NOT QUORATE

Hampshire and Isle of Wight

Hampshire and Isle of Wight Integrated Care Board

HIOW PRIORITIES COMMITTEE MEETING
Minutes of the meeting held Thursday 16th March 2023, 9:00-12:00
On-line via Microsoft Teams

Lorne McEwan	GP, Clinical Lead for Clinical Priorities, and Clinical Director – North and Mid-Hampshire Planned Care.	Hampshire and Isle of Wight Integrated Care Board (ICB)
David Carpenter	Ethics Advisor	NHS Health Research Authority
Julia Bowey	IFR Lead, Clinical Associate Planned Care and Covid Vaccine Programme Lead Southampton	Hampshire and Isle of Wight ICB
Neil Hardy	Associate Director – Medicines Optimisation	Hampshire and Isle of Wight ICB
Pippa Brown (PB) (from 9:30am)	Planned Care Transformation Programme Manager	Hampshire and Isle of Wight ICB

In Attendance:

Tiina Korhonen	Clinical Effectiveness Lead	SCW CSU
Joan Sharp	Clinical Effectiveness Manager	SCW CSU
Nicola Goodchild (NG)	Clinical Effectiveness Administrator	SCW CSU
Linda Samuels (left at 10am)	Lay member	Hampshire and Isle of Wight ICB

Apologies:

Genevieve Ryan	Senior Commissioning Manager	Hampshire and Isle of Wight ICB
Dr Timothy Whelan	GP and Planned Care Clinical Lead	Hampshire and Isle of Wight ICB
Russell Swart	GP, Farnborough PCN Clinical Director, NHCCG Clinical Lead, MSK and project support	Hampshire and Isle of Wight ICB
Lyn Darby	Planned Care Programme Director	Hampshire and Isle of Wight ICB
Steve Parker	Medical Director	Isle of Wight NHS Trust
Tracey Gwyther	Senior Commissioning Manager, Planned Care	Hampshire and Isle of Wight ICB
Anita Bjardwaj	Interface Pharmacist	Hampshire and Isle of Wight ICB
Cheryl Harding-Trestrail	Associate Director of Commissioning: Community Services and Long Term Conditions (Isle of Wight Local Delivery Team)	Hampshire and Isle of Wight ICB
Marion Mason	Interim Head of Prior Approval and Assurance – Clinical Policy Implementation Service	SCW CSU

1	**Welcome & Introductions**
1.1	The Chair opened the meeting, welcomed the Committee members, and set out the format of the meeting. All members introduced themselves as this was Lorne's first meeting as Chair.
2	**Apologies for Absence and Quoracy**
2.1	Apologies for absence recorded as above.

NOT QUORATE

	The meeting was not quorate as there were only two representatives from the four local delivery systems. The notes, actions and policies were reviewed after the meeting by another local delivery system achieving post hoc quoracy.
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, although during Agenda Item 7 the Chair declared a non-financial interest as a member of a federation which holds the contract for FibroScan for Mid Hampshire.
4	**Draft Minutes of the Priorities Committee meeting held 17th November 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 17th November 2022 – Review Actions and Matters Arising**
5.1	**Draft Minutes of the Priorities Committee meeting held 17th November 2022 – Item 5.2 NH arrange a link to the SCW/HIOW ICB Priorities Committee website** NH has arranged for a link on the ICB medicines optimisation website to access the Priorities Committee statements. **Action: Closed**
5.2	**Draft Minutes of the Priorities Committee meeting held 17th November 2022 – item 6.5 Policy 7: Continuous glucose monitoring (CGM) for diabetes** The policy statement has been approved and will soon be available on the website. The specialists have seen it and are awaiting its upload due in April 23. NH is communicating with the specialists. **Action: Closed** The Medicines Optimisation Team is in the process of producing a table of devices relating to Policy 7. **Update: Table of devices will be circulated once the new Policy 7 is effective. Action closed.**
5.3	**Draft Minutes of the Priorities Committee meeting held 17th November 2022 – Item 7 Proposed Evidence-Based Interventions List 3 (EBI3) guidance: Comparison with current HIOW Policies** Most of the actions agreed at this meeting were waiting for EBI3 to be published. This is now due in early 2023. Since the November 2022 meeting there have been a lot of changes in the EBI3 proposals, and a fresh start will be needed to compare this national guidance with current policies. **Action: Closed**
5.4	**Draft Minutes of the Priorities Committee meeting held 17th November 2022 – Item 9.1 HIOW ICB Priorities Committee Standard Operating Procedure (SOP) and Terms of Reference (ToR)** Due to organisational changes there were policies signed off by the Clinical Commissioning Group (CCG) Board in June 2022, awaiting completion of the contract notice and upload to the website. There were also other quite significant policies with commissioning position changes that were awaiting ICB agreement and contract notice. PB has subsequently organised ratification of the outstanding policies and is sending out the contract notices to providers. **Action: Closed**
6	**Recommendation for ratification of updated policies:**
6.1	• **Policy 42: Chronic fatigue syndrome / myalgic encephalomyelitis** There is no change in policy position. Residential treatment for chronic fatigue is not normally funded. It aligns with NICE guidance and the previous policy statement. The new template has been used and the pathway with patients clarified. The recommendations were agreed by CPOG and the draft policy circulated after the meeting. No comments were received. It therefore needs to be considered for formal recommendation by the Priorities Committee alongside the Equality Impact Assessment (EIA) before it is submitted to the Board for final ratification. The committee agreed to recommend this updated policy for ratification. **Action: CE Team to add this policy to the list for the Integrated Assurance Committee for progression to sign off.**

NOT QUORATE

7	**Update of Policy 38: Non-Alcoholic Fatty Liver Disease (NAFLD)**
7.1	The current policy No 38, developed in 2018, has been scheduled for a review as part of the regular policy update process. The current policy position is for information only. Up to 1 in 3 people in the UK has early stages of NAFLD. Its prevalence is rising and is becoming one of the most frequent causes of cirrhosis and liver transplantation in Europe. It has 4 potentially progressive stages: (1) simple fatty liver (steatosis), (2) non-alcohol related steatohepatitis (NASH), (3) fibrosis and (4) cirrhosis. The emerging epidemic of childhood obesity means that increasing numbers of younger people have NAFLD, with some prevalence studies showing that up to 38% of obese children have evidence of NAFLD. Early diagnosis and management are therefore important issues at all ages. If this policy is maintained, it would require reformatting using the current template, inclusion of the relevant diagnostic and procedure codes and at least some rewording to update the policy with recommendations from recent national guidance. The British Association for the Study of the Liver and British Society of Gastroenterology NAFLD Special Interest Group (2022) suggest a NAFLD primary to secondary care referral pathway whereby non-invasive tests (NITs) such as the NAFLD Score or FIB-4 Score are used in primary care to assess the patient's risk of advanced fibrosis. Those assessed as at intermediate risk are offered a second line fibrosis test e.g., FibroScan or the ELF test. Evidence published subsequently continues to support the use of combinations of the NAFLD Score or FIB-4, and FibroScan. NICE Guidance 189 Obesity: identification, assessment and management [CG189], updated 2022, makes recommendations about frequency of retesting people with NAFLD according to age group and stage of disease progression. NICE also recommends that children and young people who have type 2 diabetes or metabolic syndrome should be offered a liver ultrasound for NAFLD, to be repeated every 3 years if normal. The Portsmouth/SE Hampshire local delivery system (LDS) have been using an agreed NAFLD primary to secondary care referral pathway and community FibroScan services have been commissioned in the Southampton and SW Hampshire, and the North and Mid-Hampshire LDS areas. For prevention, NICE recommends adults identified and assessed as overweight, obese and/or with a central adiposity ratio indicating health risks should be given information about the impact this has on developing conditions such as NAFLD. For management of NAFLD in primary care, NICE and the British Association for the Study of the Liver and British Society of Gastroenterology (2022) recommend giving lifestyle advice such as improving the quality of diet, achieving a weight loss of 5-10% of bodyweight and aerobic exercise. Recent evidence indicates that appropriate diet and exercise are likely to contribute reducing liver fat and make a positive difference to at least some liver function indicators and risk factors for NAFLD, although much is weak or inconclusive. A clinician who had a lead role in developing the Portsmouth/SE Hampshire LDS pathway submitted written feedback which included an expression of hope for further work over the Hampshire and Isle of Wight (HIOW) footprint to provide more standardised pathways and access to FibroScanning, a consensus on the primary care initial assessment, and advice and guidance regarding the future assessment of patients with NAFLD. <u>Discussion</u> Concern was expressed about current availability of FibroScans, and the lack of treatment options apart from lifestyle interventions. Diagnosis helps to better manage patients with irreversible damage. At the stage(s) before then, when the disease may be reversible in patients already overweight it can be challenging to motivate and/or support them to make the necessary changes. It was felt that lifestyle advice alone was inadequate, and that social prescribing (if available locally) could be a helpful intervention.

	The current policy was developed in 2018 as a local guideline and driving force to increase provision of FibroScan services beyond the Southampton area. It was not intended to contain thresholds as would be the case for a criteria based access policy. The Committee agreed that development of a single (Ardens system based) pathway and equitable provision would be better and should be taken forward by commissioners and clinical leads with responsibility for gastroenterology/planned care. It was therefore decided to withdraw Policy 38. **Action: Clinical Effectiveness (CE) Team to inform the Clinical Policy Implementation Team to action the withdrawal of Policy 38: NAFLD.** **Post meeting note: Policy 38 has been withdrawn from the website. Action: Closed**
8	**Update of Policy 17: Faecal Microbiota Transplants (FMT)**
8.1	The HIOW policy recommendation 17: Faecal Microbiota Transplants is due to be reviewed in light of recently published NICE Medical technologies guidance MTG71 (August 2022). Faecal microbiota transplantation aims to restore a healthy gut microbiome in people who have recurrent or refractory Clostridioides difficile infections (CDI). HIOW policy recommendation 17 was developed originally in 2017 with the support of the local service and was informed by the local FMT referral pathway at Portsmouth Hospitals NHS Trust. The current policy recommends that FMT is funded for recurrent or refractory CDI up to a maximum of two transplants. FMT for any other indication is not routinely funded. However, the FMT aliquot material is now manufactured nationally by Birmingham Microbiome Treatment Centre and the local care pathway has been superseded by the Birmingham clinical protocol. It was noted that a small number of FMT procedures have been carried out across HIOW CCGs/ICB. Numbers were highest in 2016/17 and have fallen since. The majority of the procedures have been carried out for enterocolitis due to CDI. There is interest and literature exploring the use of FMT for several other indications, however, most studies conclude that further high quality research is required. The current NICE guidelines for the management of inflammatory bowel diseases and irritable bowel syndrome do not include FMT as part of the management of these conditions. It was clarified that FMT would third line treatment after vancomycin and fidaxomicin as per the antimicrobial prescribing guidance NG199. Options to consider were: • Update the policy to reflect the new pathway for CDI and maintain the position that that FMT is not normally funded for other indications. • Withdraw the policy as there is a local pathway in place. This pathway includes a position for requests to use FMT for conditions other than CDI to be considered on a case-by-case basis. The Committee acknowledged that the Birmingham protocol was quite strict and as it is used by the local service it would be very reasonable to follow this referral guidance. Requests to use FMT outside of the indications in the protocol would be considered via the Individual Funding Request process, as before. Linking the medicines optimisation website and the clinical policy website with the Birmingham protocol would support the implementation of the protocol. **Action: Retire policy statement 17. CE team to liaise with the Clinical Policy Implementation and the Medicines Optimisation teams to add the Birmingham Microbiome Treatment Centre clinical protocol to the websites.**
9	**Update of Policy 10: The place of arthroscopy in knee pain without true locking in adults over 40 years old**
9.1	The evidence review for the proposed update of Policy 10 was presented at the November 2022 Clinical Policy Operational Group (CPOG). The update was carried out as part of the three yearly policy update programme. At the November CPOG it was agreed that the CE Team would request feedback from two named local specialist orthopaedic surgeons and invite them to attend discussion of the update at the January 2023 Priorities Committee. Neither surgeon responded to the request/invite and the January 2023 Priorities Committee was later cancelled.

	The latest Academy of Medical royal Colleges (AoRMC) Evidence-based Interventions (EBI) data appears to show the annual activity goal of zero for the procedure of arthroscopic lavage and debridement as a treatment for osteoarthritis (OA) or as part of a treatment of OA unless the person has knee OA with a clear history of mechanical locking has been exceeded in HIOW ICB. It is however likely there are coding errors within this data as EBI have included codes additional to arthroscopic lavage and debridement such as those relevant to repair, resection and excision of meniscus; removal of loose bodies; and ligament repair or reconstruction. The outstanding issue for consideration by the Priorities Committee is that there are currently two criteria based access policies that refer to arthroscopic surgery for meniscal tears, with some differences in referral criteria for specialist consideration. Both Policy 10, and Policy 55 (Arthroscopic Surgery for Meniscal Tears), include the possibility of partial meniscectomy but with different thresholds for requesting prior approval. A senior physiotherapist contacted the CE Team to flag that her team found this situation confusing. Currently Policy 10 (last revised in 2018) states that arthroscopic lavage and debridement with or without partial meniscectomy in non-traumatic and persistent knee pain with no clear history of recurrent mechanical locking resulting in appreciable loss of function is not normally funded, although patients over 40 years can request prior approval for this procedure if they have persistent knee pain and a clear history of recurrent mechanical locking resulting in appreciable loss of function. Policy 55 (reviewed in 2021) is based on current British Association for Surgery of the Knee (BASK) guidance and has no age threshold. It states all patients with persistent mechanical knee symptoms should be referred to secondary care (without the need for prior approval) and should have an MRI scan of the knee to investigate for a meniscal tear and/or other pathology. Options suggested in the evidence review previously circulated were to: • Remove the reference to meniscal tears from Policy 10 and the age threshold. • To instead include the EBI recommendations for ‘Knee arthroscopy for patients with OA’ and the NICE (2022) guideline ‘Osteoarthritis in over 16s: diagnosis and management’ recommendations for arthroscopic procedures • Cross reference Policy 10 with Policy 55. OR • To withdraw Policy 10 and add the EBI and NICE recommendations to Policy 55. A possible draft for Policy 10 was shared at the meeting aligned to the EBI and NICE recommendations. <u>Discussion</u> Given the choice, patients are observed to prefer knee arthroscopy rather than knee replacement thinking that it is less invasive, but most are disappointed with the outcome. Arthroscopy has a place for such as ligament and meniscal repair but not as a treatment for OA. Historically the threshold of age 40 was thought to be related to the probability of developing OA. Now, an age criterion for arthroscopic procedures is unlikely to be supported by current evidence. It was therefore agreed to remove the age criterion. Policy 10 could be renamed as ‘Knee Arthroscopic Lavage and Debridement’. Social prescribing related to losing weight as part of conservative management could be helpful for patients. Amalgamating current policies for knee arthroscopy and knee replacement could be helpful for clinicians. Amalgamation of these knee policies could be drafted without new reviews for initial consideration. **Action: The CE Team (a) to draft a general knee pain policy by amalgamating the policies for Arthroscopic Surgery for Meniscal Tears and Knee Arthroscopic Lavage and Debridement (with the age threshold and conflicting thresholds for partial meniscectomy removed) with those relating to knee replacement (b) within this overarching policy include a recommendation for social prescribing (as part of lifestyle advice) and outline conservative and pain management options and (c) identify any areas for potential review as necessary.**

NOT QUORATE

10	**Update on South East England Regional Priorities Committee programme**
10.1	The South East Regional Programme Board is meeting regularly and HIOW Committee Chair is now a member of the Board. The long term goal is to try and align all clinical policies across the region and to remove the unwarranted variation in access to care. The areas that will be in focus first will be the ones of the biggest difference and to use those as exemplars to test how to address those differences. The program board was envisaged to morph into a shadow Priorities Committee for the six ICBs in April. However, this timeline is now revised and the likely progress to a joint committee may be the autumn at the earliest. The governance, membership, and processes are yet to be agreed. David Clayton Smith, who's leading the programme is meeting with South East Region Senior Leadership Team 6th of April for an update and forward plan. In the meantime our clinical effectiveness team is continuing with the mapping and assessment project to review all of the regional clinical policies. In the context of the South East regional development we still have a duty to take account of our local priorities in the next three to six months as a minimum. It was suggested that we prioritise topics for the local review based on the following: • New or updated national guidance e.g. NICE guidelines that recommend a change in practice. • Issues raised by IFR / policy implementation team to suggest new patient cohorts / new interventions • Clinical concern • A significant financial impact / change in current spend noted or anticipated • Significant reputational risk • Historical statements not updated to current policy template No new topic requests have been raised by the ICB. We are also waiting for the NHSE Evidence Based Interventions List 3 recommendations to be published, which may impact on local policies. It was agreed that CE team will keep the local work programme updated as outlined above.
11	**Review Terms of Reference (Membership & quoracy)**
	In the current Priorities Committee ToR each Local Delivery System is expected to be represented. Question was raised whether the membership needs reviewing in view of ICB focus moving from locality to operating as one organisation. It was acknowledged that at the moment, as the ICB is restructuring and going through a reorganisation process this may not be the ideal time to review the Committee membership. It was agreed to maintain the membership and quoracy as is for now until we know more about the regional position and the ICB reorganisation.
12	**AOB**
12.1	**Policy 002: Assisted Conception Services and the Women's Health Strategy for England (July 2022)** The Committee was made aware that there has been several enquiries in relation to the ICB Assisted conception services policy, in particular since the publication of the Women's Health Strategy for England. Specific issues have been raised in relation to the provision of artificial insemination (AI) for patients who do not/cannot have intercourse. The ICB policy maintains the position that in order to establish fertility status patients need to self-fund AI. Women's Health Strategy for England makes proposals on assisted fertility, such as NHS funding of IUI (intra uterine insemination). However, whilst this 10-year strategy sets out the ambitions for improvements the actual delivery plan is yet to be developed. ICB Chief Nurses have had an invite by NHSE to a IVF roundtable meeting 29th March to discuss specifically the IUI provision to female couples and non-clinical criteria in IVF policies (such as childlessness). Clinical effectiveness team is also invited and will feedback from the meeting. The Committee acknowledged the complexity of reviewing this policy and ideally there would be national or regional direction on this. It was agreed that local review of the policy at this time is not realistic given the national and regional developments which may offer wider basis for the policy review.

NOT QUORATE

12.2	**Future meetings – HIOW/CPOG** The Clinical Policies Operational Group (CPOG) was originally established to address policy implementation issues or consider policy updates with anticipated no or minor change in service provision. The need to have both Priorities Committee and CPOG was raised. The Committee agreed, given the current reorganisation, to keep both groups for now, but potentially review and consider merging of the meetings and/or shorten the Committee meeting going forward. The next CPOG will take place 13 April 2023.
12.3	It was suggested that a separate action tracker to accompany the meeting minutes would be helpful going forward. **Action: NG will develop an action tracker.**
13	**Next meeting**
	The next Priorities Committee online meeting will be held via 'Teams' on Thursday 18th May 2023, 9 – 12 noon.
14	**Meeting Close**
	The Chair thanked everyone for their contributions to the discussions and closed the meeting.