Northern, Eastern and Western Devon
Clinical Commissioning Group

South Devon and Torbay
Clinical Commissioning Group

Clinical Policy Committee

Minutes

Wednesday 21 March 2018, 10.00 am to 12.30 pm

The Watermark, Ivybridge

Present:

Dr Tawfique Daneshmend (Chair)	Consultant Gastroenterologist & Hepatologist	RD&E NHS FT
Dr Glen Allaway*	GP Clinical Commissioner	NEW Devon CCG
Dr Mick Braddick*	GP Clinical Commissioner	NEW Devon CCG
Dr Andrew Craig*	GP Clinical Commissioner	NEW Devon CCG
Paul Foster	Chief Pharmacist	T&SD NHS FT
Dr Lucy Harris*	GP Clinical Commissioner	South Devon & Torbay CCG
Tracey Polak	Assistant Director/Consultant of Public Health	Devon County Council
Chris Roome*	Head of Clinical Effectiveness	NEW Devon CCG
Dr Alison Round*	GP Clinical Commissioner	NEW Devon CCG
Dr Peter Rowe	Consultant Nephrologist	PH NHS Trust
Mark Taylor	Lay Public Member	

Guests:

Tomas Cudrnak	Consultant Ophthalmic Surgeon	PH NHS FT
Matt Howard	Clinical Evidence Manager	NEW Devon CCG
Hilary Pearce	Clinical Effectiveness Pharmacist	NEW Devon CCG
Naomi Scott	Healthcare Evidence Reviewer	NEW Devon CCG
Graham Simpole	Joint Formularies Support Pharmacist	NEW Devon CCG
Stephen Turner	Consultant Ophthalmic Surgeon	T&SD NHS FT

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 introductions

- Apologies were received from:

Richard Croker	Head of Medicines Optimisation Northern and Eastern Localities	NEW Devon CCG
Dr Andrew Gunatilleke	Consultant in Pain Management & Anaesthesia	T&SD NHS FT
Barbara Jones	Head of Locality Contracting	NEW Devon CCG
Mac Merrett	Lay Public Member	
Simon Polak	Deputy Chief Nursing Officer	NEW Devon CCG
Jo Roberts	GP Clinical Commissioner	South Devon & Torbay CCG
Dr Ben Waterfall	GP Clinical Commissioner	NEW Devon CCG

  Paul Foster gave apologies as he would be leaving the meeting early due to another commitment.

- The six voting members present were identified.
  Dr Ben Waterfall had deputised to Chris Roome.

- Declarations of Interest were collected. The Chair reviewed the Declarations of Interest. The Declarations made did not result in anyone being excluded from the meeting or from discussion of any item. All Declarations of Interest are reported in the minutes.

- Notification of Any Other Business

  Members were asked if they had any items of AOB to discuss.

DRUG/TECHNOLOGY TO BE CONSIDERED	PHARMACEUTICAL COMPANY / MANUFACTURER / SERVICE PROVIDER
Bevacizumab for radiation maculopathy **Bevacizumab for rubeosis iridis and neovascular glaucoma** **Bevacizumab for CNV-related conditions not including wet AMD and pathological myopia** **Bevacizumab for proliferative vascular retinopathies non-responsive to panretinal laser photocoagulation** Alternative treatments: **Ranibizumab** (Lucentis® solution for injection) **Aflibercept** (Eylea® solution for injection) **Retinal laser treatment** **Use of any of the above**	**Bevacizumab formulated for intravitreal injection produced by a variety of specials manufacturers using Avastin® concentrate for solution for infusion produced by Roche Products** **Novartis Pharmaceuticals** **Bayer Plc** As a provider of private services injecting anti-VEGF drugs for the treatment of ophthalmic conditions
Midodrine (Bramox®) **for orthostatic hypotension due to autonomic dysfunction** Alternative treatments: **Fludrocortisone**	**AAH Pharmaceuticals Ltd, Brancaster Pharma Limited** **AAH Pharmaceuticals Ltd, Alliance Healthcare (Distribution) Ltd, Aspen Pharma Trading Ltd**
The specialist management of abdominal wall hernia in adults	As a provider of private treatments for patients with hernia or divarication of recti

NAME OF ATTENDEE	ROLE	
Tomas Cudrnak	Consultant Ophthalmologist, Clinical Director REI, PHNT	Allergan UK – paid lectures, multiple sponsorship to attend national and international meetings. Allimera Sciences Ltd – paid lectures, sponsorship to attend one international meeting. Baush and Lomb – 2 educational dinners over the last 3 years. • *Work as paid adviser to above pharmaceutical/manufacturing company/companies.* – YES (Novartis, Bayer) • *In receipt of equipment or support staff from above pharmaceutical/manufacturing company/ companies.* – YES (Novartis – Joint Working Project 2016) • *In receipt of an educational/research grant for self or department from above pharmaceutical/ manufacturing drug company/companies. - YES (Novartis, Bayer)* • *Have taken part in drug trial for the above drug/s/devices/intervention/treatment.* - YES • *In receipt of lecture fees in excess of £150 in the last year from above pharmaceutical/ manufacturing company/companies.* – YES (Novartis) • *Received gifts, benefits or sponsorship of any kind, whether refused or accepted worth over £25 or several small gifts worth a total of over £100 from the above or closely related pharmaceutical/ manufacturing company/companies.* – YES (Novartis, Bayer) • *In receipt of payment/gift for transport and hospitality to attend national or international meetings or symposia.* – YES (Novartis, Bayer) • *In receipt of payment/gift for transport and hospitality to attend national or international meetings or symposia.* – YES (Novartis, Bayer) • *Any of the above interests for a competitor of this drug/device/intervention/treatment.* – YES (Novartis, Bayer) Novartis Pharmaceuticals – paid lectures, educational grants, travel grants to attend national and international meetings and honoraria to attend advisory boards. Bayer Plc – educational grants, travel grants to attend international meetings and honoraria to attend one advisory board.

2. Minutes of the meeting held on 24th January 2018 and matters/actions arising

The minutes of the meeting held on 24th January 2018 were approved.

Summary of actions		
	Action	**Lead**
17/14	*Recommended revisions to the CCGs' policy for Cryopreservation and QEIA to be prepared and subsequently progressed to final CCG approval and communication.* *The policy recommendation and QEIA have been signed off by the executive committees of NEW Devon CCG and of South Devon and Torbay CCG and is pending publication.* *The recommendation was discussed by the Clinical Policy Engagement and Consultation Panel on 11 October 2017. The panel had not considered that a full public consultation was required. However the panel did feel that people who had material stored should be contacted by letter explaining how the policy affected them to coincide with publication of the policy. A letter has been drafted.* *It has also been raised that letters should be written to the partners of people who have subsequently died but have material stored. A paper is being written for the Strategic Leadership Committee.* The paper has been written for a decision to be taken by the Strategic Leadership Committee on 21 March 2018.	Rebecca Heayn
17/17	*Azelastine hydrochloride and fluticasone propionate (Dymista®) for allergic rhinitis – Policy recommendation and QEIA to be prepared and subsequently progresses to final CCG approval and communication.* The policy has been published. Action complete.	
18/01	FreeStyle Libre device for interstitial glucose monitoring in diabetes: Policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication. The policy will be published shortly.	Rebecca Heayn
18/02	Management of Meibomian cysts (chalazia): proposed guidance to be updated in line with the discussion and shared with Lucy Harris and Fiona Irvine. Action complete.	

18/03	Management of Meibomian cysts (chalazia): policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication. The policy will be effective from 7th April 2018. Action complete.	Rebecca Heayn

3. Intravitreal Bevacizumab for radiation maculopathy

A request has been received from the lead ophthalmologist at Plymouth Hospitals NHS Trust supported by ophthalmologists from North Devon Healthcare NHS Trust and Torbay and South Devon NHS Foundation Trust for the routine commissioning of bevacizumab for the treatment of radiation maculopathy. A member of the Clinical Effectiveness team, New Devon CCG presented an evidence assessment. Mr Tomas Cudrnak, Consultant Ophthalmic Surgeon, Plymouth Hospitals NHS Trust and Mr Stephen Turner, Consultant Ophthalmic Surgeon, Torbay and South Devon NHS Foundation Trust took part in the discussion.

The committee was asked to recommend a policy position on the routine commissioning of intravitreal bevacizumab injection for the treatment of radiation maculopathy.

Radiation maculopathy is a potentially vision-threatening complication characterised by distorted vision and loss of visual acuity. It occurs in patients who have received irradiation for tumours of the eye, the orbit, paranasal sinuses and crania fossa. Untreated radiation maculopathy results in oedema, ischaemia, scarring with symptoms of distorted vision and loss of vision. There is no established treatment for this condition.

Bevacizumab is an anti-VEGF and there is a biological basis for its use in radiation maculopathy. Anti-VEGFs are established treatments for diabetic macular oedema and oedema secondary to retinal vein occlusion. In these conditions, anti-VEGFs have been shown to reduce macular oedema and stabilise or improve visual acuity. NICE TAs exist for ranibizumab and aflibercept for the treatment of diabetic macular oedema and oedema secondary to retinal vein occlusions.

Patients from Derriford Hospital with ocular cancer are referred to the Liverpool Ocular Oncology Centre (LOOC). The centre recommends intravitreal bevacizumab for the treatment of radiation maculopathy.

No randomised controlled trials (RCTs) were identified for bevacizumab for radiation maculopathy; there was only low quality evidence for consideration. Eight publications were identified for bevacizumab and one for ranibizumab including two prospective case series for bevacizumab and a phase I open-label clinical trial for ranibizumab. The majority of papers focused entirely on patients with uveal melanoma or choroidal melanoma. Two small prospective studies have shown that regular dosing of bevacizumab at the start of treatment followed by further injections as required stabilised or improved visual acuity in the majority of patients. A small phase I clinical trial of ranibizumab supports these findings. The mean follow-up period for these studies was 4 to 6 months. A retrospective review of medical records was identified from a centre which uses the same dosing regimen recommended by the Liverpool Ocular Oncology Centre. This review showed stabilisation of visual acuity for approximately nine months from the start of treatment. One retrospective review of medical records for consecutive patients compared the use of bevacizumab, triamcinolone and dexamethasone implant. The mean number of bevacizumab doses received by patients was 2 injections. Four weeks after the administration of bevacizumab stabilisation or improvement of visual acuity was reported in 92.1% of patients and 85.7% of patients receiving

triamcinolone. Almost 30% of patients receiving these treatments experienced an improvement in visual acuity.

No cost effectiveness analyses were identified for bevacizumab for the treatment of radiation maculopathy. Treatment of radiation maculopathy will be long term. Complete resolution of radiation maculopathy (without relapse) is reported to be rare.

Radiation maculopathy is most frequently seen following treatment of ocular cancers including uveal melanoma and choroidal melanoma. These cancers are rare.

It is expected that only a small number of patients will be starting treatment with bevacizumab for radiation maculopathy each year. It is estimated that patients will receive 7 injections during the first year of treatment. It is likely to be fewer in subsequent years. If it is assumed that five patients in Devon start treatment each year, the estimated cost for the first year of treatment is £8,540. For perspective, approximately 17,600 injections of anti-VEGFs were administered in Devon over a 12 month period during 2016/7.

The committee discussed issues pertinent to the policy application for Bevacizumab for radiation maculopathy:

- The specialists present complimented the paper produced by a member of the Clinical Effectiveness team. It was suggested that the paper be published.
- Patients with ocular tumours are treated at specialist centres in the UK. Specialist centres are funded by NHS England. Supportive care, including treatment for radiation maculopathy, is funded by CCGs. The specialists reported that such treatment is universally supported by ophthalmologists in England.
- There is no high quality evidence supporting treatment of radiation maculopathy with bevacizumab. However patient numbers are very low and it is unlikely that RCTs will be published in the future.
- The effectiveness of bevacizumab depends on the dose of radiation used to treat the tumour and the distance of the laser treatment from the iris. Literature searches indicate that radiation maculopathy gets worse over time. However the opinion of specialists present was that some patients can improve with treatment.
- It was noted that intravitreal bevacizumab is an unlicensed product. Intraocular steroids can be given; some patients get good results. However they have a less favourable side effect profile and are also not licensed for this indication.

The committee voted unanimously in favour of recommending acceptance of the proposed commissioning policy for the bevacizumab for radiation maculopathy.

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

4. Intravitreal Bevacizumab for rubeosis iridis and neovascular glaucoma

A request has been received from the lead ophthalmologist at Plymouth Hospitals NHS Trust supported by ophthalmologists from North Devon Healthcare NHS Trust and Torbay and South Devon NHS Foundation Trust for the routine commissioning of bevacizumab for the treatment of rubeosis iridis and neovascular glaucoma in certain circumstances. A member of the Clinical Effectiveness team, New Devon CCG presented an evidence assessment. Mr Tomas Cudrnak, Consultant Ophthalmic Surgeon, Plymouth Hospitals NHS Trust and Mr Stephen Turner Consultant Ophthalmic Surgeon, Torbay and South Devon NHS Foundation Trust took part in the discussion.

The committee were asked to recommend a policy position on the routine commissioning of intravitreal bevacizumab injection for the treatment of rubeosis iridis and neovascular glaucoma.

Neovascular glaucoma is a secondary glaucoma which has a poor visual prognosis and a high risk of surgical failure when glaucoma surgery is required. The most common causes are proliferative diabetic retinopathy and central retinal vein occlusion. These conditions occur as a result of retinal ischaemia which results in the release of angiogenic factors, including vascular endothelial growth factors (VEGF). These in turn trigger neovascularisation on the iris (rubeosis iridis). Bevacizumab is an anti-VEGF and there is a biological basis for its use in these conditions.

Progression of rubeosis iridis leads to new blood vessels appearing over the iridocorneal angle of the anterior chamber which begins to obstruct outflow of aqueous humour and if left unchecked eventually leads to closure of the angle and very high levels of intraocular pressure. The aim of treatment for rubeosis iridis is to induce regression of iris neovascularisation and prevent angle neovascularisation. Treatment of neovascular glaucoma focuses on the management of intraocular pressure and reducing the ischaemic drive.

Panretinal laser photocoagulation (PRP) is the gold standard treatment for eliminating the ischaemia which leads to neovascularisation and thus inducing regression of the new blood vessels. The local specialists had requested use of bevacizumab in the following circumstances:

1. Bevacizumab as an adjunct to PRP where laser alone has not been effective.

- No randomised controlled trials (RCTs) were identified for bevacizumab for this indication, there is only low quality evidence for consideration. For patients with a history of treatment with laser, the Clinical Effectiveness team found four prospective consecutive patient series for bevacizumab with follow-up periods ranging from 3 to 12 months plus two retrospective studies. A further prospective study of ranibizumab was included to support mechanism of action for anti-VEGFs. The majority of publications reported a significant reduction or complete regression of iris neovascularisation following a single dose of bevacizumab for rubeosis iridis and neovascular glaucoma. No progression of neovascularisation to the anterior chamber angle was reported in one study of rubeosis iridis alone.

- Early treatment appears to have a beneficial effect on angle neovascularisation. All publications reported a significant reduction in intraocular pressure (IOP) from baseline following a single dose of bevacizumab in patients with neovascular glaucoma.

2. As an adjunct to laser treatment if significant neovascularization of irido-corneal angle is already present.

   PRP has a delayed action, effects are not seen for several weeks. The Clinical Effectiveness team looked to see whether treatment with bevacizumab would induce regression of angle neovascularisation in the interval before the effects of PRP are seen.

- Low quality evidence from seven studies was identified; five prospective studies and two retrospective studies. These suggest that early treatment with bevacizumab is more likely to have a beneficial effect in patients with angle neovascularisation but no benefit is seen in patients with advanced glaucoma.

3. In the presence of media opacities which prevent the use of panretinal laser photocoagulation.

It is not possible to perform PRP in patients with media opacities. The rapid and often complete regression of iris neovascularisation seen following bevacizumab administration may reduce the risk of haemorrhage in patients who require cataract surgery. This would allow treatment with PRP to be initiated after cataract surgery. Cornea were reported to be completely clear after two injections of bevacizumab in a study of patients who were not able to receive PRP as a result of corneal oedema enabling treatment with PRP to be continued.

No cost effectiveness analyses were identified. Numbers are uncertain because of the range of circumstances in which bevacizumab may be used. It is estimated that there will be 17 new patients each year across Devon. Assuming each patient requires 2 to 3 injections of bevacizumab over a 12 month period the estimated cost of treatment would range from £8,295 to £12,445 for Devon.

Using bevacizumab may reduce the need for surgical management of IOP using trabeculectomy or insertion of drainage tubes for refractory raised IOP. The estimated cost of this for 17 patients is in the range £16,340 - £26,790. Neovascular glaucoma is associated with a high risk of surgical failure and complications compared with surgery for primary glaucoma.

The committee discussed issues pertinent to the policy application for Bevacizumab for rubeosis iridis and neovascular glaucoma.

- Specialists present stated that this was an effective treatment and the intention was to save time and money
- The primary treatment is laser but in some circumstances the blood vessels still grow. Most patients then require surgery with insertion of drainage tubes. If laser treatment does not work anti-VEGF is very useful. In addition, if the anterior chamber has closed completely laser treatment cannot be given. Nor can laser be used to treat patients with cataracts or corneal oedema.

The committee voted unanimously in favour of recommending acceptance of the proposed commissioning policy for the use of bevacizumab for neovascular glaucoma.

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

The specialists were thanked for attending and contributing to the discussion.

5. Bevacizumab for CNV-related conditions not including wet AMD and pathological myopia

Consideration of Bevacizumab for CNV-related conditions not including wet AMD and pathological myopia was deferred to a future meeting.

6. Bevacizumab for proliferative vascular retinopathies non-responsive to panretinal laser photocoagulation

Consideration of Bevacizumab for proliferative vascular retinopathies non-responsive to panretinal laser photocoagulation was deferred to a future meeting.

7. Midodrine for orthostatic hypotension due to autonomic dysfunction

Midodrine induces vasoconstriction of the venous system and increases peripheral arterial resistance, resulting in an increase in arterial blood pressure. It is licensed for the treatment of severe orthostatic hypotension due to autonomic dysfunction, when corrective factors have been ruled out and other forms of treatment are inadequate. Licensing was based on bioequivalence studies with the Gutron® brand of midodrine which was licensed in Austria in 1974.

When NICE updated their Parkinson's disease guidance in 2017 they recognised that midodrine had recently been licensed. NICE recommended midodrine as a first line pharmacological treatment option ahead of fludrocortisone. Traditionally patients with orthostatic hypotension have been treated by increasing fluid and salt in their diet and/or compression bandages. Historically the off-label use of fludrocortisone has been the first line treatment option when non-pharmacological options are unsuccessful.

Because of the NICE recommendation, the potential cost impact and the knowledge that unlicensed imported midodrine had previously featured in specialist prescribing, the Clinical Effectiveness team, NEW Devon CCG has undertaken a review of the clinical efficacy evidence. Naomi Scott, Healthcare Evidence Reviewer, NEW Devon CCG presented an evidence assessment. It is noted that the evidence base consists of a small number of non-comparable trials with significant limitations and meta analyses of these which raises questions.

In the Parkinson's guidelines NICE state that the lack of evidence comparing midodrine with the off-label and unlicensed drugs used in current practice means it could not be confident that midodrine clearly represents the optimal choice for patients with orthostatic hypotension and Parkinson's disease. However being mindful of good prescribing practice requirements it agreed it was reasonable that prescribers should consider midodrine, as a licensed product, before resorting to options without marketing authorisation.

When approached during the consultation process for this review local specialists stated that current practice would need to change in light of new NICE guidance, promoting midodrine to a first line pharmacological treatment option. As the prescribing of midodrine is £437 more expensive per patient per year than fludrocortisone the adoption of the updated NICE guidance could incur a significant cost impact to the Clinical Commissioning Groups in Devon. However, following the dissemination of the paper specialists from Plymouth and Exeter have responded with a differing position statement suggesting that in practice Fludrocortisone will remain the first line treatment option with midodrine being reserved for non-responders. This means there is unlikely to be a change in the pattern of use of midodrine.

The committee discussed issues pertinent to the prescribing of midodrine for orthostatic hypotension due to autonomic dysfunction.

- No policy application has been received from specialists for the routine commissioning of midodrine for this indication.
- The committee acknowledged that midodrine was a licensed treatment for orthostatic hypotension due to autonomic dysfunction, however the evidence for its effectiveness is limited and it is more costly than the unlicensed option.
- It is not intended that patients are switched from fludrocortisone to midodrine and the committee considered that continuation of work to produce a policy for the routine prescribing of midodrine may not be useful.
- The committee considered adding midodrine to the formulary. However it was felt that this may result in its use for other indications and GPs initiating prescribing. Under current arrangements prescribing is initiated in secondary care and GPs are asked to continue prescribing.

- The committee suggested that a reference to midodrine be added to the formulary. It was agreed that the formulary team would put together a form of words for consideration by the two formulary interface groups in Devon.

ACTION: Clinical Effectiveness team to produce a form of words for consideration by the two formulary interface groups in Devon.

8. The specialist management of abdominal wall hernia in adults

The specialist management of abdominal wall hernia in adults was reviewed by the Clinical Policy Committee in July 2017. At that time the committee requested that the criteria for functional impairment be reviewed for this policy. This work is now complete. Matt Howard, Clinical Evidence Manager, NEW Devon CCG presented a paper.

GPs working as referral facilitators at DRSS have suggested an alternative definition for the hernia policy that they felt could be consistently and equitably managed at a lower threshold of symptomatic severity and impairment than the current statement. A statement clarifying the position on surgical repair of divarication of recti was also requested by DRSS.

The Clinical Effectiveness team undertook additional consultation on the proposed changes with specialist surgeons from the four trusts. The revised definition of functional impairment suggested by DRSS provides a lower threshold for referral and surgical repair. This definition is closer to the definition of minimally symptomatic used in randomised controlled trials (RCTs) comparing watchful waiting with surgical repair of inguinal hernia in men. The revised definition was broadly acceptable to the majority of specialists who responded to the consultation.

Since the publication of the current policy, there has been a decrease in surgical hernia repairs across Devon. Adopting a revised definition of functional impairment for this policy, with a lower threshold for referral or surgery, would logically be expected to result in increased activity volumes. However feedback received during recent consultations highlighted that the current policy is not being fully implemented by DRSS, or by all surgeons at provider trusts. The reduction in the number of surgical procedures performed for hernia therefore reflects a mix of policy implementation at provider trusts and DRSS, as well as the impact of the policy on GP referral actions.

This situation is not equitable as some patients may not have been referred by their GP, in the expectation of a returned referral; other GPs may have referred patients in similar clinical circumstances, who were then passed through to secondary care. This uncertainty and a lack of data means it has not been possible to quantify the impact of changing the definition, and there is the possibility of a paradoxical further reduction in activity.

Divarication of recti is a condition where the abdominal muscles become separated in the middle, due to a widening of connective tissue. Although separations can affect both genders, they occur more often in women, and most frequently during pregnancy.

Divarications may be unsightly, but unlike hernias they do not carry a risk of strangulation or incarceration of the contents. It has been suggested that divarication of recti may result in reduced function of the abdominal muscles, lower back pain and urinary incontinence; however the evidence for this is limited and conflicting.

Divarication of the recti can be surgically repaired however, many divaricated recti spontaneously resolve without intervention. Non-surgical treatments include exercises and physiotherapy although the evidence base for these is also poor. Surgical repair of divarication of recti is not without risks, and represents a primarily cosmetic procedure in most cases. It is the position of the CCGs that NHS funding will not be provided for any treatment requested for cosmetic/aesthetic reasons.

The proposed statement clarifies the commissioning position for surgical repair of divaricated recti, and was considered clinically acceptable by the specialists who responded to the consultation. The option remains for applications to be made for exceptional funding for these patients. Including the proposed statement regarding surgical repair of divarication of recti is not expected to have a significant impact on activity.

The committee discussed issues pertinent to the specialist management of abdominal wall hernia in adults.

- The changes to the definition of functional impartment were noted. It was suggested that in order to help GPs discuss the possibility of treatment with patients, examples of patients meeting and not meeting the criteria be included in the Clinical Referral Guideline.
- It was suggested that the benefits to patients with abdominal wall hernia of smoking cessation be discussed with them. The committee acknowledged that in the first few months of smoking cessation patients may gain weight and that hernias may progress during the time patients are trying to cease smoking.
- It was suggested that when surgeons undertake larger numbers of hernia repair operations patient outcomes are better. The committee acknowledged that for the majority of medical conditions surgeons now work as specialists in the area concerned. Surgery for abdominal wall repair is currently an exception and is often undertaken as general surgery. The committee agreed that provider steer was required to reduce the number of surgeons undertaking abdominal wall hernia repair to allow those continuing to carry out a higher number of operations.
- During the initial review in July 2017 of the policy for the management of abdominal wall hernia in adults surgeons had commented that savings could be made in other ways including, for example, bulk buying of mesh and operating dedicated hernia lists. This suggestion can be rekindled and followed up by the CCGs' Planned Care Group.
- Tawfique Daneshmend suggested that he raise the issues of general surgery v specialist surgery with colorectal surgeons.

ACTION: Tawfique Daneshmend to raise issue of general surgery v specialist surgery with colorectal surgeons.

The committee voted unanimously in favour of recommending acceptance of the proposed commissioning policy for the specialist management of abdominal wall hernia in adults.

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

9. Update from NICE Planning Advisory Group (NPAG)

The committee received an update from the NICE Planning and Advisory Group meetings which took place on Tuesday 14th November 2017 and on Tuesday 9th January 2018.

NPAG meeting 14th November 2017

NPAG had considered sixteen NICE technology appraisals (TAs). It was noted that many of the TAs are commissioned by NHS England.

The Clinical Effectiveness team had raised a query with NICE about their costing template for Eluxadoline for treating irritable bowel syndrome with diarrhoea (NICE TA471), which is CCG commissioned, as it appeared to assume that patients would be treated for 26 weeks and then stop treatment for 26 weeks and then start again meaning that patients will receive treatment for only half of the year. As a result NICE had agreed to unlock their spreadsheet so that organisations can input their own data. The Clinical Effectiveness team expect that

once patients begin treatment they will receive it for 52 weeks of the year. It was noted that although irritable bowel syndrome with diarrhoea is a common condition uptake is expected to be low.

There had been discussion about several NICE public health and clinical guidelines. NPAG had expressed some concern at a lack of response from providers to some of the guidelines. These are being followed up through appropriate routes.

Other guidelines and guidance were discussed. Multimorbidity: clinical assessment and management (NG56) and Molecular testing for Lynch syndrome (DG27) in people with colorectal cancer were of particular interest.

During the consideration of Multimorbidity: clinical assessment and management (NG56), NPAG had noted that this guideline empowers and encourages prescribers to consider the total clinical circumstances of the person being treated and whether they may gain substantial benefit from their medication as an individual. Several issues had been raised by NPAG relating to GP time, relationships between providers, the work needed in secondary care and input from the Medicines Optimisation team. The issues discussed by have been raised with Samantha Smith, Iain Roberts and Tracey Polak.

CPC noted the potential benefits of not over medicating patients to both the patients and the NHS.

During the consideration of Molecular testing for Lynch syndrome it was felt that some clarity and/or prioritisation of responses were required from providers. These are being followed up. Further work and understanding is required with regard to local implementation of this guidance. Contact has been made with Jonathan Miller at the Cancer Network.

It was also noted that NEW Devon CCG had received a Freedom of Information request from a cancer charity.

CPC briefly discussed the 100,000 Genomes Project and genetics services locally.

NPAG meeting 9th January 2018

NPAG had considered fourteen NICE technology appraisals (TAs), the majority of which are NHS England commissioned.

Other guidelines and guidance were discussed. Spondyloarthritis in over 16s: diagnosis and management (NG65) was of particular interest. Written comments received by NPAG queried the resource impact suggested by the NICE costing template and indicated that the guidance is not widely followed in primary care. Formulary and referral guidance is being considered. There are links to work being undertaken by the Planned Care Group.

A member of CPC raised NICE CG71 Familial hypercholesterolaemia (update). It was noted that this had not been discussed at NPAG to date. Responses from providers are being followed up by Rebeca Heayn.

10. 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 7th February 2018.

Two topics had been discussed:

- Management of meibomian cysts (chalazia).

The panel recommended that no further engagement or formal consultation was required at this point. Once the policy has been ratified by the CCGs' Strategic Leadership Committee (SLC) Chris Roome will contact the Devon Optical Committee to ascertain whether future communication will be needed with private providers and if so who it should come from.

- FreeStyle Libre device for interstitial glucose monitoring in diabetes.

  The panel recommended that no further engagement or formal consultation was required. After considering all the patients interest factors the panel recommended that a communication be produced for specialists who run secondary care diabetes clinics clearly explaining the policy position, the reasons for it and where patients can access information on the policy from the CCG.

11. Any other business

Retirement of Dr Mick Braddick from the Clinical Policy Committee

The committee expressed sincere thanks to Dr Mick Braddick for his valuable and substantial contribution and commitment to the Clinical Policy Committee, its predecessor and the wider NHS.

The committee wished Dr Braddick well for any future endeavours and retirement.

Summary of actions

	Action	Lead
17/14	*Recommended revisions to the CCGs' policy for Cryopreservation and QEIA to be prepared and subsequently progressed to final CCG approval and communication.* *The policy recommendation and QEIA have been signed off by the executive committees of NEW Devon CCG and of South Devon and Torbay CCG and is pending publication.* *The recommendation was discussed by the Clinical Policy Engagement and Consultation Panel on 11 October 2017. The panel had not considered that a full public consultation was required. However the panel did feel that people who had material stored should be contacted by letter explaining how the policy affected them to coincide with publication of the policy. A letter has been drafted.* *It has also been raised that letters should be written to the partners of people who have subsequently died but have material stored. A paper is being written for the Strategic Leadership Committee.* The paper has been written and will be consideration by the Strategic Leadership Committee on 21 March 2018.	Rebecca Heayn
18/01	FreeStyle Libre device for interstitial glucose monitoring in diabetes: Policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication. The policy will be published shortly.	Rebecca Heayn
18/03	Intravitreal Bevacizumab for radiation maculopathy - Policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication.	Rebecca Heayn
18/04	Intravitreal Bevacizumab for rubeosis iridis and neovascular glaucoma - Policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication.	Rebecca Heayn
18/05	Midodrine for orthostatic hypotension due to autonomic dysfunction – form of words to be produced for consideration by the two formulary interface groups in Devon.	Matt Howard
18/06	The specialist management of abdominal wall hernia in adults – issue of general surgery v specialist surgery to be raised with colorectal surgeons.	Tawfique Daneshmend
18/07	The specialist management of abdominal wall hernia in adults - Policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication.	Rebecca Heayn