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

Clinical Policy Engagement & Consultation Panel Meeting

Minutes

Wednesday 14 December 2016, 14.00-15.00

CFO Room, County Hall, Exeter and via teleconference

Present:

Ray Chalmers	Head of Communications & Strategic Engagement, South Devon & Torbay CCG
Rebecca Heayn	Clinical Effectiveness Governance Manager, NEW Devon CCG
Jenny McNeill	Associate, NEW Devon CCG
Mac Merrett*	Lay Member, Clinical Policy Committee
Chris Peach*	Non-Executive Director (Patient & Public Involvement), South Devon & Torbay CCG
Chris Roome	Head of Clinical Effectiveness, NEW Devon CCG
Jennie Willmott*	Lay Member, Patient & Public Engagement, NEW Devon CCG

* Denotes voting members

1. Welcome and Introductions

Attendees were welcomed to the meeting. No apologies were noted.

2. Declaration of Interests

No new general interests or specific interests pertinent to the items for discussion on the meeting agenda were declared.

3. Notes from the meeting 11 October 2016

The group considered the notes from the meeting of the panel held on 11 October 2016 and agreed them to be an accurate record.

It was queried whether there was a need for a fast-track process to consider the patient interest issues in respect of certain clinical policy recommendations. It was discussed and felt that the operation of the panel in its current form was a valuable stage of the process and was not considered to be causing a delay to the overall clinical policy development and approval processes. The group aims to meet two weeks after the Clinical Policy Committee, which is considered timely given the work required post-meeting to prepare the necessary documentation, including the recommendation, minutes and Quality and Equality Impact Assessment (QEIA). It was agreed that if there was an occasion where something was considered to be particularly urgent or there was likely to be meeting disruption due to unavailability, the group would endeavour to meet via telephone to avoid causing any delay.

The action log was updated as follows:

Action no.	Description and update
16/07	Contact to be made with the Patient Advice and Experience teams across the CCGs to query the number of contacts made with regard to myringotomy /grommets, relating to children and to adults, in order to establish a baseline position prior to the publication and implementation of the Devon-wide policies. **The policies had now been approved by the CCGs executive groups and completed the necessary governance processes. These had been implemented from 30 October, as agreed with DRSS. Data was obtained prior to the new policies going live to ensure an accurate snapshot of public/patient contacts at that point, but it was advised from the Patient Advice and Experience teams that none had been recorded.**
16/08	Addition to be made to the checklist of public interest issues routinely considered by the Panel to include consideration of the information on the treatment and condition available to patients via NHS Choices. **This had been added as a criterion to the public interest issues discussion/ notes aid used by the group to prompt routine consideration of this aspect. The addition of this as a routine consideration was also noted during feedback to the last Clinical Policy Committee meeting.**

4. Discussion and recommendation on Clinical Policy Committee decisions from 23 November 2016

Dexamethasone intravitreal implant (Ozurdex®) for the treatment of non-infectious posterior uveitis

A summary of the Clinical Policy Committee recommendation and considerations was noted by the panel. The Clinical Policy Committee had considered the use of dexamethasone intravitreal implant (Ozurdex®) for the treatment of non-infectious posterior uveitis following a consultant application. A consultant eye surgeon was in attendance at the meeting to contribute to discussions.

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

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

   It was noted that the proposed policy resulted from a consultant request to commission the treatment and that the Individual Funding Panel processes of the CCGs were keen for a Devon-wide policy position on the availability of this treatment to provide clarity for staff and patients. The unanimous policy recommendation reached by the Clinical Policy Committee is to commission the routine use of dexamethasone intravitreal implant for the treatment of bilateral and unilateral non-infectious posterior uveitis.

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

   It was considered that the recommended policy was anticipated to have a positive impact on safety, effectiveness and patient experience. It offers patients an additional treatment option which is delivered locally to the site of inflammation via an injection every 4-6 months. It offers the opportunity to minimise patient exposure to systemic corticosteroids and their side-effects. In uveitis, the use of systemic corticosteroids is often in high doses for long periods of time, which is shown to cause a number of dermatological, haematological, endocrine and metabolic, and gastrointestinal problems. Systemic treatments are taken orally and require patients to take multiple tablets every day for extended periods of time. Combination therapy of steroid plus immunosuppressant requires patients to undergo regular blood tests at intervals of between 2-4 weeks. Dexamethasone intravitreal implant may therefore be more convenient and reduce side-effects, improving the overall patient experience of care.

4. Have the wider consequences on society been considered?

   It was felt that there were no wider consequences of the proposed policy; this increases clinical choice, representing an additional option in the treatment of uveitis which may minimise exposure to systemic corticosteroids and their side-effects. There are small numbers of patients affected in Devon as the condition is uncommon.

5. Has the opportunity cost been considered?

   The group noted that although this was expected to represent a small cost impact to the CCGs, it was likely to result in overall cost savings across the wider NHS as fewer patients will progress to more expensive treatments.

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

   Although it was acknowledged that there is often public concern relating to sensory conditions, the group were not aware of any particular public concern regarding the condition or interventions for uveitis.

7. What information on the treatment and condition is available to patients via NHS Choices?

   NHS Choices contains information relating to corticosteroid use as a treatment option for uveitis, although dexamethasone intravitreal implant is not specifically mentioned for the treatment of non-infectious posterior uveitis.

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

Guanfacine Prolonged-Release Capsules (Intuniv®) for the treatment of attention deficit hyperactivity disorder (ADHD) in children and adolescents

A summary of the Clinical Policy Committee recommendation and considerations was noted by the panel. The Clinical Policy Committee had considered the use of guanfacine for the treatment of ADHD in children and adolescents following a consultant application. Two specialists were in attendance at the meeting to contribute to discussions.

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

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

   It was noted that the proposed policy resulted from a consultant request to commission the treatment. The policy recommendation reached by the Clinical Policy Committee is not to commission the routine use of guanfacine in Devon for the treatment of ADHD in children and adolescents.

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

   There was no concern for individual patients presented by the proposed policy. This will be relevant to a low number of patients, a small proportion of those with ADHD who cannot receive stimulant drugs. Other treatment options are available in Devon for the management this patient group and guanfacine would still be available for use on an exception basis for individual patients via successful application to the CCGs Individual Funding Panel.

4. Have the wider consequences on society been considered?

   It was felt that there were no wider consequences of the proposed policy; other treatment options are available in Devon for the management of ADHD. The group raised the issue of the relative merits of medication as opposed to other treatments, e.g. therapies for the treatment of ADHD. It was noted that the specialists present at the Clinical Policy Committee had commented that school nurses have a valuable role in helping children with ADHD and that service changes affecting them could have more impact.

5. Has the opportunity cost been considered?

   The group noted the committee discussion and consideration that, due to limitations in the evidence comparing guanfacine with alternative treatment and uncertainties in cost-effectiveness, it was not considered to represent good value for the local health economy.

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

   It was discussed that there may be contact with the CCGs in relation to ADHD as parents of children with ADHD may generally be engaged and express views in respect of local services and treatments. However the group were not aware of any public concern regarding the specific treatment and felt that further engagement in respect of this particular policy recommendation would not yield further insights.

7. What information on the treatment and condition is available to patients via NHS Choices?

   The information available on NHS Choices lists guanfacine as drug treatment which is licensed in the UK.

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

Botulinum Toxin A for the management of blepharospasm and for the management of hemifacial spasm

A summary of the Clinical Policy Committee recommendation and considerations was noted by the panel. The Clinical Policy Committee had previously considered and recommended the use of botulinum Toxin A for the management of blepharospasm and for the management of hemifacial spasm, with subsequent work undertaken in consultation with local specialists to develop clinically appropriate treatment criteria which capture functional limitations consistent with the CCGs' position in relation to other conditions. A consultant ophthalmologist, who had taken a lead on this on behalf of his colleagues, was in attendance at the meeting to contribute to discussions on the final policies presented for agreement.

The panel considered the public interest themes in relation to the proposed policies:

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

   It was noted that the proposed policies resulted from scoping work, which had identified the use of Botulinum Toxin A as a possible area of inconsistency within Devon due to its complex commissioning arrangements and use in different indications. The introduction of policies would provide a logical and consistent position for Devon for the use of Botulinum Toxin A in the management of blepharospasm and hemifacial spasm.

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

   There was no concern for individual patients presented by the proposed policies. These provide clarity and equity in the treatment of patients experiencing significant function limitations due to blepharospasm or hemifacial spasm. It was noted that the criteria for function limitation had been developed to be consistent with the CCGs' position in relation to other conditions.

4. Have the wider consequences on society been considered?

   It was felt that there were no wider consequences of the proposed policy; this will provide clarity and ensure the equitable treatment of patients with blepharospasm or hemifacial spasm across Devon.

5. Has the opportunity cost been considered?

   The group noted the discussion and conclusion that introduction of logical and consistent Devon-wide commissioning policies will ensure equitable provision of treatment, delivering value for money for the NHS.

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

   Although it was acknowledged that there is often public concern relating to conditions affecting the senses, the group were not aware of any particular public concern regarding the conditions or interventions for the management of blepharospasm or hemifacial spasm.

7. What information on the treatment and condition is available to patients via NHS Choices?

   NHS Choices contains information relating to dystonia, including blepharospasm and hemifacial spasm. It notes botulinum toxin as a main treatment option for dystonia and that, although not considered to be a dystonia, hemifacial spasm can cause similar symptoms and can respond well to botulinum toxin injections.

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

It was commented that the paperwork produced for and circulated to the group ahead of the meeting was very clear, understandable and gave a comprehensive overview of the context, the committee recommendation and discussions, and the anticipated quality and equality impacts. The group felt that this supported and enabled straightforward and well informed discussions about the respective recommendations.

5. Any other business

Lay public member vacancy

It was reported that the vacancy for a new Lay Public Member of the Clinical Policy Committee, and member of this Panel, had recently been re-advertised with a closing date of 16 December. Two applications had been received to date. Shortlisting of candidates is due to be undertaken on 21 December with interviews expected to take place in the New Year.

The process for shortlisting and interview will be similar to that carried out previously and will involve Mac Merrett, Chris Roome, Dr Jo Roberts as Chair of the Clinical Policy Committee, and Chris Buswell, Community Representative for NEW Devon CCG to provide some wider lay perspective.

6. Date of next meeting

The next meeting is due to be held on Wednesday 1 February 2017 from 2.00pm in the CFO Room, County Hall, Exeter or via teleconference.

The group were asked to check their diaries and advise Rebecca Heayn if attendance was likely to be problematic for them.