Greater Manchester Effective Use of Resources Steering Group Minutes

Chair:	Dr Tariq Chauhan – Manchester CCG		
Enquiries:	Jane Carr, EUR Policy Manager – GM EUR Policy Development Team		
Date:	Wednesday, 15 July 2020	**Time:**	1.30-3.30pm
Venue:	Virtual via Microsoft Teams		

Present:		
Mike Robinson	Associate Director of Integrated Governance and Policy/IFR Panel Chair	Bolton CCG
Dr Hugh Sturgess	Clinical Director for Elective Care / GM EUR Steering Group Deputy Chair	Oldham CCG
Dr Tariq Chauhan	GM EUR Steering Group Chair / EUR Lead / GP / IFR Panel Chair	Manchester CCG
Dr Marion Roberts	GP / IFR Panel Member	Salford CCG
Dr Lydia Hardern	GP / IFR Panel Member	Stockport CCG
Dr Ann Harrison	GP / Associate Clinical Director / IFR Panel Member	Trafford CCG
Dr Hari Sukhavasi	GP/Clinical Director	Wigan CCG
Tim Weedall	Head of Specialist Care at Trafford CCG	GM Commissioning Representative
In attendance:		
Dr Sheila Will	Consultant in Public Health	GM EUR Policy Development Team
Jane Carr	EUR Policy Manager	GM EUR Policy Development Team
Andrea Clarke	Assistant EUR Policy Manager	GM EUR Policy Development Team
Lisa Williams	EUR Service Lead	GM Joint Commissioning Team

Item	Topic
1	**Introductions and apologies**
	Introductions were made by the group. Apologies were received from Dr Alison Lyon, Bolton CCG and Cathy O'Driscoll, GM Commissioning representative, both of whom sent deputies to the meeting, Mike Robinson and Tim Weedall respectively. Apologies were received from Dr Kate Hebden, T & G CCG, who provided comments on agenda items 5.1a 7.1 and 7.2. Apologies were also received from Dr Keith Pearson, HMR CCG who was unable to send a deputy to the meeting. The meeting was quorate. The current Terms of Reference (version 4.0) states that for the GM EUR Steering Group to be quorate, at least 6 CCG clinical representatives must be present. If the meeting is quorate then decisions taken at the meeting will be binding on those CCGs not present.

2	**Declarations of conflicts of interest (COI)**
	Prior to the meeting the Policy Team had been informed that Dr Khunger was no longer a representative for T&G CCG on the group and that Dr Harrison had had stepped down from her role as a board member at Trafford CCG, on completion of her 2 full terms. Dr Harrison had no other conflicts to declare at present. The master list of COI had therefore been updated accordingly. Dr Sturgess conflict of interest was noted for Items 5.1, 5.2, 5.3, and 7.2 due to his directorship position with Pennine MSK. Dr Roberts, conflict of interest was noted for item 7.1 due to her being employed by Salford Royal NHS Foundation Trust for 1 session per week as a GP with special interests in (GPwSI) Dermatology. No further declarations were made at the meeting by those members who had already submitted their conflict of interest forms. Members were reminded to notify the EUR Policy Team of any changes to their current declaration.
3	**Minutes from the previous meeting on 15th May 2020**
	The minutes were agreed as a fair and accurate reflection of the meeting.
4	**Matters arising**
4.1	As requested at the last meeting in May 2020, a letter had been sent to the Manchester Centre for Clinical Neurosciences at Salford Royal Foundation Trust in response to the points they raised with regards to the Low Back Pain and Facet Joint Injections policies as part of their recent review. There were no other matters arising which were not covered by the other items on the agenda.
5	**Policies for review**
5.1	**Low Back Pain** Dr Hugh Sturgess declared a conflict of interest with this policy due to his role as Executive Director and Partner of Pennine MSK Partnership. <u>Evidence Review</u> Dr Will reminded the members that the policy was originally solely based on NICE NG59. Amendments had been subsequently made to the policy that meant an evidence review appendix should now be added. References regarding trigger point injections would also need to be added to the evidence review, if Steering Group agreed to the inclusion of trigger point injections as an excluded therapy for low back pain. Steering Group members discussed the draft evidence review appendix that had been sent out with the papers for this meeting and agreed that this could be added to the policy without any further amendments. Agreement: Steering Group members agreed to add the evidence review appendix to the policy.

Inclusion of trigger point injections as an excluded therapy for low back pain

At the meeting held on the 15th May 2020, Steering Group members agreed to continue with the interim arrangements for trigger point injections, with requests for trigger point injections for back pain being managed in line with NG59. All other trigger point injection requests would be considered to be exclusions from the policy. The policy wording has since been amended to reflect this. Dr Will was also requested to do a full review of the effectiveness of trigger point injections (at all sites) and the Policy Team to try to establish the activity data for these specific injections and bring this back to the next Steering Group meeting for further consideration.

Following the meeting, Dr Will carried out a standard evidence search, which found very few high level studies and no NICE or SIGN guidance for trigger point injections other than NG59. The references in the NHS EBI document were reviewed but mostly related to epidural injections and did not cover trigger point injections specifically. Dr Will informed the group that the available evidence is limited, low level and equivocal, suggesting that trigger point injections for low back pain meet our definition of unproven and other therapies should be considered instead.

Based on the above findings Steering Group members were asked whether they wished to leave the policy as it is currently or whether they wished to allow applications for trigger point injections using the 'Experimental and Unproven Treatments' funding request form only. Steering Group members were also asked whether the papers cited in the discussion document should be added to the Evidence Review section of the policy.

Dr Sturgess advised the group that trigger point injections are included in the NICE general statement but the summary document at the end says 'do not commission.' The injections reviewed looked at the substance being injected rather than considering specific types of injection. Trigger point injections were included in this review. It was agreed that Dr Will would add a statement in the in the relevant section of the policy clarifying that the NICE guidance does include trigger point injections.

The Policy Team reported that they had tried to get accurate activity data specifically for trigger point injections, however due to the way these are coded that had not proved possible. It was the opinion of the group that as activity numbers for this type of injection are probably low at the moment that activity in general should be monitored and if this increases the group would look again at this type of injection. Dr Will had restricted her review to trigger point injections for back pain as the development of new policies is currently on hold due to the proposed review of the service. A fuller review of trigger point injections at all sites was therefore deferred until a later date.

Dr Sturgess stated that clarification was needed for repeat epidural Injections. He advised that these are not recommended for either acute or persistent sciatica. NICE's full evidence review states *"in acute, severe sciatica where patients would otherwise be offered surgery, an epidural injection of local anaesthetic and steroid should be considered"*. However, this is for one injection only as is stated in the current policy. Steering Group members suggested that the relevant section of the guidance should be added in to the policy around epidural injections and a link to the NICE statement added in the evidence review appendix. Dr Sturgess agreed to send Dr Will the appropriate extracts from the guidance.

Agreement: Steering Group members agreed to add a statement to the GM EUR Low Back pain policy with the relevant NICE guidance on Trigger Point injections. Steering group members also agreed to add the NICE wording for epidural injections for acute, severe sciatica to the policy with a link to the statement.

	Actions: **1) Dr Will to add the Evidence review appendix to the policy (including those in the trigger point injection discussion document)** **2) Dr Will to add a statement to the policy with regards to Trigger point injections and epidural injections for acute, severe sciatica, with a link to the statement.** **3) Policy team to make the necessary amendments to the policy.**
5.2	**Facet Joint Injections (FJI)** Dr Hugh Sturgess declared a conflict of interest with this policy due to his role as Executive Director and Partner of Pennine MSK Partnership. At the meeting held on the 15th May 2020, group members requested the Policy Team to look at both activity relating to cervical and thoracic FJIs (and Medial Branch Block (MBB)) and at the evidence base for cervical and thoracic FJIs. Dr Will advised the group that the policy previously contained specific criteria for both cervical and thoracic FJIs, but these were removed following the publication of NG59 and subsequent reviews of this policy. However, recently the decision not to commission cervical and thoracic FJIs based mostly on NG59 has been challenged. Dr Will advised that she had revisited the previous evidence review following the meeting and repeated the usual search for any papers post-dating that review, which looked at effectiveness of FJI in neck and upper back pain. Dr Will advised group members that NICE guidance and other systematic reviews highlighted the lack of evidence of effectiveness for this procedure for neck pain and upper back pain. In light of this evidence, FJIs for neck and upper back pain were considered to be an unproven therapy at the time the Facet Joint Injections Policy was developed and are therefore not routinely commissioned. The reviews described the evidence as moderate or level 2. However, some of the cited studies were subject to several potential bias effects and the methodology was not always at the standard required by e.g. a Cochrane Review. Dr Will went on to advise that the evidence for Medial Branch Block (MBB) is better but is still only considered to be fair. Steering Group members were asked whether they wished to restore the criteria in the policy for cervical and thoracic injections, but state that these should be MBB and if FJI is required exceptionality will have to be demonstrated or leave the policy unchanged. Dr Will advised the group that if the criteria for cervical and thoracic injections are adopted, then either the Low Back Pain Policy needs to change title as it now covers injections to the neck and thorax or the Facet Joint Injections Policy is reinstated as a Facet Pain Policy and a draft brought back for agreement at the next meeting. The evidence papers found would also need to be included in the evidence review section of the policy. Steering Group members were advised that a study for therapeutic cervical medial branch blocks showed that patients receive 12 to 19 weeks of benefit on average. Medial branch block is used as a diagnostic test at all levels of the spine and if patients receive an improvement then they should be referred for radiofrequency denervation (RFD). Steering Group members were of the opinion that requests for repeat denervation should have an expected benefit of around 16 month's pain relief. FJIs will only be considered by exceptionality where this pathway cannot be followed. **Agreement:** Steering Group members agreed no change to the policy other than to add a note to the policy that FJI are no longer commissioned at any level of the spine. Also that MMB is commissioned as the diagnostic injection of choice and if a positive result is obtained the patient

	should be referred for RFD which is expected to provide benefit for a minimum of 16 months. They also requested that the evidence in the discussion document be added to the policy. **Action:** **1) Dr Will to add to the policy inclusion criteria section as requested above** **2) Dr Will to add to the summary of evidence section of the policy the details of evidence of facet joint injections at cervical or thoracic level.** **3) The Policy team would make the above necessary changes.**
5.3	**Knee Arthroscopy** Dr Hugh Sturgess declared a conflict of interest with this policy due to his role as Executive Director and Partner of Pennine MSK Partnership. Steering Group members were advised that this policy had been reviewed by them at the November 2019 meeting and had subsequently come back the January and May 2020 meetings for further review. At the January 2020 meeting, the following key decision was taken: *'Arthroscopy should only be commissioned when the knee is in a permanently locked position for patients with degenerative disease, which is in line with the BMJ clinical practice guideline's recommendations* *Based on the BMJ guidance, group members were of the opinion that the following 2 bullet points should be removed from the policy as these were not supported by the guidance:-* • *In a knee where there is evidence of degenerative change where the knee has objectively been seen to be persistently locked* • *The individual is between the ages of 35 and 55 with a history of trauma to the knee and the arthroscopy will delay the need for knee replacement.* At that meeting group members were asked if they considered the changes made to the policy were significant / material and advised that if so, the policy would need to go back out for clinical engagement and then through the governance process again. They discussed and concluded that the changes were not significant, rather a tightening of criteria in view of the BMJ article. Steering Group members felt that a consultation was not required. They requested that the Director of Commissioning be made aware of the tightening of the policy and that providers were also notified of the proposed change in commissioning criteria. On reflection as Steering Group members had asked that the DoCs and providers be made aware of the tightening of the policy then this would suggest that they were of the opinion that the changes were material, which contradicts the earlier statement in the minutes that state that the changes 'are not significant.' The group were informed that this decision would not be in line with the EUR Operational Policy as the governance process for GM EUR Policies states that '*If an existing GM EUR Policy is later revised and the changes to the commissioning criteria are considered to be material the revised policy would also need Directors of Commissioning/Chief Finance Officers (DoC/CFO) approval to implement'* Policies that meet the above criteria should go back out for clinical engagement as was the case for revised the Facet Joint Injections Policy. If changes to a policy are not considered significant, then the policy is updated following Steering Group and republished. The Directors of Commissioning are notified of the changes made to the policy in a report sent to them by the Policy Team on a quarterly basis. Providers are notified of the changes via a 'Notification of changes letter to the Prior Approval Scheme' issued to them by CCG Contract Leads.

	At the May 2020 meeting the group agreed to further amend the Knee Arthroscopy policy to state that where funding is required for assessments to ensure that the patient meets the other requirements of TA477 (which relates to Autologous chondrocyte implantation for treating symptomatic articular cartridge defects of the knee), these have to be by Individual Prior Approval at clinical triage. Steering Group members were asked to review whether or not the decisions taken at the previous three meetings to amend the Knee Arthroscopy policy were deemed to be material (as defined by the GM EUR Operational Policy), due to the changes made to the commissioning criteria. Steering Group members discussed and agreed that upon reflection the changes made at the previous three meetings would be considered material changes, as these further restricted what is currently being commissioned. The changes however would bring the policy in line with the current evidence base. The group therefore agreed that the amended policy would need to go back out for clinical engagement and through the governance process again for approval to implement. **Agreement:** Steering Group members agreed that the previous changes made to the policy were considered material and the policy will need to go back out for clinical engagement and through the governance process again. Steering Group members also of the opinion that before the policy goes back out for clinical engagement and through the governance process a further evidence review should be done with regards to the effective management of 'loose bodies found on x-ray' and 'knee arthroscopy for intermittent locking' as these are in the policy but the evidence supporting these is not clear. Steering Group members were aware of a British Medical Journal (BMJ) article on lavage and debridement already in the evidence review that would need to be checked for its recommendations for these two groups of patients. Dr Will agreed to undertake the further evidence reviews and the policy would be brought back to the next meeting for further consideration prior to the policy going out for clinical engagement and through the governance process. **Agreement:** Steering Group members agreed to the further evidence review to be undertaken and the policy brought back to the next meeting for further review/consideration prior to the policy going out for clinical engagement and through the governance process. **Action:** **1) Dr Will to undertake a further evidence review** **2) Policy to be brought back to the next meeting for further consideration**
6	**GM EUR Policy update**
6.1	**<u>Clinical Engagement</u>** The EUR Policy Team Manager advised that no draft policies were currently out for clinical engagement. The 2 new GM EUR polices below were scheduled to go to the Directors of Commissioning seeking their approval to implement these. However due to current situation with COVID-19, these still to remain on hold. • Augmentative and Alternative Communication (AAC) Aids • Cough Assist (Mechanical Insufflation and Exsufflation (MI-E)) Four policies are due to be reviewed at the September 2020 meeting:- • Hernia Repair

	• Laser Eye Surgery • Tongue Tie • Squint Surgery
6.2	**<u>NHS Contract Prior Approval Scheme</u>** Following guidance released from NHSE advising that no contracts are expected to be in place for the remainder of the year, a decision has been made to roll over the current arrangements of a status quo approach, with regards to changes to CCG EUR treatment lists, until the end of September.
6.3	**<u>Formal EUR Reviews</u>** The 2 formal EUR reviews below remain on hold for the time being. • Review of the GM EUR Operating model • Review of the options available to Commissioners with regards to the GM EUR compliance agenda
7	**Operational Issues with current policies**
7.1	**Common Benign Skin Lesions** Dr Roberts declared her conflict of interest in the policy due to her work at Salford Royal NHS Foundation Trust as a GP with special interests in (GPwSI) Dermatology. Steering Group members were advised that the British Association of Dermatologists' guidelines for the care of patients with actinic keratosis 2017 had been issued recently and relates to the benign skin lesion policy. The guideline contains additional points for referral to secondary care that are not included in the current policy these are: *Consider referral for specialist care when:* • *AK fails to respond to standard treatments* • *multiple or relapsing AKs represent a management challenge* • *AK occurs in the long-term immunosuppressed* In addition, the following point is slightly more detailed than in our current policy; • lesions are likely to be AK, but there is concern that they might be SCC (use the 2-week-wait route for possible skin cancer), for example when they are (i) bleeding, (ii) painful or (iii) thickened with substance when held between finger and thumb An extract from the British Association of Dermatologists' guidelines for the care of patients with actinic keratosis 2017 was sent out with the papers for this meeting for reference. Steering Group members were asked to consider whether they wished to amend the policy in view of the guidelines. Dr Sukhavasi advised the group that GMMMG had guidance for the management of Actinic Keratosis (AK) in primary care and the use of Solarase. Steering Group members were of the opinion that this was GMMMG remit as it was in relation to prescribing and it should therefore not be included in the policy. Steering Group members discussed and considered whether the slightly more detailed bullet point mentioned above should be added to the policy and whether to add the additional points

contained in the guidance for referrals to secondary care should also be added to the policy. Steering Group members were of the opinion that the policy inclusion criteria should be amended in line with the British Association of Dermatologist guidelines. The policy criteria needed to clearly state when it is appropriate for a secondary care referral.

Agreement: Steering Group members agreed to change the current statement in the policy by adding the section in brackets, to read: *If there is any reason to suspect that it is one of the small percentage at high risk of undergoing malignant change and transforming into a squamous cell carcinoma (e.g. if they are (i) bleeding, (ii) painful or (iii) thickened with substance when held between finger and thumb.). The referral should include details of the reasons the referrer has for this suspicion.* It was also agreed that the reasons for referral should be added, i.e. "AK fails to respond to standard treatments • multiple or relapsing AKs represent a management challenge • AK occurs in the long-term immunosuppressed

Action: Dr Will /Policy team to make the necessary changes to the policy.

7.2 Hip Replacement Policy and Knee Replacement Policy

Bespoke replacements

For bespoke joint replacements the policies state that applications must show that there has been an MDT meeting with regard to the needs of the patient and that the requested treatment has been approved. Requests must be submitted with all relevant supporting evidence which must include a copy of the relevant minute from the MDT meeting where the case was discussed and approved.

On requesting a copy of the minutes the EUR Services had been advised by some clinicians that they were unable to provide minutes in support of the application as the MDT meetings were not minuted.

Steering Group members were asked therefore whether the policies and funding request forms should be amended to read: *If the MDT meeting is informal and is not minuted, then the date of the meeting at which this was discussed with an assurance that the meeting supported the decision to use a bespoke replacement, should be provided instead.*

Steering Group members raised some concerns with regards to the MDT meetings not being minuted / documented, as bespoke replacement joints are high cost. Also it is a requirement in the GIRFT, BHS and BOA Best Practice for Hip Arthroplasty Surgery Documentation. The rationale should therefore be documented in the meeting or patient's notes.

After discussion Steering Group members agreed that the date of the MDT meeting and assurance that the meeting supported the decision alone were not enough. They requested that the following wording be used in the policy: *If the MDT is not minuted then please provide the documentation where the outcome of the MDT meeting was recorded (this should meet the recommended documentation requirements in the GIRFT guidance).* They also requested a copy of the guidance be added as an appendix in the policies.

Agreement: Steering Group members agreed to change the policy statement by adding that where MDT meetings are not minuted, then documentation should be provided with the request, of the outcome of the MDT meeting where it was discussed and this should meet the recommended documentation requirements in the GIRFT, BHS and British Orthopaedic Association (BOA) best practice document. The BOA documentation should be added to the policy.

Action: Dr Will / Policy team to make the necessary changes to the policy.

8	Any Other Business
8.1	**GM EUR Annual Service Report 19-20** The group were advised that the GM EUR Annual Service Report for 2019-2020 had also been shared with CCG IFR Panels, Contract Operating Group (CoG), H&SCP Business Intelligence Colleagues, the Elective Care Reform Programme and the JCT Heads of Service. Any comments, questions or feedback should be directed to Lisa Williams, EUR Service Lead in the first instance.
8.2	**NHS England Evidence Based Interventions (EBI) Programme - List 2 Engagement** The EUR Policy Manager advised the group that as an EBI demonstrator community the GM EUR Service had been informed yesterday evening that the proposed Wave Two interventions were now the subject of an engagement exercise led by the Expert Advisory Committee. These are intended to build on an earlier list of 17 interventions which became part of the NHS's statutory guidance in March 2019. The EUR Policy Manager went on to advise that the engagement exercise would run for 6 weeks until the 21st of August via the AoMRC website. Following the exercise, the Expert Advisory Committee would analyse the responses and submit a final recommendation on whether the interventions should be adopted by the EBI programme. In addition to the opportunity to submit an online response via a survey and/or a more open submission via email, there would be a series of webinars taking place covering interventions by specialty and data-related issues. In addition, the Patients Association would be running 3 patient focused workshops on the guidance. A schedule detailing when these webinars will take place would be available shortly. The EUR Service Lead advised that there are 31 interventions proposed in Wave 2. These were broader in scope than the initial List/Wave 1 interventions. Wave 2 includes tests and treatments as well as medical procedures. Dr Will added that 9 GM EUR policies were affected by the Wave 2 interventions. The EUR Policy Manager advised that the EUR Service would be raising awareness of the engagement exercise with colleagues across Greater Manchester. It will be primarily clinical and patient engagement. The EUR Service had been asked to prepare a communication plan and group members were asked to advise who would be best placed to receive this to ensure it is disseminated effectively/appropriately. The representatives present confirmed who would be best to receive this within their respective CCGs.
8.3	**Virtual meetings** The Chair of the meeting asked members for feedback on how the last couple of virtual meeting had gone. Those present reported that virtual meetings had worked well and were happy with this arrangement. Members made a suggestion that for future meetings, when group members were not speaking, they should 'mute' themselves to avoid feedback/echoing. It was also suggested that it would be helpful to 'share screens', particularly when discussing options on discussion documents. Steering Group members queried whether the meetings would continue to be virtually. The EUR Policy Manager confirmed that it was the intention to continue with virtual meetings for the foreseeable future. Steering Group members advised that if meetings were to revert back face to face in future, the option to participate virtually should be available. Steering Group members were asked if they would be happy for the meeting to be recorded in future. Group members did not object to this but the Terms of Reference would need to be amended if this is agreed. **Action: Policy team to facilitate the above suggestions for future meetings**

8.4	**Schedule of Meeting Dates 2020-2021** A list of scheduled meetings for 2020-2021 had been sent out with the papers for this meeting for the group's information. It was agreed that calendar invites would be sent out by the EUR Policy Team for these meetings.

Next meeting			
Date:	Wednesday, 16th September 2020	**Time:**	1.30-3.30pm
Venue:	Virtual/ Microsoft Teams		
Apologies:	Dr Sturgess submitted apologies for the above meeting.		