***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 23rd September 2015**
**Board Room, Aylesbury Vale CCG, Aylesbury Vale District Council Offices, The Gateway, Gatehouse Road, Aylesbury, HP19 8FF**

In Attendance:

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| Alan Penn | Lay Member Chair | Thames Valley Priorities Committee |
| Richard Corbett | Chief Executive | HealthWatch Buckinghamshire |
| Linda Collins | NICE Lead | Oxfordshire CCG |
| Tiina Korhonen | Clinical Effectiveness Manager | South Central &West Commissioning Support Unit (CSWCSU) |
| Laura Tully | Clinical Effectiveness Manager | SCWCSU |
| Barbara Bennett | CSU Admin Support | SCWCSU |
| Sarah Robson | IFR Lead | SCWCSU |
| Philip Murray | Chief Finance Officer | Chiltern CCG |
| Dr Paul Harris | GP | Berkshire West CCGs |
| Dr Lise Llewellyn | Director of Public Health for Berkshire | Public Health Berkshire |
| Dr Lindsey Barker | Medical Director | Royal Berkshire NHS Foundation Trust |
| Dr Graham Jackson | Clinical Chair | Aylesbury Vale CCG |
| Tracey Marriot | Director of Clinical Innovation Adoption | Oxford Academic Health Science Network |
| Miles Carter | West Oxfordshire Locality Clinical Director | Oxfordshire CCG |
| Phillip Murray | Chief Finance Officer | Chiltern CCG |
| Catriona Khetyar | Head of Medicines Optimisation | Berkshire East CCGs |

Topic Specialists in Attendance for Agenda Items:

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| Mr Rakesh Kucheria | Hip and Knee Surgeon | Frimley Health NHS Foundation Trust |
| Rohini Iyer | IFR Analyst | Frimley Health NHS Foundation Trust |
| Mr Richard Dodds | Orthopaedic Surgeon | Royal Berkshire NHS Foundation Trust |
| Kavitha Anand | Head of Contract Support | Frimley Health NHS Foundation Trust |
| Dr Sheila Lane | Paediatric Oncology Consultant and Lead Clinician for the Ovarian Cryopreservation Service | Oxford University Hospital's Trust |
| Professor Enda McVeigh | Consultant and Sub-Specialist in | |

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| | Reproductive Medicine and Surgery | Oxford University Hospital's Trust |
| Dr Fiona Lisney | Consultant in Palliative Medicine | Frimley Health NHS Foundation Trust |
| Georgie Sullivan | Provider Performance Lead and Contract Specialist | SCWCSU |
| Kathy Kelly (observing) | Safeguarding Adult Lead | SCWCSU |

Apologies:

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| Professor Chris Newdick | Special Advisor – Health Law | University of Reading |
| Jane Butterworth | Head of Medicines Management | Aylesbury Vale CCG & Chiltern CCG |
| Jeremy Servian | IFR Manager | Oxfordshire CCG |
| Julie Dandridge | Assistant Director – Medicines Management | Oxfordshire CCG |
| Frances Fairman | Assistant Director – Clinical Strategy | NHS England Area Team |
| Dr Tony Berendt | Medical Director | Oxford University Hospitals NHS Trust |
| Clive Meux | Medical Director | Oxford Health NHS Foundation Trust |
| Ruth Atkins | Assistant Head of Strategic Communications & Engagement | SCWCSU |
| Dr Mark Sheehan | Special Advisor - Ethics | University of Oxford |
| Bhulesh Vadher | Clinical Director of Pharmacy and Medicines Management | Oxford University Hospital NHS Trust |
| Dr Jonathan Hull | Consultant Knee Surgeon | Frimley Health NHS Trust |

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| **1.** | **Welcome & Introductions** |
| 1.1 | The Chair opened the meeting and welcomed members of the Committee. |
| 1.2 | The Chair advised the Committee that the meeting was being recorded and asked if there were any objections to this. It was agreed that the recording would be used for the purpose of transcribing the minutes only and would be erased after use. |
| **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 23rd September 2015 – Confirm Accuracy** |
| 4.1 | The minutes were agreed as accurate. |
| **5.** | **Draft Minutes of the Priorities Committee meeting held on 23rd September 2015 – Matters Arising** |
| 5.1 | Action 4.3 After finalisation the minutes would be uploaded on the IFR website.<br>**Action Complete** |
| 5.2 | Action 5.3:<br>RA to raise awareness of the Committee work via relevant newsletters: RA updated to confirm this was in progress: The newsletter item has now been drafted and is currently being finalised.<br>**Action in Progress**<br><br>CE team to engage the CCG lay members of the Governing Body during evidence review consultation: CE Team has engaged the lay members with an invitation to receive the evidence reviews that are prepared for the committee and comment on them. TK reported that 4 out of current 8 lay members were happy to receive the reviews and pass comment. The role of the lay |

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| | member involvement with the work of the committee was discussed further and it was agreed that their role is not to provide the public and patient view but to ensure those views are properly sought and included in the committee considerations. It was agreed that the role of the lay members is in acting on behalf of the executive teams to confirm due process is followed. The CE Team will produce a brief summary of the committee role and process in order to increase lay member understanding of the due process and pass to AP and RC for agreement before distribution to the lay representatives.<br>**Action in Progress** |
| 5.3 | Action 5.5:<br>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**:** It was noted that the AO appointment within Berkshire East CCGs has been delayed and that Cathy Winfield has agreed to provide interim strategic lead for the Committee for one year to offer stability and leadership.<br>**Action Complete** |
| 5.4 | Action: 11.1<br>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.<br>**Action Complete** |
| 5.5 | Action: 6.1<br>Clinical Effectiveness Team to add Patella Resurfacing with Total Knee Replacement Surgery to the work programme<br>**Action Compete** |
| 5.6 | Action: 7.3 Clinical Effectiveness Team to arrange sub group for CSR and report back to next meeting: LT has been in touch with relevant local specialists and is working to agree a date.<br>**Action in Progress** |
| 5.7 | Action 8.2<br>Clinical Effectiveness team to produce a policy statement for pectus anomaly surgery as discussed and circulate for ratification as per usual process.<br>**Action Complete** |
| 5.8 | Action 9.1<br>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.<br>**Action Complete** |
| 5.9 | Action 9.2<br>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 the wording of the minutes: Chris Newdick provided some additional wording for inclusion in the July meeting minutes. These were noted and agreed.<br>**Action Complete** |
| 5.10 | Action 10.1<br>Clinical Effectiveness to update the current polices on D&C and circulate as per usual process.<br>**Action Complete** |
| 5.11 | Action 11.1<br>CE team to set up a working group to review the Fertility Care Pathway: LT is working with CCG representatives to confirm which specialists should be involved. It is anticipated that this should be |

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| | brought back to the next meeting.<br>**Action in Progress** |
| 5.12 | Action 12.2<br>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.<br>**Action Complete** |
| 5.13 | Action 12.3<br>Committee members to email the Clinical Effectiveness Team their availability for the November 2015 workshop.<br>**Action Complete** |
| 5.14 | Action 12.4<br>Clinical Effectiveness Team to look at alternative venues in Buckinghamshire.<br><br>The CE team investigated possibilities and confirmed that there is a meeting room at Chiltern CCG offices in Amersham that would accommodate 18 people. It was felt that Amersham would not be more convenient than the current venue and it was therefore agreed to continue the meetings at Aylesbury Vale District Council offices for the time being.<br>**Action Complete** |
| | Catriona Khetyar joined the meeting |
| **6.** | **Evidence Review: Patella Resurfacing as part of TKR** |
| 6.1 | The aim of the review is to explore the evidence for patella resurfacing with a view to establishing whether routine resurfacing improves patient outcomes and/or if there are parameters that can be used for patient selection as there are no current guidelines. The issue has arisen following the recoding of the Total Knee Replacement (TKR) by some of the local providers, increasing the tariff cost for TKR with patella resurfacing significantly.<br>The outcomes measures in the literature reviewed focus on anterior knee pain post operatively, re-operation rates and patient outcomes and function. The systematic reviews are fairly consistent in showing that anterior knee pain does not improve after patella resurfacing. Patella resurfacing can reduce re-operation rates, however, most of the reviews considered any causes of re-operation, not just those which are patella related. Furthermore, systematic reviews indicate that resurfacing does not appear to improve patient outcomes. A UK based health technology appraisal and a large randomised controlled trial also found that over 10 year period there is no clear clinical benefit to resurfacing the patella. According to the National Joint Registry (NJR), resurfacing is carried out for between 6% and 38% of TKR surgery depending upon use of cement. |
| 6.2 | The invited specialist, Mr Rakesh Kucheria, informed the Committee that the decision to carry out patella resurfacing depends upon the findings during TKR surgery and it would be very difficult to seek prior approval for this procedure before the surgery takes place. He stated that clinical practice does not change because of changes in coding, but is based on the individual patient. He also confirmed that the tariff was not in line with the cost and time involved and perhaps there suggested there should be a local agreement to reflect this. |
| 6.3 | Mr Richard Dodds, invited specialist, demonstrated how patella resurfacing is carried out during TKR operations. He stated that, during his 20 years as a knee surgeon, he has worked with surgeons who felt a TKR should always include resurfacing the patella, surgeons who never replaced as they did not believe it made a difference and also surgeons who chose at the time whether to do so. He felt that there are many other factors to TKR than resurfacing which are not considered in the research papers. For patients with osteoarthritis, the decision regarding the patella is made at the time of the procedure. Mr Dodds felt this was a complex intraoperative decision and had to be left to the clinical judgement of the operating surgeon. Agreeing thresholds for selective resurfacing would be very difficult. |
| 6.4 | View was expressed that the Committee should not get caught in a contracting tariff debate which |

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| | would override the clinical evidence review and fall outside of the role of the Committee. The Committee agreed that the difference in the tariff was not a true reflection of the additional clinical work to surface the patella, however it was noted that the code wasn't exclusively for this operation and was used for other reconstructive procedures as well which could be more complex and reflective of the cost. The Committee expressed concern that national coding was a difficult area which was beyond the remit of the Committee, and that it was the responsibility of the commissioners to take it back to local negotiation. |
| 6.5 | The Committee considered the available options. It was felt that this was a question of negotiation and agreement between the local Providers and local Commissioners. The Committee agreed that as far as this procedure is concerned, clinically, the decision to resurface the patella or not has to be made by the consultant at the time of surgery.<br><br>The Committee agreed to recommend Option 4 set out within the review paper: CCGs to attempt to agree a local price and contract variation with local providers, which more accurately reflects the actual additional cost of patella resurfacing as part of TKR. |
| | *Dr Miles Carter joined the meeting* |
| **7.** | **Policy update: Primary Hip Replacement** |
| 7.1 | The aim of this review is to consider the latest guidance relevant to the policies and update and potentially align the current Thames Valley (TV) CCG policies where appropriate. This review includes updates on policies for primary hip replacement, hip resurfacing and hip replacement revision surgery. NICE Clinical Guideline 77 Osteoarthritis, published in 2014, has updated the 2008 guidance on care and management of patients with osteoarthritis and thresholds for referral for hip surgery. Royal College of Surgeons have also published a commissioning guide for 'Pain arising from the hip in adults' in 2013. |
| 7.2 | The invited specialist, Mr Rakesh Kucheria stated that by the time most patients get to secondary care, they have had symptoms for over 6 months. The small group of patients who come before this are usually urgent referrals. He felt the biggest problem faced currently was the increasing BMI of the patients and the number of patients with BMI>40 referred for surgery. The surgeon has to make the decision about whether to operate based on the patient's level of pain and impact on quality of life against the potential intra and post-operative risks involved. |
| 7.3 | The Committee reviewed the current local policies in relation to the national recommendations and clinical feedback. The committee agreed with the principles of not using patient specific factors such as age, gender, obesity, smoking and co-morbidities as a barrier for referral for surgery and the recommendation to emphasise the use of core treatments (information, activity and exercise and interventions to achieve weight loss if overweight) for patients with osteoarthritis. However, the committee was minded to add to the threshold the encouragement to refer patients to weight management services when appropriate, as per the current primary knee replacement policy.<br>The committee also agreed, as per RCS guideline, that 3 months conservative treatment would be recommended before referral and that whist radiographic grade would not be used as criteria for surgery, evidence of arthropathy (inclusive of evidence of joint space) would be included in the policy. It was also agreed that the Oxford Hip Score would not be included in the threshold as per NICE recommendations. NICE CG discourages the use of the Oxford Hip Score as a tool for prioritisation, as it was produced to measure population based changes following surgery and has not been validated for the assessment of appropriateness of referral.<br><br>**Action:** Clinical Effectiveness team to update the policy as per committee recommendation and circulate as per usual process. |
| 7.4 | **Policy update: Hip resurfacing** |
| | NICE Technology Appraisal 304 (2014) has superseded the TV CCGs shared policy for 'Hip resurfacing for advanced arthropathy'. The current policy states that hip resurfacing is only recommended for men aged younger than 55 years. The NICE TA differs from the current TV policy in recommending that both THR and resurfacing arthroplasty are options for treatment of |

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| | end-stage arthritis of the hip, and that clinicians consider together with patients the factors associated with the risk of revision when choosing the most appropriate procedure.<br><br>NICE TA also states that prostheses for total hip replacement and resurfacing arthroplasty are recommended as treatment options for people with end-stage arthritis of the hip only if the prostheses have rates (or projected rates) of revision of 5% or less at 10 years. This recommendation supersedes the Berkshire West 'Hip prosthesis 'policy (2003) discussing the types of prosthesis used in THR.<br><br>The Committee decided on Option 1 to remove the current "Hip resurfacing for advanced arthroplasty policies' as no longer up to date and superseded by NICE, including BW 'Hip prosthesis policy (2003). |
| 7.5 | **Policy update: Hip replacement revision** |
| 7.6 | Currently Berkshire East and West CCGs and Buckinghamshire CCGs have an interim threshold policy for hip revision surgery however, since 2013, NHS England Specialised Orthopaedics (Adult) service specification includes all THR revisions. Thus, the policy should be updated to reflect the NHS England criteria or removed. The Individual Funding Request team noted that there is a need to clarify the CCG commissioning responsibilities and the hip replacement revision provision covered by the Specialised Commissioning service specification.<br><br>The Committee decided on Option 2 to retain and update the policy, without criteria but defining the NHS England commissioning responsibilities for revision of the total hip replacement. Policy update to should also state that hip replacement revisions should be carried out in specialist centres as per the Specialist Commissioning service specification.<br><br>**Action:** Clinical effectiveness team to update the policy as per committee recommendation and circulate as per usual process. |
| **8.** | **Evidence Review: Cryopreservation of Ovarian Tissue** |
| 8.1 | Cryopreservation was initially discussed at the TVPC Meeting in May 2015. However, the Committee felt there was not enough information on the use of ovarian tissue and had requested a business case to be bought back at a later meeting. The Oxford Ovarian Tissue Cryopreservation service (collaboration between the Oxford University Hospitals NHS Trust, the University of Oxford, and the Oxford Fertility Unit) provided the Committee with a business case detailing the ovarian tissue cryopreservation service which is now available locally. |
| 8.2 | The invited specialists advised the Committee that increasing rates of children with cancer can now be cured. However, as a result of this there is now a cohort of children who are surviving cancer but have to live with the side effects arising from their treatment, including infertility. Until recently in this country, there was no treatment which could be offered to pre-pubertal girls to try and prevent infertility. These girls can go through menopause in their teenage years or earlier and therefore lose both their ovarian hormonal function and their ability to have children |
| 8.3 | The Committee noted there was evidence for ovarian tissue cryopreservation in post-pubertal women but very little in the pre-pubertal group. It is recognised that this is because the girls concerned have not yet reached child bearing age.<br><br>The evidence review highlighted questions regarding safety, particularly in terms of the risk of re-implanting the cancer for certain patients. The invited specialists explained there are two techniques, one to re-implant tissue locally to restore ovarian hormonal function and fertility and also in vitro maturation of the tissue in the laboratory, which can be carried out if there is a risk of re-implanting the cancer.<br><br>The Committee discussed the impact of the ovarian tissue re-introduction on endocrine function and the side effects of premature ovarian failure in young girls. The invited specialists advised that studies suggest a 78% uptake of grafts and that this can lead to a return of normal hormonal |

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| | function and ovulation, giving the option of spontaneous or IVF pregnancies.<br><br>The invited specialists informed the Committee that the treatment is only targeted at a very selective group of patients who are having treatments which are known to have an effect on fertility.<br><br>It was clarified that the group of patients being considered were cancer patients only. There are also girls who are going through early menopause which may be considered for ovarian tissue cryopreservation to preserve fertility, however this review is focussed on the cohort of pre-pubertal cancer patients.<br><br>The Committee discussed the lack of data available regarding success rates associated with ovarian tissue cryopreservation. The invited specialists mentioned data that was presented last autumn which showed that there had been 45 births between 20 centres which arose from 150 re-implanted strips and suggested this is a similar rate to IVF treatment. The Committee noted that these rates however are for ovarian tissue cryopreservation in women rather than the age group being reviewed. The Committee was advised that the first report of a birth to a pre-pubertal girl who had tissue re-implanted was in June 2015.<br><br>The Chair noted the parity of evidence for pre-pubertal patients and reminded the Committee of the principles of the ethical framework in terms of the need to be satisfied that there is sufficient evidence of clinical and cost effectiveness. The invited specialists stated that there is clinical evidence that re-implantation in females can result in pregnancy and felt that there should be no difference between tissue in pre-pubertal and post-pubertal girls. The younger the patient, the more immature eggs there are in the ovarian tissue.<br><br>The Committee explored the costs set out in the business case presented. It was confirmed that the £6,500 per case stated was intended as a one-off cost which included ongoing storage. Further clarification was sought regarding costs associated with taking the stored tissue to live birth, and the totality of the cost including this activity. It was confirmed that the cost of re-implantation had not been included as costs in 10 to15 years might be very different to what would be offered now. The Committee noted that it would be useful to see the breakdown of the costs involved.<br><br>The invited specialists also informed the Committee that these girls all undergo a general anaesthetic to have central venous lines put in prior to their chemotherapy and the ovarian cryopreservation is done at the same time, therefore, they would not be subjected to extra anaesthetic or in-patient days.<br><br>The Committee discussed the aspect of the use of this technique in preservation of endocrine function post cancer treatment. It was noted that this aspect may be worth further exploration but as many of the studies included in the review used endocrine markers as an outcome measure there might not be a significantly different evidence base. |
| 8.4 | The Committee discussed the options and it was felt that, although the technique looked promising, this was still considered research and development and there was insufficient evidence of clinical and cost effectiveness. Therefore, they were unable to support a recommendation to fund this technique. |
| **9.** | **Evidence Review – Futile Treatments in Palliative Care** |
| 9.1 | Thames Valley CCGs requested this review to establish whether “futile” treatments in palliative care can be reduced, to establish the evidence to support development of local guidance in management decisions in end of life care and to decide whether there is potential to reduce cost and polypharmacy without impacting on quality of care.<br><br>There is consensus that polypharmacy in this group of patients creates issues such as drug interactions and side effects. Evidence also suggests that there are benefits to reconciling medications to minimise the use of drugs which are not likely to achieve a beneficial outcome in |

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| | shortened life expectancy and focus on optimising those aimed at symptom control and increasing quality of life. It was noted however, that there was a lack of evidence to confirm that there would not be repercussions associated with stopping such medicines. There were two studies included in the review which specifically looked at this, one of which looked at the effect of stopping statins and another which included very small patient numbers.<br><br>The Committee discussed the possible policy options detailed in the paper. It was noted that recommendations rely on a clear diagnosis of the terminal stage of illness and an accurate prediction of prognosis. There is much in the literature regarding the importance of advance care planning and the Committee discussed the recommendations from the University of Cork which outline broader principles for prescribers in reviewing medications such as those for primary and secondary prevention. The Committee also discussed the more detailed policy developed by Tower Hamlets CCG. This policy goes into detail around a number of clinical areas (such as frail elderly, diabetes etc) and looks at classes of drugs used in each area, making specific recommendations for each.<br><br>In terms of savings associated with reducing futile treatments, the evidence suggests that an average of 2 inappropriate medications can be stopped and the savings associated with this could be around £13,000 per 100 patients per year. |
| 9.2 | The invited specialist, a local Consultant in Palliative Care, stressed that palliative care is a very complicated area of patient care and not an accurate science. It can be difficult to know if the patient is dying until they are close to end of life. It has to be a clinical judgement of prognosis and a negotiation between the clinician and the patient and it would be very difficult to do this outside of the specialist palliative care setting. When GPs enter patients onto on end of life register, there is an opportunity for clinicians to discuss treatments and the decisions need to be agreed with the patient, their family and appropriate clinicians.<br><br>Concern was raised in regards to the evidence which suggests that this is not always happening and patients are remaining on a variety of medications towards the end of life which may be exposing them to side effects and interactions rather than adding benefit. The invited specialist felt this was due to the complexities of diagnosing dying patients.<br><br>It was suggested that having a policy may support and encourage GPs to consider reviewing medications associated with longer term benefits in the end of life period. However, it was noted that there is limited evidence demonstrating the safety of withdrawing such medications. |
| 9.3 | The invited specialist felt that this issue was more around raising awareness, education and supporting colleagues. She explained that decisions are complex and felt that decisions about withdrawing treatment may require two senior clinicians.<br><br>Committee members felt that this is a specialist area which would not benefit from being regulated by local policy. It was also raised that this is not only a palliative care problem as there is an issue around polypharmacy for all the aging population. It was proposed that it may be more appropriate for Medicines Management Teams to offer prescribers some broader guidance around medication review to assist education and raise awareness. The Committee agreed not to recommend development of a policy relating to this issue. |
| **10.** | **Any Other Business** |
| 10.1 | **Work Programme**<br>TK informed the Committee that she has been contacted by Fertility Fairness Group, formally known as The National Infertility Awareness Campaign. They wish to organise a multidisciplinary round table meeting in November 2015 to discuss issues around fertility treatment and access to treatment. They have approached the Clinical Effectiveness Team and have also written to all CCG's inviting a representative to attend the meeting. The Committee questioned the added value of re-visiting the policies that were reviewed in 2013 and 2014 and therefore there were no expressions of interest. |

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| 10.2 | The committee agreed that there were no recommendations made at this meeting which would warrant further public engagement and consultation. |
| **11.** | **Dates of the Next Meetings** |
| 11.1 | The next meeting will be **Wednesday 25th November 2015, Board Room, Aylesbury Vale CCG, Second Floor, Aylesbury Vale District Council offices, The Gateway, Gatehouse Road, Aylesbury, Buckinghamshire, HP19 8FF .** |
| **12.** | **Meeting Close** |
| | The Chair thanked everyone for their contributions to the discussions and closed the meeting. |