Nottinghamshire Area Prescribing Committee

Annual Report 2012/13

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EXECUTIVE SUMMARY

Key Achievements of the Nottinghamshire Area Prescribing Committee

- Completion and launch of the Nottinghamshire Joint Formulary and website
- Support to the QIPP agenda
  - Managed introduction of novel oral anticoagulants
  - Formularies
  - Horizon scanning
- Positive feedback from APC stakeholder survey

Year In Numbers

- 6 committee meetings.
- 80 medicines were classified on the Nottinghamshire Traffic Light System
- 7 *new* clinical guidelines, information sheets, shared care protocols, formularies & miscellaneous/position statements were developed and ratified.
- 22 *existing* clinical guidelines, information sheets, shared care protocols, formularies & miscellaneous/position statements were reviewed and re-approved.
- Overall the decisions that the APC made throughout 2012-13 with regard to traffic light classification resulted in an estimated saving/cost avoidance of £14million drug costs for the Nottinghamshire Health Community. See Appendix 3

Type of implication	Number of decisions	Cost implication
Savings	7	Predicted savings of £206,000 for the Notts Health Community
Cost avoidance	40	Cost avoidance of £14million
Cost neutral	11	Nil
Cost implications	17	£48,000 to date

Future Priorities for 13-14

- Continue to support QIPP and pathway redesign.
- Implement actions identified from the gap analysis of the NICE good practice guidance for 'Developing and Updating Local Formularies' e.g. an appeals process and inclusion on NICE TAs in the formulary
- Implement actions from the stakeholder survey

THE YEAR IN NUMBERS

Figure 1: Traffic light classification of medicines in 2012-13

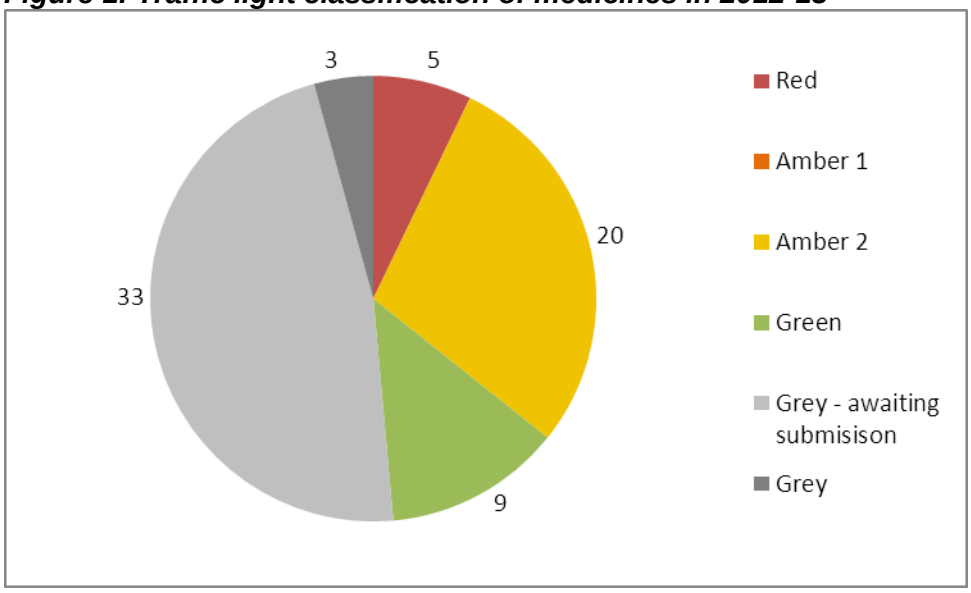


Figure 2: Documents developed/ratified by the APC during 2012-13
(See appendix 5 for further details)

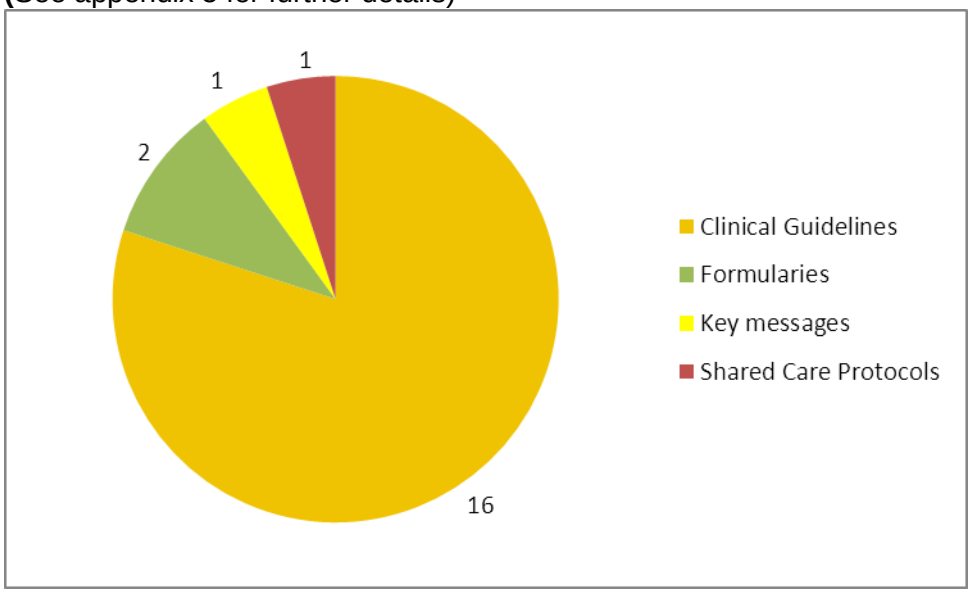


Figure 3: Nottinghamshire Joint Formulary Website Statistics

The Joint Formulary Website received 38,000 hits during 2012-13.

PURPOSE & MEMBERSHIP 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 Sherwood Forest Hospitals Foundation Trust, Nottingham University Hospitals NHS Trust, Nottinghamshire Healthcare Trust, NHS Nottinghamshire County and NHS Nottingham City.

Following the publication of the governments NHS White Paper 'Equity and Excellence – Liberating the NHS' in 2010 there have been a number of major changes to the roles and responsibilities of current NHS organisations. From the 1st April 2013 PCTs will be abolished where the commissioning responsibilities will be divided between the NHS Commissioning Board and the (authorised) Clinical Commissioning Groups (CCGs).

During 12/13 five Clinical Commissioning Groups have been operating in shadow form in NHS Nottinghamshire County (Mansfield & Ashfield CCG, Newark & Sherwood CCG, Nottingham North & East CCG, Nottingham West CCG and Rushcliffe CCG), one CCG within NHS Nottingham City (Nottingham City CCG) and one within NHS Bassetlaw (Bassetlaw CCG) (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.

Following a request for representation from community providers, Penny Keith, Long Term Conditions Specialist Nurse joined the committee as a non-medical prescriber representative from Nottingham CityCare.

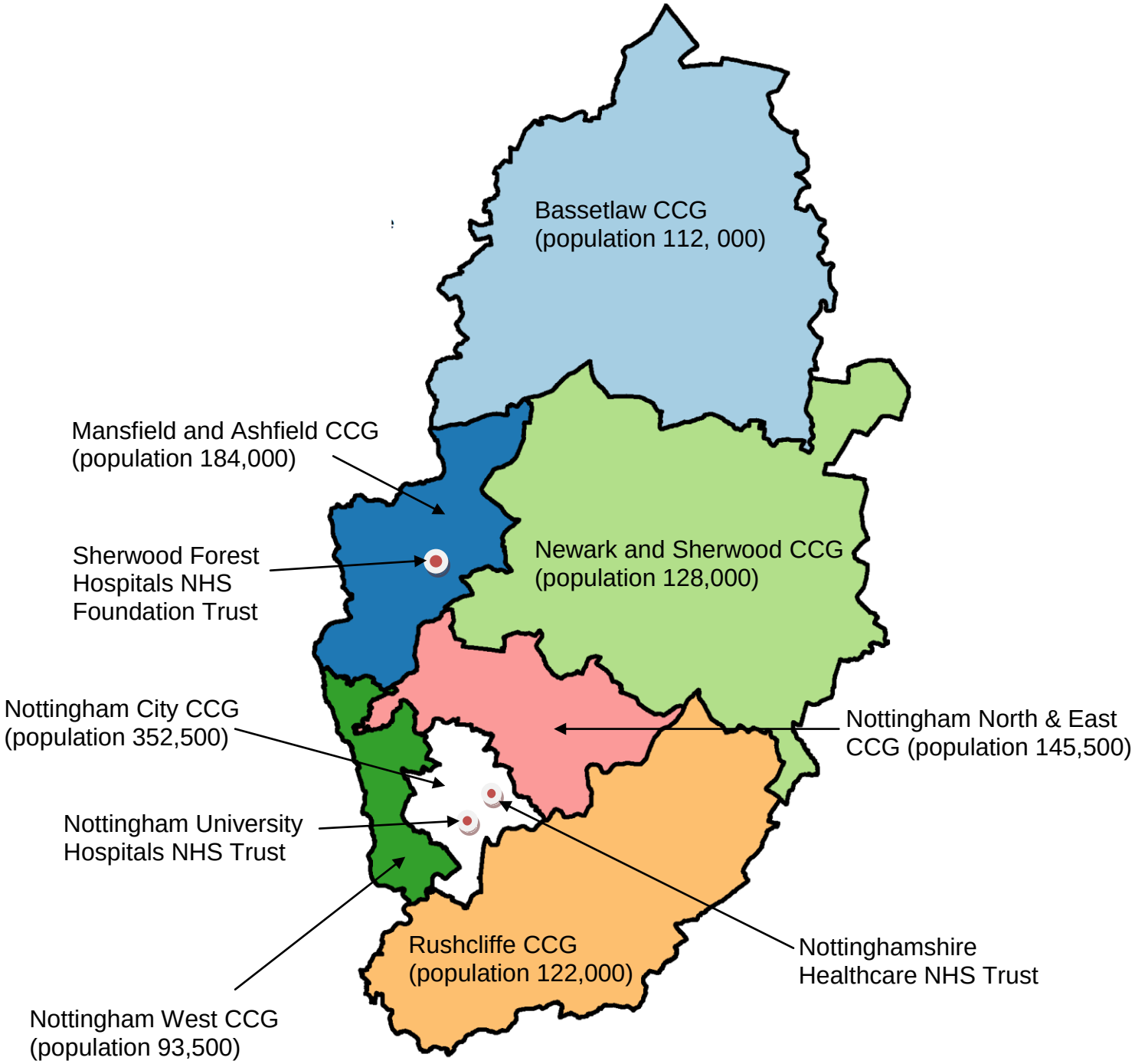
The APC is currently chaired by the Associate Director of Public Health for NHS Nottinghamshire County.

Figure 4 shows the members organisations across the counties of Nottinghamshire and Bassetlaw

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.

Figure 4 - Map of Nottinghamshire APC Member Organisations



KEY ACHIEVEMENTS DURING 2012-13

1. Completion and launch of the Nottinghamshire Joint Formulary and website

2. Support to the QIPP agenda
    i. Managed introduction of novel oral anticoagulants
    ii. Formularies
    iii. Horizon scanning

3. Positive feedback from APC stakeholder survey

1. The Nottinghamshire Joint Formulary

During 2011-12 a joint medicines formulary was developed by the Nottinghamshire Joint Formulary Group (NJFG) (sub-group of the Nottinghamshire APC) for use across primary and secondary care organisations throughout Nottinghamshire. The formulary consists of the 15 BNF chapters and was formally launched in April 2012.

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.

Initially it was hosted on an NHS website making it only available to NHS computer users or those with N3 access. Work started in the 4th quarter of 2012-13 to move the formulary to a public website which would then make it accessible to all. This was achieved in March 2013 where the formulary can now be accessed via the link www.nottinghamshireformulary.nhs.uk A full launch is planned for April 2013 to publicise that the formulary is now publicly available.

See Appendix 1 for the Specialist Interface and Formulary Pharmacists report on the achievements of Joint Formulary Group during 2012-13.

2. Support to QIPP agenda

Prescribing 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 2012 -13 through various ways. Examples include;

Managed introduction of Novel Oral Anticoagulants
During 2012/13 NICE published three positive Technology Appraisals (TAs) for the new novel oral anticoagulants (NOACs) for the prevention of stroke in patients with non-valvular Atrial Fibrillation - dabigatran (May 12), rivaroxaban (September 12) and apixaban (March 13).

There is a statutory requirement that medicines contained in positive NICE TAs must be funded within 90 days of publication. The NOACs will represent a substantial financial pressure on prescribing budgets within primary care as well as presenting challenges regarding the future commissioning of anticoagulation monitoring services.

Due to the fact that each of the NOACs are recommended by NICE for more than one clinical indication, a working group was set up to agree which one would be used first line. The working group consisted of haematology, cardiology and stroke representatives from secondary care and GP representation. Following lengthy discussion and consultation two

guidelines have been produced to define the place in therapy locally of these new agents for the treatment of deep vein thrombosis (DVT) and stroke prevention in atrial fibrillation (AF).

This collaborative approach has ensured that the NOACs have been introduced within Nottinghamshire in a managed way to maximise patient safety and minimise financial risk for the health community.

Emollient Formulary
A subgroup was convened to update the emollient formulary. The process has resulted in a formulary which will allow all member organisations to make significant cost savings whilst ensuring that a range of high quality and cost effective products are available to patients.

Self-Monitoring Blood Glucose Meter Formulary
Due to the large number and variety of blood glucose meters available in the UK, having a formulary will help health care professionals to become familiar with using specific meters and thereby assisting patients in choosing and/or using their meters correctly. The formulary was developed in collaboration with a number of stakeholders including patients and diabetes nurse specialists.

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. During 2012-13 horizon scanning has been expanded to include the relevant NICE publications and safety updates to facilitate the managed introduction of new medicines throughout the Nottinghamshire Health Community.

Medicines that were previously highlighted through horizon scanning were classified as 'grey –awaiting assessment'. This definition has since been updated to more accurately reflect what is happening in practice where these medicines are now classified as 'grey – awaiting submission'.

Patient Safety
The examples above also highlight the way in the APC has potentially contributed to minimising patient harm. Although difficult to quantify, by having prescribing guidelines, formularies and accessible resources prescribers are able to access quality information to assist them in prescribing safely to patients.

3. APC stakeholder survey

The stakeholder survey was repeated in October 2012 to find out whether the actions identified in 2010 had been addressed and to assess the overall perception of the APC two years on. The survey did not use the same questions from the 2010 survey and focused on the changes that had been made since the previous survey.

Headline findings;

- There were 149 responses to the survey (compared to 58 responses to the 2010 survey) and all stakeholder organisations were represented.
- 95% of respondents were aware of the APC and JFG. There is currently more use of the APC website than the Joint Formulary website. Most respondents found both websites useful.
- There were some functions of the APC which respondents were not aware of such as horizon scanning.

- Interest was shown by respondents in the development of a mobile device application for the APC & Joint formulary

The results of the survey will be incorporated into the 2013/14 APC action plan. See Appendix 2 for the survey report.

Specialist Interface & Formulary Pharmacist resource

During 2012-13 one of the two Specialist Interface & Formulary Pharmacists commenced maternity leave. Cover was recruited in January 2013 and will be in place on the 1st April 2013 to ensure continued delivery of the objectives agreed in the APC work programme.

FINANCIAL IMPLICATIONS OF APC DECISIONS TO PRESCRIBING BUDGETS FOR 2012 - 13

Over the last three financial years within primary care there has been a trend of increasing prescription items coupled with a reduction in prescribing costs of between 2 – 4% per annum.

Overall the decisions that the APC made throughout 2012-13 with regard to traffic light classification and inclusion in the formulary resulted in a net saving/cost avoidance of £14million drug costs for the Nottinghamshire Health Community.

Table 1: Financial implications of APC decisions to prescribing budgets 2012 – 13

Type of implication	Number of decisions	Cost implication
Savings	7	Predicted savings of £206,000 for the Nottinghamshire Health Community
Cost avoidance	40	Cost avoidance of £14million
Cost neutral	11	Nil
Cost pressure	17	£48,000 to date

The details of this, including the sources used to calculate this figure, are contained in Appendix 3.

Savings
Potential savings of £206K have been identified from APC decisions. These relate to the review of the Emollient Formulary and the use of rivaroxaban in place of low molecular weight heparins for the treatment of DVT. The Emollient Formulary was approved at the end of 12/13 so the full impact cannot yet be measured where organisations are encouraged to implement early in 13/14 to maximise savings.

Cost avoidance
Cost avoidance is defined when a medicine (either a new medicine or clinical indication) is not accepted on to the formulary or it is given a 'grey' or 'grey awaiting submission' classification. The financial implication of cost avoidance is calculated using intended patient numbers from submissions/business cases or NICE / New Drugs Online cost calculators and is based on full year effect. This classification is carried out as part of horizon scanning.

For 12/13 there was significant cost avoidance of £14,330,365 (full year effect) for medicines that are indicated for use predominantly in primary care. Much of this amount was the result of two high cost and high volume drugs; linaclotide (for IBS) and Zostavax® (shingles vaccine) both which were classified as 'grey awaiting submission'.

Cost pressure
Decisions made by the APC during 12/13 resulted in a predicted cost pressure of £508,000 per annum. However a review of prescribing (EPACT & secondary care prescribing data) data suggests that in reality these decisions resulted in a cost pressure of only £48,489 for the Nottinghamshire health community.

The largest contributors to the cost pressure were from ivabradine and eplerenone (both for heart failure) and rivaroxaban (for atrial fibrillation). Both ivabradine and rivaroxaban received positive NICE technology appraisals in 2012-13 so must legally be funded by commissioners, and are therefore an unavoidable pressure. The APC has collaborated closely with relevant clinicians to manage the introduction of these medicines to ensure that their place in therapy on a local level is clear to all prescribers thereby managing the cost impact to organisations.

Cost neutral

An assessment of these decisions suggests that they were in general cost neutral for the Nottinghamshire Health Community. There may be a slight shift between primary and secondary care but overall for the health community the decision will be cost neutral. Some examples include:

- Clarification that CoaguChek® test strips can be prescribed in the community following specialist initiation
- Initiation of ropinirole or pramipexole in primary care for restless legs. Previously it was recommended that these drugs were initiated by a specialist. By allowing initiation in primary care, referrals will be reduced as neurologists don't consider these patients require specialist input.

In both examples the place in therapy was defined so that prescribing and referrals are appropriate.

Summary of the financial implications of decisions made by the APC

Overall the APC has successfully managed the financial exposure risk for member organisations by facilitating the managed introduction of new medicines or clinical indications for existing medicines. The horizon scanning activities of the APC via the JFG has significantly increased in 12/13 and in conjunction with increased functionality of the Joint Formulary this information has been shared with member organisations.

APC decisions during 12/13 have resulted in savings, although these have been slightly lower this year compared to 11/12 as many of the big savings have already been achieved. The main focus of the APC has been in relation to minimising the cost implications of three NICE Technology appraisals for NOACs. The APC will continue to engage with member organisations in 13/14 to identify areas that may result in savings. In summary; the APC has made decisions which result in significantly more cost savings/avoidance in relation to decisions which result in cost pressures.

REVIEW AGAINST PRIORITIES IDENTIFIED IN 2011-12 ANNUAL REPORT

Implement the actions identified in the NPC Plus Fitness for purpose review
Lay engagement was highlighted as a priority, however it has not been possible to progress this due to capacity issues within the interface team. The capacity issues will be resolved in 2013-14 therefore there will be an opportunity to begin work on this action.

The outstanding actions from the NPC plus review will be incorporated to the recent gap analysis undertaken against the NICE Good Practice Guide 'Developing and Updating Local Formularies' to produce the APC action plan for 2013-14.

Develop financial monitoring of APC decisions
During 12-13 the APC agreed a financial mandate with the Nottinghamshire County CCGs to make decisions up to the value of £10K per CCG. For Nottingham City CCG the threshold is 100K per decision. Further work is now needed to establish a process with the CCGs for approving APC decisions that exceed the financial thresholds to ensure that the timeliness of decision making is not affected.

Horizon scanning has become more effective so that cost implications e.g. from NICE TAs can be highlighted to member organisations at an earlier stage in the process.

Improve engagement and consultation with CCGs
Improvement was made during 2012-13 within this area but continues to be a challenge. Communication links were constantly reviewed and updated in line with NHS structural changes throughout 2012-13.

The APC now publishes a forward work programme & work in progress on the APC website to make the work of the APC more transparent and encourage engagement from all stakeholders. It is updated on a monthly basis (usually in the last week of the month) and all interested clinicians within the Nottinghamshire health community are encouraged to contact the APC if they would like to be included in the consultation process

Rivaroxaban/dabigatran/apixaban for AF
This area of work was a high priority and a managed introduction of these medicines was achieved during 2012-13.

The Nottinghamshire Joint Formulary
The joint formulary was successfully launched in April 2012 and has been available to the NHS community as an interactive electronic resource during 12/13.

FUTURE PRIORITIES FOR 2013-14

- Continue to support QIPP and pathway redesign.
- Implement actions identified from the gap analysis of the NICE good practice guidance for 'Developing and Updating Local Formularies'
- Implement actions from the APC stakeholder survey

QIPP and pathway redesign

Supporting and identifying QIPP initiatives for prescribing will continue to be a priority for the APC in 13/14. The APC work programme is widely circulated through the CCG medicines management teams in order for CCGs to raise prescribing issues that can be addressed by the APC. This will continue in 2013-14.

NICE Good Practice Guide: Developing and Updating Local Formularies'

NICE started consulting on their good practice guide to the development of formularies during 2012 -13. The Nottinghamshire APC submitted written evidence early on in the consultation regarding the processes used. A member of the interface team was invited to give evidence to the development committee as the Nottinghamshire APC had been considered an area of good practice.

The good practice guide was published in December 2012. A gap analysis was performed using the good practice guide and actions agreed by the committee (see Appendix 4).

Key actions include;
- Establishing a process for reconsideration and appeals of decisions
- Update the terms of reference to include lines of accountability and reporting arrangements
- Review the submission form template against the 'setting decision' criteria

These actions will form the basis of the APC 2013/14 action plan.

2012-13 APC Stakeholder survey

The findings of the stakeholder survey will be incorporated into the 2013/14 APC action plan.

Key actions include;
- Improve communication with secondary care doctors at all levels
- Raise awareness of the websites, especially the Joint Formulary website

APC Committee Members

Dr Mark Devonald	NUH DTC Chair	Nottingham University Hospitals NHS Trust
Sarah Pacey (deputy Deborah Storer)	Assistant Chief Pharmacist	
Dr David Kellock	SFHFT DTC Chair	Sherwood Forest Hospitals NHS Foundation Trust
Steve May (Deputy Steve Haigh)	Chief Pharmacist	
Cathy Quinn (Chair)	Associate Director of Public Health	NHS Nottinghamshire County & NHS Bassetlaw
Dr Chris Kenny (Acting Chair)	Director of Public Health	
Nicky Bird	Senior Prescribing Advisor	
Tanya Behrendt	Deputy Head of Medicines Management	NHS Nottingham City Clinical Commissioning Group
Dr Esther Gladman	GP prescribing lead	
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 Felicity Armitage	GP –LMC	LMC
Penny Keith	Clinical Nurse Specialist – Long Term Conditions (from November 2012)	Nottingham CityCare – Non Medical Prescriber
John Lawton	Senior Pharmacist (South)	Nottinghamshire Healthcare NHS Trust
Sangeeta Bassi	Senior Pharmacist (North)	

(Deputies are acknowledged above where they have attended)

The Nottinghamshire APC is managed and supported by;

Nicky Bird, Senior Prescribing and Interface Advisor, Shared Medicines Management Service, hosted by NHS Mansfield and Ashfield CCG on behalf of Nottinghamshire County CCGs
Amanda Rawlings, Prescribing Interface Advisor, Shared Medicines Management Service, hosted by NHS Mansfield and Ashfield CCG on behalf of Nottinghamshire County CCGs
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

Acknowledgements

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 2012/2013

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 purpose of the group is to lead on the development, maintenance and review of the Nottinghamshire Joint Formulary by:

- Making evidence-based recommendations for the inclusion of medicines, medical devices, wound care products and dietary products on the Nottinghamshire Joint Formulary
- classifying of these products within the Nottinghamshire Traffic Light system

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 currently 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 whole time equivalent (WTE) Specialist Interface and Formulary Pharmacists (SIFPs). One post is based at Sherwood Forest Hospitals NHS Foundation Trust and the other at Nottingham University Hospitals NHS Trust. The final 5 months of the year, the JFG operated with one 0.6 WTE SIFP due to maternity leave.

Meetings

There have been six meetings of the NJFG with good attendance from all organisations and professional groups.

Key Achievements

Launch of the Nottinghamshire Joint Formulary

The Joint Formulary was launched in Nottinghamshire Primary Care organisations on 2nd April 2012. This built on the work in the previous year to establish core chapter contents and promotion within the large acute Trusts.

A key achievement of this year has been the publication of the Joint Formulary on the internet. This ensured that APC stakeholder organisations met the Department of Health requirement to publish local formularies by the 1st April 2013.

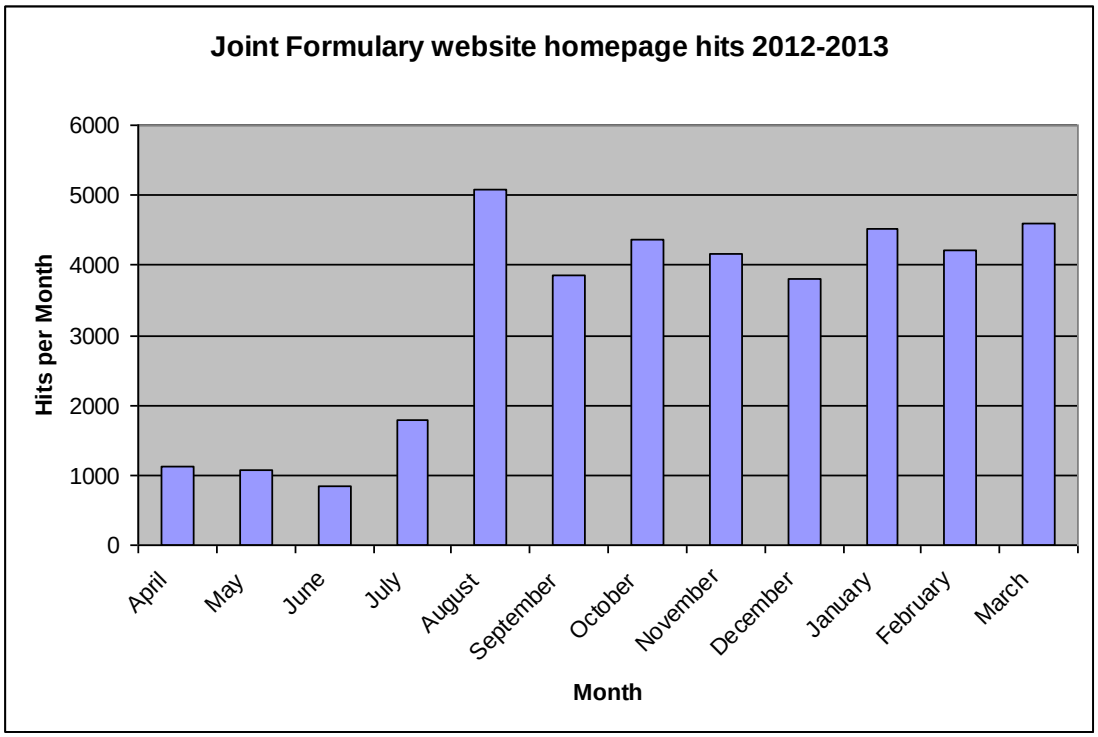
The formulary provides an online searchable database of medicines available to prescribers in Nottinghamshire with associated guidance. It is intended for use by health professionals in primary and secondary care, across all stakeholder organisations. The website address is: http://www.nottinghamshireformulary.nhs.uk

The main aims of the Joint Formulary are to:

- To promote safe, clinical and cost effective prescribing ensuring that there is consistency in access to medicines across the Nottinghamshire Health Community.
- To support the QIPP programme within the Nottinghamshire Health Community.
- To promote a seamless approach to medicines, aligning prescribing across the primary/secondary care interface.
- To encourage generic prescribing where appropriate.

The Formulary website traffic has increased substantially in the past year, from approximately 1,000 homepage hits per month in spring 2012 to 4,000 per month from August 2012 to March 2013. See chart 1 below:

Chart 1: Joint Formulary Homepage hits (2012-2013)



Chapter reviews and Traffic light classifications

Four BNF chapters have been through a process of review, consultation and ratification in this financial year. They are:

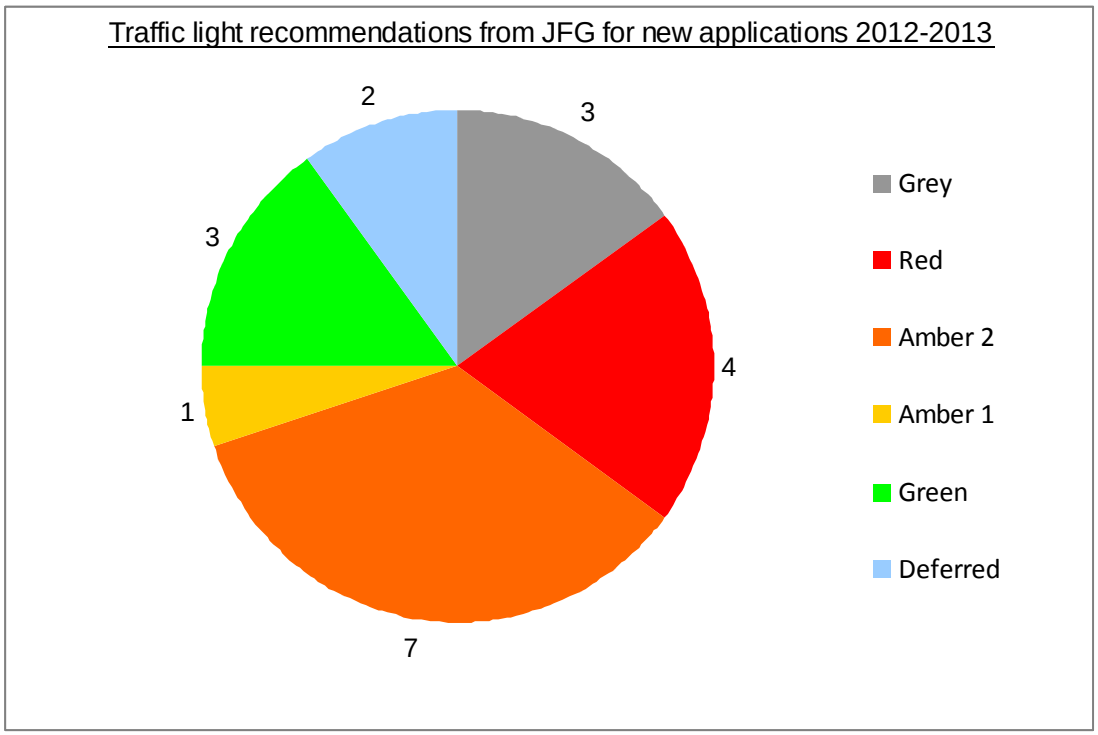
- chapter 8 (Malignant disease and immunosuppression)
- chapter 9 (Nutrition and blood)
- chapter 14 (Immunological products and vaccines)
- chapter 15 (Anaesthesia)

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.

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. An independent review of the evidence is used if available or carried out by the SIFP if not. Prior to this year the SIFP carried out independent reviews for all submissions, but a review of priorities and capacity issues within the interface team led to this change in practice. This change in practice is in line with the recommendations made within the NICE good practice guide for formulary development. Following the process of formulary consideration, recommendations for traffic light classifications are made, which are sent to APC for ratification.

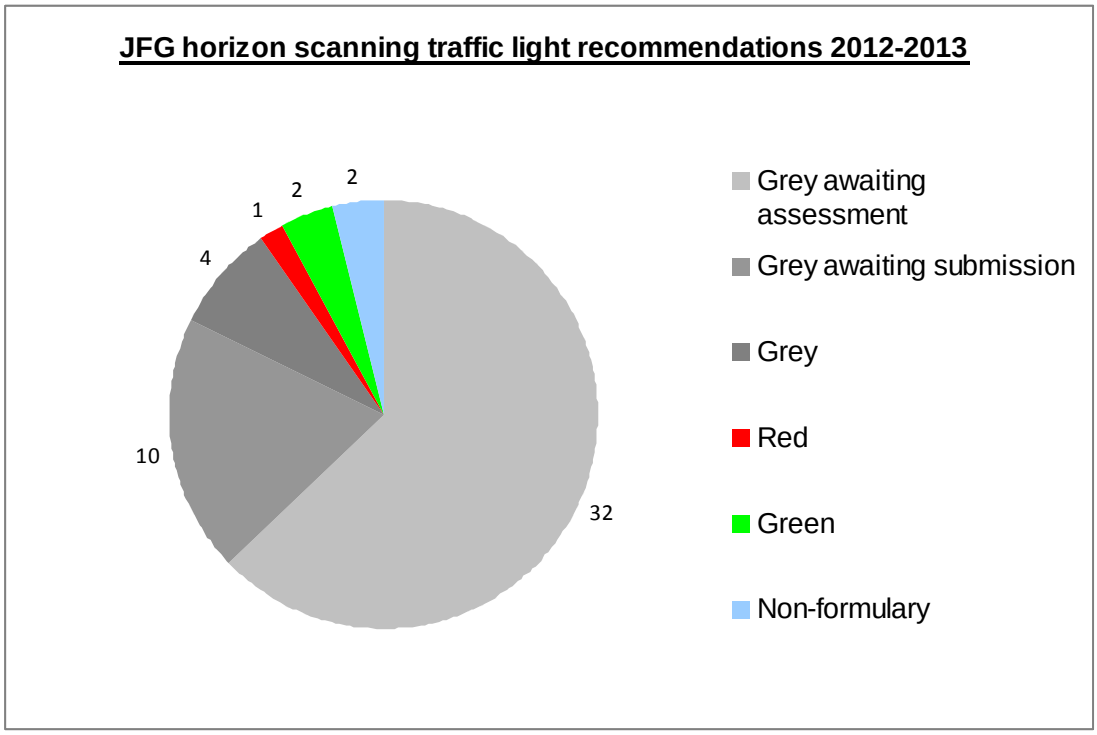
20 new applications were reviewed by the NJFG and outcomes are detailed below:



Horizon scanning.

All new medicines, or new indications for existing medicines, 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.

Traffic light recommendations have been made for 51 medicines as a result of horizon scanning activities at JFG. The details of which shown below:



Prescribing guidelines and prescribing position statements

A significant number of prescribing guidelines and prescribing position statements have been lead by, developed, updated or supported by the Specialist Interface and Formulary Pharmacists (SIFP). These include guidance for vitamin D in adults, buccal midazolam in children, common infections and infestations in primary care and prescribing information for enoxaparin for deep vein thrombosis, rivaroxaban for deep vein thrombosis and metolazone discontinuation. A full list of ratified documents, many of which the SIFPs have contributed to is listed in Appendix 5.

Changes to traffic light definitions

The JFG recommended altering the traffic light classification definitions to clarify the positions of medicines on the formulary. A classification of *Grey (awaiting submission)* was added, with the intention to clarify across the interface those medicines where a submission had not been received. The definition of non-formulary was also clarified.
The JFG recommended changes to the amber classifications with Amber 2 becoming "*specialist initiation / recommendation"* and Amber 3 being introduced as "*Primary care / non specialist may initiate as per APC guideline".*

Review against priorities identified in 2011-2012 report

The managed introduction of the new oral anticoagulants

The SIFPs have been instrumental in developing guidance across the interface regarding the new oral anticoagulants. This work was necessary to interpret NICE guidance, ensure appropriate use of these agents and ensure cost avoidance. Guidance has been developed for anticoagulant choice in atrial fibrillation, process defined for initiation of new patients, prescribing information for GPs produced and budget impact modelling carried out. The cost

avoidance associated with this work is show in Appendix 3. Work in this area will continue to be a priority in 2013-2014.

Joint formulary chapter development

Identified chapters were ratified by APC on schedule.

Access to Joint Formulary

Interim measures were put in place to improve access to the Joint Formulary in summer 2012. Publication of the formulary on the internet has facilitated unrestricted access from all stakeholder organisations.

Monitoring adherence to the formulary

The monitoring of adherence to the formulary will continue to be the responsibility of the APC stakeholder organisations. The APC annual report contains data regarding the impact of APC decisions related to the formulary.

Maintenance phase of the formulary

Development of this process is still in progress. New submissions and new national guidance has prompted formulary section review where appropriate

Insulin analogues

Recommendations regarding use of insulin analogues have been incorporated into the updated diabetes guidelines and the formulary to supporting this QIPP item.

Vitamin D guidance, Paediatric Specials Formulary and primary care enoxaparin

Guidance for prescribing of vitamin D in adults and enoxaparin were ratified by the APC in 2012. The paediatrics “specials” prescribing workstream is ongoing.

Future Priorities of the NJFG

- The Nottinghamshire Joint Formulary remains a key priority. The Formulary is a dynamic resource and will be updated on a continuous basis.
- NICE Good Practice Guide for Formulary development – ensure NJFG process are in line with the guide (including adherence to NICE TAs)
- Consultation and ratification of the unlicensed chapter of the formulary. This work will include the topic of paediatrics “specials” prescribing.
- Increase use of the formulary within both primary and secondary care
- Poisoning and enteral feeding chapters are also scheduled for consultation and ratification.
- The development and updating of prescribing guidelines and shared care protocols will continue

James Sutton, Specialist Interface & Formulary Pharmacist May 2013

Appendix 2

Nottinghamshire Area Prescribing Committee Survey – October 2012

Background to the Survey

The Nottinghamshire Area Prescribing Committee (APC) carried out a survey in 2010 which identified lack of communication of APC decisions and the bureaucratic nature of the APC process, which were perceived to be slow, as issues. The responses informed the APC development strategy and ultimately resulted in the development of the APC website, the Joint Formulary website and improvement in communication with both primary and secondary care. During this time there were also two Specialist Interface and Formulary Pharmacists appointed, with one based in each of the acute trusts to support the work of the APC.

The 2012 survey has been carried out to find out how these actions have addressed the issues identified in the 2010 survey and how effective the developments have been. The survey wasn't simply the same survey and focussed on the changes we had made since the previous survey.

As in the first survey, respondents were asked how they thought the APC and JF could be improved. This will inform the development during the next year.

Summary of Findings

- Approximately 3 times as many respondents to 2012 survey compared to 2010
- All of the stakeholder organisations were well represented.
- Several professional groups such as junior hospital doctors and hospital consultants were under represented.
- 95% of respondents were aware of the APC and the JFG
- 71% of respondents were happy with the level of communication they receive from the APC.
- 24% of respondents would like more communicaiton from the APC
- There is some uncertainty amongst respondents regarding how the APC decisions relate to them or their organisation.
- 63% of respondents have used the APC website
- 52% of respondents have used the JF website
- 80% of respondents who had used the APC website found it very useful or slightly useful
- 79% of respondents who had used the JF website found it very useful or slightly useful
- 64% of respondents who had used the APC website found it very easy or easy to use
- 65% of respondents who had used the JF website found it very easy or easy to use
- Approving SCPs, assessing the evidence to determine if medicines are suitable for prescribing, assigning a traffic light status & ensuring the cost effective management of medicines within the health community were deemed to be high priority for the APC by respondents
- Management of the joint formulary & Horizon scanning and processes for introduction of new drugs were deemed to be medium priority for the APC by respondents.
- 41% of respondents who expressed an opinion regarding the future development of the APC suggested the development of a mobile application.

Summary of Recommendations

- Improve communication with secondary care doctors at all levels
- Identify groups who are currently not receiving bulletins in all organisations and update mailing lists.
- Increase awareness of the relevance of APC decisions amongst relevant staff in all organisations.
- Raise awareness of the website, especially the Joint Formulary Website.
- Raise profile of importance of horizon scanning and the managed introduction of new medicines.
- Raise profile of the Joint Formulary

Scope the development of a Joint Formulary mobile application.

Decisions with likely COST NEUTRAL implications for the whole health community

Medicine	Date	Indication	Classification	Predicted cost Implications for member organisations	Actual cost implications for primary care	Comments / assumptions
Colecalciferol (Desunin®)	Mar-13	Vitamin D deficiency	Green	Replaces a product already prescribed with similar cost	Too early to tell from prescribing data	To be added to Vit D guideline as offers advantages over current products
Metyrapone	Nov-12	Cushing's Disease	Amber 2 (Specialist recommendation)	None -	Cost has increased from £2K to £6K per annum although items have remained static. The majority of prescribing is within City CCG.	Pragmatic decision as prescribing was already occurring in primary care
Coaguchek®	Nov-12	Self testing INR	Amber 2 (specialist recommendation)	None -	Increase from £60K per annum to £65K per annum	Pragmatic decision as prescribing was already occurring in primary care
Silicone dressings	Sep-12		Grey - unless used in line with cosmetics policy	Mainly primary care. Current annual spend c£15K	There has been a reduction in prescribing of £4.5K (27.73%) - in County CCGs whereas prescribing has remained static within City CCG	Can only be prescribed in line with cosmetic procedures policy
Ropinirole	Sep-12	Restless legs	Amber 2 (GP initiation)	Already Rxed in primary care. May help rationalise referrals	Not able to assess as multiple indications and price fluctuations. Items are increasing which has resulted in increased costs of pramipexole but reduced costs for ropinirole.	Pragmatic decision as it was acknowledged prescribing was already occurring in primary care
Pramipexole	Sep-12	Restless legs	Amber 2 (GP initiation)			
Risperidone (Risperdal Consta®▼)	Jul-12	Schizophrenia	Amber 2 (specialist initiation)	Rxing will move from secondary to primary care	Small amount of relatively static prescribing in primary care.	No prescribing has been moved at present.
Fexofenadine	Jul-12	Urticaria in adults	Green	Very small cohort of patients therefore minimum impact. May reduce referrals	Small increase in items but large increase in cost which is unlikely to be attributable to this indication. Unable to calculate due to multiple indications although only a small proportion is likely to be for this indication.	Currently a level of prescribing which would suggest that this is being prescribed for other indications eg hayfever. Review formulary wording.
Venlafaxine (≥ 300mg)	May-12	Severe depression	Amber 2 (Specialist Initiation)	None	Unable to tell from prescribing data due to no specific product for high dose treatment.	
Lamotrigine	May-12	Bipolar disease	Amber 2 (Specialist Initiation)	None	Unable to tell from prescribing data as multiple inidications.	
Exenatide once weekly (Bydureon®▼)	May-12	Type 2 diabetes	Amber 2 (Specialist Initiation)	None	Modest increase. Unable to tell from prescribing data as prescribing of GLP1s overall continues to increase significantly year on year.	Is an alternative to the daily administered preparations.

Decisions with a COST PRESSURE for the whole health community

Medicine	Date	Indication	Classification	Predicted cost pressure for health community	Actual cost pressure for primary care organisations during 2012-13	Actual cost pressure for secondary care organisations during 2012-13	Comments
Ganciclovir eye gel (Virgan®)	Nov-12	Herpes simplex keratitis	Amber 2 (Specialist recommendation)	Minor cost pressure	Increase of £200 to £1K per annum	N/A	
Linezolid (Zyvox ▼®)	Nov-12	Infections on advice of microbiologist	Amber 2 (Specialist recommendation)	Minor cost pressure due to very small patient numbers	Reduction in prescribing from £6K to £4K		Low volume expensive drug therefore small fluctuations in patient numbers can have a significant impact on budget.
Tapentadol (Palexia ▼®)	Nov-12	Opioid - 5th line	Amber 2 (Specialist initiation)	Likely to be substantial but will be dtermined by place in therapy.	Increase of £3K to £7.5K per annum. Majority of prescribing (97%) is within the County CCGs.	£2,639, with the majority of prescribing being at NUH.	Cost pressure is likely to be significant and primary care organisations may wish to audit prescribing to ensure it is in line with the formulary indication. The previous red classification had restricted prescribing due to secondary care budgetary contraints.
Rivaroxaban (Xarelto® ▼)	Nov-12	Stroke prevention AF	Amber 2 (specialist recommendation)	£1, 635, 488 from APC front sheet if used in line with NICE. By using as per the guideline this amount id reduced significantly to approximately £300K	Increase from nil prescribing to £4K per annum of the 20mg stroke prevention and DVT treatment dose.	£2,828 with the majority of prescribing being at NUH	Although the increase in prescribing has so far been modest, this class of drugs represent a significant cost pressure to the primary care prescribing budget.

Medicine	Date	Indication	Classification	Predicted cost pressure for health community	Actual cost pressure for primary care organisations during 2012-13	Actual cost pressure for secondary care organisations during 2012-13	Comments
Ivabradine (Procorolan▼®)	Nov-12	Heart failure	Amber 2 (specialist recommendation)	£20,000	Increase of £21k to £90K per annum.	N/A	NICE cost calculator estimated 67 patients would be eligible and 33 would be treated with an increase in drug cost of £20,000K. NB is also on formulary for angina so some of the increase may be attributable to that.
Eplerenone (Inspra®▼)	Nov-12	Heart failure	Amber 2 (specialist recommendation)	£165,000 for 300 patients (APC front sheet).	Increase of £11K to £61K per annum.	£5,862	Unclear as approved indication was restricted compared to submission.
Fluenz▼® (Influenza vaccine)	Sep-12	Influenza prophylaxis	Green	Unclear	nil	N/A	Availability issues and not part of immunisation programme at present. Will be part of immunisation schedule for children from September 2013.
Rivaroxaban (Xarelto®▼)	Jul-12	Stroke prevention AF	red	see above	see above	see above	RED was a holding classification to ensure formulary compliance with NICE TA whilst local guidelines were developed.
GLP 1 in combination with insulin	Jul-12	Type 2 diabetes mellitus	Amber 2 (Specialist initiation as per guideline)	GLP1 continue to be a significant cost pressure on the prescribing budget for primary care.	Unable to assess from prescribing data acannot tell if used in combination with insulin.	Unable to assess from prescribing data acannot tell if used in combination with insulin.	When added in to insulin (not licensed if insulin added to GLP 1)
Tredaptive®▼ (Nicotinic acid & laropiprant)	Jul-12	1st line monotherapy for patients with high lipoprotein A.	Amber 2 (specialist initiation)	£13,000 for primary care from submission /front sheet	Increase of £2K to £6K per annum	N/A	Was withdrawn due to safety concerns in 2012

Medicine	Date	Indication	Classification	Predicted cost pressure for health community	Actual cost pressure for primary care organisations during 2012-13	Actual cost pressure for secondary care organisations during 2012-13	Comments
Tolcapone (Tasmar®)	May-12	Parkinson's disease	RED	NUH - £8k per annum based on 4 patients in submission	Increase of £400 to £1K. Majority of prescribing in the City CCG.	Unclear, but likely to be less than the submission.	Small numbers of patients
Timolol Topical (Timoptol LA®)	May-12	Paediatric haemangioma	RED	NUH - £575 per year based on 23 patients in submission	N/A	Unable to assess due to multiple indications	
Dabigatran (Pradaxa®▼)	May-12	Stroke prevention AF	RED	Minor	Increase from 1k to £5k per annum for the stroke prevention dose of 150mg	£76	RED was a holding classification to ensure compliance with NICE TA whilst local guidelines were developed.
C1 esterase inhibitor (Cinryze▼®)	Jul-12	Hereditary angioedema - prophylaxis	red	Not given	N/A	£1,600 - £3,600. All prescribing at SFHT.	Small number of patients, high cost drug, PBR excluded
Gaviscon advance®	May-12	Larynogopharyngeal reflux (LPR)	Amber 2 (Specialist Initiation)	Unclear as approved indication was restricted compared to submission.	Reduction of £9K per annum to £267,453	N/A	Cannot interpret prescribing information as this is a high volume product with multiple indications.
Naltrexone	May-12	Alcohol detoxification	Amber 2 (Specialist Initiation)	Unlikely to be a large cost pressure.	Increase of £319 to £2400	N/A	
Menveo Vaccine (meningococcal▼)	May-12	Post splenectomy	GREEN	1,444 (from submission)	Increase of £570 to £928 per annum	N/A	As per green book
Total				**£508,019**	**£35,489**	**£13,000**	

Decisions which facilitate cost AVOIDANCE across the whole health community

Medicine	Date	Indication	Classification	Potential cost avoidance for health community	Did any prescribing take place? Details of cost.	Comments/assumptions/source
Aciclovir Lauriad (Sitavig®)	Mar-13	Recurrent labial herpes in immunocompetent patients	Grey - awaiting submission	Unable to quantify - cost unknown	Too early to assess from prescribing data	Cost unknown
Ibuprofen & famotidine (Duexis®)	Mar-13	Osteoarthritis, rheumatoid arthritis & ankylosing spondylitis	Grey - awaiting submission	Unable to quantify. Likely to be modest cost avoidance.	Too early to assess from prescribing data	Cost unknown
Ingenol mebutate (Picato®)	Mar-13	Actinic keratosis	Grey - awaiting submission	£8,750	Too early to assess from prescribing data	The NICE New Medicine Summary - the manufacturer expects 35 patients per 100,000 to use per year, which equates to 350 patients locally. £25 more expensive than current treatment options used locally.
Normegestrol & beta estradiol (Zoely®)	Mar-13	Contraception	Grey - awaiting submission	Unable to quantify. Likely to be modest cost avoidance.	Too early to assess from prescribing data	Cost unknown
Saxagliptin & metformin (Komboglyze®)	Mar-13	Type 2 Diabetes	Grey - awaiting submission	Unable to quantify. Likely to be modest cost avoidance.	Too early to assess from prescribing data	£31.60 per month. Similar to other products it would replace.
Azelastine & fluticasone (Dymisata®)	Mar-13	Allergic rhinitis	Grey - awaiting submission	Unable to quantify. Likely to be modest cost avoidance.	Too early to assess from prescribing data	Cost unknown
Mirabegron (Betmiga®)	Mar-13	Overactive bladder	Grey - awaiting submission	Unable to quantify. Likely to be modest cost avoidance.	Too early to assess from prescribing data, however we are aware of requests to primary care from secondary care.	£29 for 30 tabs which is similar price to others.

Medicine	Date	Indication	Classification	Potential cost avoidance for health community	Did any prescribing take place? Details of cost.	Comments/assumptions/source
meningococcal Group B vaccine (Bexsero®)	Jan-13	Prevention of meningococcal B	Grey - awaiting JCVI decision	Unable to quantify	Too early to assess from prescribing data	Await JCVI recommendation
Insulin degludec plus insulin aspart (DegludecPlus)	Jan-13	Type I and type II diabetes	Grey - awaiting submission	Unable to quantify	Too early to assess from prescribing data	£72 per 3x5ml. More expensive compared to other insulins. Will require work with local clinicians to decide place in therapy locally if there is no national direction.
Insulin degludec (degludec)	Jan-13	Type I and type II diabetes	Grey - awaiting submission	Unable to quantify	Too early to assess from prescribing data	More expensive compared to other insulins. Will require work with local clinicians to decide place in therapy locally if there is no national direction.
Ceftaroline (Zinfor▼®)	Nov-12	Community acquired pneumonia. Skin and soft tissue infections	Grey - awaiting assessment	Unable to quantify. Likely to be modest cost avoidance.	Too early to assess from prescribing data	
Mercaptopurin oral suspension(Xaluprine®)	Nov-12	Acute lymphoblastic leukaemia	Grey - awaiting assessment	Unable to quantify	Too early to assess from prescribing data	
Tadalafil (Cialis®)	Nov-12	Benign prostatic hyperplasia	Grey - awaiting assessment	Unable to quanify	Too early to assess from prescribing data	NICE expected June 2013
Lubiprostone (Amitiza▼®)	Nov-12	Constipation	Grey - awaiting assessment	Unable to quanify	Too early to assess from prescribing data	Cost unknown
Flutter®	Nov-12	Mucous clearance	Grey - awaiting assessment	Unable to quanify	Too early to assess from prescribing data	Device
XLS medical®	Nov-12	Slimming product	Grey	Unable to quanify	Too early to assess from prescribing data	Device. Not currently listed in drug tariff.

Medicine	Date	Indication	Classification	Potential cost avoidance for health community	Did any prescribing take place? Details of cost.	Comments/assumptions/source
Linaclotide (constella▼®)	Nov-12	IBS with constipation	Grey	£3,300,000	nil in primary care	NDO Calculator - Prevalence of IBS is about 10-15% but only a third visit their GP. About one third have IBS-C. As first in a new class of drugs and with potential for use in a large number of patients there will be interest in linaclotide which is likely to be more expensive than existing therapies for IBS-C. First line symptomatic treatment options cost <£10/month. Assume of those eligible for treatment ~33% do not respond to first line options so are eligible for linaclotide and assume cost of linaclotide is ~£60/month (£50 more than first line options but similar to prucalopride).
Powerbreathe®	Sep-12	COPD	Grey awaiting assessment	Unable to quantify. Likely to be modest cost avoidance.	£100	medical device
Alendronic Acid effervescent (Steovess▼®)	Sep-12	Osteoporosis	Grey awaiting assessment	Unable to quantify. Likely to be modest cost avoidance.	nil in primary care	
Dienogest (Visanne®)	Sep-12	Endometriosis	Grey awaiting assessment	Unable to quantify.	Too early to assess from prescribing data	
Indacaterol (Onbrez Breezhaler▼®)	Sep-12	COPD	Grey	Unable to quantify as patient numbers unclear. Likely to be modest as would replace other therapies	£3000 in primary care	£29.26 per 30 days

Medicine	Date	Indication	Classification	Potential cost avoidance for health community	Did any prescribing take place? Details of cost.	Comments/assumptions/source
Racecadotril (Hidrasec▼®)	Sep-12		Grey awaiting assessment	NICE were unable to estimate usage based on the data available therefore it is not possible to quantify.	Too early to assess from prescribing data	20 doses = £8.82
Strontium (Protelos®)	Jul-12	osteoarthritis in pts who require disease modifying therapy	Grey awaiting assessment	£306,000	Unable to assess from prescribing data due to multiple indications	£306,000 from NDO calculator.
Insujet needle free administration device	Jul-12	Diabetes	Grey awaiting assessment	Unable to quantify	nil	New device
fidaxomicin (Dificlir▼®)	Jul-12	Clostridium difficile infection	Grey awaiting assessment	Unable to quantify as place in therapy unknown.	nil prescribing in primary care	20 = £1350. Will need to compare with current treatment costs eg vancomycin. Microbiology currently discussing potential use.
nalmefene (Selincro▼®)	Jul-12	Alcohol dependence	Grey awaiting assessment	Unable to quantify as cost and patient numbers unknown	Too early to assess from prescribing data	
Solaraze® (diclofenac 3% gel)	Jul-12	Actinic keratosis	Grey	£87,000	£85,583 in primary care as this was previously classified as GREEN. There has been a slight downward trend in prescribing.	There was much prescribing in primary care therefore it will take some time of prescribing to reduce. There are more cost effective products available.
Resperate®	Jul-12	Hypertension	Grey	Unable to quantify	£243 in primary care	Medical device contained in drug tariff therefore prescribeable on FP10
asenapine (Sycrest®)	Jul-12	Bipolar disorder	Grey awaiting assessment	Unable to quantify. Likely to be modest cost avoidance.	nil	60= £102. Comparable to others in the class which it would replace.
lisdexamphetamine (Venvanse▼®)	Jul-12	Attention-deficit hyperactivity disorder (ADHD)	Grey awaiting assessment	unable to quantify - cost and patient numbers unkown	nil	

Medicine	Date	Indication	Classification	Potential cost avoidance for health community	Did any prescribing take place? Details of cost.	Comments/assumptions/source
dapaglofozin (Forxiga▼®)	Jul-12	Type 2 diabetes mellitus	Grey awaiting assessment	£295,000	nil prescribing in primary care	£295K from new drugs online calculator. £445 per patient per annum. Draft NICE guidance in February suggested it would not be recommended.Final guidance is expected in June 2013. ()
glycopyrronium inhaler (Seebri Breezhaler ▼®)	Jul-12	COPD	Grey awaiting assessment	unable to quantify as patient numbers unclear. Likely to be modest as would replace other therapies	£50 in primary care	APC have since made the decision not to include this in the formulary and have included aclidinium.
glycopyrroinum / indacaterol inhaler (Brand name unknown)	Jul-12	COPD	Grey awaiting assessment	unable to quantify as patient numbers unclear. Likely to be modest as would replace other therapies	nil prescribing in primary care	APC have since made the decision not to include this in the formulary and have included aclidinium.
Strontium (Protelos®)	Jul-12	osteoporosis in men	Grey awaiting assessment	Unable to quantify but could be large due to lack of treatment for men with osteoporosis.	Not able to assess due multiple indications	Osteoporosis guidelines currently under review.
perampanel (Fycompa®)	Jul-12	adjunctive therapy of refractory focal seizures	Grey awaiting assessment	Unable to quantify. Likely to be modest cost avoidance with small patient numbers	nil prescribing in primary care	£140 per month. Would be add on in a small number of niche patients
azilsartan (Edarbi▼®)	Jul-12	Hypertension	Grey awaiting assessment	Unable to quantify. Likely to be modest cost avoidance as m	£16 in primary care	£17 per month. Many alternative drugs in this class already available generically.
sodium hyaluronate injection (SportVis®)	Jul-12	Ankle sprains and lateral epicondylalgia of the elbow.	Grey awaiting assessment	unable to quantify as demand not clear and appears to be marketed at sport physio market	nil prescribing in primary care	Unlikely to be large demand for this.

Medicine	Date	Indication	Classification	Potential cost avoidance for health community	Did any prescribing take place? Details of cost.	Comments/assumptions/source
Varicella Zoster virus vaccine (Zostavax▼®)	Jul-12	Prevention of shingles and post-herpetic neuralgia.	grey for use on NHS (as available for private prescription only)	£10,333,615	£88,000 in Primary care.	Based on £99.96 per course. Licensed for use in patients aged over 50. There are 345183 patients aged 50+ in Notts healthcare community. If 50% uptake in all groups would be: £17,252,246 Is likely to be less than £55 per dose once introduced into the vaccination schedule which is the price at which the JCVI found the injection to be cost effective. JCVI is recommending that all 70 year olds are vaccinated with a catch up of those up to age 79 and cost will be £6,918,631 including catch up
Linagliptin (Trajenta®▼)	May-12	Type 2 diabetes	Grey	Unable to quantify. Likely to be modest cost avoidance.	£9381 in primary care	Would replace prescribing of other similarly priced products.
Eplerenone (Inspra®▼)	Sep-12	NYHa Class II (chronic) heart failure with LVD (LVEF <30%).	Grey awaiting assessment		Has since been classified as Amber 2 therefore in cost pressure section. Modest amounts of prescribing prior to decision.	
aclidinium (Eklira Genuair▼®)	Jul-12	COPD	Grey awaiting assessment		Has since been classified as Amber 3 therefore in cost pressure section. Modest amounts of prescribing prior to decision.	
ivacaftor (Kalydeco▼®)	Jul-12	Treatment of CF in pts age 6 years & older who have a G551D mutation in the CFTR gene	Grey awaiting assessment	N/A	National commissioning	Very high cost drug with low patient numbers.
Total				**£14,330,365**	**£100,790**	

Decisions which facilitate cost SAVINGS across the whole health community

Medicine	Date	Indication	Classification	Predicted savings for health community	Actual cost savings for member organisations	Comments / assumptions
Ketorolac eye drops (Acular®)	Mar-13	Post operatively after eye surgery	Amber 2	£2,200 for secondary care	Too early to assess from prescribing data	
QV lotion	Mar-13	Emollient	Green	Modest cost saving	Too early to assess from prescribing data	Cost saving as part of emollient formulary
Zerocream	Mar-13	Emollient	Green	£47,000	Too early to assess from prescribing data	Cost saving as part of emollient formulary. Cost saving estimate from emollient formulary development group.
Zerobase cream	Mar-13	Emollient	Green	£39,000	Too early to assess from prescribing data	Cost saving as part of emollient formulary. Cost saving estimate from emollient formulary development group.
Hydromol Intensive Cream	Mar-13	Emollient	Green	Modest cost saving	Too early to assess from prescribing data	Cost saving as part of emollient formulary
Fluticasone /formoterol inhaler (flutiform®)	Jan-13	Asthma	Green for new patients	£50,000	Too early to assess from prescribing data	£167K per 336K population (industry figures). Conservative estimate of approx 1/10th of company estimate is £50K
Rivaroxaban (Xarelto®▼)	Jul-12	DVT treatment	Amber 2 (specialist initiation)	£68,000	There has been a slight increase in LMWH in primary care.	Savings will be from reduced prescribing of LMWH which is more expensive compared to rivaroxaban. There has not been the expected increase in rivaroxaban prescribing for DVT treatment and therefore the savings from reduced LMWH have not yet been realised.
Total				**£206,000**		

APPENDIX 4

NICE GOOD PRACTICE GUIDE: Formulary Development.

Nottinghamshire Joint Formulary Gap Analysis

	Recommendations		Comments	Action	Timescale
2.1	**Relationships with other decision-making bodies**				
2.1.1	When developing or reviewing the local formulary, map and understand the functions of existing medicines-related networks and decision-making groups in the local and neighbouring health economies.		Was carried out as part of APC review undertaken by NPC plus (May 2011)	Annual review	
2.1.2	Avoid duplicating work by collaborating with other local decision-making groups.		Share minutes with neighbouring CCGs. Midlands formulary group run by Peter Golightly/sharing of medicine reviews. Cross reference with APC websites.		
2.1.3	Proactively identify, consider and implement recommendations in publications from national decision-making bodies, such as NICE, taking appropriate actions (see recommendations 2.5.4, 2.6.1, 2.6.2, 2.8.2 and 2.9.1)		NICE TA are a standing agenda item on JFG/APC and picked up via horizon scanning. What about NICE CG?		
2.2	**Formulary scope**				
2.2.1	Determine the scope of the local formulary through consultation with all locally defined stakeholders. Consider the: Size of patient population to be covered, Range of healthcare treatments to be included, Range and number of partner organisations adopting the formulary		Needs to be reviewed in light of organisational changes. Not clear where NCB fits in.		
2.2.2	Ensure local arrangements actively consider:				
	Consistency of care pathway arrangements across the patient population		Cannot currently be assured and sometimes there is a North/South split alignment with the acute Trusts.	Need to engage with CCGs re pathway re-design	
	Clinical engagement		In the main there is clinical engagement with APC with good attendance at meetings	Annual review	
	Resources needed to operate formulary processes		The local health economy has invested in the APCJFG with two Specialist Interface & Formulary Pharmacist (SIFP) Posts.		
2.3	**The local formulary decision-making group**				
2.3.1	Agree and document terms of reference for the local formulary decision-making group. This should include:				
	Clarification of budgetary responsibility		Agreed via APC mandate	Annual review	
	Lines of accountability and reporting arrangements		Organisational responsibility	Update TOR for APC & JFG	
	Members' roles and responsibilities		As per TOR	Update TOR for APC & JFG	
	Declaration of interest arrangements		Agreed in TOR & specific form for completion by members as part of annual declaration.		
	Arrangements for quoracy		As per TOR	Update TOR for APC & JFG	

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	Arrangements for deputies		As per TOR	Update TOR for APC & JFG	
	Pre-meeting preparation and post-meeting actions		Not in TOR	Update TOR for APC & JFG	
	The method by which final decisions will be made, recorded and disseminated		Included in SLA with CCGs	Update TOR for APC & JFG	
	Actions of the Chair			Update TOR for APC & JFG	
	Frequency of meetings		Included in TOR	Update TOR for APC & JFG	
2.3.2	Include a locally-defined mix of members from partner organisations and key stakeholders, such as patients and the public.		Mix of members are defined in the TOR. Would like patient/lay representation but currently don't have capacity to support this.		
2.3.3	Use the National Prescribing Centre's 'Local decision-making competency framework' to ensure membership has the appropriate range of skills and expertise needed to undertake all necessary activities.			Identify training needs against NPC competency framework	
2.3.4	Hold meetings sufficiently frequently to ensure decision-making is robust and decisions are made in a reasonable and practical time frame.		APC meetings are held bimonthly with JFG meeting in between time.		
2.3.5	Ensure resources are available to undertake all functions needed as determined by the scope and geographical coverage of the local formulary.		The local health economy has invested in the APC/JFG with two Specialist Interface and Formulary Pharmacists posts.		
2.3.6	If operating a local formulary covering a small population, consider sharing resources and establishing joint processes with neighbouring local formulary decision-making groups to avoid duplicating work.		Covers a relatively large population therefore N/A		
2.3.7	Ensure corporate governance arrangements are firmly established with clear lines of accountability for each partner organisation.		Organisational responsibility	Update in TOR for APC	
2.3.8	Report to relevant corporate governance bodies for each partner organisation appropriately, and as a minimum annually, and by exception when needed.		Organisational responsibility. Annual report produced for APC and JFG.	Update in TOR for APC	
2.4	**Stakeholder engagement**				
2.4.1	Ensure local strategies include stakeholder engagement with:				
	Clinical groups and networks, especially if a formulary decision needs specific knowledge and expertise or has direct implications for a clinical practice area		Clinical networks are consulted on an adhoc basis.		
	Patients or patient representative groups		Carried out on an ad hoc basis.Would like patient/lay representation but currently don't have capacity to support this.		
	Local people and communities		Would like patient/lay representation but currently don't have capacity to support this.		

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	Relevant manufacturers of medicines, for example, when the company can offer additional evidence and insight that can assist with decision-making		Undertaken on an adhoc basis.	Looking to increase engagement with pharma via ABPI facilitators	
	Other relevant decision-making groups		Cross membership at DTC for SFHT, NUH & Treatment centre. Firm up engagement for NHCT	NHCT DTC minutes to be included in APC papers	
2.4.2	Ensure stakeholder engagement is proportionate to the type of decision being made and the medicine being considered.		Undertaken during consultation process prior to decision making		
2.5	**Processes for selecting medicines to be considered**				
Recommendations for **proactive** identification of medicines for consideration					
2.5.1	Include horizon scanning as a standing agenda item in local formulary decision-making group meetings.		Standing agenda item at JFG/APC		
2.5.2	Include NICE technology appraisals as a standing agenda item in local formulary decision-making group meetings.		Standing agenda item at JFG/APC		
2.5.3	When a NICE technology appraisal does not recommend a medicine, focus discussions and actions on withdrawing and decommissioning the medicine from the formulary, in line with NICE recommendations.		Removed from formulary but not clear how to achieve it being removed from use		
2.5.4	Prioritise medicines not subject to a NICE technology appraisal for consideration using explicit criteria. Ensure these prioritisation criteria are well known, clear and transparent. Consider:				
	Impact on patient care		Included in APC front sheet		
	Timelines for new medicines reaching the market		Picked up as part of horizon scanning		
	Severity of disease and patient numbers affected		Included in APC front sheet		
	Clinical effectiveness		Included in APC front sheet		
	Patient safety		Included in APC front sheet		
	Gaps in treatment or other available treatments		Included in formulary submission		
	Cost effectiveness		Included in APC front sheet		
	Resource impact		Included in APC front sheet		
	Inappropriate variation in local current practice		Not included in APC front sheet	Include in APC front sheet	
Recommendations for **reactive** identification of medicines for consideration					
2.5.5	Ensure the process for adopting, removing or updating new medicines or indications is clear, robust and transparent. Applications should be submitted by a clinician, although manufacturers may support evidence gathering.		As per 'Framework for Managing Medicines Across the Notts Healthcare Community'	Update the 'Framework for Managing Medicines Across the Notts Healthcare Community'	
2.5.6	Provide information to the applicant to explain how the process will operate and ensure application forms are readily available. Consider inviting the applicant to a meeting to allow for a constructive discussion.		Support provided by Specialist Interface and Formulary Pharmacists. Clinician invited as appropriate.		

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2.5.7	Ensure the following information is included in application forms for new medicine or indications to be considered:				
	Details of the clinician making the application, including a declaration of interests		included in submission form		
	Local patient population		included in submission form		
	Details of the medicine, including strength, formulation, therapeutic drug class, indication, monitoring requirements and cost		included in submission form		
	Evidence submission with relevant supporting literature, including efficacy, safety and cost effectiveness		included in submission form		
	Comparison with existing treatments			make more explicit in submssion form	
	Likely place in therapy			make more explicit in submssion form	
	Recommendation for the decommissioning of a current formulary medicine, if applicable		included in submission form		
	Resource impact		included in submission form		
2.6	**Adoption of NICE technology appraisal recommendations**				
2.6.1	Include medicines with a positive NICE technology appraisal into the local formulary automatically, if clinically appropriate and relevant to the services provided by the organisation. This process should take place within 3 months (see section 1.6). Include the medicine within the relevant care pathway(s), in line with NICE recommendations.		Notts formulary is a joint formulary across primary and secondary care. Organisations provide declarations of adherence to applicable NICE Tas. For Tas that cross the interface where prescribers may require further support, small working groups will be set up to facilitate this process. This may fall outside the 3 month window for implementation.	As part of horizon scanning, identify potential implicaitons and begin discussions with relevant clinicians in a more timely manner.	
2.6.2	If a NICE technology appraisal states 'option for treatment', adopt the medicine into the local formulary, and if necessary, identify its place in the relevant care pathway(s) provided by local organisation(s), in line with NICE recommendations.				
2.7	**Setting decision criteria**				
2.7.1	Clearly define and consistently apply standard criteria for decision-making. Develop and/or apply a multi-criteria decision tool, which should include:		Have decision making tree which has been incorporated in to the front sheet		
	Patient safety		included in APC front sheet/review		
	Clinical effectiveness		included in APC front sheet/review		
	Cost effectiveness or resource impact		included in APC front sheet/review		
	Strength of evidence		included in APC front sheet/review		
	Place in therapy relative to available treatments			Include in review/FS	
	National guidance and priorities		included in review		
	Local health priorities			Include in review/FS	
	Equity of access			Include in review/FS	

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	Stakeholder views		Undertaken as part of consultation process		
2.8	**Evidence and information gathering**				
2.8.1	When there is a NICE technology appraisal for a medicine, do not duplicate NICE's evidence assessment or make a challenge to a technology appraisal recommendation.				
2.8.2	When there is no NICE technology appraisal for a medicine, use NICE clinical guidelines and other sources of high-quality information produced by national and regional horizon scanning organisations, if available. Ensure these are relevant to the medicine and indication being considered. Avoid duplicating effort locally. For examples of organisations providing relevant resources, see appendix C.		East Midlands medicines information database of reviews. SFHT also have database of reputable reviews.		
2.8.3	If local critical appraisal and evidence synthesis is needed, ensure that evidence-gathering strategies comprehensively reflect the requirements set out in the local formulary's decision-making criteria (see recommendation 2.7.1).		Pro-forma to produce a review		
2.8.4	If local critical appraisal and evidence synthesis is needed, ensure that individuals with specialist skills and competencies are available. This includes skills in:				
	Literature searching		Reviews carried out by the Specialist Interface and Formulary Pharmacists		
	Critical appraisal		carried out by the Specialist Interface and Formulary Pharmacists	Ensure that training is up to date for members	
	Interpreting and contextualising evidence		carried out by the Specialist Interface and Formulary Pharmacists	Ensure that training is up to date for members	
2.9	**Incorporating new information from regulatory authorities**				
2.9.1	Incorporate drug safety updates routinely into the local formulary. This could be achieved by having patient safety updates as a standing agenda item (see also recommendations 2.15.2 and 2.16.2).		This has recently been added to the JFG agenda as standing item.		
2.10	**Assessment of financial and commissioning impact**				
2.10.1	Routinely engage with commissioning and financial managers at an appropriate level of seniority and align local formulary decisions within the framework of clinical commissioning (see also recommendation 2.3.1).		Organisations responsibilty	Re-affirm APC mandate with organisations	
2.10.2	Address barriers that may delay the speed of adoption of medicines into the formulary, such as multiple applications to different decision-making groups, delayed or absent business planning, budget identification or service design.		Trust DTCs consider medicines specific to secondary care, JFG /APC consider medicines for use at the interface. Specialist Interface and Formulary Pharmcist Posts in place to direct/support clinician requests of interface medicines.		
2.11	**Deliberating and reaching decision**				

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2.11.1	Use explicit principles that are formally documented to guide deliberation, such as mission statements, terms of reference, decision criteria and legal and ethical frameworks.		TOR, front sheet/decision making tree	APC/JFG TOR to be updated	
2.11.2	Support individuals in deliberation and decision-making by providing appropriate training and constructive feedback.			training for members required	
2.11.3	Determine explicitly how local formulary decision-making groups reach final decisions.		APC/JFG TOR, formulary submisison and review forms, APC front sheets in place.	APC/JFG TOR to be updated	
2.12	**Documentation**				
2.12.1	Document the deliberations and actions from the meetings, the outcomes of decisions, the rationale for each decision and all formulary policies thoroughly.		Minutes produced within 2 weeks of APC/JFG meeting.		
2.12.2	Use a standard format for notes and minutes which ensures that the key points are summarised for all decisions. Ensure secretariat functions are sufficiently competent so that technical information is accurately recorded.		Minutes produced by Specialist Interface and Formulary Pharmacist / Interface team.		
2.13	**Decision outputs**				
2.13.1	Develop decision outputs with stakeholders (including clinical groups and networks) and other local decision-making groups in a timely manner, to prevent delays in access to treatment.		Bulletin produced within two weeks of meeting. Specialist Interface and Formulary Pharmacists feedback to clinicians.		
2.13.2	Develop decision outputs related to a NICE technology appraisal within a time frame that does not delay the adoption of the medicine into the formulary beyond the statutory requirements (see section 1.6).		Specialist Interface and Formulary Pharmacists / Interface team facilitate working groups where required.		
2.14	**Communication and dissemination**				
2.14.1	Publish all relevant local formulary information online, in a clear, simple and transparent way, so that patients, the public and stakeholders can easily understand it. This includes formulary policies, minutes of meetings, decision outcomes and associated decision outputs.		APC & JFG websites available to NHS users.	JFG website will be publicly available from 1st April.	
2.14.2	Publish information that sets out which NICE technology appraisals are included in the local formulary, in line with the NHS Chief Executive's letter 'Innovation, Health and Wealth publication of NHS formularies'.		JFG website will be publicly available from 1st April.		
2.14.3	Develop a local communication framework, in consultation with stakeholders, reviewed annually, to:				
	Disseminate targeted and concise information to other decision-making groups and key stakeholders, including patients and the public who need to know about the decision.		Dissemination of bulletin and minutes	Annual review	
	Routinely communicate with neighbouring local formulary decision-making groups to share practice, particularly when there are cross-boundary patient flows		Dissemination of bulletin and minutes		

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	Anticipate media response to decisions		Equality and diversity issues included in front sheet.		
2.15	**Reconsideration and appeals of decisions**				
2.15.1	Establish a robust and transparent process for reconsideration or appeals of decisions made by the local formulary decision-making group. Ensure relevant information is clear and easily accessible.		Do not have an appeals procedure or criteria for reconsideration	Update APC TOR	
2.15.2	Clearly define the criteria for a clinician to request a consideration of a decision made by the local formulary decision-making group. This should include circumstances in which:			Update APC TOR	
	Significant new information such as a drug safety alert has become available, which requires a reconsideration of the evidence		See 'Framework for Managing Medicines Across the Notts Healthcare Community'	Update APC TOR	
	The decision was based on inaccurate or incomplete information		Not included as a reason for reconsideration	Update APC TOR	
2.15.3	Clearly define the acceptable grounds for a clinician to appeal a decision made by the local formulary decision-making group. This should include circumstances in which the local formulary decision-making group is juddged not to have followed the publised process.		Do not have an appeals procedure or criteria for reconsideration	Update APC TOR	
2.15.4	Ensure the validity of a formal appeal is assessed by an independent appeals panel. The appeals panel should inform the clinician, in writing, if the appeal does not satisfy the defined grounds. The appeals panel should direct appeals that do satisfy the defined grounds to the most appropriate decision-making group for further consideration.		Do not have an appeals procedure or criteria for reconsideration	Update APC TOR	
2.15.5	Ensure the appeals panel has a clear statement of purpose. Members should together have the skills and expertise necessary to enable them to make the decisions being asked of them.		Do not have an appeals procedure or criteria for reconsideration	Update APC TOR	
2.15.6	Secure adequate training and resources to operate the appeals process. Consider collaborating with neighbouring groups to provide independet cross-organisation appeals panels.		Do not have an appeals procedure or criteria for reconsideration	Update APC TOR	
2.16	**Review and updating**				
2.16.1	Establish a robust and transparent process for reviewing and updating the local formulary. This includes:				
	Ensuring new positive NICE technology appraisal recommendations are incorporated into the formulary automatically (see recommendations 2.5.2 and 2.6.1).		Standing agenda item on both JFG and APC		

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	Ensuring that when a NICE technology appraisal does not recommed a medicine, the medicine is withdrawn from the formulary, in line with NICE recommendations (see recommendation 2.5.3).		Removed from formulary but not clear how to achieve it being removed from use	discuss with members how this can be achieved.	
	Responding to important new evidence on all medicines included in the formulary in a timely matter, including withdrawing or amending the position of a medicine in the care pathway(s).		Undertaken on an ad-hoc basis as part of formulary maintenance.		
	Responding promptly to important new information on drug safety, such as serious adverse effects (see recommendation 2.9.1).		Undertaken on an ad-hoc basis as part of formulary maintenance.	Need to formalise this with 'community rules'	
	Reviewing and updating associated decision outputs (see recommendations 2.13.1 and 2.13.2).		Rolling programme of updating guidelines/SCPs etc		
	Ensuring requests to review and reconsider the evidence are considered in a timely manner (see recommendation 2.15.2).		See section 2.15.2		
	Responding promptly to the indentification of technical errors				
	Responding promptly to the outcome of appeals (see recommendation 2.15.3).		Do not have an appeals procedure or criteria for reconsideration		
	Establishing a rolling schedule of structured formulary review.		No rolling schedule in place yet as have recently completed merging all primary and secondary care formularies.	Discuss at JFG stategy meeting	
2.16.2	Collaborate effectively with relevant stakeholders, including clinicians and other local decision-making groups.		Annual survey suggests could do this better.	Include specific section on consultation in TOR.	

Appendix 5 - Documents ratified by APC during 2011-12			
Ratification date		No of associated documents	Update or New
Clinical Guidelines			
May-12	Nottinghamshire Health Community Guideline for the use of Buccal Midazolam (10mg/ml and 5mg/ml) in Children	1	Update
May-12	Venlafaxine (≥300mg daily) in severe depression - Amber 2 information sheet	1	update
May-12	Enoxaparin for long term anticoagulation in patients unsuitable for oral anticoagulants - Amber 2 informaiton sheet	1	New
May-12	Nottinghamshire Primary Care Alcohol Community Detoxificaiton Protocol	1	Update
Jul-12	Nottinghamshire Guidelines for the use of newer anticoagulants in patients with Deep Vein Thrombosis (DVT)	1	New
Jul-12	Atypical antipsychotic prescribing sheets	5	Update
Sep-12	Nottinghamshire Health Community Treatment Algorithm for the management of Type 2 Diabetes	1	Update
Sep-12	Vitamin D guidelines: Deficiancy and insufficiency in Adults	1	New
Sep-12	Neuropathic pain: Nottingham Health Community Guide to management in primary care for adults	1	Update
Sep-12	Nottinghamshire Health Community Guidelines for Prescribing and Monitoring Lithium within Primary and Secondary care (Mental Health)	1	Update
Sep-12	Ropinirole & pramipexole for restless legs algorithm	1	New
Nov-12	Rivaroxaban for Prevention of Stroke in Patients with Non-valvular Atrial Fibrillation	1	New
Nov-12	Nottinghamshire Heart Failure Lights	1	Update
Jan-13	Nottinghamshire Guidelines on the management of common infections and infestations in primary care	1	Update
Jan-13	Dopamine receptor agonists for Parkinson's disease - Information Sheets	5	Update
Mar-13	Nottinghamshire COPD guidelines	1	Update
Shared Care Protocols			
Jan-13	Shared CareProtocol for Apomorphine in Parkinson's Disease	1	Update
Miscellaneous documents			
Sep-12	Key messages for lipid modification	1	New
Formularies			
Nov-12	Self-Monitoring Blood Glucose (SMBG) Meter Formulary	1	New
Jan-13	Nottingham Emollient Formulary	1	Update