Expected launch late 2012)
Colistin inhaler	Mar-12	Expected to be chronic colonisation of pseudomonas aeruginosa in CF	Grey awaiting assessment	N/A	N/A yet	Not available yet (Expected launch late 2012)
Afamelanotide (Scenesse)	Oct-11	Any indication	Grey (awaiting assessment)	N/A	N/A yet	Not currently available and no price available. Classified to pre-empt potential patient pressure.

Decisions with likely <u>cost neutral</u> implications for the whole health community.

Medicine	Date	Indication	Classification	Predicted Financial Implications for 2011-12 for the Nottinghamshire health community	Implications of cost movement across sectors	Assumptions
Bimatoprost/timolol	May-11	glaucoma	Amber 2 (Specialist recommendation)	Likely cost neutral	No	An administrative exercise to achieve consistency across the class
travaprost/timolol	May-11	glaucoma	Amber 2 (Specialist recommendation)			
Bimatoprost	May-11	glaucoma	Amber 2 (Specialist recommendation)			
Saxagliptin	May-11	Type 2 diabetes	Amber 2 (Specialist recommendation)	Likely cost neutral	No	Will replace a similarly priced product, however the prevalence of diabetes is increasing and the use of this class of drug is increasing.
Exenatide - once weekly	Sep-11	Type 2 Diabetes	Grey	Likely cost neutral	No	Will replace a similarly priced product, however the prevalence of diabetes is increasing and the use of this class of drug is increasing. Awaiting NICE TA.
Azathioprine	Jul-11	Inflammatory Bowel Disease	Amber 1 with SCP	Likely cost neutral	Minimal impact on primary care	small patient numbers where prescribing moving from seocndary to primary care.
Mercaptopurine	Jul-11	Inflammatory Bowel Disease	Amber 1 with SCP			
Tolterodine	Sep-11	Over active bladder	Amber 2 (GP initiation)	Likely cost neutral	No	Change in classification to bring it in line with other medicines in the same class.
Pivmecillinam	Jan-12	ESBL UTI	Amber 2	Likely cost neutral	Minimal impact on primary care	small patient numbers where prescribing moving from seocndary to primary care.
Fosfomycin	Jan-12	ESBL UTI	Amber 2			
Retigabine	Mar-12		Amber 2 (specialist initiation)	Likely cost neutral	No	Likely to be cost neutral as replacing other drugs with similar cost (NICE)
Donepezil	Oct-11	Dementia	Amber 2	Likely cost neutral	No	Decision itself is likely to be cost neutral although patient numbers will increase due to NICE guidance but cost will decrease due to patent expiry
Galantamine	Oct-11		Amber 2		No	
Rivastigmine	Oct-11		Amber 2		No	
Memantine	Oct-11	Dementia	Red	Likely cost neutral	No	Already being prescribed
Goserelin	Nov-11	Breast Cancer	Amber 2	Likely to be a cost neutral decision	Primary care	Will be moving prescribing which already occurs from secondary to primary care.
Constrictor rings to be used with vacuum constrictor device	Jan-12	to be used with vaccum constriction device for either ED or post radical prostatectomy	Amber 2	Likely cost neutrral	No	Already prescribed
Vaccum constriction device	Jan-12	Non SLS criteria	Grey	N/A	No	Should already be prescribed according to these criteria.
Vaccum constriction device	Jan-12	Erectile dysfunction	Amber 2	Likely cost neutral	No	Already Prescribed

Vaccum constriction device	Jan-12	Penile rehabilitation following radical prostatectomy	Red	Likely cost neutral	No	Already prescribed
Frovatriptan (Migard®)	Jan-12	Migraine	Green	Likely cost neutral	No	Replacing other treatment options of similar cost
Ivabradine	Mar-12	Stable angina	Amber 2 (specialist initiation)	Likely cost neutral	No	Already prescribed
ranolazine	Mar-12	Stable angina	Amber 2 (specialist initiation)	Likely cost neutral	No	Already prescribed
Actikerall (fluorouracil & salicylic acid)	Mar-12	solar keratosis	Amber 2 (GP initiation)	Likely cost neutral	No	Replacing other treatment options
Insulin 500units/ml	Mar-12	Diabetes	Red	Likely cost neutral	Potential charge back to primary care.	Cost neutral as formalising what was already happening.

Additions to the formulary with a cost implication

Medicine	Date	Indication	Classification	Implications for which sector	Actual Financial Implications for 2011-12 for the whole health community (if possible to assess at present)	Predicted Financial Implications for 2011-12 for the whole health community	Assumptions
Nuvaring	Jul-11	Contraceptive	Green as per guideline	Primary Care	£2400 @ County; £3446 @ City	£ 2,340	(20 patients at £117 per annum -submission £2340)
Tredaptive	Jul-11	Hyperlipidaemia	Red	Secondary Care	£1,700 spend in County	£ 17,000	Based on 30 patients in formulary submission.
Sapropterin	Sep-11	PKU	Red	Primary Care	Not prescribed	None - not prescribed.	Mid range dose of 12.5mg in 70kg adult = 9 tabs per day = £65,400 per patient per annum.
Tapentadol (Palexia▼®)	Oct-11	Severe Pain which has not responded to treatment with adequate doses of morphine, or where morphine is not tolerated.	Red	Secondary Care	£3137 in County, £34 spend in City	32,500 - 160,000	Based on 100 patients (as per submission) at a cost of £325 - £1600 per patient per year depending on dose
Ticagrelor (Brillique®▼)	Jan-12	Patients who meet NICE criteria but are unable to to take either clopidogrel or prasugrel	Amber 2	Primary & Secondary Care	£2,000 spend in County, Nil @ NUH, Nil @ City	£ 16,380	Based on formulary submission £16,800
Rupatidine (Rupafin▼®)	Nov-11	Urticaria	Amber 2	Primary Care	£500 In County; £312 in City	£ 2,000	Based on formulary submission = 36 patients @£61 per patient per annum
Melatonin (unlicensed immediate release)	Sep-11	Cluster headache	Red	Secondary Care	Not possible to assess due to multiple indications for this medicine.	£ 312	Based on formulary submission

Appendix 3 - Documents ratified by APC during 2011-12

Ratification date		No of associated documents	Update or New
	Clinical Guidelines		
May-11	EllaOne® (ulipristal) Prescribing guideline	1	New
May-11	Supporting guideline for the prescribing of nebulised colistin (Colomycin®) in the treatment of Pseudomonas aeruginosa lung infections in adult patients with non- Cystic Fibrosis Bronchiectasis	1	New
May-11	Sip feeds	5	New
Jul-11	NuvaRing® prescribing guideline	1	New
Sep-11	Overactive Bladder Clinical Guideline - drug therapy	1	Update
Sep-11	Lower Urinary Tract Symptoms in men	1	New
Sep-11	Nottinghamshire COPD guidelines	1	New
Sep-11	Nottinghamshire Adult Asthma Treatment Summary	1	Update
Oct-11	Nottinghamshire Smoking Cessation Treatment Algorithm	1	Update
Jan-12	Anticholinesterase Inhibitors Information Sheets	1	New
Jan-12	Managing behavioural Problems in patients with suspected dementia	1	New
Mar-12	Infant feeding guideline for Premature Infants	1	New
Mar-12	Infant feeding guideline for lactose intolerance and cows milk protein allergy	2	New
Mar-12	Solar Keratosis Primary Care Pathway	2	Update
	Shared Care Protocols		
Apr-11	Management of Rheumatological Conditions with Disease-Modifying Anti Rheumatic Drugs (DMARDs) in adults:	10	New
Jul-11	Management of Inflammatory Bowel Disease in Adults with azathioprine or 6-mercaptopurine	3	New
Aug-11	Riluzole in Motor Neurone Disease (Shared Care Protocol)	1	Update
Oct-11	Methotrexate in Psoriasis (Shared Care Protocol)	2	New
Jan-12	Memantine in Dementia (Shared Care Protocol)	1	New
Jan-12	Shared Care Protocol for methylphenidate and atomoxetine in Children and adolescents	3	Update
Mar-12	Phosphate Binders for the treatment of hyperphosphataemia in adults with chronic kidney disease	1	Update
	Miscellaneous documents		
Nov-11	generic Clopidogrel - position statement	1	Update
May-11	Gluten free - non-staple	1	New
Jul-11	Low priority medicines	1	New
Jul-11	Generic lamotrigine	1	New
Sep-11	Dabigatran Position Statement	1	New
Sep-11	Sativex	1	New
Nov-11	Gonadorelin Position Statement	1	New
Mar-12	Homeopathic Medicine	1	Update
	Formularies		
Nov-11	Wound Care Product Formulary	N/A	New
Jul-11	Joint formulary - BNF chapters 1-4 and 6.	N/A	New
Oct-11	Joint formulary - BNF chapters 7 and 10-12	N/A	New
Jan-12	Joint formulary - BNF chapters 5 and 13	N/A	New

Appendix 4

NPC Plus Fitness for purpose review May 2011 - ACTIONS

Action	Priority (high/medium/low)*	Lead	Timescale	Achieved during 2011-12
1. Reaffirmation of APC mandate with member organisations and consortia including authority for decision making and review of current committee members - Update Terms of Reference*	High High	NHSNC NHSNC	31 Oct 2011	Yes
2. Update front sheet to reflect decision making process - Review decision tree	High High	NHS NC NHS NC	31 Oct 2011	Yes
3. Review information on website e.g. meeting dates, timelines for decisions, work in progress - Develop FAQ page for patients	High High	NHS NC NHS NC	31 Oct 2011	Partially – in progress
4. Develop business case for the APC*	High	NHS NC	31 Oct 2011	Yes
5. Develop and implement effectiveness measures (see appendix 3) - Review methods and contacts for dissemination of information	Medium High	 NHS NC	31 Jan 2012 31 Oct 2011	In progress Yes
6. Develop guidance for declaration of interest	Medium	LMC	31 Jan 2012	Ongoing
7. Options for lay engagement	Medium	NHS NCity	31 Jan 2012	Ongoing
8. Identify APC member training needs and ways to achieve this	Medium	NHS NCity	31 Jan 2012	Ongoing
9. Develop a 'welcome pack' for new members, providers and prescribers* - Update member responsibilities	Low* Low*	NUH NUH	31 July 2012	Ongoing

*will depend on outcome of discussions for APC mandate and membership

5th NPC Plus Fitness for purpose review May 2011 Actions agreed July 2011.