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

# Clinical Policy Engagement & Consultation Panel Meeting

## Minutes

**Wednesday 17 August 2016, 14.00-15.30**

**CFO Room, County Hall, Exeter**

**Present:**

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| Ray Chalmers | Head of Communications & Strategic Engagement, South Devon & Torbay CCG |
| Rebecca Heayn | Clinical Effectiveness Governance Manager, NEW Devon CCG |
| Mac Merrett* | Lay Member, Clinical Policy Committee |
| 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.

Apologies were noted from Jono Broad, Lay Member, Clinical Policy Committee; Jenny McNeill, Associate, NEW Devon CCG; and Chris Peach, Non-Executive Director (Patient & Public Involvement), South Devon & Torbay CCG.

It was shared that Jono Broad had commented via email that there was nothing of concern on the meeting papers and in all instances he was convinced that the Clinical Policy Committee made the right decisions for the community.

It was noted that Jono Broad was stepping down from his role as a Lay Member of the Clinical Policy Committee following the next meeting of the committee on 14 September and would no longer be a member of the Panel. The CCGs are looking to advertise shortly in order to appoint a new Lay Member or Lay Members to replace Jono and to strengthen the Panel membership. Mac Merrett had agreed to chair the Panel in the interim.

The role description has recently been updated in conjunction with the Lay Members to ensure that this accurately reflects the current requirements of the role and the additional commitment for Clinical Policy Committee Lay Members to sit on the Clinical Policy Engagement & Consultation Panel. Rebecca Heayn has been in contact with the Communications teams for NEW Devon CCG and South Devon & Torbay CCG to link in with their bulletins and communication mechanisms, including social media, and to prepare a press release for local newspapers. The CCG web pages will be updated with details of the vacancy and role description. Contact has also been made with Healthwatch across Devon, Torbay and Plymouth, and they have all agreed to assist with circulating details of the vacancy. It was suggested that links are also made with the CCG Community Representatives and with Local Authorities to ask them to share details via their communication routes.

## 2. Declaration of Interests

No updates to the Declaration of Interests Register were required and no specific interests pertinent to the items for discussion on the meeting agenda were declared.

## 3. Notes from the meeting 11 May 2016

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

The action log was updated as follows:

| Action no. | Description and update |
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| 15/07 | Engagement with the scrutiny committees across Devon to present the final process for consideration.<br><br>Rebecca Heayn had previously made contact with the Scrutiny Committees across Devon, sharing details of the process and giving the opportunity for comment. No responses have been received to date. This would be followed up with a letter to the Committees.<br><br>For Plymouth, a paper had been shared with Jerry Clough who met with the Chair and Vice Chair of the Scrutiny Committee and gave an overview of the paper at the meeting. This was acknowledged by Councillors and we were asked to circulate this electronically following the meeting.<br><br>For Devon and Torbay text was drafted and shared with Jenny McNeill prior to contacting the Scrutiny Committees.<br>**Rebecca Heayn has subsequently contacted the Scrutiny Committees to thank them for their time in considering the process. Action complete.** |
| 16/03 | Links to be made to improve communication of clinical policy patient support information to clinicians/raise awareness of these support tools.<br><br>Chris Roome had previously advised that South Devon and Torbay GPs do not receive the Planned Care Control Centre newsletters via direct mailing; onward circulation is locally determined by South Devon and Torbay CCG. Ray Chalmers confirmed that information is included in GP updates to GPs and practice managers. This is usually short messages with onward links, but essentially all are receiving the information. Chris Roome agreed to check when the last Planned Care Control Centre News was sent out and would draft a short article to promote and remind GPs of the support information available and accessible via links from the formulary and referral website and app.<br>**Chris Roome advised that he had established the process for Planned Care communications in South Devon and Torbay compared to NEW Devon; Planned Care News and specific policy and Clinical Referral Guideline information is sent to South Devon and Torbay commissioners for them to disseminate to their GPs. He had not yet written an article for dissemination but would now do so and check with Ray Chalmers that the cascade of this occurs as planned.** |
| 16/05 | Clinical Policy Engagement and Consultation Panel Annual Report 2015-16 to be submitted to the Engagement Committee and the Commissioning and Finance Committee in South Devon and Torbay CCG, and the new Patient and Public Engagement Committee (PPEC) in NEW Devon CCG.<br><br>**The Annual Report had been submitted to the Commissioning and Finance Committee and the Quality and Engagement Committees in South Devon and Torbay CCG. Chris Peach advised that it was welcomed, accepted and consequently formally ratified by the Governing Body.** |

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| | **For NEW Devon CCG the Annual Report was submitted to the first meeting of the Patient and Public Engagement Committee (PPEC) where it was also discussed and well received. A recommendation was made to improve communication with the locality community groups so that they were better informed of clinical policy work and any recommendations/changes. Rebecca Heayn subsequently discussed with the Communications team and it was agreed that communication with community representatives would be built in as a standard part of the clinical policy communication process. Jennie Willmott agreed to provide support and advice on the content and messages to be shared. Action complete.** |
| 16/06 | Feedback on the use of the policy support information to be sought from the CCGs Patient Advice and Experience Teams and to query with the Communications team whether website download or hit rate data is available.<br>**A report had been prepared following the collation of information and was on the agenda for discussion. Action complete.** |

## 4. Clinical Policy Patient Support Information – data and feedback on use and uptake

During review of the Annual Report at the last meeting, the Panel had queried whether we could establish the uptake and success of the patient support information that had been produced on the recommendation of the Panel.

Rebecca Heayn had subsequently made contact with the Patient Advice and Experience Teams across CCGs, the Joint Formularies Technician and the NEW Devon CCG Digital Communications Specialist to collate any available data or feedback on use and uptake. A report on this was presented to the Panel. This included details of any Patient Advice/ Experience contacts relating to the policy areas, relevant Formulary and referral website page views and NEW Devon CCG website views of the clinical policy patient support information page.

It was noted that there were some limitations to the data available, which included:

- It is not possible to determine what specific content formulary viewers were searching for or accessing and we are unable to determine specific download rates for information.
- The online views do not capture instances where information has been shared via email and/or saved or downloaded for local use.
- There may be other routes of access and dissemination of information, for example with the cataract policy links were made with opticians and optometrists to disseminate this locally. Patients may also receive information relayed to them directly from their GP; contacts with the CCG Patient Advice/Experience teams may be minimal.
- All of the clinical policy patient support information produced to date is accessible via one main CCG website page; this is not broken down by specific policy area. We do not have data on specific download rates for information.

Despite the limitations it was reassuring to note that the information was clearly and consistently available across the various sources and mechanisms and it was commented than the numbers were higher than expected; there have been 350 page views of the specific clinical policy patient support information web page between September 2015 and the end of July 2016.

Given the high profile nature of cataract surgery, it was interesting to note that there had not been any contacts with the Patient Advice and Experience teams since the publication of the cataract commissioning policy in October 2015. It was suggested that this was indicative of the thorough process for producing clear clinical guidance and support information, with a careful approach to the timing and breadth of communication and dissemination.

## 5. Discussion and recommendation on Clinical Policy Committee decisions from 20 July 2016

### Dulaglutide (Trulicity®) for the treatment of Type 2 Diabetes

A summary of the Clinical Policy Committee recommendation and considerations was noted by the panel. The Clinical Policy Committee had considered the use of dulaglutide for type 2 diabetes following a consultant application, with the applicant joining the meeting via telephone 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 unanimous policy recommendation reached by the Clinical Policy Committee is to commission the routine use of dulaglutide for type 2 diabetes, to be used in line with National Institute for Health and Care Excellence (NICE) guidance for this class of drug in the management of type 2 diabetes.

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. There were no additional safety concerns presented above those already observed for this class of drug. The routine commissioning of dulaglutide extends choice, making an additional treatment option available to patients with type 2 diabetes. It was noted that the drug is administered once weekly via a ready-to-use, fixed dose pen and so represents an alternative option for patients whose lifestyle would benefit from once weekly dosing. It may save on healthcare professional time in training patients to use it, improve adherence and be simpler for carers.

4. Have the wider consequences on society been considered?

   It was felt that there were no wider consequences of the proposed policy; this represented an additional treatment option in this class of drug for patients with type 2 diabetes.

5. Has the opportunity cost been considered?

   The group noted the discussion of the cost-effectiveness analysis and the conclusion that dulaglutide offered good value for the local health economy. Budget impact models considered by the Clinical Policy Committee suggested that it could result in a small cost saving to the local health economy.

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

   Although it was noted that type 2 diabetes was a high profile condition, the group were not aware of any particular concerns regarding type 2 diabetes, or with the specific use of dulaglutide as a treatment option.

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

### Myringotomy/grommets with or without adjuvant adenoidectomy for the management of otitis media in children under 12 years

A summary of the Clinical Policy Committee recommendation and considerations was noted by the panel. The Clinical Policy Committee had recommended a policy for myringotomy/grommets with or without adjuvant adenoidectomy for the management of otitis media in children under 12 years. A consultant Ear, Nose and Throat (ENT) surgeon was present for the discussions. It was noted that the committee had voted 6-1 in favour of recommending the commissioning policy, with 4-3 in favour of the routine commissioning of adenoidectomy within the policy.

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 was part of work being undertaken to align the commissioning policies from the previous commissioning organisations into one Devon-wide policy. This would ensure consistency and clarity for patients across Devon. Directly standardised activity rates data from the Royal College of Surgeons had suggested that the CCGs in Devon were currently much higher than England averages for procedures related to childhood hearing loss, which were determined locally to be predominantly myringotomy with grommets. It was discussed that there was a plan to use the Blueteq IT system to support policy implementation as a mechanism for understanding application of the policy.

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

   The group considered that there had been detailed discussion of the effects on individual patients and parents/carers, and that this was also reflected in the and/or nature of the policy criteria. The routine commissioning of adjuvant adenoidectomy is likely to result in a small hearing gain and reduces the risk of grommet reinsertion at a later date. There was discussion of how the softer, more subjective policy criteria relating to developmental delays might be objectively measured and it was noted that an understanding of the policy application would be gained from monitoring its use via Bluteq.

4. Have the wider consequences on society been considered?

   It was felt that the wider consequences of the proposed policy has been considered, which were limited in this case. The proposed policy is in line with National Institute for Health and Care Excellence (NICE) guidance and the NHS England policy for grommets in children and adults; it does however go further in removing restrictions on the routine use of adjuvant adenoidectomy.

5. Has the opportunity cost been considered?

   It was discussed that this had been difficult to quantify. If there was no significant change in practice, costs were likely to remain the same. However the routine commissioning of adjuvant adenoidectomy may increase costs as these would not be fully offset by a reduction in grommet reinsertion rates. Although it was cost-effective and it would bring the CCGs in Devon closer to the national average rates, it was noted that it may have a small budgetary impact.

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

   The group were aware that there was public knowledge of both the condition and the interventions; this is predominately a condition of childhood and the CCGs had received letters relating to the treatment of patients. There was discussion of whether producing clinical policy patient support information would be helpful. On balance it was felt that this would not be appropriate in this instance and it may have the contrary effect of creating anxiety where this does not exist. It was noted that the policy position remains largely unchanged, with the exception that it now provided an easier route to adenoidectomy than previously. It was also noted that ENT departments would have further information available to patients relating to specific procedures.

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

It was suggested that the Patient Advice and Experience teams across the CCGs are asked 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 Devon-wide policies.

**Myringotomy with or without ventilation tubes (grommets) in adults and children aged 12 years or older**

A summary of the Clinical Policy Committee recommendation and considerations was noted by the panel. The Clinical Policy Committee had unanimously recommended a policy for myringotomy with or without ventilation tubes (grommets) in adults and children aged 12 years or older. A consultant Ear, Nose and Throat (ENT) surgeon was present for the 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 was part of work being undertaken to align the commissioning policies from the previous commissioning organisations into one Devon-wide policy. This would ensure consistency and clarity for patients across Devon. It was discussed that there was no national benchmarking data in this age group, with the number of overall procedures much lower than in children under 12 years. There is also no National Institute for Health and Care Excellence (NICE) guidance specifically relating to this age group, although it was noted that the same principles had been applied.

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; the policy is in line with the stated practice of local specialists.

4. Have the wider consequences on society been considered?

   It was felt that there were no wider consequences of the proposed policy; this represented clarification of and consistency in application of the stated practice of local specialists.

5. Has the opportunity cost been considered?

   The group noted that there was no national benchmarking data in this age group; there was not expected to be a significant impact on activity rates or costs from the proposed policy.

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

   The group were not aware of any particular public concern regarding the condition or interventions relating to this age group. It was acknowledged that this was predominately a condition of childhood and the numbers of those aged 12 and older treated were much lower.

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

**Tonsillectomy**

A summary of the Clinical Policy Committee recommendation and considerations was noted by the panel. The Clinical Policy Committee had unanimously recommended a policy for tonsillectomy. A consultant Ear, Nose and Throat (ENT) surgeon was present for the 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 was part of work being undertaken to align the commissioning policies from the previous commissioning organisations into one Devon-wide policy. This would ensure consistency and clarity for patients across Devon. It was noted that there is no National Institute for Health and Care Excellence (NICE) guidance; however the proposed policy is in line with the Royal College of Surgeons commissioning guide for

tonsillectomy which includes the Scottish Intercollegiate Guidelines Network (SIGN) criteria for referral.

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. It represents no significant clinical change from the current position, and clarifies the instances in which tonsillectomy will not be routinely commissioned. Discussions at the Clinical Policy Committee had principally related to sleep apnoea, and it was acknowledged that access to sleep studies as a way of objectively diagnosing sleep apnoea is very limited both locally and nationally.

4. Have the wider consequences on society been considered?

   It was felt that there were no wider consequences of the proposed policy; this is in line with the Royal College of Surgeons commissioning guide and ensures consistency and clarity for patients across Devon.

5. Has the opportunity cost been considered?

   The group noted that the proposed policy is not expected to have a significant impact in activity levels for tonsillectomy and there was not really scope for reduction. However with regards to addressing any local variation it was noted that if a particular provider differed from mean tonsillectomy rates by more than two standard deviations, it will need to apply via Blueteq, thereby enabling effective monitoring of the policy.

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

   The group noted that there was public knowledge of tonsillectomy, but they were not aware of any particular concerns regarding the condition or treatment. It was considered that no groups were disaffected by the proposed policy.

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

## 6. Any other business

**Next meeting date**

It was discussed and agreed that the next meeting needed to be rearranged to ensure quoracy. This had originally been scheduled for 28 September and would now be cancelled. There will be communication via email to find a suitable alternative date, bearing in mind the need for this to remain a timely process following the Clinical Policy Committee meeting on 14 September.

There was discussion of the feasibility, should the alternate date result in a delay, of arranging an extraordinary meeting via telephone to discuss any time-critical policy recommendations.

**ACTION LOG**

| Action no. | Meeting date | Action description | Lead(s) |
|---|---|---|---|
| 16/03 | 23/03/2016 | Links to be made to improve communication of clinical policy patient support information to clinicians/raise awareness of these support tools.<br><br>**11/05/2016 update: Chris Roome advised that South Devon and Torbay GPs do not receive the Planned Care Control Centre newsletters via direct mailing; onward circulation is locally determined by South Devon and Torbay CCG. Ray Chalmers confirmed that information is included in GP updates to GPs and practice managers. This is usually short messages with onward links, but essentially all are receiving the information. Chris Roome agreed to check when the last Planned Care Control Centre News was sent out and would draft a short article to promote and remind GPs of the support information available and accessible via links from the formulary and referral website and app.**<br><br>**17/08/2016 update: Chris Roome advised that he had established the process for Planned Care communications in South Devon and Torbay compared to NEW Devon; Planned Care News and specific policy and CRG information is sent to South Devon and Torbay commissioners for them to disseminate to their GPs. He had not yet written an article for dissemination but would now do so and check with Ray Chalmers that the cascade of this occurs as planned.** | Chris Roome |
| 16/07 | 17/08/2016 | 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. | Rebecca Heayn |