Northern, Eastern and Western Devon
Clinical Commissioning Group

South Devon and Torbay
Clinical Commissioning Group

Clinical Policy Committee

Minutes

Wednesday 26th September 2018, 9.30 am to 12.30

Committee Suite, County Hall, Exeter

Present:

Dr Jo Roberts (Chair)	Voting Member	South Devon & Torbay CCG
Dr Glen Allaway	Voting Member	NEW Devon CCG
Dr Andrew Craig	Voting member	NEW Devon CCG
Paul Foster	Chief Pharmacist	T&SD NHS FT
Dr Lucy Harris	Voting Member	South Devon & Torbay CCG
Dr Andrew Harrison	Voting Member	NEW Devon CCG
Mac Merrett	Lay Public Member	
Chris Roome	Head of Clinical Effectiveness	NEW Devon CCG
Dr Alison Round	Voting Member	NEW Devon CCG
Dr Peter Rowe	Consultant Nephrologist	University Hospitals Plymouth NHS Trust
Tracey Polak	Assistant Director of Public Health	Devon County Council
Simon Polak	Assistant Chief Nursing Officer	NEW Devon CCG
Mark Taylor	Lay Public Member	
Dr Ben Waterfall	Voting Member	NEW Devon CCG

Guests:

Dr Umesh Acharya	Consultant in Obstetrics	University Hospital Plymouth NHS Trust
Rebecca Cowie	Principal Embryologist	Royal Devon and Exeter NHS FT
Sally Doidge	Principal Embryologist	University Hospital Plymouth NHS Trust
Dr Lisa Joels	Consultant Gynaecologist and Responsible Person for the fertility centre	Royal Devon and Exeter NHS FT
Matt Howard	Clinical Evidence Manager	NEW Devon CCG
Dr Philip Hughes	Consultant Respiratory Specialist	University Hospitals Plymouth NHS Trust
Dr Chris Moudiotis	Consultant Paediatrician	Royal Devon and Exeter NHS Trust
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
Dr Roderick Warren	Consultant Physician	Royal Devon and Exeter NHS Trust

In attendance:

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

1. Welcome and introductions

Apologies

Richard Croker	Head of Medicines Optimisation Northern and Eastern Localities	NEW Devon CCG
Dr Nick D'Arcy	Voting Member	South Devon & Torbay CCG
Dr Tawfique Daneshmend	Consultant Gastroenterologist & Hepatologist	RD&E NHS FT

Subsequent to the meeting apologies were received from Barbara Jones, Head of Locality Contracting, NEW Devon CCG

Confirmation of voting members and Declarations of Interest

The eight voting members present were identified.
Dr Nick D'Arcy had requested Chris Roome to deputise as voting member in his absence.

Declarations of Interest were collected and reported. The Declarations made did not result in anyone being excluded from the meeting. However Dr Jo Roberts absented himself from voting in respect of two items. These were Insulin Degludec (Tresiba®) for use in patients with type 1 diabetes and Insulin Deglude (Tresiba®) for use in patients with type 2 diabetes. All Declarations of Interest are reported in the minutes.

DRUG/ TECHNOLOGY TO BE CONSIDERED	PHARMACEUTICAL COMPANY/ MANUFACTURER/ SERVICE PROVIDER
Assisted conception	Providers of assisted conception services
Fluticasone furoate, umeclidinium and vilanterol (Trelegy® Ellipta®) **combination dry powder inhaler for Chronic Obstructive Pulmonary Disease (COPD)**	GlaxoSmithKline UK
Alternative treatments:	
Any other monotherapy or combination inhalers for COPD	Various manufacturers
Cosmetic treatments	Providers of cosmetic treatments
Reversal of male and female sterilisation	Providers of procedures for the reversal of male and female sterilisation
Insulin Degludec (Tresiba®) **for use in patients with type 1 and type 2 diabetes**	Novo Nordisk Ltd
Alternative treatments:	
Insulin detemir (Levemir®)	Novo Nordisk Ltd
Insulin glargine (Abasaglar®, Lantus®, Toujeo®)	Eli Lilly and Company Ltd, Sanofi

NAME OF ATTENDEE	ROLE	Declaration
Dr Jo Roberts	Voting Member	Pfizer and Chiesi – have provided Medical and Educational Goods and Services (MEGS) to support COPD management Advisory Board Meeting Novo Nordisk – paid regarding NHS landscape.
Dr Peter Rowe	Consultant Nephrologist/Secondary Care Clinician	One interview with representative from Pfizer about apixaban, one presentation on serum free light chain assay by medical scientific officer.
Dr Roderick Warren	Consultant Physician	2016 – Novo Nordisk advisory board meeting (paid).
Dr Alison Round	Voting Member	Paid employee of Royal Devon and Exeter NHS Trust as a salaried GP

Notification of any other business

The Committee were asked if there are any items of AOB for consideration.

2. Minutes of the meeting held on 18th July 2018 and matters/actions arising

The minutes of the meeting held of 18th July 2018 were approved.

Summary of actions		
	Action	**Lead**
18/08	Fluticasone furoate and vilanterol trifenatate (Relvar® Ellipta®) combination inhaler for asthma – Policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication. The place in therapy for Fluticasone furoate and vilanterol trifenatate (Relvar® Ellipta®) is being discussed by the two Formulary Interface Groups in Devon. Once agreed the policy will be published. Published – action complete.	
18/13	Rivaroxaban for the prevention of recurrent deep vein thrombosis (DVT) and pulmonary embolism (PE): letter to be written to specialists stating that the committee had been unable to reach a decision in their absence as specific questions were raised during the discussion. The application may be considered at a future meeting subject to the	Jo Roberts

	attendance of specialists. Dr Roberts has written to specialists. No response has been received. This has been followed up by the Clinical Effectiveness Team.	
18/14	Opicapone for Parkinson's Disease - Policy Recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication. Approval is awaited from the CCGs. It is hoped that the policy will be published by the end of the week.	Rebecca Heayn

3. Assisted conception: fertilisation failure and abandon cycles

An Individual Funding Request (IFR) application has highlighted the need for a policy position on In vitro fertilisation (IVF) cycles which are abandoned as a result of total fertilisation failure (the failure of all oocytes to fertilise). This required three areas of the Devon CCGs' assisted conception policy to be addressed. The areas for consideration are indications for Intracytoplasmic sperm injection (ICSI), Indications for donor egg and Abandoned IVF or ICSI cycle. It also became apparent that clarification of the existing statements on abandoned embryo transfers was required. A member of the Clinical Effectiveness team, NEW Devon CCG presented a paper. Dr Umesh Acharya, Consultant in Obstetrics, and Sally Doidge, Principal Embryologist, University Hospitals Plymouth NHS Trust, Dr Lisa Joels, Consultant Gynaecologist and Responsible Person for the fertility centre and Rebecca Cowie, Principal Embryologist, Royal Devon and Exeter NHS Foundation Trust took part in the discussion.

The proposed changes to the Devon CCGs' assisted conception policy have been agreed with specialists during the consultation process. The generality of the approach adopted by the Assisted Conception policy is two attempts to achieve pregnancy. Under the current policy, the CCGs commission one IVF cycle, however, funding is available for two embryo transfers, one fresh embryo transfer, and one frozen embryo transfer if required and there are sufficient suitable embryos, or for a second cycle of IVF where the initial IVF cycle is abandoned.

NICE recommend ICSI first line for severe male infertility and in cases where there is failure of IVF due to no fertilisation of the eggs and "poor fertilisation". The Clinical Policy Committee was asked to consider proposed changes to the section of the policy on ICSI. One key change to the section on ICSI and two points of clarification were considered. The key change is the removal of the term "poor fertilisation" which does not have an accepted definition and replacement with the term "no embryos suitable for transfer" which is unambiguous.

The committee voted unanimously in favour of recommending acceptance of the proposed changes to the policy.

The Clinical Policy Committee was asked to consider a change to the section of the policy on donor eggs. The criterion of "certain cases of IVF treatment failure" was taken from the NICE clinical guideline. This statement lacks clarity and does not fit with the approach of the Devon CCGs' policy which is two attempts to achieve pregnancy as the first cycle may not have included ICSI.

The committee voted unanimously in favour of recommending that this criterion be removed from the policy.

The committee was asked to consider changes to the wording of the policy in respect of abandoned IVF or ICSI cycles. The changes were to provide clarification of the circumstances in which an additional IVF or ICSI cycle will be funded, and clarification of when an additional embryo transfer will be funded in the event of an abandoned fresh or frozen embryo transfer.

The committee voted unanimously in favour of recommending acceptance of the clarification of the policy in respect of abandoned IVF or ICSI cycles and abandoned embryo transfers.

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

4. Assisted conception: eligibility criterion for "previous children"

The Devon CCGs' assisted conception policy contains eligibility criteria for referral for fertility assessment and investigation, and separate eligibility criteria for assisted reproduction techniques (ART). The couple must meet these criteria to be eligible for referral and treatment. There are seven eligibility criteria for assisted reproductive techniques including one for 'previous children'. This criterion together with three further eligibility criteria requires amendment. The further criteria are for 'previous assisted conception', an overarching statement for eligibility criteria for ART and clarification of the eligibility criterion for 'previous sterilisation'. A member of the Clinical Effectiveness team, NEW Devon CCG presented a paper. Dr Umesh Acharya, Consultant in Obstetrics, and Sally Doidge Principal Embryologist, University Hospitals Plymouth NHS Trust, Dr Lisa Joels, Consultant Gynaecologist and Responsible Person for the fertility centre and Rebecca Cowie, Principal Embryologist, Royal Devon and Exeter NHS Foundation Trust took part in the discussion.

The criterion for previous children was inherited from the policy for predecessor PCTs and has been in place since at least 2010. It is based on the concept of residency and has been the subject of a number of IFR applications. Amongst CCGs in South West England a range of eligibility criteria are in place. Only the Devon CCGs and Kernow CCG have a criterion which determines eligibility based on no children living with the couple as a place of residence.

It is proposed that the current Devon criterion for 'previous children' be replaced with one of three alternative options. These are based on a review of policy positions adopted by other CCGs.

As the CCGs commission treatment for assisted conception, the CCGs recognise that infertility is a medical condition that receives funding. The fundamental question for consideration by the committee is whether assisted conception is funded to enable couples to have a child or to enable childless individuals in a relationship to have a child and whether in the case of a childless individual the existence of a child from a partner's former relationship is a reason to exclude the individual from treatment.

The committee discussed issues pertinent to the eligibility criterion for 'previous children' and voted unanimously to accept:

- There should be no living children from the current relationship, and
- At least one partner must have no living children from previous relationships

This includes biological and legally adopted children and offspring who are adults.

This position considers the two individuals in the couple and their social history. Unlike the current criteria this option recognises that couples will present for treatment where one individual has children from a former relationship and specifies a position on offering ART to these couples which is unambiguous. With this option a child from a former relationship may live with the couple (who are referred to the fertility centre), or the child may live with the former partner. The amount of time the child from the former relationship spends with each parent is not relevant.

- Specialists present indicated that this position is the most similar to the current position but was an improvement to a general policy position as in their experience the need for IFR

applications arose because, in general, women were more likely than men to have children from a previous relationship living with them.

The second point of discussion by the committee related to the current eligibility criterion for "previous assisted conception" this requires that neither partner has received NHS-funded assisted reproduction for the couple to be eligible for treatment.

The committee considered issues pertinent to eligibility criterion for 'previous assisted conception'. During discussion, at the suggestion of a member, the committee decided that the decision on eligibility criterion for 'previous assisted conception' be deferred until after the decision on the 'overarching statement for eligibility criteria for assisted reproduction treatment' was made.

The third point of discussion related to the overarching statement for eligibility criteria for assisted reproduction treatment. Comments received during the consultation prompted the proposal of an overarching statement to ensure that couples are aware that although they may meet eligibility criteria for treatment, there may be clinical reasons for not offering treatment. This means that any previous fertility treatment becomes a clinical consideration and the specialist decides whether any previous treatment is clinically relevant.

The committee voted unanimously in favour of recommending acceptance of the proposed statement.

Subsequent to the decision on the overarching statement being made the committee voted unanimously in favour of recommending that the proposed change to the wording to the criterion for 'previous assisted conception' be accepted. The statement was agreed to be amended to:

"the couple has not previously received NHS-assisted reproductive techniques".

The exception to this being if the woman has received three or more cycles of IVF in which case the couple are not eligible for IVF (as documented in the assisted conception policy).

The fourth point of discussion related to the eligibility criterion for "previous sterilisation". A proposal was put forward that provided clarification of existing criterion to emphasise that even if sterilisation has been reversed, couples are not eligible for treatment.

The committee voted unanimously in favour of recommending acceptance of the proposed clarification of the eligibility criterion for previous sterilisation.

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

5. Fluticasone furoate, umeclidinium and vilanterol (Trelegy® Ellipta®) combination dry powder inhaler (DPI) for Chronic Obstructive Pulmonary Disease (COPD)

An application has been received from Dr Philip Hughes, Consultant Respiratory Specialist, University Hospitals Plymouth NHS Trust for the routine commissioning of Fluticasone furoate, umeclidinium and vilanterol (Trelegy® Ellipta®) combination dry powder inhaler (DPI) for the treatment of Chronic Obstructive Pulmonary Disease (COPD). Dr Hughes has indicated that it would offer an additional option for patients with medium to severe COPD needing triple therapy. Graham Simpole, Joint Formularies Support Pharmacist, NEW Devon CCG presented an evidence assessment. Dr Hughes joined the discussion via teleconference.

Trelegy Ellipta is a long-acting beta-2 agonist/long-acting muscarinic receptor antagonist/inhaled corticosteroid (LABA/LAMA/ICS) triple therapy DPI indicated as a

maintenance treatment in adult patients with moderate to severe COPD who are not adequately treated by a combination of an inhaled corticosteroid and a long-acting β2-agonist. The licensed dose is one inhalation once daily, at the same time each day. It would offer an additional option for patients currently receiving ICS/LABA combination treatment who are not adequately controlled and patients currently receiving triple therapy delivered in separate devices who may benefit from a simplification of their treatment and reduction in the number of inhalers, although this is an unlicensed use as it is not licensed for switching of patients who are already stable on triple therapy, or for patients not adequately controlled on therapy other than ICS/LABA.

A systematic literature search identified two principal randomised controlled trial (RCT) studies. The FULFIL trial which compared Trelegy triple therapy to budesonide and formoterol, an ICS/LABA dual therapy and the IMPACT trial which compared triple therapy against two different dual therapy regimes, fluticasone furoate and vilanterol, an ICS/LABA, and against umeclidinium and vilanterol, a LAMA/LABA. Two further supporting RCTs with pooled data were identified however there is no evidence comparing Trelegy to other triple therapy regimes. The FULFIL and IMPACT studies, demonstrated superiority in the improvement of $tFEV_1$, St George's Respiratory Questionnaire scores and health-related quality of life, as well as significantly lowering the rate of moderate or severe COPD exacerbations when compared to dual therapy.

A study assessing the healthcare resource utilisation data and associated costs from the FULFIL study was identified which suggest that the longer-term use of triple therapy with fluticasone furoate, umeclidinium and vilanterol reduces the economic and healthcare resource burdens of COPD compared with budesonide and formoterol dual therapy. It is not known from this study how this triple therapy compares to other treatments for COPD apart from budesonide/formoterol dual therapy and also the financial impact of any differences in effectiveness between treatments.

Annually Trelegy Ellipta costs approximately £541. It is cheaper than the combination of any two current formulary recommended ICS/LABA and LAMA dry powder inhalers and is the same price as the triple therapy metered dose inhaler (MDI), Trimbow, which is currently included in the joint formulary. Specialists have previously estimated that approximately 24% of registered COPD patients would commence triple therapy which equates to 5,833 patients across Devon. Comparing the acquisition cost of Trelegy Ellipta to the current formulary DPI combination options for triple therapy, allows for a very crude estimate of potential savings between £236,000 and £1,790,000 per annum for the cohort of eligible patients across Devon. Due to the licencing restriction of Trelegy Ellipta potential cost savings may take time to realise, as bulk switching is unlikely. For patients that require triple therapy, Trelegy Ellipta is a single triple therapy DPI device, available at a lower acquisition cost than any other DPI multi-device triple therapy combination, as an alternative for patients who are unable to use the triple therapy MDI Trimbow.

The committee discussed issues pertinent to this recommendation:

- It was recognised that both the MDI device and DPI device have merit and that it would be useful to have one of each type available.
- There are some economic advantages associated with the Trelegy Ellipta DPI
- Some surprise was expressed that the product is not licenced for patients not adequately controlled on a LABA/LAMA combination. It was noted that in clinical practice these patients are stepped up to triple therapy.
- It had been stated that 24% of recently diagnosed patients are prescribed triple therapy. Whilst some members of the committee expressed surprise at this, after debate, it was concluded that this was not an unreasonable assumption for the context it was used for.

The committee voted unanimously in favour of recommending the routine commissioning of Fluticasone furoate, umeclidinium and vilanterol (Trelegy® Ellipta®) combination DPI for the treatment of COPD.

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

The Chair thanked Dr Hughes for joining the discussion.

6. Cosmetic treatments policy

The CCGs in Devon currently have a commissioning policy in place in respect of Low Priority Treatments, which comprises mostly cosmetic treatments. This policy was adopted by the CCGs in 2013, having previously been agreed by the former commissioning organisations in 2011. It is proposed that this policy is replaced by a policy for cosmetic treatments, with other non-cosmetic procedures covered by specific polices.

Cosmetic treatment is surgery or non-surgical medical treatment carried out solely to change a person's appearance to achieve what they feel is a more desirable look. Cosmetic treatments are considered a low priority for use of healthcare funds. There is no proposed change to the CCGs' position in respect of the funding of cosmetic treatments; cosmetic treatment is not routinely commissioned in Devon. However the new policy presented to the Clinical Policy Committee for approval has been updated following review and aims to provide greater clarity.

Relevant local specialists across Devon were contacted via their trust Medical Director to seek their comments on the proposed policy. The consultation process also included Individual Funding Request (IFR) Panel colleagues and a GP Referral Facilitator working for Devon Referral Support Services (DRSS).

When developing this revised policy, comparison was undertaken with policies from other CCGs, as well as consideration of the information publicly available via NHS Choices. The proposed policy lists commonly encountered cosmetic procedures which are not commissioned except under the circumstances described. However the policy applies to all treatment which is being carried out for cosmetic reasons.

Information relating to the detail of the IFR process, including guidance for the submission of applications, has been removed as this is not an IFR policy. It is suggested that this detail should be available separately from the cosmetic treatments policy so that they can be updated independently of one another. This also avoids the policy becoming too lengthy with procedural notes.

Following feedback as part of the consultation, the criteria under which scar revision treatment is funded without CCG panel approval has been amended to state "as a clinically necessary part of a staged procedure to allow for improved functional outcomes".

Some revisions have been made with the intention of making the policy clearer and more user-friendly. For example, treatments and procedures have been categorised by type or body area and further definitions of procedures have been given where this may aid understanding.

The list of commonly encountered cosmetic procedures from the existing policy was cross-referenced with the information publicly available via the NHS Choices guide to cosmetic procedures. The information available via NHS Choices makes it clear that cosmetic surgery is not routinely provided on the NHS. It states that occasionally it may be provided on the NHS for psychological or other health reasons, but generally most people who wish to have cosmetic surgery will need to pay for this privately.

It is noted that reconstructive or plastic surgery can be available on the NHS, but that this is distinct from cosmetic surgery. It is surgery to restore a person's normal appearance after illness, accident or a birth defect. It includes procedures such as rebuilding breasts after a mastectomy.

Those areas where treatments or procedures may be carried out for medical reasons (as well as cosmetic) and for which specific CCG policies are in place have been included in a separate section within the policy for clarity.

The Clinical Policy Committee discussed issues pertinent to the proposed policy:

- The committee noted that the policy does not list everything but applies to all cosmetic treatment.
- Wigs are funded by the NHS but there can be a considerable charge to the patient and may prevent some patients having a wig. There are conditions other than cancer where treatment may result in hair loss.
- The committee identified a number of conditions where the cosmetic nature or otherwise of the treatment is unclear, including dermatological conditions. The committee felt that there would always be some lack of clarity regarding what does and does not constitute cosmetic treatment. However it was felt that it was appropriate to state that the CCGs do not fund cosmetic surgical treatment. The committee noted that NHS England is undertaking work to produce a definition of cosmetic procedures/treatment although it is unclear whether this will be helpful. The Committee Chair will feed comments from the Clinical Policy Committee members and IFR panels into process.

ACTION: Chair to feed comments from the Clinical Policy Committee and IFR Panels into NHS England's work to produce a definition of 'cosmetic treatment'.

- The committee discussed psychological distress and the impact of this in determining whether treatment should be provided. There was discussion about the patient's expectation of the treatment which may be unrealistic and result in disappointment and whether treating the patient was always the most appropriate course of action in the first instance.
- Despite polices being in place patients are still coming through the IFR panel. The nature of letters coming from GPs, the need to maintain the GP/patient relationship and that Chairs of the IFR panels should raise with GPs if letters are felt to be inappropriate was noted.

The committee voted unanimously in favour of recommending acceptance of the new cosmetic treatments policy.

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

7. Reversal of male and female sterilisation policy

The CCGs in Devon currently have a commissioning policy in place in respect of Low Priority Treatments, which comprises mostly cosmetic treatments. This policy was adopted by the CCGs in 2013, having previously been agreed by the former commissioning organisations in 2011.

It is proposed that this policy is replaced by a policy for cosmetic treatments, with other non-cosmetic procedures covered by specific polices. The reversal of sterilisation was included in the low priority treatments policy and as such it is proposed that the commissioning position in respect of this is now confirmed within a separate policy.

Reversal of male sterilisation is a surgical procedure that involves the reconstruction of the vas deferens. A vasectomy can be reversed, but success rates are not very high and reduce the longer the time interval from the vasectomy. There is no guarantee that fertility will return.

Reversal of female sterilisation is a surgical procedure that involves the reconstruction of the fallopian tubes. Female sterilisation can be reversed, but it is a very difficult process that involves removing the blocked part of the fallopian tube and re-joining the ends. The success rates of female sterilisation reversal depend on factors such as age and the method that was used in the original operation. There is no guarantee that fertility will return.

Sterilisation procedure is available on the NHS and people seeking sterilisation should be fully advised and counselled (in accordance with Royal College of Obstetricians and Gynaecologists guidelines) that the procedure is intended to be permanent. Reversal of sterilisation is considered a low priority for use of healthcare funds.

There is no proposed change to the CCGs' position in respect of the funding of the reversal of male and female sterilisation; this is not routinely commissioned in Devon.

Relevant local specialists across Devon were contacted via their trust Medical Director to seek their comments on the proposed policy. The consultation process also included IFR Panel colleagues and a GP Referral Facilitator working for DRSS.

The proposed policy has been prepared with reference to the NHS England policy and policies from other CCGs, as well as the information publicly available via NHS Choices.

A proposed policy for the reversal of male and female sterilisation is presented to the Clinical Policy Committee for approval. Although no change is proposed to the CCGs' position, the need for a separate policy clarifying this has arisen from the revision and updating of the CCGs' existing low priority treatments policy.

The committee discussed issues pertinent to the proposed policy for the reversal of male and female sterilisation:

- Some people may be coerced into sterilisation by their partner. It was agreed that a paragraph would be added to the letter to specialists and also to GP letters about ensuring that a private conversation takes place with the person requesting sterilisation. People seeking sterilisation should be fully advised and counselled in accordance with Royal College of Obstetricians and Gynaecologists guidelines.

Action: Paragraph to be added to the letter to specialists and GPS about ensuring that a private conversation takes place with the person requesting sterilisation.

The committee voted unanimously in favour of recommending acceptance of the policy for the reversal of male and female sterilisation.

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

8. Insulin Degludec (Tresiba®) for use in patients with type 1 diabetes

An application for the use of Insulin Degludec (IDeg) (Tresiba®) in children and adolescents with type 1 diabetes was received from Dr David McGregor from the Royal Devon and Exeter NHS Foundation Trust. Since type 1 diabetes is a lifelong condition the clinical effectiveness team contacted specialists who treat adults.

Naomi Scott, Healthcare Evidence Reviewer, NEW Devon CCG presented an evidence assessment. Dr Roderick Warren, Consultant Physician and Dr Chris Moudiotis Consultant Paediatrician, Royal Devon and Exeter NHS Foundation Trust took part in the discussion.

IDeg, is an ultra-long-acting basal insulin licensed for the treatment of type 1 diabetes. It is given by subcutaneous administration once-daily, preferably at the same time and has a terminal half-life of over 25 hours and duration of action up to 42 hours. Local specialists proposed that, in children and adolescents, the longer duration of IDeg would reduce blood glucose variability and allow for variance in the timing of administration, which could increase adherence. This could result in a reduction in the frequency and significance of both hypoglycaemia and diabetic ketoacidosis. Local specialists suggested that IDeg would be appropriate for the treatment of adults who experience recurrent hypoglycaemia when using Insulin detimir (IDet) and/or Insulin glargine (IGlar).

The routine commissioning of IDeg for use in patients with type 1 diabetes has been considered by CPC on two previous occasions, in October 2013 and in April 2016. The applications were not successful as the evidence at the time excluded patients with poor glycaemic control or recurrent hypoglycaemia, so the committee could not determine if IDeg would be good value in these patients. One study was identified which assessed the efficacy and safety of IDeg in comparison to IDet in children and adolescents with type 1 diabetes. The study found IDeg was non-inferior to IDet for change in HbA1c after 26 weeks of treatment, and after 52 weeks rates of confirmed nocturnal and severe hypoglycaemia were not significantly different between groups. Rates of hyperglycaemia were not significantly different between groups, but rates of hyperglycaemia with ketosis were significantly lower for IDeg than IDet.

Since the last review of IDeg for adults with type 1 diabetes results of the SWITCH 1 trial have been published. This trial compared the efficacy and safety of IDeg and IGlar in patients with a risk factor for hypoglycaemia. Non-inferiority of IDeg to IGlar for change in HbA1c values from baseline was confirmed. The rates of overall symptomatic, nocturnal symptomatic and severe hypoglycaemia were significantly lower with IDeg than IGlar.

No cost-effectiveness analysis was identified which assessed the use of IDeg in children and adolescents. The assumptions of a published cost-effectiveness analysis were used to create an updated cost-effectiveness analysis for adults. In the base case of this analysis IDeg was found to be the dominant treatment option in comparison to IDet and the Lantus brand of IGlar, but a cost of £8,500 per quality adjusted life year (QALY) was found in comparison to the IGlar biosimilar Abasaglar. Sensitivity analysis assuming equal doses of IDeg and IGlar found IDeg to be cost effective in comparison to IDet but not IGlar, when utilising a cost effectiveness threshold of £20,000. These findings were driven by a lower QALY decrement associated with IDeg due to a reduction in nocturnal hypoglycaemia which equated to 1.66 fewer episodes per patient per year in comparison to IDet and 0.65 episodes per patient in comparison to IGlar. The effectiveness analysis pre dates the publication of SWITCH1. Inclusion of these results would reduce the incremental cost per QALY further.

The applicant estimates that approximately 78 to 89 children and adolescents per year may be eligible for IDeg. The acquisition cost of IDeg for these patients is £3,500 to £7,000 more than the acquisition cost of Abasaglar depending on the ratio of insulin requirements between IDeg and IGlar. Regarding the use of insulin degludec in adults, using assumptions from All Wales Medicines Strategy Group applied to diabetes prevalence data for Devon it is expected that by 2020, 1,800 patients may be eligible for IDeg. Prescribing IDeg to these patients would cost £83,000 to £145,000 more than the prescribing of abasaglar.

Subsequent to the circulation of the meeting papers, comments on the paper have been received from Dr Cordingley in North Devon. These were tabled at the meeting.

The committee discussed issues pertinent to the routine commissioning of Insulin Degludec (Tresiba®) for use in patients with type 1 diabetes:

- Proposals for IDeg to be routinely commissioned for use in patients with type 1 diabetes have been rejected in the past due to limitations in the evidence base. Since these applications were made new evidence has been published showing that IDeg is non inferior in reducing HbA1c in comparison to alternatives in adults and reduces hypos, particularly at night.
- Severe and nocturnal hypos have a significant impact on patients. A patient experiencing a severe hypo requires help from another person. Nocturnal hypos are disruptive to sleep and may make patients fearful of serious consequences.
- Patients experiencing several severe hypos may meet the criteria for an insulin pump which is more costly than IDeg.
- Specialists present indicated that they used Lantus brand IGlar not a bio-similar. The reason for this was questioned and the specialists indicated they would investigate the feasibility of this further as it was acknowledged that significant savings in drug acquisition cost could be made.
- Specialists also reported that some patients experienced significant pain/stinging when injecting Lantus, this may reduce over the first week. If pain does not reduce and psychological strategies do not help it is proposed that they could be switched to Tresiba brand IDeg.
- Local paediatric specialists encounter patients who experience hyperglycaemia with ketosis or diabetic ketoacidosis (DKA) as a result of poor adherence to their insulin regimen. Degludec would be useful because its longer duration of action would reduce the risk of DKA developing. DKA is associated with significant financial and medical costs.
- A specialist indicated that IDeg would be used for only a small number of children. Specialists indicated that when a child on IDeg transfers to adult services it is expected that treatment would be reviewed by adult services. Patients may remain on the same treatment or alternative insulin regimens instituted depending upon individual circumstances.
- The committee voted unanimously in favour of recommending the routine commissioning of Insulin Degludec (Tresiba) for use in patients with type 1 diabetes.

Dr Roberts absented himself from voting on this item.

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

The Chair thanked Dr Moudiotis and Dr Warren for joining the meeting to participate in the discussion.

9. Insulin Degludec (Tresiba®) for use in patients with type 2 diabetes

The routine commissioning of Insulin Degludec (IDeg) (Tresiba) in patients with type 2 diabetes has previously been considered by the CPC in October 2013. At that time CPC did not support the application as IDeg was more expensive than other insulins, including long acting analogues, and was not considered to represent good value for general use. Since 2013 IDeg has been shown to be non-inferior to IGlar in improving glycaemic control over a variety of patient populations with type 2 diabetes. Naomi Scott, Healthcare Evidence Reviewer, NEW Devon CCG presented an evidence assessment. Dr Roderick Warren, Consultant Physician, Royal Devon and Exeter NHS Foundation Trust took part in the discussion.

Previously the use of IDeg U200, which has 200 units of insulin per millilitre, was sought for patients with type 2 diabetes who have insulin resistance and require in excess of 100 units per dose, to avoid the need for multiple injections per dose, and as an alternative to Humulin R

500 which is unlicensed in UK. Early trials found a reduction in nocturnal hypoglycaemic events in patients without recurrent hypoglycaemia, however a recent trial of patients with a risk factor for hypoglycaemia found a significant reduction in severe hypoglycaemia across the full 32 week trial period and overall symptomatic and nocturnal hypoglycaemia in both the 16 week maintenance and 32 week trial periods.

Trials of IDeg U200 in comparison to IGlar U100 and U300 in insulin naïve patients with high insulin requirements do not provide consistent evidence for differences in rates of hypoglycaemia. However, in patients previously treated with insulin, a trial comparing IDeg U200 to IGlar U100 in patients who had a high insulin requirement at study entry found non-inferiority for change in HbA1c, significant reductions in fasting plasma glucose, and a lower rate of confirmed hypoglycaemia in patients treated with IDeg. The rates of nocturnal hypoglycaemia and severe hypoglycaemia were not significantly different. Although patients in both groups required a similar number of units of insulin each day those receiving IDeg U200 were able to administer these units with fewer injections.

For patients with type 2 diabetes using a basal-bolus insulin regimen, treatment with IDeg was shown to result in a lower utility decrement and a considerably higher cost in comparison to IGlar. The additional costs per QALY of using IDeg over Abasaglar or Lantus were above the £20,000 threshold for cost effectiveness. Results of a sensitivity analysis varying the ratio of insulin requirements between IDeg and IGlar were still above the £20,000 cost per QALY threshold.

For patients with type 2 diabetes using basal insulin in combination with oral antidiabetic drugs a cost-effectiveness analysis has shown IDeg to result in a lower utility decrement at a slightly higher annual cost than Lantus or Abasaglar. This resulted in a cost per QALY below the £20,000 per QALY threshold for cost effectiveness, which was maintained in sensitivity analysis varying the ratio of insulin requirements between IDeg and IGlar.

Following the circulation of the board pack a further cost-utility analysis using data from the DEVOTE trial of cardiovascular outcomes was identified. An overview of this was tabled at the meeting; when current insulin prices are used the outcomes are consistent with previous analyses. However, there are uncertainties in the analyses and the incremental cost effectiveness ratios (ICERs) result from very small differences in costs and QALYs; slight changes to these can result in significant changes to the resultant ICER.

IDeg is more expensive than current formulary long-acting basal insulins. Using assumptions based on the budget impact modelling from All Wales Medicines Strategy Group by 2020 there is the potential for 619 patients in Devon with type 2 diabetes to be eligible for treatment with IDeg, 302 of these patients would be expected to have a basal-bolus treatment regimen. Prescribing 72 units of IDeg per day for these patients would incur an acquisition cost which is £60,000 to £74,000 more than treatment with IGlar depending on the ratio of insulin requirements between IDeg and IGlar. Prescribing IDeg to the 317 eligible patients expected to have a basal-oral therapy regimen would incur an incremental cost over IGlar of between £28,500 and £138,000 depending on the ratio of insulin requirements between IDeg and IGlar.

The committee discussed issues pertinent to the routine commissioning of Insulin Degludec (Tresiba®) for use in patients with type 2 diabetes:

- The specialist present indicated that IDeg was requested for use in a very small group of patients requiring multiple injections per day specifically to reduce their treatment burden and not to reduce hypoglycaemia. The specialist present indicated that the absolute reduction of hypoglycaemia in type 2 diabetes is very low.
- It is expected that for some patients the number of injections may reduce from seven to two or three per day.
- The burden on the patient of the number of a high number of injections per day was acknowledged as was the potential for this to impact on physical and mental health.

However, most patients need less than seven injections and it was unclear how much benefit most patients would experience from reducing their injection burden by two injections per day.

- In assessing the reasonableness of the number of injections, comparison to type 1 diabetes is helpful where patients would normally be expected to undertake up to 5 injections per day.
- The specialist present indicated that there would be strict criteria to ensure that IDeg was only prescribed for patients requiring five or more injections per day. One alternative is the unlicensed Humulin R 500.
- It was noted that IDeg costs considerably more per patient than other insulins and the relative value obtained from a reduced number of injections needs to be weighed in relation to treatments for other conditions. There is a question over whether the benefit of a slightly fewer injections per day justifies this cost.
- The specialist present indicated that there would be around forty patients at Royal Devon and Exeter NHS Trust. It is expected that there will be one hundred and twenty to one hundred and forty across Devon. The specialist present indicated support from specialists from local trusts.

The committee voted 5 to 2 against recommending the routine commissioning of Insulin Degludec (Tresiba) for use in patients with type 2 diabetes.

Dr Roberts absented himself from voting on this item.

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

The Chair thanked Dr Warren for joining the meeting to participate in the discussion.

10. Update from NICE Planning Advisory Group (NPAG)

The committee received updates from two NICE Planning Advisory Group meetings.

<u>26 June 2018</u>

NPAG had considered nine Technology appraisals, the majority of which were NHS England commissioned.

Other guidelines and guidance considered by NPAG included two Public Heath Guidelines, three Clinical Guidelines and four pieces of Interventional Procedures Guidance.

It was noted that NICE Guideline NG77 Cataracts in adults: management states that access to cataract surgery should not be restricted based on visual accuracy.

It was also noted that clarity is required with regard to the CCGs' position on genetic testing as recommended in NICE CG71 Familial hypercholesterolemia: identification and management (update). This will be raised with the CCGs Planned Care Group.

<u>21 August</u>

NPAG had considered eleven NICE Technology appraisals, the majority of which were NHS England commissioned.

Other guidelines and guidance considered by NPAG included one Clinical Guideline, one Medical Technology, one Diagnostic Guideline and eight pieces of Interventional Procedures Guidance.

The Committee discussed issues pertinent to NICE IPG611 Prostate artery embolisation for lower urinary tract symptoms caused by benign prostatic hyperplasia.

- Consideration is being given to how to decide whether and in what configuration a range of new surgical procedures for benign prostatic hyperplasia will be commissioned across Devon as a system. If this cannot be achieved it may be necessary to bring treatments to the CPC on an individual basis.
- A query was raised as to whether it would be better to bring items to CPC to consider their merit on an individual basis in the first instance.

11. 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 14 August 2018.

One topic had been discussed.

- Opicapone for Parkinson's Disease

  The panel recommended that no further engagement or formal consultation was required at this point.

12. Any other business

Date of next meeting

The committee were advised that due to the number and state of readiness of the items for discussion the meeting scheduled to take place on Wednesday 28th November 2018 may be cancelled. The committee will be notified in due course.

Meeting dates for the remainder of 2018 and for 2019 had been circulated with the agenda.

Summary of actions

	Action	**Lead**
18/13	Rivaroxaban for the prevention of recurrent deep vein thrombosis (DVT) and pulmonary embolism (PE): letter to be written to specialists stating that the committee had been unable to reach a decision in their absence as specific questions were raised during the discussion. The application may be considered at a future meeting subject to the attendance of specialists. Dr Roberts has written to specialists. No response has been received. This has been followed up by the Clinical Effectiveness Team.	Jo Roberts
18/14	Opicapone for Parkinson's Disease - Policy Recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication. Approval is awaited from the CCGs. It is hoped that the policy will be published by the end of the week.	Rebecca Heayn

18/15	Assisted conception: fertilisation failure and abandon cycles - Policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication.	Rebecca Heayn
18/16	Assisted conception: eligibility criterion for "previous children" - Policy Recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication.	Rebecca Heayn
18/17	Fluticasone furoate, umeclidinium and vilanterol (Trelegy® Ellipta®) combination dry powder inhaler (DPI) for Chronic Obstructive Pulmonary Disease (COPD) - Policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication.	Rebecca Heayn
18/18	Cosmetic treatments policy: Chair to feed comments from the Clinical Policy Committee and IFR Panels into NHS England's work to produce a definition of 'cosmetic treatment'	Jo Roberts
18/19	Cosmetic treatments policy: Policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication.	Rebecca Heayn
18/20	Reversal of male and female sterilisation policy: Paragraph to be added to the letter to specialists and GPS about ensuring that a private conversation takes place with the person requesting sterilisation.	Rebecca Heayn
18/21	Reversal of male and female sterilisation policy: Policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication.	Rebecca Heayn
18/22	Insulin Degludec (Tresiba®) for use in patients with type 1 diabetes: Policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication.	Rebecca Heayn
18/23	Insulin Degludec (Tresiba®) for use in patients with type 2 diabetes: Policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication.	Rebecca Heayn