Hampshire, Southampton and Isle of Wight
Clinical Commissioning Group

HSI21/042

Governing Body

Title of paper	**Priorities Committee Recommendations**		
Agenda item	**7**	**Date of meeting**	8 September 2021
Exec lead	Derek Sandeman, Chief Medical Officer	**Clinical sponsor**	Derek Sandeman, Chief Medical Officer
Author	Steve Cummins, Governance Manager		

Purpose	For decision	☒
	To ratify	☒
	To discuss	☐
	To note	☐

Link to strategic objective	This paper addresses the following CCG strategic objectives: • Ensure system financial sustainability • Ensure safe and sustainable high quality services

Executive Summary

This paper outlines three recent policy update recommendations made by the eight Clinical Commissioning Groups across Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP8) Priorities Committee and subsequently reviewed by the ICS Clinical Executive Group on the 14th July 2021. Taking full regard of the National Evidence Based Interventions (EBI2) Guidelines, the Clinical Executive Group support the following recommendations.

Policy 26: Treatment of Hydrocele Version 2 (2021)

This Policy statement has been revised in line with latest evidence and to include considerations to ensure fair and equitable access but does not apply to patients with 'red flag' symptoms.

There are no significant changes to the policy statement as no new evidence or guidance supporting a change in policy were found. The policy was reformatted in line with current formatting requirements.

Detail of full recommendation and criteria can be seen in the full statement – appendix 1.

Policy 50: Primary joint replacement for hip and knee osteoarthritis (2019) (Version 2)

No changes to the clinical content. Following SHIP8 Steering Group advice, wording has been added regarding imaging to state 'The Committee supports the EBI2 guidance in relation to imaging for the diagnosis of hip and knee osteoarthritis'.

Policy dates to remain 2019 as the evidence for thresholds for surgery have not been reviewed; the EBI2 statement is for imaging only. New NICE Guideline 157 (2020) 'Joint replacement (primary): hip, knee and shoulder for joint replacement' has been referenced for joint decision making due to an out-of-date reference in the version 1.

Detail of full recommendation and criteria can be seen in the full statement – appendix 2.

Policy 67: Shoulder Radiology: Scans for Shoulder Pain and Guided Injections (2021)
This Policy statement has been reviewed as part of the 3 year policy governance cycle and reviewed against latest evidence and EBI2 wording has been added to the policy. Detail of full recommendation and criteria can be seen in the full statement – appendix 3. Following approval of recommendation statements, a non-contractual information notice letter will be issued to providers to make them aware of latest local guidance and with a refreshed on-line version of the overarching Individual Funding Request (IFR) and Restricted Treatments and Procedures (RTaP) Policy for 2021/22 for reference. All policies are available via the GP Portal and at - www.fundingrequests.cscsu.nhs.uk

Recommendations	**The Governing Body is asked to ratify and approve Priorities Committee clinical policy update numbers 26, 50 & 67.**
Publication	**Include on public website** ✓

Please provide details on the impact of following aspects	
Equality and quality impact assessment	The policy statements are not expected to specifically advantage or disadvantage any particular group. The Individual Funding Request (IFR) and Restricted Treatments and Procedures (RTaP) Policy include a process for consideration of individual cases in exceptional circumstances.
Patient and stakeholder engagement	This was fully considered by the Hampshire and Isle of Wight Priorities Committee following an evidence review carried out by the CSU's Clinical Effectiveness team which, in turn, references relevant NICE guidance which includes patient and user engagement. Public engagement in the changes to Evidence Based Interventions Policy are incorporated into Communications team work plan and stakeholders meetings are already in place in each local secondary care/provider system to periodically review implementation impact as part of the CCG's collaborative and partnership working.
Financial impact, legal implications and risk	This policy, when fully implemented, is likely to derive additional quality improvements and potential financial benefits in terms of unwarranted or un-commissioned secondary care activity. Activity reduction cannot be accurately quantified but the policy revisions offer greater assurance of activity being carried out in line with best practice evidence and expert advice. There are no known legal implications arising from this paper. There are no risks in relation to these statements. These polices confirm specific changes to treatments and procedures restricted by criteria.

Governance and Reporting- which other meeting has this paper been discussed		
Committee Name	Date discussed	Outcome
Hampshire and Isle of Wight Priorities Committee	March 2021	Agreed
Joint Hampshire, Southampton and Isle of Wight CCGs Clinical Policy Operational Group	April 2021	Agreed
ICS Clinical Executive Group	July 2021	Agreed

Clinical Executive Information Paper: Priorities Committee Recommendations

Purpose of Paper

This paper outlines procedures and treatments which are recommended as low priority procedures subject to criteria, by the Hampshire and Isle of Wight Priorities Committee (HPC). Recommendations are made following a systematic review of the evidence and/or local clinical expert discussion together with cost effectiveness analysis relating to:

Policy 26: Treatment of Hydrocele Version 2 (2021).

This Policy statement has been updated in line with latest evidence as part of a regular program of reviews and to include considerations to ensure fair and equitable access for all patients. This Policy statement has been revised in line with latest evidence and to include considerations to ensure fair and equitable access but does not apply to patients with 'red flag' symptoms.

There are no significant changes to the policy statement as no new evidence or guidance supporting a change in policy found.

The committee recommends that:

- Interventions should be delayed until at least 2 years of age
- Surgical treatment of hydrocele should only be offered if there is significant discomfort which prevents voiding, sexual function, mobility, or dressing.

Ultrasound investigations may be of value in the initial assessment of a hydrocele when there is diagnostic uncertainty, but should not be repeated.

Testicular torsion is a surgical emergency and therefore excluded from this policy.

Clinical coding is now offered to providers for clarity in recording these procedures and appears in the full statement in appendix 1.

The recommendation is that this policy statement should be adopted in full and listed as an 'amber procedure' requiring prior approval unless deemed an emergency and treatment should progress without delay.

Policy 50: Primary joint replacement for hip and knee osteoarthritis (2019; V2)

No changes to the clinical content. Following SHIP8 Steering Group advice, wording has been added regarding imaging to state 'The Committee supports the National Evidence Based Interventions (EBI2) guidance in relation to imaging for the diagnosis of hip and knee osteoarthritis'.

Policy dates to remain 2019 as the evidence for thresholds for surgery have not been reviewed; the EBI2 statement is for imaging only. The Committee supports the Evidence Based Interventions Programme List 2[1] guidance in relation to imaging for the diagnosis of hip and knee osteoarthritis.

The statement notes that:

- Obesity is an important factor in the aetiology of joint disease as well as being detrimental to outcomes.

The Committee recommends:

- Weight management has an important role throughout the patient's life and should be reflected in prevention strategies.
- There is evidence that there are poorer outcomes for patients with increased body mass index (BMI). Primary joint replacement should be reserved for patients with a BMI below 35. Prior approval for referral for specialist surgical assessment may be granted for patients with a BMI greater than 35 in the following circumstances:
    - For patients whose pain is so severe and/or mobility compromised that they are at risk of losing their independence and that joint replacement would relieve this risk OR
    - In patients whose destruction of the joint is of a severity that delaying surgery would increase the technical difficulty of the procedure AND
    - Referral has been made to a commissioned tier 2 or tier 3 obesity management programme prior to offering surgery.

The statement also notes that:

- Smoking is the most important factor for the development of postoperative cardio-pulmonary and wound-related complications in elective surgery and the most important risk factor for the development of serious post-operative complications in patients undergoing elective hip and knee replacement.

The Committee recommends:

[1] NHS England Evidence Based Interventions Programme (Policies 2T and 2X)

- Stopping smoking should be encouraged for at least 8 weeks prior to operation and patients should be referred to a structured smoking cessation programme prior to or at time of referral for surgical assessment or there should be documented informed dissent.

New NICE Guideline 157 (2020) 'Joint replacement (primary): hip, knee and shoulder for joint replacement' has been referenced for joint decision making due to an out-of-date reference in the version 1.

Policy Statement 21: Smoking and Non-Urgent Surgery (July 2017) is taken into account, namely;

- Prescribing smoking cessation medication outside of supported programmes is low priority.
- All clinicians have a responsibility to undertake patient education and offer brief intervention with every contact.
- Use of e-cigarettes is less harmful and is preferable to cigarette smoking.

Shared decision making is a new consideration and recommendation in this statement.

- Shared decision making is seen as helpful and effective at improving outcomes and should be started in Primary Care or in the Community based Musculoskeletal (MSK) service. The Committee supports the approach to shared decision making outlined by NICE[2].

- There should be a period of 3 months for patients to consider the risk and benefits to them of knee replacement surgery and to address issues such as weight loss or smoking cessation if required.

Local Context

The normal referral route for specialist opinion and support in the CCG for patients with musculoskeletal problems or pain would be via commissioned MSK services. Direct referral for surgical opinion is not recommended and may be redirected by secondary care.

The recommendation is that this policy statement should be adopted in full and cases in which the patient has a BMI over 35 should be listed as an 'amber procedure' requiring prior approval.

Policy 67: Shoulder Radiology: Scans for Shoulder Pain and Guided Injections (2021)

This Policy statement has been reviewed as part of the 3 year policy governance cycle and reviewed against latest evidence and EBI2 wording has been added to the policy.

For patients who initially present with shoulder pain in primary or intermediate care, the first line of radiological investigation should be a plain x-ray. If following an x-ray and clinical assessment, diagnosis remains in doubt then a referral to a secondary care shoulder service is supported where

[2] NICE Guideline 157 (2020) Joint replacement (primary): hip, knee and shoulder

further specialist assessment and appropriate investigations including ultrasound, CT scans and MRI scans can be arranged.

The use of these investigations outside secondary care is only supported if referral pathways have been developed with the local secondary care specialist shoulder service.

If shoulder RED FLAGS are present, an urgent referral to secondary care should be arranged for further investigation and management:

- Any history or suspicion of malignancy
- Any mass or swelling
- Suggestions of infection (e.g. red skin, fever or systemically unwell)
- Trauma, pain and weakness
- Trauma, epileptic fit or electric shock leading to loss of rotation and abnormal shape.

Guided and Landmark Injections

Injections for shoulder pain are often indicated as a first line of treatment. The common areas injected are the subacromial space, the glenohumeral joint and the acromioclavicular joint. The most common injection is a subacromial injection.

Guided injections utilising ultrasound are more expensive than unguided injections. Evidence indicates there is no additional benefit from a guided subacromial injection over an unguided landmark injection; these are no longer recommended in primary, intermediate and secondary care during routine management of patients with subacromial shoulder pain.

The Committee recommends that guided subacromial injections for the routine management of patients with subacromial pain are an intervention not normally funded by the NHS.

Other image guided shoulder injections should only be offered under the guidance of a secondary care shoulder service.

Clinical coding is offered to provider for clarity in recording these procedures and appears in the full statement in appendix 3.

Local Context

The normal referral route for specialist opinion and support in the CCG for patients with musculoskeletal problems or pain would be via commissioned MSK services. Direct referral for surgical opinion is not recommended and may be redirected by secondary care.

The recommendation is that this policy statement should be adopted in full and the procedure listed as ‘amber’ requiring individual prior approval if guided injections utilising ultrasound is required.

Hampshire and Isle of Wight Priorities Committee Recommendations Process

The Hampshire and Isle of Wight Priorities Committee (HPC) meet on alternate months to review evidence and NICE guidance and make recommendations which potentially affect commissioning decisions across the local health economy. The HPC is informed by requests for specific review by the member CCGs. Decisions are made within an ethical framework and the committee has representatives from Public Health England, lay members, a university ethicist as well as the local commissioning bodies. The HPC also takes due regard of criteria and recommendations made by the National Evidence Based Intervention (EBI) Programme Board.

Responsibility for adoption of recommendations from the Priorities Committee sits with individual CCGs. Therefore, Hampshire, Southampton and Isle of Wight CCG has formed the Clinical Policy Operational Group (CPOG) as an internal governance body to provide oversight in planning and adoption of recommendations which may have an impact on commissioning decisions for the local population. This group is inclusive of all local CCGs and will continue to maintain local provider relationships and interests. Until such time at new statutory body is formed, each CCG retains its internal sign-off governance process.

These policy statements have been shared with the Joint Hampshire, Southampton and Isle of Wight CCG CPOG with no recommendation to amend the policy statements. Therefore the above procedures are put forward with the recommendation to Clinical Executives that these statements are adopted in full as Criteria Based Access Policies (CBAP – formerly known as restricted treatments and procedures (RTAP) policy statements).

In summary the recommendations are:

Policy 26: Treatment of Hydrocele Version 2 (2021).

- This policy statement should be adopted in full and listed as an ‘amber procedure’ requiring prior approval unless deemed an emergency and treatment should progress without delay.

Policy 50: Primary joint replacement for hip and knee osteoarthritis (2019; V2)

- This policy statement should be adopted in full and cases in which the patient has a BMI over 35 should be listed as an ‘amber procedure’ requiring prior approval.

Policy 67: Shoulder Radiology: Scans for Shoulder Pain and Guided Injections (2021)

- The recommendation is that this policy statement should be adopted in full and cases in which the patient has a BMI over 35 should be listed as an ‘amber procedure’ requiring prior approval.

APPENDIX 1

SHIP8 Clinical Commissioning Groups Priorities Committee

Policy title Number/version	**Policy 26: Treatment of Hydrocele** **Version 2 (2021**
Policy position	**Criteria Based Access**
Update	This policy will be updated as per 3-year cycle or in light of a substantial body of new evidence or new national guidance (e.g. NICE) having been published.

Treatment of hydrocele

The committee recommends that:

- Interventions should be delayed until at least 2 years of age
- Surgical treatment of hydrocele should only be offered if there is significant discomfort which prevents voiding, sexual function, mobility, or dressing.

Ultrasound investigations may be of value in the initial assessment of a hydrocele when there is diagnostic uncertainty, but should not be repeated.

Testicular torsion is a surgical emergency and therefore excluded from this policy.

Clinical coding:

Primary OPCS:
N11: Operations on hydrocele sac
T19.3: Ligation of patent processus vaginalis

Primary ICD-10:
N43.0: Encysted hydrocele
N43.2: Other hydrocele
N43.3: Hydrocele, unspecified
N43.4: Spermatocele
P835 - Congenital Hydrocele

Exceptional circumstances may be considered where there is evidence of significant health impairment and there is also evidence of the intervention improving health status.

Version	Date	Reason for change
Version 1	2017	N/A
Version 2	2021	3 yearly update

- That SHIP Policy Statement 21: Smoking and Non-Urgent Surgery (July 2017) is taken into account, namely;
  - Prescribing smoking cessation medication outside of supported programmes is low priority.
  - All clinicians have a responsibility to undertake patient education and offer brief intervention with every contact.
  - Use of e-cigarettes is less harmful and is preferable to cigarette smoking.

Shared decision making

- Shared decision making is seen as helpful and effective at improving outcomes and should be started in Primary Care or in the Community based MSK service. The Committee supports the approach to shared decision making outlined by NICE[2]
- There should be a period of 3 months for patients to consider the risk and benefits to them of knee replacement surgery and to address issues such as weight loss or smoking cessation if required.

References:

[1]NHS England Evidence Based Interventions Programme (Policies 2T and 2X)
[2] NICE Guideline 157 (2020) Joint replacement (primary): hip, knee and shoulder

Exceptional circumstances may be considered where there is evidence of significant health impairment and there is also evidence of the intervention improving health status

Version	Date	Reason for change
Version 1	2019	N/A
Version 2	2021	To include Evidence Based Interventions List 2 Guidance (2020) for imaging, and shared decision aid information from NICE Guideline 157 (2020)

SHIP8 Clinical Commissioning Groups Priorities Committee

Policy title Number/version	Policy 50 Primary joint replacement for hip and knee osteoarthritis (2019) (Version 2)
Policy position	Criteria Based Access
Update	This policy will be updated as per 3-year cycle or in light of a substantial body of new evidence or new national guidance (e.g. NICE)

Imaging

The Committee supports the Evidence Based Interventions Programme List 2[1] guidance in relation to imaging for the diagnosis of hip and knee osteoarthritis.

Primary hip or knee joint replacement

Obesity

Obesity is an important factor in the aetiology of joint disease as well as being detrimental to outcomes.

The Committee recommends:

- Weight management has an important role throughout the patient's life and should be reflected in prevention strategies.
- There is evidence that there are poorer outcomes for patients with increased body mass index (BMI). The committee recommends that primary replacement should be reserved for patients with a BMI below 35. Prior approval for referral for specialist surgical assessment may be granted for patients with a BMI greater than 35 in the following circumstances:
  - For patients whose pain is so severe and/or mobility compromised that they are at risk of losing their independence and that joint replacement would relieve this risk OR
  - In patients whose destruction of the joint is of a severity that delaying surgery would increase the technical difficulty of the procedure AND
  - Referral has been made to a commissioned tier 2 or tier 3 obesity management programme prior to offering surgery.

Smoking

Smoking is the most important factor for the development of postoperative cardio-pulmonary and wound-related complications in elective surgery and the most important risk factor for the development of serious post-operative complications in patients undergoing elective hip and knee replacement.

The Committee recommends:

- Stopping smoking should be encouraged for at least 8 weeks prior to operation and patients should be referred to a structured smoking cessation programme prior to or at time of referral for surgical assessment or there should be documented informed dissent.

- That SHIP Policy Statement 21: Smoking and Non-Urgent Surgery (July 2017) is taken into account, namely;
  - Prescribing smoking cessation medication outside of supported programmes is low priority.
  - All clinicians have a responsibility to undertake patient education and offer brief intervention with every contact.
  - Use of e-cigarettes is less harmful and is preferable to cigarette smoking.

Shared decision making

- Shared decision making is seen as helpful and effective at improving outcomes and should be started in Primary Care or in the Community based MSK service. The Committee supports the approach to shared decision making outlined by NICE[2]
- There should be a period of 3 months for patients to consider the risk and benefits to them of knee replacement surgery and to address issues such as weight loss or smoking cessation if required.

References:

[1]NHS England Evidence Based Interventions Programme (Policies 2T and 2X)

[2] NICE Guideline 157 (2020) Joint replacement (primary): hip, knee and shoulder

Exceptional circumstances may be considered where there is evidence of significant health impairment and there is also evidence of the intervention improving health status

Version	Date	Reason for change
Version 1	2019	N/A
Version 2	2021	To include Evidence Based Interventions List 2 Guidance (2020) for imaging, and shared decision aid information from NICE Guideline 157 (2020)

SHIP8 Clinical Commissioning Groups Priorities Committee

Policy title Number/version	Policy 67 Shoulder Radiology: Scans for Shoulder Pain and Guided Injections (2021)
Policy position	• Criteria based access policy • Not normally funded: Guided subacromial injections for the routine management of patients with subacromial pain
Update	This policy will be updated as per 3-year cycle or in light of a substantial body of new evidence or new national guidance (e.g. NICE)

Scans for Shoulder Pain

For patients who initially present with shoulder pain in primary or intermediate care, the first line of radiological investigation should be a plain x-ray. If following an x-ray and clinical assessment, diagnosis remains in doubt then a referral to a secondary care shoulder service is supported where further specialist assessment and appropriate investigations including ultrasound, CT scans and MRI scans can be arranged. The use of these investigations outside secondary care is only supported if referral pathways have been developed with the local secondary care specialist shoulder service.

If shoulder RED FLAGS are present, an urgent referral to secondary care should be arranged for further investigation and management:

- Any history or suspicion of malignancy
- Any mass or swelling
- Suggestions of infection (e.g. red skin, fever or systemically unwell)
- Trauma, pain and weakness
- Trauma, epileptic fit or electric shock leading to loss of rotation and abnormal shape.

Guided and Landmark Injections

Injections for shoulder pain are often indicated as a first line of treatment. The common areas injected are the subacromial space, the glenohumeral joint and the acromioclavicular joint. The most common injection is a subacromial injection.

Guided injections (usually utilising ultrasound) are more expensive than unguided injections. Evidence indicates there is no additional benefit from a guided subacromial injection over an unguided landmark injection; these are no longer recommended in primary, intermediate and secondary care during routine management of patients with subacromial shoulder pain.

The Committee recommends that guided subacromial injections for the routine management of patients with subacromial pain are an intervention **NOT NORMALLY FUNDED.**

Other image guided shoulder injections should only be offered under the guidance of a secondary care shoulder service.

EBI List 2 Coding

Scans for shoulder pain:	Image guided injections for shoulder pain:
U13.2 Ultrasound of bone	U13.2 Ultrasound of bone
U13.3 Magnetic resonance imaging of bone	U13.3 Magnetic resonance imaging of bone
U13.4 Plain x-ray of joint	U13.4 Plain x-ray of joint
U13.5 Plain x-ray of bone	U13.5 Plain x-ray of bone
U13.6 Computed tomography of bone	U13.6 Computed tomography of bone
U21.1 Magnetic resonance imaging NEC	U21.1 Magnetic resonance imaging NEC
U21.2 Computed tomography NEC	U21.2 Computed tomography NEC
U21.6 Ultrasound scan NEC	U21.6 Ultrasound scan NEC
U21.7 Plain x-ray NEC	U21.7 Plain x-ray NEC
Z81.2 Acromioclavicular joint	Z81.2 Acromioclavicular joint
Z81.3 Glenohumeral joint	Z81.3 Glenohumeral joint
Z81.4 Shoulder joint	Z81.4 Shoulder joint
Z81.8 Specified joint of shoulder girdle or arm NEC	Z81.8 Specified joint of shoulder girdle or arm NEC
Z81.9 Joint of shoulder girdle or arm NEC	Z81.9 Joint of shoulder girdle or arm NEC
Z89.1 Shoulder NEC	Z89.1 Shoulder NEC
Z54.2 Rotator cuff of shoulder	Z54.2 Rotator cuff of shoulder
Z54.8 Specified muscle of shoulder or upper arm NEC	Z54.8 Specified muscle of shoulder or upper arm NEC
Z54.9 Muscle of shoulder or upper arm NEC	Z54.9 Muscle of shoulder or upper arm NEC
Z68.8 Specified bone of shoulder girdle NEC	Z68.8 Specified bone of shoulder girdle NEC
Z68.9 Bone of shoulder girdle NEC	Z68.9 Bone of shoulder girdle NEC
	W90.3 Injection of therapeutic substance into joint + Shoulder
	W90.4 Injection into joint NEC + Shoulder

Reference

[1]NHS England Evidence Based Interventions Programme (Policies 2Wi and 2Wii)

Exceptional circumstances may be considered where there is evidence of significant health impairment and there is also evidence of the intervention improving health status.

Version	Date	Reason for policy / change
Version 1	2021	New policy due to publication of Evidence Based Interventions List 2 Guidance