Northern, Eastern and Western Devon Clinical Commissioning Group
South Devon and Torbay Clinical Commissioning Group

Clinical Policy Committee (CPC)

Minutes

Wednesday, 22 July 2015 - 9.30 am to 12.30 pm

Committee Suite, County Hall, Exeter

Present:

Dr Jo Roberts* (Chair)	GP Clinical Commissioner	South Devon & Torbay CCG
Dr Mick Braddick*	GP Clinical Commissioner	NEW Devon CCG
Jono Broad	Lay Member	
Rob Cowdry	Contracts Governance Manager	NEW Devon CCG
Dr Andrew Craig*	GP Clinical Commissioner	NEW Devon CCG
Richard Croker	Head of Medicines Optimisation Northern and Eastern Localities	NEW Devon CCG
Dr Tawfique Daneshmend	Consultant Gastroenterologist & Hepatologist	RD&E NHS Foundation Trust
Miles Earl	Contract Accountant	NEW Devon CCG
Paul Foster	Chief Pharmacist	SDHC NHS Foundation Trust
Dr Andrew Gunatilleke	Consultant in Pain Management & Anaesthesia	SDHC NHS Foundation Trust
Dr Mark Kealy	Consultant in Public Health	Devon County Council
Andrew Kingsley	Patient Safety and Quality	NEW Devon CCG
Dr Peter Leman*	GP Clinical Commissioner	NEW Devon CCG
Dr Phil Melluish*	GP Clinical Commissioner	South Devon and Torbay CCG
Mac Merrett	Lay Member	
Samantha Morton	Head of Contracting and Procurement	South Devon and Torbay CCG
Chris Roome*	Head of Clinical Effectiveness	NEW Devon CCG
Dr Alison Round*	GP Clinical Commissioner	NEW Devon CCG
Dr Ben Waterfall*	GP Clinical Commissioner	NEW Devon CCG

Guests:

Ms Clare Adams	Consultant Colorectal Surgeon	Plymouth Hospitals NHS Trust
Mr Julian Barrington	Consultant Obstetrician and Gynaecologist	SDHC NHS Foundation Trust
Ms Katie Cross	Consultant Colorectal Surgeon	Northern Devon Healthcare NHS Trust
Dr Alex Degan	GP – Board member for Eastern Locality	NEW Devon CCG
Emma Gitsham	Clinical Evidence Pharmacist	NEW Devon CCG
Matt Howard	Clinical Evidence Manager	NEW Devon CCG
Mr Nicholas Kenefick	Consultant Surgeon	SDHC NHS Foundation Trust
Mr Soumya Misra	Consultant Urologist	Northern Devon Healthcare NHS Trust
Bethan Rogers	Clinical Evidence Pharmacist	NEW Devon CCG
Mr Mark Stott	Consultant Urologist	RD&E NHS Foundation Trust
Miss Melanie Walton	Urology Consultant	RD&E NHS Foundation Trust

In attendance:

Fiona Dyroff	Clinical Effectiveness Governance Support Officer	NEW Devon CCG
Rebecca Heayn	Clinical Effectiveness Governance Manager	NEW Devon CCG

* Denotes voting members

1. Welcome and announcements

Attendees were welcomed to the meeting.

Apologies

Dr Darunee Whiting	GP Clinical Commissioner	NEW Devon CCG

Notification of Any Other Business
Members were asked if they had any items of AOB to discuss.

Confirmation of voting members and Declaration of Interest
The eight voting members present were identified.

Darunee Whiting had deputised voting to Chris Roome.

Declaration of Interest forms were collected. The chair reviewed the Declaration of Interest forms. Declarations of Interest were recorded in the minutes.

DRUG/TECHNOLOGY TO BE CONSIDERED	PHARMACEUTICAL COMPANY / MANUFACTURER / SERVICE PROVIDER
Botulinum toxin for the management of overactive bladder (Botox®, Dysport®) Alternative treatments: **Neuromodulatory devices**	**Allergan, Ipsen** **various manufacturers** As a provider of private botulinum toxin treatment for patients with overactive bladder.
Botulinum toxin for the treatment of chronic anal fissure (Botox®, Dysport®) Alternative treatments: **Rectogesic ointment** **Topical diltiazem or nitrates**	**Allergan, Ipsen** **ProStraken** **various manufacturers** As a provider of private botulinum toxin treatment for patients with anal fissure
The referral and specialist management of haemorrhoids in adults	As a provider of private treatments for patients with haemorrhoids

NAME OF ATTENDEE	ROLE	
Dr Alex Degan	GP, Board Member, Eastern Locality	Partner in dispensing GP practice. Owner of shares in various pharmaceutical companies through investment funds. Wife – owner of shares in Astra Zeneca and various other pharmaceutical companies through investment funds.
Matt Howard	Clinical Evidence Manager	In previous post I attended a number of CPD events where refreshments, hospitality etc were sponsored by a variety of pharmaceutical companies.

2. Minutes from the meeting held on 10th June 2015 and matters/actions arising

The minutes of the meeting held on 10th June 2015 were approved.

Summary of actions		
	Action	**Lead**
15/01	NICE CG164 familial breast cancer: Recommendation and summary of clinical discussion to be taken to the CCGs' executive groups. It is planned that the final recommendations will be submitted to NEW Devon CCG and South Devon and Torbay CCG Executive Group meetings in April 2015. This had been delayed pending a subsequent response from NICE to the earlier queries raised. Nothing further has been received. Final recommendation to be submitted to the CCG Executive Groups next meeting (May/June 2015) for approval. The recommendation has been submitted to the CCGs' Executive Groups. Subsequently the recommendation has been approved by South Devon and Torbay CCG and is pending, along with the QEIA for NEW Devon CCG. The recommendation and QEIA have been accepted by both CCGs' Executive Groups. Action complete.	
15/09	Commissioning policy for Lixisenatide for the treatment of type 2 diabetes to be published. The decision has been taken to the North and East Formulary Interface Group and is due to be taken to the South and West Formulary Interface Group. Once formulary discussions are complete, the policy will be published. The policy has been discussed by both the Formulary Interface Groups. Sign off of the QEIA is awaited. The policy and QEIA have now been signed off by both the CCGs' Executive Groups and the decision published. Action complete.	
15/12	Recommendation and QEIA for Brimonidine for the symptomatic treatment of facial erythema of rosacea in adult patients to be submitted to CCGs' executive groups for approval. The policy and QEIA has now been signed off by both the CCGs' Executive Groups and the decision published. Action complete.	
15/13	*Recommendation and QEIA for the assessment and removal of benign skin and subcutaneous lesions to be submitted to the CCGs' Executive Groups for approval.* *Further clarification of the referral pathway is required.* The removal of benign skin and subcutaneous lesions is due to be discussed at the CPC meeting in September 2015.	Rebecca Heayn

15/16	Letter to be written to Clinical and Medical Directors of local trusts with regard to clinician engagement in the process of policy development and at CPC meetings. A letter had been drafted. At a subsequent meeting between Jo Roberts, Ali Round and Chris Roome it had been felt the issue of engagement was relevant to a wider group of clinicians including GPs. A more generic letter will be drafted. The letter has now been sent and replies have been received from some of the Medical Directors. Action complete.	
15/17	*Specialist Management of Abdominal Wall Hernias in Adults: Policy Recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication.* *The lay-member panel discussed the committee's recommendation and considered that no formal public consultation was required. The policy and QEIA have subsequently been signed off by both CCGs' Executives Groups.* Patient support information to be produced to accompany publication of the policy.	Rebecca Heayn
15/18	*Cataract Surgery: Policy Recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication.* *The lay-member panel discussed the committee's recommendation and considered that no formal public consultation was required. The policy and QEIA have subsequently been signed off by both CCGs' Executives Groups.* Patient support information to be produced to accompany publication of the policy.	Rebecca Heayn

3. Botulinum toxin for the management of urinary incontinence due to detrusor overactivity

Introduction/background to commissioning of botulinum toxin

Currently no Devon wide policy for the use of botulinum toxin exists; work is now being undertaken to clarify the commissioning position of NEW Devon CCG and South Devon and Torbay CCG. This is an area of high spend for which commissioning is split between CCGs and NHS England depending on the indication for which it is being used. Several papers considering commissioning of botulinum toxin for a number of indications will be brought to CPC over the coming months. The committee discussed issues pertinent to the proposed work, including the wide range of conditions in which botulinum toxin might be finding use and variations between trusts.

Botulinum toxin for the management of urinary incontinence due to detrusor overactivity

As part of work the being undertaken on the use of botulinum toxin (BoNT) a review has been undertaken with the aim of introducing a consistent commissioning policy for Devon regarding the use of BoNT in the management of overactive bladder. It is intended that a commissioning policy for urinary incontinence will help provide a logical and consistent CCG position for this indication. Emma Gitsham, Clinical Evidence Pharmacist, NEW Devon CCG presented a paper. Mr Julian Barrington, Consultant Obstetrician and Gynaecologist from Torbay Hospital, Mr Soumya Misra, Consultant Urologist from North Devon District Hospital, Mr Mark Stott, Consultant Urologist and Miss Melanie Walton, Urology Consultant from Royal Devon and Exeter NHS Foundation Trust took part in the discussion.

Expenditure on 319 procedures pan-Devon is estimated to be circa £250,000 annually. The proposed policy would not include patients with overactive bladder due to a neurological cause, since this commissioning responsibility belongs to NHS England. It was proposed that BoNT

injected into the bladder wall for overactive bladder would be available to patients only after the failure of conservative management options (including anticholinergic medication and mirabegron) and before surgical procedures or nerve stimulation. This pathway would be in harmony with the recently published NHS England clinical commissioning policy for sacral nerve stimulation for overactive bladder. The NHS England commissioning criteria include prior use or consideration of BoNT before sacral nerve stimulation may be provided. This clinical commissioning policy must be considered when making the final Devon-wide commissioning decision for BoNT to prevent blocking access to sacral-nerve stimulation for appropriate patients. The use of BoNT in adults for overactive bladder is supported by nationally recognised professional bodies including the National Institute for Health and Care Excellence (NICE), Scottish Medicines Consortium (SMC), British Association of Urological Surgeons (BAUS) and the European Association of Urology (EAU). Two NICE clinical guidelines make recommendations in support of the use of BoNT for overactive bladder in adult men and women. NICE assessed clinical evidence and a cost effectiveness analysis support the use of BoNT in women. NICE considered BoNT to be a more cost-effective intervention in comparison to no active treatment or sacral nerve stimulation. In 2010 the NICE recommendation for men were based on widespread clinical use at the time of forming the recommendation; NICE acknowledged the high treatment cost of BoNT and the alternative surgical options which are complex, involve major surgery and often result in unacceptable patient outcomes. A four year surveillance review by NICE in 2014 identified evidence in support of its use, which resulted in no change to the 2010 recommendations. The proposed commissioning policy for overactive bladder helps provide a logical and consistent CCG position for this indication.

The committee were asked to make a policy recommendation to the executive groups of NEW Devon CCG and South Devon and Torbay CCG regarding the commissioning policy for the use of bladder wall injection of BoNT for overactive bladder in adult male and female patients.

The committee discussed a number of issues pertinent to this recommendation:

- Specialists expressed general agreement with the paper; indicating that BoNT should be provided appropriately in line with NICE recommendations, following trial of conservative treatment options. Potential adverse side effects including infection were noted. Specialists considered that actual infection rates were less than the 25% quoted in the paper. Surgical options are expensive, complex and often result in adverse side effects.
- Response and criteria for repeated treatment with BoNT - considerable individual variation exists in the time for which patients gain benefit from injection with BoNT. However this is usually between 6 to 15 months. Response to treatment is usually a return to normal bladder function or no response. Over time a pattern can be identified for individuals and appointments for re-injection can be booked in advance.
- There are several different preparations of BoNT which have different formulations; not all preparations are licensed for the indication under review. The Trusts currently use different preparations for the management of urinary incontinence. Obtaining informed patient consent should an 'off-label' preparation be used for this indication remains the responsibility of each individual Trust.
- Vial sharing – in some indications for the use of BoNT vial sharing can reduce costs, however for urinary incontinence vials usually contain the appropriate dose for a single treatment and therefore they are generally not shared.
- Patients are treated in day patient and outpatients settings. It was agreed that the setting for administration of BoNT would be reviewed by the CCG's contracting teams with the aim of working towards a standardised and cost effective practice.

ACTION: Contracting teams at NEW Devon CCG and South Devon and Torbay CCG to review the setting in which administration of BoNT takes place with the aim of working towards a standardised and cost-effective practice.

- Variation in effectiveness in men and women – specialists noted that more clinical studies had been done in men than women. However in practice no difference was seen in the effectiveness of this treatment due to gender.

The committee voted unanimously in favour of recommending the routine commissioning of BoNT for the management of urinary incontinence due to detrusor overactivity.

ACTION: Policy recommendations and QEIAs to be prepared and subsequently progressed to final CCG approval and communication.

4. Botulinum toxin for the treatment of chronic anal fissure

As part of the work on the use of botulinum toxin (BoNT) a review has been undertaken with the aim of introducing a consistent commissioning policy for Devon regarding the use of BoNT for the treatment of chronic anal fissure. Bethan Rogers, Clinical Evidence Pharmacist, NEW Devon CCG presented a paper. Miss Clare Adams, Consultant Colorectal Surgeon, Plymouth Hospitals NHS Trust, Mrs Katie Cross, Consultant Colorectal Surgeon, Northern Devon Healthcare NHS Trust and Mr Nick Kenefick, Consultant Surgeon, South Devon Healthcare NHS Foundation Trust took part in the discussion.

Treatment with BoNT for this indication is currently off-label. The Association of Coloproctology of Great Britain and Ireland (ACPGBI) recommends 20-25 units of BoNT injected in 2 divided doses, into the internal sphincter on either side of the anal fissure. Treatment should be reserved for patients who have failed conservative management and topical treatment (glyceryl trinitrate [GTN] or diltiazem). Following failure of pharmacological treatments, surgical intervention may be considered. No NICE Clinical Guideline or Technology Appraisal exists for the use of BoNT for this indication. Local specialists follow the ACPGBI treatment algorithm.

The primary evidence sources for the efficacy of BoNT compared to lateral internal sphincterotomy (LIS) included 2 meta-analyses and 1 qualitative systematic review. Surgery was considered the appropriate clinical comparator since BoNT is only considered for patients who have failed previous topical treatments. No Randomised Control Trials (RCTs) comparing anal advancement flap with BoNT monotherapy were identified. Efficacy data in all 3 papers was largely based on the same RCTs. Cochrane meta-analysis of 5 RCTs found that injection with BoNT type A into the internal sphincter was not as effective as LIS at healing anal fissure. Cochrane considered efficacy as a combined 'non-healing' outcome including fissure persistence and recurrence. A further meta-analysis and qualitative review also found BoNT to be significantly less effective at fissure healing compared to LIS. These two additional reviews also considered fissure recurrence which was found to be significantly greater following treatment with BoNT. The follow-up period varied between RCTs; the majority of trials had a follow-up greater than 6 months. Duration of follow-up is important due to the fluctuating nature of the condition; trials with a shorter follow-up may not capture instances of later recurrence.

The risk of incontinence after surgical intervention is a key reason for trialling pharmacological treatment options before considering surgery. Reports suggest that up to 30% of patients have difficulty controlling flatus, 3-10% have episodes of leakage and up to 5% of patients experience anal incontinence following surgery. Two meta-analyses found the incidence of incontinence to be significantly greater following LIS compared to BoNT injection. Higher rates were also observed in the qualitative review. Two prospective non-randomised open-label trials demonstrated anal fissure healing in 43% and 85% of individuals who had previously failed treatment with topical 0.2% glyceryl trinitrate (GTN). In summary it was noted that BoNT was an established treatment option as recommended by the Royal College of Surgeons and ACPGBI. It was felt to represent an effective intervention with evidence supporting its efficacy in approximately 60% of patients. Furthermore it was associated with a lower risk of incontinence compared to surgical intervention.

No published cost-effectiveness analyses conducted for BoNT in anal fissure from an NHS perspective were identified. Drug costs for BoNT, at doses administered for chronic anal fissure, were roughly comparable to that of 8 weeks topical treatment with GTN or diltiazem, although costs vary with vial sharing. Additional costs were associated with BoNT administration which can be during an outpatient appointment or in theatre as a day case procedure. Administration in theatre was significantly more expensive compared to outpatient administration, although the cost in theatre remains consistent between patients receiving BoNT as a single intervention and those receiving multiple procedures. Surgical costs also varied with the choice of procedure (LIS or anal advancement flap). Patients undergoing surgical intervention were likely to have also undergone diagnostic investigations prior to surgery, which are associated with additional costs. Clinical practice appeared to vary between Trusts, with some Trusts providing an outpatient service in addition to day case administration and other Trusts administering all BoNT in theatre as a day case.

Subsequent to the circulation of the meeting papers an outstanding response was received from Plymouth Hospitals Trust (PHT) detailing the current service. The clinical effectiveness team estimate an additional cost per annum of £23,000 for NEW Devon CCG and £53,000 for South Devon and Torbay CCG if BoNT was not available for the treatment of chronic anal fissure, due to an increase in surgical procedures. However this cost was found to vary significantly with the treatment success of BoNT; at a BoNT failure rate of 20 – 30% a treatment pathway in which BoNT is available becomes more expensive than one without.

The committee were asked to make a policy recommendation to the executive groups of NEW Devon CCG and South Devon and Torbay CCG regarding the commissioning policy for the use of BoNT for the treatment of chronic anal fissure

The committee discussed a number of issues pertinent to this commissioning recommendation including:

- LIS and anal advancement flap are surgical options for patients who fail on pharmacological treatment options. In clinical practice there is a trend towards surgeons undertaking fewer LIS due to the risk of incontinence following surgery. As a result specialists suggest the number of anal advancement flaps performed may increase as surgeons become more familiar with this technique. Although more expensive than LIS, specialists suggest anal advancement flap is not associated with the same risk of long term sequelae.
- BoNT represents an established treatment option within the management pathway for chronic anal fissure. It is more expensive than topical treatments but has a lower risk of adverse events compared to surgery and was felt to be effective in clinical practice.
- The variation in the patient pathway between local trusts with regard to the setting in which administration of BoNT treatment takes place. In particular there are divergent clinical views on the need for general anaesthetic.
- A number of patients also need further investigation. This can be carried out at the same time as the BoNT injections are given in theatre.
- Hospitals differ in whether they allow surgeons to use the contents of one vial of BoNT to treat more than one patient. Since only a portion of a vial is used it saves money if this is allowed.

The committee voted 7-1 in favour of the routine commissioning of BoNT for the treatment of chronic anal fissure.

ACTION: Policy recommendations and QEIAs to be prepared and subsequently progressed to final CCG approval and communication.

It was agreed that Samantha Morton would set up a contracting meeting to work with each organisation regarding an audit of practice relating to the use of BoNT. Katie Cross stated that she would be happy to be involved.

ACTION: Samantha Morton to set up a contacting meeting regarding an audit of the use of botulinum toxin for the treatment of chronic anal fissure.

5. The referral and specialist management of haemorrhoids in adults

The proposed commissioning policy for NEW Devon and South Devon and Torbay CCGs aims to ensure equitable referral and specialist management of adults with haemorrhoids. Matt Howard, Clinical Evidence Manager, NEW Devon CCG presented a paper. Dr Alex Degan, GP, NEW Devon CCG, Miss Clare Adams, Consultant Colorectal Surgeon, Plymouth Hospitals NHS Trust, Mrs Katie Cross, Consultant Colorectal Surgeon, Northern Devon Healthcare NHS Trust and Mr Nick Kenefick, Consultant Surgeon, South Devon Healthcare NHS Foundation Trust took part in the discussion.

Currently no commissioning policies are in place across Devon for the referral and specialist management of haemorrhoids in adults. The proposed policy is based upon an interim clinical commissioning policy for haemorrhoidectomy published by NHS England in November 2013 and a commissioning guide for rectal bleeding published by the Royal College of Surgeons (RCS) in October 2013. The RCS guide is supported by the Association of Coloproctology for Great Britain and Ireland. The proposed policy is also broadly in line with the majority of haemorrhoid policies from other CCGs. It has been developed in conjunction with the GPs who act as Planned Care Leads for each locality in NEW Devon CCG and for South Devon and Torbay CCG. The intent to develop a commissioning policy for the referral and specialist management of haemorrhoids was

communicated to all surgeons identified by the four acute trusts in Devon. The proposed commissioning policy was also sent to all surgeons who expressed a wish to be involved in the development process, offering them an opportunity to comment.

The RCS commissioning guide for rectal bleeding states that any patient with rectal bleeding who meets the relevant criteria should be referred urgently under the two week wait guidelines. Patients meeting these criteria are outside the scope of this policy. The RCS guidance also recommends that urgent referral should be considered for patients with concerning symptoms which do not meet the two week wait criteria. Such patients would be expected to be referred with diagnostic uncertainty and as such would be outside the scope of this policy, which relates to patients in whom a clinical diagnosis of haemorrhoids has been made.

The estimated total annual expenditure on anal procedures for haemorrhoids in the financial year 2014/15 was nearly £600,000 for NEW Devon CCG, and approximately £195,000 for South Devon and Torbay CCG. Under the 2015/2016 tariff the same volume of procedures would result in annual expenditure for approximately £850,000 for NEW Devon and nearly £380,000 for South Devon and Torbay CCGs. Standardised data suggested that NEW Devon and South Devon and Torbay CCGs have higher rates of haemorrhoid procedure than the national mean, 18.9% higher and 33.4% higher respectively. The committee were asked to make a policy recommendation to the executive groups of NEW Devon CCG and South Devon and Torbay CCG regarding the commissioning policy for the referral and specialist management of haemorrhoids in adults.

The RCS commissioning guide states that:

- In low risk patients with rectal bleeding who are not overly anxious, it is reasonable to manage their symptoms with treatment and adopt a 'watch and wait' policy. Minimally symptomatic haemorrhoids may be safely observed.
- Patients with symptomatic haemorrhoids should be given advice about topical treatment, oral fluid intake, high fibre diet and fibre supplementation.
- Routine referral should be considered for patients with persistent or highly symptomatic haemorrhoids.
- Treatment of bleeding haemorrhoids depends on the degree of prolapse and severity of symptoms. Rubber band ligation currently provides the best available outpatient treatment for haemorrhoids with up to 80% of patients satisfied with short term outcomes.
- Surgery is reserved for bleeding or prolapsing haemorrhoids that have not responded to outpatient treatment.

Literature searches to identify publications studying cost or cost-effectiveness of haemorrhoid management produced no suitable studies. Local specialists suggested conducting a non-operative procedure such as rubber band ligation at the point of diagnosis with flexible sigmoidoscopy might be a more cost-effective option than discharging the patient to conservative management, and re-admitting a cohort of patients following treatment failure. Cost-analyses were conducted which suggested such a pathway would cost between £19,000 less to £11,000 more per 1,000 patients depending on outpatient appointment requirements.

Moderate quality evidence and expert opinion supports a watch and wait policy for minimally symptomatic haemorrhoids, with conservative management as the mainstay intervention for symptomatic haemorrhoids, followed by non-operative procedures then surgery depending on severity of disease and success/failure of previous interventions. This is supported by a number of professional organisations.

The committee discussed a number of issues pertinent to this policy:

- Some members of the committee expressed concern that GPs would be apprehensive about not referring people with rectal bleeding and discussed issues relating to diagnostic uncertainty and suspected malignancy. It was explained to the committee that this policy is only for patients who have a clear diagnosis of haemorrhoids and not for any patient where there is concern or further investigation is needed.
- It was noted that additional clinical appointments may be needed with the specialist and GP. Some specialists expressed a view that patients should be treated at the initial specialist appointment at which they were diagnosed as some of them would not respond to conservative management.

- The role of DRSS: It was noted that DRSS would not block any two week wait referral.

The committee voted unanimously to recommend the proposed policy.

ACTION: Policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication.

It was noted that there is no longer a tariff for the treatment of minor anal procedures as an outpatient. It was agreed that Samantha Morton and the CCGs' contracting teams would agree a local process.

ACTION: Local contracting process for the treatment of minor anal procedures as an outpatient to be agreed by the contracting teams of NEW Devon and South Devon and Torbay CCGs.

6. Any other business

There was no other business to report.

Summary of actions		
	Action	**Lead**
15/13	Recommendation and QEIA for the Assessment and removal of benign skin and subcutaneous lesions to be submitted to the CCGs' Executive Groups for approval. Further clarification of the referral pathway is required. The removal of benign skin and subcutaneous lesions is due to be discussed at the CPC meeting in September 2015.	Rebecca Heayn
15/17	*Specialist Management of Abdominal Wall Hernias in Adults: Policy Recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication.* The lay-member panel discussed the committee's recommendation and considered that no formal public consultation was required. The policy and QEIA have subsequently been signed off by both CCGs' Executives Groups. Patient support information to be produced to accompany publication of the policy.	Rebecca Heayn
15/18	*Cataract Surgery: Policy Recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication.* The lay-member panel discussed the committee's recommendation and considered that no formal public consultation was required. The policy and QEIA have subsequently been signed off by both CCGs' Executives Groups. Patient support information to be produced to accompany publication of the policy.	Rebecca Heayn
15/19	Contracting teams at NEW Devon CCG and South Devon and Torbay CCG to review the setting in which administration of botulinum toxin for the management of urinary incontinence due to detrusor activity takes place with the aim of working towards a standardised and cost-effective practice.	Samantha Morton
15/20	Policy recommendation and QEIA for the routine commissioning of botulinum toxin for the management of urinary incontinence due to detrusor activity to be prepared and subsequently progressed to final CCG approval and communication.	Rebecca Heayn
15/21	Policy recommendation and QEIA for the routine commissioning of BoNT for the treatment of chronic anal fissure to be prepared and subsequently progressed to final CCG approval and communication.	Rebecca Heayn
15/22	Contracting meeting regarding audit of the use of botulinum toxin for the treatment of chronic anal fissure to be set up.	Samantha Morton
15/23	Policy recommendation and QEIA for the referral and specialist management of haemorrhoids in adults to be prepared and subsequently progressed to final CCG approval and communication.	Rebecca Heayn
15/24	Local contracting process for the treatment of minor anal procedures as an outpatient to be agreed by the contracting teams of NEW Devon and South Devon and Torbay CCGs.	Samantha Morton