QUORATE

Hampshire and Isle of Wight

Hampshire and Isle of Wight Integrated Care Board

HIOW PRIORITIES COMMITTEE MEETING
Minutes of the meeting held Thursday 15th September 2022, 9:00-12:00
On-line via Microsoft Teams

David Chilvers	GP, Clinical Lead for Urgent Care and Priorities	Hampshire and Isle of Wight Integrated Care Board (ICB)
David Carpenter	Ethics representative	NHS Health Research Authority
Dr Timothy Whelan	GP and Planned Care Clinical Lead	Hampshire and Isle of Wight Integrated Care Board (ICB)
Cheryl Harding-Trestrail	Associate Director of Commissioning for UEC and Community Services (Isle of Wight Local Delivery Team)	Hampshire and Isle of Wight Integrated Care Board (ICB)
Julia Bowey	IFR Lead, Clinical representative, Clinical Associate Planned Care and Covid Vaccine Programme Lead Southampton	Hampshire and Isle of Wight Integrated Care Board (ICB)
Anita Bhadwaj	Deputising for Neil Hardy – Associate Director – Medicines Management and Innovation	Hampshire and Isle of Wight Integrated Care Board (ICB)
Neil Hardy – Joined meeting at 10:25	Associate Director – Associate Director – Medicines Management and Innovation	Hampshire and Isle of Wight Integrated Care Board (ICB)

In Attendance:

Tiina Korhonen	Clinical Effectiveness Lead	SCW CSU
Joan Sharp	Clinical Effectiveness Manager	SCW CSU
Karen Blogg	Clinical Effectiveness Administrator	SCW CSU
Nicola Goodchild	Clinical Effectiveness Administrator	SCW CSU
Marion Mason	Interim Head of Prior Approval and Assurance – Clinical Policy Implementation Service	SCW CSU
Patrick Carroll	IFR Panel Chair	SCW CSU

Apologies:

Genevieve Ryan	Senior Commissioning Manager	Hampshire and Isle of Wight Integrated Care Board (ICB)
Russell Swart	GP, Farnborough PCN Clinical Director, NHCCG Clinical Lead, MSK and project support	Hampshire and Isle of Wight Integrated Care Board (ICB)
Lyn Darby	Transformation Programme-Planned Care	Hampshire and Isle of Wight Integrated Care Board (ICB)
Steve Parker	Medical Director	Isle of Wight NHS Trust
Linda Collie	Planned Care Clinical Lead	Hampshire and Isle of Wight Integrated Care Board (ICB)
Tracey Gwyther	Senior Commissioning Manager, Planned Care, Working in North and Mid Hampshire	Hampshire and Isle of Wight Integrated Care Board (ICB)
Kate Forbes	Clinical Effectiveness Manager	SCW CSU
Linda Samuels	Lay member	Hampshire and Isle of Wight Integrated Care Board (ICB)

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1	**Welcome & Introductions**
1.1	The Chair opened the meeting, welcomed the Committee members, and set out how the on-line meeting operates.
2	**Apologies for Absence and Quoracy**
2.1	Apologies for absence recorded as above. The meeting was quorate.
3	**Declarations of Interest**
3.1	The declaration of interest (DOI) form was circulated to all members prior to the meeting. Submitted declarations were sent to the Chair for review prior to the meeting. No material DOI were noted.
4	**Draft Minutes of the Priorities Committee meeting held 21st July 2022 – Confirm Accuracy**
4.1	The Committee agreed the minutes were a true record of the meeting.
5	**Draft Minutes of the Priorities Committee meeting held 21st July 2022 – Review Actions and Matters Arising**
5.1	**Draft Minutes of the Priorities Committee meeting held 21st July 2022 – Item 5.1 Review of HSIP Priorities Committee Terms of Reference (TOR)** See item 9
5.2	**Draft Minutes of the Priorities Committee meeting held 21st July 2022 – Item 5.2 NH to connect MM with the Comms Contact.** The suggestion was for the Comms Team to look over the minutes prior to publishing on the web. **Action: NH and MM follow this through.**
5.3	**Draft Minutes of the Priorities Committee meeting held 21st July 2022 – Item 10.3 Policy 7 and 28: Continuous glucose monitoring systems** See item 6.5
6	**Recommendation for ratification of updated / new policies:**
6.1	• **Policy 54: Chalazia** • **Policy 19: Sinus Surgery for Chronic rhinosinusitis** • **Policy 71: Keloid scars** • **Policy 53 Ectropion and entropion** The policies have been bought to priorities committee for recommendation for ratification following review. The committee agreed to recommend the updated/new policies for ratification. **Action: Policies agreed for progression to sign off**.
6.5	**Policy 7: Continuous glucose monitoring (CGM) for diabetes** An evidence review for the update of this policy has previously been considered by the committee. Following this a policy position was developed which has received feedback from local specialists. <u>Discussion</u> The committee discussed the most appropriate setting for initiating CGM devices. It was noted that patients living with type 2 diabetes (T2D) who fulfil the criteria in the proposed policy for CGM will require specialist support, advice, and guidance. This will allow patients to get the most out of the devices they use as many GPs will not have the expertise to be able to interpret the considerable volume of data recorded by CGM devices. As such they will not be able to teach patients to interpret the data. Following specialist feedback, the policy wording was changed to state initiation should be by 'specialists' rather than 'secondary care' to allow for those who are working within primary care, such as GPs with special interests, to undertake this work if they feel they have the specialist knowledge required. The concern that most patients with T2D are not currently seen by specialists was noted. It was also raised that this policy update could have a big impact on the treatment of T2D and put GPs under considerable pressure.

	The current process for Southampton, West Hampshire Community Service and Hampshire hospitals is initialisation by specialist services, patients given the starter pack, switch over to FP10 (routine primary care) prescribing with no issues reported. For Portsmouth the specialist services monitor for the first 3 to 6 months and then it transfers to GPs. The Isle of Wight follows the same process. As such GPs are used to prescribing intermittently scanned CGM and it was felt that there would not be an issue for GPs to prescribe others that are in the tariff. It was considered that this approach may be suitable for patients with T2D. This approach would ensure that the decision about whether a patient meets the criteria for CGM, and which device would be most suitable for their needs would be made with specialists. There was discussion about whether education for GPs could be recommended to the diabetes programme board to consider. It was agreed that if someone says CGM is not working, GPs need to be explicitly informed the patient should no longer have CGM in primary care to avoid repeat FP10s continuing indefinitely. This should be informed by a 6 monthly or annual specialist review. There was a request for a patient information table detailing the differences between CGM devices. An information leaflet for patients with intellectual impairments was also suggested. It was noted that a specialist raised a comment about the monitoring and initial contact to try to obtain consent from the patient to share information from CGM devices. Patients are asked to allow access to the data which is held and there is an agreement in place between the manufacturer and the patient, but it is not known what the General Data Protection Regulation requirements are. **Action:** • **Policy agreed for progression to sign off.** • **NH to draft a table listing different devices their merits, drawbacks and costings**
7	**Proposed Evidence-Based Interventions List 3 (EBI3) guidance: Comparison with current HIOW Policies**
7.1	The committee had requested a comparison between the proposed 'Academy of Royal Medical Colleges (AoRMC) (2022) EBI3 and current HIOW policies. The draft proposals (published in January 2022) went out for consultation and the final EBI3 guidance is due for publication in October 2022. Additionally, on 13th October at 1pm there is an Interim Commissioner Forum for commissioners to discuss EBI4. A contact email was shared for those wishing to attend [although the date and time clashes with the October Clinical Policy Group (CPOG)]. 17 interventions are contained in the EBI3 proposals as described in the SCW paper circulated for this meeting. For 8 of these 17 EBI3 proposals there is no current HIOW policy. 6 proposals include a different commissioning position and/or contain significant differences to the relevant HIOW policies and 3 suggest the same policy position as HIOW. **EBI3 proposals where there is no HIOW policy** • **Optical coherence tomography (OCT) use in diabetic retinopathy referral** Discussion: The HIOW diabetic eye screening service offers OCT as part of its service. This is already commissioned. **Action: This proposal is likely to be accepted if (when published) EBI3 recommend it.** • **Glaucoma referral criteria** Discussion: Many of the referrals come from Community Optometrists and there are referral pathways in place, although not a single pathway across the ICS. There is no current HIOW statement. HIOW would accept this EBI3 recommendation as it currently reads. **Action: If this proposal is accepted, CHT requested the CE team draft a statement on behalf of the HIOW Priorities Committee, to communicate the recommendation to the commissioning leads for the Elective Care Board and through the Eye Health Alliance**

so individual areas can start to look at their commissioning policy.

- **Thyroid nodule referral and investigation**
  Discussion: The proposed criteria appear to remind primary care of the referral pathway(s). It is closely aligned with the HIOW pathway. There is a capacity concern with diagnostic services and therefore a criteria based access policy may be needed.
  Action: DC to compare this proposed pathway with that on Ardens IT system and if there is any discrepancy DC will communicate with Primary Care Team and ask them to liaise with Planned Care.
  Action: When EBI3 is published consider whether a criteria based access policy is required for imaging.

- **Asymptomatic carotid artery stenosis screening**
  Discussion: This is not available in HIOW except on a private basis. There is therefore no need for action on this proposal.

- **Management of abdominal aortic aneurysms (AAAs)**
  Discussion: The proposals seem to be fairly consistent with current practice although there are some differences regarding the proposed referral criteria.
  Action: DC to discuss these proposals with two local vascular surgeons.

- **Angioplasty for PCI (percutaneous coronary intervention) in stable angina**
  Discussion: This proposes criteria for performing PCI in patients with stable angina. and the thresholds need to be checked with secondary care colleagues.
  Action: DC to liaise with Richard Jones, Cardiologist, and consider whether these proposals should be adopted if/when published.

- **Non-visible haematuria**
  Discussion: This is included in Ardens IT system with a straightforward pathway. When EBI3 is released, it will need to be checked against the current pathway. One of the proposed EBI3 criteria for an urgent 2 week wait referral includes a raised white cell count on a blood test. The clinicians present considered this to be unusual and it needs to be queried with urology specialist colleagues and if necessary, referred back to EBI.
  Action: DC to discuss this proposal with urology colleagues and if necessary, raise a concern about the white cell count criteria with EBI.

- **Needle biopsy of prostate**
  Discussion: EBI3 are proposing standardised criteria for referral and triage. This proposal is about secondary care procedures.
  Action: DC to discuss these proposals with urology colleagues.

Change of Commissioning position and/or significant difference

- **Breast prosthesis removal**
  The significant difference is that the Draft HIOW (2022) Policy 15 Cosmetic Breast Surgery (awaiting finalisation of EBI3) does not propose funding a replacement prosthesis unless as part of a breast cancer care pathway. The EBI3 proposal recommends funding a replacement if the initial procedure was funded by the NHS.
  Discussion: Replacement would have significant cost implications. It was decided to consider any possible amendments of the draft policy when EBI3 is published.
  Action: CE team to discuss Policy 15 at the HIOW Priorities Committee when EBI3 is published.

- **Shared decision making for cataract surgery**
  The aim of this proposal is to reduce unnecessary referrals and improve the conversion rate of referrals to surgery. For HIOW to be in complete agreement with this proposal, the new HIOW Policy 32 Cataract Removal (ratified by the Board, awaiting upload to the CPI website) would need some adjustment to the criteria relating to the shared decision-making process. The

EBI3 proposal requires introducing a formally documented process before consideration of referral for cataract surgery.
Discussion: Although the HIOW policy includes a requirement for shared decision making, it does not specify documenting the process. Most referrals come from Optometrists through Opera (the electronic eye referral system) and the shared decision making process is not uniform across all local delivery systems. As EBI3 has not yet been published and is subject to change, it was agreed that when EBI3 is published the policy should be reviewed and revised if required.
Action: Policy 32 to progress as previously decided and then be reviewed when EBI3 is published.

- **Referral for bariatric surgery**
  The aim of this criteria based access proposal is to reduce unwarranted variation of access although AoRMC expect this would result in an increased number of referrals. HIOW have a for information only Policy 13: Bariatric surgery procedures in severely obese adults who have failed to respond to lifestyle and tier 3 interventions.
  Discussion: The proposed criteria are based broadly on NICE guidance. The current HIOW policy is for information and RAG rated as green across all localities. It was decided to reconsider this proposal with respect to the current policy once EBI3 is published.
  Action: Policy 13 to be reviewed when EBI3 is published.

- **Abdominoplasty or apronectomy**
  The aim of this proposal is to reduce unwarranted variation of access through standardised criteria. AoRMC expect however for this to result in an increased number of referrals. There are three relevant intervention not normally funded (INNF) HIOW policies. These are Policy 56, Excision of skin following massive weight loss (2019); Policy 15, Aesthetic surgery in children (2011); and the new Policy 72 (awaiting Board ratification), Cosmetic interventions for adults and children.
  Action: It was agreed that the current position(s) and policies will be reviewed when EBI3 is published.

- **Liposuction**
  The aim of this proposal is to reduce unwarranted variation of access, but AoRMC expect this would result in an increased number of referrals. There are two relevant HIOW policies: Policy 72 (2022, Awaiting Board Ratification), Cosmetic interventions for adults and children; and Policy 4 (2022, Awaiting Board Ratification), Lymphoedema treatments. The significant difference is liposuction is an INNF position in HIOW whereas the EBI3 proposal is for a criteria based access policy.
  Action: Current position(s) and policies to be reviewed when EBI3 is published.

- **Diastasis recti repair**
  The aim of this proposal is to reduce unwarranted variation of access. AoRMC however expect this to result in an increased number of referrals. There is a relevant HIOW policy: Policy 72 (2022, Awaiting Board Ratification), Cosmetic interventions for adults and children. The significant difference appears to be that the new HIOW policy lists this procedure as INNF but the EBI3 proposal is for a criteria based access policy.
  Action: Current position and policy to be reviewed when EBI3 is published.

EBI3 policy position is the same as HIOW
There are three proposed EBI3 guidelines which have the same policy positions as the relevant HIOW policies and mainly similar criteria. The proposals are for Male gynaecomastia reduction surgery, Corrective surgery for congenital breast asymmetry, and Penile circumcision.
Discussion: The EBI proposals mention criteria for individual funding requests (IFR) on an INNF policy, but IFR are for exceptional or individual funding applications. There was concern that the understanding of INNF process is not fully understood by the EBI authors and terms were being interchanged. It was suggested for the Hampshire and Isle of Wight Priorities Committee to write to EBI giving feedback relating to the clarity and difference on INNF and criteria-based access.
Action: When the final EBI3 guidance is published it should be circulated and added to CPOG agenda.

	<u>Action</u>: DC to offer feedback to EBI from HIOW relating to the differences between INNF and criteria-based access positions.
8	**Policy Update: Policy 5 Functional electrical stimulation (FES) in the management of drop foot of central neurological origin**
8.1	This is a three-year update of a current policy. The update has been discussed at the September CPOG but it was felt that local expertise input would be valuable for the update, thus brought to the Priorities Committee. The lay chair of the IFR panel, in attendance for the topic, has been reviewing FES requests locally and has a background in occupational health. The following advice was shared: FES uses electrical current to stimulate muscles to obtain a more natural lift of the foot, stepping off and forwards. Most patients with foot drop will have a dragging toe and the equipment aim is to address the risk of trips and falls alongside the level of effort required to walk. The majority of the local IFR applications are agreed as the requests are focused on people with multiple sclerosis (MS), and there is a reasonable amount of evidence that supports the use of FES in patients with MS which can defer the use of a wheelchair. There is a small number of applications for children who have had dorsal rhizotomy and FES can be a solution where patients are struggling with fixed ankle foot orthosis (AFO). Post stroke patients may also benefit from FES as an orthosis may not be good enough to provide sufficient independence of walking. Fixed AFO are offered within the commissioned contract. Patients start with an 'off the shelf' device and progress through the commissioned pathway until they receive a custom-made AFO. Customised AFOs can be as costly as the patient receiving FES. FES for therapeutic interventions, as part of a rehabilitation programme has little positive evidence. New/updated guidance: No new evidence was found to significantly alter the current policy position. The majority of evidence continues to relate to the use of FES for footdrop and shows positive outcomes for some patients. The Committee are advised however, that contrary to the current policy reference, FES is not necessarily considered 'second line' to AFO within the NICE 2013 guidance. The proposed draft policy has taken account of National Hospital to Neurology and Neurosurgery detailed FES referral criteria and included in the policy criteria for assessment for FES, precautions and contraindications for its use. The proposed policy also removes the requirement to have failed AFO.
8.2	<u>Discussion</u> The policy is proposing a criteria-based policy and anything outside of the criteria are the cases for not normally funded and would need to demonstrate exceptionality. It was thought that the criteria included in the draft policy were easily identifiable by the policy implementation team. The cost effectiveness of FES was discussed. Custom made AFOs might be expected to last around 12 to 18 months at a cost of around £2500 for each AFO. FES is around £3000 for the first year, but after this equipment costs are minimal, however, the cost of attending appointments and training to use equipment also needs to be taken into consideration for both AFO and FES. Consideration should also be given to the cost of a potential earlier need for a wheelchair, specifically with patients with MS.
8.3	The Committee agreed to recommend the draft policy for adoption. It was also agreed that the policy would be criteria based with prior approval requirement. **Action: CE team to draft policy to reflect recommendations and progress as per standard processes.**
9	**HIOW ICB Priorities Committee Standard Operating Procedure (SOP) and Terms of Reference (ToR)**
9.1	In May 2022 the Committee reviewed its Terms of Reference (ToR). At that time, it was agreed that for governance purposes the ToR would be accompanied with a Standard Operating Procedure (SOP) outlining the Priorities Committee process. The Committee has not previously had a SOP. The draft SOP was reviewed. It aims to articulate the process of achieving the aims for the committee, how topics are identified and selected for the work programme, consultation process and the evidence review methodology. The draft SOP flow chart aims to summarise the Committee process.

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	One amendment was agreed to the flowchart, to add the point when the ICB issues a contract notice to providers. It was felt that the SOP is very useful for the continued operation of the Committee and for any new members joining the Committee. Terms of Reference: Following the formation of the ICB some small changes were necessary to the Committee ToR. Tracked amendments were reviewed by the Committee. Amendments were mostly organisational terminology changes with the exception of: Section 4.1 -*The priorities committee has no formal delegated authority on behalf of the individual CCG Governing Bodies*. This was amended to reflect the new process for policy agreement: *The Priorities Committee makes recommendations to the ICB Governing Body via the ICB Integrated Assurance Committee.* Section 6.2 – *Members have a responsibility to try and reach a consensus, recognising that the impact of a recommendation may differ between 'organisations'.* This was amended to *Local Delivery Systems (LDS)*. *However, the decision to adopt these recommendations remains with ICB governing body*. LDS representation was discussed, and the importance noted to ensure different perspectives, structures and demographic issues are considered. All changes within the Terms of Reference were agreed. It was agreed that both the SOP and ToR should be published on the public facing website to ensure transparency. The Committee agreed that once the amendments had been processed these documents can be passed for website upload. **Actions:** **CE team to add the contract notice point to the SOP.** **CE team to make the amendments to the ToR as discussed to reflect the HIOW organisational changes and sections 4.1 and 6.2.** **CE team to pass the SOP and ToR to the policy implementation team be published on the policy website.**
10	**AOB: Topics for November Priorities Committee**
10.1	It was noted that currently there are no topics on the November Priorities Committee agenda. Some policy updates are being worked through with the clinical operational group which may need the Priorities Committee input. By November EBI3 will have been published, impact assessments from the final EBI recommendations could be considered in November Committee. A possible review of the current varicose veins policy was raised. There has been an increasing number of individual funding request related to the policy. Recent cases are all for patients with recurrent thrombophlebitis requiring anticoagulation either long term or intermittent. It was questioned whether the policy criteria needed to be broadened or made clearer. It was agreed to schedule the policy review into the work programme. **Action: CE team to add Varicose veins policy criteria review and pathway to the work program for November**
11	**Next meeting**
	The next online meeting will be held via 'Teams' on Thursday 17th November 2022, 9 – 12 noon.
12	**Meeting Close**
	The Chair thanked everyone for their contributions to the discussions and closed the meeting.