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 25th November 2015
Board Room, Aylesbury Vale CCG, Aylesbury Vale District Council Offices, The Gateway, Gatehouse Road, Aylesbury, HP19 8FF

In Attendance:

Alan Penn	Lay Member Chair	Thames Valley Priorities Committee
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
Ruth Atkins	Assistant Head of Strategic Communication Engagement	SCWCSU
Sarah Robson	Head of IFR	SCWCSU
Philip Murray	Chief Finance Officer	Chiltern CCG
Dr Paul Harris	GP	Berkshire West CCGs
Miles Carter	West Oxfordshire Locality Clinical Director	Oxfordshire CCG
Catriona Khetyar	Head of Medicines Optimisation	Berkshire East CCGs
Dr Mark Sheehan	Special Advisor - Ethics	University of Oxford
Cathy Winfield	Chief Officer	Berkshire West CCG
Jane Butterworth	Head of Medicines Management	Aylesbury Vale CCG & Chiltern CCG
Dr Karen West	GP	Aylesbury Vale CCG
Dr Ingrid Slade (observer)	Public Health Trainee	University of Oxford

Topic Specialists in Attendance for Agenda Items:

Mr Jonathan Hull	Consultant Orthopaedic Surgeon	Frimley Health NHS Foundation Trust
Mr Tom Pollard	Consultant Orthopaedic Surgeon	Royal Berkshire NHS Foundation Trust
Mr Paul Hadway	Consultant Urological Surgeon	Royal Berkshire NHS Foundation Trust
Mr Molham Entabi	Consultant Ophthalmic Surgeon	Royal Berkshire NHS Foundation

Apologies:

Professor Chris Newdick	Special Advisor – Health Law	University of Reading
Dr Graham Jackson	Chair	Aylesbury Vale CCG
Dr Lise Llewellyn	Director of Public Health	Public Health

Lindsay 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
Bhulesh Vadher	Clinical Director of Pharmacy and Medicines Management	Oxford University Hospital NHS Trust
Richard Corbett	Chief Executive	HealthWatch Bucks
Frances Fairman	Assistant Director – Clinical Strategy	NHS England TV Area Team
Julie Dandridge	Deputy Head of Primary Care and Medicines Optimisation	Oxfordshire CCG
Tracey Marriot	Director of Innovation Adoption	Oxford Academic Health Science Network
Mr Jas Kalsi	Consultant Urological Surgeon	Frimley Health NHS Foundation Trust

1.	**Welcome & Introductions**
1.1	The Chair opened the meeting and welcomed members of the Committee.
2.	**Apologies for Absence**
2.1	Recorded as above.
3.	**Declarations of Interest**
3.1	None were declared.
4.	**Draft Minutes of the Priorities Committee meeting held 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 5.3: RA to raise awareness of the Committee work via relevant newsletters: RA updated to confirm this was in progress: The newsletter article has now been approved and will be sent out to each CGG. **Action Complete** CE team to engage the CCG lay members for public and patient engagement of the Governing Bodies during evidence review consultation: Concerns were raised about the CCG lay member input as it was felt that the process of sending them evidence reviews prior to Committee meetings was not an effective way to ensure patient engagement in the work of the Committee and some of the lay members did not feel able to feedback on the reviews. As the CCG lay members perform their roles through the CCG Governing Bodies, due process can be ensured though this, and via the current Committee lay member input. It was agreed to no longer send reviews to the CCG lay members and to leave it up to individual CCGs to decide how their lay members fulfil their role. **Action: Clinical effectiveness team to send clarification of this to lay members.**
5.2	Action 11.1 CE team to set up a working group to review the Fertility Care Pathway: Oxfordshire have now completed their Fertility Care Pathway. LT will bring this paper to the Committee and circulate to clinicians in Buckinghamshire and Berkshire for clinical consultation. **Action in Progress**
5.3	Action 7.3 Clinical Effectiveness team to update the policy as per committee recommendation and circulate as per usual process. **Action Complete**

5.4	Action 7.6 Clinical effectiveness team to update the policy as per committee recommendation and circulate as per usual process. **Action Complete**
6.	**Policy Update: Erectile Dysfunction**
6.1	Currently all of the Thames Valley CCGs have a local policy relating to treatments for erectile dysfunction (ED), some have been reviewed recently but there are variations in the recommendations across the policies. A request to review and update this policy was raised by the TV CCG Medicines Optimisation Teams, who reported an increase in the number of requests for SomaErect vacuum pumps. There were concerns that VED manufacturers have set up non NHS funded clinics within local hospitals and are also offering home visits to patients and this may be affecting NHS prescribing. This review was focused on the areas which are either new or have different recommendations within the existing policies, with the aim being to align the local policies. Oral PDE5 Inhibitors – Sildenafil came off patent in June 2013 and is now available generically and has therefore dropped significantly in price. Because of this, it has also been taken out of the Government Selected List Scheme (SLS) which restricts NHS prescribing to certain circumstances. Other PDE5 inhibitors are still SLS restricted. The Committee was asked to consider the frequency of dosing of PDE5 inhibitors as a result of this. Vacuum Erection Devices (VED's) are also subject to SLS criteria. The Committee considered the evidence for the effectiveness of VED use in erectile dysfunction. It was noted that the CCGs have separate policies for VED use in penile rehabilitation, as opposed to ED, and this will be considered and reviewed separately. The Committee noted that the evidence for clinical and cost effectiveness for VED use in ED is limited and not of high quality, however advantages may be that they are less invasive and less costly than other second line options. It was noted however that patient tolerability has been highlighted as an issue, with some studies showing very small percentages of patients continuing to use VEDs longer term. There is no NICE Guidance for ED specifically but the NICE CG for Prostate Cancer and The British Society for Sexual Medicine Guidelines do support the use of VED's. The Committee also considered the use of Alprostadil cream, which was launched in June 2014. Alprostadil is also available as intraurethral or intracavernosal injection for ED. The topical cream currently costs approximately £10 per dose, which is more than generic sildenafil but less than other alprostadil products. NICE has carried out an evidence summary which suggested a moderate benefit with clinically relevant improvement. The response rates were less than in trials for other ED treatments but there were no "head to head" comparisons available.
6.2	Invited specialist, Mr Paul Hadway (PH), explained that he has been running an ED clinic in the Royal Berkshire Hospital for about 18 months. He felt that clinics were managed differently around the region but his hospital use a service provided by Imedicare Ltd (manufacturer of Somarect and other vacuum devices) where a trained nurse will demonstrate and fit the pumps. Treatment recommendation proformas are then provided by the service for the patient to take back to the GP to request a prescription. PH estimated that the current cost of a VED is about £230, this is a one off cost with a 5 year guarantee. In his experience VEDs are effective for about 90% of the prostate cancer patients he sees. PH felt that there was evidence that VED's were effective but the issue was whether patients continued to use the device longer term. He felt it was important to teach the patient how to use and size the device early on to avoid discontinued use. Prostate cancer patients have limited options if the nerves or blood supply to the penis are damaged in surgery as PDE5 inhibitors often don't work and many patients don't like the injectable treatments. He advised that he has used Alpostadil cream with some patients privately and felt that it had not been particularly effective. The specialist felt that for the men that have had prostate cancer surgery, VED's are a good option and could be cost effective. The only other option would be injections and a year of injections is

	probably about the same cost as a pump which lasts for 5 years. He mentioned that colleagues from other Trusts were in agreement with this. The Committee noted that one study showed that after 2 years only 2.5% of patients prescribed VEDs were still using them. PH stated that some patients stop using the pumps to try other options, but often don't like the alternatives and go back to using a pump. Some patients may only need the pumps for 6 months to a year to keep the penis stretched and working. PH felt that vacuum pumps were not as effective for patients who had long term ED and used this treatment as a last resort. He felt it was more successful for motivated patients who were impotent due to prostate surgery. The Committee considered the local specialists' feedback alongside the evidence for use of VEDs in erectile dysfunction and agreed that there was insufficient evidence of clinical and cost effectiveness and therefore recommend that use of VEDs in erectile dysfunction is not normally funded.
6.3	It was noted that PDE5 inhibitor prescribing costs for the CCGs were predominantly related to tadalafil. Now that generic sildenafil is available this is significantly more cost effective and should be prescribed first line. The Committee discussed whether other PDE5 inhibitors should be funded given they are significantly less cost effective than generic sildenafil, however it was agreed that they should remain available as there are limited alternative options and they are remain more cost effective than the injectable treatments. A review of the evidence comparing the efficacy of PDE5 inhibitors had not been carried out as part of this review but may be useful for CCG formulary reviews. The Committee discussed the frequency of prescribing which should be recommended for funding. Department of Health Guidance suggests a frequency of four times per month. Due to affordability considerations CCGs had previously agreed to fund two doses per month. The Committee agreed four doses per month would be appropriate for generic sildenafil in line with the lower acquisition cost. For all other PDE5 inhibitors the Committee would recommend funding two doses per month in order to sustain affordability, as increasing spend in this area would mean disinvesting from treatments for other NHS patients.
6.4	The Committee considered the use of alprostadil cream for erectile dysfunction. Evidence demonstrates a modest benefit with 30 to 40% of men achieving clinically relevant improvement. There are no direct head-to-head comparisons but response rates from placebo controlled studies were less than those reported with other treatments for erectile dysfunction. The Committee therefore agreed not to recommend use of alprostadil cream for erectile dysfunction in line with the lack of evidence of efficacy. **Action: Clinical Effectiveness Team to update the policy as per Committee recommendations and circulate as per usual process.**
7.	**Evidence Review – Ultrasound Guided Injections for MSK**
7.1	The aim of the review was to explore whether ultrasound (US) guidance adds value to the MSK injection therapy in terms of accuracy and effectiveness. The topic review was raised due to concerns expressed raise by local radiologists regarding increased activity in the use of ultrasound guidance for MSK injections. There are currently no policies around this within Thames Valley CCGs. The focus of this review was on injections for hip pain including joint injections and injections for greater trochanteric pain syndrome (GTPS), as these are one of the most common sites for image guided injections.
7.2	Hip joint injections for OA: NICE CG117 Osteoarthritis (2014) supports the consideration of intra-articular injections as an adjunct to core treatments (patient information, exercise and manual therapy and weight loss as appropriate) for the relief of moderate to severe pain in people with osteoarthritis. NICE does not comment on the guidance method used to deliver the injections. Local data indicates that both fluoroscopy and US are used to guide hip joint injections. Royal

	College of Surgeons Commissioning Guide (2013) supports the use of image guidance for hip joint injections. One of the invited specialists, Mr Jonathan Hull (JH), acknowledged the short term pain relief offed by steroid injections for osteoarthritis (OA) of the hip and explained that for patients with OA, steroid injections are carried out for those who have a long wait for surgery, those wishing to delay surgery or where the source of pain is uncertain. JH informed the Committee that some orthopaedic surgeons carry out the injections themselves, whilst others send patients to radiology department for their treatment. The second specialist in attendance, Mr Tom Pollard (TP), also pointed out that intra-articular injections for OA, usually carried out under fluoroscopy, are used for diagnostic tests to work out the source of pain. He explained that, due to the location of the hip joint and its depth, it is unsafe to inject without some form of imaging guidance. TP explained that there can be practical difficulties when using US guidance for hip joint injections in patients with high BMI as it is difficult to obtain an adequate image, thus fluoroscopy remains the imaging modality of choice but US can be used for selected patients. Both specialists were of the opinion that joint injections should not be carried out without image guidance. The choice of imaging would made by the clinician but it was felt that most radiologists would use fluoroscopy.
7.3	Greater trochanteric pain syndrome (GTPS): GTPS is a regional pain syndrome in which chronic intermittent pain is felt around the bony prominence in the lateral aspect of the hip. Royal College of Surgeons Commissioning guide: Pain arising from the hip in adults (2013) notes that isolated trochanteric pain due to bursitis or tendinopathy settles in 64% of patients after one year and 71% after five years. The evidence review indicates that there is very limited literature and limited high quality evidence available on the effectiveness of corticosteroid injections for GTPS and the added benefit of using US to guide the injections. JH noted that many patients with GTPS felt that this was an effective treatment after one or two injections. He personally felt that imaging was not required for administration of this treatment. TP agreed that, for trochanteric injections, there is less need for imaging as opposed to OA. The only time it would be useful would be if the patient was not improving after 2-3 injections as these patients may have an abduct tear and ultrasound would add to the diagnosis of this. He felt that the increase in referrals for US guidance is related to clinics sending patients to radiography for trochanteric injections as opposed to carrying them out using landmark guidance. It was raised that radiologists had noted that the GTPS injections were often requested as a course of 3 treatments. It was felt that is likely to have arisen form the 2010 Clinical Knowledge Summaries (CKS) advice to this effect. JH felt this was protocol driven rather than general local practice. CKS, whist supporting the use of steroid injections for persistent pain, recommend the landmark guided technique. The Committee discussed whether carrying out injections for GTPS under US guidance should be commissioned. TP advised that if patients had 2-3 failed injections, then he felt it would be reasonable to use US to support diagnosis.
7.4	The Committee agreed that the practice for hip joint injections for OA should continue as before, with clinicians choosing the choice of imaging modality as clinically appropriate. For GTPS the Committee agreed that there was little evidence to support US guided injections and conservative treatment should be encouraged as initial treatment. Ultrasound would be acceptable only after failed landmark guided injections. For GTPS the Committee agreed on Option 2 - Use of conservative methods of treatment initially and add that US guidance can be considered in refectory cases after 2-3 failed landmark guided injections, where the diagnosis is uncertain. For OA, the committee agreed on Option 1 as a positive statement to endorse the use of steroid

	injections for short term pain relief using image guidance as clinically appropriate. A statement should also be included to remind clinicians to choose the cheapest method of imaging as appropriate. SR requested the committee to consider a decision regarding the IFR prior approval requirement process when the policy goes through to CCG board for agreement. **Action: Clinical Effectiveness Team to draft the policy statement as per Committee recommendations and circulate as per usual process.**
8.	**Policy Update – Hip Impingement Surgery**
8.1	Currently all Thames Valley CCGs share a policy for surgical treatment for hip impingement developed in June 2011, which states that this surgery is not normally funded. Since the development of the current policy NICE and Royal College of Surgeons have made recommendations regarding Femoro acetabular impingement (FAI) syndrome and related surgery. NICE Interventional Procedure Guidance 408 and 403 (2011) for arthroscopic femoro–acetabular surgery and for open femoro–acetabular surgery conclude there is 'adequate' short- and medium-term evidence for symptom relief from open and arthroscopic surgery, whilst acknowledging these procedures have recognized complications. Furthermore, NICE states that only experienced surgeons should undertake open and arthroscopic femoroacetabular surgery. Royal College of Surgeons Commissioning Guide (2013) recommends that surgery for hip impingement may be considered where there is diagnosis of hip impingement and failure of non-operative management. Current evidence base regarding femoroacetabular impingement surgery is primarily observational and suggests the various surgical techniques are associated with pain relief and improved function. However, the current evidence base is lacking for non-surgical management of FAI. There are three randomised controlled trials currently underway comparing conservative methods with both placebo and surgery but these studies are not anticipated to be reporting until 2017 or 2018.
8.2	The invited specialist, JH, stated that, although this is not a new condition, there has been a change in understanding of how adults develop problems with hips and how the human hip degenerates over time. He explained that large proportion of cases of arthritis of the hip are due to shallow socket (hip dysplasia) or FAI. Understanding of the pathologic process has recently progressed and surgical treatment options have consequently also developed. The vast majority of patients are now treated arthroscopically and evidence has shown that recovery is quicker and outcomes and quality of life scores are better than for open surgery. However, a caveat should be maintained that, for some patients with extreme deformities, open surgery may be more practical. The other invited specialist, TP, made clear that NICE has been very specific in terms of specialist training. He felt this was particularly important to ensure that surgeons not only had the specialist knowledge to know which patients to operate on but also to know how to technically carry out the operation. Post-surgery rehabilitation is also critically important and needs to be carried out by physiotherapists with expertise. Therefore, he felt that these operations should be carried out at specialist units where clinicians have specific knowledge and adequate level of experience. TP explained that most surgeons performing hip arthroscopic surgery would have completed approved fellowships and also attended specialist training.
8.4	It was queried whether carrying out FAI could prevent or delay osteoarthritic changes and total hip replacement. TP stated that for young patients with very early cartilage damage there is a good chance that surgery could slow up or stop the development of arthritis. However, this is very difficult to demonstrate in clinical trials. The specialists were asked if they could identify criteria for when patients should not be operated on. TP said that clinical consensus from the International Society of Hip Arthroscopy agrees a cut off of 2.5 mm on minimum joint space width indicates sufficient healthy cartilage. Age as potential criteria for surgery was also discussed (as FAI is more common in young and middle-aged adults),

	TP stated that the vast majority of patients would fall in the range of 18-50 years old but there are occasional younger or older patients who would benefit from surgery. Good clinical judgement would be needed to treat younger or older patients.
8.5	The Committee considered the basis for recommending a change in the current commissioning position. It was acknowledge that comparative evidence of surgery compared with conservative treatment was lacking, whist there was adequate evidence for surgical treatment for symptom relief for short to medium term. There has also been an increasing number of individual funding requests for FAI which have been agreed, mostly on the basis of labral tear. Agreed referral criteria would add consistency to IFR decision making and support equality in access to treatment. The Committee agreed to recommend Option 2: Based on the limited evidence of clinical and cost effectiveness available for surgical interventions for FAI syndrome open or arthroscopic femoro-acetabular surgery for hip impingement is commissioned only if the following criteria are met; criteria as agreed per selected points in NHS England and NHS Devon policy (as per the review paper) • NHS England criteria - Keep points 1, 2, 3, 4 and expand on 5 with requirement for specialist centres and surgeons to be listed on TV register; in order to ensure high quality care the surgeons need to carry out 100-150 procedures per year; • keep points 6 and 7 regarding maintaining and submitting data to Non-Arthroplasty Hip Registry. • include NHS Devon point 2 regarding diagnosis of definite impingement but remove "X-rays, MRI and CT Scan" and leave as "appropriate investigations". • include NHS Devon point 3 regarding failure to respond to all available conservative treatment options including activity modification, pharmacological intervention and specialist physiotherapy. • include patient exclusion criteria from the NHS Devon policy (changing 2mm joint space to 2.5mm) In order to monitor the implementation of the policy it was considered that prior approval process would be appropriate and support the referral process to agreed clinicians with adequate specialist training and experience. It was noted that the new primary care DXS information system is in place in most practices now and can provide guidance to referrers. It was also noted that it would be helpful to pre-populate the Choose and Book system in order to ensure referral to appropriate specialist clinicians. **Action**: • **Clinical Effectiveness Team to update the current policy as discussed and circulate as per usual process.** • **IFR team to link with TP to maintain a Thames Valley register of appropriate clinicians specialised in carrying out FAI surgery.**
9.	**Evidence Review – Verteporfin for Chronic Central Serous Chorioretinopathy (follow-up)**
	Unfortunately as the meeting had ran over time the invited specialist was unable to wait and had to leave before joining the meeting. It was agreed that the CE team would write to him on behalf of the Committee to apologise for the inconvenience. The review was originally discussed at the July 2015 TVPC meeting. The evidence was looked at and the initial meeting and the Committee discussed possible agreement for funding if appropriate criteria could be developed. However no local specialists had been able to attend the meeting and the Committee felt that specialist input would be required in order to develop potential criteria. The conclusion was that LT would meet with some local consultants and bring back feedback to this meeting. LT has since met with Sarah Lucie Watson and Molham Entabi, Consultant Ophthalmic Surgeons at the Royal Berkshire Hospital to discuss potential patient criteria for the use of verteporfin in Chronic Serous Chorioretinopathy (CSR) and Idiopathic Polypoidal Choroidal Vasculopathy IPCV).

	They confirmed that treatment with steroids was not appropriate for these conditions and that if chronic CSR is allowed to progress, the outcomes would be loss of colour vision and a permanent blind spot. The Committee noted that although the number of patients with these particular conditions is small, the number of IFR requests for this cohort are increasing. The total CCG ophthalmology prescribing spend is growing and this is an area of significant pressure for CCGs.
9.1	The Committee considered the proposed entry and exit criteria and treatment pathway suggestions which had been suggested by the specialists. It was agreed however that further specialist input would be needed to develop policy criteria and so the topic would be deferred to the next meeting. **Action: LT to invite local specialists to attend the January 2016 meeting.**
10.	**TVPC Work Programme 2016-17**
10.1	The Work Programme was generated from topics that were submitted by the CCGs and scored at the recent Topic Setting Workshop. The Workshop also discussed having a different approach to how topics were generated and it was agreed that the CE Team will look at policies within the CSU footprint and nationally to identify any gaps and carry out a benchmarking exercise to identify opportunities for policy development. It is expected that this will identify further topics to be considered for inclusion on the 2016/17 Work Programme. It was noted that there are no further new topics for review from the 2015/16 work plan and the Committee considered the agenda content for the scheduled January and March 2016 meetings. It was felt that Bariatric surgery was a priority issue and should be scheduled for January's meeting. The current policy statement on 'NHS prescribing following private consultation' was also identified as a priority for review. It was agreed that these will be added to the January agenda replacing the scheduled existing current policy reviews. Thus the January agenda will consist of review of Bariatric surgery i.e Severe and complex obesity, NHS prescribing following private consultation', revisit of Verteporfin in CSR and IPCV along with the review plan for comparison of existing policies with national and regional policies. The outcome of the benchmarking exercise will be scheduled for the March 2106 meeting.
11.	**Any Other Business**
11.1	Venues for 2015/16 meetings was discussed. It was previously agreed that the location would be rotated yearly to make travel distance fair for members. Board rooms in both Windsor and Slough were suggested. **Action:** Clinical Effectiveness Team will research and arrange a suitable meeting location for 2015/16 meetings.
12.	The next meeting will be **Wednesday 27th January 2016, Board Room, Aylesbury Vale CCG, Second Floor, Aylesbury Vale District Council offices, The Gateway, Gatehouse Road, Aylesbury, Buckinghamshire, HP19 8FF .**
13.	**Meeting Close**
	The Chair thanked everyone for their contributions to the discussions and closed the meeting.