Clinical Policy Engagement & Consultation Panel Minutes

Thursday 9 May 2024, 14.00-15.00
G04, 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 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 group were welcomed, and apologies noted.

Apologies:

Name	Role
Nicola Bonas	Associate director of communications, involvement and inclusion, NHS Devon

Unfortunately no deputy was able to attend from the communications, involvement and inclusion team.

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 28 September 2023 and matters/ actions arising

The panel considered the minutes from the meeting held on Thursday 28 September 2023 and agreed them to be an accurate record. The action log was updated as follows:

Summary of actions			
	Action	**Lead(s)**	**Status**
23/02	Share the panel's discussion and question regarding cost recovery from the private sector with the finance team.	Chris Roome	Chris Roome reported that he had raised this query with the finance team and been advised that there is no mechanism for recovery of costs from private sector providers where the NHS had to step in and provide a subsequent procedure. The panel expressed their surprise at the lack of mechanism and asked whether this issue could be escalated, via the finance team, to a national forum. They remain concerned at the potential for this to be growing area and a recurring concern, which will be applicable beyond breast implant removal to other procedures, and an increasing burden on the NHS.

4. Discussion and recommendation on the Clinical Policy Recommendation Committee (CPRC) decisions from 17 April 2024

Tonsillectomy for quinsy

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

Barrett's oesophagus is a condition in which changes occur to the cells lining the lower part of the oesophagus, usually as a result of the abnormal backflow of stomach acid. These cells can develop an abnormality called dysplasia which may progress to become cancer.

NHS Devon has an existing commissioning policy for tonsillectomy under which it is routinely commissioned following quinsy. However a lack of specificity in the current policy wording has been identified which means that patients can be referred for surgery after only one episode of quinsy. Such referrals are being returned by ear, nose and throat (ENT) surgeons who feel that operative management is only indicated following recurrent episodes of quinsy.

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 review of NHS Devon's existing policy for tonsillectomy, specifically in relation to quinsy, had been prompted by an identified lack of specificity in the current policy wording. Under the existing policy wording patients can be referred for surgery after only one episode of quinsy, but such referrals are being returned by ENT surgeons who feel that surgery is only indicated following recurrent episodes of quinsy.

   The Clinical Policy Recommendation Committee has subsequently recommended minor revision to the commissioning policy wording to give greater clarity in respect of tonsillectomy following quinsy, i.e. that this should be for recurrent (two or more episodes) of quinsy.

   The updated policy wording is supported by Evidence Based Interventions (EBI) guidelines published by the Academy of Medical Royal Colleges which state that the NHS should only commission tonsillectomy for the treatment of recurrent severe episodes of sore throat (meeting additional criteria), obstructive sleep apnoea/sleep disordered breathing in children, and recurrent quinsy. These recommendations are also supported by commissioning guidance from ENT UK.

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

   It was noted that this does not represent a change in clinical practice, but clarification of an identified issue with the wording of the existing commissioning policy criterion in respect of quinsy. This is expected to support appropriate referrals to ENT surgeons, reducing the number of returned referrals, and providing clarity and setting suitable expectations for patients in Devon.

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?**

   There is not expected to be a change in clinical practice or in the number of tonsillectomy procedures undertaken for quinsy in Devon. The revised wording addresses an identified issue with the existing policy wording and will support appropriate referrals to ENT surgeons.

   Activity data for NHS Devon confirms that tonsillectomy is rarely undertaken for quinsy, with only 10 patients undergoing treatment between April 2022-March 2023.

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 tonsillectomy for quinsy. It was noted that this is only undertaken in a small number of patients in Devon.

It was queried whether the NHS Devon position is consistent with other areas and clarified that there was broad alignment across organisations, particularly due to the wide adoption of the EBI guidance on this topic.

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

   nhs.uk gives information on tonsillitis, noting that treatment for tonsillitis will depend on the cause. Most children and adults get viral tonsillitis which clears up on its own and for bacterial tonsillitis a GP may prescribe antibiotics.

   It is stated that it is very rare that someone needs to have their tonsils taken out. This is usually only done if you have severe tonsillitis that keeps coming back.

   Complications of tonsillitis are very rare. Sometimes you can get an area filled with pus (abscess) between your tonsils and the wall of your throat. This is called quinsy.

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

Radiofrequency ablation for Barrett's oesophagus

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

Barrett's oesophagus is a condition in which changes occur to the cells lining the lower part of the oesophagus, usually as a result of the abnormal backflow of stomach acid. These cells can develop an abnormality called dysplasia which may progress to become cancer.

NHS Devon has an existing commissioning policy for radiofrequency ablation for Barrett's oesophagus, published in 2011, which supports its use in patients with high-grade dysplasia, in accordance with the National Institute for Health and Care Excellence (NICE) guidance in place at that time.

As part of the routine management of clinical commissioning policies it has been identified that since publication of this policy there have been changes to the NICE guidance in this area. These are particularly in respect of the use of radiofrequency ablation for Barrett's oesophagus in patients with low-grade dysplasia as well as with high-grade, due to advances in the understanding of the natural history of the disease.

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 review of NHS Devon's existing long-standing policy for radiofrequency ablation for Barrett's oesophagus has been prompted by updated NICE guidance in this area, identified as part of the routine management of policies.

The current policy reflects the guidance at the time it was published but there is now a greater understanding of the disease which supports the use of radiofrequency ablation in patients with Barrett's oesophagus for low-grade as well as high-grade dysplasia.

Consultation with local gastroenterology specialists has confirmed that radiofrequency ablation is only undertaken in Devon for Barrett's oesophagus by lead specialists in Plymouth and Exeter and its use is as per current NICE guidance. This is also consistent with the British Society of Gastroenterology guidelines.

The Clinical Policy Recommendation Committee has therefore recommended retirement of this commissioning policy. The use of radiofrequency ablation for Barrett's oesophagus will instead be supported in Devon in line with NICE recommendations, which are confirmed to be current practice.

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

It was discussed that retirement of the existing policy, which is now out of date, is not expected to have an impact on patients.

Local gastroenterology specialists who treat patients with radiofrequency ablation for Barrett's oesophagus have confirmed that clinical practice in Devon is already in line with current NICE guidance, which is also consistent with British Society of Gastroenterology guidelines.

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 considered that retirement of the existing policy is not expected to have an impact on the number of patients treated in Devon. Local specialists have confirmed that clinical practice in Devon is already in line with current NICE guidance and British Society of Gastroenterology guidelines.

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 Barrett's oesophagus or the use of radiofrequency ablation, which has now become a more established treatment.

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

nhs.uk gives information on Barrett's oesophagus as a condition, however it does not include detail on treatment options and the use of radiofrequency ablation.

It is stated that Barrett's oesophagus is a condition where some of the cells in your oesophagus grow abnormally. If you have Barrett's oesophagus, you are slightly more likely to get oesophageal cancer, but that this is not common. It is sometimes called a pre-cancerous condition.

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

Alogliptin for type 2 diabetes

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

Alogliptin is used along with diet and exercise to lower blood sugar levels in patients with type 2 diabetes. It is in a class of medications called dipeptidyl peptidase-4 (DPP-4) inhibitors.

NHS Devon has an existing commissioning policy for alogliptin for the treatment of adults with type 2 diabetes, which has been in place since 2016.

Review of this policy has been prompted through the routine management of NHS Devon clinical commissioning policies, which had identified that there are a number of existing policies for the use of specific drug treatments for patients with diabetes in a therapeutic area which has evolved since these policy positions were formed.

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 review of NHS Devon's existing policy for alogliptin has been prompted by the routine management of policies, through which the existing policies for the use of specific drug treatments for patients with diabetes had been considered for their ongoing relevance and need.

   When the existing policy was formed, alogliptin had been identified as a means of reducing the cost of antidiabetic therapy at the time without adversely affecting quality of patient care. This supported the managed entry of alogliptin as a new treatment option in Devon.

   Alogliptin is now a well-established treatment choice in Devon for patients with type 2 diabetes and a specific commissioning policy is no longer considered to be needed. The Clinical Policy Recommendation Committee has therefore recommended retirement of this commissioning policy.

   NICE has also now adopted a different approach in respect of recommendations for treatment regimens. The focus in type 2 diabetes is on early use of drugs with proven cardiovascular risk benefits rather than just glucose control, and they define treatment escalation routes with reference to this.

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

   It was discussed that when the existing policy was formed this was to support the managed entry of alogliptin, as a new treatment option, in Devon. Since then, it has become an established treatment choice for patients in the Devon, which is widely used, and a specific commissioning policy is no longer considered to be needed.

   There is not anticipated to be a significant impact for patients as a result of retiring this policy. The Devon Formulary will continue to support guidance for prescribers whilst being responsive to relevant changes amongst this class of therapy, including safety updates.

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 alogliptin is now a well-established treatment choice in Devon for patients with type 2 diabetes and a specific commissioning policy is no longer considered to be needed.

   The Devon Formulary will continue to support guidance for prescribers and will also have greater flexibility to be responsive to relevant changes amongst this class of therapy, for example patent changes, licence variations, safety updates and changes in acquisition cost.

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 type 2 diabetes. 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)?**

   nhs.uk notes that alogliptin is a medicine used to treat type 2 diabetes, which is a condition where the where the body does not make enough insulin, or the insulin that it makes does not work properly. This can cause high blood sugar levels (hyperglycaemia).

   Alogliptin is prescribed for people who still have high blood sugar, even though they have a sensible diet and exercise regularly. It works by increasing the amount of insulin that your body makes.

   There are several medicines that can lower blood sugar, including: metformin, sulfonylureas, pioglitazone, DPP-4 inhibitors, SGLT2 inhibitors, GLP-1 agonists (given by injection) and insulin (given by injection). Your doctor might recommend taking more than one type of diabetes medicine at the same time.

Alogliptin is a dipeptidylpeptidase-4 inhibitor (DPP-4 inhibitor). Alogliptin is only available on prescription and comes as tablets that you swallow. Similar medicines include linagliptin, saxagliptin, sitagliptin and vildagliptin.

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

Insulin degludec for use in patients with type 1 diabetes

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

Insulin degludec works by increasing insulin levels in the body, which decreases blood sugar (glucose). It belongs to a group of medications called long-acting insulins. Insulin degludec comes as a solution to inject subcutaneously (under the skin) once a day.

NHS Devon has an existing commissioning policy for insulin degludec for patients with type 1 diabetes, which has been in place since 2018.

Review of this policy has been prompted through the routine management of NHS Devon clinical commissioning policies, which had identified that there are a number of existing policies for the use of specific drug treatments for patients with diabetes in a therapeutic area which has evolved since these policy positions were formed.

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 review of NHS Devon's existing policy for insulin degludec for type 1 diabetes has been prompted by the routine management of policies, through which the existing policies for the use of specific drug treatments for patients with diabetes had been considered for their ongoing relevance, and in light of any subsequently published NICE guidance.

   It was discussed that insulin degludec had previously been considered three times for local policy positions as part of managing the entry of new drugs into practice.

   Updated NICE guideline on type 1 diabetes in adults (NG17) has established those areas in which degludec has advantages and is broadly reflective of the Devon policy position. For children and young people, NICE guideline NG18 is less explicit and specifies regimens rather than treatments. It was also acknowledged that NICE has adopted a different approach in respect of recommendations for treatment regimens. The focus in type 1 diabetes is on the insulin regimen to be used, which then guides selection of which insulin, rather than just the insulin type itself.

   Insulin degludec is now an established product for which its place in therapy has become clearer over time. The Clinical Policy Recommendation Committee has recommended retirement of this commissioning policy. It is proposed that future recommendations should be guided by national policy direction through NICE guidelines, as is the general case for established treatments, with the Devon Formulary supporting prescribing by evolving guidance for prescribers as needed.

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

   It was noted that when the existing policy was formed this was to support the managed entry of insulin degludec in Devon for the treatment of patients with type 1 diabetes. Since then, it has become an established treatment, which is widely used, and for which its place in therapy has become clearer over time.

   The updated NICE guideline has established those areas in which insulin degludec has advantages, including a reduction in nocturnal hypoglycaemia episodes, and for people who need support from a carer/healthcare professional to administer injections as the flexibility in dose timing is helpful in this regard.

   There is not anticipated to be a significant impact for patients as a result of retiring this policy. The Devon Formulary will continue to support prescribing by evolving guidance for prescribers as needed, guided by national policy direction through NICE guidelines.

   It was clarified that NHS Devon has a separate policy for the use of insulin degludec in patients with type 2 diabetes which will remain in place unchanged.

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 insulin degludec is now an established product for which its place in therapy has become clearer over time and a specific commissioning policy is no longer considered to be needed.

   Future recommendations on this product should be guided by national policy direction through NICE guidelines, as is the general case for established treatments. The Devon Formulary will continue to support guidance for prescribers by evolving guidance for prescribers 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 type 1 diabetes. 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)?**

   nhs.uk notes that insulin is a hormone made in your pancreas, which helps your body use glucose (sugar) for energy. When your pancreas is working properly it makes small amounts of insulin all the time and releases more insulin when your blood glucose levels increase after eating. When you have diabetes, your body does not make enough insulin or the insulin it makes does not work properly.

Everyone with type 1 diabetes, and some people with type 2 diabetes or gestational diabetes, needs to take insulin to help manage their blood glucose levels. This reduces the chances of getting the symptoms of high blood glucose (hyperglycaemia) and serious long-term problems that can damage the heart, kidneys, eyes, nerves and feet.

Long-acting insulin is a type of insulin that you inject once or twice a day. It works throughout the day and night to provide you with low levels of insulin all the time. Long-acting insulin is sometimes also known as basal insulin. Some people may take long-acting insulin along with other diabetes medicines to manage their blood glucose levels.

Long-acting insulin is available on prescription only. It comes as cartridges that you use in a reusable insulin pen, pre-filled pens, and a solution in a vial (a small bottle) for injecting. There are 3 different types of long-acting insulin: insulin detemir, insulin glargine, and insulin degludec. Insulin detemir is usually taken twice a day. Insulin glargine and insulin degludec last for longer and are usually taken once a day.

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

5. Annual Report 2023-24

The panel received the annual report, which gives an account of the activity and governance of the panel in 2023-24.

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

Three panel meetings were held considering seven clinical policy recommendations across a range of topics.

As a result of previous interest from some panel members in being able to meet again in person, provisions were made during the year to hold ‘hybrid’ meetings, i.e. enabling both virtual and in person attendance depending on the needs and preferences of the panel members. It is proposed to continue this arrangement for future meetings utilising the rooms and technology at the ICB’s new office premises at Aperture House.

In respect of panel recommendations and actions, when the proposed update to the ICB policy for Breast Implant Removal and Replacement was considered, some concerns were raised about the future costs the NHS will incur resulting from its duty of care to support patients in medical need including complications from and cosmetic surgery which is becoming more normalised across society. In the case of breast implants this work had highlighted that breast implants have a finite lifespan and will therefore nearly always fail at some point.

Although the NHS will only fund removal, not replacement, of implants where the original procedure was undertaken privately it was questioned whether the NHS has any ability to recoup costs from private providers. There was concern about the increasing pressures on an already challenged NHS in terms of supporting patients to

address medical issues following private cosmetic treatment. It was suggested that this concern and the question relating to cost recovery from the private sector could be raised with the ICB finance team.

As discussed at today's meeting, feedback received emphasised that the approach of the Clinical Policy Recommendation Committee was the best (in having clear and medically appropriate criteria) as there was no mechanism for recovery of costs from private sector providers where the NHS had to step in and provide a subsequent procedure.

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

There was discussion of the panel's remit in terms of considering the costs of policy recommendations. It was clarified that it is an appropriate consideration for the panel to be satisfied that the cost implications have been fully discussed and understood in the process of forming the policy recommendation, and it is legitimate for the panel to consider, in the public interest, the opportunity costs associated with proposals.

Rebecca Owen and the Clinical Effectiveness team were thanked for their ongoing support to the panel, and in particular the quality and clarity of the meeting papers which are valued by the panel members and enable the smooth running of the group.

6. Any other business

No other business was raised.

7. Next meeting date

The next panel meeting will be held on **Thursday 18 July 2024**.

The Chair queried whether the following meeting due to take place on Thursday 26 September could be rescheduled.

ACTION: Rebecca Owen to contact the panel members to confirm availability for rescheduling the September meeting.

Summary of actions			
	Action	**Lead(s)**	**Status**
23/02	Share the panel's discussion and question regarding cost recovery from the private sector with the finance team.	Chris Roome	Chris Roome reported that he had raised this query with the finance team and been advised that there is no mechanism for recovery of costs from private sector providers where the NHS had to step in and provide a subsequent procedure. Update: The panel expressed their surprise at the lack of mechanism and asked whether this issue could be escalated, via the finance team, to a national forum. They remain concerned at the potential for this to be growing area and a recurring concern, which will be applicable beyond breast implant removal to other procedures, and an increasing burden on the NHS.
24/01	Annual Report to be reported onwards in the ICB for information and assurance	Rebecca Owen	Pending
24/02	Contact panel members to confirm availability for rescheduling the September meeting	Rebecca Owen	Pending