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Berkshire West Clinical Commissioning Group
Buckinghamshire Clinical Commissioning Group
Frimley Clinical Commissioning Group
Oxfordshire Clinical Commissioning Group

Thames Valley Priorities Committee

Minutes of the meeting held Wednesday 28TH July 2021

On-line via Microsoft Teams

Alan Penn	Lay Member Chair	Thames Valley Priorities Committee
Sue Carter	Clinical Effectiveness Manager (CCG)	Oxfordshire CCG
Dr Raju Reddy	Secondary Care Consultant	Berkshire West CCG
Dr Janet Lippett	Chief Medical Officer	Royal Berkshire
Professor Chris Newdick	Special Advisor – Law	University of Reading
David Pollock	Interface Lead Pharmacist	Berkshire West CCG
Mark Sheehan	Special Advisor – Ethics	University of Oxford
Gill Manning	Lay representative	Frimley CCG
Catriona Khetyar	Head of Medicines Optimisation	Frimley CCG
Maire Stapleton (joined at 2.30pm)	Formulary Manager	Buckingham Healthcare NHS Trust
Dr Megan John	GP, East Berkshire and Frimley Lead	Frimley CCG

In Attendance:

Kathryn Markey	Clinical Effectiveness Manager	SCW CSU
Naomi Scott - Observer	Clinical Effectiveness Manager	SCW CSU
Tiina Korhonen	Clinical Effectiveness Lead	SCW CSU
Helen Hicks - minutes	Clinical Effectiveness Administrator	SCW CSU
Funmi Fajemisin (left at 4.05pm)	Clinical Services Programme Lead Clinical Policy Implementation	SCW CSU
Christina Maslen (left at 4.06pm)	Clinical Effectiveness Manager	SCW CSU
Ameena Malik - Observer	Medicines Optimisation Pharmacist	SCW CSU

Apologies:

Edward Haxton	Deputy Finance Director	Berkshire West CCG
Dr Jacky Payne	GP, Berkshire West	Berkshire West CCG
Andrew McLaren	Deputy Medical Director	Buckinghamshire Health NHS Trust
Lalitha Iyer	Medical Director	Frimley CCG
John Reynolds	Associate Director of Medical Sciences Division (Clinical Affairs)	Oxford University Hospital (OUH) NHS Trust
Kate Stephen	Commissioning Manager	Oxford CCG
Professor Meghana Pandit	Medical Director	Oxford University Hospital NHS Trust
Fiona Slevin-Brown	Director of Strategy and Operations	Frimley CCG
Karl Marlowe	Medical Director	Oxford Health NHS Trust
Dr Andrew Brent	Director of Clinical Improvement	Oxford University Hospital (OUH) NHS Trust

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Stuart Lines	Director of Public Health for East Berkshire	Public Health Services for Berkshire

Topic Specialists in Attendance for Agenda Items:

Item – 4
Carl Davies, Director of MSK, Berkshire West Integrated Care Partnership (ICP) Professor Andrew Price, Consultant Orthopaedic Surgeon, Oxford University Hospitals NHS Trust Nicholas Bottomley, Clinical Lead, Consultant Orthopaedic Surgeon, Oxford University Hospitals NHS Trust Laura Franklin, MSK Community specialist service- service manager, Berkshire Healthcare NHS Foundation Trust Tom Pollard, Clinical Director Orthopaedics and Trauma, Royal Berkshire NHS Foundation Trust Karen Grannum, Planning and Transformation Lead, Berkshire West CCG

Item –8 and 9
Ambreen Tunio, Consultant Ophthalmologist, Buckinghamshire Health NHS Trust Professor Peter Issa, Consultant Ophthalmic Surgeon, Oxford University Hospitals NHS Trust Dr Praveen Kumar, Consultant Ophthalmologist, Royal Berkshire NHS Foundation Trust

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1.	**Welcome & Introductions**
1.1	The Chair opened the meeting and welcomed members of the Committee.
2.	**Apologies for Absence**
2.1	Apologies recorded as above.
3.	**Declarations of Interest**
3.1	CM declared one seeing eye.
4	**Review of TVPC 49, TVPC55 and TVPC 83**
4.1	Proposed changes to the policies are required. These have been circulated in advance of the meeting.
4.2	**TVPC49 Patients with osteoarthritis (OA); primary hip and knee replacement** A review of selected Musculoskeletal polices (MSK) has been initiated by the MSK lead, Berkshire West Integrated Care Partnership (ICP), to ensure policies are fit for purpose and facilitate pragmatic application of them. Current TVPC49 policy wording states that patients with a BMI over 35 are required to have actively participated and committed to a recognised weight loss programme. NICE Clinical guideline [CG177] Osteoarthritis: care and management suggest weight should not be a limiting factor for referral for surgery. In practice outcomes of attendance and active engagement at a weight loss programme is difficult to establish. A wording amendment to the policy is proposed to support patients who do have a high BMI and direct these patients that are open to referral, to weight management programmes. The pre-operative assessment will be the defining factor as to whether patients are medically fit for surgery and the proposed wording reflects this. This proposal was supported by all attending clinicians. The Committee was advised that there is unlikely to be any financial impact as a result of the proposed changes. It may result in a reduction of the use of resources, as patients do not need to be rereferred back to services pending attendance at weight management services. Following consideration and discussion the Committee agreed to recommend the proposed wording amendments: "BMI ≥ 35kg/m2 have been offered a recognised weight management programme and have been reviewed pre-operatively as to whether medically fit for surgery" In addition, reference to the use of oral opioids should be removed from the analgesics line in the section on further information. **Action: Clinical Effectiveness team to update and circulate the policy statement as outlined above.**

4.4	**Policy 83 Anterior Cruciate Ligament (ACL) reconstruction** The Committee was advised that nationally developed pathways do not include age as a defining factor. The current policy allows age to be a discriminatory factor for referral to surgery. Amendment is required to base approval for surgery on function for patients aged under 40. Patients aged over 18 will be required to access 3 months of rehabilitation. Patients aged over 40 should have primary osteoarthritis ruled out as the primary cause in the first instance. Patients over the age of 60 years should undergo rehabilitation for longer but should still be able to access surgery. The Committee was advised that there are not many people that are over the age of 50 years who require surgery for ACL rupture but it is an important group of patients that it would be useful for. Evidence suggests that commitment to 3 months of rehabilitation gives a good indication as to whether surgery is suitable. For patients over the age of 18, in order to undergo the risks of surgery, it should be first demonstrated that they are not able to stabilise themselves by having rehabilitation. Following consideration, the Committee agreed the proposed wording amendments: a) All patients under 40 are assessed based on their individual levels of function. b) All patients over 18 that do not meet the criteria in (a) should be required to adhere to 3-month rehabilitation and those over 40 should have osteoarthritis as a primary cause ruled out prior to re-assessment for suitability. c) All patients over 60 should be required to adhere to 6-months of rehabilitation and those patients have osteoarthritis as a primary cause ruled out prior to re-assessment for suitability. **Action: Clinical Effectiveness team to update and circulate the draft policy statement as outlined above.**
4.5	**Policy 55 Primary hip and knee replacement revision surgery** Hip and knee replacement revisions have an urgency and clinical risk, therefore it is proposed the policy changes from Prior Approval to approved subject to audit. The Committee noted that the implementation process for a threshold policy is CCGs specific so this is a decision to raise with the relevant CCG.
5	**Draft Minutes of the online Priorities Committee meeting held 26th May 2021 – Confirm Accuracy**
5.1	The draft minutes were accepted as a true record of the meeting.
6	**Draft Minutes of the online Priorities Committee meeting held 26th May 2021 – Matters Arising**
6.1	**Draft Minutes of the online Priorities Committee meeting held 26th May 2021 – Action 1.1** The Chair noted that there had been little input from consultants for the topics to be discussed. **Action: Commissioning teams to contact their Medical Directors to confirm papers are being distributed. ACTION Complete**
6.2	**Draft Minutes of the online Priorities Committee meeting held 27th January 2021 – Action 5.1 - 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. **May 2021 update**: In progress. ADHD due to be reviewed later in 2021. Clinical Effectiveness team to liaise with Oxfordshire CCG to take forward. **July 2021 update**: added to work scheduled. **ACTION Complete**

6.3	**Draft Minutes of the online Priorities Committee meeting held 26th May 2021 – Action 6.4 - Proposed adoption of policy statement: Use of biological and immunomodulatory therapies in the treatment of MODERATE Rheumatoid Arthritis - Interim statement** The Committee reviewed the guidance and following consideration agreed to offer filgotinib as a first choice treatment alongside adalimumab and infliximab within the proposed pathway. **Action: Clinical Effectiveness team to update and circulate the policy statement as outlined above.** Post meeting note: due to the publication of the final appraisal document for partial review of TA375 (Adalimumab, etanercept, infliximab, certolizumab pegol, golimumab, tocilizumab and abatacept for moderate rheumatoid arthritis after conventional DMARDs have failed) and rescheduled date of 14th July for final publication, the proposed pathway for moderate RA will need to be revisited at the next TVPC meeting. **ACTION Complete – agenda item 6**
6.4	**Draft Minutes of the online Priorities Committee meeting held 26th May 2021 – Action 7.6 - Policy update: Severe and complex obesity** The Committee reviewed the guidance and following consideration agreed not to adopt the additional criteria for bariatric surgery recommended by NICE CG189 guidance on the grounds of affordability and capacity for tier 3 services. The criteria regarding the presence of morbid/severe obesity for at least five years is to be removed. The policy is to be a standard policy. **Action: Clinical Effectiveness team to update and circulate the policy as outlined above. Comments to be received within the 2 week feedback period following issue. ACTION Complete**
6.5	**Draft Minutes of the online Priorities Committee meeting held 26th May 2021 – Action 8.4 Posterior tibial nerve stimulation in paediatric patients** The Committee discussed the evidence, guidance and approach to IFRs. **Action: RR to liaise with Birmingham Centre Urologists to informally ask their views and find out the practices they carry out. ACTION Complete**
6.6	**Draft Minutes of the online Priorities Committee meeting held 26th May 2021 – Action 8.5 Posterior tibial nerve stimulation in paediatric patients** The Committee reviewed the evidence and specialist clinical input. Due to the small number of patients and a lack of robust high quality evidence showing positive outcomes compared to usual care, it was agreed to recommend a position of not normally funded as an interim position. **Action: Clinical Effectiveness team to draft a policy recommendation to state intervention is not normally funded and circulate for comment. Comments to be received within the 2 week feedback period following issue. ACTION Complete** **Action: Clinical Effectiveness team to contact specialist in attendance (MB) for further evidence and patient data.** **July 2021 update:** KM advised the specialist in attendance of the Committee decisions and requested further evidence and patient data. No response received, KM to follow up within a few months.
6.7	**Draft Minutes of the online Priorities Committee meeting held 26th May 2021 – Action 9.5 - Policy update: Non-pharmacological services for dementia** The Committee reviewed the evidence and following consideration agreed to withdraw the current policy in favor of using available NICE guidance. **Action: Clinical Effectiveness team to withdraw policy 63. ACTION Complete**
6.8	**Draft Minutes of the online Priorities Committee meeting held 26th May 2021 – Action 10.1 - Policy update programme** <u>TVPC3: Anal Irrigation Systems for the Management of Faecal Incontinence/Constipation</u> NICE is to review NICE MTG36 (2018) Persistent transanal irrigation system for managing bowel dysfunction this year. Three RCTs were found which showed an improvement in bowel function

	among patients with a range of disorders and improvement in quality of life. Discontinuation rates were high although side effects were common, but equally prevalent among comparative treatments. The Committee agreed to maintain the current policy. **Action: Clinical Effectiveness team to add a new date of recommendation to TVPC3. ACTION Complete**
6.9	**Draft Minutes of the online Priorities Committee meeting held 26th May 2021 – Action 10.2 - Policy update programme** TVPC 78: Smoking cessation before planned surgery There has been no change to national guidance. A minor change is required due to expired links. The Committee agreed with the minor change. **Action: Clinical Effectiveness team to update TVPC 78 with new links. ACTION Complete**
6.10	**Draft Minutes of the online Priorities Committee meeting held 26th May 2021 – Action 10.3 – Policy update programme** TVPC6: Arthroscopic lavage & debridement for patients with OA of the knee The current policy is aligned with the statements made by the evidence-based intervention programme (EBI) phase 1 as both are based on NICE CG177: Osteoarthritis: care and management (2014) which is cited in the policy. A minor change was suggested to highlight the EBI guidance. It was advised that EBI have a new website that includes a range of patient resources which may be useful to refer to. The Committee agreed with the minor change. **Action: Clinical Effectiveness team to update TVPC6 with a link to EBI1 guidance. ACTION Complete**
6.11	**Draft Minutes of the online Priorities Committee meeting held 26th May 2021 – Action 10.4 - Policy update programme** The Committee queried the financial implications of adopting the wider criteria outlined in EBI phase 2 guidance and requested further information. **Action: Clinical Effectiveness team to investigate the financial implications of adopting EBI phase 2 guidance.** **July 2021 update:** to be discussed at September 2021 Committee meeting.
6.12	**Draft Minutes of the online Priorities Committee meeting held 26th May 2021 – Action 10.5 – Policy update programme** TVPC1: Interventional Procedures for Varicose Veins The current policy has stricter criteria for consideration of interventional treatment than EBI phase 1 guidance (which is based on NICE CG168). The TVPC policy also promotes the use of compression stockings, which are not recommended by EBI (or NICE). In addition to EBI phase 1 guidance, a new RCT has been published which shows a benefit in healing time if vascular ulcers are treated early. This study supports the NICE recommendation that patients with leg ulceration not healed within 2 weeks should be referred to a vascular service. The current TVPC policy recommends that patients should be referred if they have "recurrent and persistent leg ulceration secondary to chronic venous insufficiency, despite 6-months of conservative management with compression stockings* for the first ulcer". As the RCT was a large UK trial whose findings conflict with the current policy position, it is suggested that the policy be reviewed in full by the Committee. **Action: Clinical Effectiveness team to add to the work programme for review. ACTION Complete**
6.13	**Draft Minutes of the online Priorities Committee meeting held 26th May 2021 – Action 11.1 - Horizon scanning** The following actions were agreed: ➢ Medical technologies guidance (update) [MTG53] The PLASMA system for transurethral resection and haemostasis of the prostate **Action: To include this as part of the review of a Benign Prostatic Hyperplasia (BPH) pathway as scheduled.**

	July 2021 update: to be discussed at the September 2021 Committee meeting. ➢ Technology appraisal guidance [TA672] Brolucizumab for treating wet age-related macular degeneration **Action: Clinical Effectiveness team to schedule a review into this years' work programme. ACTION Complete – agenda item 9** NICE guideline [NG193] Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain This gives a positive recommendation to consider a single course of acupuncture or dry needling within a traditional Chinese or Western acupuncture system for people aged 16 or over to manage chronic primary pain within certain criteria. Acupuncture is referred to on 2 TVPC policies: TVPC 52 Management of lower back pain, which states management for lower back pain with or without sciatica is not normally funded; TVPC 100 complementary and alternative therapies, which was reviewed in 2020and states the use of all complementary therapies including acupuncture is not normally funded. This will have a financial impact on the policies. The overall NICE guidelines suggests there is a potential saving in terms of recommendations within the guideline regarding use of expensive drugs for chronic pain. **Action: Clinical Effectiveness team to add to the work programme for review. ACTION Complete**
6.14	**Draft Minutes of the online Priorities Committee meeting held 26th May 2021 – Action 12.1 – Annual report** The Clinical Effectiveness team has produced an annual report for 2020-21 which details evidence and policies reviewed in 2020-2021. When finalised, this will be circulated to Committee members. **Action: Clinical Effectiveness team to circulate the final version. ACTION Complete**
7	**Proposed adoption of interim policy statement: Use of biological and immunodulatory therapies in the treatment of MODERATE Rheumatoid Arthritis (RA)**

7.1	At the May 2021 TVPC Committee meeting the use of biologic drugs and Janus Kinase (JAK) inhibitors for the management of moderate rheumatoid arthritis (RA) was discussed with a view to developing a pathway to support the most cost effective prescribing. The Committee agreed that an interim statement for the use of biologic drugs and JAK inhibitors is produced that supports NICE guidance and cost-effective prescribing.
	In July, NICE brought forward the publication of TA715: Adalimumab, etanercept, infliximab and abatacept for treating moderate rheumatoid arthritis after conventional DMARDs have failed which states:
	• Adalimumab, etanercept and infliximab, all with methotrexate, are recommended as options for treating active rheumatoid arthritis in adults, only if:
	  • intensive therapy with 2 or more conventional disease-modifying antirheumatic drugs (DMARDs) has not controlled the disease well enough and
	  • disease is moderate (a disease activity score [DAS28] of 3.2 to 5.1) and
	  • the companies provide adalimumab, etanercept and infliximab at the same or lower prices than those agreed with the Commercial Medicines Unit.
	• Adalimumab and etanercept can be used as monotherapy when methotrexate is contraindicated or not tolerated, when the above criteria are met. This is in line with licensing.
	Within this Technology appraisal (TA)abatacept is not recommended for moderate RA.
	
	NICE TAG 676 for Filgotinib for treating moderate to severe rheumatoid arthritis Technology appraisal guidance [TA676] was published in February 2021. Recommendations are for both moderate and severe rheumatoid arthritis.

	• Filgotinib, with methotrexate, is recommended as an option for treating active rheumatoid arthritis in adults whose disease has responded inadequately to intensive therapy with 2 or more conventional disease-modifying antirheumatic drugs (DMARDs), only if:
	  • disease is moderate or severe (a disease activity score [DAS28] of 3.2 or more) and
	  • the company provides filgotinib according to the commercial arrangement.
	A proposed TVPC interim statement is in line with NICE TAGs and states that adalimumab, etanercept, infliximab and filgotinib should be used as options for moderate RA. Adalimumab should be offered as first line treatment due to cost effectiveness.
	The Committee is asked to consider that this interim statement is adopted for 12 months to allow new patients to commence treatment whilst discussions with clinicians are held in order to create a pathway for patients progressing from moderate to severe RA.

7.2	Committee discussion: It was agreed that it would be appropriate to a review the interim statement in 12 months' time and this should be to be added to the policy. Regarding financial impact, NICE offers a resource impact template. In terms of the patient numbers it is thought the NICE estimations do not necessarily agree with the advice given by the local clinicians. The Committee was advised that for example, the Berkshire West rheumatology team is not sure if there is an unknown cohort of patients that are being looked after in primary care, therefore there is uncertainty of patient numbers affected. It was noted that this is a NICE TA and CCGs must make funding available. A question was raised regarding potential impact on capacity and patient flow consequence and whether services will be prepared for the possible increased demand. It was agreed that local discussions are held to establish this. Following consideration, the Committee agreed to accept the proposal of an interim statement and to note that there are costs involved for local consideration. **Action: Clinical Effectiveness team to update and circulate the policy statement as outlined above.**
8	**Anti-VEGF for AMD in patients with only 'one seeing eye'**
8.1	TVPC requested a review on the use of anti-VEGF treatment (anti-angiogenic therapies) of Age-related macular degeneration (AMD) in patients with only one seeing eye. The purpose of the evidence review is to: • Define what constitutes one seeing eye. Determine whether it is clinically and cost effective to treat patients with anti-VEGF with one seeing eye before their VA drops below 6/12. • Explore potential threshold criteria for treatment of patients with wet AMD and one seeing eye (monocular vision). There is no agreed definition for "one seeing eye" (monocular vision). Monocular vision is where an individual is permanently reliant on only one eye for their vision. This causes problems with orientation in space and mobility - primarily due to visual field restrictions and loss of depth perception. Loss of vision in an only (i.e. 'better') eye can have a significant impact on patients' quality of life. Development of wet AMD in the only seeing eye, with associated loss of vision, can have a serious impact. Criteria for severely sight impaired (blind) or sight impaired (partially sighted) depends on a complex range of parameters - including VA and visual field. Impact on sight from a VA of 6/9 – 6/12 is considered mild impairment, wet AMD can cause a 30% loss of visual field and central loss, which places someone with wet AMD with monocular vision as sight impaired. Patients whose vision falls below 6/12, will lose their driving licence.

8.2	<u>National guidance and evidence</u> NICE has issued guidelines for the management and treatment of AMD in 2018 (NG82) including treatment with anti-VEGF ranibizumab and pegaptanib TA155 and aflibercept TA294. In February 2021 NICE published TA672 for the use of brolucizumab**.** The TAGs include criteria that need to be met in order to access treatment with anti-VEGFs. One criterion for treatment is: the BCVA is between 6/12 and 6/96. i.e. treatment should not commence with an anti-VEGF if VA is better than 6/12. This has implications for those who develop neovascular (wet) AMD in an "only seeing eye" – for driving and also for overall quality of life (QoL). Age-related macular degeneration NICE guideline [NG82]: The 6/12 threshold criterion comes from TAGs for ranibizumab and aflibercept that predate NG82. It contains new evidence and new economic modelling conducted since that used for the TAGs. The guideline development committee (GDC) did consider the effectiveness of first-line anti-VEGF in people presenting with VA better than 6/12. Observational data demonstrates that treating AMD when VA is good leads to the eye maintaining good VA over time. The GDC believed that this echoes clinical experience. New economic modelling suggested that extending current practice to treat eyes with visual acuity better than 6/12 consistently produced additional QALYs. Extending current practice to treat eyes with visual acuity better than 6/12 is likely to be cost effective if the agent given is aflibercept or ranibizumab (evaluated at PAS prices), with ICERs below £20,000 per QALY gained compared with not extending treatment. However, the GDC considered it inappropriate to make a specific recommendation mandating such an approach because the analysis had convincingly shown that there are many strategies that would deliver greater net benefit to the NHS than simply extending current treatment to a wider range of eyes.
8.3	<u>Financial implication</u> The financial impact of treating patients earlier than recommended in the NICE TAGs is difficult to estimate. Current activity data do not distinguish between eyes that have been treated early and treatment in an only seeing eye. It is also difficult to quantify how starting treatment early will impact on other factors associated with reduction in vision and in blindness. Using NICE estimates, the incidence of wet AMD across Thames Valley CCGs including the population of East Berkshire, is approximately 1597 patients with approximately 1357 patients eligible for treatment with anti-VEGF agents. NICE suggests that approximately 27% of these patients may be eligible for treatment of the second eye therefore a rough estimation of the number of patients requiring treatment for 2nd eye could be 366 patients per year. A discussion was held around the average confidential cost of annual treatment per patient. To note, these patients that may require treatment earlier will fulfil NICE criteria at some point due to the degenerative nature of the disease. According to the Royal National Institute for the Blind (RNIB), 23% of blindness is attributed to AMD and it is estimated that the associated reduction in wellbeing and health due to sight loss is approximately £19billion per year.
8.4	Options for consideration The Committee was presented with three possible options for consideration: Option 1 – recommend treatment for those with VA threshold of between 6/9 and 6/96 Option 2 – recommend treatment in the eye to be treated with VA threshold of between 6/12 and 6/96 Option 3 - recommend treatment for vision better than 6/12 regardless of vision in the fellow eye.
8.5	Committee discussion. The clinicians in attendance made the following points: ➢ The Committee heard that a local consultant would strongly support option 3. And believed this would be in the best interest in the patients.

	➢ Regarding one quarter of patients needing treatment for the second eye at some point, it is important to stress that those patients who have good vision in their second eye that gets affected will be monitored in order to protect the time point of when they reach the 6/12 threshold. There is an associated cost of the monitoring. If these patients are treated late, they may have more aggressive disease which is more expensive overall to treat. ➢ If the rationale to treat the second eye early is to maintain the patients' independence, any level of vision in the first eye below 6/12 would be a rationale to treat the first eye early as the patient would already not be allowed to drive. ➢ The first eye should be treated with good visual acuity as it is not known what is going to happen with the second eye. It is a bilateral disease by definition. ➢ A Committee member raised that it is an impossible question but what is the cost of not funding treatment? Patients will deteriorate and need to access more services, need carers and may need to go into institutional care. The Committee discussed the concern about the financial impact, the opportunity costs and the uncertainty of the potential savings. It was also noted that not supporting the earlier treatment may have an impact: deterioration in patients' sight may result is a need to access more services, a need for carers and a possible need to go into institutional care. It was also noted that a decision to not fund will need to be defended based on the equality act as this will disproportionally affects a cohort of the community.
8.6	The Committee reviewed the guidance and following a lengthy consideration agreed to defer a decision until additional financial information is available. A business case is required from Ophthalmology Consultants to estimate the impact such as second eye monitoring costs and impact of late treatment costs, outcomes with earlier treatment and earlier stage of disease as well as patient numbers. **Action: Clinical Effectiveness team to explore the possibility of requesting a business case from the Ophthalmology Consultants.**
9	**Review of brolucizumab for treating wet age-related macular degeneration and update to TVPC45 Sequential use of biologic therapy in Ophthalmology.**
9.1	At the May 2021 Committee meeting, it was highlighted that a new NICE TAG was published in February 2021 recommending brolucizumab for treating wet age-related macular degeneration (wAMD). It was approved via the fast-track appraisal process which means Commissioners and NHS England have to fund within 30 days of publication. The Committee agreed to review this as it may impact current policy TVPC45 Sequential use of biologic therapy in Ophthalmology. The NICE TAG makes recommendations in line with other treatments available for AMD: ➢ the best-corrected visual acuity is between 6/12 and 6/96 ➢ there is no permanent structural damage to the central fovea ➢ the lesion size is less than or equal to 12 disc areas in greatest linear dimension and ➢ there is recent presumed disease progression (for example, blood vessel growth, as shown by fluorescein angiography, or recent visual acuity changes). Clinical trial evidence and a network meta-analysis shows that brolucizumab provides similar overall health benefits to aflibercept and ranibizumab, and is similarly safe. The total costs (including administration) of brolucizumab are the same or less than those of aflibercept and ranibizumab. Information supplied by the company and information from the committee appraisal modelling shows that brolucizumab requires fewer injections per year and fewer monitoring appointments which may free up capacity in providers. The NICE resource impact report shows brolucizumab is expected to have a lower injection frequency per year for the first 2 years with potential for less monitoring associated with this.

9.2	Financial impact The total costs (including administration) of brolucizumab are the same or less than those of aflibercept and ranibizumab. NICE estimates that by 2024-2025 the incident uptake of brolucizumab will be 35% of people eligible for treatment of wAMD with anti-VEGF agents. Using this information, a local estimation may suggest that approximately 470 patients across Thames Valley CCGs per year will commence brolucizumab instead of an alternative anti-VEGF agent. This therefore may result in less follow up appointments per year for patients commencing treatment.
9.3	Evidence review: A Cochrane clinical answer January 2021 - How do alternative regimens compare with monthly injection of anti–vascular endothelial growth factor agents for treating neovascular age-related macular degeneration (ARMD)' notes that: • Balance must be ensured between the risk of unnecessary intraocular injections and the effectiveness of intravitreal injections for ARMD. No detectable difference is apparent between monthly and treat-and-extend regimens in terms of efficacy, but a standard (as required) PRN regimen, whereby injection is delayed until the condition deteriorates, does appear to have a slightly poorer outcome. • Quality of life scores were not different between fixed extended and monthly injections with a moderate level of certainty. In addition a small, short term observational, monocentre study was found that addressed patients who switched to brolucizumab. There was no indication of what and how many agents had been tried previously. The authors concluded the mean change in BCVA was not significant and they discuss that brolucizumab was approved as a new anti-VEGF agent for intravitreal administration in patients with nAMD. However, only limited data of its use in a real-world setting are available to date. Feedback was received and included in the review paper from Sarah-Lucie Watson, Clinical Lead, Consultant Ophthalmic Surgeon, Royal Berkshire NHS FT.
9.4	Considerations for the Committee 1 Add brolucizumab to the current policy TVPC45 Sequential use of biologic therapy in Ophthalmology, as an option in line with NICE TAG for wet age-related macular degeneration, and include link to NICE TAG. 2 Consider that this now offers a 3rd anti-VEGF option for the treatment of wet AMD. Based on feedback and the evidence found, continue to fund one switch to an alternative agent as already stated in the current policy. 3 Review the local uptake of the use of brolucizumab. 4 Review future associated NICE publications e.g. brolucizumab for treating diabetic macular oedema publication date tbc.
9.5	Committee discussion: The clinicians in attendance raised the following points: ➢ Within Buckinghamshire NHS Trust, many patients have already been switched or might have had a different switch as well on top of this so some patients might now be on their third switch. ➢ A consultant from a different trust highlighted that it would not be used as a first line treatment due to the pathway involved and the unknown safety profile. ➢ The majority of patients continue treatment and it is a rare event to discontinue treatment after the first 3 injections, discontinuation normally occurs further on in the treatment course. ➢ A clinician suggested that the costs are comparable but the frequency in injections for brolucizumab would require a different type of monitoring which requires different considerations.

	➢ Services have had to be reconfigured to meet Covid constraints. These constraints are not ideal from a safety point of view for the monitoring required for brolucizumab. Adjustments in pathway will need to be made in order to introduce brolucizumab. It was noted that whilst acknowledging feedback from Buckinghamshire who wish to offer a number of switches that may be more than suggested in the current policy at the moment, there is no blanket ban on treatment and there is always Individual Funding Request process (IFR) to use for cases outside of the policy. However, it was suggested by a representative of Buckinghamshire NHS FT that this may be a large number of patients.
9.6	The Committee reviewed the guidance and following consideration agreed to update the policy as is, with the addition of the new NICE TAG and no change in the guidance regarding Sequential use, with an interim status. The policy will be reviewed as soon as new guidance and evidence become available. **Action: Clinical Effectiveness team to update the current policy and circulate the interim policy statement as outlined above.**
10	**ToR; SOP; Ethical Framework**
10.1	A substantial NHS reorganisation is underway nationally with the formation of Integrated Care Systems (ICS). The governance currently sits with CCGs until ICSs launch in April 2022. ICSs will become the accountable organisations and hold the budget. This will affect the representation on the Thames Valley Priorities Committee. There will be a need to consider the membership and voting rights of members. The principle and function of the Committee will remain the same but the personnel may change. East Berkshire CCG no longer exists and is part of Frimley CCG. A Committee member from Frimley CCG advised it would be appropriate to replace East Berkshire CCG with Frimley CCG on the TVPC documents. The Committee agreed to delay updates until the November workshop, by when there may be more clarity of the local ICS developments. **Action: Discussions on the documents to be included in the workshop.** **Action: Clinical Effectiveness team to update East Berkshire CCG to Frimley CCG.**
11	**Policy update programme: 4 policies to be updated (with/without minor changes) or scheduled for further discussion**
11.1	<u>TVPC 29 Dilatation and curettage for abnormal uterine bleeding v1.2</u> No new guidance found. An update includes the addition of NICE links and patient information for EBI2. **Action: Clinical Effectiveness team to update and circulate the policy statement as outlined above.** <u>TVPC 32 Ultrasound guided injections for hip pain</u> No new guidance found. Policy date to be updated as reviewed. **Action: Clinical Effectiveness team to update and circulate the policy statement as outlined above.** <u>TVPC 33 Surgical treatment of femoro acetabular hip impingement surgery v1.1</u> Overall, there is no evidence to suggest the policy requires amendment although a local consultant provided an update on issues regarding follow ups. The Committee agreed to add a line to the policy to state that for patients who have had prior surgery and who subsequently present with related symptoms, appropriate investigations and further arthroscopy may be performed. **Action: Clinical Effectiveness team to update and circulate the policy statement as outlined above.**

NOT QUORATE

	<u>TVPC 76 Arthroscopic Knee Surgery for Meniscal Tears v2</u> National Guidance, EBI2, refers to the treatment of Meniscal Tears and recommends that British Association for Surgery of the Knee (BASK) guidelines are followed for the management of meniscal tears. A local consultant and contributing author to the BASK guidelines reviewed the current policy and confirmed that no changes are needed to the policy. The Committee agreed no changes are required to the policy. **Action: Clinical Effectiveness team to update and circulate the policy statement as outlined above.**
12	**Any other business**
12.1	**Annual Workshop** The workshop is to be held in November via MS Teams as opposed to in person as originally planned. Date to be agreed. **Action: Clinical Effectiveness team to email potential dates to Committee members.**
12.2	**Annual training event** The Committee agreed to defer the annual training event until 2022 to link in with new Committee membership when this is established.
12.3	**Annual Report** It was noted that Eleanor Mitchell no longer works for Berkshire West CCG.
13	**Date of next meeting**
	The next online meeting will be held on Wednesday 22nd September 2021 **from 2 - 4.30pm.**
14	**Meeting close**
	The Chair thanked everyone for their contributions to the discussions and closed the meeting.