***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 25th May 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 |
| Heather Motion | Clinical Effectiveness Manager | South Central &West Commissioning Support Unit (SCSWCSU) |
| Tiina Korhonen | Clinical Effectiveness Lead | SCWCSU |
| Laura Tully | Clinical Effectiveness Lead | SCWCSU |
| Rachel Finch | Clinical Effectiveness Administrator | SCWCSU |
| Sarah Annetts | IFR Manager | SCWCSU |
| Professor Chris Newdick | Special Advisor – Health Law | University of Reading |
| Dr Ingrid Slade | Public Health Registrar, Special Advisor - Ethics | University of Oxford |
| Dr Paul Harris | GP | Berkshire West CCGs |
| Cathy Winfield | Chief Officer | Berkshire West CCG |
| Tim Langran | Lead Support Pharmacist | Berkshire East CCG |
| Linda Collins | NICE Lead | Oxfordshire CCG |
| Miles Carter | West Oxfordshire Locality Clinical Director | Oxfordshire CCG |
| Jane Butterworth | Head of Medicines Management | Aylesbury Vale CCG & Chiltern CCG |
| Dr Graham Jackson | Clinical Chair | Aylesbury Vale CCG |
| Philip Murray | Chief Finance Officer | Chiltern CCG |
| Lindsey Barker | Medical Director | Royal Berkshire NHS Foundation Trust |
| Tracey Marriot | Director of Innovation Adoption | Oxford Academic Health Science Network |

Topic Specialists in Attendance for Agenda Items:

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| Mr Molham Entabi | Consultant Ophthalmic Surgeon | Royal Berkshire NHS Foundation Trust |
| Mr Andrew Gordon | Consultant General Surgery | Frimley Health NHS Foundation Trust |
| Mr Patodi | Consultant Gastroenterologist | Royal Berkshire NHS Foundation Trust |
| Dr Fatima Hussain | Consultant Gynaecologist | Frimley Health NHS Foundation Trust |

Apologies:

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| Sarah Robson | Head of IFR | SCWCSU |
| Dr Tony Berendt | Medical Director | Oxford University Hospitals NHS Trust |
| Dr Lise Llewellyn | Director of Public Health | Bracknell Forest Council |
| Dr Clive Meux | Medical Director | Oxford Health NHS Foundation Trust |
| Frances Fairman | Assistant Director – Clinical Strategy | NHS England TV Area Team |
| Jeremy Servian | IFR Manager Clinical Lead | Oxfordshire CCG |
| Catriona Khetyar | Head of Medicines Optimisation | Berkshire East CCGs |

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| **1.0** | **Welcome & Introductions** |
| 1.1 | The Chair opened the meeting and welcomed members of the Committee. Rachel Finch was introduced as the new Clinical Effectiveness Administrator and minute taker.<br>The Chair advised the Committee that Cathy Winfield has agreed to remain as the Strategic Lead for the Thames Valley Priorities Committee until March 2017. |
| **2.0** | **Apologies for Absence** |
| 2.1 | Recorded as above. |
| **3.0** | **Declarations of Interest** |
| 3.1 | None were declared. |
| **4.0** | **Draft Minutes of the Priorities Committee meeting held 23rd March 2016 – Confirm Accuracy**<br>The following amendments were agreed:<br>• Page 3 item 6.1 – "that" was inserted twice in the first line – CE Team to remove.<br>• Page 3 item 6.1 – typing error in the last line of the first paragraph "shred" should read "shared" – CE Team to correct.<br>• Page 8 item 10.3 – insert "to" in the fourth line – to read "…NHS needs to make substantial financial savings in order **to** continue to meet….." – CE Team to insert. |
| **5.0** | **Draft Minutes of the Priorities Committee meetings – Matters Arising** |
| 5.1 | Minutes of the Priorities Committee held in November 2015, Action 5.2 - Fertility care pathway: LT will bring the Oxfordshire CCG policy to the Committee and circulate to clinicians in Buckinghamshire and Berkshire for clinical consultation.<br>**Action Complete** |
| 5.2 | Minutes of the Priorities Committee held in January 2016, Action 7.3 - Severe & complex obesity thresholds for surgery: CCGs to collate information from EMIS regarding numbers of patients in different BMI groups with co-morbidities.<br>**Action Complete**<br>**It was noted that the search criteria remit for EMIS is too broad for suitable prediction data to be extracted. NHS guidance on transferring the commissioning responsibilities to CCGs has been published this week; Clinical Effectiveness team will review the draft scope and guidance and report at the 27th July 2016 meeting as planned.** |
| 5.3 | Minutes of the Priorities Committee held in March 2016, Action 6.4 - Identifying opportunities for TVPC work programme, benchmarking exercise: CE team to review the work programme and schedule the agreed topics for the programme and for scoping. CE team to bring forward the review of the policies for hernia and bunion surgery thresholds.<br>**Action Complete**<br>**All agreed topics have been included in the work programme and schedule. Hernia and bunion surgery threshold policies have been prioritised, with bunions planned for review at July 2016 meeting and hernias September 2016.** |
| 5.4 | Minutes of the Priorities Committee held in March 2016, Action 7.2 - Policy update re penile rehabilitation (PR) following prostate surgery: Clinical Effectiveness team to update the penile rehabilitation following prostate surgery policy and circulate as per usual process.<br>**Action Complete.** |
| 5.5 | Minutes of the Priorities Committee held in March 2016, Action 8.3 – Policy Updates: TVPC policies for potential withdrawal, policies relating to NHS England responsibilities for potential withdrawal and NICE technology implementation policies review: Clinical Effectiveness team to provide a Governing Body paper to outline the proposed policy withdrawals and update for CCG agreement and action as per usual process.<br>**Action Complete.** |
| 5.6 | Minutes of the Priorities Committee held in March 2016, Action 9.1 – Cryopreservation policy proposed amendment to policy wording: CE team to make the minor amendment agreed to wording of the policy and to send amended policy to IFR teams for uploading onto the policy website.<br>**Action Complete.** |

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| 5.7 | Minutes of the Priorities Committee held in March 2016, Action 10.3 - Review of ToR, SOP and Ethical Framework: CE team to make amendments to ToR, SOP and Ethical Framework as discussed.<br>**Action Complete.** |
| **6.0** | **Paper 14-056 - Evidence Review follow up: Verteprofin for Chronic Central Serous Chorioretinopathy** |
| 6.1 | LT explained that this topic was discussed in July 2015; however no clinical input was available at that time. The Committee had felt local specialist input to consider potential patient criteria for Central Serous Chorioretinopathy (CSR) & Idiopathic Polypoidal Choroidal Vasculopathy (IPCV) was required.<br>Since the July 2015 meeting LT has met with two local clinical specialists from RBFT to discuss potential patient criteria and the proposed criteria were discussed. |
| 6.2 | **Chronic Central Serous Chorioretinopathy (CSR)**<br><br>The local specialist confirmed that steroids were not appropriate in these indications and that although CSR is usually self-limiting, if chronic CSR is allowed to progress the outcomes are loss of colour vision and a permanent blind spot.<br><br>The clinical specialist informed the Committee that CSR affects both male and female patients, predominantly of working age (between 20 to 50) equally. An Acute CSR condition is unilateral; Chronic CSR is usually bi-lateral affecting both eyes & both genders, but not necessarily both eyes at the same time. Patients with Chronic CSR are monitored for 6 months for persistent symptoms and evidence of fluid leakage before IFR funding is requested. The clinical specialist considered 6 months to be sufficient time to assess the condition clinically and stated that in most cases one PDT treatment is sufficient to close the leak, with a limited number of patients requiring up to a maximum of 3 treatments. CSR should be confirmed by fluorescein angiography (FA) or indocyanine green angiography (ICGA) if necessary.<br><br>NICE guidance for AMD recommends a vision treatment threshold of 6/12 or worse, however the local specialist advised that to continue driving the threshold needs to be increased to 6/9 in the better eye. Given that patients with this condition are predominantly of working age this was felt to be appropriate.<br><br>Clinical specialists from RBFT had suggested that treatment should be stopped where response is less than an improvement in vision of 5 or more letters.<br><br>The Committee agreed that treatment with verteporfin and PDT can be initiated for treatment of CSR where:<br>• there are persistent symptoms and evidence of fluid leakage 6 months after the patients first appointment (unless vision is imminently at risk).<br>• CSR is confirmed by fluorescein angiography (FA) or indocyanine green angiography (ICGA) where necessary<br>• the patient's vision is 6/9 or worse.<br>• a maximum of three treatments is provided.<br>• treatment should be stopped where response is less than an improvement in vision of 5 or more letters.<br><br>The Committee agreed that anti-VEGF treatment would be appropriate where the fluid is located at the very centre of the fovea as it would not be appropriate to use PDT treatment due to the potential for damage to eyesight as a result of scarring. |
| 6.3 | **Idiopathic Polypoidal Choroidal Vasculopathy (IPCV)**<br>The local specialist informed the Committee that IPCV is wet matter degeneration mostly in elderly patients; it is most aggressive and quite different from CSR and was therefore considered separately. IPCV is not self-resolving and it is therefore not appropriate to monitor and delay treatment for 6 months as agreed for CSR. |

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| | The Committee heard that IPCV doesn't respond to anti-VEGF but can respond to PDT over 2 or 3 sessions. PDT can be used to kill off the pathology and stop leakage of fluid, however it does not kill the lesion under the retina which can bleed leading to catastrophic failure and this is untreatable. Diagnosis for IPCV requires Indocyanine Green Angiography.<br><br>The local specialist recommended a vision threshold for treatment of 9/12, in line with NICE recommendations for AMD treatment. A maximum of 3 treatments to stabilize vision and stop deterioration was considered to be appropriate.<br><br>The Committee agreed that treatment with verteporfin and PDT can be initiated for treatment of IPCV where:<br>• IPCV is confirmed by ICGA<br>• the patient's vision is 9/12 or worse.<br>• a maximum of three treatments is provided. |
| 6.4 | The Committee agreed to recommend use of verteporfin and PDT for IPCV and CSR within the criteria specified. It was agreed that the two conditions should be dealt with separately within the policy.<br><br>**Action: Clinical Effectiveness team to prepare policy documents and circulate for comment with the meeting minutes. Comments to be received within the 2 week comment period following issue.** |
| **7.0** | **Paper 14-068 – Evidence review: Sequential use of anti-VEGF treatment and steroid implants in ophthalmology** |
| 7.1 | LT provided an overview of the review looking at the sequential use of Anti-VEGF and steroids in ophthalmology conditions, the three most significant being Age-related Macular Degeneration (AMD), Diabetic Macular Oedema (DMO) and Retinal Vein Occlusion (RVO).<br><br>The Committee noted that spend in this area is very high and is increasing. The estimated costs, per patient for the first year of treatment, are in the region of £7,000 with anti-VEGF therapy and £2,000 for intravitreal steroid treatment.<br><br>It was noted that in terms of IFR requests there have been 6 across the Thames Valley area for sequential use (2 for DMO, 1x RVO & 1x AMD), 2 for steroids & 2 for Anti-VEGF treatment. The number is low and CCG members felt that this most likely means that although sequential use is happening it is not going through IFR. |
| 7.2 | **Diabetic Macular Oedema (DMO)**<br><br>The Royal College of Ophthalmologists (RCO) state that patients with centre-involving macular oedema and reduced vision would benefit most from anti-VEGF (Ranibizumab as licenced) treatment (with or without combination laser treatment at the outset). For those patients who have been unresponsive to other treatment, the intravitreal fluocinolone implant may be considered but taking into consideration the side-effect profile.<br><br>NICE and SMC recommend intravitreal steroids for adult patients who are pseudophakic and unresponsive to non-corticosteroid therapy. For pseudophakic patients it may be beneficial to switch from Anti-VEGF treatment to steroid treatment. This can be useful for the 30-40% of patients that don't respond to Anti-VEGF treatment.<br><br>It was highlighted however that 20-25% of patients who are unresponsive to Anti-VEGF are phakic. Steroid treatment is not recommended by NICE in phakic patients. The local specialist suggested that sequential use of anti-VEGF may be required in these patients due to the limited treatment options available. |

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| | Evidence for switching or sequential use of anti-VEGF drugs in DMO was sparse; two recent small retrospective observation studies were identified. NICE Technology Appraisal guidance on the use of aflibercept in DMO refer to switching or sequential use of anti-VEGFs. An absence of cost effectiveness of sequential treatment with anti-VEGF agents was noted. The NICE Committee noted that because an increase in costs of treatment in this circumstance would not be matched by a similar gain in QALYs it is unlikely that sequential treatment with ranibizumab followed by aflibercept would be cost effective. |
| 7.3 | **Age-related Macular Degeneration (AMD)**<br><br>Corticosteroids are not used in AMD, treatment is principally anti-VEGF based. National guidance does not comment or make any recommendations around the sequential use of Anti-VEGF agents in AMD.<br><br>The Committee noted that evidence for sequential use of anti-VEGF treatment was based on a number of small observational studies of limited quality. The local specialist did not feel there would be significant benefit from using ant-VEGF treatments sequentially in this condition. |
| 7.4 | **Retinal Vein Occlusion (RVO)**<br><br>Ranibixumab, aflibercept and intravitreal dexamethasone are licenced for the treatment of visual impairment due to macular oedema secondary to retinal vein occlusion.<br><br>A Policy was developed by TVPC in 2015 which recommends the use of intravitreal dexamethasone implants as the first option for the medical treatment of macular oedema caused by RVO. Intravitreal injections of ranibizumab anti-VEGF therapy is recommended where the patient has a contraindication or intolerance to dexamethasone implants or where dexamethasone implants are not effective.<br><br>Evidence for switching or sequential use of anti-VEGF drugs in RVO was sparse; three recent small retrospective observation studies were identified. RCO guidance states that there is no evidenced for switching from one anti-VEGF to another although they recommend a trial based on clinical experience. |
| 7.5 | The number of anti-VEGF injections given and the stopping criteria for anti-VEGF therapy was discussed. It was noted NICE guidance advises that treatment should be stopped if a person's vision gets worse and there are changes inside the eye that show treatment is not working, however there are no definitions for 'Worse' or for the changes.<br><br>The Committee agreed that more information around stopping criteria was required.<br><br>It was suggested that a review of the way AMD is commissioned would be beneficial in terms looking at commissioning a year of care per patient rather than individual drugs. There was a lot of support for considering this option and it was recommended that CCGs look into this further.<br><br>**Action: Clinical Effectiveness team to investigate further information around stopping criteria and local protocols around the conditions, particularly for DMO.** |
| **8.0** | **Paper 16-069 Policy update: Reflux surgery** |
| 8.1 | **Proposal for Policy Withdrawal Surgical techniques for the treatment of Oesophageal Stricture.**<br><br>The surgical treatment for congenital oesophageal atresia and stenosis is now commissioned and funded by NHS England. A local policy is therefore no longer required.<br>The Committee agreed to the withdrawal of the policy. |

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| 8.2 | **Clinical policy update - Laparoscopic fundoplication for chronic reflux oesophagitis AND laparoscopic gastro-oesophageal reflux surgery (LGORS).**<br>Since development of the two TVPC policies (2005 and 2009) NICE has published updated guidance on GORD (2014) and a number of other trials and reviews have become available. NICE have made recommendations on the use of laparoscopic fundoplication. Although there is general support from the studies for cost-effectiveness of laparoscopic fundoplication, the recent Cochrane Review (2015) suggests that there is inadequate evidence to fully understand the risks and benefits compared to medical management. In addition there is evidence of decreasing laparoscopic fundoplication activity in the Thames Valley (especially in Buckinghamshire and Berkshire East), and there has been a change in tariff since 2014 with an increase in price.<br><br>The Committee discussed the need for local polices when there was national guidance available, and that current procedure activity levels were not causing concern. The attending specialist confirmed that local clinical practice follows the NICE guidelines. The Committee agreed to recommend the withdrawal of the local policies as superseded by NICE guidelines.<br><br>**Action: CE team to provide a Governing Body paper to outline the proposed policy withdrawals for CCG agreement and action as per usual process.** |
| **9.0** | **Paper 16-070 Evidence review: Use of biologic drugs for ulcerative colitis** |
| 9.1 | Thames Valley Priorities Committee has requested a review of the use of biological therapies in the treatment of ulcerative colitis (UC). It is acknowledged that there are several therapy options available but it is unclear if switching between biologic agents is appropriate and whether there are parameters for using these therapies in a successional manner. NICE has indicated that sequential use of biologics was outside of the scope of their technology appraisals (TAs), therefore, it is the responsibility of the local commissioners to make decisions regarding funding of these therapies after failure of treatment or adverse events.<br><br>There are four biologics licenced and endorsed by NICE TAs for the use in UC; adalimumab, golimumab and infliximab (tumour necrosis factor -alpha inhibitors - TNFs), have been shown to be effective treatments for treatment-refractory moderately to severely active ulcerative colitis with comparable safety profiles. Vedolizumab, an anti-lymphocyte binding antibody which can offer targeted immunosuppression, is also recommended as an option for treating moderately to severely active ulcerative colitis in adults, who have had an inadequate response with, or lost response to, or were intolerant to either conventional therapy or a TNF.<br><br>NICE state that no conclusions about relative efficacy of the three TNF therapies for maintenance of response and/or remission can be drawn. NICE also acknowledged several shortcomings in the evidence base and areas of uncertainty in the cost-effectiveness analysis. NICE states that the choice of treatment between infliximab, adalimumab or golimumab should be made on an individual basis and if more than one treatment is suitable, the least expensive should be chosen.<br><br>Relative efficacy of vedolizumab in comparison to the anti-TNFs is also still uncertain. NICE considered vedolizumab as cost-effective for people in whom treatment with an anti-TNF had failed, around the upper limit of the range normally considered to be a cost-effective use of NHS resources. NICE also recommend vedolixumab as a first line option for treating moderately to severely active ulcerative colitis in adults.<br><br>There is little high quality evidence available on the efficacy of second and third line biologics use in patients with UC whose initial treatment fails or who could not tolerate their first therapy.<br><br>The invited specialist explained that the evidence base for the use of vedolizumab is growing and its use may become more common in the future. However, in current clinical practice infliximab, or a biosimilar, is used most often as the first line therapy and if infliximab has failed the second line choice is vedolizumab. The specialist agreed with the review evidence that the reason of the failure of initial treatment may impact on the effectiveness of second line therapy. Thus, in clinical practice if a patient has infusion reaction or side-effects to the first anti-TNF, a second anti-TNF |

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| | could be tried, however, if the patient has no response to first anti-TNF they are less likely to respond to second anti-TNF. The clinician confirmed that after the use of vedolizumab there would be no further biologic options used and enrolment to a clinical trial or surgery would be considered instead.<br><br>The Committee acknowledged the limited choice of therapies and noted the high cost of vedolizumab. It was felt that the use of vedolizumab was preferably an option after the initial anti-TNF therapy failure, whilst acknowledging NICE TA principles that all recommended treatments must be made available to the patients. The Committee agreed to recommend a policy encouraging the use of the most cost-effective anti-TNF therapy option first line, if more than one therapy was suitable for the patient (as per NICE Guidance) and note that after the use of vedolizumab no further biologic should be offered. Switching between anti-TNF should only occur if the patient was intolerant of the first TNF. The policy would be for the use of biologics for adults only.<br><br>**Action: CE team to draft a policy and circulate as usual process.** |
| **10.** | **Paper 16-071Fertility care pathway: update** |
| 10.1 | The Committee reviewed the local fertility care pathway some time ago, however when it was presented to CCGs for ratification some concerns were raised. The paper was brought back recently with a plan to review however in the meantime Oxfordshire CCG has developed a pathway document. It was agreed that the Committee would consider Oxfordshire's policy to consider whether this could be adopted across Thames Valley.<br><br>The Oxfordshire pathway was discussed. A copy of the Oxfordshire pathway document was sent to several clinicians within Berkshire and Buckinghamshire; however no feedback has been received. One of the differences is around azoospermic couples who would go straight to IVF rather than through the fertility clinic as per the previous proposed pathway. The Committee discussed the implications of this and it was queried whether GPs were currently able to refer straight into IVF clinics via chose and book. The local specialist also noted that in the absence of sperm a fertility appointment is still required and may be of even greater importance as azoospermic males have a higher incidence of testicular tumours and also Y micro deletion which can be passed onto a male child. They would therefore need a scrotal ultrasound and carrier typing carried out in the fertility clinic prior to referral.<br><br>The local specialist fed back some comments on the Oxfordshire pathway including that she felt the male investigations included needed to be enhanced. Within 'Female Investigations' she felt that the 'if not already known' statement relating to rubella status should be removed as it is required within the previous year.<br>She also felt that lifestyle advice also needed to be included prior to referral i.e. BMI, smoking cessation, and folic acid supplementation pre-conception.<br><br>Within Primary Care Referral (Part 2) of the Oxfordshire pathway, it is noted that HFEA rules require tests within the last 6 months, however the local specialist felt this was now within 3 months of the embryo transfer date. She informed the Committee that she sees a lot of duplication of tests as tests done previously by GPs are not valid by the time they are referred for their IVF.<br><br>The Committee agreed that it was necessary to reduce variation in approach and introduce clarity around which tests need to be carried out, at what stage in care and whether this should be in primary or secondary care. It was suggested that it would be useful to see what the necessary choose and book criteria currently was for each provider in order to try to reach a consensus for a Thames Valley wide approach.<br><br>**Action: Dr Hussain to email a copy of her local flow chart to the CE team. CE team to investigate the various providers' referral criteria and liaise with local GPs for further consultation.** |

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| **11.** | **Any Other Business** |
| 11.1 | 2016-17 updated work programme and Annual Report 2015-16 was circulated for information. |
| **12.** | The Chair reminded the Committee that from July 2016, meetings will be held at Jubilee House, in Oxford. There is currently sufficient parking as there are two empty buildings opposite to Jubilee House, directions will be included with the papers. The next meeting will be **Wed 27th July 2016. Board Room, Jubilee House, Oxford, OX4 2LH** |
| **13.** | **Meeting Close** |
| | The Chair thanked everyone for their contributions to the discussions and closed the meeting. |