Clinical Policy Engagement & Consultation Panel Minutes

Thursday 24 July 2025, 14.00-15.30
G05, Aperture House, Exeter and via Microsoft Teams

Present:

Name	Role
Steve Clark	Stakeholder Engagement and Public Affairs Manager, NHS Devon
Thandiwe Hara*	Non-executive director for citizen and community involvement, NHS Devon
Carol McCormack-Hole*	Lay Member from the Patient Engagement Forum
Mac Merrett*	Lay Public Member, Clinical Policy Recommendation Committee
Rebecca Owen	Clinical Effectiveness Governance and Individual Funding Request Panel Manager, NHS Devon
Chris Roome	Deputy Director - Clinical Effectiveness, NHS Devon
Mark Taylor*	Lay Public Member, Clinical Policy Recommendation Committee
Louise Whitehead	Senior Evidence Review Specialist, NHS Devon (observer)

* Denotes voting members

1. Welcome and introductions

Louise Whitehead was welcomed to the meeting as an observer. Louise has recently joined the Clinical Effectiveness team as a Senior Evidence Review Specialist.

The apologies received were noted as below.

Apologies:

Name	Role
Martyn Nicoll	Patient Experience Manager, NHS Devon

2. Declarations of Interests

All those attending had completed a declaration of interests which has been recorded on the panel's register of interests.

No further interests pertinent to the items for discussion on the meeting agenda were declared.

3. Minutes of the meeting held on Thursday 5 December 2024 and matters/ actions arising

The panel considered and agreed the minutes from the meeting held on Thursday 5 December 2024. There were no outstanding actions or matters arising to note.

4. Discussion and recommendation on the Clinical Policy Recommendation Committee (CPRC) decisions from 2 July 2025

Metformin for the prevention of antipsychotic induced weight gain

An overview of the Clinical Policy Recommendation Committee recommendation and the context within which it had arisen was noted.

An application had been received from specialists at Devon Partnership Trust, supported by Livewell Southwest, to consider the use of metformin in Devon for the prevention of antipsychotic induced weight gain.

Adults living with severe mental illness have an almost five times increased risk of dying prematurely compared to those living without. Antipsychotic drugs increase life expectancy; however, they commonly cause weight gain. Obesity and overweight are known to be associated with adverse health outcomes. Concerns regarding antipsychotic induced weight gain may also lead some patients to avoid taking antipsychotic medication.

The following was noted in respect of the public interest themes in relation to this policy:

1. Is the reason for introducing the policy plausible? and 2. Does the policy output address this intent?

It was noted that consideration of the use of metformin for the management of anti-psychotic induced weight gain had been prompted by an application from local mental health specialists.

Following consideration, the Clinical Policy Recommendation Committee has recommended a policy which supports the routine commissioning of metformin in Devon for the prevention of antipsychotic induced weight gain.

3. Have the effects of the policy on individual patients and carers been considered?

In addition to the impact on quality of life and physical health as a result of weight gain, it was acknowledged that local specialists had highlighted that the risk of weight gain can discourage people from adhering to antipsychotic medication. Interventions to prevent weight gain, and encourage adherence to antipsychotic treatment plans, are therefore expected to support overall treatment outcomes for patients.

It was queried at what point this treatment would be given. It was clarified that metformin would be started at the same time as antipsychotic drugs associated with a high risk of weight gain in order to try to prevent this.

It was noted that metformin is not licensed for this indication, although its use for the prevention of antipsychotic induced weight gain is supported in national prescribing guidance from the Scottish Intercollegiate Guidelines Network (SIGN), the British Association for Psychopharmacology (BAP) and The Maudsley. It was considered that it would be the responsibility of the prescribing clinician to discuss the non-licensed nature of the drug for this indication with individual patients when making informed treatment decisions.

4. Have the wider consequences on society been considered?

No wider consequences of the proposed policy were noted beyond the individuals involved.

5. Has the opportunity cost been considered?

It was discussed that there is little formal evidence of cost-effectiveness of metformin in this indication. However there is consistent lower certainty evidence suggesting that metformin is associated with a reduction in antipsychotic weight gain. The panel discussed the approach to considering cost effectiveness that had been presented at the Committee and the limitations that were inherent in this, also noting the limitations in cost effectiveness evidence that have generally informed national policy in weight loss interventions. Under the policy recommendation, it is anticipated that metformin would be offered to a maximum of 600 patients per year (those starting or switching antipsychotics) at an annual cost of approx. £17,000. The Committee had concluded that this is likely to represent good value for money in Devon and members of the panel were content with this conclusion.

6. Is there knowledge of public concern in relation to a) the disease and b) the specific intervention?

The panel were not aware of any particular public concern relating to this patient group or the use of metformin. However it was noted that there is currently a high public focus on weight loss interventions and care should therefore be taken in the context of this with policy messaging.

There was some concern regarding the potential for this to be perceived as a general weight loss medication. To ensure appropriate messaging, it was discussed that this would be best focused on the specific context of the policy and supported by appropriate formulary guidance. Initiation of treatment would be undertaken by mental health specialists which it was considered may mitigate against the risk of wider use. It was also acknowledged that there is a large cohort of patients who will already be taking metformin for type 2 diabetes.

There was discussion regarding the equity perspective with other drugs used for the treatment of different conditions which may also be associated with weight gain side effects. It was explained that the policy recommendation being considered had been prompted by a specific request from local mental health specialists due to the challenges in treating patients with mental health issues with antipsychotic drugs which are known to promote appetite. Similar evidence review work could be carried out in other areas, however there would need to be a prompt to undertake this, such as a need identified by local specialists or from national guidance.

7. What information on the treatment and condition is available to patients via nhs.uk (formerly NHS Choices)?

nhs.uk does not give any information specifically relating to the use of metformin for anti-psychotic induced weight gain, however it gives information on both antipsychotics for the treatment of psychosis and about metformin in the context of the treatment of diabetes.

It states that antipsychotic medicines are usually recommended as the first treatment for psychosis. Antipsychotics can have side effects, although not everyone will experience them, and their severity will differ from person to person. Side effects can include: drowsiness, shaking and trembling, weight gain, restlessness, muscle twitches and spasms, blurred vision, dizziness, constipation, loss of sex drive, and dry mouth.

Metformin is a medicine used to treat type 2 diabetes and gestational diabetes. It is also used to help prevent type 2 diabetes if you're at high risk of developing it. Metformin lowers your blood sugar levels by improving the way your body handles insulin.

Metformin is also used to improve fertility if you have polycystic ovary syndrome (PCOS), a condition that affects how the ovaries work. It may also be used to manage other symptoms of PCOS, but it is not officially approved to be used in this way. Metformin treats PCOS by lowering insulin and blood sugar levels. This can also improve ovulation and encourage regular periods, even if you do not have diabetes.

Metformin does not cause weight gain, unlike some other diabetes medicines.

Considering all these factors together the panel recommended that no further engagement or formal consultation was required at this point.

Fluticasone furoate and vilanterol trifenatate combination inhaler (Relvar Ellipta) for chronic obstructive pulmonary disease (COPD) and for asthma

An overview of the Clinical Policy Recommendation Committee recommendations and the context within which these had arisen was noted by the panel.

Fluticasone furoate and vilanterol trifenatate (Relvar Ellipta) is a combination dry-powder inhaler containing both an inhaled corticosteroid (ICS), fluticasone furoate, and a long-acting beta2-agonist (LABA) vilanterol trifenatate.

NHS Devon has existing clinical policies in place supporting the use of Relvar Ellipta combination inhaler in Devon for the symptomatic treatment of adults with COPD and an exacerbation history despite regular bronchodilator therapy, and for the regular treatment of asthma in adults and adolescents aged 12 years and older.

As part of the routine management of clinical policies it was identified that COPD and asthma are therapeutic areas which have evolved since the existing policy positions were formed in 2016 and 2018, respectively.

The panel considered the public interest themes in relation to these policies:

1. **Is the reason for introducing the policy plausible? and 2. Does the policy output address this intent?**

   It was noted that review of the ongoing need for these longstanding clinical policies had been prompted by changes in national guidance on the treatment of COPD and asthma.

   Chronic obstructive pulmonary disease (COPD)

   The Global Initiative for Chronic Obstructive Lung Disease (GOLD) published a report in 2024 which includes a number of changes to the management of COPD. Prompted by this report, the Devon Formulary Interface Group agreed an update to formulary guidance for the management of COPD in September 2024.

   This includes a move away from the use of ICS/LABA combination inhalers for patients without features of asthma. Further formulary guidance was subsequently developed and agreed on the management of patients currently using an ICS/LABA combination inhaler for COPD, based on advice on this subject in the GOLD report.

   Asthma

   In respect of asthma, a collaborative guideline (NG245) developed by the British Thoracic Society, NICE and SIGN was published in November 2024.

   There is now a recognised move towards anti-inflammatory reliever (AIR) therapy and maintenance and reliever therapy (MART) for asthma. AIR therapy is treatment with a reliever inhaler that contains a combination of an inhaled corticosteroid and formoterol. MART is a form of combined ICS plus formoterol treatment in which a single inhaler containing ICS and formoterol is used for daily maintenance therapy and the relief of symptoms as needed.

   Relvar Ellipta is not licensed for either MART or AIR therapy; the LABA component is vilanterol. In November 2024, the only product licensed for as-needed AIR therapy contained budesonide/formoterol.

   Following consideration of the changing clinical context, the Clinical Policy Recommendation Committee has recommended the retirement of these policies.

3. **Have the effects of the policy on individual patients and carers been considered?**

   The panel acknowledged that the Devon Formulary will continue to support guidance for prescribers in these clinical areas whilst being responsive to further changes. This includes appropriate guidance to support the continuation of treatment for patients who are stable on Relvar Ellipta.

4. **Have the wider consequences on society been considered?**

   It was felt that there were no wider consequences of the proposed policy beyond the individuals involved.

5. Has the opportunity cost been considered?

It was noted that Relvar Ellipta has become well established in practice, with prescribing levels in Devon fairly consistent over the past 5 years. However the clinical context had changed since the existing policy positions had been formed. With the changes to clinical guidance in this area there may be a reduction in the market share of Relvar Ellipta compared to other treatment options.

Future recommendations on Relvar Ellipta should be guided by national policy direction, as is the general case for established treatments. The Devon Formulary will continue to support guidance for prescribers, evolving this as needed.

6. Is there knowledge of public concern in relation to a) the disease and b) the specific intervention?

The panel were not aware of any particular public concern in respect of treatment options for COPD and asthma. There are a range of treatment options for patients, supported by Devon Formulary guidance.

7. What information on the treatment and condition is available to patients via nhs.uk (formerly NHS Choices)?

<u>Chronic obstructive pulmonary disease (COPD)</u>

nhs.uk gives information on COPD. There is no cure, but treatment can help slow the progression of the condition and control the symptoms.

Treatments include inhalers, a device that delivers medicine directly into your lungs as you breath in. There are several different types of inhaler for COPD.

For most people with COPD, short-acting bronchodilator inhalers are the first treatment used. There are 2 types of short-acting bronchodilator inhaler: beta-2 agonist inhalers – such as salbutamol and terbutaline, and antimuscarinic inhalers – such as ipratropium. Short-acting inhalers should be used when you feel breathless, up to a maximum of 4 times a day.

If you experience symptoms regularly or have flare-ups (exacerbations) despite using short-acting bronchodilators, a long-acting bronchodilator inhaler may be recommended. These work in a similar way, but each dose lasts for at least 12 hours, so they only need to be used once or twice a day.

There are 2 types of long-acting bronchodilator inhaler: beta-2 agonist inhalers – such as salmeterol, formoterol and indacaterol, and antimuscarinic inhalers – such as tiotropium, glycopyronium and aclidinium. Some new inhalers contain a combination of a long-acting beta-2 agonist and antimuscarinic.

If you're still becoming breathless when using a long-acting inhaler, or you have frequent flare-ups (exacerbations), a GP may suggest including a steroid inhaler as part of your treatment. Steroid inhalers contain corticosteroid medicines, which can help to reduce the inflammation in your airways. Steroid inhalers are normally prescribed as part of a combination inhaler that also includes a long-acting medicine.

Asthma

nhs.uk gives information on asthma, a common condition that affects your breathing. It is stated that the main treatment for asthma is medicines you breathe in using an inhaler. For most people they work well to reduce or prevent asthma symptoms.

Depending on how severe your symptoms are, you may be offered either:

- an inhaler to use only when you get symptoms – this is called an anti-inflammatory reliever (AIR) inhaler
- an inhaler to use every day to help prevent symptoms, as well as when you get symptoms – this is called a maintenance and reliever therapy (MART) inhaler
- 2 separate inhalers – a preventer inhaler to use every day to help prevent symptoms, and a blue reliever inhaler to use when you get symptoms (you should not be given a blue reliever inhaler to use on its own).

Considering all these factors together the panel recommended that no further engagement or formal consultation was required at this point.

5. Annual Report 2024-25

The Annual Report providers an account of the activity and governance of the Panel in 2024-25.

The panel continues to support the organisation in determining the need for any further engagement or formal public consultation on recommendations made by the Clinical Policy Recommendation Committee. This process is prior to a final decision being taken by the ICB on any clinical policy recommendations.

The wider public interest issues are considered to determine the need for any further engagement or for formal public consultation on clinical policy recommendations.

There has been one membership change during the year, with Steve Clark formally joining the panel as an advisory member from the Communications Team, having attended on previous occasions as a deputy for Nicola Bonas.

The frequency of the panel meetings this year was impacted by some of the Clinical Policy Recommendation Committee meetings needing to be stood down due to limited evidence reviewer capacity. However across the 4 panel meetings held, 10 clinical policy recommendations were considered across a range of topics.

This included both new and updated commissioning policy recommendations as well as the proposed retirement of policies which were determined to no longer be needed following routine review processes.

The panel accepted the annual report.

There was general discussion of the executive sign off processes within the ICB for clinical policy recommendations and the timing of various aspects of the clinical policy governance process. It was explained final sign off is undertaken by the Chief Medical Officer and Chief Nursing Officer on behalf of the ICB.

The ICB has also reviewed and revised the process for Equality and Quality Impact Assessment (EQIA), with this now being undertaken via Datix. This change in system accounts for the different style of EQIA paperwork included in the meeting papers for the items on the agenda today. Although the format and the review/approval process for these has changed, it was explained that the EQIA considerations and the information contained within assessments remains the same.

It was queried to what extent things would change as a result of government plans for further ICB reorganisation. It was outlined that a plan has been supported for Devon to form a clustering arrangement with Cornwall and Isles of Scilly, ahead of a future formal merger of the ICBs. Although discussions around the clustering arrangements are still in early stages, it was felt that the function fulfilled by the panel in terms of supporting ICB clinical policy formation would still be needed. However the specifics of how this might operate across a wider footprint were not yet known.

Rebecca Owen and the Clinical Effectiveness team were thanked for their ongoing support to the panel and for the clarity of the meeting papers in supporting the panel's understanding and meeting discussions.

ACTION: Annual Report to be reported onwards in the ICB for information and assurance.

6. Terms of Reference

The Terms of Reference had been reviewed in conjunction with the completion of the Annual Report. No material changes needed to these had been identified; however a minor update was highlighted to ensure that the latest job titles of the advisory members are detailed following the conclusion of the recent re-organisation.

ACTION: Terms of Reference to be updated and shared with the minutes of the meeting for information.

7. Any other business

It was noted that the next scheduled meeting is being stood down because the September Clinical Policy Recommendation Committee meeting has been cancelled.

8. Next meeting date

The next panel meeting will be held on **Thursday 27 November 2025**.

Summary of actions			
	Action	**Lead(s)**	**Status**
25/01	Annual Report to be reported onwards in the ICB for information and assurance	Rebecca Owen	Pending
25/02	Terms of Reference to be updated and shared with the minutes of the meeting for information	Rebecca Owen	Pending