Northern, Eastern and Western Devon
Clinical Commissioning Group

South Devon and Torbay
Clinical Commissioning Group

Clinical Policy Committee

Minutes

Wednesday 27th September 2017, 9.30 am to 12.30

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
Rob Cowdry	Contracts Governance Manager	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 FT
Dr Lucy Harris*	GP Clinical Commissioner	South Devon & Torbay CCG
Mac Merrett	Lay Public Member	
Tracey Polak	Assistant Director/Consultant of Public Health	Devon County Council
Simon Polak	Deputy Chief Nursing Officer	NEW Devon 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:

Dr Umesh Acharya	Consultant Gynaecologist	Derriford Hospital
Sally Doidge	Principal Embryologist	Derriford Hospital
Matt Howard	Clinical Evidence Manager	NEW Devon CCG
Dr Lisa Joels	Consultant Gynaecologist	RD&E NHS FT
Hilary Pearce	Clinical Effectiveness Pharmacist	NEW Devon CCG
Joanne Wilson	Senior Clinical Embryologist	RD&E NHS FT

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 introductions

Attendees were welcomed to the meeting.

Apologies

Dr Glen Allaway	GP Clinical Commissioner	NEW Devon CCG
Dr Andrew Gunatilleke	Consultant in Pain Management & Anaesthesia	T&SD NHS FT
Mark Taylor	Lay Public Member	
Paul Foster	Chief Pharmacist	T&SD NHS FT
Miles Earl	Contract Accountant	NEW Devon CCG
Barbara Jones	Head of Locality Contracting	NEW Devon CCG
Dr Andrew Craig	GP Clinical Commissioner	NEW Devon CCG

The seven voting members present were identified.

Dr Glen Allaway had deputised to Richard Croker
Dr Andy Craig had deputised to Chris Roome

Declarations of interest

Declarations of interest were collected. The chair reviewed the Declarations of Interest. All Declarations of interest are reported in the minutes.

Notification of Any Other Business

Members were asked if they had any items of AOB to discuss. No items were identified.

DRUG/TECHNOLOGY TO BE CONSIDERED	PHARMACEUTICAL COMPANY / MANUFACTURER / SERVICE PROVIDER
Assisted conception and cryopreservation	Providers of assisted conception and cryopreservation services
Access to Assisted Conception for users of e-cigarettes and nicotine replacement therapy	Manufacturers of nicotine replacement therapy or e-cigarette products

NAME OF ATTENDEE	ROLE	
Dr Umesh Acharya	Consultant	In past five years have been to two meetings with travel and accommodation being paid by Ferring and Pharmasure. Also paid by Merck for giving a talk.
Rob Cowdry	Contracts Governance Manager	Family member with a medical condition related to one of the policies under discussion. Took no part in this discussion.
Lisa Joels	Consultant Gynaecologist and Person Responsible for Fertility Centre.	Work in Fertility Exeter, an IVF clinic which is part of the RD&E. Do not undertake any private practice but decisions about IVF treatment could affect the workload and referral patterns to the clinic.

2. Minutes of the meeting held on 26th July 2017 and matters/actions arising

The minutes of the meeting held on 26th July 2017 were approved.

Summary of actions		
	Action	Lead
17/11	Safinamide (Xadago®) for mid- to late-stage fluctuating Parkinson's Disease: Policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication. The policy recommendation and QEIA have been signed off by the executive committees of NEW Devon CCG and of South Devon and Torbay CCG. The policy has subsequently been published. Action complete.	
17/12	Tiotropium bromide monohydrate and olodaterol hydrochloride (Spiolto® Respimat®) combination inhaler for chronic obstructive pulmonary disease (COPD): Policy recommendation and QEIA to be prepared and subsequently progressed to final CCG approval and communication. The policy recommendation and QEIA have been signed off by the executive committees of NEW Devon CCG and of South Devon and Torbay CCG. The policy has subsequently been published. Action complete.	
17/13	The wording of the policy for the specialist management of abdominal wall hernia in adults to be compared with that of the Gloucestershire policy, further local specialist input sought and their suggested revisions to be brought back to the committee. Action complete	

3. Cryopreservation to preserve fertility policy

The CCGs' policy for cryopreservation to preserve fertility was issued in April 2015 following publication of the NICE clinical guideline for fertility (CG156). Currently, cryopreservation is commissioned for patients of any age, the storage period is the same for all patients. The CCGs' Individual Funding Request Panel has asked for the policy to be reconsidered. A member of the Clinical Effectiveness Team, NEW Devon CCG presented a paper. Dr Umesh Acharya, Consultant Gynaecologist and Sally Doidge, Principal Embryologist at Derriford Hospital and Dr Lisa Joels, Consultant Gynaecologist and Joanne Wilson, Senior Clinical Embryologist, Royal Devon and Exeter NHS Foundation Trust took part in the discussion.

NICE guidance indicates that there is low usage of stored samples. Audits from other fertility centres report that often fewer than 15% of stored samples are used and local experience concurs. Resources are thinly spread and not targeted to those who would be most likely to benefit. The proposed changes are intended to support patients who are most likely to use their stored samples, they also reflect statutory requirements for extension to storage. The committee discussed issues pertinent to this recommendation:

- The proposed changes target resources to younger patients who have not had the opportunity to have a family by extending the time for which their samples can be stored beyond ten years. The upper age limit for patients to store their samples is thirty-nine years.

Specialists present stated that this was a big step forward for younger patients. The proposed policy would apply from the date of publication for patients who have cryopreserved material as well as for new patients.

- It is not possible to determine a precise estimate of the cost implications of changes to the criteria for funding for storage of samples. Some patients will no longer be eligible for initial storage or continuation of storage. Others will be eligible for longer storage of their sample. On balance the budget impact was not thought to be great.
- No changes have been made to the policy for patients taking teratogenic drugs. There was discussion with regard to the lack of a definitive list regarding which drugs are teratogenic and the difficulties of advising patients. Specialists reported that they use drug information pharmacists and other resources in their work advising women on teratogenic risks.
- There was discussion about gonadotoxic drugs and patients for whom stopping treatment is not an option. This patient group are included in the proposed changes to the policy.
- Routine funding of cryopreservation is not available for patients who wish to delay conception for social or lifestyle reasons and do not meet criteria for funding.

The committee voted unanimously in favour of recommending that the criteria for routine funding include:

- an upper age limit of 39 years for all patients,
- clarification that funding for the long term use of gonadotoxic and teratogenic drugs will only be considered for patients in whom stopping treatment for a prolonged period of time to enable conception is not an option.

The committee voted unanimously in favour of recommending that the criteria for which funding is not routinely provided include:

- clarification that sterilisation includes individuals in whom sterilisation has been reversed
- clarification of criteria for individuals who wish to delay conception and do not meet criteria for routine funding

The committee discussed issues pertinent to the renewal of storage at intervals of five years and enabling storage beyond ten years for younger patients:

- Storage of samples falls under statutory regulations and guidance from the Human Fertilisation and Embryology Authority (HFEA).
- Rescinding the need for all patients to apply for continuation of storage of their sample every five years through the Individual Funding Request Panel if the criteria for storage are still being met. At a previous CPC meeting it was decided that all patients must apply for continuation of storage of their samples after the initial five years for a total of ten years. This is currently done via the Panel. A query was raised as to whether it was still necessary for all cases due for renewal to be taken to the Panel and whether the paperwork could be simplified. The Panel is meant for use by patients whose circumstances are exceptional. This is not the case for younger patients requesting an extension to the storage of their samples who still meet the criteria. However it was also suggested that due to the financial circumstances of the CCG in Devon it may be preferred that the gatekeeping function be with the CCGs rather than acute trusts
- Specialists stated that in order to comply with the law, patients are seen by a specialist every five years to discuss whether the patient continues to meet the criteria for storage of samples and to renew the patient's consent for storage of the sample.

The committee voted six to one in favour of rescinding the need for all cases to go to the Panel for extension of sample storage beyond the initial five years if the patient still meets the criteria.

The committee voted unanimously in favour of:

- recommending a five year initial storage period for all patients aged 39 years and younger.
- renewal of storage at five year intervals up to the 40th birthday for females and males if they meet criteria for renewal,
- inclusion of criteria for storage in line with statutory requirements and discussion between the clinician and patient when renewal is due,
- The proposed policy would apply from the date of publication for patients who have cryopreserved material as well as for new patients.

ACTION: Recommended revisions to the CCGs' policy for Cryopreservation and QEIA to be prepared and subsequently progressed to final CCG approval and communication.

4. Access to Assisted Conception for users of e-cigarettes and nicotine replacement therapy (NRT)

The CCGs' policy for assisted conception includes criteria for access to assisted reproduction techniques (ART). These include a criterion for smoking which states that both partners should be objectively confirmed non-smokers but makes no reference to NRT or e-cigarettes. The increase in use of e-cigarettes as a means of smoking cessation has prompted enquiries from fertility centres as to whether the criterion for smoking also applies to e-cigarettes. A member of the Clinical Effectiveness Team, NEW Devon CCG presented a paper. Dr Umesh Acharya, Consultant Gynaecologist and Sally Doidge, Principal Embryologist at Derriford Hospital and Dr Lisa Joels, Consultant Gynaecologist and Joanne Wilson, Senior Clinical Embryologist at Royal Devon and Exeter NHS Foundation Trust took part in the discussion.

The majority of e-cigarettes contain nicotine and other substances, some are nicotine free. The inclusion of other substances in addition to nicotine in e-cigarettes means they should be considered separately to forms of NRT containing nicotine only. However, it would not be appropriate to discuss e-cigarettes without considering all forms of NRT as to do so would ignore the potential contribution of nicotine to the effects of smoking on fertility and the effectiveness of ART.

NICE guidance advises that smoking affects the success rates of assisted reproduction techniques. NICE has not identified any evidence on the effect of NRT on fertility or assisted reproduction techniques.

In England the majority of CCGs with policies for ART require patients to be non-smokers but make no reference to NRT or e-cigarettes. However two groups of CCGs have taken opposite positions regarding the use of e-cigarettes. Sussex CCG will not fund if either partner smokes, this includes e-cigarettes. The stated rationale is that the impact of e-cigarettes on assisted reproduction and their safety has not been established. There is no mention of other forms of NRT. This differs from the position taken by Medway and Kent CCG who advise that couples will not be funded if either partner smokes tobacco, but that there is insufficient evidence currently to suggest NRT or e-cigarettes have a negative effect on fertility or the outcome of ART and therefore patients who use them should not be excluded from NHS funded treatment.

An updated literature search conducted by the Clinical Effectiveness team, NEW Devon CCG identified no evidence for the effect of NRT or e-cigarettes on assisted reproduction.

The committee was asked to consider whether couples who wish to receive ART should be required to be non-users of e-cigarettes and other forms of NRT. The committee discussed issues pertinent to the recommendation:

- The effects of smoking on fertility, conception and the success of ART are known. Currently, there is no evidence for the harms or benefits of e-cigarettes and NRT on fertility and conception. The contribution of nicotine to the adverse effects of smoking on fertility and the success rate of assisted reproduction is not known.
- Most CCGs have policies which require people to be non-smokers but do not include e-cigarettes and NRT.
- Smoking and the use of nicotine containing products are modifiable lifestyle choices. E-cigarettes are seen as a way of reducing harm from smoking in the general population and in the absence of evidence that e-cigarettes or nicotine containing products reduce the effectiveness or pose a safety issue in fertility treatment there is not an overriding rationale to exclude users.

The committee voted 5 to 2 against recommending that couples be required to be non-users of e-cigarettes and other forms of NRT before they are able to access assisted conception services.

ACTION: Recommended revisions to the CCGs' policy for Assisted Conception and QEIA to be prepared and subsequently progressed to final CCG approval and communication.

5. Assisted Conception policy: proposed updates

The CCGs' policy for assisted conception was last updated in March 2016. Amendments are now proposed to four areas of the policy: donor insemination, intrauterine insemination, intracytoplasmic injection and cryopreservation to preserve fertility. None of these areas have been discussed since the policy was first developed in 2014/15. A member of the Clinical Effectiveness Team, NEW Devon CCG presented a paper. Dr Umesh Acharya, Consultant Gynaecologist and Sally Doidge, Principal Embryologist at Derriford Hospital and Dr Lisa Joels, Consultant Gynaecologist and Joanne Wilson, Senior Clinical Embryologist at Royal Devon and Exeter NHS Foundation Trust took part in the discussion

Fertility specialists have asked for the method of conception for donor insemination for clinical indications funded by the CCGs to be clarified and included in the policy. It is proposed that under donor insemination (renamed donor insemination for clinical indications) the method of conception routinely funded by CCGs be added and cross referenced to the sections on IVF and intrauterine insemination.

The CCGs proposal based on NICE guidance is for one cycle of IVF, or unstimulated IUI if chosen followed by one cycle of IVF if unstimulated IUI is unsuccessful (up to six cycles of IUI may be offered dependent on sperm availability, patients may switch to IVF at any time). An alternative proposal, based on current practice has been put forward by Dr Joels. This is for three cycles of stimulated IUI followed by one cycle of IVF if IUI is unsuccessful. Dr Joels considers the CCG's proposal would result in reduced pregnancy rates and increased costs.

Additionally the Clinical Effectiveness team also propose that:

- under intracytoplasmic injection (ICSI): the statements relating to surgical retrieval of sperm would be deleted as NHS England has taken over commissioning responsibility for these procedures.
- under cryopreservation to preserve fertility: deletion of explanatory text leaving reference to the existence of a separate policy for cryopreservation to preserve fertility. This will allow the cryopreservation policy to be updated independently of the assisted conception policy.

The committee discussed issues pertinent to the policy revisions:

- NICE recommend unstimulated IUI as it reduces the risk of multiple pregnancies compared to stimulated IUI.
- The CCGs proposal is based on NICE. There is no clear evidence for the optimal number of cycles of IUI.
- Specialists present stated that complications in twin pregnancies are more likely than in singleton pregnancies, however, the risks are still very low. The risks increase with higher order multiple pregnancies.
- Specialist opinion stated that stimulated IUI is more effective than unstimulated IUI.
- The costs associated with treatment options were discussed. Full economic evaluation would be a challenging task and still be subject to much uncertainty.
- If pregnancy does not result from IUI then IVF can be offered. IUI is not offered after IVF. The couple need to make a prior choice about treatment options.

Dr Ben Waterfall suggested that the proposal put forward by the CCG and the proposal put forward by Dr Joels both be included in the CCGs policy.

The committee voted unanimously in favour of inclusion of the proposal put forward by the Clinical Effectiveness team together with the proposal put forward by Dr Joels in the CCGs' policy. It was agreed that the wording would be worked up by the Clinical Effectiveness Team and circulated to specialists and the Chair of Clinical Policy Committee for agreement.

ACTION: Proposed wording of the donor insemination section of the Assisted Conception Policy to be produced and circulated to specialists and the Chair of Clinical Policy Committee for agreement.

6. Policy for the specialist management of abdominal wall hernia in adults

Following discussion of the CCGs' policy for the specialist management of abdominal wall hernia in adults at the Clinical Policy Committee meeting held in July 2017 the Clinical Effectiveness team was asked to consider the Gloucestershire CCG hernia policy and continue work with local specialists to revise the current Devon policy. Matt Howard, Clinical Evidence Manager, NEW Devon CCG presented a paper.

Since the meeting of the CPC in July 2017 when the hernia policy was discussed with hernia specialists, the Clinical Effectiveness team has liaised with the specialists to try to progress revisions to the Devon CCGs' policy along the lines outlined by the committee. A short summary highlighting the similarities and differences between the Devon and Gloucestershire (specifically referred to in earlier discussions) CCG policies was produced and circulated with the meeting papers. The two policies are broadly similar and both differ from the BHS/RCS guide. Currently consensus has not been achieved. The Clinical Effectiveness team understands that the CCGs wish to retain the resource benefits associated with the Devon wide policy for hernia surgery whilst the view of the specialists involved in consultation is generally that the Devon commissioning position should be that of the British Hernia Society (BHS)/Royal College of Surgeons (RCS) guide.

The Devon CCGs' policy was originally introduced because the rate of hernia repair in the Devon CCGs was significantly at variance to the South of England mean standardised activity rate for hernia repairs. Recent data suggest that the Devon CCGs are now closer to the mean and that any variation is likely to be due to chance. The purpose of withdrawing the current policy would be to allow additional hernia repairs, increasing activity levels. It is not possible to be certain by how much activity would increase. If activity volumes return to pre-policy levels, this would result in an increased spend of over £1 million per annum.

The Committee discussed issues pertinent to the progression of a recommendation for the policy for the specialist management of abdominal wall hernia in adults:

- At the last CPC meeting a view was expressed that there were grey areas around the definition of minimally symptomatic hernia used in the literature and that this may represent less severe cases than those that meet the Devon CCGs' functional impairment statement.
- The committee expressed a willingness to continue to pursue a consensus with specialists over the hernia policy but noted that the fixed position of some specialists made progress difficult. It was noted that there are some differences between the access criteria in the Devon and Gloucestershire policies.
- The committee considered whether the previously adopted Devon CCGs' criteria for functional impairment should be reviewed for this patient group.
- Lucy Harris explained that DRSS experience difficulties and tensions when interpreting functional limitations described in referrals against policy criteria where these are open to interpretation. The current criteria for hernia are very specific and more easily interpreted than in some other cases. However, if the committee wished she would liaise with clinical colleagues at DRSS to explore potential for a different definition for the hernia policy that would be able to be consistently and equitably managed at a lower threshold of severity than the current statement.
- A typographical error was noted in the meeting papers; the Devon CCGs' policy requires failure of conservative management for incisional hernias only (and not for inguinal hernias or umbilical hernias as stated therein).

ACTION: Lucy Harris to explore options for functional impairment criteria for hernia referral that could be applied within DRSS and feedback to the Clinical Effectiveness team.

- The committee noted that since the current policy was introduced elective activity has decreased, and there has not been an increase in emergency presentations. It was also noted that there are complications associated with hernia repair, including chronic pain. It was suggested that as these patients return to their GP and not the surgeon, surgeons may not fully appreciate the scale of the problem.
- It was observed that in general surgical outcomes tend to be better when the surgery is carried out by surgeons who undertake relatively higher numbers of the procedure compared with surgeons who undertake the procedure less frequently. It was suggested that complications with hernia repair could be reduced, outcomes improved and costs reduced if such operations were carried out through a more structured approach with fewer surgeons undertaking the procedure and greater centralisation of expertise and cost bases. It was noted that this had been identified as part of STP work and it remained for providers working within the STP to resolve.

It was agreed that the current policy should stand but remain open to revision when solutions to challenges discussed so far become more apparent. The Committee Chair, with support from the Clinical Effectiveness team, will write three letters regarding the issues discussed by the committee.

ACTION: Committee Chair to write to hernia surgeons advising them the Devon wide policy for the specialist management of abdominal wall hernia in adults still stands.

ACTION: Committee Chair to write to medical directors about comments made by surgeons at the CPC meeting in July 2017 regarding the departure of clinical practice from the CCGs' commissioning policy position.

- The committee discussed difficulties where professional society or other recommendations (based upon their view of optimal clinical care, and unconstrained by affordability considerations) conflict with policy positions which reflect the need for CCGs to manage their budget across a diverse range of services. It was noted that CPC operates in an environment of implicit financial restraint without clear points of reference to articulate when forming recommendations and policy rationale. It was agreed that the chair should write to senior CCG leadership to describe these difficulties and seek further organisational guidance.

ACTION: Committee Chair to write to CCGs leadership teams describing the difficulties encountered when forming policy recommendations.

7. Certolizumab for psoriatic arthritis

The CPC acknowledged that mandatory recommendations in National Institute for Health and Care Excellence (NICE) Technology Appraisal (TA) 445 (Certolizumab pegol and secukinumab for treating active psoriatic arthritis after inadequate response to DMARDs) published on 24 May 2017 supersede a commissioning policy for certolizumab pegol published by the Clinical Policy Committee (CPC) in March 2014. The commissioning policy has been unpublished as a result of this mandated change.

This position has been agreed by the executive groups of NEW Devon CCG and South Devon & Torbay CCG to ensure the policy change occurs in line with statutory responsibilities for the funding of mandatory NICE Technology Appraisals within 90 days of publication.

It was noted that the policy had accepted the commissioning of certolizumab as an alternative first line biological treatment option to NICE recommended anti-TNFs for psoriatic arthritis. Certolizumab was cost saving compared with other options. The acquisition costs of certolizumab pegol were approximately 25% less than the mean cost of other anti-TNFs, given by the same route of administration, for the first year and similar thereafter.

8. Dexamethasone intravitreal implant (Ozurdex®) for treating non-infectious posterior uveitis

The CPC acknowledged that mandatory recommendations in National Institute for Health and Care Excellence (NICE) Technology Appraisal (TA) 460 (Adalimumab and dexamethasone for treating non-infectious uveitis) published on 26 July 2017 supersede a commissioning policy for Dexamethasone intravitreal implant (Ozurdex®) for treating non-infectious posterior uveitis published by the Clinical Policy Committee in January 2017. The commissioning policy has been unpublished as a result of this mandated change.

This position has been agreed by the executive groups of NEW Devon CCG and South Devon & Torbay CCG to ensure the policy change occurs in line with statutory responsibilities for the funding of mandatory NICE Technology Appraisals within 90 days of publication.

At that time of the policy decision it was acknowledged that dexamethasone intravitreal implant (Ozurdex®) was likely to result in overall NHS cost savings as fewer patients would progress to more expensive therapies.

9. Collagenase injection (Xiapex®) for treating Dupuytren's contracture

The CPC acknowledged that mandatory recommendations in National Institute for Health and Care Excellence (NICE) Technology Appraisal (TA) 459 (Collagenase clostridium histolyticum for treating Dupuytren's contracture) published on 26 July 2017 supersede a commissioning policy for Collagenase injection (Xiapex®) for Dupuytren's contracture published by the Peninsula Health Technology Commissioning Group in March 2012, which was adopted by NEW Devon CCG having originally been agreed by the predecessor PCTs in Devon and Cornwall.

The commissioning policy has been unpublished as a result of this mandated change. The associated Clinical Policy Committee policy relating to Dupuytren's Contracture Treatment (May 2013) has been updated to remove reference to the Collagenase injection (Xiapex®) policy and refers to NICE instead.

This position has been agreed by the executive groups of NEW Devon CCG and South Devon & Torbay CCG to ensure the policy change occurs in line with statutory responsibilities for the funding of mandatory NICE Technology Appraisals within 90 days of publication.

10. Update from NICE Planning Advisory Group (NPAG)

The minutes of the NPAG meeting which took place on Tuesday 18th July 2017 and a summary of the NICE guidance and guidelines discussed had been circulated with the meeting papers.

11. Update from Clinical Policy Engagement and Consultation Panel

The committee received the minutes of the Clinical Policy Engagement and Consultation Panel meeting which took place on 17th August 2017.

12. Any other Business

There was no other business to report.

Summary of actions		
	Action	**Lead**
17/14	Recommended revisions to the CCGs' policy for Cryopreservation and QEIA to be prepared and subsequently progressed to final CCG approval and communication.	Rebecca Heayn
17/15	Recommended revisions to the CCGs' policy for Assisted Conception and QEIA to be prepared and subsequently progressed to final CCG approval and communication.	Rebecca Heayn
17/16	Proposed wording for the donor insemination section of the Assisted Conception Policy to be produced and circulated to specialists and the Chair of the Clinical Policy Committee for agreement.	Hilary Pearce
17/17	Options for functional impairment criteria for hernia referral that could be applied within DRSS to be explored and fedback to the Clinical Effectiveness team.	Lucy Harris
17/18	Letter to be written to hernia surgeons advising them that the Devon wide policy for the specialist management of abdominal wall hernia in adults still stands.	Jo Roberts
17/19	Letter to be written to medical directors about comments made by surgeons at the CPC meeting in July 2017 regarding the departure of clinical practice from the CCGs' commissioning policy position.	Jo Roberts
17/20	Committee Chair to write to CCGs leadership teams describing the difficulties encountered when forming policy recommendations	Jo Roberts