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

Clinical Policy Committee (CPC)

Minutes

Tuesday 7th May 2013, 14.00-16.00

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
Dr Andrew Craig	GP Clinical Commissioner	NEW Devon CCG
Richard Croker	Head of Medicines Optimisation	NEW Devon CCG
Dr Mike Finnegan	Consultant in Acute Medicine	Plymouth Hospitals NHS FT
Dr Keith Gillespie	GP Clinical Commissioner	NEW Devon CCG
Dr Andrew Gunatilleke	Consultant in Pain Management & Anaesthesia	SDHC NHS Foundation Trust
Dr Phil Melluish	GP Clinical Commissioner	South Devon & Torbay CCG
Mac Merrett	Lay Member	
Chris Roome	Head of Clinical Effectiveness	NEW Devon CCG
Mike Wade	Public Health Speciality Registrar	Devon County Council
Dr Darunee Whiting	GP Clinical Commissioner	NEW Devon CCG
Alison Wilkinson	Head of Contracting and Business Intelligence	NEW Devon CCG

Guests:

Ms Cheryl Baldwick	Lead Clinician for Trauma and Orthopaedics	North Devon District Hospital
Dr Rebecca Batchelor	Consultant Dermatologist and Lead Clinician	RDE NHS Foundation Trust
Petrina Trueman	Joint Formularies Pharmacist	NEW Devon CCG

In attendance:

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

1. Welcome and introductions

Attendees were welcomed to the meeting and the group introduced themselves.
MF was attending in the absence of Dr Tawfique Daneshmend and Dr Stuart Kyle

2. Apologies

Dr Tawfique Daneshmend	Consultant Gastroenterologist & Hepatologist	RD&E NHS FT
Paul Foster	Pharmacist	SDHC NHS FT
Dr Steven Hunt	GP Clinical Commissioner	NEW Devon CCG
Dr Alison Round	GP Clinical Commissioner	NEW Devon CCG
Mr Matt Wilson	Consultant Orthopaedic Surgeon	RD&E NHS FT
Jenny Winslade	Chief Nursing Officer	NEW Devon CCG

3 Terms of Reference (ToR)

The ToR had been agreed by the Board of NEW Devon CCG and the Board of South Devon and Torbay CCG. A formal review of the ToR will take place in six months.

ACTION: Review of ToR to be included on CPC agenda in six months.

A request was made that, in the event of any member of the group being unavailable for a meeting, a deputy should be nominated and the Clinical Effectiveness Team notified. Two weeks notice should be given if possible. If a GP cannot attend a senior manager should be nominated as his or her representative.

Members recognised that each locality had its own arrangements with regard to Board member, GP and co-opted member attendance at CPC meetings. In order for the CPC to be quorate five voting members must be present.

Members had completed Declaration of Interest forms prior to the meeting. No material interests were declared.

The group discussed how evidence should be presented. It was agreed that a transparent process should be used. Evidence will be presented with consultants/experts present. Open discussion, questions and voting will take place with all members of the group and consultants/experts present. It was acknowledged the experts may not always be able to be present at the meeting, but that it would be valuable have their comments and views during the consultation period to inform the meeting discussion.

ACTION: JR to write to Medical Directors to encourage clinician engagement with the CPC process

4. Dermatological treatments for focal hyperhidrosis

A commissioning policy statement and treatment criteria for dermatological treatments for focal hyperhidrosis was approved by NHS Devon Effective Practice Committee, working in conjunction with the Royal Devon and Exeter NHS Foundation Trust. This policy was formally adopted by NHS Torbay in March 2010, with a minor amendment (trial of anti-cholinergics prior to referral for a sweat test). In NHS Plymouth the Commissioning Policy Low Priority Treatments states for botox injections for hyperhidrosis to refer to the specific policy (NHS Devon only). In order to ensure consistency across Devon dermatology specialists have been contacted to seek their comments on the intention for the Torbay

policy to be accepted across Devon. Some minor amendments have been made to the policy (systemic anti-cholinergics named). No financial impact is expected in South Devon and Torbay CCG, however there may be limited financial impact in NEW Devon CCG as a result of an extension of access to treatments for some specialist therapies for hyperhidrosis currently not routinely available to patients of the former NHS Plymouth. As a result of the recent consultation the amended policy is now presented to the CPC for approval.

The committee considered the issues, including possible increased pressure on PHT to provide services or on other trusts if additional patients were referred from PHT. Some members felt that PHT could easily comply with the policy and that it would be difficult to treat patients from PHT differently to the rest of the Devon population. It was agreed that AW would take the policy to contracting meetings and resolve the issues with PHT.

ACTION: AW to take policy to contacting meetings and resolve any contract issues with PHT.

Members noted that the cost of providing the service might differ between Acute Trusts. It was also noted that consistency across the patch had to be considered and that 'Any Qualified Provider' could be commissioned. Consideration should also be given to ensuring a critical mass of patients to be treated by each provider. It had not been possible to identify a national tariff. The committee agreed that AW would be involved at an early stage to look at costs and a reasonable price.

ACTION: AW to be involved at an early stage to consider costs and a reasonable price.

The committee agreed that where decisions were clinically appropriate contracting issues should not create problems. The committee should consider how much to intervene in where services are provided to ensure that no one is disadvantaged. It was also noted that decisions regarding implementation may rest with localities.

Members asked if primary care should be encouraged to try systemic oral anticholinergic drugs for hyperhidrosis before referring to secondary care. Expert opinion was that this would be appropriate for generalised hyperhidrosis, but in focal hyperhidrosis the side effects are a significant limitation. It was also noted that GPs may be reluctant to prescribe as treatments are not licenced in the UK. Members asked if botulinum toxin should be preferred. The expert view was that this was limited to axillary hyperhidrosis since use for hands and feet required an anaesthetist to conduct a nerve block.

The committee agreed that all patients in Devon should have access to the agreed treatments. The policy was agreed with minor amendments.

ACTION: Commissioning policy to be published

5. Exogen ultrasound for non-union long bone fractures

The committee were asked to consider the evidence on the effectiveness of Exogen ultrasound for non-union long bone fractures in comparison to surgery. The application is made following funding requests for treatment with Exogen ultrasound and in order to assess its appropriateness in relation to local service provision. The device is suitable for adult patients. It is a 'single patient device' which is used at home for twenty minutes each day. The device makes a record of its use. An evidence assessment had been carried out by the Clinical Effectiveness Team. Petrina Trueman, Joint Formularies Pharmacist, NEW Devon CCG and Ms Cheryl Baldwick Lead Clinician for Trauma and Orthopaedics, North Devon District Hospital joined the meeting for this item.

NICE published guidance (MTG12) however provision of treatment is not mandatory. The committee noted the difficulties in defining and differentiating between 'non-union long bone fractures' and 'delayed healing'. Members also discussed the possible reasons for NICE identifying 'nine months from fracture' as being the appropriate time at which to use Exogen ultrasound.

The evidence was discussed and it was noted that although the manufacturer stated that a cost saving will be made compared to the cost of surgery, there is no direct evidence available to support this. NICE had not found any cost benefits associated with use of the device for delayed healing however cost saving for non-union fractures was likely but this was less than that stated by the manufacturer. It had not been possible to verify the cost saving claimed by the manufacturer. In addition the evidence presented to the committee noted that although a number of studies had taken place there were none which compared Exogen ultrasound with surgery and that the claimed benefits of reduced healing time and earlier return to weight bearing were not supported. However, the committee felt that the device seemed to work and that there were risks associated with surgery. No adverse events had been associated with the use of Exogen ultrasound. Expert opinion noted that although there was not a great deal of evidence for the device it was better than that for earlier devices of a similar type. The committee agreed that if the device worked it would be better for the patient than surgery, although the best outcome is for fractures to heal themselves in six weeks to three months with no intervention. It was noted that the manufacturer is offering a money back guarantee in cases where no healing takes place. Members asked that written details of the money back guarantee be brought to the next meeting.

ACTION: Written details of manufacturers money back scheme to be brought to next meeting.

The committee discussed the lack of clarity with regard to the criteria for treatment and noted that this could cause difficulties when discussing treatment with patients.

Members suggested other work that could be done including the possibility of auditing results achieved locally in order to establish the effectiveness of the treatment. However it was noted that several treatments, including oestograft and bone morhigenic, are often used simultaneously and that it is difficult to identify the benefits of each treatment

It was noted that Exogen ultrasound could be used post-surgery to encourage growth factors or to avoid the need for surgery. The possibility of undertaking an audit of pathways and use was suggested, however it was felt that this was the role of locality commissioners rather than the CPC. However, it was felt that it was within the committees remit to revisit the commissioning guidance as it may change to recommend treatment before nine months.

The committee agreed that Exogen ultrasound should be commissioned in line with NICE guidance MTG12.

The committee also agreed to review the number of Individual Funding Panel (IFP) requests made for treatment to be given before the nine months waiting period over the next twelve months.

ACTION: IFP to be asked to note the number of requests for treatment to be given before the nine month waiting period for review by CPC in twelve months.

The policy to support use of Exogen ultrasound will be in place in two weeks.

ACTION: Commissioning policy to be published

6. Dupuytren's Contracture

The committee were asked to approve some minor wording changes to the Dupuytren's Contracture Treatment policy currently in place in Plymouth and for it to be accepted for use across Devon.

The committee approved the policy.

ACTION: Commissioning policy to be published

7. Variations in predecessor organisations' clinical access policies – interim CCG policy

The committee were asked to consider how variations in polices inherited from former NHS commissioning organisations in the geographical area now comprising NEW Devon CCG and South Devon and Torbay CCG be resolved in the short term. A number of areas had been highlighted as being of concern due to the potential for a variation in access developing within a locality or CCG areas. The CCGs must have a defensible and equitable position.

A discussion took place and it was noted that an interim policy was needed on how Exceptional Treatment Panels should react when different policies are in place. The options were:

- Continue with current policy for a geographical location although this might result in a decision being based on where the patient lived until variations in policy have been resolved.
- Apply the most restrictive policy until variations in policy have been resolved.
- Apply the least restrictive policy until variations in policy have been resolved. There will be financial implications if this option is chosen.

Some members felt the financial implications should be considered before moving to the least restrictive policy. Others felt that there could be confusion if there was initially a move to use the least restrictive policy and more restrictive policies were introduced again at a later date.

It was noted that the situation for Plymouth Hospitals NHS Foundation Trust is further complicated as some patients are referred from Cornwall which has its own policies.

The committee concluded that current policies should remain in place until variations have been resolved and that this can be justified by saying that the NEW CCGs are still forming and that work is underway to resolve policy variation over the next twelve to eighteen months. The need to notify Overview and Scrutiny Committees and provide realistic timescales was noted. It had been suggested that clinicians lead task and finish groups in order to resolve variations.

ACTION: Policy variations to be resolved over the next twelve to eighteen months. Contact Local Authority Overview and Scrutiny Committee leads to appraise them of this plan.

The committee agreed that letters should be written to CCG governing bodies stating that the work would be prioritised in order that policies for treatments involving the greatest patient numbers are resolved first. Governing bodies will be asked to come back to the CPC if this is not acceptable.

ACTION: Letter to be written to CCG governing bodies regarding alignment of access policies and request that the governing bodies inform the CPC if the proposal is not acceptable.

8. Update from NICE Planning, Quality and Assurance Group (NPAG)

The role and processes of the NICE Planning, Quality and Assurance Group (NPAG) were explained. NICE Technology Appraisals are mandatory and must be commissioned within ninety days of publication, other NICE guidance is not mandatory. NPAG membership is made up of representatives from NEW Devon CCG and South Devon and Torbay CCG. NPAG can flag up aspirations in advance and seek the views of specialists on new NICE guidance. CPC is the access route for drugs going to formularies and is notified of NICE guidance through the receipt of NPAG minutes and summaries. The draft minutes of the NPAG meeting had been circulated to the committee for information and to note new mandatory TAs for acceptance of the involved drugs on to the formularies.

A discussion took place and the committee noted the lack of clinical input into NPAG and that commissioning managers had not attended the meeting. Currently it is the role of senior commissioning managers in each locality to take issues forward, primary care will be involved in NICE guidance through locality Clinical Pathway Groups(CPG)/Clinician to Clinician Groups(C2C). Members of the committee discussed this and reported that each locality has its own arrangements for CPGs/C2Cs and that some would be task and finish groups. It was also suggested that CPGs/C2Cs would require new ToRs in order to feed into NPAG. The committee felt that there was an issue for CCGs to resolve and that previously there had been a useful mechanism in place, although not everyone had liked it. CCGs must look at how evidence is taken forward, put into practice and funding made available.

The committee added that NPAG had met as an acknowledgement group and that it would benefit from clinical input. It was noted that NPAG could be changed to include clinical input however there would be a cost implication.

The committee suggested that John Finn be included, initially through verbal communication.

ACTION: Issues around the role, remit and membership of NPAG to be raised verbally with John Finn.

9. Future meeting arrangements

Dates and venues for future meetings were discussed. Committee members identified a number of conflicting commitments, however it was felt that Wednesday mornings could be possible. It was agreed that RH would finalise dates and venues.

ACTION: RH to finalise dates and venues for future meetings.

The next meeting is scheduled to take place at 2.00 pm on Tuesday 11 June 2013 in the Committee Suite, County Hall, Exeter.

10. Any other business

There was no other business to report.

Summary of actions		
	Action	**Lead**
13/01	Review of ToR to be included on CPC agenda in six months.	Rebecca Heayn
13/02	JR to write to Medical Directors to encourage clinician engagement with the CPC process.	Jo Roberts
13/03	Policy for dermatological treatments for focal hyperhidrosis to be taken to contracting meetings and issues resolved with PHT.	Alison Wilkinson
13/04	Contracting and Business Intelligence to be involved at an early stage to consider costs for focal hyperhidrosis treatment and price.	Alison Wilkinson
13/05	Hyperhidrosis commissioning policy to be published.	Rebecca Heayn
13/06	Written details of Exogen ultrasound money back guarantee to be brought to next meeting.	Petrina Trueman
13/07	IFP to be asked to note the number of requests for treatment to be given before the nine month waiting period for review by CPC in twelve months.	Rebecca Heayn
13/08	Exogen commissioning policy to be published.	Rebecca Heayn
13/09	Dupuytren's commissioning policy to be published.	Rebecca Heayn
13/10	Policy variations to be resolved over the next twelve to eighteen months. Contact Local Authority Overview and Scrutiny Committee leads to appraise them of this plan.	Chris Roome
13/11	Letter to be written to CCG governing bodies regarding alignment of access policies and request that the governing bodies inform the CPC if the proposal is not acceptable.	Jo Roberts
13/12	Issues around the role, remit and membership of NPAG to be raised verbally with John Finn.	Chris Roome
13/13	Dates and venues of future meetings to be finalised.	Rebecca Heayn