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 Tuesday 21st October 2020

On-line via Microsoft Teams

Alan Penn	Lay Member Chair	Thames Valley Priorities Committee
Jane Butterworth	Assistant Director Medicines Optimisation	Buckinghamshire CCG
Linda Collins	Clinical Effectiveness Manager (CCG)	Oxfordshire CCG
Edward Haxton	Deputy Finance Director	Berkshire West CCG
Diane Hedges	Deputy Chief Executive TVPC Strategic Lead	Oxfordshire CCG
Dr Megan John	GP, East Berkshire CCG Lead	East Berkshire CCG
Gill Manning	Lay representative	East Berkshire
Professor Chris Newdick	Special Advisor – Law	University of Reading
Dr Jacky Payne	GP	Berkshire West CCG
David Pollock	Interface Lead Pharmacist	Berkshire West CCG
Dr Raju Reddy	Secondary Care Consultant	Berkshire West CCG
Dr Mark Sheehan	Special Advisor – Ethics	University of Oxford
Dr Karen West	Clinical Director Integration	Buckinghamshire CCG

In Attendance:

Kathryn Markey	Clinical Effectiveness Manager	SCW
Rebecca Hodge	Clinical Effectiveness Manager	SCW
Tiina Korhonen (AOB only)	Clinical Effectiveness Lead	SCW
Funmi Fajemisin	Clinical Services Programme Lead Clinical Policy Implementation	SCW
Sarah Annetts	IFR Manager (Clinical)	SCW
Marion Mason	Assistant IFR Manager	SCW
Rachel Finch – Minute Taker	Clinical Effectiveness Administrator	SCW

Apologies:

Geoffrey Braham	Lay representative	Berkshire West
Mark Hancock	Medical Director	Oxfordshire Health NHS Foundation Trust
Dr Tina Kenny		Buckinghamshire Healthcare Trust
Dr Janet Lippett	Medical Director	Royal Berkshire Hospital
Lalitha Lyer	Medical Director	East Berkshire CCG

Topic Specialists in Attendance for Agenda Items:

Item 6 – Policy Update: Patients with osteoarthritis; primary hip and knee replacement
Mr Tom Pollard, Consultant Orthopaedic Surgeon, Royal Berkshire Hospital NHS Foundation Trust
Items 7, 8 & 9 – Policy Update: Ganglion cysts, Dupuytrens Contracture and Carpal Tunnel Syndrome
Mr Christopher Little, Consultant Hand Surgeon, Oxford University Hospitals NHS Foundation Trust Mr Tom Pollard, Consultant Orthopaedic Surgeon, Royal Berkshire Hospital NHS Foundation Trust Mr Zulfiquar Rahimtoola, Lead Hand and Wrist Surgeon, Royal Berkshire Hospitals NHS Foundation Trust Dawn Sharples, OSM – Trauma & Orthopaedics, Oxford University Hospitals 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	Apologies recorded as above.
3.0	**Declarations of Interest**
3.1	None declared.
4.	**Draft Minutes of the online Priorities Committee meeting held 23rd September 2020 – Confirm Accuracy**
4.1	The draft minutes were accepted as a true record of the meeting.
5.	**Draft Minutes of the online Priorities Committee meeting held 23rd September 2020 – Matters Arising**
5.1	**Minutes of the Priorities Committee held online in May 2020 – Action 5.5 – Review RMOC Statement sequential use of biologic medicines – Paper 20-001** The Committee to discuss this item further together with the financial impact and the development of a justification statement. **JULY 2020 UPDATE:** CE team experiencing difficulty in obtaining feedback from secondary care providers, most are working on it but are extremely busy at present. CE team to also approach secondary care pharmacists. **September 2020 Update:** Agenda item for November 2020 meeting **October 2020 Update:** Obtaining patient number data for all TVPC CCGs is proving difficult at present. A Berkshire West clinician has indicated offering a 4th biologic provides sufficient flexibility for RA patients. The CE team to provide an update at November 2020 meeting however this item is likely to be deferred until January 2021.
5.2	**Minutes of the Priorities Committee held online in June 2020 – Action 9.4 – Paper 20-015 – Policy Update: Functional Electrical Stimulation (FES) for foot drop** Clinical Effectiveness team to draft a policy recommendation for Functional Electrical Stimulation for foot drop defining starting / stopping criteria and identifying measurable outcomes, in collaboration with the OCE Specialist Physiotherapists. Clinical Effectiveness team to establish likely referral pathways across the TVPC locality. **October 2020 Update:** In progress, anticipate being back to November 2020 meeting.
5.3	**Minutes of the Priorities Committee held online in June 2020 – Action 10.6 – Paper 20-016 – Policy Update: Cannabis- based medicinal products** The Clinical Effectiveness team to contact Provider Trusts for more accurate numbers of patients who currently and will fulfil NICE criteria for treatment with THC:CBD spray (Sativex®). Recalculate the financial impact for Thames Valley CCGs. Liaise with CN to contact NICE. Bring back to the Committee for further discussion. **October 2020 Update:** In progress, revised data being obtained and anticipate being able to provide an update to November 2020 meeting.
5.4	**Minutes of the Priorities Committee held online in July 2020 – Action 11.2 – Paper 20-017 – Policy Update: Short-burst oxygen therapy (SBOT) for the relief of breathlessness** Clinical Effectiveness team to prepare documentation for the withdrawal of the Short Burst Oxygen (SBOT) policy and send to relevant CCG Governing Bodies for acceptance. **ACTION Closed**
5.5	**Minutes of the Priorities Committee held online in July 2020 – Action 12.1 – Paper 20-021: Clinical Feedback: TVPC 59 Policy Update: Management of Female Pelvic Organ Prolapse** Clinical Effectiveness team to circulate draft update to policy TVPC59 The Management of Female Pelvic Organ Prolapse, and the underpinning policy update to specialist clinicians for comment and bring back to November Committee. **October 2020 Update:** In progress, anticipate being back to November 2020 meeting.

6.	**Paper 20-022 – Policy Update: TVPC8 Follow-up appointments after primary hip and knee joint replacement surgery; TVPC49 Patients with osteoarthritis (OA); primary hip and knee replacement**
6.1	The Clinical Effectiveness team has undertaken a review following publication, in June 2020, of NICE guideline [NG157] Joint replacement (primary): hip, knee and shoulder. The new NICE guidance relates in the main to three current Thames Valley policy statements: TVPC8 Follow-up appointments after primary hip and knee joint replacement surgery, policy statement TVPC49 Patients with osteoarthritis (OA); primary hip and knee replacement (both updated 2018) and TVPC55: Primary hip and knee replacement revision surgery. The review also sought to ascertain whether a commissioning policy is required for patients with rheumatoid arthritis seeking specialist opinion for a joint replacement.
6.2	Expert clinical opinion for the NICE guideline development group is that implementation of the guidance will result in the number of total knee replacements with patella resurfacing increasing, the number of partial knee replacements increasing and the number of total knee replacements without patella resurfacing reducing. Overall NICE advises that implementing the guideline recommendations will lead to decrease in the number of revision surgeries each year which will result in some cost savings for commissioners. TVPC policy recommendation TVPC55: Primary hip and knee replacement revision surgery, supports funding of referral and assessment for secondary patella resurfacing after a primary total knee replacement where the patella was not resurfaced and there is evidence of cartilage loss on the patella. The NICE guideline development committee states that the consensus belief was that secondary resurfacing works to reduce pain in 50% of people who receive the surgery. It is understood that the results of secondary resurfacing are inconsistent. NICE makes no recommendations for follow-up and monitoring. TVPC policy (TVPC8) makes provision for one routine follow up appointment which is expected to take place 6-8 weeks after surgery. Routine review after the 6-8 weeks post-discharge appointment is not offered. However if patients suffer symptoms directly related to their joint replacement, that present after their 6-8 week follow-up but within one year of the procedure, they should be offered an additional appointment. Further long term routine ongoing follow up will not normally be funded.
6.3	Local activity data, based on the codes within the current TVPC policies, indicate activity for secondary patella resurfacing appears to be low but some activity may not have been identified due to coding inconsistencies. Data for patients across the Thames Valley area presenting with rheumatoid arthritis (RA) and potentially requiring primary joint replacement suggest the number of patients is low. Feedback received from local specialists concurred with the low number of patients with RA requiring primary joint surgery.
6.4	**<u>Discussion:</u>** The Committee agreed the review of joint replacement for patients with RA could be removed from the work schedule. **Tom Pollard joined the meeting at 12.23hrs** The revision policy suggests that secondary patella resurfacing will be funded. NICE guidance suggests secondary patella resurfacing is inconsistent with only potentially 50% of patients seeing an improvement in their pain. The specialist in attendance advised that there is definitely a small group of patients who have pain if they do not have their patella resurfaced. The suggestion that primary resurfacing should happen more often will result in fewer patients requiring secondary patellar resurfacing.

6.4 Cont..	The specialist in attendance made the following points regarding follow up of joint replacement: currently a patient has a routine follow up at 6 weeks and one additional follow up appointment as necessary. If a patient is problematic early on, it is likely that more than one additional appointment will be required. The clinician in attendance advised that knee surgeons will fall into 3 groups: selective patellar resurfacing; patella is resurfaced for all patients and no patellar resurfacing. A preference should not be stated in the policy and as discussed previously should be left for clinical opinion.
6.5	Following discussion and consideration of the specialist clinical input the Committee recommend no change to the TVPC8 on follow ups, no change to TVPC 55 on revision surgery. In addition it was agreed that that policy TVPC49 should be updated to include a statement with regard to MRI as detailed in draft NHSE Evidenced Based Intervention (EBI) phase 2, 'Where clinical assessment is suggestive of OA, imaging is not usually necessary. If imaging is required than weight bearing radiographs are the first line of investigation. The use of MRI is 'not usually needed'. **ACTION: The Clinical Effectiveness team to draft an update to policy recommendation TVPC49 Patients with osteoarthritis (OA); primary hip and knee replacement to include reference to MRI as per EBI and circulate for comment. Comments to be received within 2 weeks following issue.**
7.	**Paper 20-023 – Policy Update: TVPC15 Ganglion cysts**
7.1	The Thames Valley CCGs reviewed the evidence for Ganglion cysts and made a policy recommendation, TVPC15 Ganglion cysts, in March 2015 (updated July 2018). Since then, NHS England (November 2018; updated Jan 2019) has published the evidence based intervention (EBI) programme recommendation for ganglion.
7.2	The Clinical Effectiveness team provided the Committee with a comparison of policy TVPC15 Ganglion Cysts and EBI recommendations for ganglion excision. Differences in criteria were highlighted. It was noted that EBI criteria is for ganglia of the hand/wrist only, whereas TVPC15 policy includes ganglia of the foot.
7.3	Local data for the rolling 12 months ending July 2020 was obtained from the NHS Business Authority Services (NHSBA) dashboard. The dashboard provides CCGs and STPs with baseline activity figures and estimated activity reduction goals for interventions targeted by the Phase 1 EBI Programme. Some of the TV CCG may have activity reduction opportunities. It was noted that figures may be lower due to the impact COVID-19 has had on surgical activity. Local activity provided by SCW analytics for the last three fiscal years was also presented.
7.4	<u>Discussion with the clinicians in attendance.</u> The Committee was of the view that the criteria for the removal of foot ganglia which are currently in the TVPC criteria, but not EBI, should be retained. The Committee was also of the view that the term 'concern (cancer)' included in the EBI was too vague and should not form part of the criteria for intervention. Furthermore, the clinicians in attendance indicated that patient concerns about potential malignancy would be better addressed through confirmatory imaging rather than secondary care referral or (in particular) surgical excision. Concerns were raised by the Committee and clinicians about offering aspiration of ganglia in primary care. It was noted that aspiration is not part of the General Medical Services (GMS) contractual arrangement in primary care and that a policy cannot be put in place stating GPs should provide a non-GMS service (however, aspiration is part of the direct enhanced services contract for Minor Surgery). The clinicians in attendance would recommend that palmar wrist ganglia are not aspirated in the community, particularly with a wide-bore needle. Due to the proximity of the radial artery and its unpredictable course in the presence of a potentially displacing ganglion, the potential for injury is not insignificant. For this reason they would recommend image-guidance for aspiration in secondary care.

7.4 Cont	The clinicians stated that mucous cysts are a different entity and are not ganglia, but are something that affects the nail bed. The EBI criteria refer to significant nail deformity, however once significant nail deformity is reached it is irreversible. A cyst pressurising the nail bed/nail matrix, cannot be resolved with a simple excision. The clinicians did not think significant nail deformity should be included as criteria for intervention. If the policy should include mucous cyst of the distal interphalangeal (DIP) joint, the criteria for intervention should refer to functional activity and pain rather than spontaneous discharge as not all mucous cysts discharge. Aspiration has no role in the management of mucous cysts. With regards to criteria for intervention, the clinicians stated for wrist ganglia, tingling and numbness are symptoms that are regularly cited. However in clinical practice a ganglion on the dorsal aspect (outside of the wrist) is unlikely to cause numbness and tingling. Ganglia on the bola side may cause such symptoms, however aspiration should not be carried out due to risk of puncturing the radial artery. The clinicians advised the Committee that pain and functional activity are the main reasons why patients seek treatment for ganglia. Functional activity and activities of daily living (ADL) are not listed in any of the EBI criteria. The current TVPC policy refers to functional impairment as a result of seed ganglia and ganglia of the foot including reduced ability to walk and the inability to wear 'typical' footwear. The clinicians stated that a visual analogue scale can be used to assess pain and its progression.
7.5	The Committee reviewed the evidence, considered the specialist clinician feedback and agreed to recommend that the current TVPC15 policy should be updated in line with the NHSE EBI recommendation with amendments as follows: • Treatment only if causing pain or functional impairment (ADL) rather than tingling and numbness; • If there is any uncertainty whether the ganglion may be malignant in nature, refer patient via the 2 week wait referral route. • Aspiration of the ganglia in primary care can be offered if clinically appropriate and where expertise exists • Include the current criteria for ganglia of the foot **ACTION: The Clinical Effectiveness team to draft an update to TVPC15 Ganglion Cysts policy recommendation criteria and circulate for comment. Comments to be received within the two week period following issue.**
8.	**Paper 20-024 – Policy Update: TVPC 18 Dupuytren's Contracture**
8.1	The Thames Valley CCGs reviewed the evidence and made a policy recommendation for Dupuytren's Contracture in May 2015, and updated the policy in September 2017. Dupuytren's Contracture is included in phase one of NHSE EBI.
8.2	Despite different wording, NHS E EBI and TVPC18 policies have very similar criteria, the main difference being that NHSE permits surgery where there is a contracture of 20° at the proximal interphalangeal joint, whereas the TVPC criteria states proximal interphalangeal joint contracture of less than 30°. The TVPC policy also states that radiation therapy for early Dupuytren's disease is not normally funded due to limited evidence, based on 2016 NICE interventional procedures guidance (IPG) evidence. Both NHS E EBI and TVPC policies make reference to collagenase clostridium histolyticum (CCH) which is no longer available in the UK.
8.3	Local activity data shows all TVPC CCGs are currently meeting the annual activity goal set by NHS England for Dupuytren's contracture release, however surgical activity has been affected by Covid-19.

8.4	Feedback received from specialists regarding radiation therapy, states that while this is not mainstream treatment, there are some patients (particularly with early post-surgical recurrence) in whom this treatment modality may potentially have a role.
8.5	Discussion: The clinicians in attendance supported the adoption of the EBI criteria. For revision procedures, currently clinicians apply the same policy criteria however, it is felt that patients should not need to have the same degree of contracture if they are presenting with a recurrence. The CE team stated that the current EBI policy does not indicate that it applies to revision cases. **Post meeting note**: Following review of the NHSE EBI statutory guidance by the CE team, it has been identified that whilst the document does not discuss revision cases, the clinical codes used to capture activity include revision of digital fasciectomy and revision of palmar fasciectomy. Therefore it is understood that the same policy criteria should be applied to primary and revision procedures for Dupuytren's contracture.
8.6	The Committee considered the evidence presented together with specialist clinical feedback and agreed to recommend that TVPC18 Dupuytren's Contracture should be updated with the NHSE EBI criteria. The reference to collagenase clostridium histolyticum (CCH) should be removed as it is no longer available in the UK. The TVPC18 position regarding radiation therapy as 'not normally funded' should be retained as current evidence on its efficacy is inadequate in quantity and quality. **ACTION: The Clinical Effectiveness team to draft an update to TVPC18 Dupuytren's Contracture policy recommendation and circulate for comment. Comments to be received within the two week period following issue.**
9.	**Paper 20-025: Policy Update: TVPC19 Carpal Tunnel Syndrome**
9.1	The Thames Valley CCGs reviewed the evidence and made recommendations for TVPC19 Carpal Tunnel Syndrome (CTS) in July 2018. CTS release is included in the NHSE EBI statutory guidance.
9.2	No new national guidance has been published since NHS E EBI. A literature search identified three studies of relevance published since EBI in 2019: A systematic review (SR) that considered the role of joint mobilisation for individuals with CTS; a cost effectiveness evaluation of a randomised controlled trial (RCT) that compares manual physical therapy versus surgery; and a SR of studies that report the sensitivity and specificity of nerve conduction studies (NCS). None of these studies provide high quality evidence that would contradict the recommendations within EBI.
9.3	Discussion: The clinicians in attendance emphasised the importance of timely referral before permanent neurological changes. The clinicians supported the adoption of the EBI criteria, in particular consideration of surgery after a minimum of 8 weeks if symptoms have not settled with splinting or corticosteroid injection. The clinicians stated that patients with characteristic histories and supportive physical findings do not need to routinely undergo neurophysiological (nerve conduction studies) assessment. It was noted, however, that there are various incidences where they would be needed, for example for patients with uncharacteristic histories or physical findings, clinical concern about alternative diagnoses, previous neural injury, co-morbidities that predispose to neural compromise (notably diabetes), those where there is a perceived high likelihood of recurrence (to provide a baseline) and revision cases. The clinicians supported the inclusion of physiotherapy in the policy as an interventional treatment prior to referral, however, noted that this should not be mandated given the lack of evidence of clinical effectiveness. The clinicians discussed steroid injections, and that the maximum of 3 included in the TVPC policy seemed excessive. The clinicians stated that recommendations should not be too prescriptive as there is a fundamental difference between a patient receiving 6 injections over a

9.4 Cont.	10 year period because they are very efficacious over a period of time and a patient in whom a consistently good response is only seen for 2-3 weeks. Mandating a certain number of injections could lead to permanent neurological damage. The clinicians advised that different patients will have different responses to steroid injections and splinting, and therefore supported the EBI recommendation that leaves this option open. The clinicians suggested activity levels would not increase due a reduction in the required time for conservative management, but there is likely to be a reduction in the number patients who end up with permanent neurological deficit.
9.4	The Committee considered the specialist clinician feedback and agreed TVPC19 Carpal Tunnel Syndrome should be updated to reflect the NHS E EBI criteria, with physiotherapy included as an optional (but not mandated) intervention. The Committee recommended maintaining the current TVPC position on NCSs being not routinely necessary. **ACTION: The Clinical Effectiveness team to draft an update to TVPC19 Carpal Tunnel Syndrome policy recommendation and circulate for comment. Comments to be received within the two week period following issue.**
10.	**Any Other Business**
10.1	**TVPC11g Assisted reproduction policy; point 13.3**
10.1	It has been brought to Committee attention, point 13.3 of TVPC11g policy requires an amendment to rectify an oversight. Since 2016 commissioning of the provision of surgical sperm retrieval, where appropriate, lies with NHS England specialist commissioning. The Clinical Effectiveness team proposes a minor amendment to the wording of bullet point 13.3 point to "where it is clinically appropriate surgical sperm retrieval is supported and is funded by NHS England as per the criteria they outline." NHS specification incudes the criteria excluding azoospermia resulting from vasectomy. The Committee accepted the proposed minor policy amendment, noting governing body ratification is not required as the policy intention has not changed. **ACTION: The Clinical Effectiveness team to update policy TVPC11g Assisted reproduction; point 13.3 to reflect NHS England specialist commissioning for surgical sperm retrieval and issue for upload to CCG IFR websites.**
10.2	**Continuous glucose monitoring (CGM) in pregnancy**
10.2	Clinical Effectiveness team highlighted to the Committee that the NHS England long term plan states that by 2021, CGM will be offered to all pregnant women with type 1 diabetes, deliverable by March 2021. Correspondence states that a ceiling rate of £2k will be provided per patient receiving a CGM device for 12 months. Funding will be allocated to local maternity services. More understanding of the funding mechanism is required in order to update TVPC CGM policy. **ACTION: The Clinical Effectiveness team to add CGM as an item for review at January 2021 meeting.**
10.3	**Future Committee meeting dates**
10.3	Meeting are currently arranged for dates as follows: • 25th November 2020 - 2-4pm • 27th January 2021 - 2-4pm • 24th March 2021 – 2-4pm An additional meeting is proposed for 24th February 2021. **ACTION: Clinical Effectiveness team to arrange an additional Committee meeting for 24th February 2021, time to be confirmed.**
11.	**Next meeting**
	The next online meeting will be held on **Wednesday 25th November 2020 from 2-4pm**
12.	**Meeting Close**
	The Chair thanked everyone for their contributions to the discussions and closed the meeting.