Clinical Policy Recommendation Committee Minutes

Wednesday 13th November 2024
Microsoft Teams

Present:

Name	Job Title	Organisation
Dr Glen Allaway	Chair	NHS Devon
Dr Kay Brennan	Voting Member	NHS Devon
Dr Andrew Craig	Voting Member	NHS Devon
Dr Lucy Harris	Voting Member	NHS Devon
Dr Felicity Knott	Voting Member	NHS Devon
Mac Merrett	Lay Public Member	
Chris Roome	Head of Clinical Effectiveness	NHS Devon
Mark Taylor	Lay Public Member	
Charlie Thomas	Deputy Chief Pharmacist – Primary Care	NHS Devon
Dr Ben Titford	Voting Member	NHS Devon
John Trevains	Director of Nursing and Quality	NHS Devon

Guests:

Stuart Cleland	Consultant Anaesthetist	UHP
Emily Dellipiani	Specialist Pharmacist (Gastroenterology & Nutrition)	RDUH
Jonathan Digby-Bell	Consultant Gastroenterologist	RDUH - Eastern
Matt Howard	Clinical Evidence Manager	NHS Devon
Lucy Leeman	Consultant Immunologist	UHP
Sian Ludman	Consultant Paediatric Allergist	RDUH
Nic Perrem	Healthcare Evidence Reviewer	NHS Devon
Darren Wright	Joint Formulary Specialist Pharmacy Technician	NHS Devon

In attendance:

Fiona Dyroff	Clinical Effectiveness Governance Support Officer	NHS Devon
Rebecca Owen	Clinical Effectiveness Governance and IFR Panel Manager	NHS Devon

1. Welcome and announcements

Welcome to new members

The Chair welcomed Dr Felicity Knott to the committee as a voting member.

Apologies

Name	Job Title	Organisation
Richard Croker	Deputy Director for Medicines Optimisation	NHS Devon
Dr Claire Hooper	Voting Member	NHS Devon
Barbara Jones	Head of Contracting	NHS Devon

Confirmation of voting members and Declarations of interest

The six voting members present were identified.

Charlie Thomas attended as delegate for Richard Croker.
Dr Claire Hooper had delegated voting to Chris Roome

Declarations of Interest were collected and reported. All Declarations of Interest are reported in the minutes.

Andy Craig made a Declaration of Interest during the meeting as recorded below. Andy did not take part in the discussion or vote on the item related to his Declaration of Interest.

DRUG/ TECHNOLOGY TO BE CONSIDERED	PHARMACEUTICAL COMPANY/ MANUFACTURER/ SERVICE PROVIDER
Ferric Maltol (Feraccru®) **for iron deficiency anaemia in inflammatory bowel disease**	Norgine Limited
Alternative treatments:	
Oral iron supplements including: Ferrous fumarate, Ferrous sulfate, Ferrous gluconate and Sodium feredetate	Various manufacturers
Parenteral iron including: Ferinject, Venofer Diafer, CosmoFer and Ferric derisomaltose	Vifor Pharma UK Limited, Pharmacosmos UK Limited
Dymista® **(Azelastine hydrochloride and fluticasone propionate) nasal spray for allergic rhinitis**	Mylan (Viatris)
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
Clindamycin 1%/Tretinoin 0.025% w/w gel (Treclin®) **for the topical treatment of acne vulgaris**	Mylan (Viatris)

DRUG/ TECHNOLOGY TO BE CONSIDERED	PHARMACEUTICAL COMPANY/ MANUFACTURER/ SERVICE PROVIDER
Alternative treatments:	
Benzoyl peroxide with Clindamycin (Duac Only Daily or generic)	Stiefel, various manufacturers
Adapalene with Benzoyl peroxide (Epiduo)	Galderma (UK) Ltd
Topical azelaic acid	LEO Laboratories Ltd
Other topical preparations for acne containing one or more of Benzoyl peroxide, retinoid and/or antibiotic	Various manufacturers
Oral Isotretinoin (Roaccutane or generic)	Roche Products Ltd, various manufacturers
Oral antibiotics or combined oral contraceptives	Various manufacturers

Name of Attendee	Role	Declaration
Andy Craig	Voting member	Declared a nonfinancial personal interest relating to an item for discussion.

Notification of Any Other Business

AOB is reported under Item 9 of the minutes.

2. Minutes of the meeting held on 4th September 2024 and matters/actions arising

The minutes of the meeting held on 4th September 2024 were approved.

Summary of actions			
	Action	**Lead**	**Status**
24/06	Clinical Policy Recommendation Committee Annual Report 2023/24 to be submitted within the ICB for information and assurance. 26th June 2024 This will be submitted to the ICB for information and assurance alongside the CPEC Annual Report. The Clinical Effectiveness Team will plan internal onward reporting in line with changes in the organisation, i.e. the appointment of a new Chief Medical Officer. 4th September 2024 Waiting for the new Chief Medical Officer to take up his role. Will report onwards alongside other annual reports. 13th November 2024 The CPRC, CPEC and FIG annual report (which is on the agenda today) will be reported onwards together.	Rebecca Owen	Pending

24/07	NG18: Diabetes (type 1 and type 2) in children and young people: impact on policy for continuous glucose monitoring in diabetes - policy recommendation and QEIA to be prepared and subsequently progressed to final ICB approval and communication. 4th September 2024 Policy and QEIA going through the governance process for sign off. 13th November 2024 This updated policy was published on 18th October 2024.	Rebecca Owen	Complete
24/08	Guanfacine for attention deficit hyperactivity disorder (ADHD) in adults - policy recommendation and QEIA to be prepared and subsequently progressed to final ICB approval and communication. 4th September 2024 Policy and QEIA going through the governance process for sign off. 13th November 2024 As above.	Rebecca Owen	Pending
24/09	Myringotomy (with or without grommet insertion) and adjuvant adenoidectomy in children under 12 years with otitis media with effusion - policy recommendation and QEIA to be prepared and subsequently progressed to final ICB approval and communication. 4th September 2024 Policy and QEIA going through the governance process for sign off. 13th November 2024 The policy is due for publication on 14th November 2024.	Rebecca Owen	Pending
24/10	Clinical Policy Engagement and Consultation Panel Annual Report 2023-24 to be submitted within the ICB for information and assurance. 4th September 2024 Waiting for the new Chief Medical Officer to take up his role. Will report onwards alongside other annual reports. 13th November 2024 The CPEC, CPRC and FIG annual report will be reported onwards together.	Rebecca Owen	Pending

24/11	Opicapone for Parkinson' disease – policy recommendation and QEIA to be prepared and subsequently progressed to final ICB approval and communication. <u>13 November 2024</u> Policy and QEIA going through the governance process for sign off.	Rebecca Owen	Pending
24/12	Review of Open Magnetic Resonance Imaging (MRI) Scanning policy - Update version history to reflect that this policy has been reviewed and reconfirmed. <u>13 November 2024</u> The policy has been updated to reflect that it has been reviewed and reconfirmed.	Rebecca Owen	Complete

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

Nic Perrem, Healthcare Evidence Reviewer presented a paper. Stuart Cleland, Consultant Anaesthetist, UHP, Jonathan Digby-Bell, Consultant Gastroenterologist, RDUH (Eastern) and Emily Dellipiani, Specialist Pharmacist (Gastroenterology & Nutrition), RDUH attended the meeting for discussion of this item.

Ferric maltol, available under the brand name Feraccru, is an iron replacement therapy used for iron deficiency in adults. The product is available in 30mg capsules, with a recommended dose of one capsule twice daily. Ferric maltol is a more tolerable form of oral iron, especially beneficial for patients with chronic conditions like inflammatory bowel disease (IBD), who often experience gastrointestinal side effects from traditional oral iron.

Iron deficiency anaemia (IDA), impacts oxygen delivery in the body, leading to symptoms like fatigue and heart palpitations. Traditional treatment uses oral iron salts, but some patients require alternatives due to poor absorption or tolerance. Ferric maltol is recommended for patients who do not respond to standard treatments before considering intravenous iron.

An application was received from gastroenterology specialists at RDUH for Ferric maltol to be considered for routine commissioning in Devon. The applicants stated that the initiating criteria for the drug should be patients living with IBD who have IDA and are intolerant to, or have had ineffective treatment with, standard oral iron preparations.

A review of the formularies of the other ICBs which constitute the NHS England SW region found that five out of six ICBs list ferric maltol as a treatment option in the patient group of interest. Two of the ICBs list the ferric maltol as Green, two list it as a second line option, with the other ICB listing it as a red hospital only drug.

The NICE guidelines for Crohn's and ulcerative colitis do not address the management of IDA. A NICE Clinical Knowledge Summary (CKS) for IDA suggests that when standard oral preparations are not tolerated alternative oral preparations like ferric maltol should be considered. The SMC does not recommend ferric maltol due to insufficient data on its efficacy compared to IV iron and uncertainty in the economic evidence presented by the company. The All Wales Medicines Strategy Group does recommend ferric maltol limited to use in mild to moderate IDA in IBD patients. The British Society of Gastroenterology guidelines for the management of IDA supports ferric maltol for patients who are intolerant to standard oral iron preparations.

A literature review was undertaken by the Clinical Effectiveness Team which aimed to identify evidence of the effectiveness of ferric maltol for treating IDA in IBD patients. Four studies met the inclusion criteria. Gasche et al. (2015) reports the results of two placebo-controlled RCTs, these are the AEGIS 1 and 2 studies which acted as the licensing trials for ferric maltol. The results of these trials showed ferric maltol significantly improved haemoglobin (Hb) levels over placebo after 12 weeks, without substantial changes in symptom severity or quality of life (QOL) metrics. Schmidt et al. (2016) reports a 52-week open label extension period of these RCTs, reporting that Hb improvements achieved in the first 24 weeks of treatment with ferric maltol remain present when treatment continues up to 1 year. Also, patients who switched from placebo to ferric maltol demonstrated similar levels of improvement compared to patients who had received ferric maltol in the initial RCT phase. Howaldt et al. (2022) compared ferric maltol to IV ferric carboxymaltose. Ferric maltol did not meet non-inferiority to IV iron at 12 weeks, but longer-term effects appear comparable. While IV therapy produced faster Hb increases in the initial 12 weeks, both treatments achieved similar Hb levels by week 52. Cummings et al. (2020) is a retrospective report of real-world patients' data which demonstrates similar outcomes such as changes in Hb concentration following the use of ferric maltol which was observed in the controlled clinical trials.

Adverse events reported in clinical trials of ferric maltol are generally mild, with gastrointestinal symptoms being most common.

There is some uncertainty regarding the cost-effectiveness of Ferric maltol. The SMC and All Wales Therapeutics and Toxicology Centre (All Wales) committees reviewed ferric maltol for treating IDA in IBD patients and came to different overall assessments. Both committees received a cost-utility analysis from the company, comparing ferric maltol with IV iron. The Scottish Medicines Consortium (SMC) found the economic case for ferric maltol insufficient, citing limited comparisons with other oral irons and unrealistic assumptions about sustained Hb normalisation following treatment cessation, the committee also noted how the 12-week cycle lengths used, were too long compared with the 12-month time horizon of the model. The All Wales committee acknowledged strengths in the economic evidence for ferric maltol, including a well-structured model and appropriate comparator. However, they highlighted limitations such as the lack of comparison with other IV irons, assumptions about QALY gains, and concerns about real-world treatment practices. Despite these, they concluded ferric maltol was likely cost-effective for managing IDA in IBD patients who are intolerant to standard oral iron treatments.

The Clinical Effectiveness Team assessed the budget impact of the insertion of ferric maltol for iron-deficient patients intolerant to other oral iron treatments, before receiving with IV iron. Although the addition of ferric maltol into the existing treatment pathway costs more upfront, its use could lead to cost savings when by causing a reduction in other healthcare system costs, such as IV administration and consultations. In base case analysis, ferric maltol increased acquisition costs by £29.77 per patient, totalling £3,870 for the number of patients expected to be seen in Devon per year. However, in the base case all patients received 12-weeks of ferric maltol before their treatment response was assessed. In an alternative analysis when the initial treatment period of ferric maltol was reduced to four weeks, and non-responsive patients were transitioned at this point to IV iron, a reduction in costs occurred. This change in the modelled patient pathway is important as it is likely better reflective of real-world clinical practice. Therefore, a threshold analysis was undertaken which suggested that if ≥22% of patients respond adequately within four weeks, ferric maltol is less costly overall. Data from clinical trials suggests that this threshold should be met.

During the consultation the Clinical Effectiveness Team approached Devon specialists from gastroenterology, obstetrics and gynaecology, haematology, and renal services who were asked to comment on the suitability of ferric maltol for the management of IDA. Specialist feedback was supportive of the use of the product, with specialists indicating the most suitable group for use as patients living with IBD.

A discussion took place, the main points included:

- A specialist present with experience of using ferric maltol noted that there are benefits to having oral rather than IV iron which are not captured in clinical trials, these factors include patient time, cost of travel to centres which deliver IV, the environmental impact of IV treatment (and associated travel), and the clinical environment in which the treatment takes place.
- It was noted that many other health systems had already decided to commission ferric maltol.
- Specialists confirmed that treatment with ferric maltol is usually short term, until iron stores are replenished. The cost model suggested that a four-week trial of Ferric Maltol be given. However, a specialist present noted that a response may be seen in less or more than four weeks. The committee considered the length of time allowed for a response to be seen and the need to ensure that patients will not be left on the treatment if they do not respond. Some ICBs allow up to 12 weeks for a response. The budget impact model found that such an approach results in increased costs over IV iron due to the relatively high failure rate to ferric maltol.
- Specialists indicated that four weeks is a reasonable time in which an observable haematological response should occur. If at four weeks the patient shows a response, specialists expect this to continue and the patient to reach Hb normalisation.
- Specialists noted how their real-world experience had demonstrated that IV iron is faster to show a response than oral. Therefore, some patients would still require immediate IV iron instead of an initial 4-week trial of ferric maltol.
- A specialist present stated that he would not be looking to immediately incorporate ferric maltol into a pre-operative pathway.
- Specialists agreed that the criterion for initiation of ferric maltol is that the patient has failed on, or is intolerant to, other oral preparations. There are some patients for whom the use of any oral preparation is not possible. However, when oral treatment is possible, ferric maltol would be most suitable as a third line option.
- Specialists from gastroenterology, haematology, obstetrics and gynaecology, and renal services were contacted during the consultation. The patients with the most utility are patients with inflammatory bowel disease. The strongest published evidence is also available for this group.
- The committee recommended that the formulary interface group should consider ferric maltol for an amber listing in the formulary. The formulary entry should also make clear the starting criteria and the specific population in which ferric maltol should be used.

The committee voted unanimously in favour of recommending the routine commissioning of Ferric Maltol (Feraccru®) for iron deficiency anaemia in inflammatory bowel disease patients in whom 2 standard oral iron preparations have been ineffective or not tolerated.

ACTION: Policy Recommendation and QEIA to be prepared and subsequently progressed to final ICB approval and communication.

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

Nic Perrem, Healthcare Evidence Reviewer presented a paper. Sian Ludman, Consultant Paediatric Allergist, RDUH and Lucy Leeman, Consultant Immunologist, UHP attended the meeting for discussion of this item.

Azelastine hydrochloride and fluticasone propionate nasal spray is available under the brand name Dymista. This product is licensed for managing moderate to severe allergic rhinitis when

monotherapy with either antihistamine intranasal corticosteroids are insufficient. The recommended dose for children 12 and above, and adults is one actuation in each nostril, twice daily.

Allergic rhinitis is an allergic response triggered by allergens like pollen or dust, causing symptoms such as sneezing, nasal congestion, and itchy eyes. It affects 23-30% of the population and can impact quality of life, school/work performance, and sleep. Standard treatment involves antihistamines, decongestants, and nasal corticosteroids. Immunotherapy may be used in uncontrolled cases.

Dymista has been reviewed by the CPRC on two separate occasions, once in 2014 and again in 2017, and is not currently routinely commissioned in Devon. Both of the previous CPRC reviews found that evidence was available which demonstrated that Dymista achieves superior outcomes compared with monotherapy using either an antihistamine or a nasal steroid. However, no evidence was available which compared the use of Dymista with dual therapy using a nasal steroid and an oral antihistamine. Dymista was also more costly than this approach to therapy.

An application has been made for the routine funding by child and adult immunology services at RDUH and UHP. The application cites evidence of its effectiveness, and faster onset compared to oral antihistamines, and potential to improve patient compliance. The request also notes Dymista's potential to reduce secondary care referrals and costs, as it could be a less expensive alternative to immunotherapy. The request suggests funding for patients unresponsive to other treatments.

A review of the formularies of the other ICBs which constitute the NHS England SW region found that 4 out of the 6 ICBs list Dymista as a treatment option for allergic rhinitis. Two of the ICBs list Dymista as Green, one lists it as a third line primary care option, with the other ICB listing it as amber for specialist initiation. One further ICB also lists it as a black drug meaning a recommendation is in place that the product is not used.

NICE has a CKS for allergic rhinitis which is largely based on Allergic Rhinitis and its Impact on Asthma (ARIA) and The British Society for Allergy and Clinical Immunology (BSACI) guidelines. These professional body recommendations suggest intranasal corticosteroids and antihistamines as first-line treatments, with combinations considered for moderate-to-severe or persistent cases. Guidance also indicates that intranasal antihistamines, like azelastine, offer rapid symptom relief but are less effective than intranasal corticosteroids. The guidelines also recommend combining intranasal corticosteroids with intranasal antihistamines for better efficacy, however they note the evidence base for this approach is limited. The Scottish Medicines Consortium (SMC) has approved Dymista for moderate-to-severe Allergic Rhinitis when monotherapy is insufficient, and the product is available at an agreed cost within a confidential patient access scheme. All Wales Therapeutics and Toxicology Centre have not conducted an assessment for Dymista as it meets their exemption criteria.

In the 2014 review, four Phase 3 studies demonstrated Dymista’s superior efficacy compared to placebo and monotherapies like azelastine and fluticasone for moderate-to-severe allergic rhinitis (AR). Dymista provided faster symptom relief and greater symptom reduction, with a significant improvement in nasal symptoms. However, it was not directly compared to a combination of oral antihistamine and intranasal corticosteroid therapy, which was common practice at the time. The 2017 review included additional meta-analyses but found no evidence showing Dymista’s superiority over combined oral antihistamine and intranasal corticosteroid treatment. An updated literature search undertaken to identify literature published since the last review was unable to identify any new studies.

Feedback from specialists suggested that Dymista might be considered when a patient requires both an intranasal steroid and is currently using an oral antihistamine, in essence adding the addition of an intranasal antihistamine as well with the aim of avoiding the need for immunotherapy. A further search was undertaken to identify any evidence for this practice. One study which

compares azelastine nasal spray with oral fexofenadine versus monotherapy with azelastine showed no significant difference in outcomes, indicating that combining these treatments may not offer additional benefits.

A further short literature search was undertaken to explore any evidence for the use of Dymista in children under 12. The search found that the available evidence is limited, with studies showing no significant difference from placebo, and positive results only seen in post-hoc analyses with simplified symptom scoring.

Overall, Dymista demonstrates superior efficacy for the management of allergic rhinitis compared with monotherapy of either an oral antihistamine or a nasal corticosteroid, however evidence of its superiority compared with dual therapy of both these drugs is lacking.

The Clinical Effectiveness Team conducted a budget impact assessment to evaluate the resource implications of routinely funding Dymista for allergic rhinitis in Devon.

Dymista is more costly than monotherapy using either an intranasal corticosteroid or an oral antihistamine. If considered for use in all individuals with mild to moderate allergic rhinitis, who currently use a combination of a nasal steroid and an antihistamine, population level data for Devon suggests that up to 66,000 patients in may be suitable for Dymista. This number is likely higher than the numbers who would access the treatment. The applicants expect about 300 patients annually to receive it (200 adults and 100 children. If this estimate was correct it would result in an increased drug acquisition vs standard therapy by cost of £24,114 to £39,300 annually.

The applicants suggests that Dymista could be used in the patient pathway before individuals access immunotherapy, meaning that if treatment with Dymista was successful a reduction in the need for immunotherapy could occur.

Dymista, costs £182.50 annually per patient, while the formulary listed option for immunotherapy, Grazax costs £974.55 annually. Making a year's treatment with Dymista £792.05 less costly than a year's treatment with Grazax. The Clinical Effectiveness team undertook a threshold analysis to understand what the treatment success rate of Dymista would need to be to offset the costs of Dymista being used as a part of the existing immunotherapy treatment pathway. Comparing treatment pathways, a model showed that if 12% of patients respond to Dymista within 6 months, it would become less costly than Grazax. At 3 months, a response rate of 6% would generate savings.

A consultation was undertaken with local specialists in child and adult immunology alongside ENT specialists. Feedback was generally positive; however it was noted that many specialists in Devon have limited experience of the product as it has not previously been available locally.

A discussion took place, the main points included that:

- Specialists present confirmed that allergic rhinitis is primarily treated in primary care. However, there is a large group of patients whose therapy is not well optimised. Patients are more likely to adhere consistently with treatment after seeing a specialist. Dymista has been requested for patients with moderate to severe allergic rhinitis, who have not responded when other treatments are fully optimised.
- A paediatric specialist also confirmed that compliance is higher in patients when they can use one treatment as opposed to two separate treatments. As Dymista is a combined intranasal corticosteroid and antihistamine it may be easier to ensure optimised therapy compared with requesting a patient use a separate steroid and antihistamine.
- Many patients are allergic to other allergens such as dust mites, Dymista would be helpful as a treatment option in these patients.
- Paediatric patients aged 12 years and above would benefit from Dymista whist taking important education examinations. Specialists undertake a lot of work with paediatric

patients and their parents regarding steroids. Many parents do not want their children to have steroids. However, the bioavailability of steroids in Dymista is very low.

- There has been no significant developments in the evidence base for Dymista since the last time it was discussed at CPRC. However, it was noted that 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.
- There was a concern that there may be 'creep' in the use of Dymista as GPs become familiar with it. It was suggested that Dymista be classed as 'amber' (Specialist Input) in the Devon Formulary for patients initiated by adult immunology services, or specialists in paediatric allergy management.

The committee voted five to one in favour of recommending the routine commissioning of Dymista® (Azelastine hydrochloride and fluticasone propionate) nasal spray for allergic rhinitis in line with the discussion.

ACTION: Policy Recommendation and QEIA to be prepared and subsequently progressed to final ICB approval and communication.

5. Clindamycin 1%/Tretinoin 0.025% w/w gel (Treclin®) for the topical treatment of acne vulgaris

As part of routine management of clinical commissioning policies, it has been identified that NICE guidance on the approach to the management of acne has changed since the existing NHS Devon policy decision on Treclin for the topical treatment of acne vulgaris was published.

Acne vulgaris is a chronic skin condition in which blockage or inflammation of the hair follicles and accompanying sebaceous glands occurs. It principally affects the face, the back, and the chest, and usually first occurs around the age of puberty.

Treclin is indicated for the topical treatment of acne vulgaris when comedones, papules and pustules are present in patients 12 years or older.

The existing policy was published in March 2016 and states that the routine commissioning of Treclin is accepted in Devon for the treatment of moderate acne vulgaris in adults and children aged 12 years and older for treatment courses of up to 12 weeks. This was formed following an application from local dermatologists which identified it as an additional treatment option at lower acquisition cost than two other locally commissioned combination products. The resulting policy supported the addition of Treclin to the treatment options available in Devon Formulary for moderate acne at that time.

Since then, NICE has published guideline NG198 on Acne vulgaris: management which includes a specific recommendation on first-line treatment options. A 12-week course of a fixed combination of topical tretinoin with topical clindamycin is one of the options NICE recommends offering people with acne of any severity.

Rather than update the policy, it is proposed that a specific commissioning policy for Treclin is no longer needed for the local health system. This is because Treclin is now a well-established topical fixed combination treatment choice in Devon for patients with acne and since the NHS Devon policy was published, NICE has produced guidance supporting its use in acne of any severity, not just for moderate acne. The Devon Formulary will continue to support guidance for prescribers whilst being responsive to relevant changes amongst this class of therapy, for example patent changes, licence variations and safety updates.

The Committee unanimously supported the retirement of the commissioning policy for Clindamycin 1%/Tretinoin 0.025% w/w gel (Treclin®) for the topical treatment of acne vulgaris.

ACTION: Policy to be retired

6. Attendance review

An attendance review has been undertaken by the secretariat in line with good governance principles, to ensure the Terms of Reference remain fit for purpose, and to mitigate any risks to the resilience and quoracy of the Committee and therefore its ability to fulfil its functions on behalf of the ICB.

This review has been carried out within the wider context of ongoing challenges with recruitment to vacancies, which has been formally identified as an issue in the last two annual reports and escalated within the ICB accordingly. Some progress has been made in filling clinical voting member vacancies, but challenges remain in filling secondary care clinician advisory member roles on the Committee.

Committee members are expected to aim to attend all meetings. If a voting member is unable to attend, they are expected to nominate a suitable deputy from among the advisory members of the Committee. Given the outstanding vacancies on the Committee, the attendance of existing advisory members is therefore important to supporting quoracy.

Where voting members have been unable to attend, the secretariat has ensured that suitable deputies have been nominated to delegate for them. This has proved challenging on some occasions due to the limited number and availability of eligible advisory members. Most current members of the committee have met the two thirds attendance principle, although for some this has been a little lower at half of meetings, with a couple of exceptions.

Other areas for consideration include whether public health and commissioning representation are required.

The most recent Public Health representative has now stepped down. Discussions with the Deputy Director of Public Health for Devon County Council acknowledged that CPRC does not require traditional Public Health input as the skills and responsibilities are already possessed by other Committee members.

The addition of a commissioning manager could potentially strengthen the breadth of knowledge of the Committee, including bringing awareness of commissioning context, relevant service considerations, etc to inform the discussions. It would be important that the representative was able to take issues from the Committee back into the commissioning function to inform service development. This could be instead of or in addition to the suggestion to include relevant commissioning leads in the engagement/consultation phase for planned work alongside local specialists, to secure their input/awareness and understanding of relevant service issues.

The Committee considered issues pertinent to the attendance review:

- It was noted that the ICB is still undergoing organisational change. A GP present stated that attendance at CPRC meetings is not included in job plans which may affect attendance.

Post meeting Note – agreed at the CPRC meeting held on Wednesday 16th July

- *Claire Hooper noted that she had not been at the previous meeting but wanted to add that attendance at CPRC is included in her Job Plan.*

- From a governance perspective the Committee should consider whether it can still function in terms of the advisory members attending and the roles that need to be filled to give resilience to the Committee's output.

1. Secondary care clinical advisory members

The Committee was asked to consider that, there has been no-one fulfilling a secondary care clinical advisory member role on the Committee since 2021. Given the long-term vacancies should these roles be removed from the Committee membership if filling them is not a realistic prospect? Or, if not, what action can be taken to fill them?

- Some members of the group felt representation from secondary care as part of the membership of the group was not essential as specialists attend for specific topics. However, others noted the usefulness of secondary care members in supporting GPs and representing wider hospital perspectives rather than individual specialism views, particularly where there are contentious conversations. It was suggested that it would also ensure full representation across the healthcare community and add weight to decision making.
- It was noted that there are similar challenges obtaining secondary care representation on the Formulary Interface Group.
- It was agreed that the new Chief Medical Officer should be approached for assistance in resolving the lack of secondary care clinical engagement on the Committee.

2. How to deal with low levels of attendance

The Committee was asked to consider whether members should be expected step down from posts where they have been unable to maintain attendance at an acceptable level, how replacements should be sought and whether this differs for ICB positions and provider positions?

- It was noted that Paul Foster was aware that his attendance has been limited and he has resigned from the committee. Paul is happy for one of the other trust Chief Pharmacists to replace him. The committee noted this and thanked Paul for his commitment to the committee over a long period of time.
- The committee agreed that members should be expected to stand down if they are unable to attend the required number of meetings. It was suggested that attendance shouldn't be less than 50% of meetings.

3. Public Health Representation

- The group did not feel that a specific representative from Public Health was required as part of the core membership of the committee. The Terms of Reference will be updated accordingly.

4. Other advisory members – e.g. commissioning

- It was suggested that including a commissioner on the group may lend practical service organisation considerations to decision making. There would however be potential challenges for an individual commissioner as they are unlikely to possess detailed knowledge across all services. Whilst inviting a specific commissioner for specific discussions might offer a means to overcome this, in practice there are a limited number of commissioners who cover the entire breadth of healthcare activity across hospital care (elective specialities and urgent care), adult and children's services, community based services, mental health, learning disability and neurodiversity; identifying an individual who has a close knowledge of the speciality area under discussion could be problematic.

- It was noted that the role of the Committee is to make recommendations based on clinical evidence, cost effectiveness and budget impact which are signed off elsewhere in the organisation and beyond the committee's control. It could be beneficial if service impacts from the commissioner perspective were captured in discussion at the policy recommendation stage rather than becoming apparent later.
- Considering all the above aspects it was concluded that commissioning involvement should be explored.

ACTION: Terms of Reference to be updated in line with the discussion.
ACTION: Recruitment of members for agreed roles to be pursued.

7. Update from NICE Planning Advisory Group (NPAG)

It was noted that the minutes of the NPAG meeting held on 15th October will be presented to at the next CPRC meeting.

8. Devon Formulary Interface Group (FIG)

The Committee received the Devon FIG Annual Report for the period 1st April 2023 to 31st March 2024 for assurance before being made publicly available via the Devon Formulary and Referral Website. The annual report provides an account of the activity and governance processes of the group.

Following instruction from the NHS Devon ICB NICE Planning Advisory Group (NPAG), 70 Technology Appraisals and nine HSTs were added to the Formulary during the report period. In addition, the FIG agreed the formulary entry for lurasidone for schizophrenia, which was included in the formulary once the final policy was ratified. The role of the formulary and FIG in supporting safe use of medicines via drug safety updates and "Shared Care" / SMS guidelines was also highlighted.

The extent of updates to treatment guidance and product recommendations considered over the year was wide ranging and included several clinical areas such as atrial fibrillation, COVID-19, insomnia, and type 2 diabetes mellitus. It was noted that formulary updates had supported significant cost saving opportunities totalling over £1million in year. When taking decisions about inclusion of treatments in the Formulary, the FIG is mindful of environmental issues such as plastic and waste.

The new Devon Formulary and Referral website was launched in October 2023. It is working well and is a highly regarded and useful resource.

Due to a combination of change to the new website, a third-party website developer, and a change in the way data are reported and analysed within Google Analytics, it has not been possible to analyse formulary user data in the same way as in previous years. However, the Formulary Team is working with the new website developer to identify and produce data that is meaningful to the ICB. Data available from prior to the new website launch show a continued increase in page views from 133,716 in April 2023 to 155,392 in October 2023.

In year, several changes to the membership had taken place. Graham Simpole (MO pharmacist) and Tom Kallis (community pharmacist) stepped down in July and October 2023 respectively, whilst Dr Stuart Crowe, Dr Jess Danielson, Dr Lucy Harris, and Dr Alisha Kaliciak were welcomed to the FIG as GP representatives in March 2024.

It was noted that secondary care representation remains low, with only one consultant representative position currently filled. There are four consultant representative vacancies on the Devon FIG and work is ongoing to recruit additional consultant members. This issue has been escalated internally within NHS Devon. The FIG undertake several Section Reviews each year and specialist feedback during consultations is key to allowing meaningful discussions. At times, specialist engagement has been difficult to obtain, leading to challenges when considering a section review or product recommendation. It is hoped that this can be improved with greater consultant representation on the FIG to follow up / encourage colleagues within the trusts.

Thanks were expressed to the Formulary Team, FIG members and the secretariat for all their work in supporting the FIG and Formulary website.

9. Any other business

Nic Perrem announced that this would be his last Clinical Policy Recommendation Committee meeting as he is leaving the ICB to take up a new opportunity.

The Committee thanked Nic for all the hard work and support he had provided to the committee over the last few years in his role as Healthcare Evidence Reviewer and wished him well in his new role.

Summary of actions			
	Action	**Lead**	**Status**
24/06	Clinical Policy Recommendation Committee Annual Report 2023/24 to be submitted within the ICB for information and assurance. 26th June 2024 This will be submitted to the ICB for information and assurance alongside the CPEC Annual Report. The Clinical Effectiveness Team will plan internal onward reporting in line with changes in the organisation, i.e. the appointment of a new Chief Medical Officer. 4th September 2024 Waiting for the new Chief Medical Officer to take up his role. Will report onwards alongside other annual reports. 13th November 2024 The CPRC, CPEC and FIG annual reports will be reported onward together.	Rebecca Owen	Pending
24/08	Guanfacine for attention deficit hyperactivity disorder (ADHD) in adults - policy recommendation and QEIA to be prepared and subsequently progressed to final ICB approval and communication. 4th September 2024 Policy and QEIA going through the governance process for sign off. 13th November 2024 As above.	Rebecca Owen	Pending

24/09	Myringotomy (with or without grommet insertion) and adjuvant adenoidectomy in children under 12 years with otitis media with effusion - policy recommendation and QEIA to be prepared and subsequently progressed to final ICB approval and communication. 4th September 2024 Policy and QEIA going through the governance process for sign off. 13th November 2024 The policy is due for publication on 14th November 2024.	Rebecca Owen	Pending
24/10	Clinical Policy Engagement and Consultation Panel Annual Report 2023-24 to be submitted within the ICB for information and assurance. 4th September 2024 Waiting for the new Chief Medical Officer to take up his role. Will report onwards alongside other annual reports. 13th November 2024 The CPEC, CPRC and FIG annual reports will be reported onward together.	Rebecca Owen	Pending
24/11	Opicapone for Parkinson' disease – policy recommendation and QEIA to be prepared and subsequently progressed to final ICB approval and communication. 13th November 2024 Policy and QEIA going through the governance process for sign off.	Rebecca Owen	Pending
24/13	Ferric Maltol (Feraccru®) for iron deficiency anaemia in inflammatory bowel disease - Policy Recommendation and QEIA to be prepared and subsequently progressed to final ICB approval and communication.	Rebecca Owen	Pending
24/14	Dymista® (Azelastine hydrochloride and fluticasone propionate) nasal spray for allergic rhinitis - Policy Recommendation and QEIA to be prepared and subsequently progressed to final ICB approval and communication.	Rebecca Owen	Pending
24/15	Clindamycin 1%/Tretinoin 0.025% w/w gel (Treclin®) for the topical treatment of acne vulgaris - Policy to be retired.	Rebecca Owen	Pending
24/16	Attendance Review - Terms of Reference to be updated in line with the discussion.	Rebecca Owen	Pending
24/17	Attendance Review - Recruitment of members for agreed roles to be pursued.	Rebecca Owen	Pending