NHS
Devon
Clinical Commissioning Group

Clinical Policy Committee

MINUTES

Wednesday 22 May 2019, 9.30 am to 12.30 pm

Committee Suite, County Hall Exeter

Present:

Dr Jo Roberts (Chair)	Chair	NHS Devon CCG
Dr Glen Allaway	Voting Member	NHS Devon CCG
Paul Foster	Clinical Director of Pharmacy and Prescribing	T&SD NHS FT
Barbara Jones	Head of Contracting	NHS Devon CCG
Dr Lucy Harris	Voting Member	NHS Devon CCG
Dr Paul Melling	Voting Member	NHS Devon CCG
Mac Merrett	Lay Public Member	
Chris Roome	Head of Clinical Effectiveness	NHS Devon CCG
Peter Rowe	Consultant Nephrologist	University Hospitals
	Hon Associate Professor in Medicine	Plymouth NHS Trust
Simon Polak	Associate Chief Nursing Officer	NHS Devon CCG
Mark Taylor	Lay Public Member	
Dr Ben Waterfall	Voting Member	NHS Devon CCG
Dr Emily Youngman	Consultant in Public Health Medicine	Devon County Council

Guests:

Richard Haigh	Consultant Rheumatologist	RD&E NHS FT
Matt Howard	Clinical Evidence Manager	NHS Devon CCG
Hilary Pearce	Clinical Effectiveness Pharmacist	NHS Devon CCG
Naomi Scott	Healthcare Evidence Reviewer	NHS Devon CCG
Elizabeth Wilkinson	Consultant Ophthalmologist	NDHC NHS Trust

In attendance:

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

1. Welcome and announcements

Apologies

Dr Alison Round	Voting Member	NHS Devon CCG
Dr Andrew Craig	Voting Member	NHS Devon CCG
Richard Croker	Deputy Director for Medicines Optimisation	NHS Devon CCG
Dr Tawfique Daneshmend	Consultant Gastroenterologist & Hepatologist	RD&E NHS FT
Dr Andrew Harrison	Voting Member CCG	NHS Devon CCG
Dr Stuart Kyle	Consultant Rheumatologist	NDHC NHS FT

Confirmation of voting members and Declarations of Interest

The seven voting members present were identified.

Dr Ali Round had requested Chris Roome to deputise as voting member in her absence.
Andrew Harrison had delegated voting to Dr Peter Rowe.
Dr Andy Craig had delegated voting to Paul Foster.

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
Hydroxychloroquine monitoring schedule	a) Suppliers of relevant retinal imaging equipment b) Providers of private ophthalmic services
Dupuytren's contracture treatment	As a provider of private treatments for patients with Dupuytren's contracture
Surgery for carpal tunnel syndrome	As a provider of private treatments for patients with carpal tunnel syndrome
Surgery for ganglion cyst	As a provider of private treatments for patients with ganglion cyst

Name of Attendee	Role	Declaration
Dr Elizabeth Wilkinson	Consultant Ophthalmologist	Lecturer, adviser and in receipt of conference fees/travelling grants for pharmaceutical companies eg Bayer and Novartis NOT RELATED to Hydroxychloroquine. Sponsorship from Imaging companies received by Royal Society of Medicine by Imaging Companies (Zeiss, Topcon, Heidelberg) for National Diabetic Eye Screening Conference 2019 organised by me.

		Employed by Health Intelligence as NHS Diabetic Eye Screening Clinical Lead for Devon.

Notification of Any Other Business

Members were asked if there were any items of AOB for consideration.

2. Minutes of the meeting held on 27th January 2019 and matters/actions arising

The minutes of the meeting held on 27th March 2019 were approved.

Summary of actions

	Action	**Lead**
19/01	*Surgical treatment options for lower urinary tract symptoms caused by benign prostatic hyperplasia.* *Committee recommendations to be submitted to the CCGs to inform senior level commissioning discussions for services for this condition.* Formal approval though the CCG governance processes is awaited.	Rebecca Heayn
19/05	Semaglutide (Ozempic®) for the treatment of type 2 diabetes: Policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication. Formal approval though the CCG governance processes is awaited.	Rebecca Heayn
19/06	Review of FreeStyle Libre for interstitial glucose monitoring in diabetes: Policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication. Formal approval though the CCG governance processes is awaited.	Rebecca Heayn
19/07	Review: Policy for the referral and specialist management of meibomian cysts (chalazia): Clinical scenario for suspected abscess to be reflected in the CRG to support urgent referrals of appropriate patients. It is expected that this has been completed. Confirmation to be sought.	Lucinda Harris

19/08	Review: Policy for the referral and specialist management of meibomian cysts (chalazia): Policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication. Formal approval though the CCG governance processes is awaited.	Rebecca Heayn
19/09	Review: Policy for Breast Reduction: Policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication. Formal approval though the CCG governance processes is awaited.	Rebecca Heayn

3. Hydroxychloroquine monitoring schedule

The Royal College of Ophthalmologists (RCO) issued updated guidance for hydroxychloroquine retinopathy in 2018. Under the previous guidance, patients were required to undergo an annual visual acuity test at a high street optometrist. The updated guidance requires a consultant-led service to monitor patients receiving hydroxychloroquine.

The pathway for testing recommended by the RCO was discussed by the committee at the January meeting of CPC. This discussion was held to address the frequency of ophthalmological monitoring for patients receiving hydroxychloroquine. The RCO guidance recommends annual ophthalmological reviews after five cumulative years of treatment for all patients, and annual review may be considered before five years of treatment for selected patients with risk factors for retinopathy.

A paper was circulated to the committee prior to the meeting. It was noted that the RCO guidance is based on a study conducted in the U.S.A (Melles et al, 2014). This was a retrospective study of patients registered with a U.S.A. healthcare system who received a minimum of five years of continuous treatment with hydroxychloroquine. The RCO has not provided a rationale for monitoring all patients at annual intervals after five years of treatment. Review of the study by Melles et al showed that the recommendation for annual monitoring does not reflect differences in the risk of retinal toxicity over time or variation in risk at different doses. Previous discussion had highlighted that ophthalmology departments would find it difficult to incorporate the intensity of monitoring recommended in the guidelines and that they felt these were disproportionate to the risk to sight whilst threatening services for patients with higher risk conditions. In light of this, the committee were presented with two alternative schedules for monitoring patients before five years of treatment and four alternative monitoring schedules after five years of treatment. These alternative schedules took into account to varying degrees the factors associated with a particularly high risk of retinopathy and the effect of duration of treatment on the risk of retinopathy reported by Melles et al. All patients will be monitored at five years of treatment regardless of the monitoring schedules recommended by the committee.

The committee was asked to consider whether the RCO monitoring schedule should be implemented or an alternative monitoring schedule.

The committee considered issues pertinent to monitoring for hydroxychloroquine retinopathy. The main points of the discussion included:

- Currently, no monitoring takes place in Devon. The CCG is working towards establishing a consultant-led monitoring service.
- Specialist opinion stated that although the risk to a patient of experiencing hydroxychloroquine retinopathy is generally very low the system has a duty of care to monitor patients for a condition caused by treatment provided by the NHS.
- Full implementation of the RCO guidelines would have a considerable impact on resources and may disadvantage patients with conditions that are more threatening to sight. Staff would have to be trained and monitoring of patients receiving hydroxychloroquine may detect other conditions which may then need further investigation.
- Other areas in England in which the full RCO guidelines have been implemented are struggling with capacity. The frequency of patient review recommended by the RCO has implications for the resource and capacity of the ophthalmology services in Devon.
- The committee heard feedback gained from the RCO annual congress that other areas presented on their experience and described services that were struggling to accommodate the RCO monitoring into their service whilst finding very few cases of retinopathy with far lower prevalence than expected from published studies when the RCO criteria for retinopathy were applied.
- Studies from the U.S. have shown that are variations in the type of hydroxychloroquine retinopathy between ethnic groups. The committee heard from the ophthalmologist present that the ethnicity of patients in these studies is very different from the population of patients in Devon, and there is no need for additional measures.
- It was noted that there is no cure for hydroxychloroquine retinopathy. However, if the drug is stopped when retinopathy is at an early stage visual acuity is likely to remain good.
- A pragmatic approach to the implementation of the RCO guidelines is required so that patients at risk of hydroxychloroquine retinopathy are targeted for monitoring.
- The ophthalmologist attending the meeting expressed the view that ophthalmology departments would not operate a call/recall service for monitoring patients receiving hydroxychloroquine. If rheumatology specialists referring patients complete the relevant paperwork, then patients would be monitored by ophthalmology. The rheumatologist present agreed that rheumatologists should take some responsibility for referring patients to ophthalmologists.
- GPs hold responsibility when prescribing. The Local Medical Committee (LMC) have indicated they would want the provider to have a recall system.
- Hydroxychloroquine retinopathy progresses slowly. The RCO guidance indicates that some patients with early stage retinopathy may wish to continue treatment with hydroxychloroquine.
- The committee noted that locally a service review is underway focusing on sustainable services for conditions with a high risk of sight loss. NHS England is also undertaking a national review of ophthalmology services. A query was raised that if capacity is materially increased the frequency of monitoring for hydroxychloroquine retinopathy could be looked at again.
- Remote screening was discussed but this would still require consultant ophthalmologist review of the results.

All patients will be monitored at five years of treatment. The committee was asked to make recommendations on the proposed options for monitoring of patients before 5 years of treatment and for monitoring after 5 years of treatment.

Option A. Before 5 years of treatment
The committee was asked whether it recommended the implementation of the RCO monitoring schedule or an alternative monitoring schedule.

The committee voted unanimously in favour of recommending monitoring at year three for patients receiving 400mg/day and for patients receiving concurrent tamoxifen.

Option B. After 5 years of treatment
The committee was asked whether it recommended the implementation of the RCO monitoring schedule or an alternative monitoring schedule.

The committee voted unanimously in favour of recommending monitoring for patients receiving 400mg/day and also patients receiving tamoxifen: every two years until year 11 (unless test results indicate annual monitoring) and annually thereafter. For patients receiving 200mg/day: at year 10 (unless test results indicate annual monitoring) and every two years thereafter (unless test results indicate annual monitoring).

ACTION: These recommendations to be incorporated into the development of a commissioning specification for monitoring patients for hydroxychloroquine retinopathy.

4. Review: Policy for Dupuytren's contracture treatment

NHS England (NHSE) issued statutory guidance to Clinical Commissioning Groups (CCGs) in November 2018 to introduce and implement commissioning policies for selected interventions. Naomi Scott, Healthcare Evidence Reviewer, NHS Devon CCG presented a paper.

NHSE has described surgery for Dupuytren's contracture as an intervention that should only be commissioned or performed when specific criteria are met and set targets to reduce dupuytren's contracture surgery activity. The NHSE criteria and the current Devon CCG policy are broadly similar. The NHSE criteria differs to the current CCG policy in two ways:

The current policy states that surgical treatment for Dupuytren's contracture will be commissioned when there is "any degree of proximal interphalangeal joint contracture" whereas the NHSE criteria states an intervention should be considered when finger contractures cause the loss of finger extension of 20º.

The current policy states surgical treatment for Dupuytren's contracture will be routinely commissioned when there is "significant functional impairment" or "where there is significant threat to hand function due to Dupuytren's diathesis" whereas the NHSE criteria states an intervention should be considered for "severe thumb contractures which interfere with function".

Although the proposed NHSE criteria appears to be more stringent than the current policy local specialists have indicated that they would not expect the implementation of the NHSE criteria to alter referral numbers or surgical activity in Devon as it largely reflects current practice. Specialists noted that the NHSE criteria were developed with the British Society for Surgery of the Hand and that adopting the proposed criteria would help to keep a consistent approach. Concerns were raised by Devon Referral Support Services (DRSS) regarding the increased workload to support GPs if a change in policy was to occur, although this could be reduced as NHSE has announced the intention to release a suite of supporting materials.

The consultation consistently indicated that the reduction target set by NHSE was not likely to be met whether the NHSE criteria were adopted or the existing local policy maintained. However, a difference in policy from the NHSE criteria could give rise to a suggestion that it is the policy difference that contributes to the failure to reach the target.

The committee was asked to consider whether the NHSE guidance should be adopted or whether the current local policy should be maintained.

The committee discussed issues pertinent to the adoption of the NHSE guidance:

- The targets set by NHSE are the 25th percentile of all CCGs activity rates. This means that for any intervention in the Evidence Based Interventions (EBI) programme 75% of all CCGs have a target to reduce activity. NHSE have not assessed whether their criteria will lead to this target reduction.
- It was noted that, in general, the specialists state that patients receiving surgery locally are already more severely affected than the current CCG policy suggests before surgical treatment is considered.
- Specialist opinion indicated that adoption of the NHSE guidance will not impact on the treatment of patients.
- If the NHSE guidance is not adopted and the number of patients treated does not meet the NHSE target, NHSE may cite not adopting and ensuring implementation of their new criteria as the reason.

The committee voted 4 to 3 in favour of recommending adoption of the NHSE guidelines.

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

5. Review: Policy for surgery for carpal tunnel syndrome

Surgery for carpal tunnel syndrome is the second policy for hand surgery under NHS England's (NHSEs) evidence-based interventions programme. A member of the Clinical Effectiveness Team presented a paper.

NHSE has described surgery for carpal tunnel syndrome as an intervention that should only be commissioned or performed when specific criteria are met and has set a target for a reduction in surgery for carpal tunnel syndrome of 20% across Devon. A comparison between the NHSE criteria and the CCGs' existing policy was provided in the meeting papers.

The NHSE criteria and Devon CCG's policy adopt the same approach to the management of symptoms of neurological deficit; there is no prerequisite for conservative treatment for patients with these symptoms. Otherwise, the NHSE criteria are stricter than the CCG's policy as surgery is only commissioned for patients with symptoms affecting sleep or daily activities and failure of conservative treatment is required before surgery is considered. In contrast, under the existing CCG policy, conservative treatment before surgery is not required for patients suffering from significant functional impairment, pain or sleep deprivation. The CCG's policy also commissions surgery following failure of three months of conservative treatment but does not stipulate any further conditions in respect of this.

Local specialists support the adoption of the NHSE criteria. Although the proposed NHSE criteria appears to be more stringent than the current policy, local specialists have indicated that they would not expect the implementation of the NHSE criteria to alter surgical activity in Devon as it largely reflects current practice. This suggests that specialists do not operate on all patients who are referred under the current CCG policy.

The requirement, under the NHSE policy, for the patient to have significant symptoms that have not settled with conservative management will result in Devon Referral Support Services (DRSS) returning some referrals that would have progressed to secondary care under the previous policy. This will have the benefit of better targeting specialists time in outpatient clinics to assessing patients who are more likely to meet surgical criteria.

At the request of DRSS GP referral facilitators, the current interval between conservative treatment (a corticosteroid injection or night splints) and surgery has been retained at 12 weeks rather than the minimum of 8 weeks recommended by NHSE. A twelve-week interval is well established in local general practice and changing it is felt to unnecessarily cause potential confusion over criteria for surgery and the need for GP re-education on the Devon CCG's policy criteria, with little overall clinical benefit.

The committee was asked to recommend whether the NHSE criteria for surgery for carpal tunnel syndrome (with the amendment of conservative management for 12 weeks rather than 8) should be adopted into the local commissioning policy or whether the current local policy should be maintained.

The committee discussed issues pertinent to the adoption of the NHSE guidance:

- There was interest in the comments submitted by specialists. It was suggested that some patients are being referred at a late stage when surgery may be less effective. Information could be added to the clinical referral guidance and communicated to GPs to encourage earlier referral when symptoms of neurological deficit are present and to discourage multiple injections.

The committee voted 6 to 1 in favour of recommending adoption of the NHSE guidelines.

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

6. Review: Policy for surgery for ganglion cyst

Surgery for ganglion cyst is the third policy for hand surgery under NHS England's (NHSEs) evidence-based interventions programme. NHSE has described ganglion excision as an intervention that should only be commissioned or performed when specific criteria are met. A member of the Clinical Effectiveness Team presented a paper.

NHSE has set a target for a reduction in surgery for ganglion by 29% across Devon.

The differences between the NHSE criteria and the Devon CCG policy are:

- The NHSE criteria for surgery requires all patients with a wrist or seed ganglion to undergo aspiration of the ganglion cyst before surgery can be considered.
- For wrist ganglia, surgery is only commissioned if aspiration fails to resolve the symptoms and there is restricted hand movement, and for seed ganglia if the ganglia persist or recur. In comparison, the CCG commissions surgery if the ganglion causes significant pain or significant functional impairment; prior aspiration of the ganglion is not a prerequisite for surgery.
- When the CCG's policy was developed, the Devon Referral Support Services (DRSS) GP referral facilitators acknowledged that not all GPs would be able to aspirate a ganglion cyst. The proposed policy has been amended to enable aspiration to be undertaken by the GP or when the patient is referred to secondary care. Monitoring through Blueteq would be used in secondary care to ensure the patient met the criterion for surgical excision.

- DRSS GP referral facilitators requested retention of current CCG criterion of significant pain or significant functional impairment for wrist ganglion as these terms were considered to be less subjective than the NHSE criterion.
- The NHSE criteria includes aspiration for cysts which are a concern for the patient due to their worries about the possibility of cancer. Treatment of asymptomatic ganglion cysts is currently not routinely commissioned in Devon. In cases of a cancer concern the GP would refer via the appropriate 2-week wait pathway.
- Both the NHSE criteria and CCG policy commission surgery for mucoid (myxoid) cysts if there is discharge from the cyst. However, NHSE also commission surgery if there is a significant nail deformity. Surgery for cases of this nature were not included in the CCG's policy as a nail deformity was considered to be cosmetic. Consultation with specialists identified that the current Devon CCG criterion for surgery for mucoid cyst is more representative of mucoid cysts requiring a surgical procedure than the NHSE criterion
- The Devon CCG policy for surgery for ganglion cyst also covers lower limb ganglion cysts. The CCG's policy criterion for lower limb ganglion will be included in the updated policy but will remain unchanged as it falls outside of the scope of the NHSE criteria.

Wrist and Seed Ganglia

The CPC was asked to recommend whether for wrist and seed ganglia the Devon CCG's policy criteria should be maintained or the NHSE criteria should be adopted into local commissioning with other decisions to be made.

The Committee voted 5 to 2 in favour of recommending adoption of the NHSE policy criteria, with modifications to be voted on.

The Committee was then asked to make two further recommendations associated with the NHSE policy criteria for wrist and seed ganglia.

The first was whether the CCG should include the NHSE policy wording for aspiration for cysts which are a concern for the patient due to their worries about the possibility of cancer.

The committee voted unanimously against recommending inclusion of this policy wording.

The second was with reference to wrist ganglia, whether the CCG should retain the current wording of significant pain or significant functional impairment in preference to the NHSE wording of unqualified pain or restricted hand function.

The committee voted 5 to 2 in favour of recommending retaining the current wording.

Mucoid cysts

The Committee was asked to make a decision on whether to recommend adoption of NHSE's criteria for mucoid cysts or retention of the current CCG's criteria.

The committee voted unanimously in favour of recommending retention of the current CCG's criteria.

Lower limb ganglion

The committee was asked to make a decision on whether to recommend retention of the CCG's criterion for surgery for lower limb ganglion as this falls outside the scope of the NHSE criteria.

The committee voted unanimously in favour of retention of the CCG's criterion for surgery for lower limb ganglia.

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

7. Clinical Policy Committee Annual Report 2018-19

The committee received the Clinical Policy Committee Annual Report 2018-19.

It is acknowledged that from 1 April 2019 NEW Devon CCG and South Devon and Torbay CCG formally merged to become a single organisation, NHS Devon CCG. However, the Clinical Policy Committee has operated Devon wide since the inception of the CCGs in 2013.

Five meetings were held last year, considering 16 evidence assessments which resulted in 24 commissioning policy recommendations. One previous commissioning policy has also been unpublished in light of changes in clinical practice as a result of NICE drug recommendations.

Engagement with local clinical specialists takes place as part of the assessment process, and they are invited to attend meetings to contribute to discussions.

The CCGs identified that the Clinical Policy Committee is a potential expert resource to help the organisations form positions regarding some aspects of the commissioning arrangements for clinical services, in addition to its existing role in the development of commissioning policy recommendations. Two of the agenda items at the meeting in January 2019 were focused on this additional role of the committee.

Dr Nick D'Arcy and Dr Andrew Harrison were welcomed as two new voting members to the committee, joining in May 2018 and July 2018 respectively, to fill an existing vacancy plus the vacancy resulting from Dr Mick Braddick stepping down from the committee due to retirement in March 2018.

In addition to the voting members, the committee is supported by advisory members. This includes two lay public members, who ensure that the public interest of the local population is represented in discussion and decision making.

The clinical policy engagement and consultation panel continues to support the CPC and the CCGs by providing a separate opportunity to reflect on the policy recommendations and consider the public interest issues, and to determine the need for any further engagement or formal consultation to be carried out prior to a final decision being taken by the CCGs. The process and any resulting engagement or consultation precedes the CCG taking a final decision on whether to accept a clinical policy recommendation.

All policy recommendations have a Quality and Equality Impact Assessment (QEIA) undertaken as an integral step in the process following the recommendation of the committee. These are considered by the clinical policy engagement and consultation panel, submitted to the QEIA authorisation panel for approval, and submitted to the CCG along with the final policy recommendation for approval.

The annual report will be submitted to the CCG for acceptance and assurance. Following the formal merger of the CCGs, the terms of reference, appeals process, communication framework and other support materials have been refreshed.

CPC received the report as a record of activity in 2018-19. The report will be submitted to the CCG's governing body for information and assurance. It will then be published via the website to ensure it is publicly available.

The committee thanked Rebecca Heayn for producing an excellent annual report and the Clinical Effectiveness Team for producing high quality meeting papers.

ACTION: Report to be submitted to the CCG's governing body to be received and ratified.

ACTION: Once ratified the annual report will be published and made publicly available via the CCG website.

8. Revised Clinical Policy Committee Terms of Reference (ToR)

The committee received the update ToR for the Clinical Policy Committee. The ToR had been refreshed from the 1st of April 2019 to take into account the merger of the two previous CCGs into NHS Devon CCG. Otherwise the ToR remain largely unchanged.

9. Update from NICE Planning Advisory Group (NPAG)

The committee received an update of the NICE Planning Advisory Group meeting held on 2nd April 2019.

NPAG had considered eight NICE Technology Appraisals, all of which are NHS England Commissioned.

Other guidelines and guidance considered by NICE included four clinical guidelines, one piece of diagnostic guidance, four pieces of medical technology guidance and seven pieces of interventional procedures guidance.

The committee discussed issues pertinent to the NPAG meeting, including how the group was working. It was noted that the group is comprised of a small group of regular attendees. The significant contribution made by Susan Drew from the Nursing and Quality team was noted.

10. Clinical Policy Engagement and Consultation Panel Annual Report 2018 -19

The committee received the 2018-19 annual report of the Clinical Policy Engagement and Consultation Panel, which exists to support the CCGs in Devon to determine the need for any further engagement or formal public consultation on clinical policy recommendations made by the Clinical Policy Committee.

It was acknowledged that from 1 April 2019 NEW Devon CCG and South Devon and Torbay CCG formally merged to become a single organisation, NHS Devon CCG. However, the Clinical Policy Engagement and Consultation Panel has been in existence and has supported the Devon-wide clinical policy processes since 2015.

Five meetings were held last year, considering and making recommendations on 18 clinical policy recommendations. The panel were satisfied that the public interest issues had been fully considered and that further engagement or consultation would not yield additional insights. However, they made some recommendations in relation to specific policy proposals to support the communication and implementation of these across Devon:

- Reversal of male and female sterilisation and Assisted conception

  The panel recommended that considerations relating to eligibility for assessment and treatment of infertility should also be included within the letter that the Clinical Policy Committee had proposed be sent to specialists alongside the reversal of sterilisation policy to reinforce the consent process considerations for sterilisation procedure. As a result the letter to specialists which accompanied publication of the final policy made reference to the fact that patients who opt for sterilisation would be rendering themselves ineligible for future Assisted Conception as the Assisted Conception policy specifically excludes those who have had sterilisation reversed.

  The panel also recommended revised wording of the exceptionality statement for the reversal of male and female sterilisation policy to aid clarity. This allows for application to the Individual Funding Request (IFR) Panel for the consideration of treatment of an individual patient who does not meet the criteria set out in the general policy position. However, in this instance as the policy statement was simply that the reversal of sterilisation is not routinely commissioned, alternative exceptionality wording was recommended in this instance as no specific “criteria” are detailed within the policy.

- NHS England (NHSE) Evidence based interventions guidance for CCGs

  The panel considered that NHSE has already conducted a lengthy consultation on their statutory guidance, with which the CCG had actively engaged. However, it was questioned what local people would know about the national consultation and how to get the message out in terms of public education that these interventions may be unnecessary or less effective than other non-surgical options.

  It was acknowledged that there is a difference between information and education; if information leaflets for patients were produced, these would need to be supported by CCGs and specialists and may be difficult to produce locally. Further, if numerous CCGs produce local materials in respect of the national guidance this is also likely to lead to numerous differing leaflets across the country. It was discussed that it would be preferable if support materials were produced once, nationally, to support this programme of work.

  It was noted that the CCGs in Devon are part of a national NHS England demonstrator community in respect of the evidence-based interventions programme. It was recommended the need for support materials to be produced nationally to support patients and clinicians in respect of these interventions, as an extension to patient decision aid materials, should be fed into this process.

  The panel welcomed Nick Pearson, Head of Communications and Engagement in February 2019, replacing Ray Chalmers, who had been a valued advisory member of the panel for three years providing sound judgment and wisdom on matters relating to communications and engagement for the benefit of the panel.

  Chris Peach and Jennie Willmott attended their final meeting in February 2019 as they stepped down from their Governing Body roles with South Devon and Torbay CCG and NEW Devon CCG respectively. Following their departure there has been discussion of suitable replacement lay members on the panel with Andrew Millward to ensure its continued operation. As a result Charlotte Burrows, the new CCG Governing Body lay

member for patient and public involvement and Carol McCormack-Hole, one of the Patient Engagement Forum members will be joining the panel.

The annual report will be submitted to the CCG for acceptance and assurance. Following the formal merger of the CCGs, the terms of reference, including membership and reporting arrangements has been revised.

ACTION: Annual report to be submitted to the CCGs governing body for acceptance and assurance.

11. Update from Clinical Policy Engagement and Consultation Panel

The committee received an update from the Clinical Policy Engagement and Consultation Panel meeting which took place on 30th April 2019.

Five items were discussed:

- Surgical treatment for lower urinary tract symptoms caused by benign prostatic hyperplasia.

The panel recommended that no further engagement or formal consultation was required at this point.

- Semaglutide tor type 2 diabetes

The panel recommended that no further engagement or formal consultation was required at this point.

- Freestyle Libre device for interstitial glucose monitoring in diabetes.

The panel recommended that no further engagement or formal consultation was required at this point.

- The routine referral and specialist management of meibomian cysts (chalazia)

The panel recommended that no further engagement or formal consultation was required at this point.

- Breast reduction surgery

The panel recommended that no further engagement or formal consultation was required at this point. However it was suggested that clinical policy patient support information should be produced to accompany and support publication of the policy.

12. Any other Business

There was no other business to report.

Summary of actions

	Action	**Lead**
19/01	*Surgical treatment options for lower urinary tract symptoms caused by benign prostatic hyperplasia.* *Committee recommendations to be submitted to the CCGs to inform senior level commissioning discussions for services for this condition.* Formal approval though the CCG governance processes is awaited.	Rebecca Heayn
19/05	Semaglutide (Ozempic®) for the treatment of type 2 diabetes: Policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication**.** Formal approval though the CCG governance processes is awaited.	Rebecca Heayn
19/06	Review of FreeStyle Libre for interstitial glucose monitoring in diabetes: Policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication. Formal approval though the CCG governance processes is awaited.	Rebecca Heayn
19/07	Review: Policy for the referral and specialist management of meibomian cysts (chalazia): Clinical scenario for suspected abscess to be reflected in the CRG to support urgent referrals of appropriate patients. It is expected that the has been completed. Confirmation to be sought.	Lucinda Harris
19/08	Review: Policy for the referral and specialist management of meibomian cysts (chalazia): Policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication. Formal approval though the CCG governance processes is awaited.	Rebecca Heayn
19/09	Review: Policy for Breast Reduction: Policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication. Formal approval though the CCG governance processes is awaited.	Rebecca Heayn
19/10	Hydroxychloroquine monitoring schedule - recommendations to be incorporated into the development of a commissioning specification for monitoring patients for hydroxychloroquine retinopathy.	Chris Roome

19/11	Review: Policy for Dupuytren's contracture treatment – policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication.	Rebecca Heayn
19/12	Review: Policy for surgery for carpel tunnel syndrome – policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication.	Rebecca Heayn
19/13	Review: Policy for surgery for ganglion cyst – policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication.	Rebecca Heayn
19/14	Clinical Policy Committee Annual Report 2018-19 – Report to be submitted to the CCGs governing body to be received and ratified.	Rebecca Heayn
19/15	Once Ratified CPC annual report to be published and made publicly available via the CCG website.	Rebecca Heayn
19/16	Clinical Policy Engagement and Consultation Panel Annual Report 2018 – 19 to be submitted to the CCGs governing body for acceptance and assurance.	Rebecca Heayn