Northern, Eastern and Western Devon
Clinical Commissioning Group

South Devon and Torbay
Clinical Commissioning Group

Clinical Policy Committee

Minutes

Wednesday 27th March 2019, 9.30 am to 12.30

The Henlake Suite, Watermark, Ivybridge

Present:

Dr Nick D'Arcy (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
Mac Merrett	Lay Public Member	
Tracey Polak	Assistant Director/Consultant of Public Health	Devon County Council
Chris Roome	Head of Clinical Effectiveness	NEW Devon CCG
Dr Alison Round	Voting Member	NEW Devon CCG
Mark Taylor	Lay Public Member	
Dr Ben Waterfall	Voting Member	NEW Devon CCG

Guests:

Dr Patrick English	Consultant	University Hospitals Plymouth NHS Trust
Matt Howard	Clinical Evidence Manager	NEW Devon CCG
Naomi Scott	Healthcare Evidence Reviewer	NEW Devon CCG
Graham Simpole	Joint Formularies Support 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

1. Welcome and introductions

Apologies

Richard Croker	Deputy Director for Medicines Optimisation	NEW Devon CCG
Dr Tawfique Daneshmend	Consultant Gastroenterologist & Hepatologist	RD&E NHS FT
Barbara Jones	Head of Locality Contracting	NEW Devon CCG
Dr Andrew Harrison	Voting Member	NEW Devon CCG
Dr Jo Roberts	Voting Member	South Devon & Torbay CCG
Dr Peter Rowe	Consultant Nephrologist	University Hospitals Plymouth NHS Trust

Confirmation of voting members and Declarations of Interest

The six voting members present were identified.

Declarations of interest were collected and reported. The Declarations made did not result in anyone being excluded from the meeting. All Declarations of Interest are reported in the minutes.

DRUG/ TECHNOLOGY TO BE CONSIDERED	PHARMACEUTICAL COMPANY/ MANUFACTURER/ SERVICE PROVIDER
Semaglutide (Ozempic®) **for the treatment of type 2 diabetes**	Novo Nordisk Limited
Alternative treatments:	
Other GLP-1 mimetics	
Dulaglutide (Trulicity®)	Eli Lilly and Company Ltd
Exenatide (Byetta®, Bydureon®)	AstraZeneca UK Ltd
Liraglutide (Victoza®)	Novo Nordisk Ltd
Lixisenatide (Lyxumia®)	Sanofi
Other antidiabetic medication	
Metformin, Sulfonylureas, DPP4 inhibitors, SGLT2 inhibitors, Insulins	Various manufacturers
FreeStyle Libre device for interstitial glucose monitoring in diabetes	Abbott Laboratories Ltd
Alternative treatments:	
Blood glucose monitoring devices	Various
Continuous glucose monitors	Various
Management of meibomian cysts (chalazia)	Private providers of treatments for the management of Meibomian cysts
Breast reduction	Private providers of breast reduction surgery

NAME OF ATTENDEE	ROLE	DECLARATION
Dr Patrick English	Consultant	I was paid to chair and present at a meeting by NovoNordisk in March 2018. They have previously sponsored me to attend the America Diabetes Association Conference in the USA though this was outside this 3 year window in 2010. PI on SUSTAIN 8 study of semaglutide, now completed and PI on new study of oral

		semaglutide due to start later this year. Have been offered (but declined) sponsorship to EASD meeting later this year by AZ. Have received payment for educational services from Sanofi (made an educational video 2017) and received sponsorship to attend the EASD in Stockholm in 2015. I have received chairing and lectureship fees from BI and MSD and Napp within the last three years.
Dr Andrew Craig	GP	One of the GLP-1 manufacturers provided sandwiches at a Clinical Governance Afternoon in the Practice. I cannot remember which one.

Notification of Any Other Business

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

2. Minutes of the meeting held on 30th January 2019 and matters/actions arising

The minutes of the meeting held on 30th January 2019 were approved.

Summary of actions		
	Action	**Lead**
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' Chris Roome to feed this in as a suggestion to the NHS England evidence based interventions programme. Action complete.	
19/01	*Surgical treatment options for lower urinary tract symptoms caused by benign prostatic hyperplasia.* *Committee recommendations to be submitted to the CCGs to inform senior level commissioning discussions for services for this condition.* This is in progress.	Rebecca Heayn
19/02	NHS England Evidence-Based Interventions Guidance for CCGs: Policy recommendations and QEIAs to be prepared and subsequently progressed to final CCG approval and communication. Action complete	
19/03	Clinical Effectiveness team to liaise with local specialists to present the issues and an alternative policy proposal for breast reduction for discussion at the CPC meeting in March	

	2019. This item is included on the meeting agenda. Action complete.	
19/04	Confirmation of the start time of the next Clinical Policy Committee meeting to be circulated by e-mail. Action complete.	

3. Semaglutide (Ozempic®) for the treatment of type 2 diabetes

An application has been received from Dr Patrick English requesting the consideration of semaglutide for the treatment of Type 2 diabetes to be used as described for other glucagon-like peptide (GLP)1 receptor agonists in line with NICE Guideline NG28. The application is supported by specialists in North and East, and South and West Devon. Graham Simpole, Joint Formularies Support Pharmacist, NEW Devon CCG presented an evidence assessment. Dr Patrick English took part in the discussion of the item.

Semaglutide is a new GLP-1 receptor agonist (GLP-1 RA) indicated for the treatment of adults with insufficiently controlled type 2 diabetes mellitus as an adjunct to diet and exercise. It is licensed as a monotherapy when metformin is considered inappropriate due to intolerance or contraindications and also in addition to other medicinal products for the treatment of diabetes.

The applicant confirmed he was not seeking to use semaglutide or as monotherapy in combination other than as described in NICE guideline NG28.

A systematic literature search identified a suite of eight RCT studies (The SUSTAIN trials), two network meta-analyses based on a number of these trials, and an evaluation of the long-term cost-effectiveness of semaglutide versus dulaglutide in the UK. The SUSTAIN trials confirm the efficacy of semaglutide which show that it produces clinically significant reduction in HbA_{1c} and bodyweight compared to placebo and active comparators, alone and in combination with other hypoglycaemic agents including in combination with basal insulin. Pertinent to the commissioning decision is to what extent these results support the use of semaglutide in the place in therapy recommended by NICE, given that four existing drugs in this class are already commissioned.

The SUSTAIN 3 trial is considered relevant to these decisions as is SUSTAIN 6 which assesses the cardiovascular safety. The other studies, however, do not provide evidence to support the place in treatment of semaglutide in line with NICE guidelines. SUSTAIN 3 shows a statistically and clinically significant reduction in both HbA_{1c} and mean body weight for semaglutide 1.0mg versus once-weekly exenatide. This trial was supported by a network meta-analysis which found that once weekly semaglutide 1mg was associated with a significantly greater reduction in HbA1c and weight gain than all GLP-1 RA comparators whilst semaglutide 0.5mg demonstrated significantly greater reduction in HbA1c and weight gain than the majority of GLP-1 RA's.

SUSTAIN 6 was a cardiovascular outcomes trial conducted to satisfy regulatory requirement of cardiovascular safety. It confirms noninferiority to placebo and establishes that there was no clinically significant increase in major cardiovascular events although it was noted that there was an unexpected higher rate of retinopathy complications in the semaglutide group compared to the placebo group.

A cost-utility analysis from the perspective of the UK NHS, found semaglutide to dominate dulaglutide with very small differences in costs and QALYs over the 50-year time horizon of the model. This analysis suggests that semaglutide is a cost-effective add-on therapy compared to dulaglutide for patients with type 2 diabetes inadequately controlled on metformin alone. Whilst this does not directly relate to patient groups or the place in therapy of GLP-1 RAs described by NICE, the improvement in weight loss, HbA1c and blood pressure (the main drivers of the model)

produced by semaglutide 1mg over exenatide in SUSTAIN 3 exceeded those used in this model. It is therefore likely that semaglutide is cost effective compared to exenatide.

The annual cost of semaglutide is £954.86 per patient, which is equal to that of dulaglutide and the lowest dose of liraglutide, less than daily or weekly exenatide and maximal dose liraglutide but it is more expensive than lixisenatide. Each semaglutide pen is accompanied with four disposable needles which further reduces the overall cost compared to other brands of GLP-1 receptor agonists.

If semaglutide were to replace the prescribing of lixisenatide, exenatide and dulaglutide in line with NICE guidance the budget impact is expected to be a very modest cost reduction due to a very low current uptake of lixisenatide and the relatively small cost differences between semaglutide and exenatide.

The committee discussed issues pertinent to the routine commissioning of semaglutide for the treatment of type 2 diabetes:

- Semaglutide is more effective and less expensive than most other similar treatments currently commissioned.
- The specialist noted that the diabetes specialist nurses would prefer to initiate semaglutide to other treatments although it needs upward titration in three stages. GPs may prefer dulaglutide to initiate because it does not need to be up titrated.
- The specialist stated that exenatide extended release requires a more complex device.
- The potential for semaglutide to be a direct cause of increased retinopathy was raised. Specialist opinion was that although it was biologically plausible it may also be due to the rapid tightening of glycaemic control. Individual risks and benefits will be discussed with patients.
- The potential for semaglutide to cause loss of appetite and weight loss was raised. Specialist opinion was that this was not a side effect; it is one way in which semaglutide is expected to work and was a benefit, not a problem. The specialist present also noted that semaglutide causes delayed emptying of the stomach.
- Some patients experience nausea. Treatment can be stopped if a patient cannot tolerate the nausea, however, it usually diminishes over time.

The committee voted unanimously in favour of recommending the routine commissioning of semaglutide for the treatment of Type 2 diabetes as described for GLP-1 mimetics in NG28.

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

4. Review of FreeStyle Libre for interstitial glucose monitoring in diabetes

In January 2018 the Clinical Policy Committee (CPC) reviewed an application for the routine commissioning of the FreeStyle Libre device for patients with Type 1 diabetes. The committee recommended that the device should be routinely commissioned in four patient groups and a policy reflecting these recommendations was published in March 2018.

There has been considerable patient interest in this technology and the CCG has recorded fifty-four patient enquiries about the availability of the device alongside four letters from local MPs.

In March 2019 NHS England (NHSE) published national guidance outlining criteria, which when met by a patient, will result in the CCG being reimbursed a proportion of the cost of FreeStyle Libre sensors. NHSE estimate that the criteria represent up to 20% of England's type 1 diabetic population and therefore have set a threshold for the maximum amount that will be reimbursed. Across Devon this equates to 1,158 patients and a cap of around £783, 000. Between December

2018 and January 2019 864 patients were prescribed the FreeStyle Libre under Devon's current policy, this represents 75% of the reimbursement cap proposed by NHSE.

Naomi Scott, Healthcare Evidence Reviewer, NEW Devon CCG presented a review of the policy for FreeStyle Libre for interstitial glucose monitoring in diabetes in light of the NHS England guidance. Dr Patrick English took part in the discussion. Subsequent to the circulation of the meeting papers additional comments had been received from specialists. These had been forwarded to the committee and were available at the meeting. Naomi Scott read an additional comment that was received after this distribution to the committee.

There are a number of similarities and differences between the current CCG policy and the NHSE criteria for reimbursement. Both have criteria which refer to patients who are incapable of self-management and patients who have previously self-funded the FreeStyle Libre Device. The NHSE criteria includes patients who self-monitor their glucose using testing strips more than eight times a day, whereas the current policy includes patients who test their glucose eight or more times a day.

The current Devon policy includes patients who meet the NICE criteria for insulin pump therapy whereas NHSE criterion six suggests the FreeStyle Libre could be considered as an alternative to pump therapy and specific other treatment options. One of these options is as an alternative to Continuous Glucose Monitoring (CGM), which NICE recommends considering for patients with severe hypoglycaemia or complete loss of awareness of hypoglycaemia. The CPC previously recommended that "patients who have recently developed impaired awareness of hypoglycaemia" should not be included as a criterion within the current CCG policy.

The NHSE criteria includes a limited twelve month use for pregnant women with type 1 diabetes. The CPC previously recommended that the criterion "women who are currently pregnant or are trying to conceive" was not included in the Devon policy.

NHSE also includes three criteria that have not previously been discussed by the CPC; patients with any form of diabetes on haemodialysis who are on insulin treatment and test their glucose more than eight times a day, patients with cystic fibrosis who are on insulin treatment and patients with type 1 diabetes for whom the specialist diabetes Multidisciplinary Team (MDT) determines have occupational or psychosocial circumstances that warrant a six month trial of the FreeStyle Libre.

Consultation with local specialists suggests there are two potential areas of concern with the NHSE guidance:

- Criterion 4, including patients with occupational of psychosocial needs, is seen as ambiguous, subjective, difficult to interpret and has the potential to result in the prescribing of the device in more patients than has been indicated by NHSE
- Criterion 6 refers to the device as an alternative to CGM, for which the CCG does not currently have a policy for routine commissioning

The CPC were asked to consider the NHS England criteria for reimbursement and recommend whether they should replace the current CCG policy, inform additional criteria and/or amend the existing criteria, or if the current CCG policy should be maintained.

The committee discussed issues pertinent to FreeStyle Libre for interstitial glucose monitoring in diabetes:

- The committee can opt to retain the current CCG policy, move to the NHSE criteria or agreed a blend of the two.
- The specialist noted that a clinic in Edinburgh had reported, but not published, experience that all patients had been transferred to FreeStyle Libre. The greatest benefits had been seen in those who had not been monitoring and had poor control. These patients would not be eligible for a FreeStyle Libre under the current CCG or NHSE policies.

- Some members of the committee expressed unease about changing previous CPC decisions without new evidence to support a change. It was noted that the NHSE guidance is not evidence based, however they will provide some funding.
- The committee noted that the current CCG eligibility criteria identified patients who, as a result of clinical need, are self-monitoring their blood glucose 8 times or more per day, whereas the NHSE criteria states more than 8 times daily. Records of testing are required by some CCGs which is the position proposed in the NHSE criteria, for example as meter downloads.
- It was suggested that it may become mandatory for pregnant women to be offered CGM. Specialist opinion stated that if a woman is hyperglycaemic for four hours a day it may be enough to switch on genes in the unborn baby leading to complications. FreeStyle Libre may be an acceptable alternative to CGM in pregnant women.
- Specialist opinion stated that type 1 diabetes reduces life expectancy and that most of the cost of managing diabetes is in managing complications.
- It was noted that the NHSE criteria are publicly available and where the CCG criteria are different the length of discussions with patients in clinic may be increased.
- It was unclear why NHSE had included patients with diabetes associated with cystic fibrosis on insulin treatment. NHSE provided no rationale for inclusion of this group and the specialist was unsure why they had been singled out. It was noted that patients with cystic fibrosis have a generally higher disease burden and that there are special treatment goals for diabetes in cystic fibrosis. Committee members considered it not reasonable to offer FreeStyle Libre preferentially to patients with cystic fibrosis over other diseases because other co-morbid diseases also have a high disease burden. However, where testing is required 8 or more times a day then it was reasonable.

The committee were asked to make recommendations on whether or not to replace the current CCG policy with the NHSE criteria.

- The committee voted unanimously to recommend retaining the current CCG criterion – 'Patients who, as a result of clinical need, are self-monitoring their blood glucose 8 times or more a day.' It was agreed that 'verified by downloads over three months' be added to the criterion.

- The committee voted 5 to 1 in favour of recommending adoption of the NHSE criterion for patients 'with any form of diabetes on haemodialysis and on insulin treatment.'

- The committee voted 5 to 1 in favour of recommending adoption of the NHSE guidance for patients with diabetes associated with cystic fibrosis on insulin treatment with the addition of 'testing 8 or more times a day'.

  The committee noted that there are other patient groups who experience a high disease burden. The agreed criterion is stricter than the NHSE criterion alone but was felt to be fairer.

- The committee voted unanimously in favour of recommending adoption of the NHSE criterion of 'pregnant women with Type 1 Diabetes – 12 months in total inclusive of post-delivery period.'

- The committee voted unanimously in favour of recommending retention of the CCG criterion for 'patients who are incapable of self-management of their diabetes due to their physical or mental health needs, and therefore require third party assistance to carry out glucose monitoring.'

- The committee voted unanimously against recommending inclusion of the NHSE criterion 'People with Type 1 diabetes for whom specialist diabetes MDT determines have occupational (e.g. working in insufficiently hygienic conditions to safely facilitate finger-prick testing) or psychosocial circumstances that warrant a six-month trial of FreeStyle Libre with appropriate adjunct support.

Regarding occupational circumstances it was noted that handwashing was required before finger pricking is carried out and that this may be difficult in some circumstances. It was also noted that it might be difficult for some employees to 'pop out' to undertake finger prick testing. The committee noted that employers should enable an employee to undertake finger prick testing if medically required. The specialist present reported that he already wrote to employers on behalf of patients.

The committee noted specialists concerns about interpreting this criterion and that they wanted further guidance. The committee considered the risk of inequity arising from MDTs assessing psychosocial and occupational factors. Specialist opinion stated that there would be a large number of requests each year and the potential for a significantly larger use of Freestyle Libre than the 20% of type 1 diabetics that NHSE estimate and provide some funding for.

It was agreed that where psychosocial issues or occupational factors are the sole criterion for considering Free style Libre applications should go through the individual funding panel process. It was felt this would provide greater consistency, particularly in the context of applications to panel for other interventions because of occupational or psychosocial need. This would be reviewed by the panel in around six months and if necessary further dedicated discussions take place at a CPC meeting.

There was also discussion about how levels of distress experienced by a patient could be measured. The committee concluded that this was a difficult area not suitable for inclusion in a general policy.

- The committee considered the adoption of NHSE criterion for previous self-funders of Flash Glucose Monitoring with Type 1 diabetes. The committee noted that this was already included in the CCG criteria.

  The committee voted unanimously in favour recommending retention of the current CCG policy wording for the criterion for previous self-funders of FreeStyle Libre with Type 1 diabetes.

- The committee considered the NHSE criterion for 'Those with Type 1 diabetes and recurrent severe hypoglycaemia or impaired awareness of hypoglycaemia'.

  It was noted that NICE suggest a range of therapies.

  The committee discussed this criterion and noted that:

  - 'Continuous Subcutaneous Insulin Infusion' pumps are one option for patients with recurrent severe hypoglycaemia and the current CCG policy has specific criteria which are lacking from the NHSE criteria to include patients who would meet the criteria for an insulin pump
  - Trial data assessing patients using FreeStyle Libre excluded patients with impaired awareness of hypoglycaemia. A trial comparing Continuous Glucose Monitoring (CGM) with FreeStyle Libre suggested CGM is more effective.
  - Pancreas transplant is expensive and can have a negative impact on the patient's life.
  - It was also noted that access to CGM is limited. It was suggested that the committee discuss CGM separately.

  The committee voted unanimously against recommending inclusion of the NHSE criterion for 'Those with Type 1 diabetes and recurrent severe hypoglycaemia or impaired awareness of hypoglycaemia' and to replace it with criterion 2 of the current CCG policy.

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

5. Review: Policy for the referral and specialist management of meibomian cysts (chalazia)

NHS England issued statutory guidance to Clinical Commissioning Groups (CCGs) in November 2018 to introduce and implement commissioning policies for selected interventions. The guidance includes “chalazia removal” and details specific criteria which should be met before incision and curettage, or triamcinolone injection, is undertaken. The CCGs in Devon already have a policy in place for the referral and specialist management of meibomian cysts. This policy was produced in consultation with local specialists, agreed by the Clinical Policy Committee, and published in April 2018. CCGs are expected to demonstrate regard to the national guidance for their policies on the interventions covered by the guidance. NHS England does not intend to reverse legitimate local decision-making.

Matt Howard, Clinical Evidence Manager, NEW Devon CCG presented a paper.

The NHS England guidance states that “the evidence shows that alternative treatment options (warm compresses, drops or ointment, steroid injection) or a “watch and wait” approach will lead to resolution of many chalazia without the risks of surgery”. The Clinical Effectiveness Team has not undertaken any additional literature searches or evidence review. The NHS England guidance suggests no opportunity for reduction in activity of chalazia removal across Devon.

The NHS England policy and the current Devon CCGs’ policy are broadly similar, although the NHS England policy refers only to “chalazia removal”, whereas the current CCGs’ policy relates to both referral and specialist management of Meibomian cysts. The NHS England policy also includes two additional criteria not recognised in the current CCG policy:

- Interferes with the protection of the eye by the eyelid due to altered lid closure or lid anatomy
- Is a source of infection causing an abscess which requires drainage

Local specialists were contacted to seek their views on the clinical implications, the impact on services, and the impact on local activity levels, of adding these two criteria to the Devon policy. They suggested it is clinically appropriate that patients who meet either of these two criteria be offered chalazia removal. Specialists also suggested that these patients are already likely to be offered treatment, and that including these criteria is unlikely to significantly affect local activity levels.

GP referral facilitators (GPRF) at DRSS were also asked to provide their opinion on the potential impact on referrals of including the additional criteria. Feedback indicated broad acceptance of the criterion regarding protection of the eyelid as having little impact on current referrals. However, concerns were raised regarding the criterion relating to abscess. It was suggested that inclusion may result in difficulty with interpretation, and an increase in referrals.

The GPRF view was that the distinction between an abscess and an infected cyst could cause confusion, and ambiguity in referrals, potentially leading to inequity. The response from Devon Referral Support Services (DRSS) suggested that guidance from the ophthalmologists to support GPs to differentiate between an infected meibomian cyst and an abscess would be helpful. The Clinical Effectiveness Team requested guidance and input from local ophthalmologists on this point.

The committee discussed issues pertinent to the policy for the referral and specialist management of meibomian cysts (chalazia):

- The committee was happy with the inclusion to the current policy of the criterion relating to “protection of the eye by the eyelid”.
- It was noted that abscesses are uncommon and will often be obvious to a GP when present, however it may be more difficult if a GP has not previously seen an abscess on

eyelid or a periorbital abscess. The committee felt that the criterion “is a source of infection causing an abscess which requires drainage” should be considered out of scope of the policy as this is clinically urgent. Instead, the clinical scenario would be reflected in a revised local Clinical Referral Guideline (CRG) to support urgent referrals of appropriate patients.

- It was also agreed to add ‘Routine’ before ‘Referral and specialist management of meibomian cysts is only commissioned in the following circumstance:’

The committee voted unanimously in favour of accepting the proposed policy subject to the minor amendments agreed.

ACTION: Clinical scenario for suspected abscess to be reflected in the CRG to support urgent referrals of appropriate patients.

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

6. Review: Policy for Breast Reduction

NHS England issued statutory guidance to CCGs in November 2018 to introduce and implement commissioning policies for selected interventions. NHS England has described breast reduction as an intervention that should only be commissioned or performed when specific criteria are met. NHS England has set the target for Devon to reduce breast reduction surgery activity by 4 from a baseline of 37 elective interventions in 2017/18.

Naomi Scott, Healthcare Evidence Reviewer, NEW Devon CCG presented a paper.

The CCG does not currently have a specific policy for the commissioning of breast reduction surgery for non-cosmetic reasons. Whilst awaiting the publication of NHS England’s policy the CCG has been maintaining its previous position that breast reduction surgery is not routinely commissioned unless the surgery is to repair or reconstruct missing or damaged tissue that has occurred through accident or illness.

During consultation with local specialists, respondents indicated that the adoption of NHS England’s policy would not result in the proposed reduction in activity levels. Specialists indicated that to prevent an increase in procedures and the associated expenditure, it would be reasonable and fair to maintain the current position and have a policy which states that breast reduction surgery is not routinely commissioned in Devon.

The Clinical Policy Committee were asked whether the NHS England breast reduction surgery recommendations should be adopted into local commissioning policy knowing that this is likely to increase activity and expenditure, or whether the current local position should be maintained. This policy would not apply to therapeutic mammoplasty for breast cancer treatment or contralateral surgery following breast cancer.

The committee voted unanimously in favour of recommending that the CCGs’ current position that breast reduction surgery is not routinely commissioned be maintained.

The committee discussed issues pertinent to the policy for breast reduction:

- Due to the current CCG position GPs do not routinely refer patients for breast reduction surgery and the number of patients receiving such surgery is low.
- In addition, patients who have not previously been referred would likely be referred in the future. This may cause an increase in requests for breast reduction surgery and increase costs.

- Very few requests for treatment made through the Individual Funding Request Panel route are currently approved. Implementing the NHS England guidance may increase the number of patients eligible for surgery and increase the expenditure on breast reduction surgery.

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

7. Rebranding of current clinical commissioning policies from 1 April 2019

In the context of the formal merger of NEW Devon CCG and South Devon and Torbay CCG, all current clinical commissioning policies will be rebranded with the NHS Devon CCG organisational logo from 1st April 2019.

There will be no changes to the content of the policies which are not being reviewed at this time.

The Transition Sub-Committee has formally acknowledged that there is a plan in place to ensure that all current clinical commissioning policies will be rebranded with the new organisational logo from 1st April 2019. These will all be published on the new website, with links from related resources updated accordingly.

8. Devon Formulary Interface Groups Annual Report 2017-18

The Clinical Policy Committee was asked to receive the Annual Report for the Devon Formulary Interface Groups 2017/18. The report has been accepted by both the Devon Formulary Interface Groups.

The annual report provides an overview of the activities of the Formulary Interface Groups (FIGs).

The content of the Devon formulary continues to be reviewed and updated by the two FIGs with agreement reached by consensus.

The FIGs represent the collaboration of representatives from both the Devon CCGs, the four major hospitals in Devon, Devon Partnership Trust, and Livewell Southwest.

Relevant local specialists are invited to engage in the review process and attend meetings to join in discussions. This enables the Devon formulary recommendations to reflect local clinical practice and service provision.

The formulary remains broadly consistent across the county, whilst allowing variation to reflect and support the different needs of the local healthcare communities clustered around the major hospitals.

The annual report details the governance processes that support the FIGs, including the terms of reference, quoracy and declarations of interest. In order to demonstrate compliance with the CCGs' statutory responsibilities seventy-two NICE TAs and three HSTs were added to the Devon formulary during the period of this annual report.

The diligence and quality of documentation produced by the Clinical Effectiveness Governance team in supporting the FIGs was acknowledged and commended.

In terms of reviewing and updating formulary content, sections are identified by in-house horizon scanning and stakeholder requests, and a few examples have been noted in the report to give a flavour of the breadth and depth of topics that were discussed

The FIGs considered a range of product applications for new formulations, or combinations of existing formulary medicines, preferred brands, and new dressings; as well as changes to product status or prescribing advice. In addition, the output of CPC is reflected in the formulary.

The FIGs utilise a virtual eFIG process to progress some decisions at pace, or to free up face to face time for more complex discussions. Several decisions were taken using this process during the period of this report.

The FIGs also considered national guidance from NHS England on low value items that should not be routinely prescribed in primary care. 12 of the 18 items were considered by the FIGs during the period of this report, with the formulary updated where necessary.

Use of the formulary and referral website increased by approximately 15% over the previous year, with over 1.2 million page views in 2017/18.

The accompanying app was downloaded 2,198 times in that time, taking total downloads since launch to around 7,000 by the end of March 2018

At the end of 2017 the Clinical Effectiveness Formulary Team undertook a user survey in an effort to understand and improve user experience and satisfaction. Two hundred and eleven responses were received which were generally very positive, however a number of next steps were identified including some technical updates for improved functionality. Work is ongoing in this area.

9. Update from NICE Planning Advisory Group (NPAG)

The committee received an update of the NICE Planning Advisory Group meeting held on 5th February 2019.

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

Other guidelines and guidance considered by NPAG included four Clinical Guidelines, one piece of diagnostic guidance, four pieces of medical technology guidance lines and seven pieces of Interventional Procedures Guidance.

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 13th February 2019.

One item was discussed:

- Evidence based interventions guidance for CCGs.

The panel recommended that no further engagement or formal consultation was required for this item.

The panel acknowledged that Chris Peach was stepping down from his Governing Body role and thanked him for all his valued input since the inception of the panel.

11. Any other business

Meeting Governance

It was noted that the Clinical Policy Committee meeting is a formal meeting with a Terms of Reference and agreed quoracy.

Members were reminded that in the event of planned absence they must notify the meeting secretariat in advance and voting members should make arrangements for a deputy to vote in their absence. Deputies should come from the committee membership. However as agreed previously this should not be a lay member of the committee.

The committee were asked to respond promptly to e-mails from the secretariat.

Summary of actions

	Action	**Lead**
19/01	*Surgical treatment options for lower urinary tract symptoms caused by benign prostatic hyperplasia.* *Committee recommendations to be submitted to the CCGs to inform senior level commissioning discussions for services for this condition.* This is in progress.	Rebecca Heayn
19/05	Semaglutide (Ozempic®) for the treatment of type 2 diabetes: Policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication**.**	Rebecca Heayn
19/06	Review of FreeStyle Libre for interstitial glucose monitoring in diabetes: Policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication.	Rebecca Heayn
19/07	Review: Policy for the referral and specialist management of meibomian cysts (chalazia): Clinical scenario for suspected abscess to be reflected in the CRG to support urgent referrals of appropriate patients.	Lucinda Harris
19/08	Review: Policy for the referral and specialist management of meibomian cysts (chalazia): Policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication.	Rebecca Heayn
19/09	Review: Policy for Breast Reduction: Policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication.	Rebecca Heayn