THIS MEETING WAS NOT QUORATE

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 8th July 2015
Holiday Inn Aylesbury, New Road, Weston Turville, Buckinghamshire, HP22 5QT

In Attendance:

Alan Penn	Lay Member Chair	Thames Valley Priorities Committee
Richard Corbett	Chief Executive	HealthWatch Buckinghamshire
Julie Dandridge	Assistant Director – Medicines Management	Oxfordshire CCG
Linda Collins	NICE Lead	Oxfordshire CCG
Tiina Korhonen	Clinical Effectiveness Manager	South Central &West Commissioning Support Unit (CSWCSU)
Laura Tully	Clinical Effectiveness Manager	SCWCSU
Alison Fryer	Administration Assistant	SCWCSU
Sarah Robson	IFR Lead	SCWCSU
Ruth Atkins	Senior Communications & Engagement Account Manager	SCWSCSU
Philip Murray	Chief Finance Officer	Chiltern CCG
Dr Paul Harris	GP	Berkshire West CCGs
Dr Mark Sheehan	Special Advisor – Ethics	University of Oxford
Jane Butterworth	Head of Medicines Management	Aylesbury Vale and Chiltern CCGs
Catriona Khetyar	Head of Medicines Optimisation	Berkshire East CCGs

Topic Specialists in Attendance for Agenda Items:

Georgie Sullivan	Provider Performance Lead and Contract Specialist	SCWCSU
Mr. Dionisios Stavroulias accompanied by surgical registrar	Consultant Thoracic Surgeon	Oxford University Hospitals NHS Trust

Apologies:

Dr Lise Llewellyn	Director of Public Health for Berkshire	Public Health Berkshire
Professor 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

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
Clive Meux	Medical Director	Oxford Health NHS Foundation Trust
Dr Graham Jackson	Clinical Chair	Aylesbury Vale CCG
Matthew Tait	Accountable Officer	Berkshire East CCG Federation
Tracey Marriot	Director of Clinical Innovation Adoption	Oxford Academic Health Science Network
John Reynolds	Associate Head of Medical Sciences Division	Oxford University Hospitals NHS Trust

1.	**Welcome & Introductions**
1.1	The Chair opened the meeting and welcomed members of the Committee.
1.2	The Chair advised that Rita Ranmal, Clinical Effectiveness Team Leader, had left the SCWCSU at the end of June 2015. The Committee wished to record their thanks for her contribution and support of the work of the Committee.
2.	**Apologies for Absence**
2.1	Recorded as above.
2.2	**I**t was noted that without a public health representative the meeting was not quorate. **Action: Clinical Effectiveness (CE) 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 20th May 2015 – Confirm Accuracy**
4.1	The minutes were agreed as accurate pending the following amendments: • Section 7.3 and 7.4; the minutes should read 'Frimley Health NHS Foundation Trust' 7.4; to replace 'Clinical colleagues' with 'Invited specialists' for clarity. • Section 7.5; replace 'Oxford' with 'Oxfordshire CCG' area for clarity. • Section 7.7; add clarification to first paragraph 'Taking account of the clinical evidence and the views of the clinicians' … • Section 8.2 to omit 'Most patients are treated within primary care' and replace 'site' with 'site of administration' for clarity. Section 8.3; add …the Committee agreed to support Option three, to maintain current 'low priority policies' for Botulinum Toxin A and Endoscopic Thoracic Sympathectomy. **Action: CE team to make changes as discussed.**
5.	**Draft Minutes of the Priorities Committee meeting held on 20th May 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 Complete**
5.2	Action 4.2 Clinical Effectiveness to make changes to the minutes as discussed and re- circulate for approval. **Action Complete**
5.3	Action 4.3 After finalisation the minutes would be uploaded on the IFR website. It was noted that the IFR website is not yet up and running but is expected to be ready by 1st September and the minutes will then be published. **Action In Progress**

5.4	Action 5.2 Clinical Effectiveness team to format the document and make available for use as an appendix to the Assisted Conception policy. **Action Compete**
5.5	Action 5.3: RA to raise awareness of the Committee work via relevant newsletters: RA updated to confirm this was in progress. RC is assisting with a sense check regarding the wording and ease of understanding as the CCGs newsletters are available to the public. **Action In Progress** It was noted that the Committee annual report is currently being finalised and will be circulated to all committee members. **Action: In progress** CE team to engage the CCG lay members of the Governing Body during evidence review consultation: TK updated that the team has now been supplied with the contact details of the CCG lay representatives for patient and public engagement and the CE team will make contact to explain the CCG lay members expected involvement with the committee work and offer training as necessary. **Action: In Progress**
5.6	Action 5.5: Clinical Effectiveness team to circulate Preservation of Fertility policy and supporting papers. **Action Complete** MT to raise quoracy issue with CCG Accountable Officers Forum: CK informed the committee that MT is leaving on Friday 10th July. MT has confirmed that CK will replace Christina Gradowski as the member of the Committee for the East Berkshire CCGs. Cathy Winfield has also agreed to cover as Accountable Officer (AO) representation wherever possible. MT has suggested copying Cathy in to minutes and papers as well as Nigel Foster who will be Acting AO until the new post holder starts in the substantive role for the Berkshire East Federation. **Action: CE team to confirm with Cathy Winfield whether Berkshire East CCGs will continue to host the priorities service on behalf of the Thames valley CCGs and provide strategic leadership for the Committee.** Post meeting note: the BE AO appointment has been delayed and Cathy Winfield has agreed to provide interim strategic lead for the Committee for one year to offer stability and leadership.
5.7	Action 7.7: CE team to update the facet joint injection policy and circulate for ratification as per usual process. **Action Complete**
5.8	Action 8.3: CE team to update policies for treatment of hyperhidrosis as discussed. **Action Complete**
5.9	Action 9.4 CE team to update and amend the ENT policies as discussed. **Action Complete**
5.10	Action 10.3 CE Team to update and amend the hand policies as discussed. **Action Complete**
5.11	Action: 11.1 CE Team to identify relevant Patient Decision Aids and ensure they are included on the IFR website alongside the clinical policies. It was agreed that CE would send JD the links for internal agreement within OCCG. **Action: Clinical Effectiveness team to send JD the links.**

5.12	Action 11.2 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. **Action Complete: Pregablin has been removed from the work programme.**
6.	**Topic Scoring: Patella Resurfacing with Total Knee Replacements**
6.1	The Committee was asked to consider a potential new topic for the Committee work programme. New coding for Total Knee Replacement (TKR) surgery used by Royal Berkshire NHS Foundation Trust has resulted in significant increase in the cost of surgery. Previously patella resurfacing cost has been included in the TKR HRG code; however, recently some providers have re-coded the surgery, leading to an increased financial burden to the Thames Valley CCGs for a procedure where there is increasing demand. 2014 UK Health Technology Assessment estimates the price of patella component to be £116 and adding 5 minutes to surgical time, however, this is not reflected in the new coding. GS was able to confirm that the issue has been investigated with the local provider and raised with Health and Social Care Information Centre (HSCIS), responsible for the national coding. HSCIC has noted the issue; however, changing coding can take a long time, potentially three to four years. The option of local tariff was discussed, yet whist it can be negotiated it cannot be imposed on provider organisations and as the coding is in favour of the provider, a local tariff is unlikely to be agreed. This leaves the CCGs in a position where TKR surgery may impose significant financial strain on the current budget. It was therefore aged that the topic should go on the work programme with a view to establishing the effectiveness of patella resurfacing and whether there are parameters that can be used for patient selection. It was noted that as the Patella Resurfacing surgery coding is a nationwide issue, contracting teams could consider raising this with NHS Confederation. **Action: Clinical Effectiveness Team to add Patella Resurfacing with Total Knee Replacement Surgery to the work programme.**
7.	**Evidence Review: Verteprofin for Chronic Central Serous Chorioretinopathy**
7.1	The review aimed to establish the clinical and cost-effectiveness of using photodynamic therapy (PDT) with Verteporfin, with or without adjuvant anti-VEG-F intraocular injections and anti-VEG-F injections without Verteporfin and PDT. Most cases of CSR clear up without treatment between 1 and 6 months and chronic CSR is usually managed conservatively with reassurance. Only a small proportion of patients will progress to chronic CSR in which visual disturbances remain or progress. At an estimate of 8 patients across the Thames Valley, treatment with verteporfin with PDT was estimated to represent a cost of £14,400 per year. Individual Funding Requests have also been received for Idiopathic Polypoidal Choroidal Vasculopathy(IPCV) and evidence for verteporfin with PDT treatment in this indication was also reviewed. There are currently no Thames Valley policies relating to Chronic CSR or IPCV. The use of verteporfin with PDT in chronic CSR or IPCV would be an off-license indication and there are no directly related national guidelines. It is not clear whether the desired place in therapy for verteporfin in chronic CSR is as an additional treatment where laser photocoagulation is not suitable, or to replace laser photocoagulation as the preferred first-line treatment option. Anti VEGF treatments such as Ranibizumab and Bevacizumab have also been suggested as an alternative treatment option. The Committee discussed the evidence for both conditions. Laser photocoagulation is sometimes used for chronic CSR although it has been proven not to result in visual gain and only maintains vision. It can only be used where the area to be treated is well-defined and not in the centre of the fovea due to concern of incidental damage. There have been a number of systematic reviews carried out over the last few years around PDT use in CSR, however the studies were of small sample size and lacked sufficient follow-up to draw

	conclusions on long-term efficacy and safety. All studies showed short-term efficacy of PDT in CSR. Results indicated that PDT was superior in resolution of subretinal fluid (SRF) than laser photocoagulation. The evidence for anti VEGF therapy in CSR did not support use of these agents over PDT. The need for robust RCTs with longer follow-up to ascertain the role of PDT as a useful treatment option for CSR was highlighted. Two randomised controlled trials and nine retrospective studies were available for IPCV use with and without anti- VEGF therapy. PDT with or without anti-VEGF therapy was concluded as superior to anti-VEGF monotherapy. Given the inherent limitations of the included studies, however, it was noted that future well-designed RCTs are awaited to confirm and update the findings of this analysis.
7.2	Feedback from Sarah-Lucie Watson, consultant ophthalmic surgeon at Royal Berkshire NHS Foundation Trust, was considered. Dr Watson supported recommending PDT as monotherapy, possibly combined with VEGF treatment, without the need to apply for funding for each patient via the Individual Funding Request (IFR) process. It was noted that the estimated number of patients was based on prevalence data and local IFR data suggest this may be an underestimate and if it was no longer controlled by IFR then the number of patients accessing treatment may potentially increase leading to an increased cost to the CCGs in Thames Valley.
7.3	The Chair reminded the Committee that although there is some evidence for the use of verteporfin in these conditions, there is the lack of robust, longer term clinical evidence. The Committee noted that verteporfin is designated as an orphan drug for these indications. This reflects the small patient numbers and it is therefore unlikely that robust, high quality evidence will become available. It was noted that in order to develop a policy more information is required around potential patient criteria for treatment. It was agreed a sub group to include clinical specialists will be set up in order to work up potential criteria and this will be brought back to the next meeting for consideration (Wednesday 23rd September 2015). **Action: Clinical Effectiveness Team to arrange sub group and report back to next meeting.**
8.	**Evidence Review Surgery for Pectus Anomaly**
8.1	The aim of this review was to explore if there are quantifiable measures to assess the functional impact of pectus anomaly (pectus excavatum ('sunken chest') and pectus carinatum in which the sternum is raised) on patient health and consider the effectiveness and possible thresholds for surgery. A review of evidence for outcomes of pectus anomaly surgery was carried out, as there are concerns that surgery may not improve cardiopulmonary function. The issue has been raised due to the number of Individual Funding Requests received by the Thames Valley Clinical Commissioning groups. The Committee discussed the option of using pectus severity index criteria and with associated cardiopulmonary investigations to help make referral for surgery more objective. It was noted however that available systematic reviews do not consistently demonstrate clinical improvement of patients with pectus excavatum post-surgery, measured by cardiopulmonary function and exercise tolerance.
	Jane Butterworth and Mr. Dionisios Stavroulias joined the meeting.
8.2	The invited specialist, Mr Stavroulias, agreed with the review findings and added that the patients he sees mostly seek surgery for cosmetic reasons. Mr Stavroulias highlighted the psychological impact of pectus anomaly on the person's health, often manifesting as depression. The Committee noted that, as with other requests for principally cosmetic procedures, patients may benefit from appropriate psychological support rather than surgery. Mr Stavroulias questioned the reasoning behind the variation in funding between CCG areas. It was clarified that every CCG is given a budget to manage the health and social care need of its population and that the population needs do vary from area to area and thus do the CCG priorities for financial investment. Mr Stavroulias noted that areas in London do fund this procedure and

	asked if he could refer patients for treatment there. The Committee confirmed that the CCG associated with the patient's GP practice still covered the cost of the surgery, irrespective of where it is carried out, and so referring out of area to acquire funding was not appropriate. The Committee considered the lack of evidence of positive effect of surgery on the patients cardiopulmonary function and agreed to recommend that pectus anomaly surgery is not normally funded. This is in line with the existing local policy for aesthetic treatments in that Thames Valley CCGs do not normally support aesthetic or cosmetic interventions that are intended to change aspects of a person's appearance. Patients with possible exceptional clinical circumstances and /or significant physiological symptoms can be continued to be considered though the Individual Funding Request Process. Mr Stavroulias stated that it would be helpful to have an e-mail or a statement he can use in discussions with patients to explain the Thames Valley CCGs funding position. **Action: Clinical Effectiveness team to produce a policy statement for pectus anomaly surgery as discussed and circulate for ratification as per usual process.**
	Mr. Dionisios Stavroulias left the meeting.
9.	**Policy Update : Acupuncture and manual therapies for chronic non-specific low back pain and Surgery (discectomy and spinal fusion) for chronic non-specific low back pain**
9.1	This review aimed to update the existing Thames Valley Clinical Commissioning Groups' policy statements for procedures for chronic low back pain. The current polices were published in 2000 and 2010, thus a review was carried out to update the policies and consider any new evidence and national guidelines. **Acupuncture and manual therapies and policy for Osteopathy and Chiropractic:** The current Thames Valley CCG policies recommend that specific acupuncture and spinal manipulation services for patients with chronic non-specific low back pain should be low priority on the grounds of limited evidence of clinical effectiveness. However, it was noted that on the grounds that acupuncture and manual therapies may offer modest benefits and have low risk of serious adverse events, all national guidelines (NICE Clinical Guideline 88, 2009; Scottish Intercollegiate Guideline group - SIGN, 2013; Royal College of Surgeons Commissioning Guide - RCS, 2013) support the use of core therapies including exercise, manual therapy and acupuncture as optional therapies or as in combination for the care of non-specific low back pain. The NICE Guideline Development Group considered the relative merits of the three recommended therapies; acupuncture, exercise and manual therapy and concluded that the clinical and cost-effectiveness of the three approaches were of a similar magnitude when compared to usual care. Systematic reviews since the publication of the national guidelines (SIGN) offer cautious support for the use of acupuncture for short term pain relief, however it was noted that the results should be interpreted with caution, particularly in relation to the heterogeneity in the study characteristics and the low methodological quality in many of the included studies. Systematic reviews on manipulation techniques offer inconsistent findings making it difficult to draw conclusions on clinical and cost effectiveness of spinal manipulation for the treatment of LBP. The Committee acknowledged that there is little change in terms of national recommendations and discussed the provision of manual therapies and acupuncture within existing care pathways by individual NHS practitioners. The Committee agreed to recommend an update of the policy which maintains the current CCG position that due to the limited evidence for clinical effectiveness, acupuncture and manual therapies are not normally commissioned specifically outside of NHS back pain management services. However, patient can access these therapies as part of their care if provided within the care pathway, thus this recommendation was not felt to contradict NICE recommendations. The committee agreed to amalgamate the two current policy statements and recommend removal of the Osteopathy and Chiropractic (2000) – an additional BE and BW policy. **Action: Clinical Effectiveness to update the acupuncture and spinal manipulation policy as discussed, remove the outdated Osteopathy and Chiropractic policy statement and circulate as per usual process.**

9.2	**Spinal surgery (spinal fusion or discectomy) for the treatment of chronic, non-specific low back pain:** Berkshire West, Berkshire East and Buckinghamshire CCGs' current policies recommend spinal surgery as low priority for treatment of chronic, non-specific low back pain on the grounds of limited evidence of clinical effectiveness. Spinal fusion includes a number of techniques for effectively joining vertebrae in order to prevent movement between them. It is assumed that back pain is related to abnormalities of the relative movement of vertebrae and that preventing this movement will therefore reduce the pain. Discectomy i.e. partial or complete removal of intervertebral discs, is a procedure to relieve nerve compression due to a disc prolapse or protrusion. It was noted that this is seldom offered for non-specific low back pain (no specific identifiable cause). NICE Clinical Guideline 88 (2009) recommends that that spinal fusion should be reserved for a small group of selected individuals who have failed to respond to a combined physical and psychological intervention. NICE does not make recommendations regarding discectomy for non-specific low back pain. RCS Commissioning Guide (2013) notes that surgery may be considered for those patients where no other cause can be found and where a high intensity combined physical and psychological programme has failed to produce significant improvement. Recent systematic reviews of RCT and non-randomised studies do not offer support for the use of spinal fusion for degenerative spinal disease. The Committee considered the lack of evidence to support spinal fusion -since publication of the NICE CG and the RCS commissioning guide and the fact that the related NICE clinical guideline is currently under review. The Committee agreed that commissioning spinal fusion now as an in year change would not be affordable. To fund this treatment without additional funding would impose opportunity costs on other treatments which, the Committee considered, could not be justified. It agreed to recommend that the policy is updated without changes to the current commissioning positon, recognising that although NICE CG 88 supports the selective use of spinal fusion, the guideline is currently being updated (due November 2016) and will cover surgical interventions. It was agreed the policy statement will be reviewed once the updated NICE Guidance becomes available. **Action: Clinical Effectiveness to update the spinal surgery policy and circulate as per usual process. Chris Newdick (Health law) to be consulted regarding the policy and wording.** CN suggestion tracked as above (v2 draft minutes).
10.	**Policy Review: Dilatation and Curettage for Abnormal Uterine Bleeding**
10.1	All Thames Valley CCGs have current polices for dilation and currettage (D&C) in relation to dysfunctional/abnormal uterine bleeding and heavy menstrual bleeding. The aim of the review was to consider the latest guidance, update and potentially align the current Thames Valley (TV) CCG polices where appropriate or consider the removal of policies where they are no longer relevant to clinical practice. Berkshire East, West and Buckinghamshire CCGs currently have a D&C policy for women under 40 for dysfunctional uterine bleeding (2000) indicating that routine use of D&C is not normally funded. Oxfordshire CCG has a D&C policy (2008) stating that D&C is not normally funded as a therapeutic intervention for women with heavy menstrual bleeding (menorrhagia); irregular periods; or endometrial hyperplasia (thickened lining of the uterus), and D&C alone should not be used as a diagnostic tool but may be undertaken as an aid to diagnosis of the causes of abnormal uterine bleeding. Abnormal uterine bleeding (AUB) i.e. heavy menstrual bleeding (HMB), irregular bleeding and postmenopausal bleeding can affect women of both reproductive and post-reproductive age. The diagnosis and treatment of AUB are different according to the menopausal status of the person. The need to use D&C as part of diagnosis of AUB or treatment has reduced over time as clinical practice and endometrial sampling techniques have moved on, with increased use of ultrasound scanning and hysteroscopy. Hysteroscopic examination allows direct visualisation of the

	endometrial cavity and the surface of the uterine lining and it can thus be used to take tissue samples and detect some structural abnormalities. Local activity data indicates that D&C activity is low. Given the development of newer, more effective techniques, the Committee considered whether the policy was still necessary, however it was noted that IFR requests are still received for D&C and that retaining an updated policy would endorse good practice. The Committee agreed to maintain the current policy position of not recommending D&C as first line diagnostic or therapeutic intervention for AUB. **Action: Clinical Effectiveness to update the current polices and circulate per usual process.**
11.	**Fertility Care Pathway: Discussion Re: Policy Adoption Status**
11.1	It was highlighted that the Fertility Care Pathway, which was previously developed by the Committee, had not been widely adopted by Thames Valley CCGs and clinicians across the patch had raised issues with the proposed pathway. Oxfordshire LMC had also raised concerns. It was agreed it would be useful to set up a working group to review the pathway. Dr Lalitha Iyer, Clinical lead for women's health for Slough CCG, had previously expressed an interest in being involved and JD offered to attend. JB agreed to inform LT of any Bucks womens health specialists who may wish to be involved. **Action: CE team to set up a working group to review the Fertility Care Pathway.**
12.	**Any Other Business**
12.1	**Work Programme** The committee agreed to remove FeNO testing for asthma from the work programme as a NICE Clinical Guideline covering the diagnosis and management of asthma is anticipated in August 2015. Patella resurfacing will be scheduled for the September meeting to replace this topic.
12.2	**Ratification of Policies** It was raised that the IFR team is awaiting confirmation of CCG approval for a number of policies and cannot implement these until this has been received. JB confirmed that the process for ratification had been reviewed in Bucks but it may be that the CCG is not informing the CE team when policies have been ratified. CCG representatives for Bucks and Berks to establish which policies have been approved and inform the CE team. **Action: CE team to provide a list of the policies which are outstanding in Berks and Bucks. CCG members to inform the CE team of the status of these policies.**
12.3	**Workshop – November 2015** The CE team have proposed dates for the programme workshop planned for November 2015. There was a request for members of the committee to email the Clinical Effectiveness team their availability for the proposed dates. **Action: Committee members to email the Clinical Effectiveness Team their availability for the November 2015 workshop.**
12.4	**Meeting venue** The Committee had previously agreed to rotate the venue of the meetings on an annual basis, with Buckinghamshire being the location for 2015/16 meetings. It was highlighted that traveling to Aylesbury was a causing problems for some members and it was agreed that the Clinical Effectiveness Team would look at alternative venues in Buckinghamshire. **Action: Clinical Effectiveness Team to look at alternative venues in Buckinghamshire.**
13.	**Dates of the Next Meetings**
13.1	The next meeting will be **Wednesday 23rd September 2015, Board Room, Aylesbury Vale CCG, Second Floor, Aylesbury Vale District Council offices, The Gateway, Gatehouse Road,**

	Aylesbury, Buckinghamshire, HP19 8FF .
14.	**Meeting Close**
	The Chair thanked everyone for their contributions to the discussions and closed the meeting.