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Hampshire and Isle of Wight

Hampshire and Isle of Wight Integrated Care Board

HIOW PRIORITIES COMMITTEE MEETING
Minutes of the meeting held Thursday 18th May 2023, 9:00-12:00
On-line via Microsoft Teams

Dr Lorne McEwan	GP, Clinical Lead for Clinical Priorities, and Clinical Director – North and Mid-Hampshire Planned Care. Clinical Director for Primary Care Workforce.	Hampshire and Isle of Wight Integrated Care Board (ICB)
David Carpenter	Ethics Advisor	NHS Health Research Authority
Dr Timothy Whelan (left at 9:30)	GP and Planned Care Clinical Lead – Isle of Wight	Hampshire and Isle of Wight ICB
Pippa Brown (PB)	Planned Care Transformation Programme Manager	Hampshire and Isle of Wight ICB

In Attendance:

Funmi Fajemisin	Associate Director Clinical Services: Clinical Effectiveness	SCW CSU
Kathryn Markey (KM)	Clinical Services Programme Lead – Clinical Policy Implementation| Integrated Health and Care Services	SCW CSU
Joan Sharp	Clinical Effectiveness Manager	SCW CSU
Karen Blogg	Clinical Effectiveness Administrator	SCW CSU
Nicola Goodchild (NG)	Clinical Effectiveness Administrator	SCW CSU
Linda Samuels	Lay member	Hampshire and Isle of Wight ICB

Apologies:

Neil Hardy	Associate Director – Medicines Optimisation	Hampshire and Isle of Wight ICB
Tiina Korhonen	Clinical Effectiveness Lead	SCW CSU
Emma Wills	Head of Planned Care Commissioning	Hampshire and Isle of Wight ICB
Mark Roland	Deputy Medical Director & Respiratory Consultant	Portsmouth Hospitals NHS Trust
John Knighton	Medical director	Portsmouth Hospitals NHS Trust
Julia Bowey	IFR Lead, Clinical Associate Planned Care and Covid Vaccine Programme Lead Southampton	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

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1	**Welcome & Introductions**
1.1	The Chair opened the meeting, welcomed the Committee members, and set out the format of the meeting.
2	**Apologies for Absence and Quoracy**
2.1	Apologies for absence recorded as above. The meeting was not quorate as there were only two representatives from the four local delivery systems, and one was only able to attend the first half hour of the meeting. This was further discussed in item 5.5.
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. The Chair stated that he had recently been appointed the Clinical Director for Primary Care Workforce.
4	**Draft Minutes of the Priorities Committee meeting held 16th March 2023 – 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 16th March 2023 – Review Actions and Matters Arising**
5.1	**Draft Minutes of the Priorities Committee meeting held 16th March 2023 – Item 6.1 Policy 42: Chronic fatigue syndrome / myalgic encephalomyelitis** CE Team has added this policy which was recommended for ratification to the list for the Integrated Assurance Committee for progression to sign off. **Action**: **Closed**
5.2	**Draft Minutes of the Priorities Committee meeting held 16th March 2022 – Item 8.1 Update of Policy 17: Faecal Microbiota Transplants (FMT).** Policy statement 17 is to be retired and replaced with a link to the Birmingham protocol. CE team has been liaising with the CPI and the Medicines Optimisation (MO) teams regarding adding the Birmingham Microbiome Treatment Centre clinical protocol to the websites. In progress. **Action: Closed.**
5.3	**Draft Minutes of the Priorities Committee meeting held 16th March 2023 – Item 9.1 Update of Policy 10: The place of arthroscopy in knee pain without true locking in adults over 40 years old. Action: Closed (see item 9, below).**
5.4	**Draft Minutes of the Priorities Committee meeting held 16th March 2023 – Matters arising from AOB Item12.1 Update: Policy 002 Assisted Conception Services and the Women's Health Strategy for England.** In March the Priorities Committee was made aware of enquiries relating to this policy as per the minutes of that meeting. The CE Team was represented at an NHSE IVF roundtable meeting which took place on the 29th of March. The meeting focused specifically on intrauterine insemination (IUI) provision for female couples and non-clinical criteria in IVF policies. The Roundtable meeting in brief summary: • Differing policies and service provisions nationally were discussed and acknowledged. Critical points were raised re single issue focus i.e., considering only same sex female couples in isolation (and not single women, lack of donor sperm, impact on services etc). • NHSE was upfront about there being no available funding, but several attendees raised the fact that ICBs are also struggling with resources. This leading potentially to reduction in other aspects of IVF provision if IUI was to become NHS funded. Some ICBs have had to use the money to address health inequalities in the baseline. • Point was made that the anticipated NICE guideline update (2024) is unlikely to address this as their scope is 'treatment of health-related fertility problems'. But having two national 'guidelines' that may not concur is not ideal either. Responses to local enquiries to date have been to the effect of: • HIOW ICB is alert to national developments and the potential need to review the local policy. However, ideally the local review will be advised by national direction, and the ICB is hoping to work together with the NHSE national team to take this forward and are awaiting further advice from them.

	• Additionally, the CE Team is awaiting potential outcome of a legal challenge relating to the provision of artificial insemination (AI) for patients who do not/cannot have intercourse on an ICB policy similar to HIOW one and will keep the Committee informed. • We also are seeking legal advice on another ICB policy update re the provision of IUI and could share the outline of this advice once received. <u>Discussion</u> Responses have been sent to patients via the NHS Patient Advice and Liaison service (PALS) and also to MPs. The Chair informed the Committee that National guidance is expected in July although it has been delayed previously. When the NHSE guidance is produced there will be need to produce active local guidance/policy hopefully as part of the SE England regional work.
5.5	**Draft Minutes of the Priorities Committee meeting held 16th March 2023 – Matters arising from Item11, Review Terms of Reference (Membership & quoracy): Quoracy for Priorities Committee meetings.** At the March meeting it was agreed to retain the current Terms of Reference (ToR). The current terms however state that for a meeting to be quorate there needs to be representation from three of the four Local Delivery Systems (LDSs). Recent meetings have struggled to achieve quoracy. There is currently no representation from South East Hampshire and despite two names being suggested, they are not available on a Thursdays. It was clarified that PB does not represent any particular LDS and is instead part of the corporate function of the ICB. There is currently a reorganisation of planned care staff across the ICB whereby there will be less focus on people working solely in their LDSs. Priorities should not be different across the LDSs. Although there may be different services and opportunities geographically, colleagues should be representing the whole Integrated Care System (ICS). The BOBF Terms of Reference were recently updated and shared as an example. The quoracy requirements were proposed as: Chair of Committee (or deputy), one Senior ICB commissioner or Senior ICB representative (or deputy), at least one lay member, and including at least one senior clinician. It was agreed that subject to consultation by circulation of the draft May HIOW Priorities Committee minutes the requirement of representation from three out of the four LDSs in HIOW will be removed. **Action: CE Team to amend the ToR as discussed and to facilitate a consultation process, circulate the draft updated ToR with the draft Committee minutes.**
6	**Recommendation for ratification of updated policies:**
6.1	Clarity was sought on the process for ratification of new or updated policies. PB agreed to submit individual policies to the Integrated Assurance Committee/Board once they are recommended for ratification. The existing process including issue of contract notices will be used. It was felt that the less policies issued at a time would be clearer for clinicians and patients. **Action: As a starter, CE Team to send to PB the updated Policy 42: Chronic fatigue syndrome / myalgic encephalomyelitis which is on the list for the Integrated Assurance Committee for progression to sign off.** **<u>Post meeting note</u>: Action completed - closed**
7	**Mental health pathways and historic policy statements:**
7.1	There are three current policies on the website which were written some time ago and of unknown date. These are: • Adult Mental Health Individual Funding Review (IFR) • Non-NHS residential placements • Assessment and admission to Bursledon House in Southampton for in-patient treatment For the Adult Mental Health IFR there is no policy statement and the position stated on the website is that of not normally funded which is misleading. In reality, the process is that an IFR for treatments outside the standard NHS pathways can be considered by the policy implementation team or the Mental Health Panel. There is a policy statement on the website for non-NHS residential placements. The position is that they are not normally funded. There is also a policy statement on the website for Assessment and admission to Bursledon House in Southampton for in-patient treatment.

	Bursledon House is a specialist hospital/school for children aged 0-16 years. Treatment is not normally funded, unless prior approval is gained for the assessment and then the admission. NICE (2011) guidance 'Common mental health problems: identification and pathways to care' recommendations include developing local pathways that promote access to services and clear policy and protocols for operating the pathways. There is also a large volume of published NICE guidance for the management of specific mental health disorders, population groups and topics. These were out of scope for this update review. Also, NHS England oversee the commissioning of some specialised mental health services. Within the last 5 years, for non-standard pathway mental health interventions the number of IFRs requested were: 719 for adults (aged 17+), 78 for children and young people aged 0 to16 years (excluding applications for Bursledon House) and 66 for assessment and/or admission to Bursledon House of children and young people aged 0 to16 years. Most of these applications were approved – 94% for the Adult IFRs, and 73% or 74% for the children. Groups at higher risk of suffering from mental health disorders are likely to include women; those identifying as LGBTQ+ or from minority ethnic groups; and people living in geographic districts experiencing higher levels of deprivation(s) particularly deprivations relating to income, employment, education and health. <u>Summary</u> • Current information on the HIOW policy website is unnecessary and misleading. • Information about non-standard pathways relating to mental health interventions for children (apart from assessment and admission to Bursledon House) are not mentioned. • The current policy statements for Bursledon House and Non-NHS residential placements are outdated, not formatted using the current template and refer to CCGs. <u>Discussion</u> It was asked what mental health treatments would not be included in normal standard pathways. There are no other policies which relate to mental health services and the current situation is historic and confusing. There are pathways within the ICB for people requiring mental health services. Applications for a patient needing specialist assessment in a part of the country outside the ICB is an example of a non-pathway intervention for which an IFR could be submitted. Applications for admission to therapeutic communities and/or use of private apps/services might also be the subject of an IFR. The data described above is likely to include a large number of cases which are not exceptional but are in reality enquiries about whether there is a pathway for a particular treatment or condition, hence the high percentage of approvals as such cases would be moved onto a standard pathway. IFR submissions for non-residential placements are usually for standard treatments but in a facility that the ICB doesn't commission. Clinicians should know that if something other than the commissioned service was needed it wouldn't automatically be funded and would thus need to request an IFR. Pathways are outside the remit of this Committee. With Bursledon House the facility is local and the criteria for admission and treatment are known to the mental health IFR panel. The issue is there is no comprehensive list of commissioned residential providers on the website and the list is subject to frequent changes. The current situation is confusing with only three procedures being referenced. It was therefore decided that these three policies/statements should be withdrawn. **Action: CE/CPI Teams to arrange withdrawal of 'Adult Mental Health IFR', 'Non-NHS residential placements' and 'Assessment and admission to Bursledon House in Southampton for in-patient treatment' statements from the website.**
8	**Update review of Policy 51: Bunions (Hallux Vulgus)**
8.1	The current policy recommendation was made in 2019 following a committee meeting held in the presence of secondary care consultants. At this time the Committee considered the operative management of Hallux Valgus (Bunions) and heard that management of patients with bunions and peripheral neuropathy or diabetes is outside

of the scope of the review and needs to continue to be managed carefully through a multi-disciplinary approach. The evidence for benefit from surgical intervention was lacking. The Committee therefore recommended that surgical removal of bunion should be low priority. However, patients with significant functional impairment that does not respond to conservative measures must be assessed through the MSK triage service to ascertain if they are likely to benefit from intervention.

In this instance "significant" is taken to mean:

- Symptoms of significant functional impairment that prevents them from properly fulfilling work, domestic or carer duties or educational responsibilities; AND
- Significant functional impairment is present more than half the time; AND
- This impairment happens frequently over the proceeding 30 days.

Since development of this policy, feedback received from MSK clinicians advises that:

- Once someone has a severe degree of hallux valgus and bunion, the condition is permanent and therefore the use of the threshold 'significant functional impairment is present more than half the time' is not helpful.
- Hallux valgus is a structural deformity that is not going to improve until the deformity is addressed surgically.
- In addition, the impairment cannot therefore 'happen frequently over the preceding 30 days'.

The objective at this meeting was to discuss updating the threshold for surgery criteria as appropriate, in order to potentially make the policy more meaningful for MSK service, primary care and patients.

National guidelines have not been updated since the policy was developed.

Suggestions to update the policy were presented as follows:

- Surgery for patients with asymptomatic bunions for cosmetic reasons alone is not normally funded.
- The surgical removal of a symptomatic bunion will only be funded when a patient has been assessed through the MSK triage service

AND

- All appropriate conservative measures have been tried for a minimum of 3 months and have failed

AND

- Symptoms of persistent pain or deformity / disability that prevent the patient from properly fulfilling work, domestic or carer duties or educational responsibilities.
- Patients must be educated and counselled on appropriate conservative management.

It was suggested to remove the reference to 30 days as it states on current policy. The patients should be counselled to understand the outcomes of surgery and made aware of the potential complications which include, pain, stiffness to the big toe, infection, swelling, non-union, recurrence and Deep Vein Thrombosis (DVT) / Pulmonary Embolism (PE). In addition, there is no guarantee that the foot will be perfectly straight or pain-free after surgery. Patients should be informed that they are unable to drive for a number of weeks after surgery and full recovery can take an average of four to six months.

It was suggested to include reference to people who regularly participate in sporting activities and/or physical activity (this could be grouped together as physical activity). With regards to the criteria stating that the patient should be assessed through an MSK triage service, it was suggested to include 'or similar professional referral'. It was noted that Isle of Wight patients do not currently have access to a formal MSK triage service.

Action: KM to amend policy as discussed and circulate a draft as per the usual process.

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9	**Knee pain – Amalgamation of Policies 3, 10, 24, 44, 50, 55 and 69**
9.1	The CE Team was asked at the March Priorities Committee meeting to (a) 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. As requested, a draft of the new policy was circulated, containing temporary comments of explanation and queries for discussion. This draft was discussed during the meeting. The policy positions (For Information Only, Criteria Based Access and Not Normally Funded) for the component amalgamated policies is stated at the beginning. There is a proposed introduction and outline of conservative treatments for osteoarthritis (OA) based on current NICE guidance which is referenced at the end of the policy. The overarching policy is divided into two sections, the first containing current knee policies primarily relating to OA and the second, those relating to non-osteoarthritic conditions. The suggested layout comprises of: 1. Osteoarthritis (OA) • Conservative treatment • Knee Pressure Offloading Devices for Osteoarthritis • Knee arthroscopic lavage and debridement for patients with osteoarthritis • The use of partial knee arthroplasty in patients with osteoarthritis of the knee • Primary joint replacement for knee osteoarthritis for patients with a body mass index of 35 and above • Revision of knee replacement. 2. Non-osteoarthritic conditions of the knee • Arthroscopic surgery for meniscal tears • Use of autologous blood injections and platelet rich plasma injections for musculoskeletal conditions. Lifestyle advice, social prescribing, and pain management is included in the section on conservative treatment. The new 'Knee arthroscopic lavage and debridement for patients with osteoarthritis' section (formerly known as 'Policy 10: The place of arthroscopy in knee pain without true locking in Adults over 40 years old' was drafted as requested by the March Priorities Committee. It was suggested that reference to 'hip' was removed from 'Policy 50: Primary joint replacement for hip and knee osteoarthritis for patients with a body mass index of 35 and above' and that the policy be reviewed. This is because new NICE guidance states that people should not be precluded from having hip or knee replacement if they are smokers or due to their Body Mass Index (BMI). Instead, and if necessary, people should be encouraged to stop smoking and lose weight before their surgery. There is some evidence to support the achievement of good outcomes / quality of life in people with differing BMIs. It was suggested to remove the wording regarding historical process from 'Policy 44: Revision of Knee Replacement' and to replace reference to "SHIP" with "HIOW". It was also suggested to review this policy as it was last reviewed in 2018. 'Policy 55: Arthroscopic surgery for meniscal tears' includes a statement that "Arthroscopic surgery for patients with a degenerative meniscal tear with no history of a locked knee is an intervention NOT NORMALLY FUNDED". This is contrary to British Association for Surgery of the Knee (BASK) guidance and other statements in Policy 55 which request following BASK guidance.

	Discussion Most of the suggestions were agreed. There was however concern that removing all the criteria for patients with a BMI of 35+ would be likely to greatly increase the demand for hip and knee replacements. The criteria regarding weight loss for prior approval is for referral to a commissioned tier 2 or tier 3 obesity management programme prior to offering surgery. The mention of smoking in the policy is a comment, it is not a criterion and is not mentioned for patients with a BMI ≤35. The paragraph about smoking could therefore be simplified to a recommendation to advise a patient to stop smoking. It was noted that tier 2 and 3 weight loss services are not easy to access on the Isle of Wight. Advice from an orthopaedic specialist would be necessary if the knee revision policy were to be reviewed. Alignment of all policies are likely to be needed as part of the future SE England work. No clinical concerns have been raised about Policies 44 or 50. **Action: Replace the current knee policies with this overarching knee pain policy including to remove the paragraph relating to information about smoking cessation, reference to hips (where appropriate), removal of the wording relating to the policy development in Policy 44 and the contradictory statement in Policy 55. If required, further review of the component parts can be undertaken as part of the SE Priorities Committee work.**
10	**Review of outstanding actions from Clinical Priorities Operational Group (CPOG) 13th April meeting**
10.1	**Draft Minutes of the CPOG meeting held 13th April 2023 – Accuracy** The committee agreed the minutes of the meeting held on Thursday 13 April 2023. were an accurate record of the meeting.
10.2	**Review of actions from CPOG 13th April meeting:** Actions outstanding were: • RAG rating for ratified policies: Policy 33 Management of earwax/Microsuction. The RAG rating for this policy is still pending and was awaiting an update to be discussed at the next CPOG meeting. **Action: PB to speak to LD to determine the RAG for this policy.** • RAG rating for ratified policies**.** Local commissioners will not need to be approached for sign off of the RAG ratings recommended at the February CPOG. This is because teams are being amalgamated and there will be one person in the ICB responsible for all clinical priorities work. **Action: Closed.** • Recommended policy statements for Board sign off. There is a process in place (see Item 6 above). **Action: Closed.** • Grommets for tympanic retraction pocket (clinical concern). The situation is being monitored and the evidence for the use of grommets in YP for conditions associated with eustachian tube dysfunction and glue ear causing tympanic membrane retraction pocket will be considered when the review of 'Policy 37: Grommet insertion - adults and children' is due or if the number of requests for these patients increase significantly. **Action: Closed**
11	**HIOW Priorities Committee and CPOG operational group meetings going forward; potential amalgamation of meetings**
11.1	A discussion was held regarding future CPOG and Priorities Committee meetings and the future work plan. The Clinical Effectiveness team will: • review EBI list 3 following its publication. • continue with monthly policy surveillance. New topics or policy updates within the next 3-6 months could be reviewed according to: • New or updated national guidance e.g., NICE guidelines that recommend a change in practice. • Issues raised by IFR /policy implementation team to suggest increasing / high demand. • Issues of clinical concern. • A significant financial impact on /change in, current spend.

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	• Issues presenting significant reputational risk. It was suggested that it is important to maintain engagement with Priorities Committee and CPOG members for issues arising and to ensure smooth transition to the SE Regional Priorities Committee in due course. An option could be to hold shorter two-part meetings to include CPOG discussions. **Action: The next Priorities Committee meeting in two months to encompass two sections for all members.** **Action: NG to circulate survey with a suggestion of dates/times for the next meeting.**
12	**Update on SE England Regional Priorities Committee programme**
12.1	The HIOW Priorities Committee Chair continues to attend the regional meetings. There is need to keep up to date on any new changes or decisions being made. SE England Regional Programme Board is trialling the alignment of a small number of topics.
13	**AOB**
13.1	Nothing reported.
14	**Next meeting**
	The next Priorities Committee online meeting will be held via 'MS Teams' on 20 July 2023, 2-5pm.
15	**Meeting Close**
	The Chair thanked everyone for their contributions to the discussions and closed the meeting.