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 28th September 2016
Conference Room A, Oxfordshire CCG, Jubilee House, 5510 John Smith Drive, Oxford OX4 2LH

In Attendance:

Alan Penn	Lay Member Chair	Thames Valley Priorities Committee
Tiina Korhonen	Clinical Effectiveness Lead	SCWCSU
Laura Tully	Clinical Effectiveness Lead	SCWCSU
Heather Motion	Clinical Effectiveness Manager	SCWCSU
Rachel Finch	Clinical Effectiveness Administrator	SCWCSU
Linda Collins	NICE Lead	Oxfordshire CCG
Frances Fairman	Medical Director – Clinical Strategy	NHS England – South Central
Dr Paul Harris	GP	Berkshire West CCGs
Dr Graham Jackson	Clinical Chair	Aylesbury Vale CCG
Dr Megan John	GP	Bracknell and Ascot CCGs
Catriona Khetyar	Head of Medicines Optimisation	Berkshire East CCGs
Philip Murray	Chief Finance Officer	Chiltern & Aylesbury Vale CCGs
Sarah Robson	Head of IFR	SCWCSU
Dr Robert Russ (representing Miles Carter)	MSK Planned Care Lead	Oxfordshire CCG
Dr Ingrid Slade	Public Health Registrar, Special Advisor - Ethics	University of Oxford
Cathy Winfield	Chief Officer	Berkshire West CCGs

Topic Specialists in Attendance for Agenda Items:

Mr Tom Pollard	Consultant Orthopaedic Surgeon	Royal Berkshire NHS Foundation Trust
Amar Malhas	Consultant Orthopaedic Surgeon	Royal Berkshire NHS Foundation Trust
Mr Michael Booth	Consultant Upper GI Surgeon	Royal Berkshire NHS Foundation Trust

Apologies:

Lindsey Barker	Medical Director	Royal Berkshire NHS Foundation Trust
Dr Tony Berendt	Medical Director	Oxford University Hospitals NHS Trust
Jane Butterworth	Associate Director of Medicines Management & Long Term Conditions	Aylesbury Vale CCG & Chiltern CCG
Miles Carter	West Oxfordshire Locality Clinical Director	Oxfordshire CCG
Dr Lise Llewellyn	Director of Public Health	Bracknell Forest Council
Tracey Marriot	Director of Innovation Adoption	Oxford Academic Health Science Network
Kathryn Markey	Clinical Effectiveness Manager	SCWCSU
Dr Clive Meux	Medical Director	Oxfordshire Health NHS Foundation Trust
Professor Chris Newdick	Special Advisor – Health Law	University of Reading
Rosalind Pearce	Executive Director	HealthWatch Oxfordshire
Jeremy Servian	IFR Manager	Oxfordshire CCG

1.0	**Welcome & Introductions**
1.1	The Chair opened the meeting and welcomed members of the Committee.
2.0	**Apologies for Absence**
2.1	Recorded as above. This meeting was declared quorate.
3.0	**Declarations of Interest**
3.1	None were declared.
4.0	**Draft Minutes of the Priorities Committee meeting held 27th 2016 (Paper 16-076) – Confirm Accuracy** The draft minutes were accepted as a true record of the meeting.
5.0	**Draft Minutes of the Priorities Committee meetings – Matters Arising**
5.1	Minutes of the Priorities Committee held in July 2016 – Action 2.1 – Future lay representation. Clinical Effectiveness team to seek HealthWatch representation. **Update:** Rosalind Pearce will represent HealthWatch at future meetings. **Action Complete**
5.2	Minutes of the Priorities Committee held in May 2016, Action 10.1 – Fertility care pathway: 1). Dr Hussain to email a copy of her local flow chart to the CE team. 2). CE team to investigate the various providers' referral criteria and liaise with local GPs for further consultation. **Update: expected to complete in November 2016.** **Action Ongoing**
5.3	Minutes of the Priorities Committee held in July 2016 – Action 6.3 –Severe and Complex Obesity: Sara Wilds to share the Oxfordshire CCG pathway criteria. **Action Complete**
5.4	Minutes of the Priorities Committee held in July 2016 – Action 7.2 – Sequential use of biologic drugs for psoriasis: Clinical Effectiveness team to draft a policy document and circulate for comment as per the usual process. **Action Complete**
5.5	Minutes of the Priorities Committee held in July 2016 – Action 8.4 – Sequential use of biologic drugs for psoriatic arthritis: Clinical Effectiveness team to draft a policy document and circulate for comment as per the usual process. **Action Complete**
5.6	Minutes of the Priorities Committee held in July 2016 – Action 9.3 – Follow Up: Review of sequential use of anti-vascular endothelial growth factor treatment (anti-VEGF) treatment and steroid implants in ophthalmology: Clinical Effectiveness team to draft a policy document and circulate for comment as per the usual process. **Action Complete**
5.7	Minutes of the Priorities Committee held in July 2016 – Action 10.4 – Surgery for painful big toe: Clinical Effectiveness team to update the current Oxfordshire policy document to include the criteria identified at the meeting and circulate for comment in the usual manner. **Action Complete**
5.8	Minutes of the Priorities Committee held in July 2016 – Action 11.2 – Aesthetics Policy – criteria for ptosis of the eyelid to be included within the aesthetics policy. Clinical Effectiveness team to add to the work programme. **Update: Topic included in the 2017-18 work programme meeting 3rd November 2016.** **Action Complete**

5.8	Minutes of the Priorities Committee held in July 2016 – Action 11.3 – TVPC Meeting dates – Clinical Effectiveness team to investigate whether the TVPC meeting could be moved to alternative Wednesday on the understanding that attendance would be assured. **Update:** Dates identified where TVPC meetings clash with Provider Board Meetings. CE Team to consider an alternative date for January 2017 meeting. **Action Ongoing**
6.0	**Paper 16-077 – Evidence Review: Treatments for painful shoulder-subacromial pain**
6.1	This review focused on subacromial decompression of the shoulder. Evidence was presented for: • Conservative and surgical intervention for shoulder impingement syndrome (SIS) and rotator cuff repairs. • Open surgical intervention versus an arthroscopic approach.
6.2	Royal College of Surgeons (RCS) Commissioning Guide: Subacromial Shoulder Pain, 2014, advises conservative measures as being: • Education, rest, NSAIDs, simple analgesia • Appropriate physiotherapy for 6 weeks • Corticosteroid injection Surgery is recommended for persistent or significant pain and loss of function not responding to at least 6 weeks of non-surgical intervention.
6.3	A number of systematic reviews have been undertaken based on randomised controlled trials (RCTs) for conservative treatment versus surgery in shoulder impingement syndrome. Limitations to the studies included within the reviews are the small sample sizes in the studies and short follow up periods. There is also a wide range of diagnostic criteria and the definitions for shoulder impingement syndrome being used in the trials vary greatly; there is no standard definition. There is moderate evidence that surgical treatment is not more effective than active exercises on reducing pain intensity caused by shoulder impingement. There was a consensus within the conclusions of the systematic reviews that conservative interventions should be first choice before surgery is considered. A subsequent RCT in 2015 concluded that it is difficult to recommend arthroscopic acromioplasty for any specific subgroup and patients who fail conservative treatment should not be operated. Very few studies evaluated the cost effectiveness of shoulder decompression surgery. The most relevant UK based study, published in 2015, evaluated patients who were listed for an isolated subacromial decompression (SAD) having failed non-operative treatment for impingement and concluded that at a cost per QALY of £5,683 (based on 2014/15 tariff costs), subacromial decompression is an economically viable health intervention. It was noted however that this was an observational study with no control group and a follow up period of 15 months.
6.4	The evidence for open surgical intervention versus the arthroscopic approach was also discussed. The systematic reviews identified noted a sparsity of high quality evidence with notable limitations identified within the studies included. A meta-analysis carried out in 2010 concluded that arthroscopic and open acromioplasty have equivalent ultimate clinical outcomes, operative times, and low complication rates, but arthroscopic acromioplasty results in faster return to work and fewer hospital inpatient days compared with the open technique. It is noted that the meta-analysis was of low quality however, so findings may not be reliable. Other systematic reviews reported no statistical differences or inconclusive results. For rotator cuff surgery, systematic reviews were identified which compared repair with or without acromioplasty. It was noted that the evidence was of low quality, with a number of the studies being based on uncontrolled studies or case series. The majority reported not statistically significant or inconclusive results.

6.5	RCS data indicates that a number of the CCGs within Thames Valley have an activity rate per 100, 000 population for SAD which is higher than the national average. NHS RightCare Commissioning for Value Focus Packs indicate that all of the Berkshire CCGs' spend per 100,000 population is higher than that of the comparative CCG spend. Local data indicates that spend rate is significantly higher across Berkshire West CCGs than the rest of the TV CCGs.
6.6	The attending specialist indicated that very few standalone subacromial decompression surgical procedures are undertaken. Isolated impingement patients tend to be older patients with a massive subacromial spur scoring the muscle, a bursal sided cuff tear; by taking away the spur their symptoms improve and a cuff repair is not required. More often the procedure is performed as an adjunct to another procedure for example a rotator cuff repair where decompression is carried out as an addendum to provide space to technically carry out the repair and also to protect the repair. The attending specialist advised that patient response to a steroid injection can provide an indication as to whether they will respond well to a clinical procedure or not. A patient with classic impingement is injected with a local anaesthetic and a steroid: 1. If there is an immediate improvement of their symptoms i.e. 90% better within a few minutes of the local anaesthetic confirms that impingement is the likely diagnosis, therefore the steroid will aid the physiotherapy. (Responders) 2. If the injection works initially but fails later, conservative management is less likely to be successful and patients are more likely to benefit from surgery. (Transient) If the patient has had a good response for 4 or 5 weeks but it's starting to wear off then it is appropriate to consider giving a second injection. 3. If after the local anaesthetic there is no response an alternative diagnosis should be sought as it's unlikely to be impingement. (Non-responders)
6.7	The Committee discussed the threshold criteria for primary care referral for surgical opinion and agreed the following: • Patient has had symptoms for at least 3 months from the start of treatment • Symptoms are intrusive and debilitating • Patient has been compliant with conservative intervention for at least 6 weeks • Patient has initially responded positively to a steroid injection but symptoms have returned despite compliance with conservative management • at least 8 weeks following steroid injection It was also agreed the policy will include: • Primary subacromial decompression in isolation is an intervention not normally funded. • RCS red flag symptoms **ACTION: Clinical Effectiveness team to draft a policy document and circulate for comment. Comments are to be received within the 2 week feedback period following issue.**
6.8	The Committee discussed including the OPCS codes and indicative NHS tariff value on all TVPC policies relating to surgical procedures. It was agreed this would be helpful for implementation and monitoring purposes. **Action**: **Clinical Effectiveness team to include OPCS codes and an indicative value on surgery related policies.**

7.0	**Paper 16-078 – Policy Review: Primary hip and knee replacement surgery**
7.1	This topic was discussed at the March 2016 Committee meeting, it was noted that the benchmarking work undertaken for the local CCGs indicates that there may be further opportunities for efficiencies in the musculoskeletal care pathways and thresholds for surgical treatment. The Committee felt that it would be useful to revisit the current policy thresholds for surgical referral for primary hip and knee replacement due to osteoarthritis (OA) and to explore if good long term patient outcomes are achieved with the current thresholds.
7.2	Hip and knee surgery is a relatively high and expensive field of activity which is thought likely to increase in both primary and revision surgery in the foreseeable future.
7.3	The 2016 Commissioning for Value Focus packs for MSK Trauma and Injuries offer CCG level data on hip and knee surgery activity, spend and outcomes. From a commissioning perspective the data provides a mixed picture for Thames Valley CCGs but most CCGs are identified as having some opportunity in either quality (patient health gain) or activity outcomes. Provider data for local hospitals from NHS digital and the National Joint Registry also offers a mixed picture (joint specific scores around hips and knees) with performance ranging from better than national average to negative outlier, for both hip and knee surgery. Local activity and spend data over the last 3 years indicates that activity appears to have peaked in 2014-15 for both hip and knee surgery. For most of the TV CCGs it has dropped a little on average for 2015-16 but remains higher than activity levels 3 years ago. Some CCGS have had a gradual increase in activity over the last 3 years. The Committee acknowledged that hip and knee replacements are clinically and cost-effective interventions when warranted by clinical need. The attending specialist added that in terms of patient outcomes, joint replacement on the right patients results in improvement in quality of life and joint specific scores. Variation in patient outcomes was discussed and the attending specialist noted that patients with significant symptomatology (with bone-on-bone disease) generally achieve the highest health gain. Outcomes may be less predictable with a joint replacement where there is partial thickness cartilage loss. The attending specialist advised that evidence suggests that whilst the overall amount of health gain achieved is similar for patients who start with lower health state pre-operatively as for those with higher pre-operative health state, patients who start with a higher health state pre-operatively achieve higher levels of health gain in terms of scores achieved. The attending specialists also noted that routine diagnostic X-Ray for OA is not necessary in primary care. Patients can be diagnosed clinically and x-rays added to secondary care management as necessary. Pain and functional issues are key in patient diagnosis and management.
7.4	The attending specialist advised that weight reduction is very effective for treating knee pain but evidence is less clear for hip OA. A clinical view was expressed that all patients with OA should undertake all appropriate conservative measures, including weight management programmes with an aim to reduce weight below BMI 35 prior to referral for surgical opinion. The rationale for the BMI limit was discussed. The Committee was mindful that NICE Guideline 177 Osteoarthritis: Care and management in adults (2014) indicate that patient-specific factors (including obesity) should not be barriers to referral for joint surgery. The Committee also acknowledged that weight loss is core part of treatment of patients with OA and as stated by NICE Quality Standard 87 (2015) 'adults with osteoarthritis who are overweight or obese are offered support to lose weight'. There was consensus that weight loss would support the patient's general health, send a positive public health message to patients as well as reduce joint symptoms. The attending specialist acknowledged that the evidence for reducing OA pain is stronger for knees (even for bone-on-bone disease), however, weight loss would be supportive of reducing anaesthetic risk and related co-morbidities for all patients with high BMI. Given the high demand for surgery it

	was considered reasonable to tighten the current local policy to include an expectation that patients seeking surgical opinion should have been compliant with a weight loss programme as part of their core care. BMI ≥35 was agreed in line with the current NICE thresholds for bariatric surgery. The role of shared decision making was also recognised to ensure full patient involvement in their care and knowledge about all alternative treatment options. It was agreed that the completion of a Patient Decision Aid should be introduced as part of the referral threshold. The role of corticosteroid injections was discussed in the management of OA and it was agreed that steroid injections can offer short to medium term pain relief and be particularly helpful for patients who do not wish to or cannot have surgery. It can also offer a window to optimise other non-surgical treatments such as to complete a weight management programme.
7.5	An alternative draft policy paper for primary hip and knee replacement for patients with OA was circulated to the committee for discussion. The focus of the draft policy is on the core management and advice, acknowledging that the majority of patients with OA of the hip and knee can initially be managed adequately in primary and intermediate care by following NICE guidance CG177 (2014) before referral for specialist assessment. The Committee agreed the draft joint hip and knee OA referral policy with the following additions / amendments: • Patients with a BMI ≥ 35 must have been offered and have completed a weight loss programme • Patient experience joint symptoms (pain, stiffness and reduced function) that have a substantial impact on their quality of life (i.e. interfering with their activities of daily living and their ability to sleep) • Patient must have engaged in shared decision making about alternatives using Patient Decision Aids and express wish to have surgery as an option. • Corticosteroid injections should be offered to patients as part of non-surgical management • Patients who smoke should be advised to stop smoking at least 4 weeks before the operation to reduce the risk of surgery and the risk of post-surgery complications • Consideration for referral for specialist opinion outside of these criteria is not appropriate The Committee also raised the issue of partial knee replacement revision. The attending specialist confirmed that when a partial knee replacement is revised, it goes in to the National Joint Registry as a revision procedure. In general, most partial knee replacements will be revised to total knee replacement. It was noted that the coding of partial knee replacement as revision or conversion, is not clear, regardless of the revision surgery being included in the Specialised Orthopaedics Commissioning Specification and needs clarification. Post meeting note: legal advice was sought post meeting regarding the use of PDAs as part of referral criteria. Advice received was that policies should recommend (strongly) that doctors encourage patients to be fully informed and perhaps some doctors will also assist patients with using the tools. Consideration need to be given to those who are too frail, ill, young etc to be engaged in this way, exceptions would often be required for these patients. At “policy” level, clinicians and patients should be encouraged to discuss things more fully and candidly together. The draft policy recommendation wording was updated to reflect the clinician’s responsibility to support the use of PDAs. **ACTION: Clinical Effectiveness team to draft a policy document and circulate for comment. Comments are to be received within the 2 week feedback period following issue.**

8.0	**Paper 16-079 - Scoring of topics agreed for scoping**
	Topics for scoping deferred to the 2017-18 programme workshop in November 2016.
9.0	**Paper 16-080 – General Hernia Policy**
9.1	The Thames Valley CCGs currently have separate policies for inguinal and umbilical elective hernia surgery. Buckinghamshire, Berkshire East and Berkshire West CCGs share the same inguinal hernia and umbilical hernia policies. The SCWCSU IFR team provided feedback that triage against current criteria is challenging due to the general nature of the statements. The team also receives requests for hernia types not currently covered by the policies, including femoral, Spigelian, ventral, epigastric and incisional. The latter two types represent the largest cohorts. NICE have delayed development of an overall hernia clinical guideline and a date for publication has yet to be confirmed. The Royal College of Surgeons (RCS) commissioning guide for groin hernia is currently being updated and estimated for publication in December 2016. There is also a NICE Technology Appraisal and Clinical Knowledge Summary for inguinal hernia, as well as European and USA guidance available.
9.2	CCGs in the Thames Valley are at or below the national average for groin hernia surgery activity according to the RCS explorer tool. Activity for elective hernia repair in Thames Valley costs approximately £4m per year, of which £2.6m is associated with inguinal hernia.
9.3	The attending specialist cautioned around variation in interpretation of 'symptomatic' hernia in threshold criteria. There is a need for policy criteria to ensure clarification and assessment of impact factors to facilitate triage i.e. interference with daily living or work-related issues etc. Two distinct patient groups were suggested: 1. younger working individuals who are likely to return with further symptoms within 3 to 5 years and 2. older individuals who may be more prepared to live with their symptoms than accept surgery. Patients with femoral or Spigelian hernias should be referred to secondary care as there is a higher risk of strangulation. Bilateral and revision repair are most effectively carried out laparoscopically. Bilateral repair adds 15 minutes and minimal cost to the procedure. A raised BMI may increase the risk of complications but is not considered a barrier to surgery as the risk versus benefit is acceptable. The attending specialist advised that most patients suffering from chronic pain following hernia surgery are best served by pain management services. The specialist agreed that a single hernia policy is workable, with separate referral criteria for femoral and Spigelian hernias and all other abdominal/ventral hernia types (inguinal, incisional, umbilical and epigastric) grouped together with shared criteria. Written feedback from another clinical specialist was noted regarding the suggestion that the practice of second surgical opinion could be considered to ensure appropriate surgery.
9.4	Bilateral repair of groin hernia, when one hernia is asymptomatic, was discussed. According to averaged reported procedure costs for 2015-16, the additional cost of bilateral inguinal repair ranged from £40 to £215 (considerably less than double the cost of two unilateral repairs) depending on CCG area. The reduced risk for patients, presented by a single surgical episode, was also noted. Diagnosis (ICD) codes are available for bilateral hernia and should be used in conjunction with the procedure codes to generate consistent HRG tariffs.
9.5	It was confirmed that an online patient decision aid is available for inguinal hernia surgery from Right Care and these should be used prior to referral to discuss the risks of surgery and confirm the patient is willing to consider the surgical approach before a referral is made.

9.6	The Committee agreed a policy to include:
	• Femoral hernias – refer for consultation
	• Spigelian hernia – confirm diagnosis by ultrasound and refer for consultation
	• Other abdominal/ventral hernia including inguinal, incisional, umbilical and epigastric
	  o Retain current inguinal hernia policy criteria
	  o Include the additional Oxfordshire inguinal hernia policy criteria, updating criterion 5(a) to 'has become restricted to light duties because of hernia'
	  o Documented evidence is to be provided for pain, symptoms, impact on daily living activities, work related issues etc
	• Patients must have completed a Patient Decision Aid where available and/or the risk/benefit of surgery discussed and understood
	• Bilateral groin hernia repair is funded if one of the hernias fulfils the above criteria and the cost is in line with currently available data.
	• Mortality and complication rates of elective hernia surgery to be included.
	
	ACTION: Clinical Effectiveness team to draft a policy document and circulate for comment. Comments are to be received within the 2 week feedback period following issue.

11.	**Any Other Business**
	Items - Prescribing Gluten Free Foods; Penile Prostheses and Gender Dysphoria (primary care prescribing in children) were deferred and will be raised at the November programme workshop. The CCG representatives were reminded that the working group to set the next years' work programme will be take place 3rd of November in Jubilee House 14-16:30 and the topic submissions should be submitted to the Clinical effectiveness team by the 19th of October.
12.	**Next meeting**
	The next meeting will be **Wednesday 23rd November 2016, held in Conference Room A, Jubilee House, Oxford, OX4 2LH**
13.	**Meeting Close**
	The Chair thanked everyone for their contributions to the discussions and closed the meeting.