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

Clinical Policy Committee

Minutes

Wednesday 29th November 2017, 9.30 am to 12.30pm

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
Tracey Foss	Chief Pharmacist	RD&E NHS FT
Dr Lucy Harris*	GP Clinical Commissioner	South Devon & Torbay CCG
Barbara Jones	Head of Locality Contracting	NEW Devon CCG
Mac Merrett	Lay Public Member	
Anna Richards	Consultant in Public Health	Devon County Council
Chris Roome	Head of Clinical Effectiveness	NEW Devon CCG
Dr Alison Round*	GP Clinical Commissioner	NEW Devon CCG
Mark Taylor	Lay Public Member	
Dr Ben Waterfall*	GP Clinical Commissioner	NEW Devon CCG

Guests:

Dr Lee Dobson	Consultant in Respiratory Medicine	RD&E NHS FT
Dr Susie Earl	Consultant Rheumatologist	RD&E NHS FT
Matt Howard	Clinical Evidence Manager	NEW Devon CCG
Hannah Jones	Healthcare Evidence Reviewer	NEW Devon CCG
Dr Stuart Kyle	Consultant Rheumatologist	NDHC NHS FT
Dr Siân Ludman	Consultant Paediatrician	RD&E NHS FT
Dr Kirsten Mackay	Consultant Rheumatologist	T&SD NHS FT
Hilary Pearce	Clinical Effectiveness 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

- Apologies were received from:

Richard Croker	Head of Medicines Optimisation Northern and Eastern Localities	NEW Devon CCG
Paul Foster	Chief Pharmacist	T&SD NHS FT
Tracey Polak	Assistant Director/Consultant of Public Health	Devon County Council
Simon Polak	Deputy Chief Nursing Officer	NEW Devon CCG

  The seven voting members present were identified.

  Tracey Foss attended the meeting as deputy for Paul Foster.
  Anna Richards attended the meeting as representative for Public Health.

- Confirmation of voting members and Declarations of Interest.

  Declarations of interest were collected. The chair reviewed the Declarations of Interest. All Declarations of interest are reported in the minutes.

- Notification of Any Other Business

  Members were asked if they had any items of AOB to discuss. No items were identified.

DRUG/TECHNOLOGY TO BE CONSIDERED	PHARMACEUTICAL COMPANY / MANUFACTURER / SERVICE PROVIDER
Azelastine hydrochloride and fluticasone propionate (Dymista®) **for allergic rhinitis**	**Meda Pharmaceuticals**
Alternative treatments:	
Intranasal steroids	**Various manufacturers**
Intranasal and oral antihistamines	**Various manufacturers**
Grass pollen extract	**Allergy Therapeutics (UK) Ltd, ALK-Abello Ltd**
Tree pollen extract	**Allergy Therapeutics (UK) Ltd**
Fluticasone furoate and vilanterol trifenatate (Relvar®, Ellipta®) **combination inhaler for asthma**	**GlaxoSmithKline UK**
Alternative treatments:	
Fluticasone propionate/salmeterol (Aerivio®, AirFluSal®, Sereflo®, Seretide®, Sirdupla®)	**Teva UK Ltd, Sandoz Ltd, Kent Pharmaceuticals Ltd, GlaxoSmithKline UK, Generics UK t/a Mylan**
Fluticasone propionate/formoterol (Flutiform®)	**Napp Pharmaceuticals Ltd**
Beclometasone dipropionate/formoterol (Fostair®)	**Chiesi Limited**
Budesonide/formoterol (Duoresp®, Fobumix®, Symbicort®)	**Teva UK Ltd, Orion Pharma (UK) Ltd, AstraZeneca UK Ltd**
Biological agents for psoriatic arthritis	
Secukinumab (Cosentyx®)	**Novartis Pharmaceuticals UK Ltd**
Infliximab (Inflectra®, Flixabi®, Remicade®, Remsima®)	**Hospira UK Ltd, Biogen Idec Ltd, Merck Sharp & Dohme Limited, Napp Pharmaceuticals Limited**
Adalimumab (Humira®)	**AbbVie Ltd**
Certolizumab (Cimzia®)	**UCB Pharma Ltd**
Etanercept (Benepali®, Enbrel®, Erelzi®)	**Biogen Idec Ltd, Pfizer limited, Sandoz Limited**
Golimumab (Simponi®)	**Merck Sharp and Dohme Ltd**
Ustekinumab (Stelara®)	**Janssen Cilag Ltd**

NAME OF ATTENDEE	ROLE	
Lee Dobson	Consultant in Respiratory Medicine	• In receipt of lecture fees in excess of £150 in the last year from above pharmaceutical/ manufacturing company/companies. • Received gifts, benefits or sponsorship of any kind, whether refused or accepted worth over £25 or several small gifts worth a total of over £100 from the above or closely related pharmaceutical/ manufacturing company/companies. • Hospitality received where the drug(s)/devices(s)/intervention(s)/treatments(s) under consideration were discussed by a representative of a drug /manufacturing company/companies. • In receipt of payment/gift for transport and hospitality to attend national or international meetings or symposia. Has delivered sponsored lectures to Primary care over the 3 last years for a variety of the companies – TEVA, GSK, Chiesi. Has attended meetings supported by these companies and sponsorship to attend educational meetings. Has also coordinated the regional training days for the Respiratory SPRs and part of remit deals with the pharma sponsorship for these days which involves all of the companies listed.
Susie Earl	Consultant Rheumatologist	• In receipt of lecture fees in excess of £150 in the last year from above pharmaceutical/ manufacturing company/companies. • In receipt of payment/gift for transport and hospitality to attend national or international meetings or symposia. Given an educational presentation for Norvatis on the treatment of psoriatic arthritis. Has attended a medical advisory board for UCB.
Stuart Kyle	Consultant Rheumatologist	Has received honoraria from Norvartis and speaker fees and sponsorship for a conference from Celgene. Is co-investigator on MAXIMIZE an interventional study of Secukinumab in axial psoriatic arthritis.
Dr Siân Ludman	Consultant Paediatrician	Meda (due to their adrenaline autoinjector) was one of several sponsors of the Exeter University/RD&E and Derriford Hospital Allergy study day last June. No personal sponsorship or interation.
Dr Kirsten Mackay	Consultant Rheumatologist	Work as paid advisor: Has attended/participated in Adboards for: • Roche – discussing phase 3 trials for a possible new molecule – Bruton's Tyrosine Kinase Inhibitor (in context fo RA and possibly SLE) • Roche – use of Tocilizumab for difficult to treat GCA • UCB – treatment of patients with RA who wish to become pregnant

Dr Kirsten Mackay Cont…	Consultant Rheumatologist	In receipt of an educational/research grant for self or department: • AbbVie have provided an educational grant to allow us to organise a Peninsular Symposium on Rheumatology for GPs and GP trainees –this is a regional meeting and many of my consultant rheumatology colleagues also lecture at this meeting (I organise the symposium and run some workshops) • Novartis provided an educational grant to our department so we could organise a meeting to update our specialist nurses on Spondyloathritis and Psoriatic Arthritis Has taken part in a drug trial: Is a PI for many research trials including those sponsored by UCB, ROCHE, Novartis, Jansesen (and in the past MSD). Transport/hospitality to attend national or international conference • Attended an international 2 day conference - update in immunology organised by UCB. • Attended an international 2 day conference - update in rheumatology organised by AbbVie. • Attended 2 national meetings sponsored by Novartis: o Advanced Business Planning. o Advanced Communication. Lecture fees: Chaired a meeting in December 2016 when we were discussing the published data on Apremilast and a regional audit.

2. Minutes of the meeting held on 27th September 2017 and matters/actions arising

The minutes of the meeting held on 27th September were approved.

Summary of actions		
	Action	**Lead**
17/14	*Recommended revisions to the CCGs' policy for Cryopreservation and QEIA to be prepared and subsequently progressed to final CCG approval and communication*. The policy recommendation and QEIA have been signed off by the executive committees of NEW Devon CCG and South Devon and Torbay CCG and is pending publication.	Rebecca Heayn
17/15	*Recommended revisions to the CCGs' policy for Assisted Conception and QEIA to be prepared and subsequently progressed to final CCG approval and communication.* The policy recommendation and QEIA have been signed off by the executive committees of NEW Devon CCG and South Devon and Torbay CCG. The policy has subsequently been published. Action complete.	

17/16	Proposed wording for the donor insemination section of the Assisted Conception Policy to be produced and circulated to specialists and the Chair of the Clinical Policy Committee for agreement. Action complete	
17/17	*Options for functional impairment criteria for hernia referral that could be applied within DRSS to be explored and fed back to the Clinical Effectiveness team.* The criteria for functional impairment have been considered and softened. Wording has been kept to prevent positive discrimination. Action complete	
17/18	Letter to be written to hernia surgeons advising them that the Devon wide policy for the specialist management of abdominal wall hernia in adults still stands. Action complete	
17/19	Letter to be written to medical directors about comments made by surgeons at the CPC meeting in July 2017 regarding the departure of clinical practice from the CCGs' commissioning policy position. Action complete	
17/20	*Committee Chair to write to CCGs leadership teams describing the difficulties encountered when forming policy recommendations.* A definition of affordability is required. A letter has been drafted and a governing body level discussion is needed. It was noted that a decision making framework is being agreed by the CCGs. There was discussion about the large variation in the robustness of processes at CCGs outside Devon. The usefulness of knowing what the policies of other CCGs are was noted. However the committee also noted that it was not advisable to take shortcuts and duplicate polices produced by other CCGs without having a clear understanding of all the related issues. Transparency is needed in the CCGs decision making processes at CPC and at Planned Care.	

3. Azelastine hydrochloride and fluticasone propionate (Dymista®) for allergic rhinitis

An assessment of Dymista was originally presented to the Clinical Policy Committee in December 2014. At that time Dymista was not accepted for routine commissioning for the treatment of allergic rhinitis. A new formulary application has now been received from a local Consultant Paediatrician. Hannah Jones, Healthcare Evidence Reviewer, NEW Devon CCG presented an evidence assessment. Dr Siân Ludman, Consultant Paediatrician, Royal Devon and Exeter NHS Foundation Trust took part in the discussion.

Dymista is a combination nasal spray containing an antihistamine and a corticosteroid in the form of azelastine hydrochloride and fluticasone propionate. The recommended dose is one

actuation in each nostril twice a day. Dymista is licensed for the relief of symptoms of moderate to severe seasonal and perennial allergic rhinitis, if monotherapy with either intranasal antihistamine or glucocorticoid is not considered sufficient, in adults and adolescents aged 12 years and older.

The clinical efficacy evidence comes from four trials conducted in the USA. No new trials have been identified since the original CPC assessment in 2014.

The committee was asked to consider whether the context had changed sufficiently, or new evidence had been presented which satisfied the concerns described in the rationale for the decision of the current policy.

The following points from the original commissioning policy remain unchanged:

- The clinical evidence supporting the licensing of Dymista treatment was limited to comparisons against placebo, or the individual components given only as monotherapies.
- Dymista achieved a statistically significant improvement in nasal symptom scores from baseline, compared to monotherapies with the difference between treatments being greater than the minimum clinically important difference of 0.55 units.
- A significant mean improvement of ocular symptom scores were found for Dymista compared to fluticasone, but not azelastine.
- Disease specific quality of life scores improved from baseline with Dymista, but the scores compared to monotherapies did not exceed the minimum clinically important difference.
- Responder analyses found that compared to monotherapies 5-15% more patients receiving Dymista reached a 50% reduction in nasal symptom scores. 3-10% more patients achieved complete or near complete resolution of nasal symptoms at day 14.
- Dymista had not been compared with the current standard treatment of a combination of intranasal corticosteroid and oral antihistamine, and hence evidence was limited in support of this treatment at that time.

The direct acquisition cost of Dymista was higher than other established current treatment options. The assessment in 2014 reported that the price of Dymista was due to be reduced and so the budget impact was calculated using today's reduced price. The cost of Dymista is still higher and the cost difference between other established treatments has increased since 2014. Given the limitations in the evidence in 2014 it was considered that the cost of Dymista was not justified by the effectiveness demonstrated.

The current treatment for patients who have failed to achieve symptom relief with oral antihistamines and intranasal corticosteroids would involve immunotherapy with Grazax. There is no evidence that patients who have failed to achieve satisfactory symptom relief with oral antihistamines and intranasal corticosteroids would achieve better results with Dymista, and therefore avoid treatment with Grazax.

There is substantial uncertainty on the potential uptake of Dymista and therefore the resultant budget impact.

No new evidence has been presented which addresses the issues raised in the rationale of the current Devon Policy for Dymista for allergic rhinitis. The limitations in the evidence base that prevented the commissioning of Dymista in December 2014 have not been resolved.

The committee discussed issues pertinent to this policy application:

- There is no trial data available for the patient group for whom Dymista is being requested and no trial data is likely to be produced.
- Allergists would like Dymista as a formulary option for a small number of patients who have not responded adequately to current treatments. The applicant suggested this may prevent or reduce the necessity to use immunotherapy treatments and avoid situations where patients are sent out of area for treatment. Allergists have no desire to switch patients with well controlled allergic rhinitis to Dymista; specialist opinion suggested that Dymista be given 'amber' status in the formulary (requiring specialist initiation).
- Dymista can be used in patients who are twelve years of age and older. Successful control of allergic rhinitis improves quality of life. For some patients lifelong treatment may be needed.

- A member of the committee suggested that patients use two nasal sprays as a cheaper alternative. However it was noted that the nasal sprays needed are not included in the local formulary and that a fifteen minute gap is recommended between the nasal sprays which are needed twice a day. This is not the case when the drugs are combined in one nasal spray; use of two nasal sprays would increase the burden for patients already using several layers of treatment to reduce their symptoms.
- The committee expressed concern that Dymista was more expensive than most existing combinations and that costs could increase significantly if GPs started to initiate Dymista because they saw specialists initiate it. The specialist present stated that Royal College guidance states that patients reaching stage 2 should be referred to a specialist.
- It was suggested that Dymista may be suitable for access through the Trust Managed Individual Patient Route (TMIPR). The committee chair explained how the TMIPR worked. The specialist present indicated that this may be a suitable route for this group of patients. Some discussion took place about the working of the TMIPR at RD&E.

The committee voted unanimously against recommending the routine commissioning of Dymista.

The committee voted six to one in favour of recommending that Dymista be available for use via the TMIPR for the treatment of allergic rhinitis in patients who have not responded adequately to current treatment options.

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

4. Fluticasone furoate and vilanterol trifenatate (Relvar® Ellipta®) combination inhaler for asthma

An assessment for Fluticasone furoate and vilanterol trifenatate (Relvar® Ellipta®) combination inhaler for asthma was originally presented to the Clinical Policy Committee in September 2015. At that time it was not accepted for routine commissioning. A new formulary application has now been received from Dr Matthew Masoli, Respiratory Consultant, Plymouth Hospitals NHS Trust. Hannah Jones, Healthcare Evidence Reviewer, NEW Devon CCG, presented an evidence assessment. Dr Lee Dobson took part in the discussion.

Relvar® Ellipta® is a combination dry-powder inhaler containing fluticasone furoate and vilanterol trifenatate, an inhaled corticosteroid (ICS) and a long-acting beta-agonist (LABA). It is available as two different strengths, low-medium and high. Both strengths of the Relvar® Ellipta® inhaler are indicated for the regular treatment of asthma in adults and adolescents aged 12 years and older where use of an ICS and LABA is appropriate: patients not adequately controlled with ICS and 'as needed' medication. The initial licensing application included a product switching indication for people whose asthma is already controlled by an ICS and a LABA. However, the European Medicines Agency (EMA) did not consider there were data in support of the indication at that time. A change to the licence has been applied for, but a decision has not yet been made.

The clinical efficacy evidence for Relvar® Ellipta® in asthma comes from seven trials. Four of which were considered with the original application. Since then three further relevant trials have been completed. Relvar® Ellipta® when compared to fluticasone furoate monotherapy showed statistically significantly improved lung function and patient reported asthma control, but no difference in quality of life. No difference in lung function or patient reported asthma control was found when Relvar® Ellipta® was compared to Seretide Accuhaler. The Salford Lung Study, a 12-month open-label “real world” trial comparing both strengths Relvar® Ellipta® to optimised usual care revealed higher odds of being an asthma control responder and quality of life responder for Relvar® Ellipta®. No differences between groups for annual exacerbation rate, or time to first exacerbation were found.

A cost-minimisation analysis submitted to the Scottish Medicines Consortium and All Wales Medicines Strategy Group was considered during the original application. New financial calculations were undertaken for submission with the new application. Just prior to the

meeting an error in the new financial calculations contained in Table 14 on page 82 of the board pack was identified; correct information was tabled at the meeting. Duoresp Spiromax 400/12mcg contains 60 doses per device not 120. Therefore the 28 day cost of Duoresp Spiromax is £27.97 – £55.94 not £13.00 – 27.97 as stated in the board pack. This also impacts the estimated budget impact calculations.

If the estimated 1100 patients in Devon were prescribed Relvar Ellipta instead of AirFluSal MDI (the cheapest medium strength ICS/LABA) it would have cost around £47,000 more per year. However the cheapest dry powder inhaler is the Fostair Nexthaler. If the estimated 1100 patients in Devon were prescribed Relvar Ellipta instead of Fostair Nexthaler, it would have cost around £98,000 less per year. If they were prescribed Relvar Ellipta instead of Symbicort Turbohaler 200/6mcg two puffs BD (the most expensive medium strength ICS/LABA) it would cost around £210,000 less per year.

If the estimated 1100 individuals in Devon were prescribed the high dose Relvar Ellipta rather than Fostair NEXThaler 200/6mcg (the cheapest high strength ICS/LABA) it would cost about £2000 more per year. If they were prescribed Relvar Ellipta instead of Symbicort Turbohaler 400/12mcg (most expensive high strength ICS/LABA) it would cost around £600,000 less per year.

Relvar Ellipta remains the only ICS/LABA product licensed for asthma which requires once daily inhalation.

The committee was asked to consider whether the context has changed sufficiently, and/or new evidence has been presented which satisfies the concerns described in the rationale for the decision of the current policy.

The following points from the original commissioning policy remain unchanged:

- The licensed indication for Relvar® Ellipta® was regarded as restrictive compared to existing ICS/LABA products.
- The components of Relvar® Ellipta® were not available as monotherapy and thus a switch of steroid was required when stepping up and down therapy in accordance with British Thoracic Society (BTS) guidelines to add a LABA component to treatment.
- The furoate salt of fluticasone contained in Relvar® Ellipta® is more potent than the propionate salt contained in existing commonly used products so that doses of fluticasone are not interchangeable with existing combination products.
- Relvar® Ellipta® has a short in-use shelf life of six weeks, which was considered to present additional difficulties for the patient managing their inhalers and avoiding waste.
- A clinical advantage of Relvar® Ellipta® over existing products with respect to lung function, quality of life, or exacerbations, had not been demonstrated. Data from the Salford Lung Study may partially address this issue; however, limitations of the trial, including the way in which results have been presented, limits conclusions that may be drawn.
- There were no data to directly support increased adherence with Relvar® Ellipta® used once daily compared to other ICS/LABA combinations in asthma.
- Lack of clinical efficacy evidence, the limited number of trials involving comparisons with other ICS/LABAs, restricted licence, and questions over its place in therapy must be considered while making decisions regarding routine commissioning of Relvar® Ellipta® for asthma.

The committee discussed issues pertinent to this policy application:

- The specialist present highlighted that Relvar® Ellipta® is a once daily inhaler that is easy to use and is relatively inexpensive. The inhaler works well for patients with severe asthma.
- A committee member raised a concern that as Relvar® Ellipta® has a short life once opened (six weeks) patients may use the product with reduced effectiveness. However the specialist present noted that a patient would have to miss half of their doses for any product to be left at the end of the six week period.
- The low-medium strength Relvar® Ellipta® combination inhaler is in the formulary for COPD. However the product's license for use in asthma is only for initiation of new patients and not for switching of patients from other inhalers.

- A large number of products are included in the formulary for the treatment of asthma and some rationalisation is required. The cost advantages would make rationalisation and an implementation plan worthwhile if the product was granted a licence for switching.
- It was suggested that the routine commissioning of Relvar® Ellipta® combination inhaler for the treatment of asthma would not be helpful at this time. However this could be reconsidered if the product licence changed.

The committee voted 4 to 3 against the routine commissioning of Fluticasone furoate and vilanterol trifenatate (Relvar® Ellipta®) combination inhaler for asthma at the current time. The current policy remains in place.

The committee voted unanimously in favour of considering the routine commissioning of Fluticasone furoate and vilanterol trifenatate (Relvar® Ellipta®) combination inhaler for asthma if there is a change in its licence, to allow switching from other inhalers.

5. Biological agents for psoriatic arthritis

NICE has published Technology Appraisals (TAs) for seven biological agents for psoriatic arthritis. The first TAs were issued for anti-tumour necrosis factor (TNFs) in 2006 and 2007. The TAs for interleukin inhibitors, secukinumab and ustekinumab, were issued in 2015 and 2017. These TAs have been developed in isolation and the sequential use of biological agents has not been fully addressed by NICE. A member of the Clinical Effectiveness team presented a paper. Three consultant rheumatologists took part in the discussion; Dr Stuart Kyle from Northern Devon Healthcare NHS Trust, Dr Susie Earl from Royal Devon and Exeter NHS Foundation Trust and Dr Kirsten Mackay from Torbay and South Devon NHS Foundation Trust.

Three areas have been identified for consideration by the committee. These were:

- Anti-TNFs or ustekinumab for patients who have failed treatment with secukinumab as a first line biological agent.

  Secukinumab is one of the lowest cost biological therapies and would be a preferred option for first line therapy. The secukinumab TA recommends its use as a first line biological treatment option but there are no NICE TA recommendations for failure of secukinumab.

- Secukinumab as a third line agent

  There is inconsistency in the wording of the TAs for secukinumab and ustekinumab. Ustekinumab is the most expensive biological agent but is the only agent which NICE clearly recommends as a third line option. It is unclear from the secukinumab TA whether use of secukinumab as a third line option is recommended.

- Infliximab as a third line agent

  The specialists have asked for clarity on the anti-TNF, infliximab, as a third line option. Sequential use was not addressed in the TAs for the established anti-TNFs. However, NICE have since stated that sequential use of anti-TNFs is considered to be established practice in the NHS.

In summary the current position from NICE TAs leaves specialists reluctant to use secukinumab first line and leads to a high cost pathway for patients requiring a third line biological agent.

It was proposed that the committee agree acceptability of these options and make a recommendation that the Clinical Commissioning Groups confirm that for the treatment of psoriatic arthritis they will fund:

- Anti-TNFs or ustekinumab for patients who have failed treatment with secukinumab as a first line biological agent.
- Secukinumab as alternative third line biological agent.

- Infliximab as an alternative third line biological agent.

The committee discussed NICE TAs and issues pertinent to this proposal:

- This is a complicated market with many products available and fluctuating costs.
- Biosimilars are available and more will be coming to market.
- It is unlikely that these will be long term options; the options should be considered at least annually.
- Specialists take into account all the symptoms and conditions of each patient to ensure that patients receive the right treatment. If a patient has no clear phenotype the least costly treatment is given.
- The proposal aims to simplify the choices whilst ensuring that patients receive the right treatment as cost effectively as possible.

The committee voted unanimously in favour of recommending the proposal.

ACTION: Trusts to be informed that the CCG accepts anti-TNFs or ustekinumab for patients who have failed treatment with secukinumab as a first line biological agent, Secukinumab as alternative third line biological agent, and Infliximab as an alternative third line biological agent.

6. Update from NICE Planning Advisory Group (NPAG)

The committee received an update from the NICE Planning Advisory Group meeting which took place on Tuesday 12 September 2017. In particular it was noted that:

- Formulary work is required following publication of Bisphosphonates for treating osteoporosis (TA464) [and updates to TA160 and TA161 Alendronate, etidronate, risedronate, raloxifene and strontium ranelate for the primary and secondary prevention of osteoporotic fragility fractures in postmenopausal women].
- Collagenase clostridium histolyticum for treating Dupuytren's contracture (TA459) - Clarification of the services provided locally is being sought.
- Cirrhosis in over 16s (NG50) – Dr Mick Braddick had provided clarity on what the tests are for and guidance for primary care on which patients to test and the tests to be used.
- NICE has now published a number of IPGs relating to back pain and spinal conditions. Fiona Phelps, Head of Commissioning, Western Planning and Delivery Unit NEW Devon CCG will attend a network meeting at the end of November 2017 at which these will be discussed.

7. 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 Wednesday 11th October 2017.

Two topics had been discussed:

- Cryopreservation to preserve fertility policy

  The panel noted that for some patients entitlement to NHS funding for the storage of material would be extended and that for some patients the time for which material would be stored less than originally expected. The panel recommended that patients who currently have cryopreserved material are informed of the revisions to the policy so they can understand how it may affect them. The panel also recommended that in the event of significant concern being raised by patients affected, the Clinical Policy Committee should be informed and asked to reconsider the policy.

  It was noted that a letter is being drafted to be sent to all patients affected by this policy.

- Proposed changes to the commissioning policy for Assisted Conception

  The panel saw no need for public consultation.

8. Any Other Business

There was no other business to report.

Summary of actions		
	Action	**Lead**
17/14	*Recommended revisions to the CCGs' policy for Cryopreservation and QEIA to be prepared and subsequently progressed to final CCG approval and communication*. The policy recommendation and QEIA have been signed off by the executive committees of NEW Devon CCG and of South Devon and Torbay CCG and is pending publication.	Rebecca Heayn
17/17	Azelastine hydrochloride and fluticasone propionate (Dymista®) for allergic rhinitis – Policy recommendation and QEIA to be prepared and subsequently progresses to final CCG approval and communication.	Rebecca Heayn
17/18	Biological agents for psoriatic arthritis - Trusts to be informed that the CCG accepts anti-TNFs or ustekinumab for patients who have failed treatment with secukinumab as a first line biological agent, Secukinumab as alternative third line biological agent, and Infliximab as an alternative third line biological agent.	Chris Roome