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

Clinical Policy Committee Public Consultation Panel – Pilot meeting

Minutes

Wednesday 24th June 2015, 10.00-12.00

Dart Room, County Hall, Exeter

Present:

Alex Aylward*	Lay Member, Patients and Public, NEW Devon CCG
Jono Broad*	Lay Member, Clinical Policy Committee
Sallie Ecroyd	Head of Communications, 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

* Denotes voting members

1. Welcome and Introductions

Attendees were welcomed to the meeting and the group introduced themselves.

The group were all thanked for their time and commitment to this pilot meeting. The aim was to develop and pilot a process for determining the need for any wider publication consultation on clinical policy recommendations from the Devon-wide Clinical Policy Committee.

2. Update on progress so far

The notes of the initial development meeting were shared for information and the background of the development discussions which had led to this pilot meeting were outlined for the benefit of those new to the group.

It was stated that this panel process was seen as a bridge between the Clinical Policy Committee and the CCG executive decision-making groups, where a lay member led panel could routinely consider the wider public interest issues to determine the need for any wider public consultation to be undertaken on the proposed policy recommendations.

Notes were shared on the development of a framework for public consultation. These had been outlined to ensure consideration of best practice principles and considerations with regard to determining the need, timing, format and accessibility, and transparency and feedback for public consultation.

It was outlined that there were two key issues to be addressed:

- Do we need to consult with the public on a recommendation?
- How are we going to consult?

The first of these issues was the focus of this meeting. It was agreed that any subsequent consultation that is undertaken is conducted once for both CCGs in Devon in the interests of efficiency and consistency.

The Clinical Policy Committee work-up process and meeting operation was summarised. The lay members stated that their attendance was as public, not patient representatives and that they were treated equally with the other members of the committee and guests in terms of their opportunity to speak, ask questions, etc. There was a keenness that this panel process did not recreate the discussions that had already taken place at the Clinical Policy Committee but that it provided a separate opportunity to reflect on the recommendation and consider the public interest issues. The panel consideration should follow a clear process and guidelines to ensure that it is robust and consistent in the determination of consultation decisions.

3. Introduction to and consideration of the draft process proposals

The group considered a draft process outline. This has been prepared building on the previous development meeting in conjunction with CPC lay members and CCG communications and patient engagement specialists. The following process and operational points were agreed:

Process

- There are three proposed levels of determination arising from the panel consideration of a recommendation:
    1. No formalised wider public consultation is recommended as it would be unlikely to elicit new public interest issues. The public will be informed of policy decisions in the normal way.
    2. A public consultation is to be carried out under timescales proportionate to the issue to be considered (and taking into account any holiday periods).
    3. A maximum public consultation (12 weeks duration) should be carried out.
- Actions arising from recommendations 1 and 2 will automatically be actioned by the Clinical Effectiveness team on the decision of the panel. Recommendation 3 decisions will be referred to the CCG executive groups for agreement prior to commencement due to the additional resource and other potential implications arising.

Capturing the public interest issues

- The following themes which are in the public interest were agreed to produce a rounded identification of the key drivers to consult on a particular issue:
    1. Is the reason for introducing the policy plausible?
    2. Does the policy output address this intent?
    3. Have the effects of the policy on individual patients and carers been considered?
    4. Have the wider consequences on society been considered?
    5. Has the opportunity cost been considered?
    6. Is there knowledge of public concern in relation to:
        a) the disease?
        b) the specific intervention?

Membership and voting

- It was agreed that the group should be lay-member led and strategic in nature.
- The group would be chaired by a lay member, who it was suggested be one of the Clinical Policy Committee lay members who could bring the benefit of summarising the committee discussions.
- The lay members would be the voting members of the group, with other non-voting members assisting in an advisory capacity. The chair would not vote unless the voting was split.
- It was suggested that the addition of a further one or two lay members to the panel would be desirable in terms of strengthening the group and the balance of discussions. It was felt that this would be best achieved through open advertisement Devon-wide to ensure that lay members possess the required strategic level competencies. This suggested recruitment would be pursued; in the meantime it was agreed that the panel would operate as per the current membership in order to establish a process.

4. Discussion, decision and recommendation on Clinical Policy Committee decisions from 10th June 2015

The specialist management of abdominal wall hernia in adults

A summary of the Clinical Policy Committee considerations was given and the committee lay members advised that they were both content with the decision taken in its entirety. Clarifications on the clinical content were provided by the clinical effectiveness lead for the benefit of the panel.

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?

   The rationale for the policy was clear; it intends to reduce the rate of abdominal hernia surgery in Devon. The rates of abdominal hernia surgery in Devon are currently notably higher than the national rate, with the percentage annual growth also higher than the national growth rate. A reduction would be achieved through the implementation of a policy across Devon where none had previously existed. Data on the number of elective hernia repairs and referral data for patients with umbilical or incisional hernia could be monitored through the Business Intelligence team and DRSS functions respectively.

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

   There was discussion of the lifestyle management advice contained within the proposed policy and it was noted that a patient's weight or smoking status did not prevent them from being referred for hernia repair. However there was evidence to suggest that these factors increased the risk of postoperative complications and the development and recurrence of hernias. The provision of lifestyle advice by GPs will therefore support better outcomes for patients with hernia and was encouraged. The main negative effect was stated to be the stricter functional impairment criteria and patients' disappointment at being told they are not eligible for hernia repair, where they may have been prior to the implementation of this policy.

4. Have the wider consequences on society been considered?

   It was felt that the wider consequences of the proposed policy had been considered, which were limited in this case. The potential cost savings for the health service from the implementation of this policy were noted.

5. Has the opportunity cost been considered?

   It was noted that a reduction in inguinal, umbilical and incisional hernias, prepared from a range of estimates, is anticipated to save approximately £305,249 per annum across Devon.

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 with regard to abdominal hernia or hernia repair. It was noted that the policy is based on NHS England, Hernia Society and Royal College of Surgeons guidance and as such ensures national consistency for our local policy position.

Considering all these factors together the group felt there were no significant public interest issues that had not been adequately addressed and that public consultation would be unlikely to elicit new public interest issues. However they suggested that there should be communication of appropriate positive information to support the implementation and understanding of the policy.

Cataract surgery

A summary of the Clinical Policy Committee discussions, which had taken place over two meetings, was given. Clarifications on the clinical content were provided by the clinical effectiveness lead for the benefit of the panel.

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?

   The rationale for the policy was clear; it intends to reduce the rate of cataract surgery in Devon. The rates of cataract surgery in NEW Devon CCG are much higher than nationally and it had been identified that there was currently variation in rates across Devon. The requirement for cataract surgery is expected to increase with increasing life expectancy. A reduction in cataract surgery would be achieved through the implementation of a policy across Devon where none had previously existed, with all referrals managed via DRSS.

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

   It was noted by the committee lay members that meeting discussions had included detailed consideration of the impact of the proposed policy on patient care. The main negative effect noted at the meeting was that this is a progressive condition and the impact of introducing access criteria largely serves to move the activity to a later time point. It was noted at the panel that there would be potential for patients who get referred when visual acuity deteriorates to meet policy criteria experiencing further deterioration if delays for surgery were lengthy. However, the panel noted that if the implementation of the policy addresses its aim to reduce the rates of cataract surgery overall, this should have a positive impact on waiting times for patients and that currently activity rates are often driven or curtailed by capacity issues rather than a planned commissioning policy.

4. Have the wider consequences on society been considered?

   A question was raised as to whether people could perceive there to be wider societal consequences. There was consideration of the risk of falls in people with cataracts but noted that falls is a multifactorial issue and as such cannot be clearly attributed to a single factor. Issues with refractive difference between eyes, glare and reduced contrast sensitivity were raised and it was noted that these were covered by specific exemptions within the policy. It was also noted that the current visual standards required to drive detail a visual acuity of 6/12.

5. Has the opportunity cost been considered?

   It was noted that a reduction in the rates of cataract surgery for NEW Devon CCG to the national cataract surgery rate would result in cost savings of approximately £657,000 per year.

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

   The group felt there was public concern about service changes affecting sensory capability. Cataracts would be included in this and locally achieved a profile in the public arena because of the Urgent and Necessary measures proposed by NEW Devon CCG. However the group noted that the current policy recommendation followed engagement with specialist ophthalmologists and optometrists and the policy was modified during that process. Factors affecting vision other than visual acuity have been adequately addressed. Devon appeared to be an outlier for rates of age-adjusted cataracts. The policy proposed was founded on the guidance from the Royal College of Ophthalmologists.

Considering all these factors together the group felt there were no significant public interest issues that had not been adequately addressed and that public consultation would be unlikely to elicit new public interest issues. However they suggested that there should be communication of appropriate positive information to support the implementation and understanding of the policy.

5. Next meeting and future arrangements

Future meeting arrangements

It was agreed that future meetings would be scheduled for one hour duration, principally via teleconference and be held approximately two weeks after Clinical Policy Committee meetings. The Clinical Effectiveness Governance Manager will contact the group to establish availability before scheduling and circulating future dates.

Public interest themes discussion aid

The list of questions detailing the public interest themes to be considered for each policy recommendation would be shared as a template. This could be used by members for their own notes and assessment of future papers. Where a member is unable to attend a meeting it was suggested that they share their notes and thoughts with the Chair who will ensure that these are fed into the meeting discussions. However only those lay members present at the meeting will be eligible to vote.

Maintaining a register of declared interests

It was determined that the most appropriate handling of declaration of interests for the group would be via an annual register maintained by the Clinical Effectiveness Governance Manager. The group will then note as a standing agenda item for each meeting whether any additions/amendments to this have been advised or whether there are any specific interests to declare related to the particular items for discussion at that meeting.