Northern Treatment Advisory Group

Minutes of meeting 25th February 2014, 9-12am, The Durham Centre, Durham, DH1 1TN.

Present:

- David Campbell, Chief Pharmacist, Northumbria Healthcare NHS Foundation Trust
- Joe Corrigan, Chief Finance Officer, Newcastle & Gateshead Alliance CCGs
- Ian Davidson, Director of Quality and Safety, North Durham CCG & chair of N-TAG
- Tim Donaldson, Chief Pharmacist, Northumberland, Tyne & Wear NHS Foundation Trust
- Paul Fieldhouse, Principle Pharmacist (Prescribing Support), Regional Drug & Therapeutics Centre (Newcastle)
- Jackie Gillespie, Prescribing Lead, Sunderland CCG
- Janet Hattle, Chief Pharmacist, Gateshead Healthcare NHS Foundation Trust
- William Horsley, Pharmacy Lead for Specialised Commissioning, CNTW Area Team (NHS England) & temporary secretary to N-TAG
- Mike Lavender, Consultant in Public Health Medicine, Durham County Council
- Paul Madill, (11-12am) Public Health Trainee
- Carl Parker, General Medical Practitioner, Hartlepool
- Nick Quinn, Consultant Physician, South Tees Hospitals NHS Trust
- Geoff Stephenson, Medical Director, Sunderland CCG
- Janette Stephenson, Head of Medicines Optimisation, North of England Commissioning Support
- Roger Wheeler, General Medical Practitioner, Middlesbrough
- Ali Wilson, Chief Officer, Hartlepool & Stockton-on-Tees CCG
- Glen Wilson, (10-11am) Public Health Trainee

Apologies were received in advance from: Geoff Crackett, Neil Watson, Toks Sangowawa, Hilary Wynne, Simon Thomas, Keith Godfrey, Andrew Berrington, Craig Steele, Andrea Loudon, Sue Hunter, & Alison Thompson.

Introductions were made by all parties present at the request of the chair. The chair welcomed everyone to the first meeting of N-TAG and thanked the secretary for his work in helping to establish the group.

The chair invited declarations of interest. None were made.

Terms of Reference

Discussion ensued regarding the terms of reference for the group. An error was noted on the membership list. It was noted that the ToR was based largely on those of NETAG and as such some aspects required amendment, in particular 3.1.3. The history of NETAG with respect to advisory status of outputs was discussed and agreed that this would be the same for N-TAG. A request to ensure that all recommendations are relayed to the Northern CCG Officers Forum was made and supported. Discussion ensued as to quoracy and actions to

be taken in the event of a non-quorate meeting. A number of options were considered which the group agreed with. Discussion ensued regarding attendance at meetings and the group agreed that this be open to continual review with respect to adequate representation across roles and organisations, and with respect to participation. Point 3.0.3 was requested to be clarified with respect to mandatory and non-mandatory guidance. A suggestion was made that the group should seek accreditation with NICE. This met with general approval and would be followed-up by the permanent secretary.

The group discussed patient representation and noted that this is currently a gap in the membership. The group noted that a number of Health Watch groups exist within the relevant catchment and these could prove to be a useful source of appropriate patient representation. The permanent secretary would follow this up. Discussion widened to consider how the group engages with patients and users more generally, particularly in the consultation phase. It was noted that N-TAG would make information available via a public website and interested parties would be able to identify appraisals and communicate with the group via that route. The permanent secretary would investigate this point further and seek advice on all aspects of patient involvement from Health Watch.

Due to the timing of the meeting, the chair invited members to raise any other business at this point. The group discussed an appeal process and agreed to adopt the NETAG process with any necessary amendments to reflect the new ToR. The group also agreed that it would hear any appeals of recommendations made by NETAG.

The group discussed the work plan in general terms. The permanent secretary would produce a draft work plan as a priority for consultation with the group. A request was made that the permanent secretary consider the future involvement of public health registrars in completion of treatment appraisals and the group agreed with this sentiment.

The group was asked whether a decision making tool in the format of a structured summary of a recommendation would be useful. In addition, a scoring tool could be employed to help determine the work plan. The group welcomed these suggestions and would be keen to review samples.

The NETAG legacy website was discussed in particular with reference to updating current content and informing any users of the website that content may not be up to date. The secretary informed the group that the website had essentially been mothballed and prepared for such with a message already in place. The group still felt that the NETAG website could be utilised in error and requested that the secretary investigate the potential to update it and remove any documents which are definitely superseded, e.g. due to NICE guidance.

The group discussed whether its recommendations should have an expiry or review date attached. Differing opinions were expressed and the permanent secretary would advise accordingly, with reference to standard or accepted practice in other localities.

Review of Treatments:

Nalmefene

The appraisal report concerning nalmefene in the management of alcohol dependence was presented by the author. The pertinent points concerning the treatment and related service implications were succinctly described. The group was particularly interested to know of the associated psychosocial intervention and expressed concerns that this could be adequately replicated in practice. The group was also concerned as to the longer-term aims in the management of the relevant patient group in particular that nalmefene was proven to reduce consumption whereas NICE guidance and existing services were aiming for total abstinence. The group duly noted recommendations from other authorities, namely the SMC and AWMSG, but was unclear as to the rationale underlying those recommendations. The group discussed the practical and analytical methodology used within the key studies and noted some potential deficiencies. The group also considered the practical implications of the observed clinical effects and again, concerns were expressed whether these would be clinically relevant for the target patient group. The group considered the cost of treatment, commissioning implications, and relationship between specialist services and primary care. On balance the group did not support the use nalmefene in the management of alcohol dependence and did not recommend the treatment.

Despite the nalmefene recommendation being unanimously supported, the group did pause to consider whether a formal vote was required. The chair duly instigated such and all those present supported the motion not to recommend nalmefene.

Sequential therapies in the management of macular oedema secondary to retinal vein occlusion

The appraisal report concerning sequential pharmacological therapies in the management of macular oedema secondary to retinal vein occlusion was introduced by the secretary. Later the report author also attended the meeting to inform discussions. The group noted the general paucity of any relevant data to support a change from one pharmacological therapy to another in the treatment of RVO, and that the small amount of evidence that was available was of low quality. The group considered the outline protocol from the North East Retinal Group and was of the opinion that certain aspects of the protocol, such as those relating to adverse effects and tolerability, although not supported by clinical evidence were empirically rational. However, the group was unable to support the rationale for therapy changes due purely for reasons relating to efficacy, or lack thereof. The group considered the commissioning constraints with respect to NICE technology appraisals and acknowledged that clinicians could change between therapies regardless, although each change would need to be treated as a new treatment episode with the necessary requirements from NICE satisfied. The group was of the opinion that unconstrained switching between therapies would lead to additional costs to the local health service. The group noted that a third biological treatment was likely to be recommended by NICE for the same indication and considered how the clinical situation may be affected by this. After further consideration and deliberation the group felt it was unable to support the current suggestion for the use of

sequential pharmacological therapies for RVO, however it was minded to make allowance for such use pending receipt of a suitably refined treatment protocol from the appropriate clinical group.

As per the earlier appraisal and deliberation, the chair instigated a vote concerning the group's recommendation. The group opted not to recommend the sequential treatment of RVO, accepting the caveats discussed, by a clear majority vote. The secretary and report author were requested to work with local clinicians to achieve the requested treatment protocol.

During the consideration of the sequential RVO treatment report the group made a number of suggestions with respect to future appraisal reports, in particular a request for clarity around use of terms such as 'clinically significant' and better descriptions of the pertinent patient characteristics from clinical studies. These comments were duly noted.

The meeting thus concluded.

Minutes produced by W Horsley, 2nd May 2014.