Berkshire West Clinical Commissioning Group
Buckinghamshire Clinical Commissioning Group
East Berkshire Clinical Commissioning Group
Oxfordshire Clinical Commissioning Group

Thames Valley Priorities Committee

Minutes of the meeting held Wednesday 27th November 2019

Room G29/G30, 57-59 Bath Road, Reading RG30 2BA

Alan Penn	Lay Member Chair	Thames Valley Priorities Committee
Catriona Khetyar	Head of Medicines Optimisation	East Berkshire CCG
Professor Chris Newdick	Special Advisor - Law	University of Reading
Edward Haxton	Deputy Finance Director	Berkshire West CCG
Funmi Fajemisin	Interim Head of IFR	SCW
Dr Jacky Payne	GP	Berkshire West CCG
Jane Butterworth	Assistant Director Medicines Optimisation	Buckinghamshire CCG
Linda Collins	Clinical Effectiveness Manager (CCG)	Oxfordshire CCG
Marion Mason	Assistant IFR Manager	SCW
Dr Mark Sheehan	Special Advisor - Ethics	University of Oxford
Dr Megan John	GP, East Berkshire CCG Lead	East Berkshire CCG
Dr Raju Reddy	Secondary Care Consultant	Berkshire West CCG
Shairoz Claridge (Item 9 only)	Operations Director	Berkshire West CCG

In Attendance:

Tiina Korhonen	Clinical Effectiveness Lead	SCW
Kathryn Markey	Clinical Effectiveness Manager	SCW
Kate Forbes	Clinical Effectiveness Manager	SCW
Rachel Finch	Clinical Effectiveness Administrator	SCW

Topic Specialists in Attendance for Agenda Items:

Item 6 – Policy Update: Circumcision
Mr Peter Malone, Consultant Urological Surgeon at Royal Berkshire Hospital Miss Heidi Tempest, Consultant Urologist, Oxford (via telephone)
Item 9 – Policy Update: Functional Electrical Stimulation for upper and lower limb dysfunction
Professor Paul Taylor, Consultant Clinical Scientist, Salisbury District Hospital and Clinical Director, Odstock Medical Limited Sophie Pearce, Funding and Contracts Manager, Odstock Medical Limited Kelvin Grantwood, Managing Director, Odstock Medical Limited

Apologies:

Dr Janet Lippett	Medical Director	Royal Berkshire Hospital Foundation Trust
Dr Karen West	Clinical Director Integration	Buckinghamshire CCG
Meghana Pandit	Medical Director	Oxford University Hospital
Ravi Lukha	Public Health Specialist Registrar	Public Health Services for Berkshire

1.	**Welcome & Introductions**
1.1	The Chair opened the meeting and welcomed the members of the Committee.
2.	**Apologies for Absence**
2.1	Apologies recorded as above.
3.0	**Declarations of Interest**
3.1	• Jane Butterworth declared an interest in item 9, Functional Electrical Stimulation for upper and lower limb dysfunction. Confirmed as not material for the Committee decision making. • Professor Paul Taylor, Consultant Clinical Scientist, Salisbury District Hospital and Clinical Director, Odstock Medical Limited, refer to item 9.
4.	**Draft Minutes of the Priorities Committee meeting held 24th July 2019 - Confirm Accuracy**
4.1	The draft minutes were accepted as a true record of the meeting.
5.	**Draft Minutes of the Priorities Committee meetings – Matters Arising**
5.1	**Minutes of the Priorities Committee held in May 2019 – Action 2.1 – Matters Arising** Clinical Effectiveness team to update the Thames Valley Priorities Committee Terms of Reference (ToR) removing Public Health (PH) representation as a requirement for quoracy. The updated ToR to be issued to CCGs for Governing Body acceptance together with an explanatory note expressing the important and valued input of PH and that the Committee reluctantly agreed to remove them from the function. **November 2019 Update: An amended copy of the ToR has been distributed to the Committee for comment. At present a copy has not been issued to CCG Governing Bodies for acceptance pending enquiries with the new Oxford Director of Public Health to ascertain if interest in sending a representative to the Committee.**
5.2	**Minutes of the Priorities Committee held in May 2019 – Action 13.1 – Any Other Business – Annual training session** Committee members to indicate to the Clinical Effectiveness team if a training session is needed this year and if so identify the training required. **September 2019 Update:** No suggestions have been received yet, however, if the Committee members have any further thoughts please forward to the CE team. **November 2019 Update: Topic suggestions received are: lifestyle choices and elective care, and specialised commissioning. More topics are required for a training event to be cost effective. The Clinical Effectiveness team would welcome further agenda items from the Committee for a training session to be planned for spring or summer 2020. Action complete.**
5.3	**Minutes of the Priorities Committee held in May 2019 – Action 13.3 – Any Other Business – Host CCG for 2020 meetings** Clinical Effectiveness team to make enquiries with Wexham Park Hospital (Frimley Health Foundation Trust) and St. Marks Hospital, Maidenhead. **November 2019 Update:** Action is ongoing, alternative venues in East Berkshire are being explored; the fallback position is Jubilee House Oxford.
5.4	**Minutes of the Priorities Committee held in September 2019 – Action 6.1 - Policy Update TVPC22: Tonsillectomy for surgical management of recurrent tonsillitis and obstructive sleep apnoea in children and adults** The Clinical Effectiveness team drafted an update to TVPC22 Tonsillectomy for surgical management of recurrent tonsillitis and obstructive sleep apnoea in children and adults to align with the EBI and retain the CENTOR criteria and circulate for comment. Comments to be received within the 2 week feedback period following issue. **ACTION Complete**
5.5	**Minutes of the Priorities Committee held in September 2019 – Action 7.4 – Policy Review: Surrogacy and assisted conception for infertile couples** Clinical Effectiveness team to draft an update to the Assisted reproduction services for infertile couples policy statement and return to the Committee for review at 27th November meeting. **November 2019 Update Paper 19-024:** At the September meeting the Committee acknowledged single woman can have access to assisted reproduction services (AR) but did not

5.5 cont..	include that category in the policy guidance. The number of single women accessing AR services is relatively small; nationally about 3% over all but much of this may be privately funded. As there was no explicit agreement made to change the premise of the policy from 'couples' policy based on the old NICE guidance, the Committee revisited the issue. It was acknowledged that NICE guidance is dated; the new HFEA position, effective last year, is that single people can apply for a parental order, albeit they may not be the biological parent. The Committee agreed that single women should have access to fertility services, with the principle that single woman needs to establish their fertility status as noted already in the policy for same sex couples and couples unable to undertake vaginal intercourse. The policy was discussed in view of amending 'couples' to 'patients' throughout the policy. It was also agreed to add the clinical definition of infertility in the policy for clarity. The Committee confirmed that any other area of the policy remains unchanged, including the number of cycles funded and the age of female at the time of referral to specialist services, acknowledging the current financial position of the CCGs and that no new or additional funds to change the current service provision are available. **Action: Clinical Effectiveness team is going to draft a second draft of policy statement 11g Assisted reproduction services for infertile patients, circulate it to Committee members. Only to come back to TVPC if there are significant changes that require further discussion**.
5.6	**Minutes of the Priorities Committee held in September 2019 – Action 8.4 – Paper 19-020 Evidence Review and Policy Update: Anti-VEGFs for a range of rare eye conditions** The Clinical Effectiveness team to draft a policy recommendation: Rare eye conditions other than age-related macular degeneration (AMD) supporting the treatment of rare eye conditions with anti-VEGF and circulate for comment. Comments to be received within the 2 week feedback period following issue**. ACTION Complete**
5.7	**Minutes of the Priorities Committee held in September 2019 – Action 9.4 – Paper 19-021 Policy Update: Verteporfin and photodynamic therapy in chronic central serous chorioretinopathy (CSC) and idiopathic polypoidal choroidal vasculopathy (IPCV)** Clinical Effectiveness team to draft governing body paper to recommend withdrawal of policy TVPC42 Verteporfin and photodynamic therapy in chronic central serous chorioretinopathy (CSC) and idiopathic polypoidal choroidal vasculopathy (IPCV). **ACTION Complete**
5.8	**Minutes of the Priorities Committee held in September 2019 – Action 11.1 – Any Other Business - Management of Earwax** Clinical Effectiveness team to undertake further review for the management of earwax for the specific group of patients that may need community services and return a paper to the Thames Valley Priorities Committee for discussion at January 2020 meeting. **ACTION Closed as concluded outside of the meeting.**
6.	**Paper 19-025 - Policy Update: Circumcision**
6.1	This policy was originally adopted by all Thames Valley CCGs in 2017. It was based on Royal College of Surgeons (RCS) Commissioning Guide (2013) which is still current; the British Association of Dermatologists (BAD) 2010 guidelines for the management of lichen sclerosus (LS); NICE Clinical Knowledge Summary Balanitis; NICE Clinical Guidance 2007 Urinary tract infection in under 16s: diagnosis and management, and previous Berkshire commissioning policies. The Thames Valley wide policy currently funds male circumcision for the following indications: • Penile malignancy • Traumatic foreskin injury • Pathological phimosis • Recurrent paraphimosis • Recurrent balanitis / balanoposthitis

6.1 cont..	A review of the policy by the Committee has been requested due to issues with interpretation of policy having been identified locally.
6.7	The BAD updated its guidelines for the management of lichen sclerosus (LS) in 2018. Recommendations include offering all adult male patients with genital LS, clobetasol propionate 0.05% ointment once daily for 1–3 months with an emollient as a soap substitute and as a barrier preparation. For all male patients with LS who have failed to respond to topical steroids, a referral for circumcision should be offered. For children and young people BAD advises to offer a trial of an ultrapotent topical steroid applied once daily for 1–3 months combined with emollients and barrier preparations for phimosis caused by LS. Those who do not respond after 1–3 months should be referred to a paediatric urologist for circumcision.
6.8	Since development of the previous policy, a Cochrane review has concluded that further studies are required to determine if probiotics or other interventions such as circumcision have any role in preventing UTI in children with VUR. A further systematic review (2018) which was not of robust methodology demonstrated that for 89 patients with LS treated with topical corticosteroids, circumcision was avoided in 31/89 (35%) patients. A large assessment (2018) of UK population based surgical management for LS in boys under the age of 16 years demonstrated that more boys underwent a second procedure following preputioplasty than they did following circumcision.
6.9	The clinician in attendance raised the following points: • To limit circumcision is a reasonable to be carried out only in specific circumstances. • Children and adults should be considered as separate populations in the policy. • Babies are born frequently with an unretractile foreskin. In the vast majority of these children it resolves without treatment. The foreskin will pull back almost certainly by the age of 16 years. Paraphimosis in a child is not an indication for circumcision. Very rarely you get unusual presentation which may need surgery. • When children get LS it is usually quite severe as they have a pinhole phimosis, treatment with steroids is difficult, as getting the cream in to the correct place is not possible, therefore this indication does need listing for circumcision. • About 1% of adolescents still cannot pull back their foreskin. These boys have a real problem as they are now facing adulthood with a non-retractile foreskin and cannot maintain adequate hygiene and when they attempt intercourse at an average age of 16 years they find sex exceedingly painful. If they cannot pull the foreskin back by the time they are 15-16 years it is unlikely to resolve physiologically. If circumcision is refused in these patients they are likely to suffer painful intercourse, will be unable to maintain hygiene and in the long term recurrent infections can increase the incidence of penile cancer. Circumcision may not prevent penile cancer but it may reduce the likelihood as the surface area is being reduced. Penile cancer is a rare cancer but more likely in patients with LS or phimosis. • In adults, repeatedly applying steroid creams for LS is a waste of resources. LS also affect the urethra potentially resulting in strictures. For mild LS it is reasonable to apply steroid creams. • Rare indications for circumcision include pilonidal sinus, lymphedema of the penis, lymphedema of the penis associated with Crohn's disease. • Circumcision is very effective in patients with uncontrolled Zoon's balanitis. • Children with LS should be circumcised and it is not unreasonable to circumcise adults.
6.10	The Committee was advised by one of its members that patients undergoing hypospadias repair should not have circumcision done at all. When a hypospadias is repaired it will look like a circumcised penis because the skin (inside lip) is used for reconstruction therefore this should be removed from the policy.

6.11	Following discussion the Committee agreed a change to the current TVPC circumcision policy was required to provide clearer threshold criteria. Policy update recommendation to include the following: • Circumcision is not undertaken for social, cultural or religious reasons • Insert separate thresholds for children and adults within the policy • Circumcision will be funded for pre pubertal (under 15) children with LS and balanitis • Circumcision will be funded for patients with a diagnosis of lichen sclerosus (LS) also known as balanitis xerotica obliterans (BXO) Note: where LS is mentioned include reference to the British term BXO • Physiological reasons affecting quality of life or are causing pain • Consider removing 'for 1-3 months' from pathological phimosis section. However, please note the clinician confirmed he would use a steroid potentially in mild disease **ACTION: Clinical Effectiveness team to draft an update to policy recommendation: TVPC63 Circumcision, send to the attending clinician for comment before circulating to the Committee members for comment. Comments to be received within the 2 week feedback period following issue.**
7.	**Paper 19-026 – Policy Review: IgE blood testing to prevent asthma exacerbations**
7.1	The Thames Valley Priorities Committee requested an evidence review of the diagnostic accuracy and cost effectiveness of serum IgE and skin prick tests in the diagnosis of asthma. The Clinical Effectiveness team was asked to explore whether specific IgE blood testing and the providing advice on how to avoid triggers reduces hospital admissions.
7.2	No evidence was found to suggest that IgE testing can be used as a diagnostic tool. Skin pick testing is used to determine the cause of an allergy. Serum IgE testing is performed to identify patients who might benefit from treatment with monoclonal antibodies. The IgE test can be carried out whilst people remain on antihistamine medication. There may be a group of patients who are atopic and unable to identify exactly what their exacerbations are due to. Services for severe asthma are commissioned by NHS England.
7.3	It is not possible to identify activity and costs of IgE testing across Thames Valley CCGs as this is embedded in bloc contract for pathology services. The activity for skin prick testing in patients diagnosed with asthma appears to be small.
7.4	Following discussion the Committee agreed to retain the current position of no policy and rely on national guidelines and the judgement of local clinicians for appropriate use of IgE testing and skin prick testing tests in the management of asthma.
8.	**Paper 19-022 – Policy Update: Elfornithine and facial hirsutism**
8.1	A review of current Thames Valley policies for the use of elfornithine in facial hirsutism was requested by the Committee in order to ascertain whether there was any new evidence or guidance to change the current commissioning position Berkshire CCGs and Buckinghamshire CCG hold a policy whereby elfornithine is not normally funded for facial hirsutism. Oxfordshire CCG holds a policy that states the treatment of facial hirsutism is low priority. Both policies are referred to on the current aesthetic policy (TVPC16).
8.2	Limited evidence was found that addressed the management of facial hirsutism and to support the use of elfornithine. A Cochrane review found two small studies but drew no conclusions regarding the use of elfornithine in the management of facial hirsutism Dermatologists from Buckinghamshire Healthcare Trust provided feedback and were in agreement that treatments for facial hirsutism could be added to the TVPC16 aesthetic policy as not normally funded.

8.3	The Committee discussed and recommended that due to the lack of national guidance and high quality evidence, treatment of facial hirsutism is not normally funded. Clinical Effectiveness team to add a statement for the treatment of facial hirsutism to existing Policy TVPC16 Aesthetic treatments for adults and children. **ACTION: Clinical Effectiveness team to draft an update to policy recommendation TVPC16 Aesthetic treatments for adults and children to include a 'not normally funded' statement and circulate for comment. Comments to be received within the 2 week period following issue.**
9.	**Paper 19-021 – Policy Update: Functional Electrical Stimulation (FES) for upper and lower limb dysfunction of Central Neurological Origin**
9.1	Declaration of Interest: Professor Paul Taylor acknowledged a conflict of interest as Clinical Director of Odstock Medical which is majority owned by Salisbury NHS Foundation Trust. As a co-founder Professor Taylor holds a small number of shares in the Company, though to date has not received any income from the Company. Grant funding for research has been received from various bodies which goes to the Foundation Trust.
9.2	Current policy position: A not normally funded Policy TVPC62: FES for Upper and lower limb dysfunction of central neurological origin was agreed by the Committee in July 2017. The reasons for this policy update were: • 3 years since previous evidence update and Committee recommendations • Concern regarding applying the policy to a cohort of patients provided with FES prior to policy adoption, or via an Individual Funding Request (IFR) application, who still report benefit from its use.
9.3	Evidence review: New guidance published since July 2017 is limited to NICE guideline NG119 Cerebral palsy in adults (2019) which recommends considering a referral to FES services depending on local service provision and a person's needs. A number of systematic reviews (SR) and randomised control trials (RCT) have been published since adoption of the current policy: Lower limbs 4 SRs, (relating to multiple sclerosis [MS] and cerebral palsy)and 3 RCTs (relating to multiple sclerosis (MS) and stroke) Upper limbs – 2 SRs (relating to shoulder subluxation post stroke and functional upper limb activities). The majority of studies for lower limb measured both orthotic and therapeutic effects. The studies mostly reported on surface FES rather than implanted. The assessed quality of evidence was generally considered weak to moderate in the SRs, limited by heterogeneity of outcomes and limited methodology of included studies. Studies evaluating effectiveness in MS may be affected over time by the progressive nature of the condition as patients may be deteriorating.
9.4	Input from attending clinicians: A presentation of the FES service at Salisbury and evidence collated by their team was presented to the Committee, including video examples of patients walking both with and without FES in situ. Patient subjects in the videos showed correction of gait, appearing to lead to faster, more efficient walking. <u>Patient cohort:</u> The majority of Salisbury patients have MS and stroke but the Centre also treats patients with spinal and head injuries, Parkinson's, and paediatrics patients. Patients are also seen for improvement of neuropathic pain in shoulder subluxation.

9.4 cont..	Cost of provision: Following referral from healthcare professional, patients attend an assessment clinic, have 2 'set up' appointments to teach them how to use the device and follow up at 6, 18, 44 and 72 weeks, then annually for as long as they use the device. First year cost with all the appointments is £1,776 then £322 per year thereafter. Cost includes all consumables, equipment, and clinician time. Machines can be re-used. Once the device has been applied patients can wear it for the whole day. 55% of patients use it all day every day, 33% of patients use it 4-5 days per week and some less often. The machine lasts for approximately 5 years which is the average time a patient will use FES for. Duration of benefit: For drop foot: A minority of patient's progress to no longer requiring the device, however due to the patient cohort, which includes those with multiple morbidities and degenerative conditions, many patients are no longer able to use the device at 5 years. Drop foot usually doesn't become a significant problem until MS has progressed; there is a period within the disease pathway when FES is useful. The majority of patients start FES around the age of 55-60. For shoulder subluxation; some patients the effect is relatively long lasting and effects may be permanent but some patients require sessions 2-3 times a week. Of the patients assessed 12 -18% are still using it a year later. Activity: This varies according to local policies. Some CCGs have 'routinely funded' policies, some have restrictions. It was estimated within the meeting that Wiltshire has a population of circa 470,000 and currently 195 users of FES. The clinician stated that not all stroke patients would be suitable for FES and estimated 10% of the stroke population would benefit. Stopping criteria The attending clinician advised that if there is clear evidence that patients are not using the device, there is no significant improvement to walking, or there are safety concerns, then FES is discontinued. Outcomes: The attending clinician advised that MS patients do not show a training effect (due to the progressive nature of the condition) but a significant orthotic effect. Two studies were highlighted which showed that patients using FES had less falls, better ground clearance than an ankle foot orthotic (AFO), and increased confidence. 79% of patients treated at Salisbury report increased confidence with FES. Users have reported that they are less dependent on their partners or carers and have greater participation in and improvement in daily living. The clinician highlighted a number of cost effectiveness studies reviewing both FES and FES compared to AFO. 1 study which looked at FES in comparison to AFO demonstrated that FES was more cost effective than the AFO due to greater improvement in quality of life and the abandonment rate in AFO which was double that in FES.
9.5	Committee discussion The Committee agreed that although the evidence was limited, for some groups of patients the device appears clinically effective. The Committee agreed that further projected costs were required should FES be routinely funded for patients with drop foot or upper limb deficits as a result of central neurological deficits. Draft starting and stopping criteria would also be of benefit to inform future policy making.
9.6	Actions The Committee discussed and agreed more information was required before a decision could be made. The Clinical Effectiveness team was asked to undertake the following in conjunction with

9.6 cont..	clinical specialists: • Determine potential patient benefit including a scoring system to aid threshold rationale • Determine starting and stopping criteria • Cost predictions over 5 years • Obtain physiotherapy opinion from an alternative specialist rehabilitation centre (due to conflict of interest declaration from Salisbury) **ACTION: Berkshire West CCG to provide the Clinical Effectiveness team with a copy of their draft threshold criteria for patients who are historic FES users.** **ACTION: Clinical Effectiveness team to draft a policy recommendation: FES for lower limb dysfunction for review at the January 2020 Committee meeting.**
10.	**Paper 19-028: Horizon scanning**
10.1	For information the Committee was provided with a paper identifying key guidelines or new technologies which may impact on CCG clinical policy or present opportunity for policy development.
11.	**Any Other Business**
11.1	**Paper 19-029: TVPC12 Botulinum Toxin A**
11.2	NICE technology appraisal guidance TA605 published in October recommends the use of Botulinum Toxin A as a treatment option for chronic sialorrhoea caused by neurological conditions in adults. The Committee agreed TVPC12 Botulinum Toxin A policy should be updated to reflect NICE guidance. **ACTION: Clinical Effectiveness team to draft an update to TVPC12 Botulinum Toxin policy to include Sialorrhoea (severe drooling) and circulate for comment. Comments to be received within the 2 week feedback period following issue.**
11.2.	**Paper 19-030: Work Programme for 2020/21**
12.1	A copy of the Committee work programme for 2020/2021 year was distributed for information.
13.	**Next meeting**
	The next meeting will be **Wednesday 22nd January 2020, venue to be advised.**
14.	**Meeting Close**
	The Chair thanked everyone for their contributions to the discussions and closed the meeting.