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 24th March 2021

On-line via Microsoft Teams

Alan Penn	Lay Member Chair	Thames Valley Priorities Committee
Jane Butterworth	Assistant Director Medicines Optimisation	Buckinghamshire CCG
Linda Collins	Clinical Effectiveness Manager (CCG)	Oxfordshire CCG
Dr Raju Reddy	Secondary Care Consultant	Berkshire West CCG
Andrew McLaren	Deputy Medical Director	Buckinghamshire Health NHS Trust
Dr Karen West	Clinical Director Integration	Buckinghamshire CCG
Dr Janet Lippett	Medical Director	Royal Berkshire NHS Foundation Trust (RBFT)
Edward Haxton	Deputy Finance Director	Berkshire West CCG
Mark Sheehan	Special Advisor – Ethics	University of Oxford
Gill Manning	Lay representative	East Berkshire
Professor Chris Newdick	Special Advisor – Law	University of Reading
Dr Jacky Payne	GP	Berkshire West CCG
David Pollock	Interface Lead Pharmacist	Berkshire West CCG
Dr Megan John	GP, East Berkshire CCG Lead	East Berkshire CCG
Catriona Khetyar	Head of Medicines Optimisation	East Berkshire CCG
Maire Stapleton Joined 2.26hrs left 3.15hrs	Formulary Manager	Buckingham Healthcare NHS Trust

In Attendance:

Kathryn Markey	Clinical Effectiveness Manager	SCW
Kim Tie Joined 3.49hrs	Clinical Effectiveness Manager	SCW
Katie Newens	Clinical Effectiveness Manager	SCW
Helen Hicks - minutes	Clinical Effectiveness Administrator	SCW
Tiina Korhonen Joined 3.15hrs	Clinical Effectiveness Lead	SCW
Funmi Fajemisin Joined 2.31hrs	Clinical Services Programme Lead Clinical Policy Implementation	SCW

Apologies:

Diane Hedges	Deputy Chief Executive TVPC Strategic Lead	Oxfordshire CCG
Marion Mason	Interim Head of Prior Approval and Assurance - Clinical Policy Implementation Service	SCW
Lalitha Iyer	Medical Director	East Berkshire CCG

John Reynolds	Associate Director of Medical Sciences Division (Clinical Affairs)	Oxford University Hospital (OUH) NHS Trust
Professor Meghana Pandit	Medical Director	Oxford University Hospital NHS Trust
Fiona Slevin-Brown	Director of Strategy and Operations	East Berkshire CCG
Tessa Lindfield	Strategic Director of Public Health for Berkshire	Public Health Services for Berkshire
Matthew Covill	Director of Business Planning	Oxford University Hospital NHS Trust

Topic Specialists in Attendance for Agenda Items:

Item 6 – **Policy Update: TVPC43 Use of biologic therapies for ulcerative colitis in adults (18 years and over)**
Dr Oliver Brain, Consultant Gastroenterologist, Oxford University Hospital; Annamaria di Felice, Senior Pharmacist, Frimley Health NHS Foundation Trust
Item 7 – **RMOC statement for the sequential use of biologic medicines – Amendment to current TVPC policies**
Annamaria di Felice, Senior Pharmacist, Frimley Health NHS Foundation Trust

1.	**Welcome & Introductions**
1.1	The Chair opened the meeting and welcomed members of the Committee. The Chair thanked LC for all her contributions to the Committee and wished her well in her retirement.
2.	**Apologies for Absence**
2.1	Apologies recorded as above.
3.	**Declarations of Interest**
3.1	None declared.
4.	**Draft Minutes of the online Priorities Committee meeting held 27th January 2021 – Confirm Accuracy**
4.1	Amendments required: • Louise Coates to Laura Coates • Laura Davies to Louise Davies The draft minutes were accepted as a true record of the meeting once amendments have been actioned.
5.	**Draft Minutes of the online Priorities Committee meeting held 27th January 2021 – Matters Arising**
5.1	**Minutes of the Priorities Committee held online in November 2020 – Action 7.8 - Policy Update: TVPC43: Use of biologic therapies for ulcerative colitis in adults (18 years and over)** The Clinical Effectiveness team to draft an update to TVPC43: Use of biologic therapies for ulcerative colitis in adults (18 years and over) policy recommendation and circulate to local consultants for comment in the first instance. Post meeting note, this will be discussed at a subsequent TVPC meeting. **ACTION In progress. Clinical Effectiveness team to bring to the March meeting if possible. ACTION Complete (agenda item 6)**
5.2	**Minutes of the Priorities Committee held online in November 2020 – Action 10.1 - Flash Glucose Monitors (Flash) for people living with diabetes and a learning disability** The Clinical Effectiveness team to draft an update to TVPC73 Flash Glucose Monitoring System (Freestyle Libre®) policy recommendation and circulate via email for comment. Comments to be received within the 2 week period following issue. **ACTION Clinical Effectiveness team to amend the policy to include the extra group of patients as stated by NHS England.** **January 2021 Update:** Clinical Effectiveness team received a query from Bucks Healthcare to inquire whether it is considered that the updated policy is generic and can therefore refer to Freestyle Libre 2 which is now available for prescribing. The sensors are the same price. TVPC73 does refer to Flash Glucose Monitors throughout the policy but holds Freestyle Libre in brackets in the title. The Committee agreed this can be considered to be generic enough in the same way that specific brands are not mentioned in the Continuous Glucose Monitoring policy. No further action. **ACTION Complete**
5.3	**Draft Minutes of the online Priorities Committee meeting held 27th January 2021 – Action 6.3 - RMOC statement for the sequential use of biologic medicines – Update** The Committee reviewed the guidance and following consideration of the specialist clinical input agreed to recommend an interim statement to allow the sequential use of up to 4 biologic / high cost immunomodulatory drugs whilst further discussions should be considered for a different system for commissioning treatment and monitoring. **Action: Clinical Effectiveness team to return to the Committee with some proposed changes to current policies to include an interim statement to allow provision of up to 4 biologic / high cost immunmodulatory drugs for RA and PsA. ACTION Complete (agenda item 7)**
5.4	**Draft Minutes of the online Priorities Committee meeting held 27th January 2021 – Action 7.3 - Revised estimation of the financial impact of the THC:CBD spray (Sativex®)**

	The Committee reviewed the evidence and guidance and following intense consideration of the potential patient numbers and financial impact, the Committee agreed to recommend an interim policy to be reviewed when NICE publishes further guidance and after further consideration of patient numbers and financial impact in area of the country that have agreed to commission the prescribing of THC:CBD (Sativex®). **Action: Clinical Effectiveness team to draft an interim policy that supports prescribing of THC:CBD spray (Sativex®) for patients whose only remaining option for management of spasticity is intrathecal baclofen. Based on clinical estimates of numbers of patients provided by local acute trusts currently fulfilling NICE criteria, the commissioning of THC:CBD (Sativex) spray is unaffordable to Thames Valley CCGs. The policy will be reviewed when further NICE guidance is published and further assessment of financial impact may be available. This will update the current interim policy TVPC 81 and replace South Central Priorities Committees Policy Statement: Cannabinoids in the Management of Multiple Sclerosis and Chronic Pain. ACTION Complete**
5.5	**Draft Minutes of the online Priorities Committee meeting held 27th January 2021 – Action 8.2 - Policy Update: TVPC 10 Interventions for non-union fracture: Low-intensity Pulsed Ultrasound (LIPUS) (marketed in the UK as the Exogen® system) and teriparatide** The Committee reviewed the evidence and following consideration agreed for a not normally funded position for LIPUS and teriparatide for the treatment of non-union fractures. **Action: Clinical Effectiveness to update and circulate policy 10. Comments to be received within the 2 week feedback period following issue. ACTION Complete**
5.6	**Draft Minutes of the online Priorities Committee meeting held 27th January 2021 – Action 9.2 - Policy Update - Donepezil, galantamine and rivastigmine and memantine for the treatment of dementia** The Committee reviewed the evidence and recommended that due to the new guidance available and the up to date CCG formulary guidance for dementia that is already in place, agreed to remove the current recommendations. **Action: Clinical Effectiveness team to withdraw the current policies:** **• Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease** **• Donepezil, galantamine and rivastigmine for the treatment of dementia associated with Parkinson's disease or Lewy Bodies** **ACTION Complete**
5.7	**Draft Minutes of the online Priorities Committee meeting held 27th January 2021 – Action 10.1 - Policy Update Programme** Regarding TVPC71, the Committee heard that Oxford Health are reviewing the shared care pathway for ADHD for Oxfordshire and may wish to contribute to an update of the current policy. **Actions: Clinical Effectiveness team to liaise with Oxford Health NHS FT regarding a potential update of the ADHD policy and add new dates to TVPC 68, 69 and 70.** **March 2021 update:** KM to contact Juliet Long prior to 1st April when the team moves to Health Education and Social Care for joint commissioning.
5.8	**Draft Minutes of the online Priorities Committee meeting held 27th January 2021 – Action 10.2 - Policy Update Programme** • The Committee agreed for these minor changes to be made to the policies. • TVPC67 NHS England Specialised Commissioning Services. Suggestion to include a link to the NHS England national programmes of care and The Manual. • TVPC4 Vasectomy – male sterilisation. Policies held by East Berks and Bucks: Suggestion to add in a line to emphasise that female sterilisation is not funded locally. **Action: Clinical Effectiveness team to circulate the updated policies TVPC67 and TVPC4. Comments to be received within the 2 week feedback period following issue.** **ACTION Complete**

5.9	**Draft Minutes of the online Priorities Committee meeting held 27th January 2021 – Action 10.3 - Policy Update Programme** The Committee discussed the issue of individual funding requests (IFR) for hysterectomies following resolve of symptoms using Zoladex®, either as basis for diagnosing endometriosis or for supporting hysterectomy for non-specific pelvic pain. The Committee agreed that treatment algorithms for both endometriosis and PMS should be included along with a statement that hysterectomy for non-specific pelvic pain is not normally funded. **Action**: **Clinical Effectiveness team to update and circulate TVPC58 as outlined above. Comments to be received within the 2 week feedback period following issue.** **ACTION Complete**
5.10	**Draft Minutes of the online Priorities Committee meeting held 27th January 2021 – Action 11.1 - Evidence-Based Intervention (EBI) List 2 update** **Action: Clinical Effectiveness team to circulate a summary of information presented on the 31 policies to Committee members and seek responses from TVPC members. ACTION Complete (agenda item 8)** **Action: Clinical Effectiveness team to start comparison of current TVPC policies against EBI 2 policies. ACTION Complete (agenda item 8)**
6.	**Paper 20-040: TVPC43 Use of biologic therapies for ulcerative colitis in adults (18 years and over**
6.1	In November 2020, the Committee discussed the use of biologic drugs and Janus-associated tyrosine kinases (JAK) inhibitors for ulcerative colitis. Dr Brain presented a pathway that he developed with colleagues from OUH and RBFT. This was edited slightly to reflect the Committee's discussions. The Clinical Effectiveness team circulated the draft policy to gastroenterologists in February. Feedback from Dr Hossain, Buckinghamshire Healthcare Trust, indicated the pathway was in line with their practice. The objective of discussions was to agree a TVPC commissioning statement and pathway. It is envisaged that the process in which these drugs are managed will be reviewed when CCGs merge into an integrated care system (ICS).
6.2	A discussion was held regarding a possible limit on the number of biologics / JAK inhibitors that could be tried by a patient and the potential financial impact of this. The original reason for addressing the use of biologics was because they are an expensive group of drugs. The Committee heard from the specialist in attendance that if a patient loses response to a drug with one mode of action despite having high levels of the drug in their system then the right thing to do is move onto a drug with a different mode of action. Until biomarkers inform which mechanism a patient responds to, it is not appropriate to preclude using the full range of drugs if people have active disease and do not otherwise require surgery. The specialist in attendance advised that the number of patients that will cycle through drugs with four modes of action is relatively small as either it is not appropriate to use one of the available drugs due to safety reasons or the patient's disease becomes so severe they need a colectomy. A committee member suggested that compartmentalising different modes of action and stating that a patient can only have one from each misrepresents the clinical benefit of trying 1 or 2 from within each class. The specialist in attendance advised that there are limits in the way the drugs are used and it is ensured that they are not used inappropriately. It was noted that the choice of drug should be limited to the least expensive within the options at any step of the pathway.
6.3	The Committee reviewed the evidence and guidance and following consideration of the potential patient numbers and financial impact, the Committee agreed to recommend an

	interim statement to state TVPC supports the use of biologic drugs and JAK inhibitors as per algorithm without restricting the number of drugs a patient may try. **Action: CE team to remove all statements regarding 4th and 5th biologic/ JAK inhibitor treatment and recirculate draft policy for comment.**
7	**Paper 20-041: Regional Medicines Optimisation Committee (RMOC) Advisory Statement Sequential Use of Biologic Medicines – Amendment to current TVPC policies**
7.1	In January 2021, the Committee discussed TVPC46 Sequential use of biologic therapy in Psoriatic Arthritis and TVPC51 Use of biological and immunomodulatory therapies in Rheumatoid Arthritis, with respect to the RMOC statement. Laura Coates, a rheumatologist, was previously present to provide specialist input. The Committee requested draft policies for discussion and agreement to allow provision of 4 biologics / JAK inhibitors in order to increase flexibility and patient choice compared to the current policy which allows for the use of up to 3 biologic drugs or JAK inhibitors. Considerations for the Committee: • Local injection reaction or infusion reaction with any biologic drug warranting a switch to an alternative drug is not considered a switch for the purpose of the policies. • Consider the need to include reference to all NICE TAGs. This is useful for algorithms but less useful for statements. • Agree wording to ensure consistency for policies for axial spondyloarthritis, Crohn's disease and psoriasis. • Consider the need for a statement of rationale for the policy. • Agree a review of a future process to potentially allow a multidisciplinary team (MDT) approach to the sequential use of biologic / high cost drugs. This could remove the need for commissioning statements and use of the individual funding request (IFR) process. Policies have been amended following discussions held at previous meetings.
7.2	The Committee discussed that these would be interim policies and would recommend up to 4 biologic drugs or JAK inhibitors for psoriatic arthritis and rheumatoid arthritis. This was supported by the specialist in attendance. The Committee noted these policies are strictly interim and acknowledges the differences in recommendations between ulcerative colitis and rheumatic condition medications. The Committee discussed that the differences in recommendation are because ulcerative colitis has fewer biologic drugs and JAK inhibitors approved by NICE and there are notable differences in their modes of action. In addition, the Committee was advised that number of patients requiring a 4th subsequent drug for ulcerative colitis is likely to be small. There is a greater range of biologic drugs with similar modes of action including biosimilars, and JAK inhibitors available for rheumatic conditions. The number of patients with rheumatic patients is expected to be high and the potential diminishing effect of using similar biologic drugs is uncertain. It is noted that there is no blanket ban on treatment and the individual funding request (IFR) process is available for cases outside of the policies. TVPC supports the prescribing of clinically appropriate drugs.
7.3	The Committee agreed to recommend an interim statement to support sequential use of up to 4 different biologic drugs / JAK inhibitors in total. The Committee was happy with the current wording of the policies for the axial spondyloarthritis, psoriasis and Crohn's disease policies. **Action: CE team to update the Psoriatic Arthritis and Rheumatoid Arthritis policies to state that up to 4 biologic drugs or JAK inhibitors can be used as an interim statement.** **Action: CE team to circulate updated draft policies for comment.**

	Post meeting note: Following the meeting, it has been agreed that the use of biologic drugs and JAK inhibitors for moderate RA will be reviewed separately due to recently published NICE TAG.
8.	**Paper 20-042: Evidence Based Interventions List 2**
8.1	Following the meeting in January 2021, an overview document of Evidence Based Interventions List 2 (EBI2) was circulated to the Committee. There are 31 policies for tests, treatments and procedures where the evidence about their effectiveness or appropriateness has changed. This includes 2 tests / treatments that should be no longer commissioned: • Exercise ECG for screening for coronary heart disease • Helmet therapy in the treatment of positional plagiocephaly in children EBI2 policies which may impact TVPC statements are as follows: • 2B Repair of minimally symptomatic inguinal hernia • 2C Surgical intervention for chronic rhinosinusitis • 2D Removal of adenoids for treatment of glue ear • 2E Arthroscopic surgery for meniscal tears • 2J Lumbar Discectomy • 2K Lumbar radiofrequency facet joint denervation • 2Q Removal of inflamed gall bladder • 2Y Fusion surgery for mechanical axial low back pain It is suggested to review TVPC policies in line with this EBI2 guidance and amend accordingly. It is likely there will be no detailed evidence review or clinical consultation required. Treatments that TVPC does not hold a current statement for are: • 2G Surgical removal of kidney stones • 2I Surgical intervention for benign prostatic hyperplasia The Committee agreed for these to be added to the forward programme schedule for review. **Action: CE team to add to the forward programme schedule.** There are three guidelines that may not require a statement and the national contract will come into play regarding EBI: • 2V Vertebral augmentation (vertebroplasty or kyphoplasty) for painful osteoporotic vertebral fractures. VP or KP may be considered following NICE Technology Appraisal Guidance 279 therefore it is anticipated that there is no need for a separate TVPC policy statement. • 2Z Helmet therapy for treatment of positional plagiocephaly/brachycephaly in children • 2EE Blood transfusion There have been no individual funding requests (IFR) for helmet therapy across Thames Valley CCGs over the last 3 years. The Committee agreed no action is required for these guidelines. TVPC has already incorporated some diagnostic guidelines into existing policies. These are the remaining diagnostic guidelines from EBI2: • 2AA Pre-operative chest x-ray • 2BB Pre-operative ECG • 2CC Prostate-specific antigen (PSA) test • 2DD Liver function, creatinine kinase and lipid level tests – (Lipid lowering therapy) • 2A Diagnostic coronary angiography for low risk, stable chest pain • 2F Troponin test • 2H Cystoscopy for men with uncomplicated lower urinary tract symptoms

	• 2L Exercise ECG for screening for coronary heart disease • 2M Upper GI endoscopy • 2N Appropriate colonoscopy in the management of hereditary colorectal cancer • 2O Repeat Colonoscopy • 2P ERCP in acute gallstone pancreatitis without cholangitis • 2R Appendicectomy without confirmation of appendicitis It was suggested endoscopy and colonoscopy may require a TVPC policy statement as this was submitted as a work request from BOB STP due to concern about the number of inappropriate referrals. In addition a pathway for benign prostatic hyperplasia (BPH) could include guidelines for appropriate use of a Prostate-specific antigen (PSA) test. The Committee agreed separate statements for the remaining diagnostic guidelines are not required. Reviews of endoscopy and colonoscopy will be added on to the TVPC work programme. Review of the use of PSA tests will be included in a review of BPH and added onto the TVPC work schedule.
8.2	**Paper 20-043 Chronic Sinusitis** A policy update is part of the work schedule for three yearly update and review against the EBI2 recommendations. EBI2 make recommendations on the management of chronic rhinosinusitis (CRS) with intranasal steroids and nasal saline irrigation as a first-line treatment. They are low cost and low risk, with newer generations of nasal steroids safe for long-term use owing to minimal systemic absorption. There is also evidence to support the trial of oral steroids when nasal polyposis is present. TVPC21 policy and EBI2 recommendations have been based on the same guidelines by the Royal College of Surgeons Commissioning Guide: Chronic Rhinosinusitis. No major differences in TVPC21 and EBI2 guidelines were identified. The recommendation is to update the policy to add a clearer time lines and note on primary care diagnostics. • A clinical diagnosis of CRS has been made (as set out in RCS/ENT-UK Commissioning Guidance Appendix 1) in primary care and patient still has moderate / severe symptoms after a 3-month trial of intranasal steroids and nasal saline irrigation. • For patients with bilateral nasal polyps there has been no improvement in symptoms 4 weeks after a trial of 5-10 days of oral steroids (0.5mg/kg to a max of 60 mg) • No investigations, apart from clinical assessment, should take place in primary care or be a pre-requisite for referral to secondary care (e.g. X-ray, CT scan). There is no role for prolonged courses of antibiotics in primary care. In terms of CCG activity, there are no significant annual activity reduction targets. The Committee agreed to adopt the EBI pathway with additions. **Action: CE team to amend the policy with the agreed additions.**
8.3	**Paper 20-044 Hernia** TVPC48 Elective surgical hernia repair in adults was last reviewed in 2016 and again in 2019 with no changes except to remove a patient decision aid. EBI2 guidance is for repair of minimally symptomatic inguinal hernia and states the following: <u>Proposal</u>

	• Minimally symptomatic inguinal hernia can be managed safely with watchful waiting after assessment. Conservative management should therefore be considered in appropriately selected patients. In women, all suspected groin hernias should be urgent referrals. The noted differences are: • EBI is a statement regarding watchful waiting for minimally symptomatic inguinal hernia only and does not include criteria for surgery or reference to other types of hernia. • EBI guidance applies to adults over the age of 19. TVPC policy applies to adults. • TVPC policy statement includes immediate referral for femoral and spigelian hernias. • TVPC policy statement includes criteria for consideration of referral for all other abdominal/ ventral hernias: o Documented history of incarceration of, or real difficulty in reducing, the hernia o Documented pain or discomfort significantly interfering with activities of daily living. Details of nature and extent of impact must be provided at referral o Increase in size month to month. o Work-related issues (includes domestic duties and unpaid caring): • has become restricted to light duties because of hernia • off work/missed work/unable to work because of hernia Suggestions to add to the current TVPC policy: Minimally symptomatic inguinal hernia can be managed safely with watchful waiting after assessment. Conservative management should therefore be considered in appropriately selected patients. Add to the list of immediate referrals: • 'In women, all suspected groin hernias should be urgent referrals' The criterion within the current policy relating to increasing size of hernia was discussed. The RCS guidance questions the use of increasing size as a threshold for referral for surgery. Authors highlight that hernias do not increase in size in a smooth fashion, with some months seeing significant growth and others seeing limited or no growth. They suggest that this makes it extremely difficult to assess when a patient may require surgery. The Committee noted the guidance, however, agreed that from clinical experience, a growing and enlarging hernia is a helpful criterion and should remain as part of the referral thresholds. The Committee agreed to add the EBI2 statement and maintain the rest of the policy as it is. **Action: CE team to add EBI2 statement to the policy.**
9.	**Paper 20-045: Policy Updates**
9.1	The TVPC policy update programme reviews all TVPC policies every 3 years and identifies new or updated national guidance and if applicable, clinical and cost effectiveness evidence. <u>TVPC 77: The diagnosis and treatment of Foetal Alcohol Spectrum Disorders (FASD) in children, adolescents and adults.</u> New guidance has been published, SIGN 156 (2019) Children and young people exposed prenatally to alcohol. This includes a description of a pilot study in Scotland which compared a specialist foetal alcohol assessment and support team vs usual care (CaMHS and community paediatrics). The specialist team was reported to have better access to the multi-disciplinary staff that were required to diagnose FASD and were more confident in making a formal diagnosis. However both teams found difficulties in assessing this condition. Overall, the pilot concluded that it wasn't sustainable to provide a specialist service in the long term and proposed the condition be managed within the context of the wider services and mental health

	teams which is the premise of the TVPC policy. It was proposed that no changes were required to the policy wording. The Committee noted that it would be helpful to cite the new SIGN guidance in the updated policy. **Action: CE team to add a footnote to TVPC 77 to reference SIGN 156 (2019) Children and young people exposed prenatally to alcohol.**
9.2	<u>TVPC 72: Management of Haemorrhoids</u> The EBI first phase (2018) recommendations for the treatment of haemorrhoids were presented to the Committee; these were published shortly after the TVPC policy recommendation was made. The EBI and TVPC policies are supported by a similar evidence base but the premise of the two policies differ. TVPC 72 states referral criteria for specialist assessment and management of the condition (this could include non-surgical treatments such as rubber banding) however EBI states criteria for surgical treatment only. As the two policies are not directly comparable, the Committee agreed that no changes should be made to the policy and a link be included to the EBI guidance for information. **Action: CE team to amend TVPC 72 to include a link to the EBI guidance.**
9.3	<u>TVPC 74: Adhesive Capsulitis (Frozen Shoulder)</u> The Committee has previously reviewed the wording of this policy in line with the EBI list 2 guidance and recommended a minor change to the use of imaging in primary/ intermediate care. The current review has also checked national guidance and recently published clinical evidence; no further additions are required. **Action: CE team to amend the policy to reflect EBI list 2 guidance as previously recommended.**
9.4	<u>TVPC 75: Management of asymptomatic gallstones</u> This policy was reviewed in line with the EBI list 2 guidance which recommends that patients admitted to hospital with acute cholecystitis or mild gallstone pancreatitis should have index laparoscopic cholecystectomy performed within that admission. The Committee agreed that this guidance should be added to the current policy. **Action: CE Team to amend the policy to reflect EBI list 2 guidance.**
9.5	<u>TVPC50: Subacromial decompression for Shoulder Impingement</u> A new Cochrane systematic review of recent evidence including two large sham surgery trials based in the UK and Finland concludes that there is high-certainty evidence that subacromial decompression does not provide clinically important benefits over placebo in pain, function or health-related quality of life. A related BMJ clinical practice guideline issued a strong recommendation against subacromial decompression surgery. The Committee agreed that this new evidence base requires further consideration and noted that due to the potentially large numbers of surgeries being carried out, that it should be prioritised for a full review. **Action: CE team to schedule TVPC 50 for a full update.**
9.6	Paper 20-046: Therapeutic use of facet joint injections and medial branch blocks for chronic neck pain Current Policy (2016) states facet joint injections and medial branch blocks for diagnostic and therapeutic purposes are not normally funded. The policy update review identified one international guideline: American Society of Interventional Pain Physicians (ASIPP) Guidance (2020). This states there was moderate strength, moderate level evidence for diagnostic and therapeutic cervical facet joint nerve blocks and weak strength, consensus-based evidence for therapeutic intraarticular facet joint injections. -

	One systematic review (SR) Manchikanti et al. (2016) was identified. The SR found moderate evidence for diagnostic and therapeutic cervical facet joint nerve blocks, which is in alignment with the ASIPP guidance, and fair evidence for cervical intra-articular injections. In terms of activities and costs, numbers have been on a downward trend in all four Thames Valley CCGs since 2016/17. Clinical feedback was received from two consultant spinal surgeons, both agreed with the current policy that facet joint injections and medial branch blocks should not be used in chronic neck pain. No comment was received from pain specialists. The Committee recommended to update the policy statement on diagnostic and therapeutic facet joints injections and medial branch blocks and maintain the position of not normally funded for chronic neck pain, due to lack of evidence on cost and clinical-effectiveness **Action: CE team to update the policy statement on diagnostic and therapeutic facet joints injections and medial branch blocks for chronic neck pain.**
10.	**AOB**
10.1	Future meetings location/online Currently all meetings for 2021 are booked as Microsoft Teams virtual meetings. Some organisations are in the process of returning to the office environment and the Committee was asked how they would like to continue with meetings going forward taking this into account. The annual workshop could provide an opportunity to hold a face to face meeting. **Action: CE team to liaise with Committee members to ascertain how many meetings they would like to have face to face.**
11.	**Next meeting**
	The next online meeting will be held on Wednesday 26th May 2021 **from 2 - 4.30pm**
12.	**Meeting Close**
	The Chair thanked everyone for their contributions to the discussions and closed the meeting.