NHS
Devon
Clinical Commissioning Group

Clinical Policy Engagement & Consultation Panel

MINUTES

Thursday 26 November 2020, 14.00-15.00

Via Microsoft Teams

Present:

Nicola Bonas	Deputy Head of Communications
Charlotte Burrows*	Governing Body Lay Member for patient & public involvement
Rebecca Heayn	Clinical Effectiveness Governance Manager
Carol McCormack-Hole*	Lay Member from the Patient Engagement Forum
Mac Merrett*	Lay Public Member, Clinical Policy Committee
Chris Roome	Head of Clinical Effectiveness
Jon Taylor	Strategy Manager
Mark Taylor*	Lay Public Member, Clinical Policy Committee

* Denotes voting members

1. Welcome and Introductions

The group were welcomed.

2. Declaration of Interests

No updates to the register or specific interests pertinent to the item for discussion on the meeting agenda were declared.

3. Minutes from the meeting 24 September 2020

The panel considered the minutes from the meeting held on 24 September 2020 and agreed them to be an accurate record.

It was noted that there were no outstanding actions or matters arising.

4. Discussion and recommendation on the Clinical Policy Committee decisions from 11 November 2020

Rosuvastatin for the primary and secondary prevention of cardiovascular disease

An overview of the Clinical Policy Committee recommendation and the background to this treatment was noted by the panel.

Cardiovascular disease (CVD) describes a group of disorders of the health and blood vessels caused by atherosclerosis and thrombosis, which includes coronary heart disease, stroke and peripheral arterial disease.

The use of high intensity statins for the treatment of primary and secondary prevention of CVD is recommended by NICE, with atorvastatin recommended as the first line treatment option. Although not specifically recommended by the NICE guideline, rosuvastatin is placed as an alternative to atorvastatin in the national lipid management pathway.

The panel considered 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 the deputy director of medicines optimisation had requested the consideration of rosuvastatin for the treatment of primary and secondary prevention of CVD, as an additional option for patients who are intolerant of other statins. After consideration, the Clinical Policy Committee has recommended that its routine commissioning is supported in Devon for patients who are intolerant of other appropriate statins.

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

   It was acknowledged that, in the absence of rosuvastatin, patients who are intolerant of other high intensity statins may be stepped down to a medium intensity statin. Rosuvastatin offers an additional treatment option for patients unable to tolerate other high intensity statins, decreasing the number of patients reducing to medium intensity statins. This gives patients a better chance of the recommended reductions in their LDL cholesterol. Its availability may also have a positive impact on the experience for some patients as it may avoid referral into secondary care.

   The panel commented on the potential positive impact for those patients from certain ethnic minorities (south Asian and African or Caribbean backgrounds), in whom CVD is more common as they are more likely to have other risk factors, as well as in other groups in whom CVD risk may be greater, as identified by the Equality Impact Assessment.

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 Devon's prescribing of high intensity rosuvastatin is currently in the middle range in comparison to other CCGs. It is expected that there will be an increase in the number of patients prescribed high and medium intensity rosuvastatin as a result of this recommendation. If prescribing were to increase to the level of the highest CCG this would equate to an additional annual cost of up to £84k. The panel discussed the balance between the addition cost likely to be incurred compared to the cost of patients experiencing a cardiovascular event.

   It was explained that NICE had made a number of assumptions in making recommendations for high intensity statins; it is therefore difficult to reliably estimate the cost of avoidance of cardiovascular events. However preventative treatment reduced the risk of a cardiovascular event by approximately one third. In the context of cardiovascular events the panel commented that this was not felt to be an excessive cost. The Clinical Policy Committee had concluded that, although it would

not be supported as the 'go to' first line treatment option due to its cost, its use was supported in patients who could not tolerate other options.

It was queried whether a choice is offered to patients at the point of consultation. National guidance supports the use of atorvastatin as a first line treatment option. If a patient experienced side effects or problems, they would usually then try an alternative. Whilst rosuvastatin provides an additional choice, it was questioned whether its availability might result in some clinicians being more likely to switch to more expensive options without trying other things first, and whether some educational material for primary care might support its use as intended. It was noted that there had been a lengthy discussion by the Clinical Policy Committee and differing clinical opinions on its routine use. Consequently the Formulary team had been asked to give thought to how rosuvastatin should be appropriately framed in the local formulary to support education and the management of reported intolerance and the use of rosuvastatin as a second line option.

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 the prevention of cardiovascular disease or the use of rosuvastatin. However it was acknowledged that this is a common condition, particularly with an ageing and growing population, and with improved survival rates. The use of lipid-lowering drugs such as statins is also well known.

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

   nhs.uk gives general information on statins, including rosuvastatin. It is stated that how much a person will take will depend on what it is being taken for, e.g. prevention of heart attacks and strokes, high cholesterol etc. It is noted that statins all work in the same way, but they differ in how well they lower cholesterol. When used at a higher dose, rosuvastatin and atorvastatin produce a bigger reduction in cholesterol than other statins.

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

5. Any Other Business

A query was raised as to the whether there was an intention to resume face-to-face meetings when this is permissible. It was commented that all meetings are being held virtually via MS Teams at this time. When more normal working arrangements resume it is likely that a number of meetings will continue to be held virtually, however it was acknowledged that there is still benefit for groups and committees in holding face-to-face meetings, even if these were less often, i.e. once or twice per year.

When resumption of face-to-face meetings becomes an option, the preferences of the panel will be taken into account in determining future meeting arrangements.

6. Next meeting date

Due to the cancellation of the Clinical Policy Committee meeting in January the panel next meeting scheduled for Thursday 11 February 2021 will also now be cancelled.

The next meeting will now be held on Thursday 22 April 2021.