Northern, Eastern and Western Devon Clinical Commissioning Group
South Devon and Torbay Clinical Commissioning Group

Clinical Policy Committee (CPC)
Minutes

Wednesday 16th July 2014, 10.00 am to 12 noon

The Hayridge Centre, Cullompton

Present:

Dr Keith Gillespie* (Chair)	GP Clinical Commissioner	NEW Devon CCG
Dr Mick Braddick*	GP Clinical Commissioner	NEW Devon CCG
Jono Broad	Lay Member	
Dr Andrew Craig*	GP Clinical Commissioner	NEW Devon CCG
Bryan Foreshew	Interface Medicines Optimisation Pharmacist (N&E)	NEW Devon CCG
Dr Andrew Gunatilleke	Consultant in Pain Management & Anaesthesia	SDHC NHS Foundation Trust
Dr Stephen Hunt*	GP Clinical Commissioner	NEW Devon CCG
Andrew Kingsley	Patient Safety and Quality	NEW Devon CCG
Dr Phil Melluish*	GP Clinical Commissioner	South Devon and Torbay CCG
Mac Merrett	Lay Member	
Samantha Morton*	Head of Contracting and Performance	South Devon & Torbay CCG
Simon Mynes	Director of Pharmacy	Plymouth Hospitals NHS Trust
Chris Roome	Head of Clinical Effectiveness	NEW Devon CCG
Dr Alison Round*	GP Clinical Commissioner	NEW Devon CCG
Tracey Polak	Assistant Director/Consultant of Public Health	Devon County Council
Dr Darunee Whiting*	GP Clinical Commissioner	NEW Devon CCG

Guests:

Emma Hewitt	Joint Formularies Pharmacist	NEW Devon CCG
Dr Philip Kell	Consultant Physician	Torbay Sexual Medicine Service
Mr Richard Pearcy	Consultant Urologist	Plymouth Hospitals NHS Trust
Bethan Rogers	Clinical Evidence Pharmacist	NEW Devon CCG
Dr Ray Sheridan	Consultant Physician	Royal Devon & Exeter NHS Trust
Petrina Trueman	Joint Formularies Pharmacist	NEW Devon CCG
Dr James Greig	Consultant Medical Microbiologist	Plymouth Hospitals NHS Trust

In attendance:

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

* Denotes voting members

1. Welcome and announcements

Attendees were welcomed to the meeting.

Dr Jo Roberts had delegated voting authority to Samantha Morton for this meeting. Samantha Morton also represented the CCGs contracting departments.
Bryan Foreshew attended the meeting as representative for Medicines Optimisation.

Apologies

Rob Cowdry	Contracts Governance Manager	NEW Devon CCG
Richard Croker	Head of Medicines Optimisation	NEW Devon CCG
Jo Roberts	Clinical Member and Group Chair	South Devon & Torbay CCG
Tawfique Daneshmend	Secondary Care Clinician	Royal Devon & Exeter NHS Trust

Confirmation of voting members and Declarations of Interest

The eight voting members present were identified.

Declaration of interest forms were collected. The Chair informed the committee of declarations of interest received.

DRUG/TECHNOLOGY TO BE CONSIDERED	PHARMACEUTICAL COMPANY / MANUFACTURER / SERVICE PROVIDER
Fidaxomicin (Dificlir®)	**Astellas**
Alternative treatments:	
Vancomycin	**various manufacturers**
Metronidazole	**various manufacturers**
Dapoxetine (Priligy®)	**Menarini Farmaceutica Internazionale SRL**
Alternative treatments:	
Paroxetine	**various manufacturers**

NAME OF ATTENDEE	ROLE	
Dr James Greig	Consultant Medical Microbiologist	In last 3 years – no conflicts regarding Astellas. (In relation to discussion on fidaxomicin [Dificlir®] Astellas)
Dr Ray Sheridan	Consultant Physician	On-going local researcher for MODIFY – monoclonal antibody multi-centre trial for C.Difficile. Actively recruits for the trial but receives no direct financial benefit from being involved in this trial. (In relation to discussion on fidaxomicin [Dificlir®] Astellas)
Dr Philip Kell	Consultant Physician	Has worked as paid adviser to above pharmaceutical / manufacturing company / companies. Is in receipt of lecture feeds in excess of £150 in the last year from above pharmaceutical manufacturing company/companies. (In relation to discussion on dapoxetine [Priligy®] Menarini Farmaceutica Internazionale SLR).

Mr Richard Pearcy	Consultant Urologist	Worked as paid lecturer at a meeting of other medical practitioners Received a meal at a meeting which was part sponsored. (In relation to discussion on dapoxetine [Priligy®] Menarini Farmaceutica Internazionale SLR).

2. Minutes of the meeting held on 4th June 2014 and matters/actions arising

The minutes of the meeting held on Wednesday 4th June were approved.

Actions from previous meeting:

14/04 *Lisdexamfetamine for ADHD in children and adolescents commissioning policy to be published.*

The policy has been drafted and agreed by the CPC chair. Once it has been ratified by the CCGs' governing bodies and taken through the FIGs process the policy will be published.

14/05 *Existing NHS Plymouth policy on dilatation and curettage to be rescinded.*

Action complete

14/06 *Local Medicines Evaluation in Service proposal to be raised with Tim Burke.*

Action complete

14/07 *Development of Local Medicines Evaluation in Service proposal to be taken forward.*

A meeting has been arranged for 5th August 2014. Action complete.

14/08 *Governing bodies of NEW Devon CCG and South Devon and Torbay CCG to be asked to accept and ratify the annual report and endorse the role of the committee.*

The annual report has been submitted for ratification and endorsement of the role of the committee to the governing bodies of both CCGs.

Action complete

14/09 *Ratified annual report to be published*.

The annual report has been submitted to the CCGs, once ratified it will be published.

14/10 *Process for non-attendance/acceptable level of attendance by committee members to be developed.*

This has been included on the agenda as item 8 for discussion. Action complete.

14/11 *Functions of lay board members to be discussed and list of functions to be produced for inclusion into the Committee's Term of Reference.*

This has been included on the agenda as item 7 for discussion. Action complete.

14/12 *Copy of spread sheet containing details of NICE guidance discussed at NPAG and responses from Trusts to be brought to a future CPC meeting.*

A process is in place and any risks are being reported via the CCGs' risk reporting process. The committee agreed that this action could be removed from the outstanding action log.

Action complete.

3. Fidaxomicin for Clostridium difficile infection

Two applications have been received requesting the inclusion of Fidaxomicin into local formularies. Application one requests its use in all patients with Clostridium difficile infection (CDI). Application two requests its use in line with Public Health England (PHE) guidance and for all life threatening cases. The committee were asked to consider the evidence. Bethan Rogers, Clinical Evidence Pharmacist, NEW Devon CCG presented an evidence review. Dr James Greig, Plymouth Hospitals NHS Trust and Dr Ray Sheridan, Royal Devon and Exeter NHS Foundation Trust were in attendance for this item. Written comments provided by clinicians were tabled at the meeting.

Fidaxomicin is a novel antibiotic licensed for the treatment of CDI also known as *C.difficile*-associated diarrhoea (CDAD) in adults. It has a narrow spectrum of antibacterial activity and limited effect on the normal microflora. It is poorly absorbed systemically and exerts its activity in the gastrointestinal tract, primarily against *C.difficile.* Fidaxomicin is available as a 200 mg tablet which is administered twice daily for 10 days.

Public Health England (PHE) provide clinical guidance but note its high cost and recommend local decision making to determine its use. The All Wales Medicine Strategy Group (AWMSG) and the Scottish Medicines Consortia (SMC) recommend restricted use in defined but differing circumstances.

The committee reviewed the evidence for commissioning of fidaxomicin for (1) use in all patients with CDI and (2) for use in line with PHE guidance; that is in severe primary infections in patients with multiple co-morbidities taking concomitant antibiotics, in recurrent non life-threatening cases following standard 1st line treatment with vancomycin or metronidazole and as a treatment option in severe CDI not responding to oral vancomycin. This application also requests the use of fidaxomicin as a treatment option in life-threatening CDI.

Two large well conducted phase III, double-blind, randomised non-inferiority studies were identified. These compared outcomes after treatment with fidaxomicin or vancomycin administered for 10 days, the primary end point was 'clinical cure'. Both trials demonstrated non-inferiority of fidaxomicin to vancomycin for clinical cure. Fidaxomicin was superior to vancomycin in reducing CDI recurrence within 28 days post treatment. Evidence for Fidaxomicin in non-severe disease is limited to an indirect comparison with metronidazole. This found no significant difference between fidaxomicin and metronidazole for clinical cure or recurrence rates in patients with non-severe CDI. Results seen in subgroups of patients with severe and recurrent disease were broadly similar to those of the whole trial population. A greater proportion of patients taking concomitant antibiotics achieved clinical cure with fidaxomicin and a reduced rate of recurrence when compared to vancomycin. Patients in whom antibiotics were expected to continue for more than 7 days were excluded from the trials; however in the relatively small subgroup of patients who subsequently received at least one dose of an additional antibiotic during the study period, fidaxomicin was found to achieve a 10.6% greater clinical cure rate than vancomycin. There is no evidence supporting use of fidaxomicin in multiple recurrent cases, following treatment failure with vancomycin, or life-threatening CDI. No studies comparing its use to alternative treatments currently used in these patient groups were found.

Fidaxomicin has a significantly higher acquision cost compared to both vancomycin and metronidazole; drug costs for a 10 day treatment course are £1350, £126.16 and £1.73 respectively.

In cost effectiveness analyses submitted to AWMSG and SMC hospital length of stay for recurrent episodes and recurrence rates with fidaxomicin were identified as key drivers for cost effectiveness. Fidaxomicin was found to dominate vancomycin for the treatment of CDI in the first recurrence subgroup; that is it is more effective at less overall cost. It was also found to dominate vancomycin in the severe disease subgroup in the Welsh report but was associated with an incremental cost-effectiveness ratio (ICER) of over £16,000 per QALY gained in Scotland. Subsequent threshold analysis found that ICERs increased to values of £20,000 and £30,000 in the majority of cases. The budget impact has been calculated based on the drug costs and the estimated CDI cases. Based on PHE case numbers it is estimated that there would be a reduction of 6 cases per annum if PHE guidance is adopted and 19 if all patients with CDI infection were treated. This would be a cost of £191k or £481k respectively. There is some uncertainty due to the differing number of cases reported by local labs and local opinion on the recurrence rate.

The committee discussed a number of issues pertinent to this therapy:

- Cost effectiveness – this is an expensive drug, with a number of uncertainties in the benefit that its use would bring
- Trial evidence shows that Fidaxomicin reduces recurrence rate in those treated for CDI however in clinical practice it is difficult to predict who will relapse with multiple factors that might seem to have an influence.
- Resistance to antibiotics - this is a new antibiotic and care should be taken with its use.
- Potential place in therapy for fidaxomicin: other antibiotics work and there are other treatments with high success rates including faecal transplants.
- The overall trend in cases of CDI is down.
- Hospitals may want to use this occasionally, the drug is in tariff and no transfer of funding would currently occur. Work is underway to develop a common Devon wide mechanism to facilitate similar practice in hospitals when this is appropriate.

Application 1: The committee voted unanimously against commissioning fidaxomicin for this indication.

Application 2: The committee voted 7 to 1 against commissioning fidaxomicin for this indication.

ACTION: Commissioning policy to be published

4. Dapoxetine for premature ejaculation

A formulary application has been received requesting the inclusion of Dapoxetine into local formularies for the treatment of premature ejaculation (PE). The committee were asked to consider the evidence. Emma Hewitt, Joint Formularies Pharmacist, NEW Devon CCG presented an evidence review. Dr Philip Kell, Torbay Sexual Health Clinic and Mr Richard Pearcy, Plymouth Hospitals Trust were in attendance for this item.

Dapoxetine is the only licensed oral treatment for PE. Its use could potentially eliminate the need to prescribe 'off label' medications for the treatment of this indication. The recommended starting dose for all patients is 30 mg taken as needed approximately 1 to 3 hours before sexual activity. The maximum daily frequency is once every 24 hours. If the individual response to 30 mg is insufficient and the patient has not experienced moderate to severe adverse reactions of prodromal symptoms suggestive of syncope, the dose may be increased to a maximum of 60 mg. GMC guidance regarding the use of unlicensed medicines states that 'prescribing unlicensed medicines may be necessary where a suitable licensed medication that would meet the patient's needs is not available'. The guidance also states that "you should usually prescribe licensed medicines in accordance with the terms of their licence. However, you may prescribe unlicensed medicines where, on the basis of an assessment of the individual patient, you conclude, for medical reasons, that it is necessary to do so to meet the specific needs of the patient."

The committee reviewed the evidence for commissioning dapoxetine as a treatment for PE.

Five phase III randomised, double-blind, placebo-controlled trials and one integrated analysis of the five phase III trial papers demonstrated the efficacy of dapoxetine in the short term compared to placebo. Both doses of dapoxetine were shown to be significantly more efficacious in delaying intravaginal ejaculatory latency time at weeks 12 and 24 compared to placebo. Approximately ⅓ of patients receiving dapoxetine 30 mg were classed as 'responders'. It has been shown that there were 12% more 'responders' receiving 30 mg compared to placebo and up to a further 10% more 'responders' at the higher dose. Approximately ⅓ of patients receiving treatment with dapoxetine achieve at least a 'better' response in Clinical Global Impression of Change for this indication. One comparison study against the currently used unlicensed paroxetine was available. At a total daily dose of 20 mg paroxetine has been shown to achieve a greater increase in latency time at 12 weeks compared to a total daily dose of 60 mg dapoxetine. Patients receiving dapoxetine achieved increased patient reported outcome measures; however they do not achieve the same results as men not affected by this condition. Similar results were seen in latency times; men without PE have been shown to achieve a much longer mean duration compared to that achieved by men taking dapoxetine, however one study reported that the minimum important change in latency time is 1 minute for men with PE. Patients treated with placebo also achieved this minimum time point.

No UK published cost-effective analyses for dapoxetine were found. The clinical effectiveness team examined and modelled the only available study which reported the health utility of patients with PE. In comparison to paroxetine, dapoxetine is a more expensive treatment option. This and the potentially lower efficacy in comparison to a currently recognised and used medication should be considered in light of dapoxetine being the only licenced medication for this indication. In addition consideration of the costs incurred through delivery of the service will be required.

The committee considered a number of issues pertinent to this therapy:

- Issues relating to the prescribing of unlicensed medicines.
- Budget impact: some uncertainty exists about potential patient numbers; some limited data are available on existing consultations for PE; the degree to which increased investment in this area aligns with the strategic healthcare priories facing Devon.
- The limitations of the comparison study against paroxetine - the committee agreed that it was not making a decision about alternative treatments and only focussed on the commissioning of dapoxetine.
- High dropout rates seen in the literature. It was suggested that patients withdraw from trials due to their intrusive nature rather than adverse events associated with this medication.
- Safety and ease of use - dapoxetine only needs to be taken when required rather than on a daily basis.
- Equality and diversity - although trials only enrolled heterosexual men, there is no reason to restrict prescribing in this way.
- Cost effectiveness – the magnitude health gain associated with dapoxetine treatment is uncertain but the costs are known and considered poor value for NHS funds.

The committee voted unanimously against commissioning dapoxetine for this indication.

ACTION: Commissioning policy to be published

5. Taking decisions in the context of recommendations in NICE clinical guidelines

CCGs are not legally bound to comply with non-statutory guidance, however a recent court ruling made it clear that non-statutory guidance must be properly addressed and that in the absence of special factors which exceptionally justify departure from NICE guidance, the default position is that simple disagreement with guidance is not a valid reason for refusing to follow it. It was noted that committee members must be mindful of this judgement when making decisions, particularly in light of the proposed widening of the remit of CPC.

It is proposed that in addition to taking decisions on new drugs and treatments, CPC becomes a clinical discussion forum for the consideration of other issues for which commissioning decisions are required. The output of the committee in these instances would be recommendations to senior CCG executive groups for final decision making. A number of NICE Clinical Guidelines have already been identified as being in need of commissioning decisions.

The proposed changes to the remit of CPC have been raised with the Chairs of NEW Devon CCG and South Devon and Torbay CCG. Changes will be required to Terms of Reference of CPC and meetings will include a 'Part 2' discussion for these items.

The committee expressed agreement with this proposal.

6. Update from NICE Planning, Quality and Assurance Group (NPAG)

One NPAG meeting has taken place since the Clinical Policy Committee meeting held on 4th June 2014. The committee received a summary of the NICE guidance discussed.

NPAG had looked at NICE CG92 Venous Thromboembolism (VTE). It was suggested that this issue may be brought to a future CPC meeting for discussion as a 'Part 2' item and to produce a recommendation to the CCGs executive groups.

7. Addition of lay membership to roles and functions of group members

Mac Merrett and Jono Broad had produced a description of the 'roles and functions' of lay members of the Clinical Policy Committee to be included in the committee's Terms of Reference. The committee were in agreement with the description.

The Chair thanked Mac and Jono for their contribution.

8. Member attendance levels and nominated deputies

Following the presentation of the first annual report of the Clinical Policy Committee a paper has been produced setting out recommendations regarding the minimum levels of committee member attendance and the expectations for the nomination of deputies. It was noted that no minimum attendance had been set previously; the recommendations state that committee members are expected to attend 100% of meetings and that attendance should be monitored on a rolling basis by the secretariat. Any attendance below 66% should be notified to the Chair to follow up with the member. The statement on deputies had been amended to request that all nominated deputies are current advisory members of the committee and that a deputy can only deputise for one voting member at any given meeting. The lay members asked that the ToRs specify that this should only relate to non-lay members as they felt that being asked to act in a voting capacity would conflict with their role in representing the public interest of the local population.

The committee discussed a number of issues pertinent to the recommendations:

- It was agreed that a nominated deputy should be a current advisory member of the committee but not a lay member. Amendment to be reflected in the Terms of Reference.
- In order for the committee to be quorate four GP voting members should be present. However it was noted that committees find decision making easier when more members are present.

ACTION: Terms of reference to be amended to reflect agreement that a nominated deputy should be a current advisory member of the committee but not a lay member.

9. Any other business

Terms of Reference

A draft amended Terms of Reference for the Clinical Policy was tabled at the meeting. Following amendment to reflect the previous discussion the draft Terms of Reference will be taken to the CCGs governing bodies for ratification.

ACTION: Amended draft Terms of Reference to be taken to the CCGs governing bodies for ratification.

Summary of actions

	Action	**Lead**
14/04	*Lisdexamfetamine for ADHD in children and adolescents commissioning policy to be published.* The policy has been drafted and agreed by the CPC chair. Once it has been ratified by the CCGs governing bodies and taken through the FIGS process the policy will be published.	Rebecca Heayn
14/09	*Ratified annual report to be published.* Once ratified by both CCGs the annual report will be published.	Rebecca Heayn
14/13	Fidaxomicin for Clostridium difficile Infection commissioning policy to be published.	Rebecca Heayn
14/14	Dapoxetine for premature ejaculation commissioning policy to be published.	Rebecca Heayn
14/15	Terms of reference to be amended to reflect agreement that a nominated deputy should be a current advisory member of the committee but not a lay member.	Rebecca Heayn
14/16	Amended draft Terms of Reference to be taken to the CCGs governing bodies for ratification.	Rebecca Heayn