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

Clinical Policy Committee (CPC)
Minutes

Wednesday 23 November 2016, 9.30 am to 12.30 pm

Committee Suite, County Hall, Exeter

Present:

Dr Jo Roberts* (Chair)	GP Clinical Commissioner	South Devon & Torbay CCG
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
Dr Tawfique Daneshmend	Consultant Gastroenterologist & Hepatologist	RD&E NHS FT
Paul Foster	Chief Pharmacist	T&SD NHS FT
Dr Andrew Gunatilleke	Consultant in Pain Management & Anaesthesia	T&SD NHS FT
Barbara Jones	Head of Locality Contracting	NEW Devon CCG
Dr Lucinda Harris*	GP Clinical Commissioner	South Devon & Torbay CCG
Mark Kealy	Consultant in Public Health	Devon County Council
Andrew Kingsley	Patient Safety and Quality	NEW Devon CCG
Mac Merrett	Lay Member	
Chris Roome	Head of Clinical Effectiveness	NEW Devon CCG
Dr Alison Round*	GP Clinical Commissioner	NEW Devon CCG
Dr Ben Waterfall*	GP Clinical Commissioner	NEW Devon CCG

Guests:

Mr Daniel Byles	Consultant Ophthalmologist	RD&E NHS FT
Louise Crathorne	Clinical Evidence Scientist	NEW Devon CCG
Dr Muriel Gijsel	Consultant Child & Adolescent Psychiatrist	Devon Integrated Children's Services
Dr Jonathan Graham	Consultant Paediatrician	T&SD NHS FT
Matt Howard	Clinical Evidence Manager	NEW Devon CCG
Mr Peter Simcock	Consultant Eye Surgeon	RD&E NHS FT
Petrina Trueman	Clinical Evidence Pharmacist	NEW Devon CCG

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

Attendees were welcomed to the meeting and introduced themselves.

Welcome to new members

Due to changes at GP practices and other commitments Dr Peter Leman, Dr Darunee Whiting and Dr Phil Melluish had recently stepped down from the committee. The committee expressed thanks to the three members who were stepping down for all their hard work. The chair welcomed Dr Lucinda Harris, South Devon and Torbay CCG and Dr Glen Allaway, NEW Devon CCG to the committee, taking up their new roles as GP Clinical Commissioners. One vacancy remains in respect of a replacement for Dr Peter Leman from the Western Locality, NEW Devon CCG.

Apologies

Richard Croker	Head of Medicines Optimisation Northern and Eastern Localities	NEW Devon CCG
Miles Earl	Contract Accountant	NEW Devon CCG
Samantha Morton	Head of Contracting and Procurement	South Devon & Torbay CCG

Confirmation of voting members and Declarations of Interest

The seven voting members present were identified.

Declaration of Interest forms were collected and reviewed by the Chair. All Declarations of Interest are reported in the minutes.

DRUG/TECHNOLOGY TO BE CONSIDERED	PHARMACEUTICAL COMPANY / MANUFACTURER / SERVICE PROVIDER
Guanfacine (Intuniv®) **for attention deficit hyperactivity disorder (ADHD) in children and adolescents**	**Shire Pharmaceuticals Limited**
Alternative treatments:	
Atomoxetine (Strattera®)	**Eli Lilly and Company Limited**
Dexamethasone intravitreal implant (Ozurdex®) **for the treatment of non-infectious posterior uveitis**	**Allergan Ltd**
Alternative treatments:	
Various steroids and immunosuppressants (various branded and generic)	**Various manufacturers**
Botulinum toxin A for the management of blepharospasm (Botox®, Dysport®, Xeomin®)	**Allergan, Ipsen, Merz Pharma UK** As a provider of private botulinum toxin treatment for patients with blepharospasm
Botulinum toxin A for the management of hemifacial spasm (Botox®, Dysport®)	**Allergan, Ipsen**
Alternative treatments:	
Microvascular decompression	**Specialist neurosurgery providers** As a provider of private treatments for patients with hemifacial spasm

NAME OF ATTENDEE	ROLE	
Dr Muriel Gijsel	Consultant Child Psychiatrist	Attended meeting sponsored by Shire Pharmaceuticals Limited

Notification of Any Other Business

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

2. Minutes of the meeting held on 14th September 2016 and matters/actions arising

The minutes of the meeting held on 14th September 2016 were approved.

Summary of actions		
	Action	**Lead**
16/07	*Policy recommendation and QEIA for Dulaglutide (Trulicity®) for the treatment of type 2 diabetes to be prepared and subsequently progressed to final CCG approval and communication.* *This has been considered by the Clinical Policy Engagement and Consultation Panel. The policy recommendation and QEIA were approved by NEW Devon CCG on 7th September 2016 and will be presented to South Devon and Torbay CCG on 15th September 2016.* The policy was published on 14 October 2016. Action complete	
16/08	*Policy recommendation and QEIA for Myringotomy/grommets with or without adjuvant adenoidectomy for the management of otitis media in children under 12 years to be prepared and subsequently progressed to final CCG approval and communication.* *This has been considered by the Clinical Policy Engagement and Consultation Panel. The policy recommendation and QEIA were approved by NEW Devon CCG on 7th September 2016 and will be presented to South Devon and Torbay CCG on 15th September 2016.* The policy was published on 30 October 2016. Action complete	
16/09	*Policy recommendation and QEIA for Myringotomy with or without ventilation tubes (grommets) in adults and children aged 12 years and older to be prepared and subsequently progressed to final CCG approval and communication.* *This has been considered by the Clinical Policy Engagement and Consultation Panel. The policy recommendation and QEIA were approved by NEW Devon CCG on 7th September 2016 and will be presented to South Devon and Torbay CCG on 15th September 2016.* The policy was published on 30 October 2016. Action complete.	

16/10	*Policy recommendation and QEIA for Tonsillectomy to be prepared and subsequently progressed to final CCG approval and communication.* *This has been considered by the Clinical Policy Engagement and Consultation Panel. The policy recommendation and QEIA were approved by NEW Devon CCG on 7th September 2016 and will be presented to South Devon and Torbay CCG on 15th September 2016.* The policy was published on 30 October 2016. Action complete.	
16/11	*Policy recommendation and QEIA for Ivermectin (Soolantra®) for Rosacea to be prepared and subsequently progressed to final CCG approval and communication.* Awaiting approval of QEIA prior to publication.	Rebecca Heayn
16/12	*Policy recommendation and QEIA for Linaclotide (Constella®) for the treatment of irritable bowel syndrome with constipation (IBS-C) in adults to be prepared and subsequently progressed to final CCG approval and communication.* Awaiting approval of QEIA prior to publication.	Rebecca Heayn
16/13	*Policy recommendation and QEIA for surgery for Ganglion Cyst to be prepared and subsequently progressed to final CCG approval and communication.* Awaiting confirmation of implementation date from DRSS prior to publication.	Rebecca Heayn

3. Guanfacine (Intuniv®) for attention deficit hyperactivity disorder (ADHD) in children and adolescents

A formulary application has been received from Dr Dag Vinthagen, Consultant Paediatrician, Plymouth Hospitals NHS Trust for the use of guanfacine (Intuniv®) for the treatment of ADHD in children and adolescents. An evidence review had been undertaken by Petrina Trueman, Clinical Evidence Pharmacist, NEW Devon CCG. This was presented by Matt Howard, Clinical Evidence Manager, NEW Devon CCG. Dr Muriel Gijsel, Consultant Child and Adolescent Psychiatrist, Devon Integrated Children's Services and Dr Jonathan Graham, Consultant Paediatrician, Torbay and South Devon NHS Foundation Trust participated in the discussion of this item. Dr Vinthagan had provided a written response to a number of questions. This was reported to the committee.

Guanfacine is a selective α2A-adrenergic receptor agonist. Prolonged-release guanfacine is licensed for the treatment of ADHD in people aged 6-17 years old for whom stimulants are not suitable, not tolerated or are ineffective and should only be used as part of a comprehensive ADHD treatment programme. NICE CG72 on ADHD diagnosis and management pre-dates the licensing of guanfacine in the UK; it considers methylphenidate to be the first line treatment, atomoxetine is recommended if methylphenidate is ineffective at the maximum tolerated dose or the patient is intolerant to low or moderate doses of methylphenidate. Guanfacine would be an alternative to atomoxetine after failure of stimulants, or in patients where stimulants are contraindicated. The joint formularies in Devon include atomoxetine alongside methylphenidate, and lisdexamphetamine as options for the management of ADHD.

In short term studies the superiority of guanfacine over placebo was shown using a range of validated scoring tools. Symptom improvement measured using the validated ADHD-RS-IV scale was the primary end point used in most studies. The pivotal randomised controlled trial (RCT)

demonstrated that patients treated with guanfacine achieved significantly greater reduction in ADHD-RS-IV total score compared with placebo from baseline to end of trial. Statistically significant differences were also seen for guanfacine compared to placebo in the proportion of participants with symptoms that were "very much improved" or "much improved" on the clinician assessed CGI-I symptom severity scale. Patients with both a 30% reduction in ADHD-RS-IV and either "very much improved" or "much improved" symptoms were defined as "responders". A greater proportion of "responders" was seen in the guanfacine group than placebo. Direct comparative evidence evaluating guanfacine against other ADHD treatments is lacking. The randomised controlled trial (RCT) included atomoxetine as a reference control arm. It reported numerically greater improvement in symptom scores with guanfacine than atomoxetine, but the study was not powered to detect a difference between the two treatments. Two indirect comparisons carried out to address the lack of direct comparative data, suggest that guanfacine may be more effective than atomoxetine in terms of reduction in ADHD symptoms. However, uncertainties within the analyses mean that the degree of any difference in efficacy of guanfacine compared to other treatments is unclear. Adverse events are dose- and exposure-related. In clinical studies the most frequently reported adverse reactions include somnolence, headache, fatigue, upper abdominal pain and sedation. Serious adverse reactions include hypotension, weight increase, bradycardia and syncope.

Cost utility analyses carried out by the manufacturers calculated that, compared to atomoxetine, guanfacine would be associated with an incremental cost effectiveness ratio (ICER) of approximately £13,500 per quality adjusted life year (QALY). Whilst the base case analyses suggest ICERs below £20,000 per QALY, there is uncertainty in the efficacy assumptions that underpin it. Plausible scenario analyses suggest ICERs well above the threshold which would usually be considered to represent value for money for the NHS. Budget impact models supplied by the manufacturer suggest maximum increased prescribing costs associated with the use of guanfacine entirely instead of atomoxetine of up to £90,000 per annum. Assuming a 30% uptake after three years there would be increased costs of £26,000 per annum. The manufacturers suggest that approximately 60% of the increased prescribing costs may be offset by a reduction in healthcare resource utilisation resulting in a suggested net financial impact to the local health economy of approximately £11,000 per annum after three years. However it is noted that any reduction in health resource utilisation represents a notional saving which may free up capacity but is unlikely to be cash releasing.

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

- The specialists present stated that guanfacine (Intuniv®) may benefit a small number of patients; it could be used as an alternative to atomoxetine. Specialist experience is that patients stop taking atomoxetine and that methylphenidate has other side effects.
- Clinical trials for guanfacine (Intuniv®) are short term and provide limited evidence. The benefits and side effects of long term use are not known. Patients may experience sedation, although this usually wears off and weight gain, which can be significant.
- NICE recommend a multidisciplinary approach with families. Specialists present stated that teachers and parents report longer term benefits; however it is difficult to identify the reason for improvement. The desired outcomes can be expected many years on from initial treatment.
- The prescribing costs of guanfacine (Intuniv®) are expected to increase but there may be savings from patients needing fewer appointments.
- Specialists noted that school nurses have a valuable role in helping children with ADHD and that service changes affecting them could have more impact.

The committee voted 6 to 1 against recommending the routine commissioning of guanfacine (Intuniv®) for attention deficit hyperactivity disorder (ADHD) in children and adolescents

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

The committee discussed the options for specialists wishing to prescribe guanfacine for their patients. The committee noted that funding for guanfacine (Intuniv®) would require specialists to make an individual case application for exceptionality through the Individual Funding Panel (IFP).

4. Dexamethasone intravitreal implant (Ozurdex®) for the treatment of non-infectious posterior uveitis

A formulary application has been received for the use of Dexamethasone intravitreal implant (Ozurdex®) for the treatment of non-infectious posterior uveitis. Louise Crathorne, Clinical Evidence Scientist, NEW Devon CCG presented an evidence assessment. Mr Peter Simcock, Consultant Eye Surgeon took part in the discussion of this item.

Dexamethasone intravitreal implant (Ozurdex®) is a biodegradable ophthalmic implant which contains 0.7 mg of the active drug. Each implant is administered intravitreally using a single-use polymer drug delivery system or applicator. A NICE medical technology appraisal is currently underway evaluating ozurdex® and adalimumab for the treatment of posterior non-infectious uveitis. The final appraisal determination is due in July 2017. Neither the Scottish Medicines Consortium nor the All Wales Medicines Strategy Group recommends Ozurdex® for use in this indication due to a non-submission from the manufacturer.

Uveitis is the term used to describe inflammation of any structure within the eye that when very severe may cause visual loss, in this case the posterior of the eye. Epidemiology evidence suggests that prevalence is between 3 and 10 per 100,000 population, currently the patient pathway as indicated by NHS England suggests approximately 20% of these patients have severe sight-threatening uveitis. Approximately 10% of patients fulfil criteria for biologics adalimumab or infliximab which can be accessed via specialist centres. The applicant, Mrs Hirut von Lany, Consultant Ophthalmic Surgeon, Royal Devon and Exeter NHS Foundation Trust has requested the routine commissioning of Ozurdex® for the following populations:

- Patients failing prior multiple or contraindicated to prior therapies
- Patients with severe unilateral uveitis

Available clinical trial evidence is the same for both populations. Clinical trial evidence has shown Ozurdex® to exhibit efficacy in comparison to sham across a range of measures that assess vitreous haze visual acuity. Ozurdex® was associated with clinically significant gains in visual acuity compared with sham. There are no head-to-head trials versus an active comparator.

Ozurdex® is associated with ocular adverse events; it has a low incidence of non-ocular adverse events and in particular avoids systemic exposure to steroids and the consequent side effects. Ozurdex® is likely to result in overall NHS cost savings as fewer patients will progress to more expensive therapies. Implications for local budgets depend on where Ozurdex® is placed in the treatment pathway.

The committee were asked to make a recommendation on the use of Ozurdex® in the two separate patient populations specified.

The committee discussed issues pertinent to this recommendation:

- Posterior uveitis is comparatively rare and disease presentation varies. This leads to differences in initial and subsequent treatment decisions. Broadly, there is a need to consider the disease type, (bilateral or unilateral) and the severity of disease. Patients with severe disease receive local injections of steroid with biologics added in.
- Patients with severe disease would receive steroids in line with Bristol. Those with a good response and low side effects would remain on this treatment.
- Ozurdex® is a steroid injected directly into the eye. It works for between four and six months and avoids the need for many patients to take systemic steroids for long periods which may result in serious side effects including infection.
- Ozurdex® is recommended and approved for inflammatory disease. A large evidence base is available as a result of its use in other indications. There are some potential side effects associated with Ozurdex® but these are generally manageable, reversible or topically controlled.
- A small deterioration in vison can have a significant impact on quality of life. Non-infectious posterior uveitis can cause sight loss.
- Overall there will be a cost saving for the NHS but a cost pressure to the CCGs.

The committee voted unanimously in favour of recommending dexamethasone intravitreal implant (Ozurdex®) for the treatment of bilateral non-infectious posterior uveitis.

The committee voted unanimously in favour of recommending dexamethasone intravitreal implant (Ozurdex®) for the treatment of unilateral non-infectious posterior uveitis.

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

5. Botulinum Toxin A for the management of blepharospasm and for the management of hemifacial spasm

Botulinum toxin A for the management of blepharospasm and for the management of hemifacial spasm was considered by the Clinical Policy Committee in September 2015. At that time botulinum toxin was accepted for routine commissioning, pending development of clinically appropriate treatment criteria which capture functional limitations consistent with the position the CCGs adopted in relation to other conditions.

The Clinical Effectiveness team was asked to liaise with specialists from the four acute trusts in Devon to develop these criteria. An extensive consultation period followed, during which consideration was given to strategic direction, professional guidance, the position of other CCGs, clinical scales of symptom frequency, severity of disease, quality of life that have been used in clinical trials; and criteria applied in current Devon CCGs' commissioning policies for other conditions. Matthew Howard, Clinical Evidence Manager, NEW Devon CCG presented this item. Mr Daniel Byles, Consultant Eye Surgeon attended to take part in the discussion of this item.

No relevant strategic direction or guidance were able to directly inform development of these criteria. A search was conducted to identify other CCGs' commissioning policies relating to BoNT A for any indication. 40 policies were identified which cover blepharospasm and/or hemifacial spasm. Of these policies, 39 routinely commission BoNT A for blepharospasm, and 37 routinely commission BoNT A for hemifacial spasm.

Mr Daniel Byles, from the Royal Devon and Exeter NHS Foundation Trust had agreed to act as representative for the four trusts and meet with representatives of the Clinical Effectiveness team to develop criteria.

This meeting considered clinical rating scales, the position of other CCGs, and criteria relating to functional impairment in current commissioning policies adopted by the CCGs in Devon. The resulting criteria for treatment are based on functional impairment criteria included in two other current Devon-wide commissioning policies – namely those for cataract surgery; and the specialist management of abdominal wall hernia in adults. The proposed criteria are therefore based on, and consistent with, current Devon CCGs' commissioning policies with respect to functional impairment.

Mr Byles circulated draft policies to specialist representatives from the ophthalmology departments of the four acute trusts in Devon for further comment; no additional comments were received during this consultation period.

During consultation it was suggested by local specialists that adoption of any criteria could either:
a) increase referral and treatment by highlighting the conditions; or
b) lead to an inappropriate reduction in referral and treatment with BoNT A.

Whilst local specialists indicate that the proposed policy is broadly in line with current practice, it has also been suggested that adoption of these criteria may support discussions with patients with milder symptoms who would not meet the threshold for treatment. By adopting consistent, equitable, clinically appropriate treatment criteria across Devon, there may therefore be a small, but not clearly quantifiable reduction in patients undergoing treatment of blepharospasm or hemifacial spasm with botulinum toxin A.

The committee discussed issues pertinent to the proposed policies for botulinum toxin for the management of blepharospasm and hemifacial spasm:
- the policies may stop a few very mild cases being treated,
- patients with idiopathic blepharospasm cannot drive unless their condition is controlled.

The committee voted unanimously in favour of recommending the proposed policies for botulinum toxin for the management of blepharospasm and hemifacial spasm.

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

6. Degarelix for advanced hormone-dependent prostate cancer

The Committee received a paper 'Commissioning policy for degarelix for advanced hormone-dependent prostate cancer' for information.

The paper reported that in August 2016 NICE had published a mandatory recommendation in Technology Appraisal 404 (degarelix for treating advanced hormone-dependent prostate cancer), which in part supersedes a commissioning decision by the Peninsula Health Technology Commissioning Group. This decision was previously adopted by the CCGs in Devon having originally been agreed by the predecessor PCTs in Devon and Cornwall.

The Peninsula Health Technology Commissioning Group concluded that degarelix would not be routinely commissioned for advanced hormone-dependent prostate cancer as it was considered that there was insufficient evidence of clinical benefit compared to current standard therapy with gonadorelin analogues. NICE TA404 recommends the use of degarelix for treating advanced hormone-dependent prostate cancer in patients with spinal metastases. The NICE Appraisal Committee noted that the use of degarelix for treating the broader population of patients with advanced hormone-dependent prostate cancer was not considered to be a cost-effective use of NHS resources.

The CCGs commissioning policy has been updated in line with NICE Technology Appraisal 404 in accordance with statutory responsibilities to commission within 90 days of publication but continues to apply to patients without spinal metastases. This position has been ratified by the CCGs' Executive Groups.

7. Updates from NICE Planning, Quality and Assurance Group (NPAG)

NPAG meeting 6th September 2016

The committee received an update from the NPAG meeting which had taken place on 6th September 2016. At the meeting the group had considered eleven pieces of NICE Technology Appraisal Guidance, one piece of highly specialised technology guidance, two NICE Guidelines, one piece of public health guidance, three clinical guidelines, and eight pieces of Interventional Procedures Guidance.

NPAG meeting 1 November 2016

The committee received an update from the NPAG meeting which had taken place on 1 November 2016. At the meeting the group had considered thirteen pieces of NICE Technology Appraisal Guidance, one piece of clinical guidance, four pieces of NICE guidance, two pieces of diagnostic guidance, four pieces of interventional procedures guidance.

The committee discussed issues pertinent to NPAG:

- Some concern was expressed with regard to lack of engagement with the group by commissioners and contracting.
- Some areas of work previously undertaken have ceased
- NPAG will act as an advisory group.

8. Update from Clinical Policy Engagement and Consultation Panel

The committee receive the minutes of the Clinical Policy Engagement and Consultation Panel meeting which took place on Tuesday 11th October 2016.

It was reported that the group had considered three policy recommendations from the Clinical Policy Committee meeting held on Wednesday 14th September 2016 and agreed that no further engagement or public consultation action was required.

9. Update on Lay Public Member vacancy

Jono Broad, Lay Public Member had previously stepped down from the committee. An advertisement for a replacement has been placed and one application had been received. However the shortlisting panel felt that the applicant had not demonstrated their suitability for the role. The position has subsequently been re-advertised with a closing date of 16 December 2016.

10. Any other business

Specialist engagement

A great deal of work is involved in producing papers for the Clinical Policy Committee. It was noted that the Clinical Effectiveness team were experiencing difficulties in securing engagement from specialists when developing commissioning policies. The committee discussed issues pertinent to this:

- It was agreed the trust chief pharmacists and the Drug & Therapeutic Committee chairs or equivalents be added to relevant Clinical Effectiveness distribution lists and thereby notified of any formulary applications received. They would then endeavour to promote engagement by specialists.

ACTION: Trust chief pharmacists and Drug and Therapeutic Committee chairs or equivalents be added to relevant Clinical Effectiveness distribution lists and thereby notified of any formulary applications received.

- More than one specialist must want a treatment to be made available to justify its consideration for inclusion as a commissioned treatment. It was suggested that on receipt of a formulary application communication is sent to relevant specialists informing them of the application and stating that it will only be taken forward if there is widespread support with a clear rationale.
- It was suggested that if there is no specialist representation at the CPC meeting, either in person or via teleconferencing, the item will not be discussed.
- More in depth responses will be required from specialists answering questions with regard to a formulary application. Answers must be the independent views of the specialist not simply an expression of agreement with a response from another specialist.

Clinical Effectiveness Staffing

Petrina Trueman is leaving the CCG to take up a new role. The group thanked Petrina for all her hard work and extended their best wishes for the future.

Clinical Policy Committee Meeting Wednesday 18th January 2017

It was agreed that Dr Ali Round will chair the Clinical Policy Committee meeting due to take place on 18th January 2017 in the absence of Dr Jo Roberts.

Summary of actions		
	Action	**Lead**
16/11	Policy recommendation and QEIA for Ivermectin (Soolantra®) for Rosacea to be prepared and subsequently progressed to final CCG approval and communication. Awaiting approval of QEIA prior to publication.	Rebecca Heayn
16/12	Policy recommendation and QEIA for Linaclotide (Constella®) for the treatment of irritable bowel syndrome with constipation (IBS-C) in adults to be prepared and subsequently progressed to final CCG approval and communication. Awaiting approval of QEIA prior to publication.	Rebecca Heayn
16/13	Policy recommendation and QEIA for surgery for Ganglion Cyst to be prepared and subsequently progressed to final CCG approval and communication. Awaiting confirmation of implementation date from DRSS prior to publication.	Rebecca Heayn
16/14	Policy recommendation and QEIA for Guanfacine (Intuniv®) for attention deficit hyperactivity disorder (ADHD) in children and adolescents to be prepared and subsequently progressed to final CCG approval and communication.	Rebecca Heayn
16/15	Policy recommendation and QEIA for Dexamethasone intravitreal implant (Ozurdex®) for the treatment of non-infectious posterior uveitis to be prepared and subsequently progressed to final CCG approval and communication.	Rebecca Heayn
16/16	Policy recommendation and QEIA for Botulinum Toxin A for the management of blepharospasm and for the management of hemifacial spasm to be prepared and subsequently progressed to final CCG approval and communication.	Rebecca Heayn
16/17	Specialist engagement with processes of the clinical policy committee – trust chief pharmacists and Drug and Therapeutic Committee chairs or equivalent be added to distribution lists and thereby notified of any formulary applications received.	Matt Howard