***Aylesbury Vale Clinical Commissioning Group***
***Bracknell and Ascot Clinical Commissioning Group***
***Chiltern Clinical Commissioning Group***
***Newbury and District Clinical Commissioning Group***
***North and West Reading Clinical Commissioning Group***
***Oxfordshire Clinical Commissioning Group***
***South Reading Clinical Commissioning Group***
***Slough Clinical Commissioning Group***
***Windsor, Ascot and Maidenhead Clinical Commissioning Group***
***Wokingham Clinical Commissioning Group***

**Thames Valley Priorities Committee**
**Minutes of the meeting held Wednesday 23rd March 2016**
**Board Room, Aylesbury Vale CCG, Aylesbury Vale District Council Offices, The Gateway, Gatehouse Road, Aylesbury, HP19 8FF**

In Attendance:

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| Alan Penn | Lay Member Chair | Thames Valley Priorities Committee |
| Tiina Korhonen | Clinical Effectiveness Manager | South Central &West Commissioning Support Unit (SCSWCSU) |
| Laura Tully | Clinical Effectiveness Manager | SCWCSU |
| Barbara Bennett | CSU Admin Support | SCWCSU |
| Kathryn Markey | Clinical Effectiveness Manager | SCWCSU |
| Sarah Robson | Head of IFR | SCWCSU |
| Professor Chris Newdick | Special Advisor – Health Law | University of Reading |
| Dr Paul Harris | GP | Berkshire West CCGs |
| Catriona Khetyar | Head of Medicines Optimisation | Berkshire East CCGs |
| Dr Ingrid Slade | Public Health Registrar, Special Advisor - Ethics | University of Oxford |
| Jane Butterworth | Head of Medicines Management | Aylesbury Vale CCG & Chiltern CCG |
| Frances Fairman | Assistant Director – Clinical Strategy | NHS England TV Area Team |
| Richard Corbett | Chief Executive | HealthWatch Bucks |
| Dr Toby Gillman | GP | Aylesbury Vale CCG |
| Lindsey Barker | Medical Director | Royal Berkshire NHS Foundation Trust |
| Cathy Winfield | Chief Officer | Berkshire West CCG |
| Linda Collins | NICE Lead | Oxfordshire CCG |

Apologies:

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| Asmat Nisa | Special Advisor – Health Law | University of Reading |
| Dr Graham Jackson | Clinical Chair | Aylesbury Vale CCG |
| Dr Tony Berendt | Medical Director | Oxford University Hospitals NHS Trust |
| Tracey Marriot | Director of Innovation Adoption | Oxford Academic Health Science Network |
| Tim Langran | Lead Support Pharmacist | Berkshire East CCG |
| Julie Dandridge | Deputy Director. Head of Primary Care and Medicines Optimisation | Oxfordshire CCG |
| Jeremy Servian | IFR Manager Clinical Lead | Oxfordshire CCG |
| Miles Carter | West Oxfordshire Locality Clinical Director | Oxfordshire CCG |

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| **1.** | **Welcome & Introductions** |
| 1.1 | The Chair opened the meeting and welcomed members of the Committee. |
| **2.** | **Apologies for Absence** |
| 2.1 | Recorded as above.<br>The Chair informed the Committee that this is Barbara Bennett's last meeting and thanked her for her input, a replacement for the administrator role is currently being advertised. The Chair also informed the Committee that Mark Sheenan is standing down and noted he will be greatly missed. The Chair also wanted to thank Mark for his longstanding and valuable input into the work of the Committee. Dr Ingrid Slade will be replacing Mark as ethics advisor and was welcomed.<br>The Chair also wanted to thank Richard Corbett for his input into the Committee as this was his last meeting. HealthWatch Oxfordshire has been approached to confirm his replacement. |
| **3.** | **Declarations of Interest** |
| 3.1 | None were declared. |
| **4.** | **Draft Minutes of the Priorities Committee meeting held 27th January 2016 – Confirm Accuracy**<br><br>The following amendment was agreed:<br>• Page 3 – "as long" was inserted twice into the last paragraph – CE Team to remove this. |
| **5.** | **Draft Minutes of the Priorities Committee meeting held on 27th January 2016 – Matters Arising** |
| 5.1 | Action 4. Draft minutes of the Priorities Committee held in November 2015: CE Team to make changes as discussed and circulate to the Committee for approval.<br>**Action Complete** |
| 5.2 | Action 5.2 CE team to set up a working group to review the Fertility Care Pathway: LT will bring this paper to the Committee and circulate to clinicians in Buckinghamshire and Berkshire for clinical consultation. Due to come to the Committee for the March meeting 2016. LT stated that the CE Team are still awaiting for clinical feedback so this will be brought back to the May 2016 Meeting.<br>**Action in progress** |
| 5.3 | Action 6.1 Evidence review follow up for verteporfin for Chorionic Central Serous Chorioretinopathy (CSR): LT will contact alternative specialists to see if they will be able to attend a future meeting. LT confirmed that the CE Team have included the CSR item in the May meeting agenda when another ophthalmology item will also be considered in order to utilise the attending clinicians for both topics.<br>**Action Complete** |
| 5.4 | Action 7.3 Evidence Review - Severe and Complex Obesity Thresholds for Surgery: CE team to draft an interim policy based on the NHS England threshold policy and circulate as per the usual process. Review of the interim policy to be scheduled for the July Committee meeting.<br>**Action Complete**<br>Action 7.3 Clinical Effectiveness team to draft a letter to the Chairs of the TV Health and Wellbeing Boards regarding the interim Severe and Complex Obesity policy development to share information and to raise awareness.<br>**Action Complete**<br>Action 7.3 CCGs to collate information from EMIS regarding numbers of patients in different BMI groups with co-morbidities. JB agreed to discuss this with CE team outside of the Committee meeting in view of obtaining a sample of EMIS data for Aylesbury Vale, to see what is available and how useful this data may be. NHS England data and guidance on transferring the commissioning responsibilities to CCGs is yet to be made available.<br>**Action in progress** |

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| 5.5 | Action 8.2: Policy Update - Managing the Boundaries between NHS and Private Health Care: Clinical Effectiveness team to draft the policy updates for the following policies as per the Committee discussion and circulate as usual process;<br>• Managing the boundaries of NHS and privately funded healthcare<br>• NHS prescribing following private consultation<br>• Excess treatment costs for non-commercial clinical trials<br>• Research trials and NHS funding<br>LT noted that the policy review had focused on the first two items mentioned above. However, during the meeting it was decided that the two further policies should also be refreshed. A post meeting note was sent to the CCG representatives flagging the amendments, in particular regarding the excess treatment costs (ETC), which were not raised at the actual meeting. The policy states that funding for ETCs is not routinely available unless they have been agreed for specific named clinical trials in advance with the relevant commissioning CCGs. The Committee confirmed they wished to retain this recommendation.<br>**Action Complete** |
| 5.6 | Action 9.1 Identifying Opportunities for TVPC Work Programme-National and Regional Policy Comparison: Clinical Effectiveness team to add Surrey policies to the policy comparison table.<br>**Action Complete** |
| 5.7 | Action 9.2 Identifying Opportunities for TVPC Work Programme: Clinical Effectiveness team to obtain IFR data to identify potential topics for further consideration**.**<br>**Action Complete** |
| 5.8 | Action 10.2 Schedule for Current Policy Updates: Clinical Effectiveness team to schedule and carry out the policy updates accordingly.<br>**Action Complete** |
| **6.** | **Identifying Opportunities for TVPC Work Programme: Benchmarking Exercise** |
| 6.1 | The Thames Valley Priorities Committee Working Group proposed that the Clinical Effectiveness team carry out an exercise on behalf of the Committee to identify opportunities and variation in clinical policies in order to enable an evidence based approach in making topic recommendations to the Priorities Committee work plan 2016-17. The review and collation of the agreed data sources presented to the Committee offered an overview of the shared opportunities for the TV CCGs.<br><br>The top opportunities for both spend and outcomes shared by most of the Thames Valley CCGs, identified in the updated Commissioning for Value packs, are trauma and injuries. Opportunities arise in terms of saving in elective and day case admissions and in terms of patient outcomes in injuries due to falls in people aged 65+ and length of stay for patients with fractured femur.<br><br>In elective care, the largest opportunity in terms of savings arise in the field of elective and day case admissions for musculoskeletal systems problems (non-trauma). Potential opportunities culminate in elective orthopaedic surgery, in particular hip surgery, elective knee surgery, 'elective spend' and better collection of EQ5D index for patients before surgery also appear as opportunities for the TV CCGs.<br><br>Based on the indicators in the Atlas of Variation pathways, the TV CCGs do have a wide range of identified opportunities when benchmarked against best performing peers. However, there are two indicators that occur more often among the TV CCGs than any other, both of these relate to early diagnosis of cancer.<br><br>The RCS Quality Dashboards also indicate that MKS activity in the TV is higher than the national average in several fields; total hip replacement, arthroscopic decompression for subacromial pain (painful shoulder impingement), surgery for painful great toe and spinal fusion for low back pain. |

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| 6.2 | It was noted that the MSK opportunity was significant, particularly in Berkshire West and it was felt this would need to be looked at and decisions made to establish more effective care pathways. Berkshire West CCGs are currently carrying out an arthritis care pathway pilot where patients cannot be referred for surgical review unless they have been through the service providing comprehensive conservative management support first. This has been successful with patients taking part so far and feedback from patients has shown that they are less likely to opt for surgical management when they have had an opportunity to have further information and consider alternative management strategies. It was noted that Oxfordshire CCG have very recently audited their MSK referrals to local providers and early results showed that the thresholds were potentially set low. The Committee felt that it would be useful if patient reported outcome data could be compared with thresholds to explore if good long term patient outcomes are achieved with the current thresholds. It was agreed that both primary hip and knee replacement surgery should be added to this year's work programme. This should include looking at the long term outcomes and revision rates. |
| 6.3 | The Chair asked the Committee to consider the recommendations set out on the paper.<br><br>Trauma and injuries - it was felt this was mainly relating to falls prevention and, as there are programmes already in place, this was not something that needs to be picked up in this Committee. It was also felt that there has already been a lot of work carried out for length of stay for fractured neck of femur.<br><br>Topics for potential policy development where other CCGs have policies and TV CCGs have received IFR requests were discussed:<br>**Foot and Ankle Surgery**; some of these interventions come through IFR but will be carried out as there is no current policy and this is seen as a standard treatment within a main NHS hospital. It was decided that this could be initially a scoping exercise to collect detail of the interventions involved.<br>**MRI Scan - Open/Standing**; Oxfordshire CCG currently commission this for patients with claustrophobia or for patients who would not fit into a horizontal MRI scanner. It was felt that it would be helpful to have a policy and threshold to support assessment of patient eligibility for this.<br>**MSK Patellar tendinopathy**; Oxfordshire CCG currently has a policy for this. As there are currently no IFR's for this it was decided that this should be scoped for activity and spend in the first place.<br>**Female genital surgery for stress incontinence and prolapse**; several CCGs have clinical policies on this topic and it was agreed it would be worth reviewing this and adding to the work programme.<br>**Frenuloplasty;** there are currently no policies within the TV but Bedfordshire does have a policy which covers three issues - treatment for infants with feeding problems, if they require day case or in-patient stay and speech problems. The Committee agreed to review this topic and add to the work programme to consider adopting the Bedfordshire policy.<br>**Ear Wax Removal in secondary care**; the Committee decided that due to no IFR activity and likely low activity in general not to add this to the work programme.<br>**Management of haemorrhoids**; it was acknowledged that across TV there is wide variation in activity. It was decided that scoping the activity and spend and potential policies would be helpful.<br>**Surgery for hydroceles**; due to small patient population affected the Committee agreed not to include this in the work programme.<br>**Therapy for lymphoedema**; several other CCG's have policies for this including Oxfordshire. There is currently no IFR activity. It was noted that the current Oxfordshire policy does not cover surgical treatment but is in response to requests for treatments at private clinics which offer micro surgery for lymphoedema. Many CCGs have local service in place and the Committee felt that this would not be a priority for review.<br><br>**Revision surgery for unicompartmental knee surgery;** this was raised as an additional issue. It was queried whether unicompartmental knee surgery should be followed by TKR surgery. It was recognised that whilst partial knee replacement was specialised commissioning responsibility the TKR would come under CCG commissioning. The Committee felt that this should be scoped and brought back to the meeting for review. |

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| | Other topics that were identified in the review as potential opportunities for the TV CCG policy development but have been already included in the work programme are: chronic low back pain treatments, painful shoulder conditions, Platelet Rich Plasma Injections (PRP) and continuous blood glucose monitoring. |
| 6.4 | The Chair asked the Committee if they wished to remove or bring forward any topics already on the work programme. It was felt that the policy review for bunions should be brought forward due to identified high activity across TV. It was also felt that the policy for hernias should be bought forward for a review and update as the current policies only cover specific hernias and a wider policy including all relevant hernias could be developed.<br><br>Additionally, in emergency general surgery there may be potential opportunities to explore the care pathways for abdominal pain, in particular, right iliac fossa pain (appendicectomy) and the local provision for non-operative management. The RCS offer a comprehensive Commissioning Guide for 'Emergency general surgery (acute abdominal pain)'. The Committee considered how this could be taken forward and it was suggested that CCGs could take this forward by highlighting and endorsing the RCS Guidelines with local providers or potentially ask providers to carry out an audit to review care pathways against the RCS guidelines.<br><br>Biosimilar therapies were discussed. The Academic Health Science Network has biosimilars in their work programme for 2016-17. It was also noted that biosimilars are now covered by NICE in the context of a Multiple Technology Appraisal programme in parallel with their reference products in the indication under consideration, as per NICE position statement January 2016. It was agreed that CCG and trust Medicines Optimisation teams were leading this work and it would not need be added to the Committee work plan.<br><br>Issue was raised in relation to new NICE TAs where there is a common TV clinical policy. Any new NICE TA's need to be captured quickly in order to remain within the 90 days implementation date. This can be done in two ways - either to warn CCG's that there is a minor tweak within the existing policy that can put through internal processes and doesn't need to come back to the TVPC or agree it needs to come back to the TVPC for review. Some NICE TA's now will have a shorter implementation date of 30 days.<br><br>Issue of the Committee engagement in the wider public health and health promotion agenda was discussed. In general, it was acknowledged that whilst the local needs assessments do inform local commissioning priorities and each CCG was pursing different avenues on areas of common concern such as obesity and alcohol misuse, there could be some good practice to be shared. The Chair suggested that, if there were issues to be considered for the work programme, the Committee would need to decide where there were significant problems and identify areas of common interests. He suggested asking the working group, which decides the core work programme, to bear in mind the public health issues that could be considered in the future planning of the Committee work.<br><br>It was felt that the review and the benchmarking exercise carried out was a very good piece of work and was useful for the Committee.<br><br>**Action: CE team to review the work programme and schedule the agreed topics for the programme and for scoping:**<br>• Foot and Ankle Surgery; for scoping<br>• MRI Scan - Open/Standing; for policy development<br>• MSK Patellar tendinopathy; for scoping<br>• Female genital surgery for stress incontinence and prolapse; for policy development<br>• Frenuloplasty; for policy development in view of adopting the Bedfordshire policy<br>• Management of haemorrhoids; for scoping<br>• Revision surgery for unicompartmental knee surgery; for scoping<br>• Primary hip and knee replacement surgery; for policy review<br>**Action: CE team to bring forward the review of the policies for hernia and bunion surgery thresholds.** |

| 7. | **Policy Update: Penile Rehabilitation (PR) Following Prostate Surgery** |
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| 7.1 | LT explained that this policy is separate from the policy for Erectile Dysfunction (ED) which was recently reviewed by the Committee. Rather than use of erectile dysfunction treatments to achieve sexual intercourse, PR is where the intervention is used on a regular basis to try and strengthen the muscles with a view to returning to spontaneous erection. The Committee noted that Mr Hadley, a local Urologist who attended the January meeting to provide specialist input into the policy review regarding erectile dysfunction, did also discuss penile rehabilitation in post prostatectomy patients.<br><br>In terms of national guidance, there is nothing that specifically relates to the use of ED treatments for PR. NICE Clinical Guideline 175 (2014) for Prostate Cancer states that men with prostate cancer who experience loss of erectile function should be offered phosphodiesterase type 5 (PDE5I) inhibitors to improve their chance of spontaneous erections, however this recommendation does not specify the use of PDE5Is regularly rather than as required for erectile dysfunction. The NICE Guideline Development Group highlighted that research needs to be carried out into the timing and effectiveness of treatments for ED and noted that they did not rate this topic as a health economic priority and therefore the cost-effectiveness literature on this topic was not reviewed. As the evidence review is reported from the 2008 publication of the guideline and was not updated in the 2014 update, the Committee agreed it was appropriate to consider any more recently published systematic reviews or RCTs.<br><br>A comprehensive UK Medicines Information (UKMI) report was published in August 2014, this focused on the use of PDE5I drugs in PR and concluded that studies are not well enough designed to draw firm conclusions over which regimens offer the best treatment outcomes. Other recent systematic reviews also draw attention to the fact that the main RCT's around the use of PDE5Is in PR have conflicting results and it is therefore difficult to draw conclusions.<br><br>A systematic review carried out in 2013 looked at a variety of different treatments for PR including alprostadil injections, PDE5 inhibitors and VED's (vacuum pumps). The review concluded that there was very little evidence for injections and again it was reported that there was more evidence for the use of PDE5 inhibitors in PR but the results were conflicting. The review states that whilst there was a lot of evidence for VED's in rodents, these results have not been confirmed in humans.<br><br>It was noted that there were many limitations to the studies included in the systematic reviews identified. One such limitation was the lack of standard protocol for PR, as treatment was approached differently for each trial. For example, for PDE5 inhibitors, initiation ranged from the day after surgery to over 24 months later. There were also limitations around the defined period of penile rehabilitation. The optimal programme and duration for penile rehabilitation is still uncertain.<br><br>The Committee also noted other studies published after the most recent systematic review. For VED and alprostadil injection use in PR, no RCTs were found. A number of small studies, retrospective reviews and case series were identified but were not found to be of high quality. Limitations included inconsistency in PR protocol and use of disease rather than patient orientated primary outcomes. |
| 7.2 | In summary, it was felt that, in line with the Ethical Framework, there was insufficient evidence of clinical and cost effectiveness to support the use of daily PDE5 inhibitors, alprostadil injections or VEDs in PR. The lack of evidence of cost effectiveness for PR treatments was felt to be a key factor in considering local affordability given that most of the CCG's will be going into the next financial year with unidentified savings. The Committee therefore agreed the policy recommendation would remain as per the current policy, which states that PR is not routinely funded.<br><br>**Action: Clinical effectiveness team to update the Penile Rehabilitation Following Prostate Surgery policy and circulate as per usual process.** |

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| 8. | **Policy Update – Current Policies Review** |
| 8.1 | TVPC Policies for potential withdrawal |
| | There are currently three Thames Valley policies which could be considered for withdrawal. The first two, cascade-testing for familial hypercholesterolemia and natriuretic peptide testing in the diagnosis of heart failure in primary care have been endorsed by NICE and considered to be normal practice, therefore the local policies may no longer be required. The policy for liquid based cytology has been superseded by NICE technology appraisal (TA) guidance and thus should be removed.<br><br>The Committee agreed to recommend the removal of the policies. It was agreed that for policy withdrawal items a brief single Governing Body paper should be produced for CCG information and agreement. |
| 8.2 | NHS England Policies for Potential Withdrawal |
| | This paper identified 11 TV policies where CCGs may wish to assess whether the policies are suitable for withdrawal or update, based on the associated services currently provided by NHS England.<br><br>The Committee agreed to recommend the withdrawal of the following policies for interventions now within the remit of NHS England:<br>• Maraviroc in the management of human immunodeficiency virus type 1 (HIV-1) infection resistant to standard therapy<br>• Pegvisomant in the management of Acromegaly<br>• Eculizumab for the management of Paroxysmal Nocturnal Haemoglobinuria (PNH)<br>• Parenteral drugs for hereditary angioedema<br>• Palivizumab for the prevention of serious Respiratory Syncytial Virus (RSV) disease in at risk pre-term infants<br>• Trans-cranial Doppler ultrasonography with frequent transfusion to prevent stroke in children with sickle cell disease<br>• Temporomandibular Joint Replacement<br>• Manipulation of the Temporomandibular Joint together with intra-articular injection of steroids under general anaesthesia<br>• Hemicraniectomy for malignant middle cerebral artery infarction<br><br>The Committee agreed to recommend that the policy for the use of continuous subcutaneous insulin infusion for diabetes should be kept and refreshed in view of the CCG retaining the commissioning responsibility for the service provision for adult patients.<br><br>Similarly the Committee agreed to recommend that the policy for deferasirox in the management of iron overload in myelodysplastic syndrome in adults should be kept and refreshed in view of the CCG retaining the commissioning responsibility for this particular patient group. |
| 8.3 | NICE Implementation Policies Review |
| | All of the TV CCGs currently have policies to outline the process for implementation of NICE Interventional Procedure Guidance and implementation of NICE Medical Technology Guidance and Diagnostic Technology Guidance. This review aimed to assess whether the policies are suitable for withdrawal or minor update.<br><br>The statements contained in the local policies reflect information and responsibilities outlined in other nationally available sources. IPGs are not for mandatory uptake by commissioners, but should be reviewed at local NHS level. MTGs are not intended to replace or limit other established technologies with a similar evidence base. DTGs are recommended as options only. The TVPC policies offer a succinct summary of relevant CCG responsibilities and procedures around implementation of NICE appraised technologies. The Committee felt this may prove a useful quick-reference tool when misunderstandings arise around the status of NICE appraisals and recommendations. |

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| | The Committee agreed to recommend the adoption of the draft policy proposal for all technology funding requests which will merge and update the current policies.<br><br>**Action: CE team to provide a Governing Body paper to outline the prosed policy withdrawals and update for CCG agreement and action as per usual process.** |
| 9. | **Cryopreservation Policy – Proposed amendment to wording for policy** |
| 9.1 | The Committee noted that this policy was not being refreshed or reviewed. However, it recently became clear that fertility providers and local hospitals have misinterpreted the first sentence: "The patient is a post pubertal male or a post pubertal, pre-menopausal female under the age of 35 years", and interpreted this to mean that the male also had to be under the age of 35. As this was not the intention of the policy it was suggested that this sentence be clarified by replacing this point with "The patient is a post-pubertal male OR a female, post pubertal and pre-menopausal under the age of 35 years", as the point under "Eligibility Criteria".<br><br>The Committee noted that the amended policy wording had been circulated to CCG representatives who were all happy with the change. As this was only a change in wording of the current policy and not a content change, it was agreed that this could be changed on the policy website without further CCG ratification.<br><br>**Action: CE team to send amended policy to IFR teams for uploading onto the policy website.** |
| **10.** | **Review of ToR, SOP and Ethical Framework** |
| 10.1 | The Chair asked if there were any proposed suggestions or amendments to the Committee documents.<br>ToR – One amendment was suggested under Section 2.2 Membership: There should be two Individual Funding Request Manager delegates rather than one, as the Committee feeds into two distinct CCG IFR processes. The Committee agreed with the suggestion.<br><br>Discussion took place about the impact of the NHS England requirement for health and care systems to come together, to create its own ambitious local blueprint, Sustainability and Transformation Plans (STP), for accelerating the implementation of the NHS Forward View. STPs will be place-based, multi-year plans built around the needs of local populations and will aim to drive a genuine and sustainable transformation in health and care outcomes between 2016 and 2021. They will be subject to formal assessment in July 2016 following submission in June 2016. The local TV footprint will be Buckinghamshire, Oxfordshire and Berkshire West, whilst Berkshire East is located in a Frimley Health footprint. The Committee felt that as the STP development is in early phase the Committee will continue its work as before, whilst bearing in mind potential future developments and opportunities for wider co-operation. |
| 10.2 | SOP – one amendment was suggested to point 8.2 Consultation: It was noted that if Committee Lay Members were referred to as "representatives of the public" then there would be some requirement of them to consult the public, when it was felt that their role was to offer a lay person perspective and view. It was suggested that the word "representative" be removed and replaced with "a public view will be sought". The Committee agreed with this change. |
| 10.3 | Ethical Framework – Minor amendment was proposed to update the footnotes 1 and 4 to reflect more recent national documents. In addition, discussion took place regarding the sentence relating to the footnote 1: "Further, despite an incremental increase in funding, the NHS needs to make substantial financial savings in order to continue to meet increasing demands for care and treatment." The Committee agreed that this sentence does not mention the fact that the NHS are going to have to make significant cuts, not just savings, and it was suggested that the sentence should be more forthright about the challenges the NHS is facing and the Committee role in trying to support the CCGs in resolving them. The Committee agreed to amend the sentence to read "Further, the NHS needs to make savings to narrow the substantial financial gap in order to continue to meet the demands for care and treatment."<br><br>**Action: CE team to make the amendments to ToR, SOP and Ethical Framework as discussed.** |

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| **11.** | **Any Other Business** |
| 11.1 | The CE team have been approached by Berkshire West CCGs to raise the issue of Patella resurfacing to the attention of the Committee. Some CCGs we concerned that at the higher HRG cost, the procedure may no longer be cost effective and for affordability reasons some CCGs may have to re-consider the appropriateness of funding patellar resurfacing. TVPC considered this topic in September 2015 and at that time the Committee agreed that the key to resolving the issue of re-coding and high cost of surgery centred around negotiation and agreement between the local providers and local commissioners. The Committee previously agreed that clinically, the decision to resurface the patella or not was intraoperative clinical decision. The Committee was asked if there was any interest in re-visiting this topic with a view to reviewing potential thresholds for surgery. The Committee acknowledged the issue and that the HRG coding for TKR as reconstructive surgery is disproportionate and does not reflect the actual cost of patella resurfacing. However, the Committee retained the view that introducing a threshold policy would not be clinically appropriate and therefore did not wish to review the topic. The recommendation from the Committee remains that the issue would be ideally resolved with local negotiation, to agree local price which more accurately reflects the actual additional cost of patella resurfacing as part of TKR. |
| **12.** | The Chair reminded the Committee that from July 2016, meetings will be held at Jubilee House, in Oxford. The issue of parking at Jubilee House was raised, however, the Committee was reassured that there is currently sufficient parking as there are two empty buildings opposite to Jubilee House. However, if this changes an alternative venue in Oxfordshire will be sought.<br><br>The next meeting will be **Wednesday 25th May 2016, Board Room, Aylesbury Vale CCG, Second Floor, Aylesbury Vale District Council offices, The Gateway, Gatehouse Road, Aylesbury, Buckinghamshire, HP19 8FF .** |
| **13.** | **Meeting Close** |
| | The Chair thanked everyone for their contributions to the discussions and closed the meeting. |