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 20th May 2015
Board Room, Aylesbury Vale CCG, Second Floor, Aylesbury Vale District Council offices, The Gateway, Gatehouse Road, Aylesbury, Buckinghamshire, HP19 8FF

In Attendance:

Alan Penn	Lay Member Chair	Thames Valley Priorities Committee
Dr Graham Jackson	Clinical Chair	Aylesbury Vale CCG
Richard Corbett	Chief Executive	HealthWatch Buckinghamshire
Julie Dandridge	Assistant Director – Medicines Management	Oxfordshire CCG
Matthew Tait	Accountable Officer	Berkshire East CCG Federation
Linda Collins	NICE Lead	Oxfordshire CCG
Justin Wilson	Medical Director	Berkshire Healthcare Foundation Trust
Dr Miles Carter	West Oxfordshire Locality Clinical Director	Oxfordshire CCG
Tiina Korhonen	Clinical Effectiveness Manager	SCWCSU
Rita Ranmal	Clinical Effectiveness Team Lead	SCWCSU
Laura Tully	Clinical Effectiveness Manager	SCWCSU
Alison Fryer	Administration Assistant	SCWCSU

Topic Specialists in Attendance for Agenda Items:

Mr Bernard Nawarski	Consultant in Anaesthesia and Clinical Lead for Pain Medicine	Frimley Health NHS Foundation Trust
Karin Cannons	Nurse Consultant Pain Management	Frimley Health NHS Foundation Trust
Sue Altman	Programme Manager	Oxford University Hospitals NHS Trust
Adam Way	Consultant Orthopaedic Spinal Surgeon	Frimley Health NHS Foundation Trust
Tom McCormick	Consultant in Anaesthesia	Oxford University Hospitals NHS Trust

Apologies:

Dr Lise Llewellyn	Director of Public Health for Berkshire	Public Health Berkshire
Christina Gradowski	Head of Corporate Affairs	Berkshire East CCG
Philip Murray	Chief Finance Officer	Chiltern CCG
Dr Paul Harris	GP	Newbury and District CCG
Dr Mark Sheehan	Special Advisor – Ethics	University of Oxford

Prof Chris Newdick	Special Advisor – Health Law	University of Reading
Jeremy Servian	IFR Manager	Oxfordshire CCG
Tim Langran	Acting Head of Medicines Optimisation Team	Berkshire East CCG Federation
Ruth Atkins	Senior Communications & Engagement Account Manager	SCWSCSU
Dr Lindsey Barker	Acting Medical Director	Royal Berkshire NHS Foundation Trust
Dr Bhupinder Mann	Associate Medical Director	Buckinghamshire Healthcare NHS Foundation Trust
Frances Fairman	Assistant Director – Clinical Strategy	NHS England Area Team
Dr Lindsey Barker	Acting Medical Director	Royal Berkshire NHS Foundation Trust
Dr Tony Berendt	Medical Director	Oxford University Hospitals NHS Trust
Lisa Beaumont	Head of Operations	SCWCSU
Clive Meux	Medical Director	Oxford Health NHS Foundation Trust

1.	**Welcome & Introductions**
1.1	RR opened the meeting and welcomed members of the Committee and attendees as the Chair was delayed in arriving.
2.	**Apologies for Absence**
2.1	Recorded as above.
2.2	Quoracy: The meeting was not quorate. It was confirmed that any policy recommendations made by those present would be emailed to absent members for approval *post hoc*. Absent members must confirm their endorsement of the recommendations within two weeks of receipt according to the terms of reference. The members of the Committee endorsed this. **Action: Clinical Effectiveness to circulate minutes detailing any policy recommendations made by the Committee to absent members for approval.**
3.	**Declarations of Interest**
3.1	None were declared.
4.	**Draft Minutes of the Priorities Committee meeting held 25th March 2015 – Confirm Accuracy**
4.1	The following amendments were agreed: • Page 3, section 5.4: contraception to be changed to conception. • Page 3 section 5.5 and page 6 section 10.4: 'Changes' to be replaced with 'significant changes' to capture the discussion on the need of public consultation when making changes to the provision of NHS services; in
4.2	JD explained that she was not in attendance at the previous meeting (Wednesday 25th March 2015) and did not feel able to comment on the minutes without more detail being included, in particular the section relating to the changes to the ToR, SOP and Ethical framework. JD also expressed concern that the wording of the section in the minutes detailing the discussion on the use of biologic mesh gave the impression of decision-making inconsistent with the committee principles. It was agreed that the Clinical effectiveness team would review the minutes and they will be recirculated. **Action: Clinical Effectiveness to make changes as discussed and re- circulate for approval.**
4.3	It was noted that after finalisation the minutes would be uploaded on to the IFR website as agreed at the last meeting.

5.	**Draft Minutes of the Priorities Committee meeting held on 25th March 2015- Matters Arising**
5.1	Action 2.2: Clinical Effectiveness to circulate minutes detailing any policy recommendations made by the Committee to absent members for approval. **Action Completed**
	The Chair joined the meeting.
5.2	Action 5.4 Financial implications of NICE recommendations for Assisted Conception policy: JD queried the status of the paper and noted that, whilst a helpful document, it was not formatted as a formal Committee document. It was agreed that this would be available for CGGs to use as an appendix to the policy statement if desired. **Action: Clinical effectiveness team to format the document and make available for use as an appendix to the Assisted Conception policy.**
5.3	Action 5.5: •For all future Committee recommendations to the CCG governing bodies; Committee to advise whether the changes are significant and warrant public consultation and if so, in what form. **Action complete.** •Minutes of the Committee meeting to be made available via the IFR website (in addition to other relevant information such as work plan); **Action in progress**. •RA to raise awareness of the Committee work via relevant newsletters; As RA was not present, this point was agreed to be deferred to the next meeting (Wednesday 8th July 2015). **Action deferred.** •Clinical Effectiveness team to engage the CCG lay members of the Governing Body during evidence review consultation: **Action Outstanding**. It was clarified that the Clinical effectiveness team will engage the lay members of each CCG directly, rather than via the CCG representative. This will also require some introduction to expectations of the lay member's involvement. CCGs to support the Clinical effectiveness team to identify and contact the lay members.
5.4	Action 5.7 It was noted that the CCGs had not been in receipt of the updated Preservation of Fertility Policy Statement. The action had been originally delayed as the meeting was non-quorate which resulted in delays in obtaining approval of Committee recommendations from absent delegates post hoc. It was now ready to be sent to CCGs for agreement. It was hoped that this meeting would be able to agree several other outstanding draft polices and they would be all sent out together. As this was not the case (non-quorate meeting) the Preservation of fertility will be sent out separately as soon as possible.
5.5	The issue of non-quoracy of meetings was discussed. It was acknowledged that it leads to significant delays to the process of sending new draft policy statements for CCG consideration and as a consequence, delays to ratification and implementation of policies. The option of sending the draft policy statements to CCG governing bodies with a note that the meeting was not quorate was discussed. It was acknowledged that the final decision to ratify the TVPC recommendation rests with the CCG, however, the purpose of the Thames Valley Priorities Committee joint decision making was to make sure that the CCGs are more secure in their priority setting and policy decisions, thus making recommendations which are endorsed by all members required for quoracy is important. MT explained that this issue needs to be mentioned to the Accountable Officers in the CCGs to discuss and suggested that CCG AOs can be copied to the e-mails relating to quoracy, for information and endorsement.

	Action: • **Clinical Effectiveness team to circulate Preservation of Fertility policy and supporting papers** • **MT to raise quoracy issue with CCG Accountable Officers Forum.**
6.	**Committee Quoracy and Process**
6.1	The Chair welcomed Matthew Tait.
6.2	MT mentioned that when he is unable to attend Committee meetings, Cathy Winfield, Berkshire West Accountable Officer will attend on his behalf. GJ added that there is also a commitment from all the CCGs Clinical Chairs, as well as the Accountable Officers to play a more active role in the Committee's work, as appropriate.
	The full agenda item (Committee Quoracy and process) was discussed under matters arising.
	Facet Joint Injections Topic Specialists joined the meeting.
	LT joined the meeting.
7.	**Policy review: Therapeutic Facet joint injections**
7.1	LT summarised the related guidelines, evidence, local activity data and feedback received from clinical colleagues. NICE Guideline 88 does not support the use of facet joint injections for low back pain of duration greater than 6 weeks and less than one year, however, it was noted that this guidance is under review and the update is expected to publish in November 2016. It was noted that there is no robust evidence to support the use of therapeutic facet joint injections. The available evidence is based on small studies and the results of the RCTs available are conflicting. It was also noted that it is difficult to obtain accurate local activity data as data will include acute and diagnostic, as well as therapeutic use of facet joint injections.
7.2	TMC mentioned two facet joint trials which are commencing and suggested that the results of these trials may give more information to aid decision making. The group noted that it is likely to be a number of years before these results are published.
7.3	KC highlighted that there is variation in access to facet joint injections within the Frimley Health NHS Foundation Trust due to the Trust servicing a number of CCGs with different policies on facet joint injections. KC pointed out that this is very difficult to justify to patients. The Committee noted that other CCGs had a variety of policies in place with differing recommendations and agreed this was not ideal for either provider organisations or for patients, whose access to the same treatment may differ based on their CCG policy approach. Facet Joint Injections are currently considered a low priority across the Thames Valley. It was noted that that there are inequalities in access to care due to the variation in pain pathways and that some NHS Trusts have a long waiting list to access to the pain clinic services.
7.4	Invited specialists expressed support for the use of facet joint injections as part of the pain care pathway and informed the Committee of internal audits carried out within the local provider trusts. It was stated that as per the pathway in use within Frimley Health NHS Foundation Trust, all patients had already unsuccessfully tried other pain control strategies and estimated that 40% of patients find that facet joint injections carried out within the Trust have been successful. Invited specialists raised concerns that if facet joint injections are not offered, then the next alternative is spinal fusion operations, which are invasive and associated with a much greater cost. It was queried how often patients went on to require spinal surgery despite having received facet joint injections. AW confirmed this was not often the case as most patients would not be suitable for the surgical approach.

7.5	It was noted that whilst current policy aims to reduce the number of Facet Joint Injections, the data shows that the number of facet joint injections in Oxfordshire CCG area has doubled in the last year.
7.6	The Chair thanked the topic Specialists for their time and asked them to leave the room for the Committee to make their decision.
	Mr Bernard Nawarski, Karin Cannons, Sue Altman, Tom McCormick and Adam Way (invited Specialists) left the meeting.
7.7	Taking into account the clinical evidence and the views of the clinicians the Committee agreed to maintain the current commissioning position of not normally commissioning facet joint injections as there was insufficient evidence of clinical and cost effectiveness. It was noted that the decision would be reviewed upon publication of updated NICE Guidance or in light of new evidence becoming available. The Committee discussed the paragraph in the current policy which states 'Patients who have already received at least one therapeutic injection with benefit should have the option to continue to receive this treatment until it is considered appropriate to stop'. It was noted that the statement had been included in the current policy in order to create a phasing out period during which the number of facet joint injections being used was anticipated to reduce. IFR teams had raised the issue of increasing activity and suggested the statement now be reviewed. The Committee agreed this paragraph could be removed. **Action: Clinical Effectiveness Team to update the facet joint injection policy and circulate for ratification as per usual process.**
8.	**Evidence review: Treatments for hyperhidrosis**
8.1	The review aimed to establish the evidence for treatments for primary focal hyperhidrosis and make recommendations on treatments which have good outcomes, agree treatment thresholds and referral guidelines for evidence based treatments; as well as update existing policies on use of Botulinum Toxin A for severe hyperhidrosis and the Berkshires East and West policy for Endoscopic Thoracic Sympathectomy, a surgical procedure. The current CCG policies recommend that Botulinum Toxin A and Endoscopic Thoracic Sympathectomy for the treatment of hyperhidrosis are low priority.
8.2	Current clinical practice for primary focal hyperhidrosis typically involves use of topical and oral agents followed by iontophoresis then Botox if funded (depending on the site of administration). Surgery is a last resort. It was noted that although there was a lot of literature in this area, there was little good quality new evidence. No NICE guidelines had been published although a NICE Clinical Knowledge Summary was available. The Committee considered the impact of Hyperhidrosis on patients on functioning and quality of life, It also considered the increase in Individual Funding Requests and clinical feedback that Botox should be made routinely available for selected cases (estimated to be approximately 10 per year per service) due to its potential benefits.
8.3	Following discussion, the Committee agreed to support Option three, to maintain current low priority policies for Botulinum Toxin A and Endoscopic Thoracic Sympathectomy, as no new robust evidence was available. **Action: Clinical Effectiveness to update the policies and circulate for ratification as per usual process.**

9.	**Policy review: ENT- tonsillectomy, adenoidectomy and grommets**
9.1	**Tonsillectomy**: Currently there are three slightly different Thames Valley (TV) polices for the surgical intervention for tonsillitis in adults and children. These polices are all out of date with the national guidance and could be updated and aligned to reflect the updated SIGN guidance (2010) and the Royal College of Surgeons (RCS) commissioning guide (2013). These recommendations increase the number of episodes of tonsillitis expected to have occurred prior to referral for surgery. Tonsillectomy for obstructive sleep apnoea is not included in current polices and could be added as per RCS guide. The Committee noted the clinical feedback received and in particular detailed feedback and comments from the ENT team from Royal Berkshire Hospital Foundation Trust. The principles of referral for surgical treatment was agreed to be for patients with episodes tonsillitis which are increasing in severity and frequency. However, the impact of the severity of recurrent tonsillitis on patient's quality of life should also be taken into consideration, not only the number of the episodes. It was generally felt that increasing the number of episodes of tonsillitis from current minimum of 5 to 7 in 12 months before referral for surgery would lead to significant morbidity and absenteeism form work or school. It was suggested that that in order to assess the severity of the episode of tonsillitis, the use of Centor scoring would be helpful, indicating the need for antibiotic treatment. Centor criteria *(post meeting note)* •The Centor criteria was developed to predict bacterial infection (Group A beta-haemolytic streptococcal infections-GABHS) in people with acute sore throat. The four Centor criteria are: ◦Presence of tonsillar exudate. ◦Presence of tender anterior cervical lymphadenopathy or lymphadenitis. ◦History of fever. ◦Absence of cough. •The presence of three or four of these clinical signs (Centor score 3 or 4) suggests that the person may have GABHS (40–60% chance) and may benefit from antibiotics treatment. •The absence of three or four of these signs suggests that the person is unlikely to have an infection (80% chance), and antibiotics treatment is unlikely to be necessary. References: http://www.nice.org.uk/guidance/cg69/resources/guidance-respiratory-tract-infections-antibiotic-prescribing-pdf (2008) Clinical Knowledge summaries (2012) http://cks.nice.org.uk/sore-throat-acute#!scenario The Committee agreed to retain current criteria of 5 episodes of tonsillectomy in 12 months, and add modified SIGN criteria of 3 or more in each preceding 2 years. It was also agreed to include the need to use Centor criteria to assess the severity and antibiotic need of the episodes of tonsillitis (score of 3-4) and to add criteria for indications for tonsillectomy for sleep apnoea in the policy. It was noted that national RCS data indicates that all TV CCGs have day case rates worse than expected by chance for tonsillectomy and most TV CCGs have low day case rate for tonsillectomy for sleep disordered breathing in children. RCS guide for tonsillectomy proposes that providers demonstrate that day case is the expectation for both adults and children.
9.2	**Otitis media with effusion (OME) for grommet**s: Currently there are three slightly different policies in TV outlining the referral criteria for OME. The policy by Berkshire East and West CCGs (2011) reflects the most up to date national guidance by NICE. The Committee agreed to recommend the use the NICE criteria for local policy, based on audiology threshold for referral for intervention.
9.3	**Chronic rhinosinusitis (CRS) and nasal polyposis**: Currently in Thames Valley Berkshire East and West and Buckinghamshire CCGs have a policy for rhinosinusitis and nasal polyposis, which was agreed in February 2013. This is largely in line with the recent RCS (2013) recommendations; however, the RCS care pathway offers more detail in primary and secondary care management of CRS prior to referral to surgery. Principle of care is to offer patients conservative methods of

	management of CRS and offer referral for endoscopic sinus surgery only after failure of maximum medical therapy. The Committee agreed that the current Berkshire East and West and Buckinghamshire CCGs policy was up to date and offered sufficient advice on management principles without needing the added detail from RCS guide, which could also be interpreted as being very prescriptive.
9.4	**Action: Clinical effectiveness team to update and amend the ENT polices as discussed.**
10.	**Policy review: Hand policies-carpal tunnel syndrome, Dupuytren's contracture, trigger finger**
10.1	**Carpal tunnel syndrome**: Currently the Thames Valley CCGs have four slightly differing policies for the treatment of carpal tunnel syndrome (CTS). These policies could be aligned and updated to reflect the additional conservative management options namely physiotherapy, as per 2013 RCS guide and the European consensus guideline (2014). The Committee agreed the policy proposal as per the RCS guide and to include an amendment to note that initial primary care management of CTS is conservative *as per local DES (Directed Enhanced Services).* The Committee also agreed an addition from the European consensus guideline recommendations of up to 3 steroid injections, which was supported by local clinical view. The availability of splints on the NHS in primary care was raised, however it was considered acceptable to either obtain them via the physiotherapy service or over the counter from pharmacies.
10.2	**Trigger finger and Dupuytren's contracture**: There is little new information relating to the treatment of Dupuytren's contracture and trigger finger. The current Thames Valley CCG polices largely reflect the British Society for Surgery of the Hand (2010) treatment criteria and the European consensus guidelines (2014 and 2013 respectively), thus the policies can be updated with minor changes. The Committee agreed the Dupuytrens contracture policy update with addition of a note of the two NICE interventional procedure guidelines not endorsing the use of radiation therapy or collagenase for the treatment of Dupuytren's. The Committee agreed the policy update on trigger finger with an addition of advice on duration of the use of split and the number of steroid injections as per the European consensus guideline (2014).
10.3	**Action: Clinical effectiveness team to update and amend the hand polices as discussed.**
10.4	The Chair asked whether any of the policies discussed at the meeting today involved significant changes requiring public consultation. The Committee agreed that no formal consultation was needed for the policy changes agreed.
11.	**Any Other Business**
11.1	TK explained that in relation to the clinical policy updates considered by the Committee, there are patient decision aids available for a number of conditions. The decision aids have been developed by the 'Rightcare Shared Decision Making programme' and endorsed by NHS England. The patient decision aids (PDAs) feature evidence-based information, images and diagrams. These have been designed to help patients understand and consider the pros and cons of possible treatment options and to encourage communication between them and their healthcare professionals. The PDAs are available online and in paper format, so patients and their carers, if appropriate, can examine their options in their own time. The PDAs developed through the Quality, Innovation, Productivity and Prevention (QIPP) Right Care Programme were all based on specific clinical evidence searches that included, where they were available, latest NICE clinical guidelines and Quality Standards. It was agreed that where the decision aid reflects the local policy they could be helpful for patients

	and clinicians and it was agreed that a link to the PDA be added to the IFR website. **Action: Clinical Effectiveness Team to identify relevant PDAs and ensure they are included on the IFR website alongside the clinical policies.**
	JD informed the Committee that the topic of Pregablin scheduled for discussion at the next meeting may need to be removed from the work plan due to current legal issues. It was agreed that JD would discuss with the Clinical Effectiveness team outside the meeting and the final decision should be made by the Heads of Medicines Management. **Action: Clinical Effectiveness to consult with Heads of Medicines Management to decide whether the Pregablin topic schedule for July's meeting should be removed from the work programme.**
12.	**Dates of the Next Meetings**
12.1	The next meeting will be **Wednesday 8th July 2015, Holiday Inn, Aylesbury.**
13.	**Meeting Close**
	The Chair thanked everyone for their contributions to the discussions and closed the meeting.