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 22nd March 2017
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
Kate Forbes	Clinical Effectiveness Manager	SCWCSU
Kathryn Markey (Part)	Clinical Effectiveness Manager	SCWCSU
Rachel Finch	Clinical Effectiveness Administrator	SCWCSU
Lindsey Barker	Medical Director	Royal Berkshire NHS Foundation Trust
Dr Tony Berendt	Medical Director	Oxford University Hospitals NHS Trust
Linda Collins	NICE Lead	Oxfordshire CCG
Dr Megan John (Part)	GP	Berkshire East CCGs
Gareth Kenworthy	Director of Finance	Oxfordshire CCG
Catriona Khetyar (Part)	Head of Medicines Optimisation	Berkshire East CCGs
Rachel Luxton	PPM Lead	SCWCSU
Rebecca MacLean	Senior Public Health Registrar	Swindon Borough Council
Dr Anees Pari	Senior Public Health Registrar	Bracknell Forest Council
Dr Jacky Payne	GP	Berkshire West CCGs
Rosalind Pearce	Executive Director HealthWatch	Oxfordshire
Sarah Robson	Head of IFR	SCWCSU
Dr Mark Sheehan	Special Advisor – Ethics	University of Oxford
Richard Smith representing Dr Tina Kenny	Assistant Medical Director	Buckinghamshire Health Care NHS Trust
Dr Karen West representing Dr Graham Jackson	Clinical Director Integration	Buckinghamshire CCGs
Cathy Winfield	Chief Officer	Berkshire West CCGs

Topic Specialists in Attendance for Agenda Items:

Helen Jefferies	Sub-specialty trainee in Urogynaeology	John Radcliffe Hospital Oxford

Apologies:

Jane Butterworth	Associate Director of Long Term Conditions & Medicines Management	Aylesbury Vale CCG & Chiltern CCGs
Miles Carter	West Oxfordshire Locality Clinical Director	Oxfordshire CCG
Frances Fairman	Medical Director – Clinical Strategy	NHS England – South Central
Lalitha Iyer	GP/Medical Director	Berkshire East CCGs
Dr Graham Jackson	Clinical Chair	Aylesbury Vale CCG
Jo Jefferies	Consultant in Public Health	Bracknell Forest
Dr Tina Kenny	Medical Director	Buckinghamshire Health Care NHS Trust
Tracey Marriot	Director of Innovation Adoption	Oxford Academic Health Science Network
Dr Minoo Irani	Medical Director	Berkshire Healthcare NHS Foundation Trust
Jeremy Servian	IFR Manager	Oxfordshire CCG
Fiona Slevin-Brown	Director of Strategy & Operations	Berkshire East CCGs
Amy Wire	Chief Pharmacist	Royal Berkshire NHS Foundation Trust

1.0	**Welcome & Introductions**
1.1	The Chair opened the meeting and welcomed the members of the Committee.
2.0	**Apologies for Absence**
2.1	Recorded as above.
3.0	**Declarations of Interest**
3.1	None were declared.
4.0	**Draft Minutes of the Priorities Committee meeting held 1st February 2017 (Paper 16-092) – Confirm Accuracy** • This meeting was not quorate however post meeting the Clinical Effectiveness team received a response from Berkshire West CCG accepting all of the proposals made. • The draft minutes were accepted as a true record of the meeting.
4.1	**Committee update**
4.1.1	Cathy Winfield advised that Louise Patten, Chief Office, Aylesbury Vale CCG will take over as strategic lead for the Committee. The Committee expressed their thanks to Cathy for her time and valued contribution.
5.0	**Draft Minutes of the Priorities Committee meetings – Matters Arising**
5.1	Minutes of the Priorities Committee held in May 2016, Action 10.1 – Fertility care pathway - CE team were asked to investigate the various providers' referral criteria and liaise with local GPs for further consultation. **March 2017 Update:** Berkshire East are in the process of setting up a working group and will report back once further progress has been made. **Action: Dr John to develop a draft patient fertility care pathway for consideration by the Committee.**

5.2	Minutes of the Priorities Committee held in July 2016 – Action 11.3 – TVPC Meeting dates – It was agreed that for 2017/18 meetings will be held in Berkshire East. CE team to identify a suitable venue. **March 2017 Update:** Brants Bridge does not have sufficient capacity. An alternative suggestion was Albert House, High Wycombe. **Action: CE team to explore the suitability and availability of Albert House, High Wycombe as a venue option.**
5.4	Minutes of the Priorities Committee held in November 2016 – Action 6.6 - Paper 16-082 Policy Review: Insulin pumps. The Clinical Effectiveness team to draft a policy document based on TA151 with the addition of gastroparesis and IHA in line with NG17. **February Update:** CE team have drafted a policy document but have not circulated for comment as it includes reference to Continuous Glucose Monitoring (CGM) which is still to be agreed. **March Update: Ongoing, CGM to be discussed further at next meeting in May 2017**
5.5	Minutes of the Priorities Committee held in February 2017 – Action 6.12 – Paper 16-087 - MRI Scan – Open/Standing. Clinical Effectiveness team to draft a policy document for open MRI scans and circulate for comment in the usual manner. **Action Complete**
5.6	Minutes of the Priorities Committee held in February 2017 – Action 7.9 - Paper 16-088 – Low Back Pain. Clinical Effectiveness team to draft a policy document for Low Back Pain and sciatica in over 16's in line with NICE guideline NG59 (2016). The Committee agreed to retain the neck pain element of the current policy (TVPC24 2015 & PS69 2012) for diagnostic and therapeutic facet joint injections (not normally funded). **Action Complete**
5.7	Minutes of the Priorities Committee held in February 2017 – Action 8.4 - Paper 16-089 – Radiofrequency denervation of sacroiliac joint (SI). Clinical Effectiveness team to include a statement as part of the low back pain policy that SI joint denervation is not normally funded. **Action Complete**
5.8	Minutes of the Priorities Committee held in February 2017 – Action 9.8 – Paper 16-090 – Use of melatonin in children to improve sleep and subsequent behaviour. The Clinical Effectiveness team to draft a policy for the use of melatonin in children with neurodevelopmental disorders including autism, ADHD and learning difficulties in children with challenging behaviour. The draft policy to be circulated for comment in the usual manner. **Action Complete**
5.9	Minutes of the Priorities Committee held in February 2017 – Item 11.2 – Terms of Reference and Ethical Framework. The Committee agreed to review these documents and to look at the definition of 'exceptionality' at a workshop on 19th July ahead of the TVPC meeting to be held on the same day. **ACTION: Clinical Effectiveness team to arrange a workshop and advise Committee members accordingly**
6.0	**Paper 16-096 – Evidence Review: Female Genital Surgery for Stress Incontinence and Prolapse**
6.1	A benchmarking exercise comparing national policies identified that several other CCGs have policies for female genital surgery for stress incontinence and prolapse. As Thames Valley CCGs do not currently have a policy the Committee requested a review of the recommendations.

6.2	**Stress Urinary Incontinence (SUI)** NICE Clinical Guidance CG171 for urinary incontinence in women provides recommendations on the conservative and surgical management of stress urinary incontinence (SUI). The guidance for conservative management such as pelvic floor muscle training and lifestyle interventions was updated by NICE in 2015, and no further evidence was found during the literature review which affected this. Surgery or other invasive treatment is considered only if appropriate conservative management and pharmacological treatments have been unsuccessful. Endoscopic Injection is the most commonly performed surgery for SUI. The cost of surgery across the TV CCG's appears static. A NICE update is due in February 2019 which will include guidance regarding surgery for SUI combined with the management of Pelvic Organ Prolapse (POP). Following discussion the Committee agreed that a Thames Valley policy for stress incontinence outside of prolapse would not be developed as NICE guidance (CG171) is comprehensive.
6.3	**Pelvic Organ Prolapse (POP)** At present there are no specific clinical guidelines in relation to conservative management for POP. NICE have published IPGs for some surgical techniques and limited related national guidelines from Royal College of Obstetricians and Gynaecologists (2015) could be found for post-hysterectomy vaginal vault prolapse. The stages of prolapse can be graded using the POP Quantification System (POP-Q) on a scale of 1-4. Symptoms of prolapse are often identified using validated, patient completed questionnaire. The stage of prolapse does not always correlate with the prolapse symptoms. Conservative management of POP includes lifestyle advice, and pelvic floor muscle training (PFMT). Pessaries are commonly used however there is limited evidence for their effectiveness. In some cases oestrogen is used; however again there is very limited evidence for the effectiveness of oestrogens and side effects were identified. There is a lack of evidence for the long term effectiveness of conservative measures and whether women will go on to require surgery in any case. Timescales for conservative measures in the Pelvic Organ Prolapse studies were variable. There are a number of surgical interventions for POP which include native tissue pelvic floor repair, vaginal repair with mesh, vaginal hysterectomy, abdominal vault and uterine support procedures with and without the use of mesh, and colorectal surgery to repair posterior vaginal wall prolapse.
6.4	The attending specialist stated that the majority of women will start with conservative measures. There are a high proportion of women who seek help quite late having endured symptoms for a long time before seeking treatment. The Committee heard that an average of 1 in 5 women will present at some time in their lifetime with a uterine prolapse. The specialist advised that physiotherapists need to be specially trained women's heath rather than musculoskeletal physiotherapists. In Oxford the wait for women's Physiotherapy is 2 months, whereas the wait for surgery is 12 months. Current evidence suggests a high recurrence rate of prolapse after surgery, however the Committee was advised there have been changes in practice over the last 10-15years. Surgery is now generally undertaken laparoscopically rather than vaginally with complex and repeat work carried out by an accredited centre. Oxford 10 year output data shows a 2.8% recurrence risk compared to anything between 10-14% quoted in the literature.

6.5	The following points were suggested for consideration for POP policy development: • the severity of the symptoms including incontinence • only make recommendations around stress incontinence when it's in the context of prolapse • failure of conservative methods including pessary • impact on daily living activities • exclude conservative measures for severe stage prolapse • evidence for PFMT is based on early stage prolapse • timescales for Conservative measures
6.6	A review of the local data and financial impact shows the activity levels for prolapse surgery across the Thames Valley to be low with the exception of Oxford which is high. The Committee asked that the data is investigated in more detail to ascertain whether coding differences are affecting the data and report findings back at the next meeting, before progressing to consider a local policy. **ACTION: Clinical Effectiveness team to investigate the coding of the TV CCG prolapse surgery activity and provide an assessment at the next meeting (May 2017).**
7.0	**Paper 16-093 – Policy Update: Primary Hip and Knee Revision**
7.1	The Priorities Committee has sought clarification from NHS England (NHSE) specialised commissioning team for definitions used and their commissioning responsibility in relation to hip and knee revision surgery. The current local policies adopted across Thames Valley CCGs were based on NHSE Service Specification 2013, stating that all revision surgery is Specialised Commissioning. It has now come to light that there are also NHSE 'Identification Rules' which identifies that only third revision and beyond is commissioned by NHSE, all other revision surgery continues to be commissioned by CCGs. The February 2017 TVPC Committee agreed the current policies will need to be adjusted to reflect the NHSE definitions and identification rules. The Committee agreed that as an interim the current TVPC policy was to be amended to state that the first revision (second procedure) can be done locally, however, it was agreed that a further consideration about the place of surgery for revision procedures should take place before a final policy recommendation could be made.
7.2	Additional notes received from clinicians form Royal Berkshire Hospital NHS Foundation Trust and Frimley Health NHS Foundation Trust.
7.3	NHS England Specification indicates there is a relationship between volume and surgery outcomes i.e. surgeons and hospitals who carry out high volumes of surgery have potentially better outcomes. NHSE does not offer threshold or detentions for 'high volume'. The NHE Specification notes that comprehensive system of care for people requiring specialist orthopaedic treatment can be provided by Specialist Orthopaedic Centre as well as Specialist Orthopaedic Unit, a spoke unit (i.e generally a District General Hospital) that works in collaboration through a network with a Specialist Orthopaedic Centre as a part of formalised network to provide care for patients classified in the complex category.
7.4	Feedback received from Clinical Specialists indicates that frequently second or third revision surgery may not be more complex than first revision and local DHG have the expertise to deal with most revision cases. For example many second revisions are of revisions implanted at least 10 years ago with cemented components. In these situations, revision to uncemented components is often of similar technical difficulty to a first-time revision of cemented components. Feedback also indicates that complex revision surgery is only performed by nominated surgeons by some providers. The Specialists proposed that going forward a Hub-Spoke model, potentially with (multidisciplinary) MDT discussions of individual cases is desirable,

	although not yet formally established, however, in practice this occurs frequently given the well-established informal links already in place between surgeons with revision cases. The clinical view was noted that patients requiring specialist procedures for massive bone defects, pelvic fractures, infection or complex segmental femoral reconstruction are referred to a local specialist centre.
7.5	The Committee agreed to modify the current interim statement to state that: • Revision surgery can be carried out by local DGH (Specialist Orthopaedic Units) with the required expertise, with the exception of patients requiring specialist procedures for massive bone defects, pelvic fractures, infection or complex segmental femoral reconstruction, who are to be referred to a local Specialist Orthopaedic Centre. **Action: Clinical Effectiveness team to modify the Hip and Knee Replacement Revision Interim Statement to the effect that revision surgery can be undertaken locally in DGH (Specialist Orthopaedic Units) providing the procedure is not complex surgery; complex surgery is to be referred to a Specialist Orthopaedic Centre.**
8.0	**Paper 16-083 – Policy Update: Continuous Glucose Monitoring Systems**
8.1	Thames Valley Priorities Committee requested a further review of Real-time continuous glucose monitors and flash glucose monitors (e.g. Freestyle Libre) following discussion at the November 2016 Committee meeting. The Committee requested that a draft policy document based on TA151 with the addition of gastroparesis and impaired hypoglycaemic awareness (IHA) in line with NG17 should be drawn up and a modelling exercise carried out to estimate the associated resource impact as NICE had only indicated where potential savings might be made and not given any related financial cost.
8.2	The Committee reviewed the estimated resource impact data. It was noted that NICE had not provided any costing resources, thus the impact assessment had been based on prevalence data. It was noted that overall costs are likely to be over-estimated as wide prevalence ranges were reported and the estimates are based on the higher end of these. Many patients will fall into multiple cohort groups and therefore be counted a number of times.
8.3	The Committee noted financial impact for CCG's is not clear and impact assessment based on prevalence data varies widely from that predicted by the Oxford University Hospital specialist. The Committee agreed that in the absence of clear data around patient numbers and costings, further investigation would be required. It was suggest that contacting CCGs who have policies in place (Bedfordshire, Herts) to obtain patient numbers and interrogate their costs might help to give a better indication of scale and impact. It was also suggested that it might be possible to utilise the Health Economy Research Unit, University of Oxford, who may be able to model the impact. Other local providers could also be asked for information on the likely take-up and are the early expected benefits realised.
8.4	The Committee agreed to defer the policy to undertake further investigation around the resource impact. **ACTION 8.4.1: Clinical Effectiveness team to contact CCGs with policies in place for Continuous Glucose Monitoring Systems (Bedfordshire, Herts) to obtain patient numbers and interrogate their costs.** **ACTION 8.4.2: Dr Anees Pari to provide the Clinical Effectiveness team with the Health Economy Research Unit, University of Oxford contact details.** **ACTION 8.4.3: Clinical Effectiveness team to approach local providers for the likely take-up of Real-time continuous glucose monitors and flash glucose monitors (e.g. Freestyle Libre) and the early expected benefits realised.** **ACTION: 8.4.4: Clinical Effectiveness team to provide an update on actions in relation to Continuous Glucose Monitoring Systems at the next meeting (May 2107).**
9.0	**Paper 16-094 – Evidence Review: Sequential Use of Biologics for Rheumatoid Arthritis**

9.1	The Committee has considered the evidence of the clinical and cost effectiveness and NICE Technology Appraisal Guidance (TA) for the sequential use of biologic therapies in Rheumatoid Arthritis (RA). The aim of the review was to clarify the role of sequential use of biologics in rheumatoid arthritis and develop joint Thames Valley guidelines to support the most cost-effective use of these therapies.
9.2	In November 2016 the Committee recommended a policy adapted from the current Oxfordshire CCG policy, which sets out the treatment of RA with biologics in line with NCIE guidance but does not recommend further switching of cycling between biologic agents.
9.3	Since the evidence review was carried out a further Randomised Control Trial (RCT) has been published which compares the outcomes following a switch from one anti-TNF agent to another. This is the first head to head study to be published and the Committee agreed to further review the evidence for biologics in RA with this study included.
9.4	The Committee reviewed the systematic reviews identified in the original paper together with the new study. The systematic review indicated that patients still achieve significant clinical benefit from subsequent therapy, but highlight the need for prospective RCT. A cost effective study carried out in 2013 indicated that switching from one anti-TNF agent to another after first-line treatment failure may not be a cost-effective treatment strategy. The new RCT published was 2 year study comparing the efficacy and safety of certolizumab pegol with adalimumab in RA. At 12 weeks, patients who were non-responders were switched to the other TNF inhibitor. The study failed to prove that certolizumab was superior to adalimumab. However, when the patients were switched over to the other TNF inhibitor they continued to have a good clinical benefit. The new study only looked at certolizumab and adalimumab. The Committee agreed whilst this was a good quality study and demonstrated further clinical benefit when switched between the two ant-TNFs included within the study, it was not possible to extrapolate these results from one study and say that switching from any anti-TNF to another one would be clinically and cost effective.
9.5	The Committee discussed the evidence and agreed to adopt the previously agreed draft policy (TVPC51) which sets out the treatment of RA with biologics in line with NICE guidance but does not recommend further switching of cycling between biologic agents. The Committee asked that the policy be reviewed should further studies be published. **ACTION: Clinical Effectiveness team to circulate the draft sequential use of biologic therapy in RA policy document for comment. Comments are to be received within the 2 week feedback period following issue.**
10.	**Paper 16-095 – Evidence Review: Autologous Blood Injections in the treatment of Musculoskeletal Conditions**
10.1	Thames Valley CCGs have requested a review of the autologous blood injections (including platelet-rich plasma) for musculoskeletal disorders due to a rise in the number of Individual Funding Requests (IFR). Currently Thames Valley CCGs do not have any policies relating to autologous blood injections (ABI) or platelet-rich plasma (PRP).
10.2	This review specifically looked at tendinopathy and rotator cuff tears as these are the main musculoskeletal conditions where ABI has been studied and the main conditions for which Thames Valley IFR requests have been received.

10.3	Tendinopathy describes a range of conditions that affect tendons, usually caused by overuse; commonly the elbow, heel and knee tendons. Tendinopathy usually resolves over a period of several months with conservative treatments i.e. rest, analgesic, anti-inflammatory medication, use of orthotic devices, eccentric exercise and physiotherapy. Local injection of steroids, or sometimes surgery is required to release the tendon from the underlying bone or constricting surrounding tissue. A period of rehabilitation is usually needed after surgical intervention.
10.4	Rotator cuff tears can be caused by an injury or can develop gradually. Minor tears are common and may not cause any problems. Conservative treatment may include physical therapy, pharmacological treatments and corticosteroid injections. If the tear is severe or has not responded to other treatments, surgical interventions such as debridement, rotator cuff repair, subacromial smoothing, tendon transfer or shoulder arthroplasty may be needed.
10.5	In autologous blood injection, blood is taken from the patient and re-injected around the affected tendon with an aim to supply the tendon with growth factors that promote the healing process. After the procedure, patients are usually advised to avoid strenuous or excessive us of the tendon for a few weeks, after which physiotherapy is started. The procedure may be repeated if necessary.
10.6	There have been a number of relevant systematic reviews and randomised control trials (RCT) published since the publication of the SRs was carried out from 2006-2016. However, the evidence of efficacy for autologous blood injection (including platelet-rich plasma) for musculoskeletal conditions remains unclear. There is also very limited data available on cost-effectiveness as clinical effectiveness evidence is still limited. The limitation of studies include a large number of different conditions included within studies (including site and duration), a large number of different methods of preparing and delivering autologous blood injection, and relatively short follow up. The comparator used also varies between studies which makes comparison of effectiveness to other treatments difficult. In addition the outcome measures used varies between studies which can make combining results of different studies very difficult.
10.7	The Committee considered the level of evidence for autologous blood injections to be low. This was supported by feedback received from local Specialist. The Committee agreed to recommend the option 1; There is limited evidence to support autologous blood injections (ABI) for tendinopathies or rotator cuff repairs. ABI (including platelet-rich plasma) for tendinopathy or rotator cuff injuries) is therefore not normally funded. **ACTION: Clinical Effectiveness team are to circulate a draft policy stating that ABI (including platelet-rich plasma) for tendinopathy or rotator cuff injuries) is not normally funded.**
11.	**In year requests for Scoping**
11.1	Since the November 2016 workshop a number of in year requests have been received. The Committee were asked to collectively score the items to see where they fall within the 2017-18 programme. Scoring is undertaken using the scoring sheet template devised in November 2015 to standardise topic selection. **NOTE: There was no Berkshire East representatives present for this item.**
11.2	**Meniscal arthroscopy tears** – Scope widened to include all knee arthroscopy procedures. **Total Score: 26**
11.3	**Joint prosthesis other than hip and knee** – No policy currently in place for joint prosthesis other than hip and knee i.e. shoulders, ankle, elbow. These are low volume but potentially high cost treatments. Score as one item rather than individual topics. **Total Score: 23** Note, Painful shoulder (shoulder arthroscopy) is already on the programme also with a score of 23.

11.4	**Hip arthroscopy** – Current TVPC policy covers hip impingement (arthroscopic and open approach). Other CCGs have developed polices to cover a wider range of arthroscopic interventions including loose bodies and excision of radiological proven labral tears in the absence of osteoarthritic changes. A low number of people affected across the Thames Valley. **Total Score: 10. This topic will not be added to the work programme.**
11.5	**Iron chelation** – The myelodysplastic syndromes (also known as MDS or myelodysplasia) are haematological (i.e. blood-related) medical conditions with ineffective production (or dysplasia of all blood cells) with an incidence of approximately 4 cases per 100,000 populations per year; predominately affecting the elderly. No NICE Guidance. **Total Score: 28**
11.6	**ACTION: Clinical Effectiveness team to update the 2017/2018 programme as appropriate to the score rating achieved.**
12.	**Any Other Business**
11.1	**Clarification of Cataracts Policy:** NICE Guidance is due out in October 2017. In the meantime the Committee agreed for a TVPC Cataracts policy to be developed for the second eye surgery.
12.	**Next meeting**
	The next meeting will be **Wednesday 24th May 2017, to be held in Conference Room B, Jubilee House, and Oxford, OX4 2LH.**
13.	**Meeting Close**
	The Chair thanked everyone for their contributions to the discussions and closed the meeting.