SPECIALISED COMMISSIONING - CLINICAL EVIDENCE EVALUATION CRITERIA FOR A PROPOSITION FOR A CLINICAL COMMISSIONING POLICY FOR ROUTINE COMMISSIONING

URN: A03X14
TITLE: Total pancreatectomy with islet autotransplant for recurrent acute pancreatitis

CRG: Specialised endocrinology
NPOC: Internal medicine
Lead: Ursula Peaple

Date: 02/02/16

The panel were presented a policy proposal for routine commissioning.

Question	**Conclusion of the panel**	**If there is a difference between the evidence review and the policy please give a commentary**
<u>The population</u> 1. Are the eligible and ineligible populations defined in the policy consistent with the evidence of effectiveness, and evidence of lack of effectiveness; and where evidence is not available for the populations considered in the evidence review?	The eligible population(s) defined in the policy are the same or similar to the population(s) for which there is evidence of effectiveness considered in the evidence review	
<u>Population subgroups</u> 2. Are any population subgroups defined in the policy and if so do they match the subgroups considered by the evidence review?	A: The population subgroups defined in the policy are the same or similar as those for which there is evidence in the evidence review	
<u>Outcomes - benefits</u> 3. Are the clinical benefits demonstrated in the evidence review consistent with the eligible population and/or subgroups	A: The clinical benefits demonstrated in the evidence review support the eligible population and/or	The panel recognises that there is evidence in a large case series where up to 60% of cases cease narcotics as a result of pancreatectomy. In the smaller series only 25%

presented in the policy?	subgroups presented in the policy	of patients were insulin independent. The panel did not have evidence presented to it on the state of insulin control and the associated complications of poor insulin control to recommend that the 25% achieving insulin independence is sufficient benefit to justify routine commissioning of TP IAT. As a result the panel recommendation is that the policy should go forward as a not routinely commissioned policy. In order to change its position, evidence would be needed to define the degree of insulin control, and to show that any benefit is long lasting.
<u>Outcomes – harms</u> 4. Are the clinical harms demonstrated in the evidence review reflected in the eligible and / or ineligible population and/or subgroups presented in the policy?	A: The clinical harms demonstrated in the evidence review are reflected in the eligible population and/or subgroups presented in the policy	
<u>The intervention</u> 5. Is the intervention described in the policy the same or similar as the intervention for which evidence is presented in the evidence review?	A: The intervention described in the policy the same or similar as in the evidence review	
<u>The comparator</u> 6. Is the comparator in the policy the same as that in the evidence review?	No comparator.	Modern systems of diabetic control (such as continuous glucose monitoring systems) should be considered as a comparator.

7. Are the comparators in the evidence review the most plausible comparators for patients in the English NHS and are they suitable for informing policy development.		
<u>Advice</u> The Panel should provide advice on matters relating to the evidence base and policy development and prioritisation. Advice may cover: • Uncertainty in the evidence base • Challenges in the clinical interpretation and applicability of policy in clinical practice • Challenges in ensuring policy is applied appropriately • Issues with regard to value for money • Likely changes in the pathway of care and therapeutic advances that may result in the need for policy review.		The panel considered that TP IAT could be provided within standard tariffs for pancreatectomy.

<u>Overall conclusions of the panel</u>

The policy will progress as a non-routine commissioning policy.

Report approved by:
James Palmer
Clinical panel Chair
07/03/16

<u>Post meeting note:</u>
Policy amended from proposition for routine commissioning to non-routine commissioning.