NHS
Devon
Clinical Commissioning Group

Clinical Policy Engagement & Consultation Panel

MINUTES

Tuesday 9 July 2019, 14.00-15.30

Dart Room, County Hall, Exeter and via teleconference

Present:

Charlotte Burrows*	Governing Body Lay Member for patient and public involvement
Rebecca Heayn	Clinical Effectiveness Governance Manager
Carol McCormack-Hole*	Lay Member from the Patient Engagement Forum
Jenny McNeill	Associate Director of Planning Development
Mac Merrett*	Lay Public Member, Clinical Policy Committee
Nick Pearson	Head of Communications and Engagement
Chris Roome	Head of Clinical Effectiveness
Mark Taylor*	Lay Public Member, Clinical Policy Committee

* Denotes voting members

1. Welcome and Introductions

Charlotte Burrows and Carol McCormack-Hole were welcomed to the meeting as new members of the panel. Introductions were made for the benefit of the group.

Apologies were noted from Jon Taylor, Strategy Manager.

2. Declaration of Interests

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

3. Minutes from the meeting 30 April 2019

The panel considered the minutes from the meeting held on 30 April 2019 and agreed them to be an accurate record.

The action log was updated as follows:

Action no.	Description and update
19/03	Prepare patient support information to accompany publication and communication of the breast reduction surgery policy. **This has now been published. Action complete.**

19/04	Annual report to be reported to the CCG for information and assurance. **The Annual report was received by the Clinical Policy Committee and the Commissioning Business Meeting on behalf of the CCG. Action complete.**
19/05	Terms of Reference to be revised to reflect the merger of the CCGs and the impact on the membership of the panel. **Action complete.**

4. Discussion and recommendation on the Clinical Policy Committee decisions from 22 May 2019

It was noted that all the items on the agenda for consideration were recommended revisions to existing CCG policies. For the benefit of the new members of the panel, it was explained that this work had been undertaken in response to NHS England statutory guidance to CCGs to introduce and implement commissioning policies for selected interventions, which had been published in November 2018.

The NHS England guidance sets out 17 interventions; four of which should not be routinely undertaken, with applications for treatment via individual funding request (IFR) only, and 13 for which criteria for treatment apply.

For the interventions for which no local policies were in place, the CCG has adopted the NHS England commissioning recommendations. For the remaining interventions, for which the CCG has existing local policies in place, there is a programme of work to review these via the Clinical Policy Committee to demonstrate regard to the national guidance. This process involves consultation with relevant local specialists for their input in assessing the clinical, service and financial impacts of the differences between the NHS England guidance and the existing CCG policy.

Dupuytren's contracture treatment

NHS England issued statutory guidance to CCGs in November 2018 to introduce and implement commissioning policies for selected interventions. This had prompted review of the existing CCG policy for Dupuytren's contracture treatment. Local specialists had been asked for their input in terms of assessing the clinical, service and financial impacts of the differences between the NHS England guidance and the existing CCG policy. As a result a revised commissioning policy which adopts the NHS England criteria has been recommended by the Clinical Policy Committee.

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

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

   It was acknowledged that the current CCG policy had been reviewed with regard to statutory guidance published by NHS England in November 2018, and a revised CCG policy had been proposed as a result.

3. <u>Have the effects of the policy on individual patients and carers been considered?</u>

   It was noted that with adoption of the NHS England criteria, patients would now need to satisfy a specified 20° angle of contracture to be referred by their GP for surgical intervention, rather than the previous more subjective criteria. However the changes are not expected to alter the overall number of patients referred or the level of surgical activity; specialists advised that they would not operate on patients with

lesser disease. Furthermore, the criteria were developed with the British Society for Surgery to the Hand which would help ensure a consistent approach.

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 discussed that the adoption of the NHS England criteria was not expected to alter current clinical practice, referral numbers or surgical activity for Dupuytren's contracture. It was noted that NHS England has set a challenging target for reduction in activity for Dupuytren's contracture treatment which local specialists consistently indicated was overly ambitious and unlikely to be met, either with adoption of the NHS England criteria or if the existing policy is maintained.

   It was questioned why this would be the case and how NHS England had set these targets. It was explained that the targets are the 25th percentile of CCGs activity rates, meaning that 75% of all CCGs will have a target to reduce activity. However NHS England has not assessed whether their criteria will lead to this reduction.

   It was discussed how adherence to commissioning policy is monitored locally, and if this does not occur, whether we should have a system in place. Whilst it was commented that the procedural requirements of monitoring systems should not negatively impact clinical specialists who should be trusted to undertake their roles, it was also noted that appropriate monitoring systems (such as the use of Blueteq software) would enable the local health community to demonstrate that all patients treated met the relevant criteria, and hence that a failure to meet activity target reductions is not due to a failure to implement policy criteria.

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 in respect of Dupuytren's contracture.

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

   nhs.uk states that Dupuytren's contracture tends to get slowly worse over many months or years, and that treatment cannot usually help in the early stages. It advises that patients should see a GP if one or more of their fingers are bent and they cannot put their hand down flat or are having difficulty with daily activities. In this case patients will probably be offered treatment and the GP may refer them to a surgeon to discuss the options.

   It is stated that the three main types of treatment are surgery to straighten fingers, injections into the hand and using a needle to straighten the fingers. However it is advised that the finger may not be completely straight after treatment and might not be as strong and flexible as it used to be. The contracture could also come back after a few years.

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

Surgery for carpal tunnel syndrome

NHS England issued statutory guidance to CCGs in November 2018 to introduce and implement commissioning policies for selected interventions. This had prompted review of the existing CCG policy for surgery for carpal tunnel syndrome. Local specialists had been asked for their input in terms of assessing the clinical, service and financial impacts of the differences between the NHS England guidance and the existing CCG policy. As a result a revised commissioning policy has been recommended by the Clinical Policy Committee which adopts the NHS England criteria, with the exception of the duration of conservative treatment prior to surgery which is being maintained at 12 weeks.

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

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

   It was acknowledged that the current CCG policy had been reviewed with regard to statutory guidance published by NHS England in November 2018, and a revised CCG policy had been proposed as a result.

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

   It was noted that the NHS England criteria are stricter than the current CCG policy, which may result in some referrals no longer progressing where they would have done previously.

   However local specialists believe there will be little difference in surgical activity levels with implementation of the revised policy because it reflects the patients they currently operate on. There is therefore potential benefit from better management of referrals in targeting specialists time in assessing patients who are more likely to meet criteria for surgery and in avoiding disappointing patients who may have had expectations of receiving surgical treatment. Furthermore, the criteria were developed with the British Society for Surgery to the Hand which would help ensure a consistent approach.

   It was considered that in the majority of cases non-operative management of symptoms is appropriate and the 12 week timeframe set out in the policy poses no long term issues for the patient. However the policy clarifies that referral should not be delayed for patients with symptoms indicating a risk of damage to nerves. Specialists indicated that some patients who fall within this sub group are currently being referred to them at a late stage when surgery may be less effective.

   There was discussion of how this feedback from specialists is best communicated to GPs to reinforce appropriate referral messages. It was discussed that this would be best clarified in the clinical referral guidance for GPs which is published on the Devon Formulary and Referral. It should also be reiterated when the revised policy is communicated that a single corticosteroid injection should be administered, rather than repeated injections, and that referrers should avoid any delay in referring patients with risk of nerve damage.

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 noted that NHS England has set a challenging target for reduction in activity for carpal tunnel syndrome release which local specialists consistently indicated was

overly ambitious and unlikely to be met, either with adoption of the NHS England criteria or if the existing policy is maintained.

Local specialists believe there will be little difference in surgical activity levels with implementation of the revised policy because it reflects the patients they currently operate on. However it is expected that some referrals which would previously have progressed will now be returned, which would have the benefit of better targeting specialists time in assessing patients more likely to meet criteria for surgery.

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 in respect of carpal tunnel syndrome.

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

   nhs.uk states that the symptoms of carpal tunnel syndrome often start slowly and come and go. They are usually worse at night. Patients can often treat it themselves by wearing a wrist splint, stopping or cutting down on things that may be causing it, taking painkillers, and with hand exercises, but it can take months to get better.

   If this has not helped, a GP might recommend a steroid injection into the wrist to bring down swelling around the nerve and ease symptoms. However steroid injections are not always a cure.

   If it is getting worse and other treatments have not worked, a GP might refer a patient to a specialist to discuss surgery, which usually cures carpal tunnel syndrome, although it can take a month after the operation to get back to normal activities.

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

Action: DRSS to be advised of the need for clinical referral guidance to be updated in respect of carpal tunnel syndrome and for appropriate referral messages to be reiterated with communication of the revised policy.

Treatment for ganglion cyst

NHS England issued statutory guidance to CCGs in November 2018 to introduce and implement commissioning policies for selected interventions. This had prompted review of the existing CCG policy for surgery for ganglion cyst. Local specialists had been asked for their input in terms of assessing the clinical, service and financial impacts of the differences between the NHS England guidance and the existing CCG policy. As a result a revised commissioning policy has been recommended by the Clinical Policy Committee. This proposes adoption of the NHS England criteria in respect of wrist and seed ganglia, with retention of the CCG's wording in respect of significant pain or significant functional impairment as this was felt to be less subjective and easier to manage equitably. In respect of mucoid cysts, it is proposed that the existing CCG policy criterion is maintained as specialists felt this was more representative of mucoid cysts requiring surgical procedure, rather than those which are primarily cosmetic.

It was noted that the scope of the NHS England criteria was hand ganglia only. The current CCG policy also contains criteria relating to lower limb ganglion, which will be maintained.

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

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

   It was acknowledged that the current CCG policy had been reviewed with regard to statutory guidance published by NHS England in November 2018, and a revised CCG policy had been proposed as a result.

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

   It was noted that local specialists have suggested that adoption of the NHS England criteria for wrist and seed ganglia will not have a significant impact on activity. Maintaining the existing CCG policy wording in respect of significant pain or significant functional impairment is also felt to be less subjective and easier to manage in an equitable way.

   In respect of mucoid cysts and lower limb ganglia, the existing CCG policy criteria are being maintained so this will represent no 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 noted that NHS England has set a challenging target for reduction in activity for ganglion excision which local specialists consistently indicated was overly ambitious and unlikely to be met, either with adoption of the NHS England criteria or if the existing policy is maintained.

   Local specialists have suggested that adoption of the NHS England criteria for wrist and seed ganglia will not have a significant impact on activity.

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 in respect of ganglion cysts and their treatment.

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

   nhs.uk states that ganglions are harmless but can sometimes be painful. If they do not cause any pain or discomfort, they can be left alone and may disappear without treatment, although this can take a number of years. Treatment is usually only recommended if the cyst causes pain or affects the range of movement in a joint. The two main treatment options for a ganglion cyst are draining fluid out of the cyst with a needle and syringe (aspiration) and cutting the cyst out using surgery.

   It is stated that most CCGs do not fund treatment for ganglion cysts unless they cause significant pain or disrupt daily activities.

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

5. Any Other Business

No other business was raised.

6. Next meeting date

The next meeting is due to be held on Thursday 22 August 2019 from 2.00pm in the Otter Room, County Hall, Exeter or via teleconference.

ACTION LOG

Action no.	Meeting date	Action description	Lead(s)
19/06	09/07/2019	DRSS to be advised of the need for clinical referral guidance to be updated in respect of carpal tunnel syndrome and for appropriate referral messages to be reiterated with communication of the revised policy.	Rebecca Heayn