THIS MEETING WAS NOT QUORATE

Aylesbury Vale Clinical Commissioning Group
Bracknell and Ascot Clinical Commissioning Group
Chiltern Clinical Commissioning Group
Newbury and District Clinical Commissioning Group
North and West Reading Clinical Commissioning Group
Oxfordshire Clinical Commissioning Group
South Reading Clinical Commissioning Group
Slough Clinical Commissioning Group
Windsor, Ascot and Maidenhead Clinical Commissioning Group
Wokingham Clinical Commissioning Group

Thames Valley Priorities Committee
Minutes of the meeting held Wednesday 25th March 2015
Board Room, Aylesbury Vale CCG, Aylesbury Vale District Council offices, The Gateway, Gatehouse Road, Aylesbury, Buckinghamshire, HP19 8FF

In Attendance:

Ruth Atkins	Senior Communications & Engagement Account Manager	CSCSU
Dr Paul Harris (part)	GP	Newbury CCG
Tiina Korhonen	Clinical Effectiveness Manager	CSCSU
Prof Chris Newdick	Special Advisor – Health Law	University of Reading
Alan Penn	Lay Member Chair	Thames Valley Priorities Committee
Rita Ranmal	Clinical Effectiveness Team Lead	CSCSU
Sarah Robson	IFR Manager	CSCSU
Jeremy Servian	IFR Manager	Oxfordshire CCG
Dr Mark Sheehan	Special Advisor – Ethics	University of Oxford
Laura Tully	Clinical Effectiveness Manager	CSCSU
Jane Butterworth	Head of Medicines Management	Aylesbury Vale & Chiltern CCG
Dr Graham Jackson	Clinical Chair	Aylesbury Vale CCG
Tracey Marriott	Director of Innovation Adoption	Oxford Academic Health Science Network
Richard Corbett	Chief Executive	HealthWatch Buckinghamshire
Dr Lise Llewellyn	Director of Public Health for Berkshire	Public Health Berkshire

Observer:

Andrea Buron Pust	Public Health Ethics	

Topic Specialists in Attendance for Agenda Items:

Mr Brendan Smith	Consultant Oncoplastic Surgeon	Royal Berkshire Hospital

Apologies:

Dr Tony Berendt	Medical Director	Oxford University Hospitals NHS Trust
Christina Gradowski	Head of Corporate Affairs	Berkshire East CCG
Tim Langran	Acting Head of Medicines Optimisation Team	Berkshire East CCG Federation
Dr Clive Meux	Medical Director	Oxford Health NHS Foundation Trust
Dr Jairaj Rangasami	Deputy Medical Director	Heatherwood & Wexham Park Hospital
Matthew Tait	Accountable Officer	Berkshire East CCG Federation

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Bhulesh Vadher	Clinical Director of Pharmacy and Medicines Management	Oxford University Hospitals NHS Trust
Dr Lindsey Barker	Acting Medical Director	Royal Berkshire NHS Foundation Trust
Dr Kathy Cann	Associate Medical Director	Buckinghamshire Healthcare NHS Foundation Trust
Dr Miles Carter	West Oxfordshire Locality Clinical Director	Oxfordshire CCG
Julie Dandridge	Assistant Director – Medicines Management	Oxfordshire CCG
Frances Fairman	Assistant Director – Clinical Strategy	NHS England Area Team
Philip Murray	Chief Finance Officer	Chiltern CCG
Justin Wilson	Medical Director	Berkshire Healthcare Foundation Trust

1.	**Welcome & Introductions**
1.1	The Chair welcomed members of the Committee and attendees to the meeting.
1.2	Richard Corbett, Chief Executive of Healthwatch Buckinghamshire was introduced. Richard advised that he was representing Healthwatch across Thames Valley.
1.3	The Chair advised that Jo Baskerville had left the CSCSU. The Committee wished to record their thanks for her contribution and support of the work of the Committee.
2.	**Apologies for Absence**
2.1	Recorded as above.
2.2	Quoracy: The meeting was not quorate. The Chair confirmed that any policy recommendations made by those present would be emailed to absent members for the approval *post hoc*. The members of the Committee endorsed this. **Action: Clinical Effectiveness to circulate minutes detailing any policy recommendations made by the Committee to absent members for approval.**
3.	**Declarations of Interest**
3.1	None were declared.
4.	**Draft Minutes of the Priorities Committee meeting held 28th January 2015**
4.1	The minutes were approved.
5.	**Matters arising from the Minutes of the Priorities Committee meeting held 28th January 2015**
5.1	Action 2.2 Quoracy - It was confirmed that recommendations made by those present had been emailed to absent members for approval *post hoc*. It was noted that the process of seeking approval *post hoc* had delayed the drafting of policies and related actions. **Action Complete**
5.2	Action 4.1. Item 10.2.4 of the minutes were amended to include full details of Option 1. **Action Complete**
5.3	Action 5.1 Progress engagement of Healthwatch representatives: It was noted that Healthwatch were represented at today's meeting. Healthwatch planned to send a representative from one of the Healthwatch organisations within Thames Valley to future meetings. **Action Complete**

5.4	Action 5.3 Financial Implications of NICE recommendations for Assisted Conception: This had been drafted and would be circulated shortly. **Action: In Progress**
5.5	Action 5.8: CE team to look at guidance on public consultation for CCGs and bring back to the Committee for comment: TK presented a short paper on public consultation which was discussed by the Committee. Highlighted key points: CCGs are subject to a duty to involve public when making significant changes to the provision of NHS healthcare. Public involvement ensures that decisions are well informed, and reduces prospects of litigation. Involvement should be proportionate to the issue considered and should begin in the formative phase of the proposals. Not all proposals require full 12 week consultation. Also there is not set mechanism for consultation, what matters is clear and timely information. Currently the potential need for consultation is considered as part of the evidence review process and the committee ToR requires the committee to make recommendations to the CCGs regarding the need for consultation. **Actions:** • **For all future Committee recommendations to the CCG governing bodies; Committee to advise whether the changes are significant and warrant public consultation and if so, in what form.** • **Minutes of the Committee meeting to be made available via the IFR website (in addition to other relevant information such as work plan).** • **RA to raise awareness of the Committee work via relevant newsletters.** • **Clinical Effectiveness team to engage the lay member of the Governing Body during evidence review consultation.**
5.6	Action 6.2 Clinical Effectiveness team to consult the relevant CCGs regarding the withdrawal of the 'Hearing Aid Technology' policy: Berkshire West CCGs have agreed to the removal of the policy. Awaiting response form Berkshire West CCG representative. **Action Complete**
5.7	Action 7.3 Clinical Effectiveness Team to update the Preservation of Fertility Policy Statement as detailed above and distribute to CCGs for consultation and ratification: LT advised that this was work in progress. The action had been delayed as the meeting was non-quorate which resulted in delays in obtaining approval of Committee recommendations from absent delegates post hoc. **Action: In progress.**
5.8	Action 9.4 Set up working group to review Aesthetic treatments and procedures in the current policy. **Action Complete**
6.	**Aesthetic Surgery policy update**
6.1	TK presented the recommendations of the working group set up specifically to review this policy. The Committee considered the working group recommendations and agreed the proposals. In four areas, breast reduction surgery, breast reduction surgery for gynaecomastia, removal of symptomatic skin lesions and lipomata, and labial surgery the Committee agreed to maintain the general principles of aesthetic surgery policy as low priority, but agreed a guidance notes on criteria for considering applications for funding, to support consistent triage process across Thames Valley CCGs and offer applicants guidance what clinical circumstances may amount to exceptional clinical circumstances. Labial surgery: to add note regarding the current Female genital Mutilation Act 2003.

	Smoking: it was agreed that patients who smoke need to be offered smoking cessation support services prior to surgery, similarly to other polices. **Action: Clinical Effectiveness to update the policy statement on aesthetic treatments as per Committee recommendations.**
	PH left the meeting. Mr Brendan Smith (invited specialist) joined the meeting.
7.	**Ganglion policy update**
7.1	TK presented a review of the evidence. The aim of the review was to update the current policy include ganglion on wrists; consider the evidence on ganglion cysts to the feet; and consider potential criteria for ganglion removal due to the high number of Individual Funding Request applications received.
7.2	It was noted that the current evidence base is limited and there is little specific evidence related to ganglions cysts in the feet and ankles. The review findings highlighted that reassurance should be the first therapeutic intervention for most patients with ganglion cyst (and all children) because of the high rate of spontaneous resolution and because it avoids the potential complications of invasive therapy.
7.3	The Committee agreed to recommend Option 2 for guidance on the clinical circumstances which may amount to exceptional clinical circumstances for surgical removal of ganglion on hands and feet and takes account of the Berkshire West CCG criteria proposal. **Action: Clinical Effectiveness to update policy as per Option 3**
8.	**Biological Mesh**
8.1	The Chair welcomed Mr Brendan Smith, Consultant Oncoplastic Surgeon, Royal Berkshire Hospital who had kindly joined the meeting to provide specialist knowledge for the discussion on biological mesh for breast re-construction and answer questions raised by the Committee.
8.2	LT presented a review of the evidence on the use of biological mesh implants for complex and contaminated abdominal wall repair and breast re-construction post mastectomy for breast cancer. It was noted that this is a complex area and interpretation of the evidence is difficult due to the variety of meshes used and the variation in surgical approaches. An advantage of using biologic meshes in both indications is the potential for a one stage surgical approach.
8.3	In relation to *breast re-constructive surgeries*, different products are in wide use, yet only limited clinical data is available. There is currently a lack of high-quality evidence to support the use of acellular dermal matrix (ADM) in prosthetic breast re-construction.
8.4	Breast reconstructions are divided into implant-based reconstructions and reconstructions performed with the patient's own tissue (autologous). Tissue based reconstructions avoid the complications of an implant. Mr Smith explained that the size and shape of the breast and the patients' body habitus governs the choice of reconstructive technique which is appropriate for a patient. In practice tissue based reconstructions are only suitable for a small number of patients as the volume of tissue available often does not match the volume of the other breast. Mr Smith explained the potential role of the use of acellular dermal matrix (ADM) in implant based breast reconstruction for selected patients. He explained the matrix provides a layer of soft tissue support over the implant and presents a useful alternative for patients who are unsuitable for autologous reconstruction. In cases where the patient's body does not support the autologous approach (eg insufficient donor tissue) the use of biological mesh allows for a one stage procedure. Mr Smith described the multi staged approach where a procedure is carried out to insert an expander and the tissue is expanded over a number of months to accommodate the implant, this involves several additional outpatient appointments. A further procedure is then required to insert the implant. Mr Smith advised the group that using biological mesh extends the number of patients

	suitable for implant only reconstruction, rather than the latissimus dorsi (LD) flap with implant technique. The Committee queried the use of synthetic mesh in breast reconstruction as a less expensive option. Mr Smith acknowledged that this may be an option for the future but a lack of evidence and knowledge around the use of synthetic meshes for this indication meant use is not presently widespread. The Committee then explored the cost effectiveness of this method. Biologic meshes vary in price according to size, with the largest being the most costly. The price ranges from several hundred up to £15k per matrix. Mr Smith confirmed that the smaller meshes are used in breast reconstruction and so when the reduced cost associated with a one stage procedure is taken into account, the approach was agreed to be cost effective. The Committee discussed the evidence of potential harm when using ADM for patients undergoing radiotherapy. Mr Smith agreed that he used planned radiotherapy as a contra-indication for ADM use. Mr Smith updated the Committee on the ongoing national multi centre audit of all implant reconstructions (iBRA audit) and suggested that all cases should be inputted into the audit. It was agreed that the audit would provide useful data around the use of ADM in breast reconstruction and this should be stipulated in the policy. The agreed policy should be reviewed once the audit results have been published. The committee chair reminded the committee of the decision making principles of the Committee in view of evidence of clinical effectiveness. The Committee acknowledged that there is currently a lack of high-quality evidence to support the use of acellular dermal matrix (ADM) in prosthetic breast re-construction and that cost-effectiveness studies have not been carried out. Nevertheless, the Committee felt the clinical case for selected patients was compelling and would be cost-effective given the single stage approach. The Committee agreed to recommend the of biological meshes in breast reconstruction where: • an autologous dermal flap in single-stage immediate breast reconstruction is not appropriate • the patient is not anticipated to require radiotherapy • all cases must be entered in the iBRA national breast reconstruction audit
8.5	Following the discussion on breast re-construction the Committee agreed to recommend biological meshes in breast re-construction where an autologous dermal flap in single-stage immediate breast reconstruction is not appropriate. It was agreed however that the use of biologic mesh was not recommended for patients who were anticipated to require radiotherapy. It was also agreed that all cases would be required to be included in the iBRA National Audit. The policy for the use of biologic mesh will be reviewed once the National Audit findings are made available.
8.7	In relation to the use of biological meshes in *complex and contaminated abdominal wall repair*, LT explained that a business case had been received from the general surgeons of the former Wexham Park Hospital, putting a case forward for the use of Strattice® mesh for this indication. Strattice Mesh is a procine derived ADM. It was noted that abdominal wall repairs are considered complex and challenging, particularly when bacterial contamination is present and that the use of synthetic mesh is considered contra-indicated in contaminated settings. The outcomes for which biological mesh can potentially be advantageous include rates of surgical site infection (SSI), recurrence rates and the use of a one stage approach. The Committee noted however that evidence regarding recurrence rates and SSI was of poor quality and the various systematic reviews carried out concluded that further studies are required to evaluate these outcomes and justify the additional cost of the materials. It was also noted that the larger repairs warranted the use of the more costly meshes due to the larger size of matrix required. The group agreed that as it wasn't clear from the evidence whether recurrence occurred anyway, thus still requiring a second procedure despite the use of the biological mesh, and given the significant additional cost for the larger matrices the use of biological meshes may not be cost effective. The Committee therefore

	did not feel there was sufficient evidence of clinical or cost effectiveness to recommend the use of biologic meshes in this indication.
	Action: Clinical Effectiveness to draft policy circulate as per usual process.
	BS left the meeting after the decision was made on breast reconstruction.
9.	**Ketone Testing**
9.1	LT presented a review on the use of Ketone testing for adults with diabetes in primary care. Diabetic ketoacidosis is a serious and life threatening condition by major metabolic disturbance and coma in severe cases. ketone testing allows early confirmation of the condition and may prevent development of full DKA, potentially avoiding hospitalisation and reducing morbidity and mortality. It was noted that there is significant variation between areas in DKA admission rates. No guidelines explicitly consider the issue of how primary care should assess and manage adults presenting with diabetic ketoacidosis. There is however guidance from national bodies (e.g SIGN) that recommend the use of ketone testing and emphasise the importance of 'sick day rules'.
9.2	There are two different ways to test for ketones, urine testing and more recently blood testing. More specific readings are obtained from blood ketone testing and results are in real time compared to urine testing. The Committee noted that evidence suggests patient testing for blood ketones is more sensitive and translates into lower DKA admission rates and better outcomes.
9.3	The Committee considered the OCCG guidelines included in the paper. This outlines the high risk groups who should receive ketone testing strips to self-monitor when required. Blood testing is recommended where possible, otherwise patients are advised to use urine test strips.
9.4	The Committee agreed that ketone monitoring should be offered in high risk groups and to adopt the OCCG guidance. It was however agreed that clarification should be sought over the number of boxes recommended for each patient group as the time frame was not specified. **Action: Clinical Effectiveness to draft policy and circulate as per usual process.**
	GJ, LL left the meeting.
10.	**Review of Terms of Reference, Standard Operating procedure and Ethical Framework**
10.1	The Committee discussed the proposed changes to the terms of reference, standard operating procedures and ethical framework.
10.2	The Committee agreed the following changes to the *terms of reference:* • 1. Functions: remove bracketed note *Ethical Framework (currently under review)* • 2.1 Membership: Keep original statement on annual training • 2.2 Membership: change of provider name to Frimley Health NHS Foundation Trust • 2.4 Quoracy: Keep original list of members but also add, '*at least two clinicians (of which one is medical)'*. • 3. Meeting logistics: clarification - absent delegates refers to list 2.4 and '*absent delegates confirm approval of the committee's recommendations via the minutes of the meeting'.* • 6. Review: 'Work of the Thames Valley Priorities Committee will be reviewed annually (April 2014)… The SOP and ToR will be reviewed in October 2014'. Amended to; *'Work of the Thames Valley Priorities Committee, SOP and ToR will be reviewed in March of each year'*. The Committee also recommended adding a statement that CCGs should send a deputy if they are unable to attend themselves (under Meeting logistics). Delegates should notify the clinical effectiveness team if they or a deputy are unable to attend. The Committee discussed whether invited specialists should be present when it made its final

	recommendations. It was agreed that it was useful in case of further queries, however, they could be asked to leave to facilitate focused committee discussion.
10.3	The Committee agreed with the following changes to the *standard operating procedures*: • 8. Consultation: 'The Priorities Committee will make recommendations to the Thames Valley Clinical Commissioning Groups regarding the need for public engagement or full public consultation on each policy or care pathway proposal'. It was clarified that this will take place at each meeting and stated in the Governing Body papers. • Page 5. Review: 'Work of the Thames Valley Priorities Committee will be reviewed annually (April 2014)… The SOP and ToR will be reviewed in October 2014'. Amended to: '*Work of the Thames Valley Priorities Committee, SOP and ToR will be reviewed in March of each year*'. • Appendix 1. Box 3: 'Submitted topics are debated at an annual Working Group meeting and a 'score' assigned to each topic using a standard scoring sheet. The highest scoring topics are selected for the Priorities Committee's annual work programme' Amended to: *annual to bi-annual working group meeting* • Appendix 1, Box 5: To amend to reflect the fact that IFR communicate new policies to the public and providers via website and contract meetings for Bucks, Berkshires East and West. Note to be added to last box on flow chart. • Appendix 1.Box 10: CSU makes any minor amendments/significant amendments are sent to Committee members for review. Final policy recommendations (with standard cover sheet, engagement advice, Diversity Impact Assessment) are sent to each CCG Priorities Committee Lead for adoption by their Governing Body. Add: *'Including recommendation for public consultation or not'.* • Terminology used in final policy proposals was discussed: currently the polices and the CCGs use mixed terminology of low priority, recommended procedures, procedures of limited clinical value, threshold dependent procedures and procedures with criteria. Preferred terminology was agreed as Interventions Not Normally Funded and Interventions with Criteria. This was considered preferable for supporting clinical engagement and clarity for public. • Appendix 2: Topic Selection pro forma: to amend to better reflect scoring criteria.
10.4	The Committee agreed with the proposed changes to the *Ethical Framework* with the following amendments: • Page 2, Bullet point 3: 'Ensuring that the principles and legal requirements of the NHS Constitution and the Public Sector Equality Duty are adhered to'. Add *the legal requirement to involve public when making significant changes to the provision of NHS healthcare*. • Page 5, point 8: The addition of a definition of exceptionality was raised last year by Berkshire West CCG. It was agreed that there is no need to amend section to include definition of exceptionality, as this is detailed on the CSU IFR web site for Berkshire East CCGs, Berkshire West CCGs and Buckinghamshire CCGs and identical definition is on Oxfordshire CCG website.
10.5	**Action: Clinical Effectiveness to update Terms of Reference, Standard Operating procedure and Ethical Framework as per the Committee recommendations and re-circulate.**
10.6	The Committee discussed the Quoracy issues further and the importance of CCG representation at the meetings. Where decisions needed to be agreed post hoc by absent delegates, it was suggested that voting buttons are used to ensure a response. **Action: Alan Penn to write to Accountable Officers of each CCG highlighting importance of meeting attendance.**
11.	**Any Other Business**
11.1	**Facet joint policy:** Sarah Robson raised an issue in relation to the Facet joint policy. The current policy states the procedure is low priority. However the wording of the policy denotes that patients who have had the procedure with therapeutic effect can have further injections. Thus the policy appears to be contradicting itself. Due to lack of time for discussion, it was agreed that the

	proposed interim action before the start of the new financial year, to amend the policy would be e-mailed to the committee members for action. **Action: Clinical Effectiveness to e-mail proposal to Committee members as an urgent interim action.**
11.2	**The ethics of commissioning reproduction and contraception: A series of practice oriented workshops:** MS was seeking comment on this paper. Due to lack of time for discussion, it was agreed that this would be emailed to members for comment.
12.	**Dates of the Next Meetings**
12.1	The next meeting will be **Wednesday 20th May** and the venue will be: Board Room, Aylesbury Vale CCG, First Floor, The Gateway, Gatehouse Road, Aylesbury, Bucks, HP19 8FF. A map and reminder will be sent to the Committee.
13.	**Meeting Close**
	The Chair thanked everyone for their contributions to the discussions and closed the meeting.