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 23rd May 2018

Conference Room, 2nd Floor, Albert House, Queen Victoria Road, High Wycombe HP11 1AG

Alan Penn	Lay Member Chair	Thames Valley Priorities Committee
Linda Collins	Clinical Effectiveness Manager (CCG)	Oxfordshire CCG
Mike Fereday	Vice Chair HealthWatch	Berkshire West
Darrell Gale	Acting Strategic Director of Public Health	Berkshire
Edward Haxton	Deputy Finance Director	Berkshire West CCG
Dr Megan John	GP, Berkshire East CCG Lead	East Berkshire CCG
Chris Newdick	Professor of Health Law	University of Reading
Dr Raju Reddy	Secondary Care Consultant	Berkshire West CCGs
Amaka Scott	Commissioning Interfacing Pharmacist	Berkshire West CCGs
Dr Mark Sheehan	Special Advisor – Ethics	University of Oxford
Dr Karen West (For Dr Graham Jackson)	GP	Buckinghamshire CCG

Observers:

Monique Burger (with Dr Mark Sheehan)	Student	
Shirine Davies	Associate Director of Contracting Innovation	SCW

In Attendance:

Tiina Korhonen	Clinical Effectiveness Lead	SCW
Kathryn Markey	Clinical Effectiveness Manager	SCW
Kate Forbes	Clinical Effectiveness Manager	SCW
Katie Newens	Clinical Effectiveness Researcher	SCW
Rachel Finch	Clinical Effectiveness Administrator – Minute Taker	SCW

Topic Specialists in Attendance for Agenda Items:

Item 8 – Fertility Care Pathway for Primary Care		
Dr Lalitha Iyer (LI)	Medical Director & Women's Health Lead	NHS East Berkshire CCG
Miss Fatima Husain (FH)	Consultant in Obstetrics & Gynaecology	Frimley Health NHS Foundation Trust
Item 9 – Preservation of Fertility Policy TVPC17 revisit		
Miss Fatima Husain	Consultant in Obstetrics & Gynaecology	Frimley Health NHS Foundation Trust

Apologies:

Lindsey Barker (LB)	Medical Director	Royal Berkshire NHS Foundation Trust
Dr Tony Berendt	Medical Director	Oxford University Hospitals NHS Trust
Jane Butterworth (JB)	Associate Director of Long Term Conditions & Medicines Management	Buckinghamshire CCGs
Dr Miles Carter	West Oxford Locality Clinical Director	Oxfordshire CCG
Rebecca Hodge	Clinical Effectiveness Manager	SCW
Dr Graham Jackson	Clinical Chair	Aylesbury Vale CCG
Dr Tina Kenny	Medical Director	Buckinghamshire CCG
Louise Patten (LP)	Accountable Officer	Buckinghamshire CCG
Dr Jacky Payne	GP	Berkshire West CCG
Rosalind Pearce (RP)	Executive Director HealthWatch	Oxfordshire
Chandi Ratnatunga	Associate Medical Director	Clinical Networks & Partnerships
Laura Tully	Assistant Director of Clinical Quality	SCW
Boo Vadher	Clinical Director of Pharmacy & Medicines Management	Oxford University Hospital NHS Trust

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	None were declared.
4.	**Draft Minutes of the Priorities Committee meeting held 21st March 2018 - 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 2016, Action 10.1 – Fertility care pathway** - **September 2017 Update:** A working group has been formed; an initial meeting is being arranged. **November 2017 Update:** Two GPs, from Berkshire East and Berkshire West are looking at the primary care fertility pathway; they will consult with clinicians from all of the relevant localities to produce a final draft. A report will be presented to this Committee, provisionally in March 2018. **May 2018 Update:** Refer to agenda item 8.
5.2	**Minutes of the Priorities Committee held in September 2017 – Action 7.5 – Paper 17-013 Treatment Pathway for Adults with Attention Deficit Hyperactivity Disorder (ADHD)** The Committee noted that shared care pathway protocols vary across the Thames Valley CCGs and agreed it would be of benefit to have a common shared care protocol. Thames Valley Accountable Care System is currently undertaking work to generate an overall shared care protocol; details to be provided to the Committee when available. An update to be provided at the March 2018 meeting. **March 2018 Update:** LB to provide an update at the May 2018 meeting. **May 2018 Update:** Clinical Effectiveness team to correspond with LB via email
5.3	**Minutes of the Priorities Committee held in March 2018 – Action 3.2 – Non-quorate Committee Meeting of 24th January reference Paper 17-026 Draft Policy Review: Flash Glucose Monitoring System (FGS) and proposed Patient Agreement Forms** JB to contact each TVPC CCG representative to discuss and agree the audit criteria and time frame to monitor the use of FGS. **May 2018 Update:** JB to provide an update at the July 2018 meeting.
5.4	**Minutes of the Priorities Committee held in March 2018 – Action 7.1 – Evidence Review: Iron Chelation for Myelodysplastic Syndromes** Time constraints within the March meeting prevented the evidence review of Iron Chelation for Myelodysplastic Syndromes being presented to the Committee; this item was deferred to the 23rd May 2018 meeting. **May 2018 Update:** Due to other priority items on the May agenda Iron Chelation has been deferred to 25th July 2018 meeting.
5.5	**Minutes of the Priorities Committee held in March 2018 – Action 8.3 – Paper 17-036 Policy Update: Sequential use of Biologics in Rheumatoid Arthritis** Specialist clinicians to provide the Clinical Effectiveness team with a copy of their rituximab audit report data. **ACTION Complete**
5.6	**Minutes of the Priorities Committee held in March 2018 – Action 8.5 – Paper 17-036 Policy Update: Sequential use of Biologics in Rheumatoid Arthritis** The Clinical Effectiveness team to draft a policy recommendation update: Use of Biologics in Rheumatoid Arthritis and circulate for comment. **May 2018 Update:** Refer to Matters Arising: Use of Biological and Immunomodulatory Therapies in RA.
5.7	**Minutes of the Priorities Committee held in March 2018 – Action 10.1 – Paper 17-038 Policy Clarification: TVPC50 Subacromial Decompression of the Shoulder** The Clinical Effectiveness team to change TVPC50 policy title from 'Subacromial Decompression of the Shoulder' to 'Subacromial Decompression for Shoulder Impingement' and remove the last paragraph in the current policy. **ACTION Complete**

5.8	**Matters Arising: Paper 17-041 - Use of Biological and Immunomodulatory Therapies in RA**
5.8.1	During development of the draft policy specialist clinicians raised the following points: 1. Patients who develop injection site reactions (and are able to take methotrexate) – the current algorithm suggests switching these patients to rituximab, however, the specialist clinicians advise that for patients who have demonstrated a good response to treatment but has developed an injection site reaction, it would be better for these patients to remain on a drug with the same mode of action. a. The Committee agreed that if a patient experienced an injection site reaction to the **initial** biologic, they could trial another drug within the same part of the pathway and that this would not count as additional to the maximum number of 3 treatments. 2. On the methotrexate section of the algorithm for patients who have an inadequate response to rituximab their only remaining option is an IL6 inhibitor i.e. tocilizumab or sarilumab. The clinicians felt that JAK inhibitors should be included as an option at this point of the pathway to provide another mode of action. a. Agreement confirmed by the Committee. The Committee considered a request from Buckinghamshire Healthcare and Buckinghamshire CCGs for the policy algorithm to list the drugs in each box in order of cost (cheapest first). The Committee felt that as cost is frequently subject to change, drug cost would not be included within the policy document. **ACTION: The Clinical Effectiveness team to update the draft policy recommendation: Use of Biological and immunomodulatory therapies in Rheumatoid Arthritis and circulate for comment. Comments to be received within the 2 week feedback period following issue.**
6.	**Paper 18-001 – Evidence Review: Smoking Cessation before Elective Surgery**
6.1	Thames Valley Clinical Commissioning Groups (CCGs) requested a review of smoking cessation in relation to elective surgery. The request was to consider the evidence of effectiveness for smoking cessation prior to surgery, impact on the outcomes of surgery (intra and post-operative complications), to explore the effective duration of pre-operative smoking cessation and to consider the economic impact.
6.2	Key national guidance available: Recently published (2018) NICE Guidance (NG92) Stop Smoking Interventions and Services states that people should be encouraged to stop smoking and should be referred to local stop smoking support before planned surgery. NICE recommends that stop smoking support referral is an opt-out approach rather than being offered as an opt-in. The Joint briefing by Action on Smoking and Health (ASH) 2016, discusses the benefits of stopping smoking before surgery and the importance of using the teachable moment. They note that evidence regarding the optimum time to quit smoking prior to surgery varies. They, however, cite evidence that quitting two months prior to surgery provides the most benefit. For smokers who are unable to quit, the Royal College of Anaesthetists (RCoA) advises that smokers should give up smoking for at least several weeks before surgery and certainly not to smoke on the day of an operation. The joint briefing for the RCoA, the Royal College of Surgeons of Edinburgh (RCSEd) and the Faculty of Public Health, notes that the evidence to date has not identified any major concerns about the use of electronic cigarettes around surgery.

6.3	The systematic reviews (SR) on effectiveness of smoking cessation interventions all found that interventions offered before planned surgery were effective to a degree. However, Cochrane SR Thomsen et al (2014) found that intensive interventions initiated at least four weeks before surgery that included multiple contacts for behavioural support and the offer of pharmacotherapy were beneficial for changing smoking behaviour preoperatively and in the long term for up to 12 months. There were eight reviews exploring the impact of smoking cessation on complications. One of the eight reviews (Mayers et al 2011) found no statistical difference in the overall complications between smokers and patients who had stopped smoking for eight weeks. The other seven reviews found significant reduction in either overall complications or surgical site infection/wound healing complications in quitters compared to current smokers. The results of the Cochrane review by Thomsen et al (2014), however, found that only intensive intervention had a significant effect on overall complications and on wound complications. In terms of the optimal time to stop before surgery the evidence is less conclusive. The SR by Thomsen et al (2014) concluded that the optimal pre-operative intervention intensity remains unknown but interventions that begin 4-8 weeks before surgery, include weekly counselling and use of nicotine replacement are more likely to have an impact on complications and on long-term smoking cessation. NICE (PH48) and the joint briefing note that there are significant positive effects of stopping smoking in the 8 weeks running up to surgery. The Committee were provided with the NICE (2013) Economic analysis of smoking cessation in secondary care showing there is a societal saving of up to £4,800 per patient over a lifetime (£800 being health care cost savings and £4,000 representing productivity savings i.e. absence from work and taking smoking breaks whilst at work).
6.4	The Committee discussed the points that the stop smoking service provision falls within the Public Health funding. There are a number of local authorities covering the Thames Valley CCGs region with notable variation in availability and spend on stop smoking services. It is known that whilst the NHS stop smoking services are effective, many people achieve non-smoking status through their own efforts. It was also noted that smoking behaviour varies markedly by income, demonstrating social inequalities in smoking. Public Health teams do not believe any policies should impact on inequalities in health. Part of the aims of Public Health teams is to work with upstream interventions that assist in addressing the reasons for people smoking, for example socioeconomic factors, familial factors and societal factors. Pre-operative smoking cessation needs to be reviewed in the context of a holistic view of the patient, being part of the overall healthcare pathway for all surgical interventions, just as recovery, physiotherapy and interventions are considered after surgery.
6.5	NHS Oxfordshire CCG have had a policy since 2010 which states that that smokers identified as needing routine elective surgery must be advised to give up smoking and may be referred to smoking cessation advice prior to their operation. GPs and secondary care clinicians must record smoking status and the relevant advice given to the patient. Patients are also advised that if they continue to smoke they will not be denied surgery or have it delayed unless their surgeon/anaesthetist considers that the risk to the patient is too great.
6.6	The Committee agreed a policy should be developed using but strengthening the current Oxfordshire CCG policy and as per NICE NG92 opt out principle: • Patients must be advised to give up and should be referred to stop smoking service • Patients may be referred if appropriate and advice given documented if patient opts out of the referral.

	The Committee agreed that the adoption of this policy did not constitute a significant change as the surgical treatment will not be denied or delayed based on smoking status of the patient. **ACTION: The Clinical Effectiveness team to draft a policy recommendation: Smoking Cessation before Elective Surgery and circulate for comment. Comments to be received within the 2 week feedback period following issue.**
7.	**Paper 18-002 - Evidence Review: Mandated Weight loss before Surgery**
7.1	Thames Valley Clinical CCGs requested an evidence review for the benefits and risks of mandated weight loss prior to elective surgery. Currently the local CCGs have policies for certain lower limb joint procedures which include the need to offer advice and access to a weight loss programme before treatment. There is no overarching approach to weight loss before planned surgery. There is a lack of evidence available in relation to success rates for weight loss in patients prior to elective surgery. The level of success of weight loss programmes in general is difficult to establish from the literature and there is further difficulty in extrapolating this information for a cohort of patients who may be elderly with other comorbidities. Due to the breadth of the topic, which included all elective procedures, results from literature searches were restricted. Data for weight loss before and after elective surgery was very sparse. Several cohort studies simply tracked weight overtime and did not review whether or not patients were requested to lose weight and the method of weight loss. One cohort study tracking weight following joint replacement found that patients regained weight after the joint had been replaced. No cost modelling could be identified which compared mandated attempts at weight loss for surgery compared to surgery prior to weight loss attempts. NICE have undertaken cost modelling for weight loss programmes in general; the rate of weight regain was often the most important single factor in determining whether an intervention was cost effective. It is estimated by NICE not to be cost effective to intervene for any cohort whose return to a without-an-intervention weight trajectory is lower than 3 years. The Association of Anaesthetists of Great Britain and Ireland Society for Obesity and Bariatric Anaesthesia (2015) guidelines identify that patients with comorbidities and patients with centrally distributed weight are at greater perioperative risks This guidance highlights the increased intraoperative and post-operative risks relating to obesity. Orthopaedic guidelines highlight the risks in delaying surgery as a joint may be more likely to deteriorate before surgery is carried out, resulting in increased risk of surgical complications. NICE OA clinical guidance (2014) states that patient-specific factors (including obesity) should not be barriers to referral for joint surgery Nuffield Council of Bioethics Ethical consider it would not generally be appropriate for NHS treatment of health problems associated with obesity to be denied to patients simply on the basis of their obesity. Some groups of people have a greater likelihood of becoming obese and there are many socio- demographic causes of obesity.

7.2	The Committee expressed concern in terms of the lack of clinical evidence to support mandated weight reduction prior to elective surgery, and the difficulty for patients in losing weight when suffering from co-morbidities. The Committee acknowledged that for a person with a high BMI the anaesthetic risks are greater, surgery is much more difficult and potentially can lead to more complications and that patients should be counselled to this affect by clinicians. The Committee noted that weight / BMI should be included in policies where it is specifically relevant, but decided against having a broader policy for all surgeries. The Committee agreed that due to the lack of evidence available for this cohort of patients, a policy mandating weight loss prior to elective surgery would not be progressed.
8.	**Paper 18-003a & 18-003b – Fertility Care Pathway for Primary Care**
8.1	LI was tasked on behalf of the local CCGs to review and work at unifying the guidelines for primary care management of sub fertility across the Thames Valley. It was noted there is a lot of variation in primary care with regards to which investigations are requested and how they are requested before the patient is referred to secondary care. The aim of the draft pathway is to ensure adequate and appropriate investigations are undertaken in primary care, so that the secondary care consultation can be best utilised for further management and to potential assisted conception services on the NHS. The Committee was asked to review and agree the general principles.
8.2	The following points were raised: • As per the TV wide Policy for 'Assisted reproduction services for infertile couples' the duration of sub-fertility should be at least two years. • Further evidence is needed for the cut off age for referral for NHS funded investigations. Buckinghamshire CCGs have a draft pathway which proposes that women above the age of 42 would not be referred to the NHS but to the private sector only. The current policy for 'Assisted reproduction services for infertile couples' notes that 'women should be referred from primary care to secondary care in sufficient time for all necessary interventions to be undertaken so that couples found to be infertile can be referred to a specialist assisted reproduction service before the woman's 35th birthday'. • Pathway needs to clarify that whilst tests may have been carried out, it does not automatically mean IVF treatment is available. • Add to the pathway the options at the end of the pathway, other than IVF i.e. specialist advice and guidance. • Clarification of BMI; TV Policy for 'Assisted reproduction services for infertile couples' notes that women must have a BMI of between 19 and 29.9 inclusive at the time of referral for specialist assisted reproduction assessment and at the time of any specialist treatment. • Clarify that stop smoking advice includes nicotine replacement products including e-cigarettes. **ACTION: LI to provide further clarifications on the points raised at the Committee and update the draft proposal for the Fertility Care Pathway for Primary Care and present to the Committee for consideration at the 25th July 2018 TVPC meeting.**
9.	**Paper 18-004 & 13-016: Preservation of Fertility policy TVPC17 revisit**
9.1	Thames Valley CCGs currently have a joint policy in place for the preservation of fertility (TVPC17) recommended by the TVPC Committee in January 2015 and adopted by all TVPC CCGs. This policy relates to the preservation of gametes (oocytes and semen) and embryos, in post-pubertal patients, in advance of chemotherapy or radiotherapy treatment for cancer that carries a high risk of infertility.

	The Committee agreed that as there is no provision within the current policy for any other surgery or intervention that carries a high risk of infertility to have their gametes stored and agreed that a review of the policy is appropriate as a priority. **ACTION: Clinical Effectiveness team to provide an Evidence Review: Preservation of Fertility for consideration by the Committee at the 26th September 2018 meeting.**
10.	**Paper 18-005 - Horizon scanning**
10.1	This is a new item for inclusion on future TVPC meeting agendas. The paper identifies key guidelines and new technologies published by NICE in February, March and April 2018 which may impact on CCG clinical policy or present an opportunity for policy development. There are a number of NICE guidelines (mandatory and non-mandatory) identified, some of which are relevant to current TVPC policies and will be taken into consideration by the Clinical Effectiveness team when undertaking policy updates. The Committee agreed that use of the document for steer would be helpful, to note the guidance that may have an impact on the current local policies. It was noted that as the NICE TAGs are mandatory they can be included just for information, however, they may need to be highlighted if they relate to existing policies which may subsequently need updating such as the sequential use of biologics.
11.	**Any Other Business**
11.1	**Review for: Threshold for referral for investigation of hypersomnia's & circadian rhythm sleep-wake disorders**
	This topic has been on the TVPC work programme for some time pending publication of NICE guidance. NICE has now advised that their guidance is subject to further quality assurance internally, therefore there is no date for publication. The Committee agreed to defer this topic until NICE proposed timeline is known.
11.2	**Annual training event**
	The Committee agreed that the annual training event would be welcome and it was agreed that it would be held during the morning of 28th November 2018 in Jubilee House Oxford before the TVPC meeting. Suggested ideas: Ethics; Law; NICE field team presentation. Other item requests to be sent to the Clinical Effectiveness team for consideration. **ACTION 11.2: The Clinical Effectiveness team to arrange a TVPC training event in Jubilee House, Oxford on 28th November 2018 ahead of the TVPC meeting.** **ACTION 11.2.1: Discussion items for the 28th November training event to be sent to the Clinical Effectiveness team for consideration.**
12.	**Next meeting**
	The next meeting will be **Wednesday 25th July 2018, to be held in Conference Room A, Jubilee House, 5510 John Smith Drive, Oxford OX4 2LH**
13.	**Meeting Close**
	The Chair thanked everyone for their contributions to the discussions and closed the meeting.