NHS
Devon
Clinical Commissioning Group

Clinical Policy Committee

MINUTES

Wednesday 11 March 2020

Committee Suite, County Hall, Exeter EX2 4QD

Present:

Dr Nick D'Arcy	Chair	NHS Devon CCG
Dr Glen Allaway	Voting Member	NHS Devon CCG
Dr Andrew Craig	Voting Member	NHS Devon CCG
Richard Croker	Deputy Director for Medicines Optimisation	NHS Devon CCG
Dr Tawfique Daneshmend	Consultant Gastroenterologist & Hepatologist	RD&E NHS FT
Paul Foster	Clinical Director of Pharmacy and Prescribing	T&SD NHS FT
Dr Lucy Harris	Voting Member	NHS Devon CCG
Dr Andrew Harrison	Voting Member	NHS Devon CCG
Dr Claire Hooper	Voting Member	NHS Devon CCG
Barbara Jones	Head of Contracting	NHS Devon CCG
Dr Paul Melling	Voting Member	NHS Devon CCG
Mac Merrett	Lay Public Member	
Tracey Polak	Assistant Director/Consultant of Public Health	Devon County Council
Chris Roome	Head of Clinical Effectiveness	NHS Devon CCG
Dr Peter Rowe	Consultant Nephrologist Hon Associate Professor in Medicine	University Hospitals Plymouth NHS Trust
Dr Ben Waterfall	Voting Member	NHS Devon CCG

Guests:

Dr Andrew Gunatilleke	Consultant in Pain Management & Anaesthesia	T&SD NHS FT
Tim Harrower	Consultant Neurologist	RD&E NHS FT
Jeremy Hobart	Consultant Neurologist	University Hospitals Plymouth NHS Trust
Matt Howard	Clinical Evidence Manager	NHS Devon CCG
Louise Jarrett	MS Clinical Nurse Specialist	RD&E NHS FT
Jenny Pye	Specialist Nurse	T&SD NHS FT
Naomi Scott	Healthcare Evidence Reviewer	NHS Devon CCG
Graham Simpole	Medicines Optimisation Pharmacist	NHS Devon CCG
Dr Nick Keysell	GP, DRSS	NHS Devon CCG
Mr Michael Foster	Consultant Urologist	NDHC NHS FT
Professor Adam Zeman	Professor of Cognitive & Behavioural Neurology	University of Exeter Medical School

In attendance:

Fiona Dyroff	Clinical Effectiveness Governance Support Officer	NHS Devon CCG
Rebecca Heayn	Clinical Effectiveness Governance Manager	NHS Devon CCG

1. Welcome and announcements

Apologies

Dr Alison Round	GP	NHS Devon CCG
Mark Taylor	Lay Public Member	
Lorraine Webber	Deputy Director of Quality Assurance and Improvement (Lead Nurse)	NHS Devon CCG

Confirmation of voting members and Declarations of interest

The seven voting members present were identified.

Declarations of Interest were collected and reported. All Declarations of Interest are reported in the minutes. After declaring an interest, Chris Roome left the meeting for the discussion of Sativex. Chris was present for all other items discussed.

DRUG/ TECHNOLOGY TO BE CONSIDERED	PHARMACEUTICAL COMPANY/ MANUFACTURER/ SERVICE PROVIDER
Sativex® for the treatment of spasticity in multiple sclerosis	GW Pharma Ltd
Alternative treatments:	
Botulinum toxin injections (Botox®, Dysport®, Xeomin®)	Allergan Ltd, Ipsen Ltd, Merz Pharma UK Ltd
Intrathecal baclofen pumps	Various
Pitolisant hydrochloride (Wakix®) **for the treatment of narcolepsy with or without cataplexy in adults**	Lincoln Medical Limited
Alternative treatments:	
Modafinil	Various
Dexamfetamine	Various
Sodium oxybate (Xyrem®)	UCB Pharma Limited
Invicorp® for erectile dysfunction	Evolan Pharma AB
Alternative treatments:	
Alprostadil (Caverject®, Muse®, Viridal Duo®, Vitaros®)	Pfizer Limited, Mylan, UCB Pharma Limited, Ferring Pharmaceuticals Ltd
Penile prosthesis	Various
Minimally invasive treatments for low back pain with and without sciatica	As a private provider of minimally invasive treatments for low back pain

Name of Attendee	Role	Declaration
Chris Roome	Head of Clinical Effectiveness	I am co-author of a paper on the cost effectiveness of Sativex (Lu L et al) which NICE based their 2014 recommendations on.
Timothy Harrower	Consultant Neurologist	Contributed to Advisory Boards, prepared training courses and attended conferences for all three Toxins. One current study – Merz Pattern is looking at spasticity management of the lower limb but not in Multiple Sclerosis. All of this work has been for Cervical Dystonia, Migraine and Sialorrhoea not spasticity. Currently unpaid co-founder and director of British Nerotoxin Network.
Jeremy Hobart	Consultant neurologist/Professor	We were a site for the MUSEC clinical trial (a cannabinoid but not sativex) and are a site for the upcoming GW studies.

Notification of Any Other Business

Members were asked if there were any items of AOB for consideration.

2. Minutes of the meeting held on 20th November 2019

The minutes of the meeting held on 20th November 2019 were approved.

Summary of actions		
	Action	**Lead**
19/21	Review: Referral Policy for surgical management of heavy menstrual bleeding. Policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication. The policy has been published. Action complete.	

19/22	Review: Referral Policy for varicose veins. Policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication. The policy has been published. Action complete.	
19/23	Review: Policy for referral and specialist management of haemorrhoids in adults. Policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication. The policy has been published. Action complete.	
19/24	Loteprednol etabonate 0.5% (Lotemax®) for the treatment of steroid responsive inflammatory conditions of the eye. Policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication. The policy has been published. Action complete.	

3. Sativex® for the treatment of spasticity in multiple sclerosis (MS)

After declaring an interest, Chris Roome left the meeting for the discussion of Sativex. Chris was present for all other items discussed.

Sativex is an oromucosal spray containing two cannabis-based medicinal products, delta-9-tetrahydrocannabinol and cannabidiol. It is indicated as add-on treatment for patients with moderate to severe spasticity due to multiple sclerosis who have not responded to other anti-spasticity medication and who demonstrate a clinically significant improvement in spasticity related symptoms during a 28-day trial. Naomi Scott, Healthcare Evidence Reviewer, NHS Devon CCG presented a paper. Tim Harrower, Consultant Neurologist, RD&E NHS FT, Jeremy Hobart, Consultant Neurologist, University Hospitals Plymouth NHS Trust, Jenny Pye, Specialist Nurse, T&SD NHS FT and Louise Jarrett, MS Clinical Nurse Specialist RD&E attended the meeting for the discussion.

The SPC for Sativex states that treatment must be initiated and supervised by a physician with specialist expertise in treating this patient population. The patient's response should be reviewed after four weeks of treatment and if a 20% improvement in spasticity related symptoms is not seen during this initial trial period, treatment should be stopped.

Sativex costs £300 for three vials which contain 90 sprays each. There is currently a manufacturer scheme in place, where patients can have a trial of Sativex at no cost to the NHS.

Sativex was considered by the Peninsula Health Technology Commissioning Group in September 2010. Although it was concluded that the clinical evidence generally supported the efficacy of Sativex, it was not found to be cost effective and therefore the decision was to not routinely commission Sativex.

In 2019 NICE produced a guideline regarding cannabis-based medicinal products which recommended Sativex for its licenced indication. This recommendation was based on a new cost effectiveness model created by NICE which built on the previous model by including data from an additional trial and incorporated savings associated with the reduced need for social care support when patients respond to Sativex. The base case for this analysis resulted in an ICER of £19,512.

A systematic literature search identified two directly applicable randomised controlled trials comparing Sativex and placebo which were not published when Sativex was reviewed in 2010. These trials required patients to achieve a 20% improvement in spasticity symptoms during a trial period with Sativex to be eligible for inclusion within the treatment phase of the study where patients were randomised to Sativex and placebo. The studies found patients treated with Sativex were more likely to achieve a 30% improvement in spasticity symptoms than those treated with placebo. Regardless of the measure used neither of the studies found Sativex treated patients to have a significant improvement in quality of life in comparison to placebo.

NICE estimates that 80 patients in Devon will be eligible for long term treatment with Sativex. NICE's resource impact template proposes that the acquisition costs of Sativex can be partially offset against NHS savings in spasticity management costs of £123 per patient per year. Taking this into account the budget impact to the CCG of prescribing Sativex is £182,000 in year one and £198,000 in subsequent years.

Although this budget impact represents the cost of Sativex to the NHS, NICE proposes that savings will be made in social care by a reduction in the need for home care visits. The benefits of Sativex are therefore accrued across the health and social care sector whilst costs fall in the health sector. Where this is the case, the Better Care Fund is a programme spanning both the NHS and local government which seeks to join-up health and care services. The use of Sativex would therefore seem highly suitable for funding from this fund.

Sativex is licenced for patients whose spasticity is not adequately controlled on oral antispasticity treatment. The next step in the treatment pathway are invasive procedures that require healthcare staff to administer. The use of Sativex in this population gives a non-invasive treatment option that can be self-administered, which may also reduce the need for, or delay the progression to, invasive treatment options that have high resource requirements.

The committee considered issues pertinent to the routine commissioning of Sativex for the treatment of spasticity in multiple sclerosis.

- Specialists present reported that the management of MS has changed in the last 10-15 years; patients are receiving treatment earlier than previously so the number of patients who will require treatment for spasticity is likely to reduce over time. Consequently, the recurring costs of Sativex are likely to decrease over time.
- Local specialists have privately prescribed Sativex to around 40 patients and therefore have experience in the use of Sativex and the potential benefits to patients. The benefits reported include an increase in the time patients can avoid needing a wheelchair, reductions in spasticity, bedsores and fatigue.

- Locally the rate of ongoing prescribing in privately funded patients is similar to that of patients taking part in trials. Only 15 of the 40 patients privately prescribed Sativex continued treatment long term
- The pay-for-responder scheme was discussed. Local specialists would require patients to achieve a 20% improvement in symptoms to continue treatment.
- Specialists present suggested that quality of life improvement may be understated in the evidence from trials. Anecdotal evidence suggests that patients benefit from treatment with Sativex.
- Sativex is usually an add on therapy and it is unlikely that patients will be prescribed Sativex as monotherapy
- Individual Funding panel applications were considered. However, due to the number of MS patients who may benefit from Sativex this group does not meet the 'exceptionality' criteria for treatment via the Individual Funding Panel route.
- Alternative treatments include botulinum toxin A; this is very specifically targeted to the area in which the patient needs it. The drug cost is similar to Sativex however it is a lot more time consuming in clinics. Intrathecal baclofen is used by a small number of patients in Devon the results are variable and the treatment invasive.

The Committee voted 6 to 1 in favour of recommending the routine commissioning of Sativex for the treatment of spasticity in multiple sclerosis.

ACTION: Policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication.

4. Pitolisant hydrochloride for the treatment of narcolepsy with or without cataplexy in adults

Pitolisant is an inverse agonist of histamine H3 receptors and works by enhancing the activity of brain histaminergic neurons. It is available as film-coated tablets containing 5mg and 20mg of pitolisant hydrochloride (equivalent to 4.5mg and 18mg of pitolisant respectively) and is licensed for the treatment of narcolepsy with or without cataplexy in adults.

An application for the routine commissioning of pitolisant has been received from Professor Adam Zeman, Professor of Cognitive and Behavioural Neurology at the University of Exeter Medical School who has indicated that pitolisant would provide an additional licensed option for the treatment of narcolepsy with or without cataplexy in adults. Graham Simpole, Medicines Optimisation Pharmacist, NHS Devon CCG presented a paper. Professor Zeman attended the meeting for this discussion.

A systematic literature search identified two short-term RCTs comparing pitolisant to modafinil and placebo and one RCT comparing pitolisant to placebo alone. A single-arm, open label study assessing the long-term safety and efficacy of pitolisant, and a network meta-analysis comparing pitolisant to modafinil, sodium oxybate and placebo were identified. No relevant studies relating to cost-effectiveness of pitolisant for the treatment of narcolepsy were identified.

The primary endpoint in two of the RCTs were excessive daytime sleepiness, with a number of secondary endpoints being reported, including cataplexy rate. The other RCT reported the weekly cataplexy rate as the primary endpoint and included excessive daytime sleepiness amongst a number of secondary outcomes.

Pitolisant demonstrated superiority to placebo in the primary endpoint of excessive daytime sleepiness in one RCT but failed to show any significant difference in the other.

In both of the RCTs including modafinil as a comparator, pitolisant failed to demonstrate non-inferiority compared to modafinil for excessive sleepiness after 8 weeks. In the same two trials there was no significant improvement in the secondary outcome of cataplexy rate in the pitolisant group compared to the modafinil group.

In the trial which considered cataplexy as its primary endpoint, pitolisant demonstrated superiority to placebo. This was supported by the secondary outcome result in one RCT study but contradicted in another RCT where no significant differences were reported.

The applicant has estimated that, if accepted, approximately 10 patients are likely to be initiated on pitolisant in Devon in the first year, reducing to 5 patients per year in subsequent years.

Both the 4.5mg and 18mg strengths of pitolisant cost £310 per pack of 30. As a consequence of the flat pricing structure the annual cost of pitolisant could potentially range from approximately £3,771 to £15,086 per patient, per year, depending on the dose titration and dose regimen. Threshold analyses suggest pitolisant is unlikely to be cost-effective at usual thresholds compared to modafinil or dexamfetamine but may be a cost-effective option in those patients who would otherwise be prescribed sodium oxybate.

Under most circumstances, routine commissioning of pitolisant for narcolepsy is expected to increase annual expenditure by around £55,000 to £65,000 in year one, plus an additional £27,000 to £32,500 per year thereafter. However, if use were limited to those patients who would otherwise be prescribed sodium oxybate, reduced expenditure of between £23,700 and £34,000 in year 1 plus a further reduction of £11,800 to £17,000 per year thereafter, may be possible.

The main consideration for pitolisant is that it would provide an alternative for patients in whom other options have been ineffective or not tolerated, and may prevent the need for progression to more costly sodium oxybate.

The committee discussed issues pertinent to the routine commissioning of pitolisant hydrochloride for the treatment of narcolepsy with or without cataplexy in adults:

- Modafinil and amfetamines are generally effective. Modafinil and dexamfetamine are currently used first line. However, some patients cannot tolerate these medications or experience side effects. A number of medications treat only cataplexy or narcolepsy alone. An estimated seventy-five percent of patients with narcolepsy also have cataplexy.
- It was suggested that the quality of the evidence published to date is inadequate and that further trials are needed. The pitolisant doses used in one of the trials was low. Specialist opinion suggested that pitolisant is an effective but expensive drug. Currently sodium oxybate (Xyrem®) is commissioned for use in Devon under certain specific conditions as an alternative medication for the treatment of narcolepsy with cataplexy.
- It is proposed to use pitolisant following modafinil but before sodium oxybate.

The committee voted 5 to 2 in favour of the routine commissioning of pitolisant hydrochloride for the treatment of narcolepsy with cataplexy in adults who would otherwise be eligible for treatment with sodium oxybate.

ACTION: Policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication.

5. Invicorp® for erectile dysfunction (ED)

An application for the routine commissioning of Invicorp for the treatment of ED has been received from Mr Mason from Torbay and South Devon Hospital. Invicorp is an intracavernosal therapy for the treatment of ED. It is available as a 0.35ml ampoule of solution for injection which contains 25 micrograms of vasoactive intestinal polypeptide which relaxes cavernosal smooth muscle and is thought to have a veno-occlusive action and 2mg of phentolamine which relaxes smooth muscle and causes vasodilation. The combination of the two treatments leads to penile tumescence following sexual stimulation.

Naomi Scott, Healthcare Evidence Reviewer, NHS Devon CCG presented a paper. Dr Michael Foster, Consultant Urologist, North Devon Healthcare NHS Foundation Trust joined the meeting via teleconference for the discussion of this item.

Currently the first line treatment option for patients with ED is PDE5 inhibitors. If patients do not respond to these and decline or do not respond to vacuum pumps, they are offered alprostadil. Alprostadil is available in three formulations, topical, intraurethral or via intracavernosal injections. Topical and intraurethral formulations are significantly less effective. Following failure of alprostadil, patients may be considered for a penile prothesis, a surgical procedure commissioned by NHS England.

It is proposed that Invicorp provides an alternative treatment option to alprostadil for patients who have failed to respond to PDE5 inhibitors and meet NHS Drug Tariff Selected List Scheme (SLS) criteria. Invicorp has been accepted for use in Wales in patients who have not responded to PDE5 inhibitors. In Scotland it is accepted for use in patients who have not responded to PDE5 inhibitors and other non-injectable formulations of ED medications.

A systematic literature search identified two randomised trials which found patients were significantly more likely to achieve a grade 3 erection, suitable for sexual intercourse, with Invicorp than placebo. A further randomised trial comparing the adverse event profiles of alprostadil and Invicorp was identified, however as it was not adequately powered and failed to present comparative statistics for its primary outcome it not possible to draw firm conclusions as to whether Invicorp is associated with fewer adverse events than alprostadil. It was noted that, during the dose finding phase of this trial, patients were significantly more likely to have a grade 3 erection following treatment with alprostadil than Invicorp.

Invicorp is more expensive than the 10 microgram doses of alprostadil, but it is either the same cost or less expensive than 20 and 40 microgram doses. ePACT2 data showed that the actual cost of a dose of Invicorp is £8.82 and the weighted mean cost of a dose of alprostadil is £12.76. Thus, on average, prescribing Invicorp costs £3.94 less per dose than alprostadil.

Invicorp is only available in one strength and thus patients may not require as many outpatient appointments as when prescribed alprostadil, which requires titration. A reduction in demand for outpatient appointments is a notional saving and the primary benefit would be freeing up capacity. If Invicorp was to be accepted for routine commissioning and a proportion of patients were prescribed Invicorp rather than alprostadil there is likely to be a small saving to the CCG. However, as Invicorp offers an additional treatment option for patients who otherwise may be considered for a prosthesis, there is a possibility of an increase in the overall number of patients treated with injectables.

The committee discussed issues pertinent to the routine commissioning of Invicorp for erectile dysfunction.

- In general terms specialist opinion stated that patients who do not respond to alprostadil injections may respond to Invicorp.

- The supply of injectable alprostadil has been variable over recent years. Sometimes Invicorp is the only injectable available.
- Specialist experience is that Invicorp is less painful for some patients to administer than Alprostadil (a small proportion of patients cannot use alprostadil due to pain).
- Only one dose of Invicorp is available; this enables patients to use an injectable where they cannot or are unable to work with a titratable dose regimen as with Alprostadil.
- On average Invicorp is slightly cheaper than alprostadil
- Initiation onto Invicorp should be commenced under specialist advice.
- Specialist opinion suggested that there will not be a significant increase in expenditure due to use of Invicorp, if at all. It will be used as an alternative to alprostadil, however it is not expected to attract any extra patients to this method of treatment (i.e. injectable agents).
- Invicorp has potential advantages. Some local experience of its use was gained before it had a UK licence.

The committee voted unanimously in favour of recommending the routine commissioning of Invicorp for erectile dysfunction.

ACTION: Policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication.

6. Minimally invasive treatments for low back pain with and without sciatica

Chris Roome, Head of Clinical Effectiveness, NHS Devon CCG presented a paper on minimally invasive treatments for low back pain with and without sciatica. Dr Andrew Gunatilleke, Consultant in Pain Management & Anaesthesia, T&SD NHS FT and Dr Nick Keysell, GP Clinical Lead for DRSS, NHS Devon attended the meeting for the discussion of this item.

The Clinical Policy Committee had previously recommended the CCG adopt NHS England's Evidence Based Interventions (EBI) recommendations on injections for non-specific low back pain without sciatica, the policy for which was published in March 2019.

Alongside the implementation of this policy there has been system wide assessment of the CCG's spinal pathway. The policy for injections for non-specific low back pain adopted from the NHS England guidance referred to a limited range of procedures for a subgroup of patients with low back pain. Although it referred to other treatments it did not give explicit criteria to detail patient eligibility. During collaboration with local specialists as part of this work it has become apparent that there was inconsistency in the interpretation of the policy, which patient groups were excluded and what alternative treatments were available. Furthermore, clarity was sought over the commissioning of treatment for patients with sciatica.

The National Institute for Health and Care Excellence (NICE) guideline NG59 (Low back pain and sciatica in over 16s: assessment and management, 2016) provides recommendations regarding the use of radiofrequency denervation for patients with chronic low back pain and spinal injections for patients with sciatica. These are also reflected in the recent Getting It Right First Time (GIRFT) spinal services report and recommendations (2019).

A suite of policies was presented to the committee. These included an update to the policy for injections for non-specific low back pain without sciatica to clarify the policy inclusion and exclusion criteria.

A policy for radiofrequency denervation for patients with chronic or non-specific low back pain and a policy for spinal injections for sciatica has been agreed with specialists, and also a policy specifically dealing with interventions for sciatica, or more generally radicular pain. During consultation it was decided to retain the term sciatica in keeping with the terminology of the NICE guideline. These policies were developed with extensive clinical engagement with the responsible commissioning teams, as part of the spinal workstream within the peninsular clinical services strategy.

The implementation of these policies is intended to provide clear recommendations as to what treatments are routinely commissioned for low back pain with and without sciatica. This aims to ensure appropriate interventions are provided consistently across Devon.

Further work is underway on the development of a policy for the use of back injections for people whose back pain is attributed to a specific cause. These were outside the scope of the polices presented for recommendation.

The committee considered issues pertinent to the three proposed policies for minimally invasive treatments for low back pain with and without sciatica.

- Specialist opinion noted the need for implementation of a Devon and Cornwall wide policy. The specialist present also highlighted the importance of ensuring that all patients should have access to psychological and physical therapies. It was also noted that patients cope differently with pain, some cope well, others less so.
- There was discussion about facet joint injections. The specialist present said he used this term to describe medial branch blocks and also injections into the facet joint. His opinion was that a lot of facet joint injections take place to keep people mobile with medial branch blocks sometimes being effective for many months. The specialist present only repeats injections that are effective for a worthwhile period.
- It is intended to address some of the issues related to degenerative diseases of the spine such as osteoarthritis in a separate policy. The specialist present suggested that no research has been undertaken specifically on people over 60 years of age and therefore the lack of evidence to guide judgements on interventions in this group is problematic for policy making.
- Some patients are repeatedly sent back to clinics but receive no benefit from treatment. The policy covers part of the pathway and will help avoid patients being sent back to clinics when there is no benefit.
- A number of other treatments were noted, including denervation and branch block. It was noted that lidocaine plasters and opioids should not be used.

<u>Spinal injections for non-specific low back pain without sciatica</u>

The committee voted unanimously in favour of recommending adoption of the proposed updated policy for spinal injections for non-specific low back pain without sciatica.

<u>Radiofrequency Denervation</u>

The committee voted unanimously in favour of recommending adoption of the proposed policy for radiofrequency denervation.

<u>Spinal injections for sciatica</u>

The committee voted unanimously in favour of recommending adoption of the proposed policy for spinal injections for sciatica

ACTION: Policy recommendations and QEIA to be prepared and subsequently progressed to final CCG approval and communication.

7. Update to Dupuytren's contracture treatment policy in response to withdrawal of collagenase clostridium histolyticum

The committee noted that in February 2020, the National Institute for Health and Care Excellence (NICE) withdrew mandatory technology appraisal guidance TA459 on Collagenase clostridium histolyticum for treating Dupuytren's contracture. This is because collagenase clostridium histolyticum (Xiapex) is no longer available in the UK.

The CCG currently has a policy in place for Dupuytren's contracture treatment, which had stated that medical treatment of Dupuytren's contracture with collagenase injections (Xiapex) is commissioned in accordance with NICE technology appraisal TA459. In light of the withdrawal of this guidance, reference to it has now been removed from the CCG policy.

The remainder of the policy is unaffected by the withdrawal of this guidance and will therefore be maintained. This relates to surgical intervention for Dupuytren's contracture (needle fasciotomy, fasciectomy and dermofasciectomy), in accordance with NHS England criteria for surgery for Dupuytren's contracture treatment set out in their Evidence Based Interventions guidance for CCGs.

8. Update from Clinical Policy Engagement and Consultation Panel

The committee received an update from the Clinical Policy Engagement and Consultation Panel meeting which took place on 10th December 2019.

The Clinical Policy Engagement and Consultation Panel had considered four items:

- Referral for the surgical management of heavy menstrual bleeding
- Referral and specialist management of haemorrhoids
- Referral for varicose veins
- Loteprednol (Lotemax®) eye drops for steroid responsive inflammatory eye conditions

The panel saw no reason for further engagement or consultation actions on any of the issues discussed.

9. Update from NICE Planning Advisory Group (NPAG)

Two NPAG meetings had taken place since the last CPC meeting.

1st October 2019

NPAG had considered eight NICE Technology Appraisals and one Highly Specialised Technology Appraisal. Three of the TAs were CCG commissioned and five of the TAs and the Highly Specialised Technology were NHS England commissioned.

NPAG had also considered seven Antimicrobial Guidelines, five Clinical Guidelines, one Social Care guideline, two Medical Technology Guidelines and five pieces of Interventional Procedures Guidance.

3rd December 2019

NPAG had considered eight NICE Technology Appraisals and one Highly Specialised Technology Appraisal. Four of the TAs were CCG commissioned and four of the TAs and the Highly Specialised Technology were NHS England commissioned.

NPAG had also considered one Antimicrobial Prescribing Guideline, five Clinical Guidelines, two Medical Technology Guidelines and ten Interventional Procedures Guidelines.

10. Any other business

Next meeting - Post meeting note

Due to the COVID-19 pandemic a decision has been taken to cancel the meeting scheduled to take place on Wednesday 6th May 2020.

Summary of actions

	Action	Lead
20/01	Sativex® for the treatment of spasticity in multiple sclerosis (MS) Policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication.	Rebecca Heayn
20/02	Pitolisant hydrochloride for the treatment of narcolepsy with or without cataplexy in adults Policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication.	Rebecca Heayn
20/03	Invicorp® for erectile dysfunction (ED) Policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication.	Rebecca Heayn
20/04	Minimally invasive treatments for low back pain with and without sciatica. Policy recommendations and QEIA to be prepared and subsequently progressed to final CCG approval and communication.	Rebecca Heayn