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 24th January 2018

Conference Room, 2nd Floor, Albert House, Queen Victoria Road, High Wycombe HP11 1AG

In Attendance:

Alan Penn	Lay Member Chair	Thames Valley Priorities Committee
Laura Tully	Assistant Director of Clinical Quality	SCW
Tiina Korhonen	Clinical Effectiveness Lead	SCW
Kathryn Markey	Clinical Effectiveness Manager	SCW
Kate Forbes	Clinical Effectiveness Manager	SCW
Rebecca Hodge	Clinical Effectiveness Manager	SCW
Katie Newens	Clinical Effectiveness Researcher	SCW
Sarah Annetts	IFR Manager (Clinical)	SCW
Lindsey Barker (LB)	Medical Director	Royal Berkshire NHS Foundation Trust
Dr Tony Berendt	Medical Director	Oxford University Hospitals NHS Trust
Jane Butterworth (joined at 2.25pm)	Associate Director of Long Term Conditions & Medicines Management	Buckinghamshire CCGs
Shairoz Claridge	Operations Director Director for Planned Care	Newbury and District CCG Berkshire West CCGs Federation
Linda Collins	Clinical Effectiveness Manager (CCG)	Oxfordshire CCG
Darrell Gale	Acting Strategic Director of Public Health	Berkshire
Dr Graham Jackson	Clinical Chair	Aylesbury Vale CCG
Thalia Jervis	CEO, HealthWatch	Buckinghamshire
Dr Megan John	GP, Berkshire East CCG Lead	Berkshire East CCGs
Dr Jacky Payne	GP	Berkshire West CCGs
Amaka Scott	Commissioning Interfacing Pharmacist	Berkshire West CCG

Topic Specialists in Attendance for Agenda Items:

Mr Tom Pollard	Consultant Orthopaedic Surgeon British Orthopaedic Association Community Champion	Royal Berkshire NHS Foundation Trust
Mr Nicholas Bottomley	Consultant Orthopaedic Knee Surgeon	Oxford University Hospital NHS Foundation Trust

Apologies:

Gillian Barlow	Clinical Effectiveness Manager	SCW
Miles Carter	West Oxfordshire Locality Clinical Director	Oxfordshire CCG
Frances Fairman	Assistant Director Clinical Strategy	NHS England, TV Area Team
Rachel Finch	Clinical Effectiveness Administrator	SCW
Dr Mark Hancock	Medical Director	Oxford Health NHS Foundation Trust
Edward Haxton	Deputy Finance Director	Berkshire West CCGs
John Lisle	Chief Officer	Berkshire East CCGs
Tracey Marriott	Director of Innovation Adoption	Oxford Academic Health Science Network
Eleanor Mitchell	Operations Director	South Reading, Berkshire West CCG
Chris Newdick	Professor of Health Law	University of Reading
Louise Patten (LP)	Accountable Officer	Buckinghamshire CCGs
Rosalind Pearce (RP)	Executive Director HealthWatch	Oxfordshire
Sarah Robson	Head of IFR	SCW
Sangeeta Saran	Head of Operations	Berkshire East CCG
Jeremy Servian	IFR Manager	Oxfordshire CCG
John Seymour	Consultant – Chief of Service – Medicine	Frimley Health Foundation Trust
Dr Mark Sheehan	Special Advisor – Ethics	University of Oxford
Fiona Slevin-Brown	Director of Strategy & Operations	Berkshire East CCGs

1.	**Welcome & Introductions**
1.1	The Chair opened the meeting and welcomed the members of the Committee.
2.	**Apologies for Absence**
2.1	Recorded as above. The meeting of 22nd November 2017 was not quorate. The Chair confirmed that subsequent to the meeting absent members have approved the policy recommendations made by the Committee.
2.2	The meeting of 24th January 2018 was not quorate. **Action: Clinical Effectiveness team to circulate minutes detailing any policy recommendations made by the Committee to absent members for approval.**
3.0	**Declarations of Interest**
3.1	None were declared
4.	**Draft Minutes of the Priorities Committee meeting held 22nd November 2017 - Confirm Accuracy**
4.1	**The draft minutes were accepted as a true record of the meeting.**

5.	Draft Minutes of the Priorities Committee meetings – Matters Arising
5.1	**Minutes of the Priorities Committee held in May 2016, Action 10.1 – Fertility care pathway** - **September 2017 Update:** A working group has been formed; an initial meeting is being arranged. **November 2017 Update:** Two GP's, from Berkshire East and Berkshire West are looking at the primary care fertility pathway, they will consult with clinicians from all of the relevant localities to produce a final draft. A report will be presented to this Committee, provisionally in March 2018.
5.2	**Minutes of the Priorities Committee held in September 2017 – Action 6.5.1 – Paper 17-012 Ectropion and Entropion, Indications for Surgery** Clinical Effectiveness (CE) team to add a note to the Aesthetic Treatments for Adults and Children policy (TVPC16) regarding ectropion and entropion surgery once the Ectropion and Entropion - Indications for Surgery policy (TVPC70) has been adopted by Governing Bodies. It is anticipated this action will be completed by March 2018 **January 2018 Update:** Clinical Effectiveness team to monitor policy acceptance; no Committee involvement therefore **action closed**.
5.3	**Minutes of the Priorities Committee held in September 2017 – Action 7.5 – Paper 17-013 Treatment Pathway for Adults with Attention Deficit Hyperactivity Disorder (ADHD)** The Committee noted that shared care pathway protocols vary across the Thames Valley CCGs and agreed it would be of benefit to have a common shared care protocol. Thames Valley Accountable Care System is currently undertaking work to generate an overall shared care protocol; details to be provided to the Committee when available. **January Update:** Lindsay Barker to provide an update at the March 2018 meeting.
5.4	**Minutes of the Priorities Committee held in September 2017 – Action 8.3.1 – Paper 17-014 – Policy Update: Male Sterilisation – Vasectomy Services** Shairoz Claridge (SC), Berkshire West to share their post vasectomy decommissioning review with the Committee when available. **January 2018 Update:** The Committee felt there was no benefit in pursing this action as the Committee had recommended continuing commissioning of vasectomy services. **ACTION Closed**
5.5	**Minutes of the Priorities Committee held in September 2017 – Action 13.1 – Clinical Policy Website** Clinical Effectiveness (CE) team to provide a copy of the draft Website Introduction Statement to LP to revise the wording. RP to review and comment on the revised document. CE team to circulate the revised wording to the Committee for comment. **ACTION Complete**
5.6	**Minutes of the Priorities Committee held in September 2017 – Action 13.2 - Clinical Policy Website** Clinical Effectiveness team to arrange for paper 17-017b 'Will the NHS pay for my treatment' to be uploaded to Thames Valley CCG IFR websites. **ACTION Complete**
5.7	**Minutes of the Priorities Committee held in November 2017 – Action 6.6 – Paper 17-019 – Painful Shoulder – Arthroscopic Surgery for Adhesive Capsulitis (Frozen Shoulder)** The Committee considered the specialists' discussion and the BESS guidance pathway and agreed referral criteria. The Clinical Effectiveness team to draft a painful shoulder – arthroscopic surgery for adhesive capsulitis (frozen shoulder) policy and circulate for comment. **ACTION Complete**
5.8	**Minutes of the Priorities Committee held in November 2017 – Action 7.4 - Paper 17-020 – Evidence Review: Treatment of Haemorrhoids** Clinical Effectiveness team to draft a management of haemorrhoids policy and circulate for comment. **ACTION Complete**

5.9	**Minutes of the Priorities Committee held in November 2017 – Paper 17-021 – Policies for Potential Withdrawal or Updating** • **Action 8.2:** The Committee agreed the Multiple Chemical Sensitivities (MCS) and Clinical Ecology Environmental Medicine (2001) policy is to be withdrawn as it is dated and no longer necessary. Clinical Effectiveness team to draft the withdrawal paperwork and issue to the relevant CCG Governing Bodies for acceptance. **ACTION Complete** • **Action 8.3:** After discussion the Committee felt the policy for Elfornithine for Facial Hirsutism (2005) was still helpful in support of prescribers. The Clinical Effectiveness team to review the evidence and if it has not changed, note that the policy has been reviewed. If the evidence has changed this item is to be scheduled for discussion with TVPC. **ACTION Complete** • Following discussion the Committee agreed the following policies could be withdrawn: ▪ **Action 8.4:** Rectal Investigation and Surgery (2006) is no longer required. ▪ **Action 8.5:** Prostatism (2006) is no longer required as broader guidance is available ▪ **Action 8.6:** Speech and Language Therapy in Parkinson's disease (2012) is no longer required as more up to date NICE Guidance is available. o Clinical Effectiveness team to draft the withdrawal paperwork and issue to the relevant CCG Governing Bodies for acceptance. **ACTIONS Complete** • **Action 8.7:** Clinical Effectiveness team to add Chronic Fatigue Syndrome, Short Burst Oxygen Therapy for Relief of Breathlessness and Non pharmacological services for dementia patients to the policy review programme for evidence review, discussion and potential update of policy. **ACTION Complete**
5.10	**Minutes of the Priorities Committee held in November 2017 – Action 9.6 - Paper 17-022 – Evidence Review: Flash Glucose Monitoring, Freestyle Libre** Clinical Effectiveness team to draft a Flash Glucose Monitoring policy for type 1 diabetes and a draft CGM policy. **ACTION Complete - Refer to item 6 below**
5.11	**Minutes of the Priorities Committee held in November 2017 – Action 10.1 - Paper 17-023 – Assisted Reproductive Services for Infertile Couples – Update** The Committee agreed the Clinical Effectiveness team is to update the wording of the Assisted Reproduction Services for Infertile Couples (2013) policy to reflect the language in the service contract specification. A footnote is to be added to the policy to indicate the update is merely to align the wording of the policy document with the service contract specification. January 2018 Update: The Clinical Effectiveness team amended the policy but omitted to issue the update version for comment. The Committee accepted the update was merely to align the wording of the policy with the language used in the service contract specification. The content of the policy is not affected. **ACTION Complete**
5.12	**Minutes of the Priorities Committee held in November 2017 – Action 12.1 – Any Other Business – Hip Arthroscopy for Femoro-acetabular Impingement Guidelines** Sarah Robson (SR) to review the Hampshire policy website and identify whether there is a hip impingement for arthroscopic femoro-acetabular surgery policy in place and if so provide details. **January 2018:** Hampshire has a policy which does not have the same requirements as TV policy regarding Clinical competence. **ACTION Complete**
5.13	**Minutes of the Priorities Committee held in November 2017 – Action 12.2 – Any Other Business – Referral pro forma** Sarah Robson to discuss the MSK referral pro forma criteria with Eleanor Mitchell and provide an update to the Clinical Effectiveness team and update the clinical team. **January 2018:** Update at March 2018 meeting

5.14	**Minutes of the Priorities Committee held in November 2017 – Action 12.3 – TVPC Work Programme for 2018-19 year** Clinical Effectiveness team to circulate a copy of the TVPC Work Programme for 2018-19 with the draft minutes. **ACTION Complete**
6.	**Paper 17-026 a, b & c - Draft Policy review: Flash Glucose Monitoring and proposed Patient Agreement Forms**
6.1	Following circulation of the draft policy statement Flash Glucose Monitoring Systems (FGS) for patients with Type 1 diabetes, feedback received by the Clinical Effectiveness team included amendments and proposed additions to the content agreed by the Committee at the November TVPC meeting. As the changes were more than formatting the Committee was asked to revisit the recommendations. In addition, the November Committee agreed it would be useful to have a 'contract' with patients at the start of their use of FGS however nothing was agreed at the time. Following the meeting Oxfordshire CCG (OCCG) in consultation with their local clinicians and Diabetes UK have developed patient agreement forms for both adults and children. The Committee was asked to consider the Oxfordshire patient agreement forms for adoption across the TV CCGs.
6.2	Graham Jackson expressed concern regarding the % units quoted for HbA1c in the policy document and the patient leaflets and considered this should be mmol/mol with the HbA1c % in brackets and that this should be consistent across the documents.
6.3	The Committee discussed the criteria for continued use of FGS and agreed that it should state that **all** patients should perform >4 scans per day to demonstrate evidence of FGS use in self-management **and** then **any one** of the following: • Reduction in severe/non- severe hypoglycaemia frequency by >1 episode per week. • Reduction in DKA events. • Reversal of impaired awareness of hypoglycaemia. • HbA1c reduction of 5mmol/mol (0.5%) within 6 months. • Reduction in frequency of self-monitoring of blood glucose by finger prick test. • Continued delay of CSII/pump therapy initiation due to sustained HbA1c 69 mmol/mol) (<8.5%) or reduction in disabling hypoglycaemia.
6.4	The Committee discussed the discontinuation criteria with regard to "Failure to achieve any of the above criteria **or agreed personal targets** (dependent on the indication)". It was considered that personal targets would be difficult to audit as well as being open to interpretation, leaving potential for personal targets being lowered in order to meet the criteria. The Committee agreed that the highlighted section of this criterion should be removed.
6.5	A further comment by TV Diabetes Network (Sarah Roberts) was discussed regarding suggestion that the threshold of 'Frequent admissions (>2 per year) with diabetic ketoacidosis (DKA) or hypoglycaemia, could be amended to ≥2 DKA or hypoglycaemia admissions. A study was referenced indicating increased mortality with recurrent DKA admissions. The study comparators were grouped as single, 2-5 admissions or more than 5 admissions. It was noted that it remains unclear what the difference in outcomes and numbers of patients would be between 2 to 3 admissions. It was also noted that the original wording frequent admissions (>2 per year) was agreed at the Committee meeting and is taken directly from the RMOC statement. The same threshold is supported in the ABCD and ACDC guidelines. The Committee did however, agree an amendment to make it explicit that single episode of 'either' DKA or hypoglycaemia counts towards the >2 per year. The Committee agreed the other additional points noted in the draft policy and the use of patient agreement forms.

	ACTION 6.5: Clinical Effectiveness team to amend and check the HbA1C units in the policy and patient agreements. **ACTION 6.5.1: Clinical Effectiveness team to amend the FGS policy continuation criteria to state that all patients should perform >4 scans per day and then any one of the other criterion.** **ACTION 6.5.2: Clinical Effectiveness team to remove the words "or agreed personal targets" from the FGS policy discontinuation criteria.** **ACTION 6.5.3: Clinical Effectiveness team to add 'either' to the threshold for 'Frequent admissions (>2 per year) with diabetic ketoacidosis (DKA) or hypoglycaemia' and amend the draft Flash Glucose Monitoring System (Freestyle Libre®) policy and patient agreement forms, as outlined in the amended draft policy, and circulate for final comments. Comments to be received within the 2 week feedback period following issue.**
7.	**Paper 17-027 – Evidence Review: Knee Arthroscopy for the Treatment of Meniscal Tears**
7.1	Thames Valley Clinical Commissioning Groups have requested a review of arthroscopic surgery for meniscal tears to enable commissioners to establish the clinical and cost- effectiveness of the procedure in comparison to conservative management and to agree a common policy across Thames Valley CCGs. Meniscal tears can occur as a result of acute injury or degeneration. Damage can be treated conservatively which may include rest and physiotherapy. More severe cases would involve the removal of the damaged part of the meniscus, referred to as arthroscopic partial meniscectomy (APM). Meniscal repair is only possible in a minority of patients.
7.2	The BMJ published a clinical practice guideline which concluded that arthroscopic knee surgery in patients with degenerative knee disease it not recommended. The European Society for Sports Traumatology, Knee Surgery and Arthroscopy (ESSKA) (2016) Meniscus consensus project advises that surgery should not be proposed as a first line treatment for degenerative meniscal tears. After three months of persistent pain / mechanical symptoms, APM may be proposed. Surgery can be proposed earlier for patients presenting considerable mechanical symptoms. A Canadian Health Technology Assessment of arthroscopic surgery in degenerative meniscal injury concluded that moderate-quality evidence shows no significant difference in pain or functional status in patients who received arthroscopic debridement with or without meniscectomy compared with placebo (sham surgery). Low-quality evidence shows no significant difference in pain or functional status among patients who received APM compared to usual care or physiotherapy. Two systematic reviews with some limitations that addressed APM in degenerative meniscal tears drew slightly different conclusions. One found there were small and statistically significantly favourable results for APM up to 6 months but no differences were found between the two groups at longer follow up. The other systematic review concluded that there was no benefit to arthroscopic meniscal debridement. Two randomised controlled trials (RCTs) showed no clinically relevant difference between patient groups in knee patient reported outcome measure (PROM) scores between patients undergoing APM or patients undergoing a programme of exercises. Very little evidence was found that addressed meniscal tears as a result of injury or trauma. In 2016-17 expenditure across all TV CCGs was approximately £3.8m. Most CCGs are showing a downward trend in activity and expenditure.

7.3	The specialists in attendance made the following points: • Patients with a previously normal knee, no bone on bone arthritis and an MRI scan which shows an unstable injury are the patients suitable for surgery as these patients tend to get better but there is no RCT which shows this. • Most knee Patient Reported Outcome (PROM) data is based on arthritis. A PROM that is designed to look at an arthritic knee cannot detect a difference in treatments when the indication is non-arthritic. In the experience of the specialists there are patients who get significantly better with arthroscopic surgery but not if it is a bone on bone arthritic condition. Patient selection for the right indications is important and the need for surgery has to be carefully assessed. • If a patient has symptoms of a meniscal tear beyond 3 months, it is unlikely that a meniscal tear will get better. It is of the view of the specialists that referral to an orthopaedic surgeon should happen after 6 weeks of unresolved symptoms. • There may be some patients with partial thickness cartilage damage with a meniscal tear where patients may get better but this is unpredictable. Very often patients need a discussion with the surgeon about the detail of their knee, how best to manage the pain and why the patient may not be suitable for an operation. Physiotherapy or exercise will help strengthen the muscles but is unlikely to help a flapping meniscal tear. • Patients who have knee pain with full thickness cartilage loss in a degenerative knee who should not be referred for arthroscopic surgery may benefit from a specialist opinion. • Previous arthroscopy should not be exclusion to policy.
7.4	The Committee considered the evidence, other CCG policies and discussion with the attending specialists. The Committee agreed the treatment criteria to be drafted as follows: **For meniscal tears as a result of trauma and injury:** • Funding for arthroscopic surgery will be considered for meniscal tears after 3 months of unresolved symptoms. Conservative treatment may include non-steroidal anti-inflammatories (NSAIDs), physiotherapy and exercise. **Meniscal tears in the degenerate knee with full thickness cartilage loss as evidenced by radiological imaging:** • Arthroscopic surgery will not normally be funded **ACTION: Clinical Effectiveness team to draft a policy recommendation: Knee Arthroscopy for the Treatment of Meniscal Tears, and circulate for comment. Comments to be received within the 2 week feedback period following issue.**
8.	**Paper 17-028 – Evidence Review: Diagnosis of Foetal Alcohol Syndrome Disorder (FASD) and Alcohol Related Neurodevelopment Disorder (ARND)**
8.1	An evidence review of this topic was requested by the Committee following an Individual Funding Request (IFR) for specialist assessment and treatment at a National Clinic in Surrey which charges £3,500 for a diagnostic assessment of Foetal Alcohol Spectrum Disorder (FASD). FASD is an umbrella term for a number of various presentations. Foetal Alcohol Syndrome (FAS) is the only type of FASD that has a specific profile identified by physical features and cognitive difficulties and is a distinct group within the umbrella of different types. The British Medical Association Report into FASD acknowledges that there is a significant gap in knowledge of how many people this affects in the UK. Diagnosis of FASD is complicated; there does not appear to be consensus within the literature of clear diagnostic criteria (with the exception of FAS). It is difficult to ascertain alcohol consumption during pregnancy and environmental influences are a significant factor. Evidence suggests that children with FASD are

	disproportionately represented in the care system. Any developmental difficulties are likely to be identified later in childhood. There is some weak evidence that certain deficit's such as difficulties with executive functioning are more prevalent in FASD than in other conditions such as ADHD. There is a range of generic tools for children which assess cognitive perceptual and behaviour difficulties; however there is a lack of assessment tools for this specific condition. One literature review identified some cognitive problems which may be more prevalent in children with FASD rather than ADHD.
8.2	The key questions for the review were: Is there evidence that a specialist diagnosis of FASD improves long term outcomes? • The guidelines found suggest that FASD is under diagnosed. • Clinicians indicate throughout the literature that early diagnosis and management is preferred in order to optimise outcomes; this is based on clinical opinion rather than specific research. • Treatment approaches include parent interventions, behavioural and cognitive strategies. Is there an age cut off for useful diagnosis? • No age cut off was found within the evidence however clinical opinion does suggest that early treatment is optimal. Is there evidence that children with FASD need to have their behavioural difficulties treated differently than other children with learning difficulties? • There are some neurological deficits which are more common in FADS but there a paucity of evidence for treatment approaches. One systematic review on different treatment modalities reported that the included studies had small samples sizes and short follow up, due to the variety of cognitive approaches it was very difficult to draw any meaningful conclusions. The authors concluded that there is very limited good quality evidence for specific interventions. In relation to the need for specialist services, it is likely that a proportion of patients who have cognitive or behavioural difficulties are being treated by existing services such as CAM's, paediatrics, neurological, and learning disability services; it is however very difficult to know the patient numbers and the service they are attending.
8.3	The Committee agreed that there are local services available within different specialities for treatment of children and young adults with difficulties arising from FASD. Specific discussion was held regarding the need to treat individual presenting deficits as opposed to focusing on the need for a lengthy assessment, particularly as there is limited consensus regarding diagnostic criteria. Concern was raised regarding 'labelling' children with the condition and the possibility of blame for mothers who consumed alcohol during pregnancy.
8.5	The Committee considered the evidence, the specialist feedback and agreed the following criteria: • A 'not normally funded' policy to be developed for referral for a Specialist (Regional) FASD assessment • Suggested wording may include: FASD is within the spectrum of neuro developmental or neurological difficulties and can be usually assessed and treated by local services **ACTION 8.5: Clinical Effectiveness team to draft a policy recommendation for the diagnosis and treatment of FASD in children, adolescents and adults, and circulate for comment. Comments to be received within the 2 week feedback period following issue.**

9.	**Paper 17-029 – Policy Update: Gallstones (treatment of patients with previously symptomatic gallstones who are now free of symptoms)**
9.1	Thames Valley Clinical Commissioning Groups have requested a review of the policy for gallstones; treatment of patients with previously symptomatic gallstones who are now free of symptoms. Oxfordshire CCG reviewed their policy most recently in 2016 and made some minor alterations, which did not change the referral thresholds of the policy. The combined policy for all other CCG's in the Thames Valley Group is dated 2011. The term used for removal of the gallbladder is 'cholecystectomy'. The current TVPC policy states that: • In asymptomatic people with gallstones and previous uncomplicated biliary symptoms, the funding of cholecystectomy is recommended only in those with more than one episode of such symptoms. • This recommendation does not restrict funding for patients who are admitted to hospital as a result of on-going biliary symptoms, and where it is deemed clinically appropriate to proceed to cholecystectomy during this admission.
9.2	NICE and the Royal College of Surgeons have published guidance for the management of gallstones. NICE defines the presence of gallstones as follows: • Asymptomatic: Stones that are found incidentally, as a result of imaging investigations unrelated to gallstone disease in people who have been completely symptom free for at least 12 months before diagnosis. • Symptomatic: gallbladder stones found on gallbladder imaging, regardless of whether symptoms are being experienced currently or whether they occurred sometime in the 12 months before diagnosis.
9.3	NICE guidance issued in 2014 (CG188) recommends that people with asymptomatic gallbladder stones found in a normal gallbladder and normal biliary tree are reassured that they do not need treatment unless they develop symptoms. NICE recommends that laparoscopic cholecystectomy should be offered to people diagnosed with symptomatic gallbladder stones. Additionally NICE recommends that people with acute cholecystitis should be offered laparoscopic cholecystectomy within 1 week of diagnosis. People should be advised to avoid food and drink that triggers their symptoms until they have their gallbladder removed. NICE CG188 (2014) also recommends that bile duct clearance and laparoscopic cholecystectomy to people with symptomatic or asymptomatic common bile duct stones. NICE recommend that to clear the bile duct either: • surgically at the time of laparoscopic cholecystectomy or • with endoscopic retrograde cholangiopancreatography (ERCP) before or at the time of laparoscopic cholecystectomy. Royal College of Surgeons (RCS) Commissioning Guidance (2013, updated 2016) for Gallstone disease, concurs with NICE CG, noting that patients in Primary Care with an incidental finding of stones in an otherwise normal gallbladder require no further investigation or referral and that patients with symptomatic gallstones who present with a self-limiting attack of pain that lasts for hours only can often be controlled successfully with appropriate analgesia. When pain cannot be managed or if the patient is otherwise unwell (e.g. sepsis) the patient should be referred to hospital as an emergency. Both the NICE and RCS report that there is variation nationally in the way gallstone disease is managed. Local data for elective cholecystectomy activity per 100,000 population by TVPC CCG suggests some variation, but not to the extent reported nationally by RCS.

9.4	The Committee considered the national guidance and clinical feedback received and agreed that TVPC policy should reflect NICE CG definitions and endorse NICE recommendations; • Reassure people with asymptomatic gallbladder stones found in a normal gallbladder and normal biliary tree that they do not need treatment unless they develop symptoms. • Offer laparoscopic cholecystectomy to people diagnosed with symptomatic gallbladder stones **ACTION: Clinical Effectiveness team to draft a Gallstones (treatment of patients with previously symptomatic gallstones who are now free of symptoms) policy and circulate for comment. Comments to be received within the 2 week feedback period following issue.**
10.	**Paper 17-030 – Update: Cataract Surgery – post final NICE guidance publication**
10.1	The TVPC Committee agreed in May 2017 TVPC Policy 60 for Cataract Removal in Adults – Threshold for Surgery, with a view of revisiting the final NICE appraisal once it is published. The final guidance Cataracts in adults: management guideline 77 was published in October 2017. The NICE referral criteria for this guidance now states that access to cataract surgery should not be restricted on the basis of visual acuity and that second-eye cataract surgery should be offered using the same criteria as first-eye surgery. NICE cost modelling anticipates short term increased activity because of pent up demand due to CCGs previously having visual acuity thresholds. NICE anticipates that once the initial demand has passed, activity will not excessively increase; the timing of surgery will change but not the numbers of patients. Based on the NICE costing template it is difficult to estimate the local cost impact of the recommendations, as not all modelled data is available. The Committee noted the numbers of patients who were declined in 2016-17, however, the figures are based on patients who have been declined based on the on policy thresholds but do not reflect numbers of patients not referred or declined specifically because of visual acuity. On an individual basis, cataract surgery is a cost effective intervention with a few exceptions.
10.2	The current TVPC policy has a visual acuity threshold of 6/12 or worse in either eye. The Clinical Specialist who attended the review in May 2017 identified that the current policy avoids the referral of asymptomatic patients. The Committee discussed the key differences between NICE guidance and the current TVPC60 policy: **1. Do not restrict access to cataract surgery on the basis of visual acuity (NICE)** o We are unable to quantify how many people are currently having cataract surgery restricted because of visual acuity rather than any of the other NICE recommendations as TVPC60 policy is wider than just visual acuity. o It is noted that Point 2 of TVPC60 policy referral threshold reads "Visual Acuity 6/12 or worse in either eye **OR "**the cataract and visual symptoms experienced by the patient should negatively affect the patient's lifestyle." All of the other NICE recommendations have been adopted and the policy does include the word 'OR'. **2. Offer second-eye cataract surgery using the same criteria as for the first-eye surgery (NICE)** o TVPC60 policy is consistent with NICE although the wording "The same thresholds will apply for second eye surgery" differs slightly. NICE supports bilateral surgery for appropriately identified patients as long as the risk is fully explained; this could reduce the cost impact slightly, however a surgeon may be reluctant to undertake such surgery. The Clinician who attended the TVPC meeting (2017) did not feel that substantial numbers of patients would be given this option due to the very rare but potentially devastating risk of blindness.

	The Committee acknowledge the NICE NG77 as national best practice guidance, however, the Committee agreed to recommend maintaining the current TVPC 60 policy Cataract Removal in Adults – Threshold for Surgery without alteration, based on affordability and clinical support for having visual acuity for referral support to identify the symptomatic patients. The policy does not restrict access to surgery based on visual acuity alone, but emphasises visual symptoms affecting the patient and as such maintains the intent of NICE recommendation. **ACTION: Clinical Effectiveness team to re-circulate TVPC 60 policy Cataract Removal in Adults – Threshold for Surgery for comment. Comments to be received within the 2 week feedback period following issue.**
11.	**Policy Update: Hip and Knee Revision – MHRA MDA Metal on Metal Hip Replacement**
	The TVPC Committee was requested to consider whether TVPC55 - Primary hip and knee replacement revision surgery policy should be updated to include a statement regarding the Medicines and Healthcare products Regulatory Agency (MHRA) Medical Device Alert (MDA) on metal on metal (MoM) hip replacements. The Committee agreed that TVPC55 should be updated to include 'Routine follow-up after primary hip and knee revision surgery will include MHRA alerts and surveillance offered in line with MHRA recommendations'. **ACTION: Clinical Effectiveness team to update TVPC55 - Primary hip and knee replacement revision surgery to include reference to the Regulatory Agency (MHRA) Medical Device Alert (MDA) on metal on metal (MoM) hip replacements.**
12.	**Accountable Care Organisations (ACO)- Update; bi-monthly standing item**
12.1	Recent parliamentary announcements indicate Jeremy Hunt, Health Minister has paused the move towards Accountable Care Organisations (ACO). NHS England announced there will be a consultation on the contracting arrangements for ACOs. With regard to Accountable Care Systems (ACSs) or now Integrated Care Systems (ICS) locally, the ACSs are developing in Buckinghamshire, Berkshire East and Berkshire West. Louise Pattern is now Accountable Office (AO) for Oxfordshire as well as retaining her AO position in Buckinghamshire. The ultimate aim is that there will be one ACO for Buckinghamshire and Oxfordshire. A Clinical Leadership forum and a clinical voice has started to grow across the whole area where any clinician in any part of the Buckinghamshire system can come together to build a much more collaborative view about how decisions are made going forward. The relevance to the TV Priorities Committee is that we have always worked as a Thames Valley wide committee and the work of the Committee is anticipated to carry on as it does now. Going forward in the developing ACS landscape, the Committee does need to bear in mind resilience, risk sharing, diversity and potentially wider collaborative work in the ACSs.
13.	**Any Other Business**
13.1	**TVPC Meeting Dates and Venue for 2018-19 programme year**
	Berkshire West is due to host TVPC meetings with effect from 23rd May 2018 on dates as indicated in the table below, however, there are no appropriately sized rooms available at Bath Road, Reading until January 2019. As a stop gap rooms have been booked for 2018 in Jubilee House, Oxford and Albert House, High Wycombe pending enquiries at Bath Road by Shairoz Claridge. Bath Road can accommodate the meeting in January and March 2019, these have been secured. Meeting dates are as follows:

DATE	ROOM	VENUE
21st March 2018	Conference Room	Albert House, High Wycombe
23rd May 2018	Tba	Tba
25th July 2018	Tba	Tba
26th September 2018	Tba	Tba

	28th November 2018	Tba	Tba
	23rd January 2019	G29/30	Bath Road, Reading
	27th March 2019	G29/30	Bath Road, Reading
	ACTION 13.1: Shairoz Claridge to make enquiries with Bath Road Reading for room availability to accommodate TVPC meeting on four dates in 2018. **ACTION 13.1.1: Clinical Effectiveness team to issue calendar invites to Committee members for 2081-19 meetings.**		
13.2	**Biologics in Rheumatoid Arthritis Policy**		
	Oxfordshire CCG has highlighted some issues with the TVPC policy 51 Sequential use of Biologics in Rheumatoid Arthritis, which was recommended in November 2017. This policy has not been adopted by all TV CCGs. It was agreed that the Clinical Effectiveness team are undertaking further work on this item and propose to reschedule this for discussion at the meeting on 21st March. **ACTION 13.2: BW to provide the Clinical Effectiveness team with a copy of their amended Biologics in Rheumatoid Arthritis Policy.** **ACTION 13.2.1: Clinical Effectiveness team to bring a review and update for the Sequential use of Biologics in Rheumatoid Arthritis Policy to the 21st March 2018 TVPC meeting. The work programme may need to be adjusted to accelerate this topic.**		
13.3	**Sequential use and dose escalation of biologics in Crohn's disease**		
	Oxford University Hospitals (OUH) NHS Foundation Trust has locally agreed criteria for dose escalation of infliximab for Crohn's disease. The Committee was asked if this topic should be brought forward in the work programme, the subject is due for discussion in July 2018. The Committee considered that this item could remain for review in July 2018 as planned.		
14.	**Next meeting**		
	The next meeting will be **Wednesday 21st March 2018, to be held in Conference Room, Albert House, High Wycombe HP11 1AG.**		
15.	**Meeting Close**		
	The Chair thanked everyone for their contributions to the discussions and closed the meeting.		