Berkshire West Clinical Commissioning Group
Buckinghamshire Clinical Commissioning Group
East Berkshire Clinical Commissioning Group
Oxfordshire Clinical Commissioning Group

Thames Valley Priorities Committee (Interim)

Minutes of the meeting held Tuesday 22nd July 2020

On-line via Microsoft Teams

Alan Penn	Lay Member Chair	Thames Valley Priorities Committee
Jane Butterworth	Assistant Director Medicines Optimisation	Buckinghamshire CCG
Linda Collins	Clinical Effectiveness Manager (CCG)	Oxfordshire CCG
Edward Haxton	Deputy Finance Director	Berkshire West CCG
Dr Megan John	GP, East Berkshire CCG Lead	East Berkshire CCG
Professor Chris Newdick	Special Advisor - Law	University of Reading
Dr Jacky Payne	GP	Berkshire West CCG
Dr Raju Reddy	Secondary Care Consultant	Berkshire West CCG
Dr Mark Sheehan	Special Advisor - Ethics	University of Oxford
Dr Karen West	Clinical Director Integration	Buckinghamshire CCG

In Attendance:

Kathryn Markey	Clinical Effectiveness Manager	SCW
Kate Forbes	Clinical Effectiveness Manager	SCW
Funmi Fajemisin	Clinical Services Programme Lead Clinical Policy Implementation	SCW
Rebecca Hodge (Item 5)	Clinical Effectiveness Manager	SCW
Rachel Finch – Minute Taker	Clinical Effectiveness Administrator	SCW

Apologies:

Catriona Khetyar	Head of Medicines Optimisation	East Berkshire CCG
David Pollock	Interface Lead Pharmacist	Berkshire West CCG
Shairoz Claridge	Operations Director	Berkshire West CCG

1.	**Welcome & Introductions**
1.1	The Chair opened the meeting, welcomed the Committee members and set out how the on-line meeting is to operate.
2.	**Apologies for Absence**
2.1	Apologies recorded as above.
3.0	**Declarations of Interest**
3.1	None declared.
4.	**Draft Minutes of the online 'Teams' Priorities Committee meeting held 24th June 2020 – Confirm Accuracy**
4.1	The draft minutes were accepted as a true record of the meeting. A request was made for additional text to be added to agenda item 9.4 Individual Funding Requests 'COVID has effected a significant portion of the population and therefore cannot be considered exceptional'. The Committee agreed to the amendment.

5.	Draft Minutes of the online 'Teams' Priorities Committee meeting – Matters Arising
5.1	**Minutes of the Priorities Committee held online in May 2020 – Action 5.5 – Review RMOC Statement sequential use of biologic medicines – Paper 20-001** The Clinical Effectiveness (CE) team to draft a potential statement to be added onto each of the biologics policies advising that a 4th biologic or immunomodulatory drug will be funded if it possesses a mode of action previously not tried or if a patient has suffered an adverse drug reaction that necessitates discontinuation. The Committee to discuss this item further together with the financial impact and the development of a justification statement. **JUNE 2020 UPDATE:** Financial impact in progress. The CE team to bring back to the Committee in due course. **JULY 2020 UPDATE:** CE team experiencing difficulty in obtaining feedback from secondary care providers, most are working on it but are extremely busy at present. CE team to also approach secondary care pharmacists. The CE team plans to bring back this item to the November 2020 Committee meeting.
5.2	**Minutes of the Thames Valley Priorities Committee sub-group held June 2020 - System recovery post COVID-19** **ACTION: The Clinical Effectiveness team to update document: Principles for Prioritisation of Elective Care Patients document with details of the Chair, date and attendees.** The minutes were accepted as a true accuracy of the meeting. **ACTION:** CN to provide wording regarding NHS waiting times to the CE team for inclusion in the System recovery post COVID-19 document prior to it being sent to Diane Hedges. **ACTION Complete** **ACTION:** CE team to update the System recovery post COVID-19 Principles for Prioritisation of Elective Care Patients document to include comments from Chris Newdick and send to Diane Hedges for consideration and feedback with a copy to Committee members. Post meeting note: document with CH's comments has been circulated to Diane Hedges. Mark Sheehan has recirculated document to TVPC subgroup with further comments for feedback within 3 working days. Actions completed by 1st July 2020. **ACTION Complete**
5.3	**Minutes of the Priorities Committee held online in June 2020 – Action 6.6 – Policy Update: Sodium oxybate for cataplexy and excessive daytime sleepiness in narcolepsy in adults – Paper 20-006** The CE team to draft a policy recommendation for the use of sodium oxybate for narcolepsy with cataplexy for patients transitioning into adult services. For other adult patients sodium oxybate is not normally funded. The draft policy recommendation is to be circulated for comment. Comments to be received within the 2 week period following issue. **JULY 2020 UPDATE:** Comment received to amend the third bullet point as patients are likely to have received treatment with sodium oxybate for longer than 3 months. The Committee agreed to change the wording to read: 'Discontinue if there is inadequate response to treatment. Expert clinical review and patient history will contribute to this assessment'
5.4	**Minutes of the Priorities Committee held online in June 2020 – Action 7.5 – Policy Update: Intravenous versus oral steroids for exacerbations of multiple sclerosis – Paper 20-007** CE team to prepare CCG governing body papers recommending withdrawal policy recommendation statement 67: Intravenous versus oral steroids for exacerbations of multiple sclerosis. **ACTION Complete**
5.5	**Minutes of the Priorities Committee held online in June 2020 – Action 8.5 – Policy Update: Chronic Fatigue Syndrome/Myalgic Encephalomyelitis – Paper 20-008** CE team to update policy statement 76 and 130: Chronic fatigue syndrome/myalgic encephalomyelitis to note that they have been reviewed by the Committee, and to add a footnote to indicate that no changes had been made. The footnote should also note that the policy will be reviewed upon publication of new NICE guidance. The CE team to circulate for comment. Comments to be received within the 2 week period following issue.

5.5 Cont..	**JULY 2020 UPDATE:** Comment received that the draft wording of the footnote suggests incorrectly that the evidence was fully reviewed in June 2020. The Committee agreed to change the wording of the footnote to read: 'In June 2020 the Thames Valley Priorities Committee reviewed the evidence for CBT and GET only. As NICE guidance: Myalgic encephalomyelitis (or encephalopathy)/chronic fatigue syndrome: diagnosis and management is expected to be published in 2021 a decision was made to make no changes to the policy intention before a review following this publication'.
5.6	**Minutes of the Priorities Committee held online in June 2020 – Action 9.1 – Any Other Business: Clarification: TVPC63 Circumcision and Preputioplasty – Paper 20-009** The CE team to update TVPC63 Circumcision and Preputioplasty to clarify the position with regard to: • 'Paraphimosis where the foreskin is retracted and cannot be returned back to the end of the penis' add 'Circumcision for pathological phimosis will be funded'. Post meeting note, sentence rephrased to state 'this does not include pathological phimosis'. • 'Recurrent UTIs' add 'where there is no abnormal renal or urinary tract anatomy' • A footnote to be added to highlight that where there is abnormal renal or urinary tract anatomy it is usually funded by NHS England Commissioning specialist urology service. As the updated policy is purely a clarification it was agreed that these changes do not require Governing Body acceptance. **ACTION Complete**
9.3	**Minutes of the Priorities Committee held online in June 2020 – Action 9.3 – Any Other Business: TVPC meeting arrangements going forward** Clinical Effectiveness team to send out new and revised TVPC calendar invitations for monthly meetings up to the end of November 2020. **ACTION Complete**
6.	**Paper 20-011 Defining activities of daily living (ADL)**
6.1	<u>Background:</u> TVPC highlighted that an agreed definition of ADL in clinical policies would help to ensure patients are treated equitably and would define need in a way which is understandable for patients. ADL is used within some TVPC policies as part of a treatment threshold. Not all threshold policies require the same level of functional impairment; some surgery needs to be undertaken at a lower level of ADL impairment to maximise surgical outcomes. ADL has been cited in Individual Funding Requests (IFRs) as a means of describing the potential benefits of treatment. <u>Defining ADL:</u> ADLs are sometimes classified into basic ADL (BADL) and instrumental ADL (IADL). BADL are those skills required to take care of one's own body including personal hygiene or grooming, dressing, toileting, transferring or walking, and eating. IADLs include more complex activities that are related to a person's ability to live independently in the community. These include activities such as, managing finances and medications, food preparation, housekeeping and laundry. What specifically constitutes an ADL, how important it is to a person, and how a person undertakes it may be quite different for different individuals. There are many measures of ADL often validated for different clinical populations and specific purposes. Measures do not always take into account the time taken, the impact of pain, or the influence of contextual factors. The World Health Organisation (WHO) International Classification of Functioning includes a description of impairments classifying them as mild, moderate and severe. <u>Individual Funding Requests (IFR)</u> NHS England's advice to patients who are considering an IFR for specialised services states that non-clinical factors should not be considered in IFR decision making. All current TVPC policies have a footnote regarding IFR which states that 'exceptional circumstances may be considered by a patient's CCG where there is evidence of significant health status impairment (e.g. inability to perform activities of daily living) and there is evidence that the intervention sought would improve the individual's health status.

6.2	Discussion: ADL: It was highlighted that a distinction between BADL and ADL may not be helpful as treatment can make a significant difference in a general way to the quality of someone's life; in the context of policy making 'ADL' is most useful. IFR/ NHSE Specialised Commissioning statement It was highlighted that the NHSE Specialised Commissioning statement could be seen as counter to decision making in the NHS in relation to resources; NHS reported outcomes relate to equality and diversity and quality of life. It was highlighted that it would be useful to have a statement to advise clinicians and patients regarding what constitutes an ADL and the impact of a person's condition. Defining ADL in policies: Discussion was held regarding the merits of defining ADL further in TVPC policies and it was decided that this was not the approach the Committee wished to take, as policies have been drafted with full input previously from the Committee and clinicians.
6.3	**ACTION: Clinical Effectiveness team to draft a statement to describe activities of daily living (ADL) for the purposes of individual funding requests (IFR). The draft policy recommendation is to be circulated for comment. Comments to be received within the 2 week period following issue.**
7.	**Paper 20-012 – Policy Update: Complementary and alternative therapies**
7.1	Across the Thames Valley CCGs there are number of policies held with respect to complementary and alternative therapies. Buckinghamshire CCG and Oxfordshire CCG hold policy: 'Complementary and Alternative therapy' which includes acupuncture; such therapies are considered low priority interventions not routinely funded. Berkshire West CCG and East Berkshire CCGs currently hold a policy for homeopathy that states this is an intervention not routinely funded. Berkshire West and East Berkshire CCGs hold a separate acupuncture policy which states that acupuncture should remain a procedure not routinely funded due to the limited evidence for clinical effectiveness. All Thames Valley CCGs hold policy TVPC52 Management of low back pain and sciatica. This states that acupuncture for managing low back pain with or without sciatica is a not normally funded intervention.
7.2	NHS England guidance (2017 updated 2019): Items which should not be routinely prescribed in primary care: Guidance for CCGs, states that herbal and homeopathic treatments are products of low clinical effectiveness where there is a lack of robust evidence of clinical effectiveness or there are significant safety concerns. Guidance is that CCGs should advise prescribers in primary care that they should not initiate herbal or homeopathic items for any new patient. Prescribers should be supported in de-prescribing herbal items in all patients and where appropriate, ensure the availability of relevant services to facilitate this change.
7.3	NICE guidelines referring to complementary therapies include NICE NG71 (2017) 'Parkinson's disease in adults' which considers the use of the Alexander technique; NICE guideline (2016) 'Low back pain and sciatica in over 16s: assessment and management' recommends to consider manual therapy (spinal manipulation, mobilisation or soft tissue techniques such as massage) for managing low back pain with or without sciatica, but only as part of a treatment package including exercise, with or without psychological therapy. NICE guidance does not recommend acupuncture for managing low back pain with or without sciatica NICE Guidance on cancer services (2004): 'Improving Supportive and Palliative Care for Adults with Cancer' which suggests complementary therapies are accessed by patients with cancer and that commissioners should potentially review services they offer and how they are accessed. NICE Clinical guideline (2012, updated 2015) 'Headaches in over 12s: diagnosis and management' states for prophylactic treatment of tension type headache, consider a course of

7.3 Cont..	up to 10 sessions of acupuncture over 5–8 weeks. For prophylactic treatment of migraine with or without aura, if both topiramate and propranolol are unsuitable or ineffective, consider a course of up to 10 sessions of acupuncture over 5–8 weeks according to the person's preference, comorbidities and risk of adverse events.
7.4	A search of the Cochrane database was undertaken specifically for acupuncture. A number of systematic reviews (SRs) and Cochrane Clinical Answers were found. Specifically with regards to the use of acupuncture in the management of headache, a Cochrane Clinical Answer: 'How does acupuncture compare with drug treatment for preventing episodic migraine?' states that for adults with episodic migraine with or without aura, moderate-certainty evidence shows that, compared with prophylactic drug treatment (beta-blockers, flunarizine, or valproic acid), acupuncture probably slightly reduces headache frequency after treatment and probably leads to a response in more people at three and six months of follow-up. Fewer people withdrew because of adverse effects with acupuncture than with drug treatment. This is based on a 2016 update of a 2009 Cochrane SR (no-acupuncture control group, a sham-acupuncture control group, and a comparator group receiving prophylactic drug treatment). A Cochrane SR: Acupuncture for the prevention of tension-type headache: 2016 (update of 2009 SR) concluded that the proportion of participants experiencing at least 50% reduction of headache frequency was much higher in groups receiving acupuncture than in control groups. Acupuncture was compared with sham acupuncture in seven trials regarded to be of moderate to high quality. Available results suggest that acupuncture may be considered for treating frequent episodic or chronic tension-type headaches. There is a need for large, high quality trials comparing acupuncture to other effective (pharmacological and nonpharmacological) treatments for frequent or chronic tension-type headache. The evidence for the NICE Clinical guideline 'Headaches in over 12s: diagnosis and management', states that for tension type headache low quality evidence demonstrated that acupuncture is more clinically effective than sham at reducing the number of headache days at 3 months. Studies comparing acupuncture to any pharmacological management were excluded. Included studies addressed acupuncture vs sham acupuncture. For patients with migraine, three studies with 1299 people suggested that acupuncture is more clinically effective than sham acupuncture in reducing the number of migraine days at three months, but there is some uncertainty. A network meta-analysis of 12 studies comparing 7 interventions showed acupuncture to be ranked joint second most effective treatment for reducing the number of migraine days with propranolol and telmisartan. Placebo was ranked 6th most effective treatment. One study was not included in a meta-analysis, this demonstrated that there was no difference between acupuncture plus placebo and sham acupuncture plus beta-locker in reducing migraine frequency.
7.5	An economic study based on a RCT conducted in the UK showed acupuncture to be cost-effective when compared to no treatment in people with migraine or tension type headache. However base case analysis for NICE showed that acupuncture is not cost-effective compared to other treatments for migraine. When the number of sessions used in NICE's model was reduced to less than 10 sessions, acupuncture was considered to be cost-effective compared to no treatment.
7.6	Between April 2017 and July 2020, Berkshire West CCG, East Berkshire CCG and Buckinghamshire CCG received 8 individual funding requests (IFRs) for acupuncture and one IFR for complementary therapies; all were declined. Oxfordshire CCG, from 2018, received 2 IFRs for acupuncture; both were declined. There were no other requests received for any other complementary therapies. Inpatient and outpatient data activity across Thames Valley CCGs in year 2019-2020 for acupuncture identified activity costing £2295 for 8 patients.

7.7	The Committee discussed the evidence and agreed a TVPC policy should be drafted stating that due to lack of national guidance and robust high quality evidence of clinical and cost effectiveness comparing complementary and alternative therapies to other pharmacological agents and conventional health care interventions, complementary and alternative therapies are not normally funded except in the case of manual therapies for the management of low back pain and sciatica as part of a musculoskeletal treatment package and only as part of NHS back pain pathways. The definition of complementary and alternative therapies, as reflected in the paper, is to be included in the policy. **ACTION: The Clinical Effectiveness team to draft a policy recommendation for complementary and alternative therapies and circulate for comment. Comments to be received within 2 weeks of issue.**
8.	**Paper 20-013 – Policy Update: Management of Pelvic Organ Prolapse (POP)**
8.1	Background: The current policy TVPC59 'The Management of Female Pelvic Organ Prolapse' was recommended by TVPC in March 2017. Subsequent to this, NICE has issued an updated guideline for urinary incontinence and pelvic organ prolapse in women. NICE clinical guideline for pelvic floor dysfunction is due for publication in 2021. Current Policy: Currently, referral for specialist assessment for surgical interventions is only funded when there has been failure of a trial of conservative methods such as pelvic floor muscle training and/or pessary for 3 months. In addition to this, symptoms must cause significant functional impairment that prevents the patient from properly fulfilling work, domestic or carer activities, or educational responsibilities or the woman has a severe symptomatic prolapse with urethral sphincter incompetence or urinary/faecal incontinence. NICE guidance: Recommendations for lifestyle modification and topical oestrogen are based on NICE Committee expertise. With regards to conservative management, low quality evidence was found for pelvic floor muscle training (PFMT) for stage 1-2 prolapse and insufficient evidence to recommend it for stages 3-4 prolapse. For surgical management, NICE states evidence on surgery is limited; it is difficult to draw definite conclusions about the benefits and risks of the different types of surgery. NICE highlights that it is important to give women information on all the treatment options, including no treatment, physiotherapy, pessaries and the range of surgical options. There is substantial uncertainty about the long-term success and complications associated with each intervention. Evidence published following NICE guidance: One systematic review (SR) looked at PFMT versus watchful waiting in women with stage 2 prolapse one year postpartum which concurred with NICE findings that the evidence was of low quality and included studies had limitations. A SR for pessary use versus PFMT before surgery cited benefits in terms of relief of symptoms, but there were methodological limitations of included studies. One RCT looked at pessary replacement intervals and found there was a non-significant difference between a 6 month replacement, recommended by NICE, and 3 month replacement interval. One SR looked at laser therapy for POP however the evidence was inconclusive and the therapy is currently considered to be experimental. The use of synthetic Mesh: The Independent Medicines and Medical Devices Safety Devices Review published the 'First Do No Harm Report' in July 2020. This references NICE IPGs, which state that mesh cannot be used trans-vaginally for POP unless the operation is part of a research trial. Other abdominal pelvic organ prolapse mesh procedures, including rectopexies for rectal prolapse, can only be carried out under 'high-vigilance' regimes. The report does not recommend a complete ban on the use of mesh in the treatment of urinary incontinence or repair of pelvic organ prolapse.

8.1 Cont..	NICE Interventional Procedures Guidance: A number of NICE IPGs regarding prolapse have been published since 2017. All use mesh and state that the procedure should only be used in the context of research. Patient decision aids: Two patient decision aids have been published for patients considering surgery: Surgery for uterine prolapse & Surgery for vaginal vault prolapse. Data: The Committee was provided with local activity and cost data for the last four financial years.
8.2	Discussion: There was discussion regarding including reference to the Independent Medicines and Medical Devices Safety Devices Review in any policy update. There was discussion regarding stage 3-4 prolapse not being appropriate for PFMT. It was agreed that the policy would reference 'failure of a trial of conservative methods or where conservative methods are clinically inappropriate' rather than stage of prolapse as symptoms do not always correlate well with stage.
8.3	The Committee reviewed the evidence and agreed to amend the current threshold policy to include: • Lifestyle management including weight loss if BMI >30 kg/m2, supervised PFMT for prolapse stage 1-2, topical oestrogen in appropriate patients, pessary in appropriate patients. • NICE recommendation of 16 weeks for supervised PFMT and to continue afterwards if found beneficial. • National guidance to be followed for any surgical techniques taking note of the Independent Medicines and Medical Devices Safety Devices Review. • Referral for surgery only if a trial of conservative methods has failed or where conservative methods are clinically inappropriate • Use of patient decision aids for any patient considering surgery **ACTION: Clinical Effectiveness team to draft an update to policy TVPC59 The Management of Female Pelvic Organ Prolapse and circulate to specialist clinicians for comment. On receipt of comments the Clinical Effectiveness team to circulate to the Committee to comment. Comments to be received within the 2 week period following issue.**
9.0	**Paper 20-014: Policy Update - TVPC61 Snoring and obstructive sleep apnoea / hypopnoea syndrome**
9.1	Currently all Thames Valley CCGs hold TVPC61: Snoring and Obstructive sleep apnoea hypopnoea syndrome (OSAHS) in adults. This policy was recommended by the TVPC in May 2017. A review of the policy is now due.
9.2	Since adoption of the policy, NHS England Evidence Based Intervention (EBI): 'Uvulopalatopharyngoplasty, Laser assisted Uvulopalatoplasty & Radiofrequency ablation of the palette in an attempt to improve the symptom of snoring', has been published. This states that these interventions should no longer be routinely commissioned in the management of simple snoring. NICE TAG139 (2008) Continuous positive airway pressure (CPAP) for the treatment of obstructive sleep apnoea/hypopnoea syndrome has not been updated and is still current. NICE guidance: 'Obstructive sleep apnoea/hypopnoea syndrome and obesity hypoventilation syndrome in over 16s' is in development The scope of the proposed publication is relevant to the TVPC policy.

9.3	A Cochrane review (2020) included in the last review has been updated and now concludes that high-quality evidence suggests that interventions employing active, motivational, cognitive and behavioural strategies, lead to a relatively large and clinically-significant increase in CPAP machine usage (hours per night). A Cochrane review (2019) addressing positional therapy including supine vibration alarm devices and physical positioning e.g. specially designed pillows or semi-rigid backpacks demonstrated that studies comparing positional therapy with inactive control therapy showed lower AHI scores and Epworth Sleepiness Scale (ESS) scores in favour of positional therapy. However the authors felt unable to draw a conclusive statement with respect to the interventions.
9.4	In light of the information found in this review and that NICE guidance is expected (no date of publication confirmed) the Committee agreed it would be sensible to update the policy as reviewed and schedule further review following publication of NICE guidance.
9.5	**ACTION: Clinical Effectiveness team to update TVPC61 Snoring and obstructive sleep apnoea / hypopnoea syndrome as being reviewed and schedule a further review following publication of NICE guidance. The updated policy to be sent to CCG governing bodies for acceptance.**
10.	**Any Other Business**
10.1	**EBI Two consultation update**
10.1	The Committee was advised of the publication of EBI phase 2 consultation which concludes on 21st August 2020. This phase has 31 interventions with proposed recommendations. The Association of Royal Medical Colleges is hosting the consultation. South, Central and West CSU will be responding to the first three questions covering future possible interventions, impact on patients who cannot access healthcare, and intervention codes. **ACTION: Clinical Effectiveness team to provide the Committee with a link to the EBI consultation document.**
10.2	**September meeting topics**
10.2	The Clinical Effectiveness team propose expanding the online 'Teams' meeting to the wider Committee and specialist clinicians for FES and Cannabis topics. Accepted by the Committee.
10.3	Two lay representatives, one from East Berkshire and the other Berkshire West, are interested in joining the meeting. The Committee agreed.
10.4	The Committee discussed the request of the LMC representative to attend future TVPC meetings. It was noted that the Committee has GP representation and further representation of the LMC is not necessary. The LMC may however be included in the consultation process. **ACTION: Clinical Effectiveness team to respond to LMC declining attendance at TVPC meetings.**
11.	**Next meeting**
	The next online meeting will be held on **Wednesday 23rd September 2020 from 2-4pm**
12.	**Meeting Close**
	The Chair thanked everyone for their contributions to the discussions and closed the meeting.