Clinical Policy Engagement & Consultation Panel Minutes

Thursday 13 October 2022, 14.00-15.30
Via Microsoft Teams

Present:

Name	Role
Nicola Bonas	Associate director of communications, involvement and inclusion, NHS Devon
Thandiwe Hara*	Non-executive director for citizen and community involvement, NHS Devon
Carol McCormack-Hole*	Lay Member from the Patient Engagement Forum
Martyn Nicoll	Patient Experience Manager, NHS Devon
Rebecca Owen	Clinical Effectiveness Governance Manager, NHS Devon
Chris Roome	Head of Clinical Effectiveness, NHS Devon
Mark Taylor*	Lay Public Member, Clinical Policy Recommendation Committee

* Denotes voting members

1. Welcome and introductions

The group were welcomed, and introductions were made for the benefit of new members of the panel.

Apologies:

Name	Role
Mac Merrett*	Lay Public Member, Clinical Policy Recommendation Committee

2. Declarations of Interests

No interests pertinent to the items for discussion on the meeting agenda were declared.

3. Minutes of the meeting held on Monday 13 June 2022 and matters/actions arising

The panel considered the minutes from the meeting held on Monday 13 June 2022 and agreed them to be an accurate record.

The action log was updated as follows:

Summary of actions			
	Action	**Lead**	**Status**
22/01	Communicate the discussion of the Panel's remit to Nicola Bonas, specifically the potential for members to support the ICB's broader business engagement activity.	Rebecca Owen	RO raised with NB whether there were any opportunities for members to support the ICB's broader business engagement activity, outside of the scope of the panel. It was noted that some panel members are already engaged with other panels and networks. There is also a well-established Citizen's Panel, an online platform with over 2000 members, which has good representation across the Devon population and continues to grow - https://involve.onedevon.co.uk/ NB to follow up separately with the lay members in respect of any opportunities, which it was felt are more likely to be at a place-based level. Action closed.
22/02	Consult with existing and new panel members to understand views and explore options for future meeting arrangements.	Rebecca Owen	Action complete.

4. Discussion and recommendation on the Clinical Policy Recommendation Committee (CPRC) decisions from 21 September 2022

Assisted Conception: 'relationship' eligibility criterion for assisted reproduction techniques

An overview of the Clinical Policy Recommendation Committee recommendation and the context within which it had arisen was noted by the panel.

A change is proposed to the relationship eligibility criterion within the NHS Devon Assisted Conception policy following a query from the Exeter fertility centre about the existing wording, which they have found difficult to apply in practice. The change proposed requires couples to be in a stable relationship for at least two years but removes the specific requirement that they are spouses or civil partners or cohabiting as partners in a financially interdependent relationship.

The panel considered the public interest themes in relation to this policy:

1. **Is the reason for introducing the policy plausible? and 2. Does the policy output address this intent?**

   It was noted that the relationship criterion within the Assisted Conception policy had been reviewed as the result of a query from the Exeter fertility centre indicating that they find the existing wording difficult to apply in practice. They had received enquiries from couples on how a financially interdependent relationship is defined, and how this can be evidenced.

   Following consideration, the Clinical Policy Recommendation Committee has proposed that the specific requirement that couples are spouses or civil partners or cohabiting as partners in a financially interdependent relationship is removed; however couples should be in a stable relationship for at least two years to be entitled to receive NHS funded assisted reproduction techniques.

   The proposed amendment seeks to establish a clear position that can be understood and applied consistently. Local lead fertility specialists stated that they consider the amended wording can be fairly applied in practice.

3. **Have the effects of the policy on individual patients and carers been considered?**

   It was queried whether the proposed wording was consistent with the approach taken by other areas, or whether this would lead to variation or being an outlier. It was advised that the policies in the other 6 ICBS in the NHS South West region had been considered as part of the review; all require a ‘stable relationship’ and the majority (5) specify this should be for a period of two years.

   The perception from the patient experience team was that the avoidance of variation across different areas is a very important issue from the patient perspective and would therefore be encouraged.

   It was felt that the welfare of any child born as a result of assisted reproduction was paramount and, in that context, the need for a stable relationship was supported. It was acknowledged that the Human Fertilisation and Embryology Authority (HFEA) is the regulator of fertility services in the UK and their code of practice requires service providers to take account of the welfare of any child who may be born as a result of fertility treatment. There is an additional, separate criterion within the Assisted Conception policy relating specifically to considerations of the welfare of the child. The relationship criterion is principally aimed at ensuring the couple are genuinely together in an enduring relationship.

   The basis for specifying that the relationship should have been for a two-year period was discussed. It was commented that there can be no control over what happens in a relationship after any child is born; however there was general support for the time period given that this aligns with the time that NICE recommend that a couple will need to have tried to conceive through unprotected vaginal sexual intercourse, or equivalent artificial insemination attempts for same-sex couples, unsuccessfully before they receive assisted reproduction techniques.

   The panel discussed the subjective nature of what might be considered a ‘stable’ relationship and whether it was appropriate for a clinician to make a moral judgement on this issue to determine a couple’s eligibility to access assisted

reproduction. It was a concern that the definition of what was ‘stable’ was open to differing interpretation, and therefore potential challenge, and suggested that there were potential difficulties with this.

4. Have the wider consequences on society been considered?

It was acknowledged that the Assisted Conception policy seeks to treat the clinical problem of infertility, rather than the wider social desire to have a baby. Fertility investigation has to involve both the male and female partners because the reason for the failure to conceive could be the result of a medical issues in either, or both.

However the area under consideration relates to a non-clinical eligibility criterion for accessing fertility assessment, investigation and treatment. It was noted that, with the changing social nature of relationships, this is one a number of non-clinical aspects which fall with the domain of this policy area. Others include, for example, definitions of family structure, single people, trans people, NHS funding for establishing infertility in same sex couples and surrogacy, all of which have specific considerations around equity.

This is a complex and multi-faceted area which includes a wide range of social factors which will require broader consideration by the organisation as they go beyond the clinical treatment of infertility.

5. Has the opportunity cost been considered?

It was noted that the proposed amendment is not anticipated to have financial implications for the funding of assisted reproduction techniques in Devon; this was about establishing a clear position which could be applied consistently.

6. Is there knowledge of public concern in relation to a) the disease and b) the specific intervention?

It was discussed that the patient experience team frequently receive queries from patients about the eligibility criteria for assisted conception and the subject of the proposed amendment fits with the context of these queries. A lack of variation in criteria across geographical areas was also noted to be an important issue from the patient perspective, and a position which was both equitable and consistent with other areas would therefore be encouraged.

Nevertheless, it was felt that there could be some potential difficulties with the determination of what would be a ‘stable’ relationship, however, it was questioned what would be the consequences of not adopting this and whether there should be some further engagement or consultation of this issue.

To establish the practical implementation consequences of not adopting this, it was agreed that should the organisation be considering not accepting the Clinical Policy Recommendation Committee recommendation and removing the need for a “stable” relationship then this was a question that should be posed to the local fertility centres for their advice before finalisation.

In respect of further engagement or consultation, it was suggested that it may be difficult to consult due to the subjective nature of the question; however potentially

some involvement work could be undertaken, rather than formal consultation, working with existing networks. However before progressing this there was a need to consider what value this engagement would add, whether this is feasible and to explore what form this might take.

It was also noted that this fits within the wider context of other non-clinical factors for which the ICB will need to take decisions, as a result of the social nature of relationships and societal changes. This requires specific consideration by the organisation as these broader societal issues go beyond the clinical policy which focuses on the treatment of clinical infertility.

7. **What information on the treatment and condition is available to patients via nhs.uk (formerly NHS Choices)?**

nhs.uk notes that if you have fertility problems, the treatment you are offered will depend on what is causing the problem and what is available from your local ICB.

It states that fertility treatment funded by the NHS varies across the UK and waiting lists for treatment can be very long in some areas. The eligibility criteria can also vary. A GP will be able to advise about your eligibility for treatment or you can contact your local ICB.

Considering all these factors together the panel recommended that the ICB is asked to consider further engagement work around the requirement for a 'stable relationship'. This is recommended within the context of other non-clinical factors relating to the social nature of relationships, which it was acknowledged are a growing area. These are broader than the clinical factors for infertility, and as such the ICB is asked to consider how it will address these issues.

ACTION: Share the panel's recommendation that the ICB is asked to consider further engagement work around the requirement for a 'stable relationship', and to consider how other non-clinical factors in relation to the social nature of relationship will be addressed where they sit outside the clinical policy criteria.

ACTION: If, after due consideration of the complexities raised by the panel discussion, the ICB decide that further engagement would be beneficial before policy ratification the clinical effectiveness team should contact the local fertility centres. This would be to make them aware of the potential delay while this issue is considered further, and to seek clarification on what they perceive would be the consequences/impact of not having the proposed relationship criterion wording.

Continuous Glucose Monitoring for Diabetes

An overview of the Clinical Policy Recommendation Committee recommendation and the context within which it had arisen was noted by the panel.

Patients with diabetes who are treated with insulin are regularly required to test their glucose levels. As an alternative to self-monitoring blood glucose levels using finger-prick testing, continuous glucose monitoring (CGM) technology allows patients to

monitor their interstitial glucose levels, with users wearing a small adhesive sensor which is attached to their skin. The sensor transmits glucose readings wirelessly to a reader device or mobile phone. There are two types - intermittently scanned devices (also known as FreeStyle Libre) which require the user to take an active measurement by bringing the reader within proximity to the sensor, and real time devices which take continual measurements of glucose levels and transmit these continuously to the reader.

NHS Devon currently has policies in place for continuous glucose monitoring (CGM) and FreeStyle Libre for patients with diabetes. An updated policy is proposed to replace these, following consideration of the updated recommendations in the National Institute for Health and Care Excellence (NICE) guidelines NG17, 18 and 28 on the diagnosis and management of type 1 and type 2 diabetes in adults and children.

The panel considered the public interest themes in relation to this policy:

1. **Is the reason for introducing the policy plausible? and 2. Does the policy output address this intent?**

   It was noted that the existing NHS Devon commissioning policies for continuous glucose monitoring and FreeStyle Libre for patients with diabetes had been reviewed following the publication of updated NICE non-mandatory guidelines on the diagnosis and management of type 1 and type 2 diabetes in adults and children.

   The Clinical Policy Recommendation Committee has proposed the adoption of a new policy position in line with the NICE guidelines, following consultation with local diabetes specialists.

3. **Have the effects of the policy on individual patients and carers been considered?**

   The updated NICE guidelines recommend that all adults, children and young people with type 1 diabetes should be offered a real time continuous glucose monitor, and that a small, specified group of adult patients with type 2 diabetes who are treated with insulin should be offered an intermittently scanned device to measure their glucose levels.

   The proposed change to NHS Devon policy to align with these updated NICE recommendations would see a significant increase in the provision of CGM devices in Devon, with an additional 3,700 patients with diabetes now eligible for a device.

   It was felt that the availability of this technology gives patients the ability to manage their own condition, with the potential avoidance of complications of their diabetes and the associated costs of these. A CGM device may aid more frequent testing in patients with an impaired awareness of hypoglycaemia or hypoglycaemia unawareness, who often do not perceive the symptoms and therefore may not test their glucose at the appropriate time to be aware of low or impending low glucose levels, or who may be unable to communicate this. Real time systems also provide the benefit of programmable alerts for hypo and hyper glycemia which could help improve diabetes control and potentially reduce hospital admissions.

4. **Have the wider consequences on society been considered?**

   It was felt that there were no wider consequences of the proposed policy beyond the individuals involved.

5. **Has the opportunity cost been considered?**

   It was acknowledged that adoption of the proposed policy would significantly increase the number of patients eligible for a CGM device compared to the existing NHS Devon policy positions. The financial impact of this is estimated to be an additional spend of up to £2.3 million per year, with the impact predominantly on the primary care prescribing budget.

   It was discussed that the Clinical Policy Recommendation Committee had initially considered this policy area at its meeting in July 2022, where the principle of adopting the updated NICE recommendations was supported. However the committee were conscious of the large financial implications of unrestricted hospital procured real time CGM devices in patients with type 1 diabetes and asked the clinical effectiveness team to undertake further work with local specialists to clarify the circumstances under which these will be offered in Devon to ensure the best use of resources. The output of this work was considered at the following meeting in September 2022 where the committee made its policy recommendation. The overall aim is to provide CGM technology to patients in line with the NICE recommendations, whilst also ensuring that the provision of hospital procured real time CGM devices is limited to those patients with a specific clinical need for the technology to ensure the greatest benefits are achieved within the finances and resources available to the NHS in Devon.

   If the proposed policy position is agreed by the ICB, further work will be needed via the Devon Diabetes Delivery Group and the Devon Formulary Interface Group to help support the implementation of this change across Devon.

6. **Is there knowledge of public concern in relation to a) the disease and b) the specific intervention?**

   The widespread public and clinician support for CGM technology for patients with diabetes was discussed.

   There has been considerable interest in the availability of CGM technologies for patients in Devon over the past few years. This has increased since the publication of the updated NICE guidance, with the patient experience team handling frequent queries on this topic from patients who are very vocal about the change in NICE guidance and their wish to have this technology available to them. A significant number of queries have also been received on behalf of individuals via their MP, and from staff and clinicians in Devon.

7. **What information on the treatment and condition is available to patients via nhs.uk (formerly NHS Choices)?**

   nhs.uk gives information on continuous glucose monitoring (real time) and flash (intermittently scanned) glucose monitoring.

It states that continuous glucose monitoring or flash glucose monitoring should be available on the NHS to anyone with type 1 diabetes. Children and young people will usually be offered continuous glucose monitoring. Adults will usually be offered a choice of continuous glucose monitoring or flash.

Considering all these factors together the panel recommended that no further engagement or formal consultation was required at this point.

ACTION: Review and update previously produced clinical policy patient support information on 'Glucose monitoring technology to help patients manage their diabetes' and 'Easy Read about Diabetes and FreeStyle Libre Sensors' to support the publication and communication of any changes to commissioning policy.

Rezum for treating lower urinary tract symptoms secondary to benign prostatic hyperplasia

An overview of the Clinical Policy Recommendation Committee recommendation and the context within which it had arisen was noted by the panel.

Lower urinary tract symptoms are common in men over the age of 50, usually due to enlargement of the prostate gland. The most common cause of prostate enlargement is benign prostatic hyperplasia in which the size of the cells of the prostate enlarge, making the entire prostate increase in size.

In 2019 the Committee considered a range of surgical treatment options for an enlarged prostate which resulted in a number of commissioning policies. Rezum, a minimally invasive transurethral technique which uses thermal energy from steam to vaporise excess prostate tissue, was included in this review but a decision was taken at that time not to routinely commission its use in Devon as it was a relatively new procedure with a limited evidence base.

Since then, NICE has published medical technology guidance MTG49 on Rezum, which recommends its use as a treatment option for patients with a moderately sized prostate who also have moderate to severe lower urinary tract symptoms. Rezum is also included, alongside other surgical options for lower urinary tract symptoms secondary to benign prostatic hyperplasia, in the NHS England MedTech Funding Mandate policy 2022, which aims to direct the NHS on which MedTech innovations are effective and likely to give savings on investment.

The panel considered the public interest themes in relation to this policy:

1. **Is the reason for introducing the policy plausible? and 2. Does the policy output address this intent?**

   It was noted that the existing NHS Devon policy on Rezum as a treatment option for lower urinary tract symptoms secondary to benign prostatic hyperplasia has been reviewed in light of the publication of NICE medical technology guidance supporting its use, and its inclusion in the MedTech Funding Mandate policy 2022.

The Clinical Policy Recommendation Committee has recommended a revised commissioning policy which now accepts the use of Rezum in Devon for treating lower urinary tract symptoms secondary to benign prostatic hyperplasia.

3. **Have the effects of the policy on individual patients and carers been considered?**

   It was discussed that, with a number of surgical treatment options available for patients in Devon with lower urinary tract symptoms secondary to benign prostatic hyperplasia, it is expected that a process of shared decision making is used so that patients can make an informed decision about which procedure is best suited to their individual needs. This would include consideration of the short-term side effects and the longer-term outcomes of respective treatment options.

   The panel considered that some patients may prefer Rezum as it has a different side effect profile to other treatment options, including a lower risk of sexual dysfunction. It is also a shorter procedure which can be carried out as a day case, and it can be undertaken in low acuity settings which may improve waiting times for patients as well as being less subject to disruptions to planned treatment than surgical options in other settings.

4. **Have the wider consequences on society been considered?**

   It was felt that there were no wider consequences of the proposed policy beyond the individuals involved.

5. **Has the opportunity cost been considered?**

   It was acknowledged that the use of Rezum may have some overall system benefits and a positive impact on elective waiting lists. Rezum is expected to be a cost saving treatment option compared with some of the alternatives. It is also a shorter procedure which can be undertaken in a lower acuity setting, which may have a positive impact on surgical waiting times and less risk of cancellation, potentially allowing further efficiency to be achieved within the Devon health care system.

   Its inclusion in the NHS England MedTech Funding Mandate policy also encourages its uptake as an effective innovation which is likely to give savings on investment.

6. **Is there knowledge of public concern in relation to a) the disease and b) the specific intervention?**

   No particular public concern was highlighted, although it was noted that this is a common condition for which demand for surgical treatments has increased in recent years due to a growing cohort of older men.

7. **What information on the treatment and condition is available to patients via nhs.uk (formerly NHS Choices)?**

   nhs.uk gives information on benign prostate enlargement, which it states is common in men aged over 50. Most men with urinary symptoms do not need to have surgery, but it may be an option if other treatments have not worked.

It states that surgery and other procedures can include transurethral resection of the prostate (TURP), open prostatectomy, prostatic urethral lift implants, cystoplasty, prostate artery embolization, botulinum toxin, implanted sacral nerve root stimulation, urinary diversion, and water ablation.

Considering all these factors together the panel recommended that no further engagement or formal consultation was required at this point.

PLASMA (bi-polar TURP) for treating lower urinary tract symptoms secondary to benign prostatic hyperplasia

An overview of the Clinical Policy Recommendation Committee recommendation and the context within which it had arisen was noted by the panel.

Lower urinary tract symptoms are common in men over the age of 50, usually due to enlargement of the prostate gland. The most common cause of prostate enlargement is benign prostatic hyperplasia in which the size of the cells of the prostate enlarge, making the entire prostate increase in size.

NHS England has published the MedTech Funding Mandate policy 2022, which aims to direct the NHS on which MedTech innovations are effective and likely to give savings on investment. The policy includes a number of surgical options for lower urinary tract symptoms secondary to benign prostatic hyperplasia, including PLASMA, a system for bi-polar transurethral resection of the prostate (TURP).

The panel considered the public interest themes in relation to this policy:

1. **Is the reason for introducing the policy plausible? and 2. Does the policy output address this intent?**

   It was noted that this treatment option had been considered in light of the MedTech Funding Mandate policy, published by NHS England earlier this year, which includes a number of surgical options for lower urinary tract symptoms secondary to benign prostatic hyperplasia which are promoted as effective and cost saving innovations. This includes PLASMA, a system for bi-polar transurethral resection of the prostate (TURP), which is also supported by positive NICE medical technology guidance MTG53 published in 2021.

   Bipolar TURP procedures are the most common form of surgery for the prostate in Devon, with two systems currently in use locally.

   The Clinical Policy Recommendation Committee has recommended a commissioning policy which formally supports the use of bipolar TURP in Devon, aligning with the NICE medical technology guidance and the MedTech Funding Mandate policy. However the proposed policy does not differentiate between different manufacturers' systems, in line with the evidence base and clinical opinion.

3. **Have the effects of the policy on individual patients and carers been considered?**

   The proposed policy formally supports the use of bipolar TURP in Devon for lower urinary tract symptoms secondary to benign prostatic hyperplasia.

It was discussed that, with a number of surgical treatment options available for patients in Devon with lower urinary tract symptoms secondary to benign prostatic hyperplasia, it is expected that a process of shared decision making is used so that patients can make an informed decision about which procedure is best suited to their individual needs. This would include consideration of the short-term side effects and the longer-term outcomes of respective treatment options.

4. **Have the wider consequences on society been considered?**

   It was felt that there were no wider consequences of the proposed policy beyond the individuals involved.

5. **Has the opportunity cost been considered?**

   It was acknowledged that the NHS England MedTech Funding Mandate policy encourages the uptake of effective innovations which are likely to give savings on investment. The 2022 policy includes PLASMA, a system for bi-polar TURP, which NICE found to be cost saving when compared to standard monopolar TURP.

6. **Is there knowledge of public concern in relation to a) the disease and b) the specific intervention?**

   No particular public concern was highlighted, although it was noted that this is a common condition for which demand for surgical treatments has increased in recent years due to a growing cohort of older men.

7. **What information on the treatment and condition is available to patients via nhs.uk (formerly NHS Choices)?**

   nhs.uk gives information on benign prostate enlargement, which it states is common in men aged over 50. Most men with urinary symptoms do not need to have surgery, but it may be an option if other treatments have not worked.

   It notes that surgery and other procedures can include transurethral resection of the prostate (TURP), open prostatectomy, prostatic urethral lift implants, cystoplasty, prostate artery embolization, botulinum toxin, implanted sacral nerve root stimulation, urinary diversion, and water ablation.

Considering all these factors together the panel recommended that no further engagement or formal consultation was required at this point.

Lumbar discectomy for the management of sciatica

An overview of the Clinical Policy Recommendation Committee recommendation and the context within which it had arisen was noted by the panel.

Development of a policy for lumbar discectomy had been prompted by the second wave of the evidence-based interventions (EBI) programme guidance to CCGs published by the Academy of Medical Royal Colleges.

Lumbar discectomy is a surgical procedure for removal of intervertebral disc material to manage symptoms resulting from the compression of spinal nerve roots, known as lumbar radiculopathy or sciatica. Surgical management is usually reserved for persistent or severe cases of sciatica; for most patients their symptoms improve with non-operative management.

The EBI guidelines for lumbar discectomy are in line with the NICE clinical guideline NG59 for low back pain and sciatica and the national back and radicular pain pathway.

The panel considered the public interest themes in relation to this policy:

1. **Is the reason for introducing the policy plausible? and 2. Does the policy output address this intent?**

   It was noted that the development of an NHS Devon policy for lumbar discectomy for the management of sciatica has been prompted by the Academy of Medical Royal Colleges EBI guidance to CCGs.

   The Clinical Policy Recommendation Committee has subsequently recommended a policy which acknowledges the EBI recommendations and is in line with the NICE clinical guideline NG59 on low back pain and sciatica and the national back and radicular pain pathway.

3. **Have the effects of the policy on individual patients and carers been considered?**

   The panel acknowledged that local specialists have indicated that clinical practice already reflects the criteria recommended in the EBI guidelines so there is not expected to be any significant change for patients.

4. **Have the wider consequences on society been considered?**

   It was felt that there were no wider consequences of the proposed policy beyond the individuals involved.

5. **Has the opportunity cost been considered?**

   It was acknowledged that local specialists have indicated that current practice in providers of lumbar discectomy in Devon already reflects the criteria recommended in the EBI guidelines so no significant impact on local activity is anticipated.

   However there may be a positive impact from providing clarity for staff and patients in Devon of when lumbar discectomy is routinely commissioned for the management of sciatica and in supporting appropriate referrals.

6. **Is there knowledge of public concern in relation to a) the disease and b) the specific intervention?**

   The panel were aware that sciatica is common; however they were not aware of any particular public concern in respect of its treatment, including lumbar discectomy surgery.

7. What information on the treatment and condition is available to patients via nhs.uk (formerly NHS Choices)?

nhs.uk states that lumbar decompression surgery is a type of surgery used to treat compressed nerves in the lower (lumbar) spine. It is usually only considered if non-surgical treatments have not worked, and symptoms are affecting your quality of life.

It advises that non-surgical treatments include painkillers, physiotherapy and spinal injection therapy. Lumbar decompression surgery may also be considered if you experience serious side effects when taking medications that affect your ability to work. Surgery may become likely if difficult symptoms last up to 2 months. Surgery around 4 months after symptoms start is seen by some as the right time for the best results and recovery. Surgery will only be recommended if you're healthy enough to withstand the effects of the anaesthetic and the surgery.

Considering all these factors together the panel recommended that no further engagement or formal consultation was required at this point.

5. Annual Report 2021-22

The panel received the annual report for 2021-22. It was noted that on this occasion it covers a slightly longer period up to the end of June 2022 as a final report of all activity before the transition from the CCG to the ICB on 1 July 2022.

The panel continues to support the organisation in determining the need for any further engagement or formal public consultation on recommendations made by the Clinical Policy Committee, prior to a final decision being taken by the organisation.

It does so by routinely considering the wider public interest issues to determine the need for any further engagement or formal public consultation.

The panel meetings in 2021-22 were again disrupted by the continuing Covid-19 pandemic, with some meetings cancelled due to the Clinical Policy Committee meetings being stood down as there were no urgent items to progress.

Nevertheless, four panel meetings were held virtually during the reporting period, considering 16 clinical policy recommendations across a range of topics.

The panel were satisfied that no further engagement or formal public consultation was needed for any of the clinical policy recommendations; however on consideration of the proposed update to the FreeStyle Libre policy for glucose monitoring in diabetes it was recommended that there was some communication support to relay the message about its availability for patients with diabetes and a learning disability. This resulted in development of an easy read leaflet co-produced by Living Options and Devon Link up following consultation with service users which was made available alongside the policy to support those with learning disabilities.

As previously discussed, with the transition to the ICB it was agreed that the existing process should be replicated within the new organisation. The ongoing role of the panel was supported, with its core role and purpose in supporting the organisation's clinical policy process unchanged.

There have however been two changes of membership since 1 July 2022, with the panel welcoming Thandiwe Hara, ICB non-exec for citizen and community involvement and Martyn Nicoll, Patient Experience Manager.

ACTION: Annual Report to be reported onwards in the ICB for information and assurance.

6. Any other business

No other business was raised.

7. Next meeting date

The next meeting will be held on Thursday 8 December 2022 from 14.00 via Microsoft Teams.

Summary of actions

	Action	Lead(s)	Status
22/03	Share the panel's recommendation that the ICB is asked to consider further engagement work around the requirement for a 'stable relationship', and to consider how other non-clinical factors in relation to the social nature of relationship will be addressed where they sit outside the clinical policy criteria.	Chris Roome/ Rebecca Owen	Pending
22/04	If, after due consideration of the complexities raised by the panel discussion, the ICB decide that further engagement would be beneficial before policy ratification the clinical effectiveness team should contact the local fertility centres. This would be to make them aware of the potential delay while this issue is considered further, and to seek clarification on what they perceive would be the consequences/impact of not having the proposed relationship criterion wording.	Chris Roome/ Rebecca Owen	Pending
22/05	Review and update previously produced clinical policy patient support information on 'Glucose monitoring technology to help patients manage their diabetes' and 'Easy Read about Diabetes and FreeStyle Libre Sensors' to support the publication and communication of any changes to commissioning policy.	Chris Roome/ Rebecca Owen	Pending
22/06	Annual Report to be reported onwards in the ICB for information and assurance.	Rebecca Owen	Pending