Clinical Policy Recommendation Committee Minutes

Wednesday 4th September 2024
Microsoft Teams

Present:

Name	Job Title	Organisation
Dr Glen Allaway	Chair	NHS Devon
Dr Andrew Craig	Voting Member	NHS Devon
Richard Croker	Deputy Director for Medicines Optimisation	NHS Devon
Dr Lucy Harris	Voting Member	NHS Devon
Chris Roome	Head of Clinical Effectiveness	NHS Devon
Mark Taylor	Lay Public Member	
Ben Titford	Voting Member	NHS Devon

Guests:

Sonali Dharia	Consultant	RDUH NHS FT
Emma Edwards	Parkinson's Specialist Nurse	Livewell Southwest
Matt Howard	Clinical Evidence Manager	NHS Devon
Grace McMahon	Clinical Effectiveness Support Officer	NHS Devon
Nic Perrem	Healthcare Evidence Reviewer	NHS Devon
Ray Sheridan	Consultant Physician	RDUH NHS FT
Nicky Stapleton	Parkinson's Specialist Nurse	UHP NHS FT

In attendance:

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

1. Welcome and announcements

Apologies:

Name	Job Title	Organisation
Dr Kay Brennan	Voting Member	NHS Devon
Paul Foster	Clinical Director of Pharmacy and Prescribing	T&SD NHS FT
Dr Claire Hooper	Voting Member	NHS Devon

Barbara Jones	Head of Contracting	NHS Devon
Mac Merrett	Lay Public Member	
John Trevains	Deputy Chief Nursing Officer	NHS Devon
Emily Youngman	Public Health Representative	DCC

Confirmation of voting members and Declarations of interest

The five voting members present were identified. It was noted that in addition to the identified voting members the Chair could vote if necessary.

Dr Claire Hooper had delegated voting to Chris Roome.
Dr Kay Brennan had delegated voting to Richard Croker.

Declarations of Interest were collected and reported. The Declarations made did not result in anyone being excluded from the meeting or from the discussion of any item. All Declarations of Interest are reported in the minutes.

DRUG/ TECHNOLOGY TO BE CONSIDERED	PHARMACEUTICAL COMPANY/ MANUFACTURER/ SERVICE PROVIDER
Opicapone (Ongentys®) **for Parkinson's Disease** Alternative treatments: **Entacapone** **Levodopa with carbidopa and entacapone combination products** (Stalevo®, Sastravi®, Stanek®) **Tolcapone** (Tasmar®) **Apomorphine** (APO-go®) **Co-careldopa intestinal gel** (Duopoda®) **Deep brain stimulation**	BIAL Pharma UK Ltd various manufacturers Orion Pharma (UK) Ltd, Actavis UK Ltd, Teva UK Ltd Meda Pharmaceuticals Ltd Britannia Pharmaceuticals Ltd AbbVie Ltd
Open MRI scanning	Would benefit from private provision of open MRI scanning

Name of Attendee	Role	Declaration
Emma Edwards	Parkinson's Specialist Nurse (guest for opicapone)	I have received honorariums x 2 in last 1 2months from Bial to speak at sponsored events on Suicide prevention in Parkinson's.
Rebecca Owen	Clinical Effectiveness Governance Manager	Declared an indirect non-financial personal interest.
Ray Sheridan	Consultant Physician (guest for opicapone)	Have taken part in trial for the above drug(s) /device(s)/intervention(s)/treatment(s) - PI for Opicapone trial locally over 5 years ago - no additional salary taken for PI role

Notification of Any Other Business

No other items of business were noted.

2. Minutes of the meeting held on Wednesday 6th June 2024 and matters/actions arising

The minutes of the meeting held on Wednesday 26th June 2024 were approved.

Summary of actions			
	Action	**Lead**	**Status**
24/02	Tonsillectomy for quinsy – policy recommendation and QEIA to be prepared and subsequently progressed to final ICB approval and communication. 26th June 2024 The final outstanding approval (for the QEIA) has now been received and the updated policy will be published shortly. 4th September 2024 The policy was published on 8th July 2024.	Rebecca Owen	Complete
24/03	Review of commissioning policy for radiofrequency ablation for Barrett's oesophagus - policy recommendation and QEIA to be prepared and subsequently progressed to final ICB approval and communication. 26th June 2024 The final outstanding approval (for the QEIA) has now been received and the retirement of this policy will be actioned shortly. 4th September 2024 The policy was retired on 26th June 2024	Rebecca Owen	Complete
24/04	Review of commissioning policies for drug treatments for diabetes: Alogliptin for type 2 diabetes - policy recommendation and QEIA to be prepared and subsequently progressed to final ICB approval and communication. 26th June 2024 The final outstanding approval (for the QEIA) has now been received and the retirement of this policy will be actioned shortly. 4th September 2024 The policy was retired on 27th June 2024.	Rebecca Owen	Complete

24/05	Review of commissioning policies for drug treatment for diabetes: Insulin degludec for type 1 diabetes - policy recommendation and QEIA to be prepared and subsequently progressed to final ICB approval and communication. <u>26th June 2024</u> The final outstanding approval (for the QEIA) has now been received and the retirement of this policy will be actioned shortly. <u>4th September 2024</u> The policy was retired on 27th June 2024.	Rebecca Owen	Complete
24/06	Clinical Policy Recommendation Committee Annual Report 2023/24 to be submitted within the ICB for information and assurance. <u>26th June 2024</u> 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. <u>4th September 2024</u> Waiting for the new Chief Medical Officer to take up his role. Will report onwards alongside other annual reports.	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. <u>4th September 2024</u> Policy and QEIA going through the governance process for sign off.	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. <u>4th September 2024</u> Policy and QEIA going through the governance process for sign off.	Rebecca Owen	Pending

24/09	Myringotomy (with or without grommet insertion) and adjuvant adenoidectomy in children under 12 years with otitis media with effusion - consider whether to keep good practice guidance on educational and behavioural strategies during watchful waiting periods.	Chris Roome	Complete
24/10	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.	Rebecca Owen	Pending
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4. Opicapone for Parkinson's disease

Nic Perrem, Healthcare Evidence Reviewer presented a paper. Dr Sonali Dharia, Consultant Neurologist and Dr Ray Sheridan, Consultant Physician, RDUH NHS FT, Emma Edwards, Parkinson's Specialist Nurse, Livewell Southwest, and Nicky Stapleton, Parkinson's Specialist Nurse, UHP NHS Trust, attended the meeting for discussion of this item.

Opicapone is a catechol-O-methyltransferase inhibitor (COMTi). Other drugs in this class include entacapone and tolcapone. Tolcapone is a hospital only drug, entacapone was considered the comparator for this review.

Parkinson's disease is a neurodegenerative condition. Individuals living with Parkinson's disease display a range of motor, and non-motor symptoms. The primary treatment provided to individuals living with Parkinson's disease is levodopa, this drug increases the amount of dopamine available in the central nervous system which results in symptomatic relief. Over time the effects of levodopa begin to reduce, meaning some patients begin to experience periods towards the end of an individual dose of levodopa's effectiveness, where they will see an increase in their motor symptoms. These periods are termed "off" times. Levodopa is commonly taken with dopa decarboxylase inhibitors (DDCi) such as carbidopa, or benserazide. These drugs inhibit the metabolism of levodopa, allowing it to enter the central nervous system. In Devon, the formulary lists two combination products which combine levodopa with a DDCi and these are co-careldopa and co-beneldopa. COMTis, such as opicapone and entacapone are used to prolong the effects of levodopa treatment with the aim of reducing off time in patients with Parkinson's disease who are experiencing end of dose motor fluctuations.

Opicapone is routinely commissioned in Devon following a review by the CPRC in July 2018. The existing policy stipulates that opicapone should only be used in patients who are unable to

tolerate entacapone. The decision of the CPRC to recommend opicapone as second line to entacapone occurred as the evidence available at the time demonstrated that opicapone was non-inferior to entacapone for outcomes such as a change in total off time, but that opicapone was a considerably more costly approach to therapy.

An application received from the movement disorder team at UHP requested that the existing policy for opicapone was reviewed so that opicapone can be used as a first line option alongside entacapone. The rationale for this request was that:

- Opicapone provides a benefit to patients as it is taken once daily whilst entacapone is required to be taken with each dose of levodopa.
- As opicapone is taken once daily, it allows for easier alteration of the daily dose of levodopa taken compared with entacapone.
- Once established on opicapone it may be possible to reduce the daily dose of levodopa.
- Opicapone tablets are smaller in size compared with entacapone providing a benefit for patients who are experiencing swallowing issues.
- The price of opicapone had been reduced since the commissioning policy decision was made.

NICE guideline 71 covers the management of Parkinson’s disease. This recommends the use of a COMTi as an adjunct to levodopa for people with Parkinson's disease who have developed dyskinesia or motor fluctuations despite optimal levodopa therapy. However, no recommendation is made regarding the position in therapy of opicapone or entacapone.

Both the Scottish Medicines Consortium (SMC) and the All-Wales Medicines Strategy Group (AWMSG) have approved the use of opicapone in 2024 and 2022 respectively. Both bodies reversed previous decisions not to approve the use of opicapone in their NHS regions. The rationale for this change related to a reduction in the price of opicapone. Neither body now offer formal guidance regarding the position in therapy of opicapone.

Opicapone is listed as an amber drug in all six formularies of the other ICBs which constitute the NHS England southwest region. Four of the six ICBs stipulate that opicapone is only to be used second line to entacapone.

An updated evidence review was conducted which aimed to identify any evidence comparing the effectiveness of opicapone to entacapone which was published since the previous CPRC review. The literature search identified six papers: four systematic reviews with network meta-analyses, and two retrospective cohort studies.

Evidence from the network meta-analyses suggested that there was likely no difference in off time experienced between those treated with opicapone and those receiving entacapone. Conflicting findings relating to changes in the unified Parkinson disease rating scale are reported in different reviews.

Data from one retrospective analysis of real-world patient records suggests that patients treated with opicapone may use a lower daily dose of levodopa compared to those using entacapone. Data from this study also found a reduction in health care resource use in opicapone treated patients. Whilst these findings may suggest some clinical benefit of opicapone compared with entacapone, they must be interpreted with caution due to the potential for bias in this type of study, there may also be issues relating to unequal sample sizes, and drop out rates in this analysis.

Data from another small retrospective analysis of records in a patient database suggests that patients treated with entacapone may experience worsening non-motor symptoms compared with patients receiving opicapone. However, these results must again be interpreted with some caution due to the study design being prone to selection bias.

The novel findings of both of these retrospective analyses require replication in prospective clinical trials to fully understand their implications for local health care planning.

No published cost utility or cost comparison analysis undertaken in a UK healthcare setting were identified. A cost comparison analysis undertaken by the company was submitted to both the SMC and AWMSG to guide their most recent assessment. The model submitted to the SMC is not publicly available, and the full model used by AWMSG is not available for review. A brief summary of the AWMSG committee discussions notes that a discount of 37% was applied to opicapone in January 2024, and using this price the company were able to demonstrate some cost savings when opicapone was used in place of entacapone. As the model is not publicly available the clinical effectiveness team have been unable to review the method used and are therefore unable to comment on its applicability.

Cost modelling undertaken by the clinical effectiveness team which used historical prescribing costs for Devon estimated that treatment with opicapone is on average £294.44 more costly per patient per year than treatment using entacapone 200mg tablets. However, treatment with opicapone may cost £125.97 less than the use of entacapone triple therapy formulations, this is a product which combines entacapone with levodopa and a DDCi in one tablet.

Historical data reviewed for all entacapone treated patients demonstrated that there is around a 50/50 split in patients which are treated using 200mg tablets with separate levodopa combination product and those receiving a triple therapy combination product. Therefore, a secondary analysis which considered the average costs associated with all entacapone prescribing compared with opicapone was undertaken. This analysis demonstrated that opicapone was £87.61 per patient per year more expensive than treatment with entacapone.

The application received for this item suggested that it may be possible to reduce the amount of levodopa required in opicapone treated patients compared with entacapone treated patients. A threshold analysis was completed to understand the likely dose reduction of levodopa required to make opicapone less costly than entacapone, this suggested that the levodopa daily dose would need to reduce by at least 218mg in opicapone treated patients.

A budget impact analysis was also undertaken which aimed to understand the likely cost implications of a change in the existing opicapone policy so that the product could be prescribed as a first line option alongside entacapone. This analysis estimated that 142 new COMTi initiations occur in Devon each year; if the policy was amended and equal numbers of patients were initiated on each agent, the budget impact would be an increase of £2,799 annually, if all patients were initiated on opicapone this would rise to £9,019.

In the initial consultation, feedback was received from one consultant neurologist who supported this application. In summary this feedback indicated that opicapone may be easier to tolerate than entacapone and may also be easier to up-titrate. The specialist also reported that the use of opicapone can result in fewer daily tablets being required per patient. Further feedback received after the initial consultation closed was shared with the committee.

The committee considered issues pertinent to the request that the existing policy for opicapone is reviewed so that opicapone can be used first line alongside entacapone. The main point raised included:

- Since opicapone was last brought to CPRC for consideration the cost of the drug has reduced significantly (37% price reduction in January 2024).
- Specialists reported that roughly one in five patients get side effects from entacapone, these include severe diarrhoea which can lead to weight loss, lack of compliance with medication and patients experiencing more off time and not being able to undertake other activities which help keep them well.

- Specialists reported that patients do not usually experience diarrhoea for the first few weeks and before this happens have good results with entacapone. Therefore, once entacapone is initiated a follow up review for a few weeks is routinely booked, this is not the case with opicapone. Specialists also indicated that it is not uncommon for diarrhoea to begin a few months post initiation of entacapone and in some such cases patients reviewed in primary care have undergone investigations such as colonoscopies.
- Specialists suggested that compared with opicapone, entacapone use results in further system costs which were not captured in the Clinical Effectiveness Team economic model. Such costs include additional neurology outpatient appointments (initial follow up) and the potential for colonoscopies and lab tests investigating late onset diarrhoea etc. Specialists also suggested that due to the long-lasting effect of opicapone, some patients display better motor control when waking which can reduce the risk of falls (and associated emergency department attendance).
- The committee noted how specialists' experiences in this area aligned with the findings of a published retrospective analysis of patient data showing more health service use in patients treated with entacapone compared with those receiving opicapone.
- Specialists reported how opicapone provides more flexibility with levodopa dosing such as the ability to alter formulations between immediate and prolonged release throughout the day.
- It is anticipated that about three quarters of new patients would be started on opicapone, and the impact on the system would be gradual.
- The committee felt the right decision had been taken on opicapone when it was reviewed in 2018. However, the reduction in price alongside the insight provided from the local specialists regarding the clinical benefit of opicapone meant that a change in policy position was now acceptable. The committee noted the value of specialists attending.

The committee voted unanimously in favour of recommending that the existing policy for opicapone be amended so that opicapone can be used a first line option alongside entacapone.

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

5. Review of Open Magnetic Resonance Imaging (MRI) Scanning policy

As part of the routine management of clinical commissioning policies the existing, long-standing, policy for Open (as opposed to circular closed bore) MRI Scanning, which was published in 2011, has been reviewed to assess its relevance and the ongoing need for the policy.

MRI is a medical imaging technique that may be used to help diagnose or monitor treatment for a variety of conditions. It uses strong magnetic fields and radio waves to produce detailed images of the inside of the body, which can be used to help diagnose conditions, plan treatments and assess how effective previous treatment has been.

In conventional MRI systems patients are slid into a cylindrical space and scanned by a strong magnetic field. Open MRI systems are by contrast open, allowing for imaging without the patient being placed within an enclosed space.

Some of the key differences between closed and open MRI scanners are the strength of the magnetic field and therefore the quality of the images produced, the scope of their use across body areas, and the length of time taken to produce scans. Closed MRIs can capture high-quality, detailed images because of their strong magnetic field, supporting the diagnoses of a large range of problems. In comparison, open MRI scanners produce a lower magnetic field strength which can result in reduced quality images. Imaging of some body areas may be limited due to less ability to discriminate between fat and water during the scan. Open MRIs are also

associated with a longer duration of scanning as they only use magnets on two sides of the patient, unlike closed MRIs which surround the patient with magnets on all sides.

The existing ICB policy supports referral for open MRI as an alternative to conventional MRI in patients who suffer from claustrophobia where an oral prescription sedative has not been effective, or in patients who are obese or cannot fit comfortably in conventional MRI scanners. Consultation with local specialists has confirmed the ongoing need for access to open MRI and that the existing policy criteria remain largely appropriate.

In respect of patients with claustrophobia, it was commented that if a conventional scan cannot be tolerated with oral sedation, in practice an MRI under general anaesthetic would be considered. It was also acknowledged that there have been some changes in bore sizes since the existing policy was developed; these are now larger than they were, and many claustrophobic patients can therefore tolerate them better. Similarly, the larger bore size means that many obese patients can fit in these without the need for referral out of area for open MRI. However the main concern for open MRI would be for a patient that is too large for more conventional scanners as for them an open scanner can be the only option to allow for a diagnosis and appropriate treatment. Not all examinations are suitable for an open scanner due to image quality, but if all other options do not work, this should be an available option to allow for a diagnosis.

There are some limitations in the activity data for open MRI scanning, however they suggest that this is only undertaken in a small number of patients. This would correspond with the feedback from specialists which suggests they would endeavour to support patients to undergo MRI locally wherever possible.

Following review of the policy it is proposed to retain this policy without change. The version history will be updated for governance purposes to reflect that this has been reviewed and re-confirmed.

The committee considered issues pertinent to the review of the MRI Scanning Policy. No areas of concern were noted.

The committee voted unanimously in favour of retaining the policy and updating the version history to reflect that this has been reviewed and reconfirmed.

ACTION: Update version history to reflect that this policy has been reviewed and reconfirmed.

6. Update from NICE Planning Advisory Group (NPAG)

The committee received an update from the NPAG meeting on Tuesday 30th July 2024.

The group had considered three Technology Appraisals (TAs) for ICB commissioning. These are:

- Lebrikizumab (TA986) a new specialist drug for severe atopic dermatitis. There are now a number of these (including JAK inhibitors and biologicals). The effect is that in aggregate these are expected to increase capacity pressures on dermatology departments. NICE estimates use in 7,300 people across all options after five years, adding 732 hours of clinic time and 2,930 blood tests. Homecare is suggested as the means of delivery for about 80% of cases.
- Remdesivir and tixagevimab plus cilgavimab for treating COVID-19 (TA971) is recommended as an in-hospital treatment option for adults if they are at risk of serious illness and for babies, children and young people if they are aged 4 weeks to 17 years and weight at least 3 kg and

have pneumonia and need supplemental oxygen or weigh at least 40 kg and have a high risk of serious illness. Tixagevimab plus cilgavimab is not recommended within its marketing authorisation.

- Atogepant (TA973) for migraine prophylaxis. Whilst NICE do not anticipate this guidance to have significant resource implications, this is because it estimates that only 9.2% of patients who meet the TA criteria (total about 4000) will access treatment. Feedback from providers regarding this overall class of agent is very different and is having a large impact. This will be exacerbated by recent safety restrictions which the MHRA have placed on the use of topiramate, which had become a commonly used off-label prophylactic treatment.

- 13 NHSE commissioned TAs.

- Seven Clinical Guidelines – responses from providers to updates on Delirium in hospital and long-term care (CG103), and Hypertension in pregnancy (NG133) were considered to raise no particular issues. The other guidelines were:

    - An Acne guideline update (NG198) incorporated the MHRA safety action on use of isotretinoin has been incorporate into the formulary already. There is some lack of awareness of referral responsibility shown in the NICE guideline regarding expectations of GPs in respect of isotretinoin which provider responses have picked up.

    - An update to a guideline on Epilepsy (NG217) is stated to largely reinforce current best practice but there is a focus on the regular review of females needed for the safe use of valproate and topiramate, which may have significant impact. There is a local working group set up led by the ICB Chief Nurse.

    - A new guideline of Depression in adults (NG222) replaces an older one. This places an emphasis on psychological therapies (IPT) which it notes has not been fully implemented across the country from the previous guideline. This is the area of greatest resource impact.

    - A new guideline on Self-harm assessment management and prevention (NG225) is stated to reinforce best practice. These are quite detailed and all-encompassing holistic recommendations.

    - A new guideline on Barrett's oesophagus monitoring and management (NG231). The recommendations on Radiofrequency ablation have already been addressed through review of the existing policy via this committee.

- Two Diagnostic Guidelines were also considered. One on Automated ankle brachial pressure index (ABPI) measurement (DG52) which is recommended only in research and one for MRI fusion biopsy systems for diagnosing prostate cancer (DG53) which is only recommended in in research.

- One Medical technology Guideline (MTG38) Neuropad for detecting peripheral neuropathy (IPG) which is not is supported.

- Six Interventional Procedures Guidelines:
    - Aquablation for Benign prostatic hyperplasia (IPG770)
    - Biodegradable subacromial spacer insertion for rotor cuff tears (IPG775) is not to be used, or only used in research depending on whether debridement is an option.
    - Extracorporeal CO2 removal in acute respiratory failure (IPG776) is not to be used.
    - Middle meningeal artery embolisation for chronic subdural haematoma (IPG779) is only to be used in research.
    - Intravascular lithotripsy for calcified arteries in peripheral arterial disease IPG780)

- Electrical stimulation for neurogenic dysphagia (IPG781)

7. NICE Planning Advisory Group (NPAG) Annual Report 2023-24

The committee received the NPAG annual report for 2023-24.

The annual report provides an account of the activity and governance of the group and assurance to the ICB of how its statutory responsibilities are fulfilled in respect of mandatory NICE guidance.

NPAG has ensured continuity of process and provided a forum for the ICB to fulfil its statutory responsibilities in respect of mandatory NICE TAs and HSTs. NPAG also enables the ICB to be appraised of any obstacles to the implementation of all newly published NICE guidance and guidelines and to consider their resource and service implications.

There is an established process for ensuring that NICE TAs and HSTs are added to the local formulary within 3 months of publication (or 30 days if recommended through a fast-track appraisal process) in line with the ICB's statutory responsibilities.

Seven meetings of the group were held during the year, receiving 181 reports relating to NICE guidance. Just under half of these related to mandatory guidance, which is prioritised on meeting agendas; the remainder were split between clinical guidelines and other technology guidance. Compared with the previous year the guidance noted or considered by NPAG saw a 32% increase. This may be explained by the fact that only 5 NPAG meetings were held in 2022/23. There has not been an increase in the frequency of meetings, this simply reflects how they have fallen in the calendar during the reporting period.

The average number of pieces of guidance considered per meeting is 25 pieces. The general trend is also for a year-on-year increase in the volume of guidance considered by NPAG since it was formed in 2013.

Over the year NICE published 214 new and updated guidance and guidelines (which includes 16 terminated appraisals). In line with the split of NPAG agendas, mandatory guidance accounts for nearly half of NICE's published guidance.

A noted growth area for NICE has been in the production of Healthcare Technology Evaluations (HTEs). Four were published in 2022/23 and 18 published in 2023/24. These have resulted in conditional recommendations for the early use of technologies in the NHS, alongside an evidence generation plan to support a full recommendation for use of the technology to be made at a later point. Topics selected for a HTE are for technologies that address a clinical, system or service user problem as suggested by NHS England and stakeholder engagement and where their adoption is expected to have the most impact and add value to the health and social care system.

However, as a group, NPAG remains conscious of the potential future challenges for the local health system which could result from technologies which are conditionally supported for use at this time subsequently not being recommended for routine adoption in the NHS. The reality of this concern will only become apparent over time as these evaluations are used and satisfy the evidence generation plans set out and the information collated by the NPAG process in terms of local uptake will be helpful in understanding any future implications.

NICE carried out a consultation on their proportionate approach to TAs. The approach, which looks to speed up the TA process and increase capacity, will be incorporated into the health

technology manual as part of standard process and methods. This faster turnaround clearly has the potential to increase the rate of NICE output further.

During the reporting period, eight TAs were recommended through the cost comparison process (fast track appraisal). In this process, commissioners have committed to providing funding for the technologies within 30 days of publication. All eight TAs published through this process this year were ICB commissioned. Similarly, one ICB commissioned TA was published through the Early Access to Medicines Scheme.

In contrast, for the publication of TA943 HCL systems for managing blood glucose levels in type 1 diabetes, the normal period of compliance was extended to five years because NHS England submitted a funding variation request. As a result, NHSE has developed a five-year implementation plan with advice and guidance to NHS providers on a phased uptake approach.

The Clinical Effectiveness team has proactively engaged with the NICE consultation on Methods and Processes for including NICE TA recommendations in guidelines as NICE seek to further refine and streamline their processes to understand the potential implications for the ICB and on NPAG processes.

Likewise, specific projects have been undertaken by the Clinical Effectiveness Team to better understand the usefulness of NICE tools, including their benefits and any limitations and to clarify how they may be best used locally. This included production of two reports:

- NICE report: Estimated vs Actual
- NICE Productivity Resource Report

Grace McMahon was thanked for the significant amount of work put into producing NPAG and NICE related documentation.

Grace thanked Rebecca Owen and Fiona Dyroff for their input into the NPAG Annual Report.

8. Update from Clinical Policy Engagement and Consultation Panel

The committee received an update from the Clinical Policy Engagement and Consultation Panel meeting (CPEC).

It had previously been reported that the panel had discussed the question of recovery of costs from the private sector where the NHS has had to provide a treatment following treatment in the private sector, such as for removal of cosmetic breast implants, and that there is no mechanism in place to recover the costs. Chris Roome confirmed that this has been highlighted to the Deputy Director of Finance and the action is now closed.

The Clinical Policy Engagement and Consultation Panel considered three items:

- Continuous glucose monitoring (CGM) in diabetes.
- Guanfacine for attention deficit hyperactivity disorder (ADHD) in adults
- Myringotomy (with or without grommet insertion) and adjuvant adenoidectomy in children under 12 years with otitis media with effusion (OME)

The panel saw no reason for further engagement or consultation action on any of the items discussed.

9. Any other business

Reflection on discussion of Opicapone for Parkinson's Disease

The group noted the value of specialist engagement and attendance at CPRC for discussions.

There was reflection on the change in direction of the discussion of Opicapone for Parkinson's Disease following input from specialists present.

The committee agreed with these comments and were confident that the right decision had been made and that specialists' responses to questions raised by the committee had highlighted areas in which there may have been unintended consequences of not updating the policy to allow opicapone can be used as a first line option alongside entacapone.

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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.	Rebecca Owen	Pending
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24/11	Opicapone for Parkinson' disease – policy recommendation and QEIA to be prepared and subsequently progressed to final ICB approval and communication.	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.	Rebecca Owen	Pending