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

Clinical Policy Engagement & Consultation Panel Meeting

Minutes

Tuesday 17 April 2018, 14.00-15.30

CFO Room, County Hall, Exeter and via teleconference

Present:

Rebecca Heayn	Clinical Effectiveness Governance Manager	NEW Devon CCG
Mac Merrett*	Lay Public 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
Jon Taylor	Commissioning and Transformation Manager	NEW Devon CCG
Mark Taylor*	Lay Public Member, Clinical Policy Committee	
Jennie Willmott*	Lay Member, Patient & Public Engagement	NEW Devon CCG

* Denotes voting members

1. Welcome and Introductions

Attendees were welcomed to the meeting.

Apologies were noted from Ray Chalmers, Head of Communications & Strategic Engagement, South Devon & Torbay CCG.

2. Declaration of Interests

No changes to the Register of Interest were advised and no specific interests pertinent to the items for discussion on the meeting agenda were declared.

3. Minutes from the meeting 7 February 2018

The panel considered the minutes from the meeting held on 7 February 2018 and agreed them to be an accurate record.

The action log was updated as follows:

Action no.	Description and update
17/05	Letter to be drafted to inform patients who currently have cryopreserved material of the revisions to the policy so that they can understand how this may affect them. The CCGs should engage with the fertility centres in order to identify and communicate with those individuals affected. This should accompany communication/publication of the revised cryopreservation to preserve fertility

	policy (subject to approval by the CCGs). 12/12/2017 update: Chris Roome advised the group that a letter had been drafted by the Clinical Effectiveness team to communicate with individuals affected by the revised cryopreservation to preserve fertility policy. This will now be shared with providers for the content and approach to be agreed, and to coordinate the sending of letters with publication of the revised policy. 07/02/2018 update: Subsequently it has been agreed that the partners of patients who have died with cryopreserved material should also receive a letter explaining how the policy may affect them. The CCGs' Strategic Leadership Committee is to decide by the end of March the CCG's policy position regarding funded storage of material for patients who have died. **The CCGs have now taken a decision. The letter and policy are being prepared for publication and circulation on 30 April 2018. Action complete.**
18/01	Letter to be drafted and sent to local specialists, NEW Devon CCG PACT and Ray Chalmers providing the explanation to be given to patients who are not eligible for the FreeStyle Libre device due to not meeting the criteria. **A letter was prepared and shared with specialists and the patient advice/communications teams in conjunction with policy publication. Action complete.**
18/02	Contact to be made with the Devon Local Optical Committee about the policy for Meibomian cysts, once ratified, to ascertain whether further communication was needed to private providers and if so who it should come from. **Contact was made with the Devon Local Optical Committee via Devon Referral Support Services (DRSS) as part of the planned implementation of the policy. The policy has now come into effect. Action complete.**

4. Discussion and recommendation on the Clinical Policy Committee decisions from 21 March 2018

Intravitreal Bevacizumab for radiation maculopathy

A summary of the Clinical Policy Committee recommendation and considerations was noted by the panel. Radiation maculopathy is a vision-threatening complication after exposure to radiation for the treatment of ocular cancer. The Clinical Policy Committee had considered the use bevacizumab for the management of radiation maculopathy following a request from local ophthalmologists, two of whom were present for the committee discussion.

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 request was for use of a well-recognised but unlicensed drug in a small number of patients with this condition. Its use is in line with the national specialist centre, who use and recommend this treatment as part of their protocol for patients.

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

   It was considered that this would be a positive enhancement for patients with this condition. Enabling the use of bevacizumab in Devon for these patients as part of local supportive care arrangements will avoid the need for patients to travel to the specialist centre in Liverpool to receive this treatment.

4. Have the wider consequences on society been considered?

   It was felt that there were no wider consequences of the proposed policy; this is an area with no broader impact beyond the individuals involved. However it was acknowledged in general that there may be wider social and wellbeing benefits from the preservation of sight.

5. Has the opportunity cost been considered?

   It was advised that the costs of treatment were fairly low, with only a small number of patients expected to start treatment for this condition each year. It was clarified that although patients with ocular cancer are referred to national specialist centres for treatment, the treatment of radiation maculopathy is commissioned by CCGs.

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

   The panel were not aware of any specific public concern regarding this condition. It was acknowledged that ocular cancers are rare and the number of patients with this condition is small. There was general discussion about the use of unlicensed treatments and whether this posed any concerns. It was discussed that this was not unusual in NHS practice. Healthcare professionals may recommend the use of off-label or unlicensed medicines, i.e. those which are not licensed for treatment of the specific condition, but which have a licence to treat another condition and have undergone clinical trials for this. Unlicensed medication may be recommended if the clinician thinks it will treat the condition effectively and the benefits are greater than any risks.

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

   NHS Choices gives information on eye cancer, but does not specifically contain information on radiation maculopathy.

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

Intravitreal Bevacizumab for rubeosis iridis and neovascular glaucoma

A summary of the Clinical Policy Committee recommendation and considerations was noted by the panel. The Clinical Policy Committee had considered the use bevacizumab for the management of rubeosis iridis and neovascular glaucoma following a request from local ophthalmologists, two of whom were present for the committee discussion. It was noted that this is a secondary glaucoma where blood vessels grow across the front of the eye.

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 request was for use of a well-recognised but unlicensed drug in a small number of patients. It was advised that the standard treatment is with laser, although in some cases patients do no respond to this alone; significant neovascularisation of the iridocorneal angle may already be present and therefore a quicker response may be needed; or patients may have opacities (such as a cataract) preventing the use of laser.

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

   It was considered that there were benefits for patients in enabling bevacizumab as a treatment option for rubeosis iridis and neovascular glaucoma. It may achieve better visual outcomes, enabling immediate action to lessen impairment and potentially decrease the need for glaucoma surgery or make surgery more successful when it is required.

4. Have the wider consequences on society been considered?

   It was felt that there were no wider consequences of the proposed policy; this is an area with no broader impact beyond the individuals involved. However it was acknowledged in general that there may be wider social and wellbeing benefits from the preservation of sight.

5. Has the opportunity cost been considered?

   It was advised that the number of patients expected to start treatment each year was low; approximately 17 across Devon. It was noted that the use of bevacizumab offers a way of treating patients which may save costs, although this is difficult to quantify. Unlike laser, bevacizumab action is immediate, which may prevent or lessen impairment and decrease the need for glaucoma surgery. The failure rate of glaucoma surgery is much higher if there is an active neovascular process in the eye and such patients usually require glaucoma tubes. Early intervention with a combined approach (bevacizumab and laser) is less expensive than glaucoma surgery and achieves much better visual outcomes. Controlling the neovascular drive will make glaucoma surgery more successful when it is required.

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

   The panel were not aware of any specific public concern regarding this condition or the treatment options.

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

   NHS Choices gives information on the diagnosis and treatment of glaucoma, but does not specifically contain information on rubeosis iridis and neovascular glaucoma.

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

The specialist management of abdominal wall hernia in adults

A summary of the Clinical Policy Committee recommendation and considerations was noted by the panel. The revised CCGs' policy for the specialist management of abdominal wall hernia proposes a revised definition of significant functional impairment for this policy and the inclusion of a statement to clarify that the surgical repair of divarication of recti/diastasis of abdominal muscle (separated stomach muscles) is not routinely commissioned. It was advised that local specialists were consulted and were broadly in agreement with the proposed changes.

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 existing policy in place was developed in 2015. At the request of local specialists, a review of the content of the policy was considered in 2017, but no agreement was reached at this time. However the discussions prompted review of the definition for significant functional impairment in relation to this policy and the GP Referral Facilitators working for DRSS suggested that the existing policy was not being consistently applied.

   The revised definition has been proposed by clinicians at DRSS, who also requested inclusion of a statement clarifying the position on surgical repair of divarication of recti.

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

   It was noted that the revised definition of significant functional impairment provides a lower threshold and therefore some patients may now be eligible for referral who would not be under the existing policy. It was acknowledged that clarification of the position on surgical repair of divarication of recti was not expected to have a significant impact as it was already established that the NHS would not routinely fund treatments for cosmetic reasons.

   It was queried whether the differential criteria in the policy for men and women with inguinal hernia posed any equality issues. It was discussed that this distinction was for clinical, anatomical reasons only; women have a higher mortality risk compared to men due to greater risk of emergency procedure. This was noted in the policy rationale and had also been captured in the Quality and Equality Impact Assessment (QEIA) carried out on the policy.

4. Have the wider consequences on society been considered?

   It was felt that there were no wider consequences of the proposed policy; this is an area with no broader impact beyond the individuals involved. However there was discussion about the definition of significant functional impairment across different policies. It was advised that this had previously been discussed by the Clinical Policy Committee. It was felt that a uniform position for all conditions was unattainable, but that it was important to consider the appropriateness of statements of functional limitation when contextualised by the procedure or condition under review.

5. Has the opportunity cost been considered?

   It was acknowledged that the proposed statement regarding surgical repair of divarication of recti was not expected to have a significant impact on activity levels.

   It was noted that it was not possible to quantify any potential change in expenditure due to a number of uncertainties. The lower threshold for referral for surgical repair may be expected to increase referrals and associated activity. However inconsistent application of the current policy means that a lower threshold could actually lead to decreased activity if the policy is now consistently implemented.

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

   The Panel was not aware of any particular public concern with regard to abdominal hernia or hernia repair, although it was noted that hernias are common.

   When the current policy was considered by the Panel in 2015, it was recommended that although no further engagement was required, that there should be communication of appropriate positive information to support the implementation and understanding of the policy. Clinical policy patient support information was subsequently produced to accompany and support publication of the final commissioning policy. It was agreed that it should be checked whether any updates to this are required in light of the revised policy and that the existence of this resource should be reiterated when the revised policy is published.

   ACTION: Rebecca Heayn to check whether any updates are required to the hernia clinical policy patient support information and ensure this is communicated alongside the revised policy.

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

   NHS Choices includes information on assessing a hernia, which outlines that a number of factors will be considered when deciding whether surgery is appropriate. These include the type and content of the hernia, the symptoms and impact on daily life, and the patient's general health.

   Information on separated stomach muscles (diastasis recti) is also included. It is noted that it is common in pregnancy and usually goes back to normal, however exercises can reduce the size of the separation between the stomach muscles.

   It was discussed that the procedure is currently offered on the website of one of the acute trusts in Devon and agreed that contact should be made with them in light of the policy revision to seek to avoid conflicting messages for patients.

   ACTION: Chris Roome to contact the local acute trust offering procedures for divarication of recti on their website to make them aware of the revised policy and to seek to avoid conflicting messages for patients.

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

5. Any Other Business

Annual report 2017-18

Rebecca Heayn stated the intention to produce an annual report from the group, detailing the business conducted during 2017-18. It was suggested that this was drafted for discussion and presentation to the next meeting in June, before onward reporting to the CCGs for assurance purposes.

6. Date of next meeting

The next meeting is due to be held on Wednesday 6 June 2018 from 2.00pm in the CFO Room, County Hall, Exeter or via teleconference.

Mark Taylor gave his apologies for the next meeting.

ACTION LOG

Action no.	Meeting date	Action description	Lead(s)
18/03	17/04/2018	To check whether any updates are required to the hernia clinical policy patient support information and ensure this is communicated alongside the revised policy.	Rebecca Heayn
18/04	17/04/2018	To contact the local acute trust offering procedures for divarication of recti on their website to make them aware of the revised policy and seek to avoid conflicting messages for patients.	Chris Roome