Clinical Policy Engagement & Consultation Panel Minutes

Thursday 5 December 2024, 14.00-15.30
G01, Aperture House, Exeter and via Microsoft Teams

Present:

Name	Role
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
Martyn Nicoll	Patient Experience Manager, NHS Devon
Rebecca Owen	Clinical Effectiveness Governance and Individual Funding Request Panel Manager, NHS Devon
Chris Roome	Head of Clinical Effectiveness, NHS Devon
Mark Taylor*	Lay Public Member, Clinical Policy Recommendation Committee

* Denotes voting members

1. Welcome and introductions

The apologies received were noted as below.

Apologies:

Name	Role
Steve Clark	Partnerships, Involvement and Inclusion Manager, NHS Devon

2. Declarations of Interests

All those attending had previously 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 17 October 2024 and matters/ actions arising

The panel considered and agreed the minutes from the meeting held on Thursday 17 October 2024. The action log was updated as follows:

Summary of actions			
	Action	**Lead(s)**	**Status**
24/03	Contact all panel members to confirm whether they are satisfied that the public interest issues relating to the updated policy recommendation for Opicapone for Parkinson's Disease have been fully considered and no further action is needed, or whether there are any issues that they wish to discuss via a rescheduled meeting.	Rebecca Owen	Complete
24/04	Contact all panel members to confirm acceptance of the minutes from meeting held on Thursday 18 July 2024 so that these can be finalised.	Rebecca Owen	Complete

4. Discussion and recommendation on the Clinical Policy Recommendation Committee (CPRC) decisions from 13 November 2024

Ferric Maltol (Feraccru®) for iron deficiency anaemia in inflammatory bowel disease

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

Iron deficiency anaemia occurs when the body has an impaired capacity to produce red blood cells due to low iron stores. Inflammatory bowel disease (IBD) is a long-term condition which causes relapsing-remitting, non-infectious inflammation of the gastrointestinal (GI) tract. The inflammatory processes which occur in the GI tract of individuals living with IBD can causes issues with vitamin and mineral absorption. As such, iron deficiency anaemia is a common presentation in individuals living with IBD.

Traditional treatment uses oral iron salts. However, some patients with iron deficiency anaemia who also have IBD have poor outcomes when standard oral iron preparations are used due to poor absorption or tolerance of the products. Ferric maltol is recommended for patients who do not respond to standard oral iron treatments and who would otherwise require intravenous iron.

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 ferric maltol in Devon had been prompted by an application from local gastroenterology specialists to consider its use in patients who have failed or are intolerant to standard oral iron preparations and who otherwise would need to receive intravenous iron.

The Clinical Policy Recommendation Committee has recommended a policy which supports a 4-week trial of ferric maltol for the treatment of iron deficiency anaemia in patients with IBD in whom 2 standard oral iron preparations have been ineffective or not tolerated. If a clinically acceptable haematological response has been achieved after 4 weeks, treatment may continue for a further 12 weeks.

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

It was noted that ferric maltol is taken orally, which can be an advantage for patients who would otherwise need to receive iron intravenously due to the convenience of avoiding hospital visits for administration of the infusion.

It was queried whether the use of ferric maltol instead of intravenous iron poses any risks to patients or impact to their expectations of treatment given that it may take longer for their haemoglobin to normalise. It was clarified that the committee discussions did not identify any risk posed to patients and overall its use was considered to be beneficial. Intravenous iron would still remain as a treatment option for patients if needed. It was also clarified that ferric maltol would not be used for any patients with clinical urgency, i.e. those with critical anaemia.

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 acknowledged that the use of ferric maltol potentially releases healthcare resources for other activity compared to intravenous iron administration. Although normalisation of haemoglobin may take a few weeks longer and there is a small increase in drug acquisition cost associated with ferric maltol, it was considered that its use in Devon would result in overall patient benefit and local NHS cost savings by reducing the number of patients who require intravenous iron.

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 ferric maltol. It was noted that five of the six drug formularies of the other ICBs in the SW region list ferric maltol as a treatment option in this patient group.

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

nhs.uk gives information on iron deficiency anaemia. It states that bleeding in the stomach and intestines is a common cause of iron deficiency anaemia. This can be caused by taking non-steroidal anti-inflammatory drugs, such as ibuprofen and aspirin, stomach ulcers, inflammation of the bowel or oesophagus, piles and cancers of the bowel or stomach – but this is less common.

It is noted that iron deficiency anaemia is treated with iron tablets and by eating iron-rich foods. However ferric maltol is not specifically mentioned.

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

Dymista® (Azelastine hydrochloride and fluticasone propionate) nasal spray for allergic rhinitis

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

Allergic rhinitis is an allergic response triggered by allergens like pollen or dust, causing symptoms such as sneezing, nasal congestion, and itchy eyes. It can impact quality of life, school/work performance, and sleep. Standard treatment involves antihistamines, and nasal corticosteroids. Immunotherapy may be used in uncontrolled cases.

Dymista nasal spray is licensed for managing moderate to severe allergic rhinitis when treatment with either antihistamine or intranasal corticosteroids is insufficient. The recommended dose for adults and children aged 12 and above is one actuation in each nostril, twice daily.

NHS Devon has an existing policy in place which states that Dymista is not routinely commissioned in Devon. It has been reviewed on two occasions (in 2014 and 2017), but no evidence was available which compared it with dual therapy using a nasal steroid and an oral antihistamine, and Dymista was more costly. Subsequent review of this policy has been prompted by an application from local child and adult immunology services to reconsider the use of Dymista in Devon.

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 NHS Devon has an existing policy for the use of Dymista for allergic rhinitis, following previous requests from ENT specialists for consideration of its use. Subsequent review has been prompted by an application from local child and adult immunology services to reconsider its use for patients in Devon. Since the previous review, Dymista now appears in various national and professional body guidance covering the management of allergic rhinitis and has also been accepted for use in other health systems.

   Following consideration, the Clinical Policy Recommendation Committee has recommended an updated commissioning policy which supports the use of Dymista in Devon for the management of moderate to severe symptoms of allergic rhinitis where allergy specialists have optimised treatment with standard combination therapies.

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

   The panel acknowledged that local specialists report that patient concordance to treatment is higher when they can use one treatment as opposed to two separate treatments, resulting in improved outcomes. Dymista is a combined intranasal corticosteroid and antihistamine and so it may be easier to optimise therapy for patients, especially teenagers who may particularly benefit whilst taking educational exams.

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 the cost of Dymista is higher than an antihistamine and an intranasal corticosteroid, however it may prevent some patients requiring more costly treatment with immunotherapy and therefore has the potential to reduce drug acquisition costs at a Devon system level.

   There was discussion around the potential for 'creep' in the use of Dymista, i.e. with use spreading wider than the intended commissioning position, which had been raised at the Committee meeting. This concern was acknowledged, and it was agreed that a firm stated position, supported by local formulary guidance, would clarify and help to direct the appropriate use of this in Devon.

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 allergic rhinitis or the use of Dymista. It was noted that four of the six drug formularies of the other ICBs in the SW region list Dymista as a treatment option for allergic rhinitis.

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

   nhs.uk gives information on allergic rhinitis which for most people is easy to treatment with medicines from a pharmacist.

   It is stated that if pharmacy medicines do not help ease allergic rhinitis symptoms, a GP may prescribe a different medicine, such as prescription steroid nasal sprays or antihistamines. Patients may be referred to a specialist for further tests and treatment if it is not clear what is causing the symptoms, or they are severe.

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

5. Any other business

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

6. Next meeting date

The next panel meeting will be held on **Thursday 3 April 2025**.