Berkshire West Clinical Commissioning Group
Buckinghamshire Clinical Commissioning Group
East Berkshire Clinical Commissioning Group
Oxfordshire Clinical Commissioning Group

Thames Valley Priorities Committee

Minutes of the meeting held Wednesday 23rd January 2019

Room G29/G30, 57-59 Bath Road, Reading RG30 2BA

Alan Penn	Lay Member Chair	Thames Valley Priorities Committee
Lindsey Barker	Medical Director	Royal Berkshire NHS Foundation Trust
Jane Butterworth	Associate Director Medicines Optimisation	Buckinghamshire CCG
Linda Collins	Clinical Effectiveness Manager (CCG)	Oxfordshire CCG
Prof. Chris Newdick	Professor of Health Law	University of Reading
Edward Haxton	Deputy Finance Director	Berkshire West CCG
Dr Graham Jackson	Clinical Chair	Buckinghamshire ICS Clinical Lead
Dr Jacky Payne	GP	Berkshire West CCG
Dr Megan John	GP, Berkshire East CCG Lead	East Berkshire CCG
Dr Raju Reddy	Secondary Care Consultant	Berkshire West CCG
Dr Mark Sheehan	Special Advisor – Ethics	University of Oxford
Rachel Dalton (Observer)	Senior Project Support Officer	
Georgie Sullivan (agenda item 7 only)	Contract Team	Berkshire West CCG
Scarlett Heath (agenda item 7 only)	Project Implementation Team	Berkshire West CCG
Dr Michelle Sharma (Observer)	GP, Clinical Policies Lead	Swindon CCG

In Attendance:

Tiina Korhonen	Clinical Effectiveness Lead	SCW
Kathryn Markey	Clinical Effectiveness Manager	SCW
Rebecca Hodge	Clinical Effectiveness Manager	SCW
Gillian Barlow	Clinical Effectiveness Manager	SCW
Katie Newens	Clinical Effectiveness Researcher	SCW
Rachel Finch	Clinical Effectiveness Administrator – Minute Taker	SCW

Topic Specialists in Attendance for Agenda Items:

Item 6 – Evidence Review: Clinical threshold for access to audiology services		
Alan Bryant	Deputy Head of Audiology	Royal Berkshire NHS Foundation Trust
Item 7 – Policy Update: Retinal vein occlusion		
Mr Molham Entabi	Consultant Ophthalmic Surgeon	Royal Berkshire NHS Foundation Trust
Sarah-Lucie Watson	Consultant Ophthalmic Surgeon	Royal Berkshire NHS Foundation Trust
Item 8 – Primary hip and knee joint replacement revision surgery – proposed thresholds		
Mr Tom Pollard	Clinical Director for Orthopaedics	Royal Berkshire Hospital, Reading

Apologies:

Noel Burkett	Assistant Director of PMO	Aylesbury
Jo Jefferies	Consultant in Public Health	Bracknell Forest
Dr Tina Kenny	Medical Director	Buckinghamshire NHS FT
Tessa Lindfield	Strategic Director for Public Health	Berkshire
Robert Majilton	Deputy Chief Officer	Buckinghamshire CCG
Rosalind Pearce	HealthWatch	Oxfordshire
Sarah Robson	Head of IFR	SCW
John Reynolds	Associate Director of Medical Sciences Division (Clinical Affairs)	Oxford University Hospital
Amaka Scott	Commissioning Interfacing Pharmacist	Berkshire West CCG
Bhulesh Vadher	Clinical Director of Pharmacy and Medicines Management	Oxford University Hospital

1.	**Welcome & Introductions**
1.1	The Chair opened the meeting and welcomed the members of the Committee.
2.	**Apologies for Absence**
2.1	Apologies recorded as above.
2.2	The meeting of 28th November 2018 was not quorate. **Post meeting note:** Clinical Effectiveness team are still seeking acceptance of the minutes and recommendations from non-attending members of the Committee. Robert Majilton, Deputy Chief Officer, Buckinghamshire has been in conversation with Tessa Lindfield, Director of Public Health Berkshire to seek a nominee for regular attendance at Committee meetings. **March 2019:** Acceptance of minutes and recommendations has been received from non-attending Committee members. **ACTION Closed**
3.0	**Declarations of Interest**
3.1	Alan Penn and Professor Chris Newdick both declared an interest in agenda item 6 with regard to hearing loss.
4.	**Draft Minutes of the Priorities Committee meeting held 26th September 2018 - 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 July 2018 – Action 6.6.2 - Paper 18-006 – Evidence Review: Sequential use and dose escalation of biologics in Crohn's disease** Attending specialist clinicians agreed to develop a policy and pathway for the sequential use of biologics in Crohn's disease with their colleagues from Oxford, Reading, Buckinghamshire and Frimley. The Committee suggested this may be presented to the 26th September TVPC meeting. **September 2018 Update:** Specialist clinician is meeting with colleagues in early October to commence the policy and pathway development process. Committee to be updated at 28th November meeting. November 2018 Update: Clinical Effectiveness team to contact specialist clinician for a date when the policy and pathway can be presented to the Committee. **January 2019 Update:** The clinicians are still committed to preparing a pathway to present to the Committee however no information has been received from them yet. **ACTION: The Clinical Effectiveness team to ask the clinicians to bring their pathway to the next meeting, 27th March. Lindsey Barker agreed to follow up with RBH.** Should clinicians be unable to provide information for the next meeting the Clinical Effectiveness team propose looking at the Buckinghamshire and Berkshire West policy's with a view to developing an agreement.

5.2	**Minutes of the Priorities Committee held in July 2018 – Action 7.6 - Paper 18-007 - Evidence Review: Topical negative pressure for wound therapy (NPWT); vacuum-assisted wound closure dressings** The Clinical Effectiveness (CE) team were asked to review the patient population for diabetic foot ulcers and provide further local data and financial impact for review at the 26th September 2018 meeting. **September 2018 Update:** The Committee acknowledged the lack of accurate local data and evolving evidence base. However, felt a local policy may be helpful in supporting the monitoring of the use of NPWT. Further exploration of the data by the CE team would be helpful. The CE team to further review NPWT data refresh the paper to put forward a recommendation to the Committee at 28th November meeting. **November 2018 Update:** Due to a full agenda dedicated to orthopaedic topics the Chair agreed to defer this topic until January Committee. **January 2019 Update: refer to agenda item 5.**
5.3	**Minutes of the Priorities Committee held in September 2018 – Action 12.1 – Any Other Business – 2019-20 Work Programme Workshop** A TVPC Workshop was held on 5th November 2018 when submitted topics where considered and scored. Clinical Effectiveness team to provide a draft copy of the 2019-2020 work programme with minutes of the 28th November meeting. **ACTION Complete**
5.4	**Minutes of the Priorities Committee held in November 2018 – Action 6.1 – HealthWatch representation** Healthwatch informed the Committee by correspondence expressing concern about their representation at TVPC meetings. The Chair and the Clinical Effectiveness team to respond to Healthwatch on behalf of the Committee accepting that the Committee recognises the resource issue and values their membership, however, would like to ask Healthwatch to reconsider the issue of voting rights and the preference for a regular attendee with a deputy, as per Terms of Reference (ToR) of the Committee. The Committee considered that should Healthwatch no longer commit to regular attendance, alternative lay member representation should be sought. Dr Graham Jackson to approach some existing Buckinghamshire lay representatives to ask them to consider TVPC lay representation. **January 2019 Update: Healthwatch responded to a letter sent to them by the Chair confirming they will not attend the Committee as voting members. Dr Graham Jackson to progress with seeking non-executive lay representation.**
5.5	**Minutes of the Priorities Committee held in November 2018 – Action 7.4 – Evidence Review: Unicompartmental knee replacement** The Clinical Effectiveness team to update TVPC49: Patients with osteoarthritis (OA); primary hip and knee replacement policy to include unicompartmental knee replacement. The policy is to reflect the GIRFT sentiment that; 'UKR is an option for clinically appropriate patients who meet the criteria above. UKR is a complex procedure and therefore it is recommended that contractual minimum annual volumes for UKR are agreed with providers, in collaboration with the orthopaedic specialist societies, as discussed in the GIRFT (2015) National Review of Adult Elective Orthopaedic Services in England report.' Comments to be received within the 2 week feedback period following issue. **ACTION Complete**
5.6	**Minutes of the Priorities Committee held in November 2018 – Action 8.6 – Evidence Review: Arthroscopic surgery for Anterior Cruciate Ligament (ACL) rupture.** The Clinical Effectiveness team to draft a policy recommendation: Anterior Cruciate Ligament (ACL) Reconstruction and circulate for comment. Comments to be received within the 2 week feedback period following issue. **ACTION Complete**

5.7	**Minutes of the Priorities Committee held in November 2018 – Action 9.4 – Policy Update: Corticosteroid injections for patella tendinopathy & Evidence Review: Steroid injections to joints.** The Clinical Effectiveness team to amalgamate current separate CCG documents into draft policy recommendations and circulate for comment: • Corticosteroid injections for Patella, elbow and Achilles tendinopathy into TVPC84 and • Corticosteroid injections for Pre Patella and olecranon Bursitis into TVPC85 Comments to be revived within the 2 week feedback period following issue. **ACTION Complete**
5.8	**Minutes of the Priorities Committee held in November 2018 – Action 10.2 – Policy Update: TVPC8: Routine follow-up after Primary Hip & Knee Joint Replacement Surgery** The Clinical Effectiveness team to draft an update to policy recommendation: TVPC8: Routine follow-up after primary hip and knee joint replacement surgery with an amendment that patients can have an additional follow up appointment within a year, if they have symptoms that directly relates to their hip or knee joint replacement, and circulate for comment. Comments to be received within the 2 week feedback period following issue. **ACTION Complete**
5.9	**Minutes of the Priorities Committee held in November 2018 – Action 11.3 – Policy Clarification: TVPC55: Primary hip and knee replacement revision surgery** The Clinical Effectiveness team together with the specialist clinicians to draft an update to policy recommendation TVPC55: Primary hip and knee replacement revision surgery and return to the January meeting for discussion by the committee. **January 2019 Update: Refer to agenda item 8.**
5.10	**Minutes of the Priorities Committee held in November 2018 – Action 12.1 – Interim Statement: Cannabis based products for medicinal use** Clinical Effectiveness team to draft an interim statement: cannabis based products for medicinal use and circulate for comment. Comments to be received within the 2 week feedback period following issue. **ACTION Complete**
6.	**Paper 18-027 – Matters Arising – Negative Pressure Wound Therapy - Update**
6.1	The Committee were asked to note an error with Table 3 (page 2) of the paper; under 'Rate per 100,000 population' the number of people should read 140 rather than 56; similarly the paragraph under the table should also read 140/100,000.
6.2	The Committee had asked the Clinical Effectiveness team to establish the Thames Valley (TV) patient population being treated for diabetic foot ulcer (DFU), to provide further local data and financial impact should NPWT be adopted for all cases of non-healing DFU. Where possible the Clinical Effectiveness team have used national and local data. Where such data is not available estimates have been calculated based on data from a variety of evidence sources including those gained from literature searches. Contact has also been made with local tissue viability and podiatry teams across the TV.
6.3	The number of diabetics across the TV CCGs is estimated to be 125,411 based on the average rate of 5.6% of the TV population (Public Health England fingertips data 2016-17). There is limited national data available and no standard data source regarding DFU. To identify the number of patients with DFU the NICE guideline NG19 Management of diabetic patients with foot ulcers rate of 2.5% of the diabetic population has been used. This estimates that there are 3,135 people across the TV CCGs with DFU (a rate of 140 per 100,000 population). However, it has not been possible to determine whether these patients have mild or severe DFU.

6.4	Local services and NICE guidance report that there are no defined standard treatments. Treatment includes a variety of wound dressings ranging from basic to advance to anti-microbial dressings. Staff time along with the time to heal and treat also needs to be taken into consideration. Time to heal is often difficult to predict, it is dependent upon clinical condition of the patient, wound characteristics, treatment compliance and vascular status. Due to the lack of national and local data available the costs are based on estimates of treating DFU according to NG19 Management of diabetic patients with foot ulcers; the overall average cost per patient to treat those with less severe DFU (SINBAD score of ≤2) is £3,221 per patient, giving a potential estimated cost of £450,940 across the TV. Weekly cost for standard care compared to NPWT care was estimated to be £207 per week, based on weekly dressings and professional time to dress those wounds. Cost of a Venturi MiNO NPWT System (pump unit and canister for exudate storage plus weekly therapy wound care set) suitable for use on patients with diabetic foot ulcers is £300 per week, professional time costs are not included. Treatment time is based on 23 weeks, evidence shows this as the length of time estimated for an ulcer to be healed. In the absence of robust data a direct cost comparison between future adoption of NPWT and current care for local populations is not possible. In regards to the potential reduction in bed days for patients discharged from the acute sector, in 2016-17 OUH estimated an average of 133 days per month had been potentially saved by discharging patients with NPWT into the community who would otherwise have had to stay in hospital. Between April and November 2018, 11 patients with DFU were discharged with NPWT, saving a total number of 228 bed days giving a potential saving of £50,616. Calculations are based on the number of days post discharge patients used the machine and on NICE NG27 (2015) calculation of £222 per bed day. The Committee was asked to view the calculation of prevalence data for DFU for the TV CCGs with caution due to the assumptions made. In addition due to the lack of consensus regarding the indications for commencing NPWT (other than post debridement as per NG 19) accurate cost projections cannot be made.
6.5	The Committee discussed the following points; whilst the reduction in bed days appears positive it was acknowledged that the local estimates are based on assumptions of currently available data. The patients with DFU area small sub-set of potential cohort for NPWT use, however there is some evidence and NICE guidance to support it use and the data indicates it is currently being used, therefore it would be helpful to have a local position. The Committee agreed there was sufficient evidence and data available for a policy to recommend NPWT as an option for a sub-set of DFU patients who can be treated at home following debridement and for patients with post-operative open abdominal wounds. The policy should incude that; • NPWT it is for initiation by specialist in secondary care. • That there must be adequate expertise and resource in the community to deliver the service. • There is no clinical evidence for its use for pressure ulcers or venous leg ulcers. **ACTION: The Clinical Effectiveness team to draft a policy recommendation: Topical negative pressure for wound therapy (NPWT); vacuum – assisted wound closure dressings and circulate for comment. Comments to be received within the 2 week feedback period following issue.**

7.	Paper 18-028 – Evidence Review: Clinical threshold for access to audiology services
7.1	Thames Valley Clinical Commissioning Groups requested a review of hearing loss to establish whether the TVPC can recommend a clinical threshold for the provision of NHS funded hearing aids. Levels of growth are significant for the population likely to be affected by hearing loss. The review focuses on hearing aids for presbyacusis - age related hearing loss. Hearing level is quantified relative to 'normal' hearing in decibels (dB), with higher numbers of dB indicating worse hearing. Hearing loss is graded by the World Health Organisation as follows: Normal hearing: less than 25 dB in adults Mild hearing loss: 25-39 dB Moderate hearing loss: 40-69 dB
7.2	NICE has recently published guidance NG98 (2018): Hearing loss in adults: assessment and management. The Clinical Effectiveness team have conducted evidence searches from the time guidance NG98 was issued to date. NICE recommend: • For adults who present for the first time with hearing difficulties/suspected hearing difficulties, exclude alternative causes and refer for an audiological assessment. • Consider referring adults with diagnosed or suspected dementia or mild cognitive impairment to an audiology service for a hearing assessment because hearing loss may be a comorbid condition. NICE recommend that these patients, and those with a diagnosed learning disability are referred to audiology services for a review every two years. • Offer hearing aids to adults whose hearing loss affects their ability to communicate and hear, including awareness of warning sounds and the environment, and appreciation of music. • Offer 2 hearing aids to adults with aidable hearing loss in both ears. Explain that wearing 2 hearing aids can help to make speech easier to understand when there is background noise, make it easier to tell where sounds are coming from, and improve sound quality. • Consider using motivational interviewing or engagement strategies and goal setting when discussing hearing aids with adults for the first time, to encourage acceptance and use of hearing aids. The Committee were also provided with details of 2016 NHS England guidance, 'Commissioning Services for People with Hearing Loss: A framework for clinical commissioning groups' which provides a guide to what 'good' commissioning should look like for hearing loss services and meets the key recommendations of the Action Plan on Hearing Loss. It also presents data and figures around the impact of hearing loss, increased rates of dementia, high risk of falls, employment etc.

7.3	The clinician in attendance noted that the national guidance in the last 3-4 years has focused on robust hearing management. There is a consistent message from these documents that good outcomes lead to good value for money, QALY scores and the wider economic and health benefits in terms of dementia and employment. The Commissioning Framework discusses the aim to improve integrated care and improving services for patients locally. The clinician would not recommend a threshold for access to audiology services. The specialist raised the following points: • That wearing hearing aids was unlikely to reduce dementia, but would influence some of the related factors that exacerbate it, such as social isolation. • Concerns have been raised about patients being able to access hearing aids from independent providers without a referral from a GP. This is not currently the case, although is being lobbied for by some charities. If this were to happen without sufficient governance, there were concerns raised by the clinician and committee that this may result in the inappropriate provision of NHS hearing aids. • Local practice for Royal Berkshire NHS Foundation Trust reflects the NICE guidance published in 2018. • There is clinical evidence that people with lesser degrees of hearing loss benefit from hearing aids and good cost effectiveness can be demonstrated. • The danger of introducing any possible barriers for access to hearing aids is that it can take a long time for people to accept their hearing loss and adjust to its management. The clinician referred to the >40bd threshold in the North Staffordshire CCG policy and noted that clinically at 40db average people are really struggling to hear as they probably have hearing loss at high frequencies in the 60db's and the low frequencies towards the 30db's. People with that degree of hearing loss are unlikely to be able to hear a discussion unless they're in a 1:1 situation and really close. The policy incudes a 'Hearing Handicap Inventory for the Elderly' and the view was expressed that it may not be a suitable measure. • Hearing loss predominantly starts at age 50, however patients of all ages and different types of hearing loss are seen by audiology services. Some of the patients that struggle the most are younger patients. They may not have the higher thresholds of hearing loss, but its impact can be greater because of their social environments, high phone use and work expectations, such as listening to customers. • The committee enquired whether issuing one hearing aid instead of two would reduce the ongoing costs (batteries and maintence etc.) associated with hearing aids. The clinician indicated that patients may in that case come back with continued problems. There is therefore a danger of added cost if there is an option for a second aid later. • There is also an adjustment period with hearing aids and if the brain gets used to unilateral hearing, patients would then have to get used to the second hearing aid and the acclimatisation period doubles. Although patients would get used to one hearing aid they still would not ever have the benefit of binaural hearing which is what is needed for speech and background noise. • It was noted that hearing aids are not actively renewed. Currently it is patient initiated. Those seeking renewal before the 3 years are quite a small percentage, 25%. The other 75% usually use the aids for 4 to 5 years. Setting limits around time scales when a hearing aid can be renewed may have a small resource impact. • Currently no service is offering a top up system for the provision of hearing aids, as with glasses. There are very basic hearing aids which are no longer provided by the NHS as they were the ones which historically did end up in drawers and where some of the reputation of poor aid use came from some 20 years ago. The committee added that NHS and private provision cannot be combined in the same spell of treatment.

7.4	**ACTION: The Clinical Effectiveness team to draft a policy recommendation for adults with mild hearing loss and circulate for comment. The draft recommendation is to include the following criteria:** • **Define mild hearing loss as patients diagnosed with hearing loss greater than 25db** • **Offer hearing aids to adults whose hearing loss affects their ability to communicate and hear, including awareness of warning sounds and the environment, and appreciation of music.** • **Offer 2 hearing aids to adults with aidable hearing loss in both ears. Explain that wearing 2 hearing aids can help to make speech easier to understand when there is background noise, make it easier to tell where sounds are coming from, and improve sound quality.** • **This policy does not apply to patients with dementia or those with learning disabilities.** **Comments to be received within the 2 week feedback period following issue.**
8.	**Paper 18-029 – Policy Update: Anti-VEGF treatments and dexamethasone implants for macular oedema caused by central and branch retinal vein occlusion**
8.1	The Committee have been asked to review TVPC5 for retinal vein occlusion (RVO), a policy originally recommended by the Committee in April 2014. The current policy is based on NICE Technology Appraisals (TA) for anti-VEGF therapy and dexamethasone for both central (CRVO) and branch retinal vein occlusion (BRVO). The first anti-VEGF license was for ranibizumab for both types of RVO however for BRVO there was a requirement to trial laser treatment first (2013). The second anti-VEGF to be licensed was aflibercept for CRVO only. The current policy recommends that dexamethasone is used as the first option with anti-VEGF therapy only to be given where there is a contraindication or intolerance to dexamethasone implants or when these are ineffective. Since April 2014 a new NICE TA (TA409) has been published which recommends the second anti-VEGF aflibercept for BRVO with NICE stipulating there is no requirement for trial of laser first. This is based on evidence showing that laser is less effective and also that it delays treatment of the condition. In addition there is good quality evidence from randomised controlled trials showing that anti-VEGF therapy results in greater gains in visual acuity than laser treatment, this includes ranibizumab. The evidence also shows that when dexamethasone is provided as per the license (every 6 months), visual acuity declines from 2-3 months, and is also associated with greater increases in intraocular pressure and cataract formation.
8.2	The specialists in attendance raised the following points: • Patients receiving dexamethasone have to come back for frequent visits to check for raised intraocular pressure. This can be detrimental and must be treated with eye drops. • Dexamethasone is the right treatment for some patients and is safer for patients who have cardiovascular risk factors, angina or previous stroke or heart attacks. Dexamethasone is not appropriate for young patients due to the risk of cataracts or for patients who've ever had herpetic infection of the eye. • The costs of dexamethasone and anti-VEGF therapy are comparable as locally agreed prices are favourable and anti-VEGF injections are given less frequently than the published trials. Every patient will have 3 x monthly injections with a VEGF inhibitor at the start and further injections as frequently as needed, this depends on how much the swelling goes down and how much the vision responds. On average 4 injections are provided in the first 6 months. There are also clear exit times when treatment is stopped.

8.2 cont.	• Dexamethasone is no longer an appropriate drug to be used first line. There is evidence showing that anti-VEGF is superior to dexamethasone implants by at least 12 letters against 5 in favour of anti-VEGF and up to 20 letters in some real world data published from Newcastle, Moorfield's and Southampton. • In general, the average treatment period is 2 years, and there are currently no patients in the local clinic who have been treated for 5 years. Very few patients present with a recurrent disease.
8.3	The Committee queried the cost of treating the complications associated with dexamethasone treatment. The specialist clinician reported that 24% of patients treated with the dexamethasone implant develop raised ocular pressure and 1-5% require glaucoma filtration surgery. It was also stated that dexamethasone has been temporarily withdrawn from the market and been unavailable since October 2018. The Committee queried the cost implications of using the unlicensed drug bevacizumab for treating RVO. The specialist clinician advised that although the costs of 6-months of treatment with bevacizumab are much lower than licensed anti-VEGF therapy or dexamethasone, there is no evidence for 'treat and extend' with bevacizumab. The more frequent appointments and injections would make delivery of bevacizumab a significant challenge. The Committee discussed the potential financial implications of removing the requirement to use dexamethasone first. Bucks CCG reported that a previous audit has shown that the costs of dexamethasone and anti-VEGF therapy to be comparable. **ACTION: Jane Butterworth to send the results of the Bucks CCG audit to the CE team who will circulate to the Committee for information.** The Committee discussed that use of laser first is less effective and potentially more expensive than anti-VEGF therapy. The Committee agreed to remove the recommendation to use dexamethasone as first line and recommended that the treatments available (laser, dexamethasone, anti-VEGF) should be equal options based on clinical grounds. The Committee agreed to take out reference to unlicensed and off-label anti-VEGF therapies, to cross reference TVPC45, and to amend the wording of the patient access scheme.
8.4	**ACTION: The Clinical Effectiveness team to draft an updated recommendation to policy TVPC 5: Anti-VEGF treatments and dexamethasone implants for macular oedema caused by central and branch retinal vein occlusion and circulate for comment. The draft recommendation is to be updated as follows:** • **update in line with NICE TA409 to state that patients with branch retinal vein occlusion (BRVO) can be prescribed aflibercept** • **remove the use of intravitreal dexamethasone implants as the first option for medical treatment of macular oedema caused by retinal vein occlusion (RVO)** • **remove the requirement for trial of laser therapy prior to other treatments for BRVO** • **remove the statement regarding the use of unlicensed and off-label anti-VEGF therapies** • **amend the statement regarding 'patient access scheme money' to read 'where a patient access scheme exists those prices should be used' and move to the end of the policy document** • **add a statement to also refer to related policy TVP45: Sequential use of biologic therapy in Ophthalmology** **Comments to be received within the 2 week feedback period following issue.**

9.	**Paper 18-030 – Primary hip and knee joint replacement revision surgery – proposed thresholds**
9.1	Policy TVPC55 primary hip and knee replacement revision surgery policy was developed to clarify the commissioning responsibilities of CCGs and NHS England. Although the policy title is 'primary hip and knee replacement revision surgery' it only includes criteria for knee replacement there is no threshold within the policy for hips. At the November 2018 the attending orthopaedic clinicians highlighted that some clinical scenarios do not fit into the policy, resulting in difficulties with gaining prior approval for procedures. It was agreed that the Clinical Effectiveness team, together with the specialist clinicians, would review the current policy criteria and draft an update to the policy. The draft policy was returned to the January meeting for review by the committee.
9.2	The specialist clinician presented the draft policy recommendation. The recommendation added the following criteria to the policy: • Periprosthetic fracture, where the prosthesis is loose, or where revision is likely to yield superior clinical outcome to fixation of the fracture with retention of the prosthesis • Bearing surface-related complications. There is evidence of polyethylene wear or periarticular osteolysis or adverse soft tissue reaction to particulate debris or the patient has a metal on metal hip replacement (regardless of metal ion levels or imaging findings), or ceramic bearing complications such as squeaking or ceramic fracture • Instability. Total hip replacement: 3 or more dislocations or subluxations. Total knee replacement: Instability based on specialist clinical assessment. Partial knee replacement: bearing dislocation • Disease progression after partial knee replacement. Where OA has progressed in compartments of the knee that have not been replaced • Other indications for revision as listed on the latest National Joint Registry Revision proforma, such as: secondary patellar resurfacing after a primary total knee replacement where the patella was not resurfaced, or implant fracture, or head/socket mismatch, or malalignment, or component/liner dissociation, or stiffness, or unexplained pain The specialist clinician advised that there was unlikely to be a resource impact associated with the changes, but that it would result in a smoother process when applying for funding for revision procedures. The Committee agreed with the recommended changes.
9.3	**ACTION: The Clinical Effectiveness team to circulate the draft update to policy recommendation TVPC55: Primary hip and knee replacement revision surgery for comment as minuted. Comments to be received within the 2 week feedback period following issue**
10	**Paper 18-031 – Current Policy Updates**
10.1	19 current TVPC policies that were more than 2 years old were reviewed and recommendations presented for no change, minor changes or further update required. The following points were raised: • Two of the 19 policies, TVPC48 Hernia and TVPC49 Patients with osteoarthritis (OA) primary hip and knee replacement contain links to patient decision aids (PDA's) to be discussed / completed with the patient before referral for treatment; these NHS England PDAs are no longer available. The Committee agreed to recommend that a general statement on shared decision making be added to the two policies but that it should no longer be part of the threshold criteria. • TVPC40 Penile rehabilitation and TVPC48 Hernia cite systematic reviews which is not in-line with the wording of current policies. The Committee agreed that these references could be removed for consistency of policy format.

10.1 Cont.	• TVPC44 & TVPC46 refer to the sequential use of biological therapies in psoriasis and psoriatic arthritis. New NICE technology appraisal (TA) guidance has been published which recommend new biologics for these conditions. The Committee agreed to add in the new guidance, and add in statements regarding the preferential use of biosimilars and future publication of NICE TA guidance. A full update to the policy will be made in two years' time to allow the anticipated NICE TAs to be published. • The Committee discussed removing the NICE TAs present in the policy, TVPC 45: Sequential use of biological therapies in ophthalmology but decided to retain them as they are a useful reference for patients and enhance the robustness of the policy.
10.2	The Committee agreed to withdraw policy TVPC26 Pectus anomaly surgery as this is commissioned by NHS England.
10.3	**ACTION: to draft the updated policies as discussed and circulate for comment. The Clinical Effectiveness team to withdraw TVPC26. Comments to be received within the 2 week feedback period following issue.**
11.	**Paper 18-032 – NHSE Evidence based interventions (EBI) - Update**
11.1	The Committee were presented with a brief summary of the EBI project. The EBI policies will be linked to the NHS England standard contract from April 2019. It was clarified that as a general principle as long as commissioners 'have due regard' to the EBI document they may hold an enhanced local position in relation to nationally-devised criteria. The document is designed to provide a national baseline to which commissioners should at least follow but does not preclude them from going further. The Committee discussed the summary of the local compare and contrast document in relation to the clinical content of the current TVPC policies against the 17 national recommendations. It was noted that CCGs in TV are, in a number of procedures, considerably further ahead than those set out in the EBI document. There is only one policy in the EBI document where the TV CCGs do not already have a position (chalazia) and one policy were we have an opportunity to tighten current thresholds for referral for surgical opinion (tonsillectomy). It was agreed that where there is an opportunity to agree a new policy from EBI or tighten current thresholds as per the EBI document, the Committee will support that. For the other current policies it was agreed to review them and take account of the EBI policies as per the normal policy update schedule. **ACTION: The Clinical Effectiveness team to schedule policies for chalazia and tonsillectomy for early review and adoption.** **Post meeting note re EBI coding:** The SCW analytics team is currently working to solve the evident issue of the data presented and the associated clinical coding in the EBI document published in November 2018. There is a concern that the anticipated savings for CCGs may be overestimated. SCW analytics team is currently working with clinical coders to ensure comprehensive and accurate coding and are planning to run the 17 procedures against codes that reflect the content of the EBI policies. SCW team in Hampshire ('a demonstrator community' for EBI) is linking with NHS England and will be raising this issue with them.
12.	**Integrated Care System (ICS) - Update**
12.1	In Buckinghamshire there is now a clinical senate, with ICS members and clinicians across the local authority, all the providers and primary care. All the policies now go to the senate for discussion on adoption and implementation. As long as the clinical senate approves the policies this is now the methodology for ratification. However, because the CCG cannot pass the authority to the senate around finance, decisions for additional investment need to be rubber

12.1 cont.	stamped by the executive committee. This will hopefully lead to better coverage across all partners, better implementation and ownership and Bucks CCG is using the group to generate ideas going forward.
13.	**Any Other Business**
13.1	**Public Health representation at Case Review Committee**
	The Public Health (PH) representative from East Berkshire has sent a query to the Committee regarding the PH representation in the Individual Funding Request 'case review committees'. A question was also put to the Committee regarding what equity audits have been carried out about the impacts of our policy recommendations, and whether socio economic status and ethnicity are audited. Due to lack of time at the Committee, it was agreed that this will be discussed at the next meeting matter arising. **ACTION: For discussion at the March Committee meeting.**
13.2	**Flash Glucose Monitoring – NHSE recommendation**
	This item was raised to alert the CCGs to the announcement by Simon Stevens, in November 2018 National Diabetes Day, that the Flash Glucose Monitoring system should become available on the NHS in April 2019 to everyone who meets the criteria. TVPC agreed a local policy recommendation for this in January 2018, based on the NHS England Regional Medicines Optimisation Committee (RMOC) 2017 Position Statement. Not all local CCGs have adopted the policy. The item is a note for the CCGs in case any changes in commissioning position needs to be considered. Currently there no specific information on the NHS England website on the detail of the policy or funding arrangements.
14.	**Next meeting**
	The next meeting will be **Wednesday 27th March 2019, to be held in Meeting Room GU29/30 Bath Road, Reading RG30 2BA**
15.	**Meeting Close**
	The Chair thanked everyone for their contributions to the discussions and closed the meeting.