Aylesbury Vale Clinical Commissioning Group
Bracknell and Ascot Clinical Commissioning Group
Chiltern Clinical Commissioning Group
Newbury and District Clinical Commissioning Group
North and West Reading Clinical Commissioning Group
Oxfordshire Clinical Commissioning Group
South Reading Clinical Commissioning Group
Slough Clinical Commissioning Group
Windsor, Ascot and Maidenhead Clinical Commissioning Group
Wokingham Clinical Commissioning Group

Thames Valley Priorities Committee
Minutes of the meeting held Wednesday 27th January 2016
Board Room, Aylesbury Vale CCG, Aylesbury Vale District Council Offices, The Gateway, Gatehouse Road, Aylesbury, HP19 8FF

In Attendance:

Alan Penn	Lay Member Chair	Thames Valley Priorities Committee
Tiina Korhonen	Clinical Effectiveness Manager	South Central &West Commissioning Support Unit (SCSWCSU)
Laura Tully	Clinical Effectiveness Manager	SCWCSU
Barbara Bennett	CSU Admin Support	SCWCSU
Heather Motion	Clinical Effectiveness Manager	SCWCSU
Sarah Annetts	IFR Manager	SCWCSU
Jeremy Servian	IFR Manager Clinical Lead	Oxfordshire CCG
Dr Paul Harris	GP	Berkshire West CCGs
Catriona Khetyar	Head of Medicines Optimisation	Berkshire East CCGs
Dr Mark Sheehan	Special Advisor - Ethics	University of Oxford
Jane Butterworth	Head of Medicines Management	Aylesbury Vale CCG & Chiltern CCG
Julie Dandridge	Deputy Director. Head of Primary Care and Medicines Optimisation	Oxfordshire CCG
Dr Graham Jackson	Clinical Chair	Aylesbury Vale CCG
Richard Corbett	Chief Executive	HealthWatch Bucks
Philip Murray	Chief Finance Officer	Chiltern CCG
Tianne Thompson	Interim Head of Corporate Affairs	Berkshire East CCGs
Miles Carter	Clinical Lead for Medicines Management	Oxfordshire CCG

Topic Specialists in Attendance for Agenda Items:

Mr Gregory Jones	Consultant Upper GI and Bariatric Surgeon	Royal Berkshire NHS Foundation Trust
Dr Theingi Aung	Consultant Physician and Endocrinologist	Royal Berkshire NHS Foundation Trust

Apologies:

Professor Chris Newdick	Special Advisor – Health Law	University of Reading
Dr Lise Llewellyn	Director of Public Health	Public Health
Cathy Winfield	Chief Officer	Berkshire West CCG
Dr Tony Berendt	Medical Director	Oxford University Hospitals NHS Trust

Sarah Robson	IFR Manager	SCWCSU
Tracey Marriot	Director of Innovation Adoption	Oxford Academic Health Science Network

1.	**Welcome & Introductions**
1.1	The Chair opened the meeting and welcomed members of the Committee.
2.	**Apologies for Absence**
2.1	Recorded as above.
3.	**Declarations of Interest**
3.1	None were declared.
4.	**Draft Minutes of the Priorities Committee meeting held 25th November 2015 – Confirm Accuracy** The following amendments were agreed: • It was noted that JD's title had changed and confirmed it should be as above. • It was also noted that some actions points did not include the policy title referred to. It was agreed this should be inserted into each action point for clarity. • Section 6. Erectile dysfunction policy update: It was agreed that this section of the minutes needed to be very clear that the evidence review and decision related to treatments for erectile dysfunction and not to the use of vacuum pumps for penile rehabilitation. Penile rehabilitation is covered by a separate policy and the evidence base will be reviewed as part of the update of this policy which is planned for March 2016. Members to email any further comments on this section for inclusion in the update of the draft minutes. • Section: 6.2. It was agreed to clarify the last sentence of the first paragraph by adding "primarily seeing patients post prostatectomy" regarding the ED clinic in the Royal Berkshire Hospital. • Section: 9. Verteporfin review: It was agreed to re-word the last paragraph to note when the meeting with Sarah Lucie Watson and Molham Entabi took place. • Section: 7.2. Hip Impingement review: For clarity, it was felt that the word "hip" should be added before the word "joint" in the sentence "both specialists were of the opinion that joint injections should not be carried out without image guidance", **Action: CE team to make changes as discussed and circulate to the Committee for approval.**
5.	**Draft Minutes of the Priorities Committee meeting held on 25th November 2015 – Matters Arising**
5.1	Action 5.1 CE team to engage the CCG lay members for public and patient engagement of the Governing Bodies during evidence review consultation: It was agreed to no longer send reviews to the CCG lay members and to leave it up to individual CCGs to decide how their lay members fulfil their role. Clinical Effectiveness team to send clarification of this to lay members. **Action Complete**
5.2	Action 5.2 CE team to set up a working group to review the Fertility Care Pathway: LT will bring this paper to the Committee and circulate to clinicians in Buckinghamshire and Berkshire for clinical consultation. Due to come to the Committee for the March meeting 2016. **Action in progress**
5.3	Action 6.4 Clinical Effectiveness team to update the Erectile Dysfunction policy as per Committee recommendations and circulate as per usual process**.** **Action Complete**
5.4	Action 7.4 Clinical Effectiveness team to draft the US Guided Injections for MSK policy statement

	as per Committee recommendations and circulate as per usual process. **Action Complete**
5.5	Action 8.5 Clinical Effectiveness team to update the current Hip Impingement Surgery policy as discussed and circulate as per usual process. IFR team to link with TP to maintain a Thames Valley register of appropriate clinicians specialised in carrying out FAI surgery. List of appropriate clinicians now available. **Actions Complete**
5.6	Action 9 Evidence review for Verteporfin: CE team to write to the invited specialist on behalf of the Committee to apologise for the inconvenience. **Action Complete**
5.7	Action 9.1 LT to invite local specialists to attend the January 2016 meeting for the verteporfin review. **Action Complete**
6.	**Evidence Review Follow-up – Verteporfin for Chronic Central Serous Chorioretinopathy**
6.1	The invited specialist did not attend the meeting so the topic will be postponed to a future meeting. **Action: LT will contact alternative specialists to see if they will be able to attend a future meeting.**
7.	**Evidence Review: Severe and Complex Obesity Thresholds for Surgery**
7.1	NHS England is transferring the commissioning responsibility of severe and complex obesity and bariatric surgery back to the CCG's from April 2016. In January 2016 NHS England confirmed the transfer and also stated that they are preparing information for CCGs, which will include activity data, commissioning guidance and model clinical guidance to support the transfer. Anticipated date of publication is mid-February. The reasons for the transfer outlined by NHS England include issues such as the concern over the artificial divide in the patient pathway created by the split of commissioning responsibilities between NHS England and CCG's, acting as a barrier for integrating services around people who need the full suite of obesity services. NHS England also notes that having a single commissioner should be a major step forward in creating better incentives to invest in lower tier services. The aim of this review was to explore the latest national guidance and related evidence in order to support the development of a threshold policy across the Thames Valley CCGs, with a focus on access to bariatric surgery. The current NHS England Service Specification for Severe and Complex Obesity (all ages) has a care pathway and thresholds for bariatric surgery largely based on NICE CG43 (2006) recommendations. The updated NICE CG189 (2014) retains the previous recommendations and adds further new recommendations in relation to recent onset type 2 diabetes; consideration of expedited assessment for surgery for patient with recent onset type 2 diabetes and BMI over 35 and consideration for assessment for surgery for patient with BMI 30-34.9 and for patients of Asian family origin with lower BMI, as long as they will also receive assessment in tier 3 service (pre-bariatric surgery multidisciplinary intensive level input to patients). New recommendations are also made for post-surgery care and care for patients using low-calorie diets.
7.2	The invited specialist, Mr Jones, commented on the comprehensiveness of the review paper and stated that he felt there was overwhelming evidence that bariatric services and surgery are effective interventions, both in this country and abroad. He stated that there are worldwide studies that provide evidence of an improvement in weight, diabetes, other co-morbidities and quality of life. Cost effectiveness studies show that the cost of surgery is recouped within 24 months and

	savings are made in public health costs normally within 2-3 years after a procedure is carried out. Dr Aung, a local endocrinology specialist, added the following: Her referrals to tier 3 services have increased significantly over the last year. After a year of tier 3 services, at the exit point patients have an option of going back to tier 2 if they do not wish to have surgery but some patients do come back to tier 3 services. Referrals for patients with BMI 30-35, with recent onset of diabetes controllable with tablets and insulin have also increased. She feels that these are now the patients to note, especially the patients of Asian family origin due to their recognised risk of developing diabetes at lower BMI levels than other ethnic groups. Dr Aung also felt that, to improve the overall long term outcomes, the policy and service review should not only focus on the patients who have surgery at tier 4 (specialised complex obesity services including bariatric surgery), but also the whole population who flow through tiers 1, 2 (primary care and community advice and interventions) and tier 3 in a streamlined way. Mr Jones clarified that that the BMI threshold of 35 was originally decided 20 years ago by the insurers as arbitrary threshold and we now have an opportunity to consider surgery for the population who clinically need it rather than only those that have a BMI of 35 and over. Mr Jones explained that there is increasing demand for bariatric surgery services, with currently over 40 new referrals a month, 75% are expected to proceed to surgery after appropriate time and management in tier 3 and 4. RBH NHS Trust is predicting to carry out approximately 150 operations this year. With increasing referrals, they have developed plans to increase capacity to be able to carry out 250 operations a year in order to meet the demand within the Berkshire and Thames Valley region. A question was raised regarding whether it would be more beneficial to invest in more bariatric surgery or in enhanced tier 3 services. Mr Jones felt that, in terms of investment, it was difficult to separate the services and if the money was put into only one service, the system would fail. He therefore felt that any investment should be made across the service as a whole. With regards to the aftercare, post-bariatric surgery, Dr Aung confirmed that patients are followed up for 2 years after surgery. For bypass surgery, aftercare includes a post-operative appointment with the surgeon and then 3 monthly dietician input in the first year and 6 monthly dietician input in the second year. After this, there are drop-in sessions offering continued support. Gastric Band surgery has a life-long follow up because of the band adjustment process. The specialists confirmed that their policy approach preference was for Option 1. i.e commission bariatric surgery services as per updated NICE CG189 recommendations.
7.3	The Committee accepted the clinical evidence, that surgery results in greater improvement in weight loss outcomes and weight associated co-morbidities compared with non-surgical intervention and whilst bariatric surgery is more expensive than conservative management in the short term, overall, it offers considerable cost-savings derived from reduced diabetic and obesity related co-morbidities. The Committee agreed in principle with the recommendations made by NICE CG CG189 including the consideration assessment for surgery for patient with recent onset type 2 diabetes with BMI 30-34.9 and for patient of Asian family origin with lower BMI (as long as long as they will also receive assessment in tier 3 service). The Committee noted that the unmet need is unknown and the capital investment which CCGs would need to make in the short term in order to meet the extra demand in implementing the NICE recommendations would be significant. The additional workload burden on provider services and whether there was sufficient capacity to carry out the increased number of operations within local trusts was also highlighted as a risk. The Committee considered different commissioning models such as a phased threshold policy working towards the NICE recommendations over time or funding a limited amount of operations and allowing clinicians to decide how they prioritise the patients. However, the Committee agreed that there are several uncertainties related to the issue, including the CCG funding allocation which is yet to be decided by NHS England, the numbers of patients accessing services in different tiers,

	in particular tiers 3 and 4 and the proportion of patients in different BMI groups with co-morbidities. The Committee acknowledged the difficulty in making accurate projections for the demand for services, service capacity and the affordability of the different threshold options with current information and data, therefore the Committee agreed to recommend an interim policy, based on the current NHS England eligibility for bariatric surgery. The interim policy will be reviewed in the light of NHS England data and guidance and when there is clarity of the CCG funding allocation. It was agreed to schedule the review for July 2016 Committee meeting. It was suggested that for any individual funding requests, for patients not meeting the policy criteria, the application should be made by the responsible specialist i.e. Consultant Endocrinologists or Orthopaedic/Bariatric surgeon rather than the patient's GP. It was acknowledged that the Committee policy consideration is part of a wider development of services for severe and complex obesity and it was noted that the Academic Health Science Network is holding meetings with stakeholders about co-commissioning tier 3 and 4 obesity weight management services. It was proposed that in order to share information and awareness of this significant public health matter the Committee would write to the Health and Wellbeing Board Chairs directly to raise the issue. **Actions: Clinical Effectiveness team to daft a policy based on the NHS England threshold policy and circulate as per the usual process. Review of the interim policy to be scheduled for the July Committee meeting.** **Action: Clinical Effectiveness team to draft a letter to the Chairs of the HWBs as per the Committee considerations**. **Action: CCGs to collate information from EMIS regarding numbers of patients in different BMI groups with co-morbidities.**
8.	**Policy Update – Managing the Boundaries between NHS and Private Health Care**
	This item was raised to review the current policies to ensure they remain in-line with National Guidance. The policies are currently based on the initial Department of Health (DoH) Principles in 2009, however, in 2013 a more detailed interim policy was published by the NHS Commissioning Board. The Committee agreed that apart from a few minor differences the Thames Valley policies are in line with current guidance. However the IFR team for Bucks and Berkshire CCGs had highlighted a some issues for consideration and these are included in the options.
8.1	An issue was raised regarding the impact of a number of Pharmaceutical Company's 'zero cost schemes' for drugs prior to NICE approval considered by Thames Valley Wessex CCG's This is in response to a new trend whereby patients are being provided with treatments free of charge, prior to NICE assessment. If NICE do not approve the treatment then the provider and patient expect the treatment to continue in line with the usual NICE stance of allowing continuation for patients already receiving the treatment. The Committee discussed whether it would be useful to include in the policy review that the CCG's will not pick up the ongoing costs unless the drugs meet the NICE clinical criteria within the updated policy. MS mentioned that NICE is reviewing this issue.
8.2	The Committee considered the options for the policy review and decided to retain the existing separate TVPC policies, 'Managing the boundaries of NHS and privately funded healthcare' and 'NHS prescribing following private consultation', using the current Berkshire version which includes the following additional point: 'Patients may commence care privately, but then request that further treatment be provided within the NHS. In this case, the patient may be transferred to the NHS care and should be re-assessed for NHS treatment within the same regime of priorities applicable to NHS patients'. The Committee discussed that the current policy seemed to allow for an Individual Funding

	Request (IFR) for treatment to be submitted by a private consultant. It was agreed to change the wording to state that an IFR may be submitted by an NHS Clinician only. The Committee considered whether they wanted to include further clarification in the policy regarding the issues in Option 2 below: • clarity around what represents an episode of care • requests for NHS continuation of treatment following treatment associated with a clinical trial • requests for NHS continuation of treatment for medications not normally funded locally but which have demonstrated benefit to the patient when provided by a private provider • the potential for 'queue jumping'; reaching waiting lists earlier by purchasing investigations privately. It was agreed that no further clarification was required. The Committee also discussed the two related policies currently held by Thames Valley CCGs around excess treatment costs and funding of treatments post clinical trial. It was felt the wording of these remained appropriate and it was agreed they would remain separate policies with no changes to the current content. **Action: Clinical Effectiveness team to draft the policy updates for the following policies as per the Committee discussion and circulate as usual process:** • Managing the boundaries of NHS and privately funded healthcare • NHS prescribing following private consultation • Excess treatment costs for non-commercial clinical trials • Research trials and NHS funding
9.	**Identifying Opportunities for TVPC Work Programme: National and Regional Policy Comparison**
9.1	The TVPC working group requested a review of the Thames Valley CCGs policies against CCG policies within the CSU footprint and nationally in order to identify opportunities and variation in clinical policies. This paper aims to enable commissioners to identify any policies which may be beneficial for further scoping in order to consider for inclusion on the Thames Valley work plan for 2016/17. It was noted that a comparable CCG group would be Surrey as they have similar demographics. **Action: Clinical Effectiveness team to add Surrey policies to the policy comparison table.**
9.2	The Committee discussed the policies within the table for which most CCG's had policies, implying that there has been a local issue and a cost implication. Policies included tongue tie, haemorrhoids, lymphoedema and DEXA scanning. It was agreed that in order to identify policies which may be useful to scope further it would be useful to obtain local IFR data to review the level of requests relating to each topic. This mapping exercise will also be considered alongside the benchmarking exercise currently being carried out in order to identify any outliers in terms of activity and opportunities for efficiency and quality improvements. **Action: Clinical Effectiveness team to obtain IFR data to identify potential topics for further consideration.**
10.	**Schedule for Current Policy Updates**
10.1	A draft schedule was developed and prioritised according to CCG risk, where local policies are not in line with national guidance, date of last review and taking into consideration any new national guidance due to be published. It was noted that if the Committee wanted to re-arrange or re-prioritise any of the policies in accordance with local issues or experience, this would be possible. The proposed meeting dates are indicative only of timescale and may be changed subject

	Committee priorities. The topics have been bundled together where there are others within a similar clinical area to try and streamline the process. Penile Rehabilitation was discussed and felt to be a priority and it was therefore agreed that this should be reviewed at the next meeting in March 2016.There are a number of policies which may be suitable for discontinuation and the Committee also agreed to review these at the March 2016 Committee meeting.
10.2	The Committee discussed whether the policies held by only one CCG would need to be brought to the TVPC meeting for discussion rather than taken through internal CCG processes. When discussed previously it was felt that reviewing via the Committee would be beneficial for shared learning and it was noted that the benefit of this was the application of the ethical framework and availability of legal and ethical guidance. If decisions were taken out of the Committee, processes may be less robust and CCG's may therefore leave themselves open to more risk of legal challenge. It was decided that, for those policies held by only one CCG, the CCG concerned should consider first whether they felt happy to make the decision locally or if they wish to raise the matter via the Committee. **Action: Clinical Effectiveness team to schedule and carry out the policy updates accordingly.**
11.	**Any Other Business**
11.1	It has been agreed to rotate the TVPC meeting location to make the travelling distance fair and the 2016-17 meetings will take place in Oxfordshire. However, the meeting on 25th May 2016 will be held in Aylesbury as the meeting room in Oxford is unavailable on this day. The remaining meetings will be held in Jubilee House in Oxford. It was noted that parking at Jubilee House may become unavailable during the year in which case the Clinical Effectiveness team will look for alternative venues.
11.2	MS informed the Committee that he is currently organising a Public Health Ethics Forum where people working in public health can bring along issues for discussion. The Forum aims to make ethical issues in public health more accessible. At the moment, the forum involves local authorities within the Thames Valley region but he wanted to invite Thames Valley CCG representatives to take part. The first meeting will be held on Monday 8th February 2016 at Unipart House in Oxford and he will circulate the details.
11.3	The Chair reminded the CCG members to notify the Clinical Effectiveness team when policies have been agreed by the CCGs.
12.	The next meeting will be **Wednesday 23rd March 2016, Board Room, Aylesbury Vale CCG, Second Floor, Aylesbury Vale District Council offices, The Gateway, Gatehouse Road, Aylesbury, Buckinghamshire, HP19 8FF .**
13.	**Meeting Close**
	The Chair thanked everyone for their contributions to the discussions and closed the meeting.