Aylesbury Vale Clinical Commissioning Group
Bracknell and Ascot Clinical Commissioning Group
Chiltern Clinical Commissioning Group
Newbury and District Clinical Commissioning Group
North and West Reading Clinical Commissioning Group
Oxfordshire Clinical Commissioning Group
South Reading Clinical Commissioning Group
Slough Clinical Commissioning Group
Windsor, Ascot and Maidenhead Clinical Commissioning Group
Wokingham Clinical Commissioning Group

Thames Valley Priorities Committee
Minutes of the meeting held Wednesday 24th May 2017
Conference Room B, Oxfordshire CCG, Jubilee House, 5510 John Smith Drive, Oxford OX4 2LH

In Attendance:

Alan Penn	Lay Member Chair	Thames Valley Priorities Committee
Tiina Korhonen	Clinical Effectiveness Lead	SCW
Laura Tully	Assistant Director of Clinical Quality	SCW
Kate Forbes	Clinical Effectiveness Manager	SCW
Kathryn Markey	Clinical Effectiveness Manager	SCW
Rachel Finch	Clinical Effectiveness Administrator	SCW
Dr Tony Berendt (from 2.15pm until 4pm)	Medical Director	Oxford University Hospitals NHS Trust
Jane Butterworth	Associate Director of Long Term Conditions & Medicines Management	Aylesbury Vale CCG & Chiltern CCGs
Miles Carter	West Oxfordshire Locality Clinical Director	Oxfordshire CCG
Linda Collins	Clinical Effectiveness Manager (CCG)	Oxfordshire CCG
Dr Graham Jackson (from 3.20pm)	Clinical Chair	Aylesbury Vale CCG
Dr Megan John	GP	Berkshire East CCGs
Catriona Khetyar	Head of Medicines Optimisation	Berkshire East CCGs
Chris Newdick	Professor of Health Law	University of Reading
Louise Patten	Accountable Officer	Aylesbury Vale & Chiltern CCGs
Dr Jacky Payne	GP	Berkshire West CCGs
Rosalind Pearce (from 2:45pm)	Executive Director HealthWatch	Oxfordshire
Sarah Robson (from 2:40pm)	Head of IFR	SCW
Dr Mark Sheehan	Special Advisor – Ethics	University of Oxford
Gry Wester	Observer	Visitor accompanying Dr Sheehan

Topic Specialists in Attendance for Agenda Items:

Dr Maxine Hardinge	Consultant Respiratory Physician, Consultant lead COPD service & Consultant Sleep & Ventilation	Oxford Centre for Respiratory Medicine
Dr Annabel Nickol	Lead Consultant in Respiratory Medicine; Sleep and Ventilation	Oxford Centre for Respiratory Medicine
Chetan Patel	Clinical Lead in Ophthalmology	John Radcliffe Hospital Oxford

Apologies:

Lindsey Barker	Medical Director	Royal Berkshire NHS Foundation Trust
Frances Fairman	Medical Director – Clinical Strategy	NHS England – South Central
Dr Minoo Irani	Medical Director	Berkshire Healthcare NHS Foundation Trust
Lalitha Iyer	GP/Medical Director	Berkshire East CCGs
Jo Jefferies	Consultant in Public Health	Bracknell Forest
Dr Tina Kenny	Medical Director	Buckinghamshire Health Care NHS Trust
Gareth Kenworthy	Director of Finance	Oxfordshire CCG
John Lisle	Chief Officer	Windsor, Ascot & Maidenhead CCG
Tracey Marriot	Director of Innovation Adoption	Oxford Academic Health Science Network
Eleanor Mitchell	Operations Director	South Reading, Berkshire West CCG
Chandi Ratnatunga	Associate Medical Director, Clinical Networks & Partnership	Oxfordshire
Sarah Rayfield	Speciality Registrar in Public Health	Berkshire
Sangeeta Saran	Associate Director Planned Care and Slough Operations	Slough, Berkshire East CCG
Jeremy Servian	IFR Manager	Oxfordshire CCG
John Seymour	Consultant – Chief of Service - Medicine	Frimley Health Foundation Trust
Fiona Slevin-Brown	Director of Strategy & Operations	Berkshire East CCGs
Bhulesh Vadher	Clinical Director of Pharmacy and Medicines Management	Oxford University Hospital Trust
Cathy Winfield	Chief Officer	Berkshire West CCGs
Amy Wire	Chief Pharmacist	Royal Berkshire NHS Foundation Trust

1.0	**Welcome & Introductions**
1.1	The Chair opened the meeting and welcomed the members of the Committee.
2.0	**Apologies for Absence**
2.1	Recorded as above. This meeting was not quorate. **Action: Clinical Effectiveness team to circulate minutes detailing any policy recommendations made by the Committee to absent members for approval PH Consultant and Chief Finance Officer.**
3.0	**Declarations of Interest** Tony Berendt declared a conflict of interest as he has a close relative, not within the Thames Valley area, being treated with continuous positive airway pressure (CPAP) for sleep apnoea. Linda Collins noted that she has had surgery for cataract.
3.1	None were declared.
4.0	**Draft Minutes of the Priorities Committee meeting held 22nd March 2017 (Paper 16-097) – Confirm Accuracy** • The draft minutes were accepted as a true record of the meeting.
4.1	**Committee update**
4.1.1	The Committee was advised that Laura Tully has secured a new role as Assistant Director of Clinical Quality. Laura will still be involved with the Committee. The Committee offered their congratulations.
4.1.2	The Committee welcomed Louise Patten, Accountable Officer, Aylesbury Vale CCG as the strategic lead for the Committee.
5.0	**Draft Minutes of the Priorities Committee meetings – Matters Arising**
5.1	Minutes of the Priorities Committee held in May 2016, Action 10.1 – Fertility care pathway - CE team were asked to investigate the various providers' referral criteria and liaise with local GPs for further consultation. **March 2017:** Berkshire East are in the process of setting up a working group and will report back once further progress has been made. **May 2017 Update:** Berkshire East report their endeavours to set up a working group to develop a draft patient fertility care pathway have met with very limited response. The Clinical Effectiveness (CE) team agreed to take the pathway review forward. In the first instancethe CE team will identify key personnel to be involved in the development group, make enquires across other STPs, arrange an initial working group meeting and report back to the Committee on how the group will proceed at the next meeting. Dr Jackie Payne agreed to make enquiries with Berkshire West GPs for a representative. **Action 5.1.1: Clinical Effectiveness team to identify key personnel to be involved in the development of a draft patient fertility care pathway set up an initial working group meeting and provide a progress update at the July 2017 meeting.** **Action 5.1.2: Clinical Effectiveness team to contact other STPs for their developments regarding fertility care pathway.** **Action 5.1.3: Dr Jackie Payne to make enquiries with Berkshire West GPs for a fertility care pathway working group representative.**
5.2	Minutes of the Priorities Committee held in July 2016 – Action 11.3 – TVPC Meeting dates – It was agreed 2017/18 meetings will be held in Berkshire East. Albert House in High Wycombe has been booked for TVPC meetings from July 2017. **Action: Complete**

5.3	Minutes of the Priorities Committee held in November 2016 – Action 6.6 - Paper 16-082 Policy Review: Insulin pumps. The Clinical Effectiveness team to draft a policy document based on TA151 with the addition of gastroparesis and IHA in line with NG17. **February 2017 Update:** CE team have drafted a policy document but have not circulated for comment as it includes reference to Continuous Glucose Monitoring (CGM) which is still to be agreed. **May 2017 Update: refer to Action 5.7**
5.4	Minutes of the Priorities Committee held in February 2017 – Item 11.2 – Terms of Reference and Ethical Framework. The Committee agreed to review these documents and to look at the definition of 'exceptionality' at a workshop on 19th July ahead of the TVPC meeting to be held on the same day. **ACTION: Complete**
5.5	Minutes of the Priorities Committee held in March 2017 – Action 6.6 - Paper 16-096 – Evidence Review: Female Genital Surgery for Stress Incontinence and Prolapse A review of the local data and financial impact showed activity levels for prolapse surgery across the Thames Valley to be low with the exception of Oxford which is high. **ACTION:** Clinical Effectiveness (CE) team to investigate the coding of the TV CCG prolapse surgery activity and provide an assessment at the next meeting (May 2017). **May 2017 Update:** A further data run using identical codes for all CCGs across the Thames Valley (TV) resulted in the Oxford activity spread being mid-range. It is noted that none of the TV CCGs are spending more than £26k per 100,000 population on prolapse surgery. The Committee agreed that in view of the revised data a draft policy is to be developed and circulated to the Committee for consideration. The daft policy will be based on the review considered in the March TVPC meeting. The Committee agreed comments on the draft will be returned via email as per usual process. **Action: Clinical Effectiveness team to develop a draft Management of Female Genital Prolapse Policy.** **The Clinical Effectiveness Team to additionally provide the May 2017 revised data and circulate to the Committee for consideration. Comments to be returned to CE team via email.**
5.6	Minutes of the Priorities Committee held in March 2017 – Action 7.5 - Paper 16-093 – Policy Update: Primary Hip and Knee Revision, Clinical Effectiveness team to draft a final policy. **Action Complete**
5.7	Minutes of the Priorities Committee held in March 2017 – Action 8.4 - Paper 16-083 – Policy Update: Continuous Glucose Monitoring Systems **The Committee agreed to defer the policy to undertake further investigation around the resource impact.** **ACTION 8.4.1: Clinical Effectiveness team to contact CCGs with policies in place for Continuous Glucose Monitoring Systems (Bedfordshire, Herts) to obtain patient numbers and interrogate their costs.** **ACTION 8.4.2: Dr Anees Pari to provide the Clinical Effectiveness team with the Health Economy Research Unit, University of Oxford contact details.** **ACTION 8.4.3: Clinical Effectiveness team to approach local providers for the likely take-up of Real-time continuous glucose monitors and flash glucose monitors (e.g. Freestyle Libre) and the early expected benefits realised.** **ACTION: 8.4.4: Clinical Effectiveness team to provide an update on actions in relation to Continuous Glucose Monitoring Systems at the next meeting (May 2107).** **May Update: Local data collection is underway. Follow up at July 2017 meeting.**
5.8	Minutes of the Priorities Committee held in March 2017 – Action 9.5 - Paper 16-094 – Evidence Review: Sequential Use of Biologics for Rheumatoid Arthritis. Clinical Effectiveness team to circulate the draft sequential use of biologic therapy in RA policy. **Action Complete**

5.9	Minutes of the Priorities Committee held in March 2017 – Action 10.7 - Paper 16-095 – Evidence Review: Autologous Blood Injections in the treatment of Musculoskeletal Conditions Clinical Effectiveness team are to circulate a draft policy. **Action Complete**
5.10	Minutes of the Priorities Committee held in March 2017 – Action 11.6 – In Year Scoping Clinical Effectiveness team to update the 2017/2018 programme as appropriate to the score rating achieved. **Action Complete**
6.0	**Paper 17-001 – Evidence Review and Policy Update: Snoring and Sleep Apnoea**
6.1	Thames Valley (TV) Clinical Commissioning Groups (CCGs) have requested a review of snoring and sleep apnoea. These include referral criteria for snoring and sleep apnoea, Continuous Positive Airway Pressure (CPAP), time frames and stopping criteria for CPAP. Currently NHS Buckinghamshire and NHS Oxfordshire CCGs have policies relating to snoring and sleep apnoea. Both state that treatments for snoring where snoring is the sole problem are not normally funded.
6.2	**Snoring** NICE 2014 Interventional Procedures Guidance (IPG) 476 for Radiofrequency ablation of the soft palate for snoring has been reviewed in conjunction with the two existing TV CCG policies. The IPG is non-mandatory and is based on low quality evidence.
6.3	**CPAP** NICE Technical Appraisal Guideline (TAG) 139 recommends CPAP as a treatment option for adults with moderate or severe symptomatic Obstructive Sleep Apnoea Hypopnoea Syndrome (OSAHS). Severity is assessed on the basis of symptoms, particularly daytime sleepiness and also parameters from the sleep study. CPAP is also recommended as a treatment option for adults with mild OSAHS if the patients symptoms affect their quality of life and their ability to go about their daily activities or if lifestyle advice and any other relevant treatment options have been unsuccessful or are considered inappropriate.
6.4	**Stopping CPAP** Only one small two week trial was found that addressed stopping CPAP in patients who had used CPAP for longer than 12months. After the two weeks patients had returned to sleep disordered breathing. The authors of the study concluded that it was too difficult to prolong the study time for longer than two weeks. Feedback from the consultants suggested that it may be possible to consider a trial of stopping CPAP for patients who have lost excessive weight through for example bariatric surgery.
6.5	NICE TAG 139 refers to other treatments for OSAHS including lifestyle advice. Evidence found for the review was of low quality and clinical significance of the outcomes was not discussed. However, it is likely these interventions did result in positive effects including weight loss as increased weight is known to be a risk factor for sleep apnoea. Lifestyle measures could be regarded as an adjunct to other treatment for sleep apnoea.
6.6	Mandibular Advancement Devices (MADs) are referred to in NICE TAG 139 as an alternative option for the treatment of sleep apnoea for mild and moderate OSAHS. Evidence shows that they are a cost effective option in the management of mild to moderate OSAHS and if the patients is intolerant to CPAP or if CPAP is inappropriate. It was noted by a member of the Committee that MADs are not available on NHS prescription.
6.7	**Surgery** NICE TAG 139 refers to resection of the uvula and redundant retrolingual soft tissue. Evidence found for the review refers to orthognathic surgery. The evidence base for surgery is very small and of low quality. The Royal College of Surgeons (RCS) Commissioning Guide: Orthognathic Procedures appears to be biased towards the use of orthognathic surgery in patients with OSAHS surgery. Orthognathic surgery may be an option for a small number of patients with very severe sleep apnoea, where other treatments have failed or in patients who have craniofacial

	abnormalities.
6.8	The attending specialists stated that obstructive sleep apnoea is a very symptomatic condition resulting in debilitating sleepiness. CPAP is the main stay of treatment and can be life changing for many patients. The specialists would welcome engagement with lifestyle advice, weight loss and smoking cessation in parallel with sleep apnoea but these should be seen as an adjunct to other treatment for OSAHS. The attending specialists felt it would be beneficial to be able to provide MADs for patients. The attending specialists support the use of the STOP-BANG questionnaire f or screening in Primary care. This assesses a patient's risk of developing sleep apnoea. The specialists would address referrals for pilots and sleepy drivers urgently, if flagged in the referral, particularly HGV and professional drivers. Referrals are received from Primary Care, Secondary Care and Tertiary Care and are triaged. The starting point is a sleep study. One third of referred patients will have minimal symptoms and need educational and conservative treatment; one third of referred patients will definitely have sleep apnoea and within one visit will see the doctor or specialist nurse for a consultation then see the nurse for an educational session to start CPAP; third of referred patients will need to meet with the specialist for additional information and to decide on the next step. After starting CPAP the follow up is at 2 weeks to address initial issues such as mask leaks, machine noise, and wrong pressure, which is important at this stage when the patient is engaged. Further one follow up takes place at 1 year. The specialists reported that in Oxfordshire and neighbouring areas there are currently over 11,000 patients using CPAP. The attending specialists reported that the average renewal time span of a CPAP machine is 7 years. The current price for a machine is approximately £350 to £400. The current price for a mask is approximately £60 to £80. One mask last approximately a year. Patients order their own consumables directly from the manufacturer / supplier. If a machine is returned by a patient it can be issued to another patient. The attending specialists reported that data shows CPAP use of approximately 4 hours per night will result in health benefits as a guide. The machines can be analysed for a nightly profile to ascertain machine usage.
6.9	The Committee discussed the evidence and agreed the following criteria: 1. Treatment for snoring as a sole problem is not normally funded. 2. Prior to referral to a specialist centre for sleep apnoea the patient should have either the results of a STOP-Bang Questionnaire or for excessive daytime sleepiness an ESS Assessment. 3. CPAP should be initiated in accordance with NICE TAG 139. 4. Patients must be advised of lifestyle factors including weight loss. 5. Patient to demonstrate compliance sufficient to achieve significant benefit, assessed at 12 months and if not stop. 6. Mandibular Advancement Devices (MADs) are not available on NHS prescription; patients are encouraged to see a dentist. 7. Surgery for sleep apnoea is not normally funded except where it is tonsillectomy in accordance with existing policy TVPC 22. **ACTION: Clinical Effectiveness team to circulate the draft Sleep Apnoea, CPAP and Snoring policy document for comment. Comments are to be received within the 2 week feedback period following issue.**

7.0	Paper 17-002 – Evidence Review and Policy Update: 'Second Eye' Cataract Removal in Adults
7.1	Thames Valley CCG's have requested a review of second eye cataract removal surgery to agree a common policy across TV. Currently the CCG's have individual policies for first eye surgery thresholds, some of which include second eye. The Committee were advised that the paper for this meeting was consulted on and written just prior to the draft NICE Clinical Guideline 'Cataracts in Adults: Management' being published in .
7.2	Currently the TV policies indicate a requirement of visual acuity worse than 6/12 for first eye surgery and when stated, the criteria also applies to second eye thresholds. Visual acuity is not always indicative of the visual impairment. Depth perception, glare and contrast sensitivity difficulties also result in negative impact on lifestyle factors. Nationally second eye surgery accounts for almost one third of the total number of cataract surgeries. In relation to the evidence for second eye; most of the studies reviewed excluded those with any other comorbidity visually. Generally patients in the studies had good pre-surgery vision; this is of note as with current thresholds in place local population may differ from the study population. There is a much smaller evidence base for second eye cataract compared to first eye. Referral thresholds throughout the literature are not defined for first or second eye. The review found that there was no consensus on timing of second eye surgery in terms of clinical outcomes. The clinical and commissioning guidelines from the Royal College of Ophthalmology currently support the surgery for second eye an effective and cost effective intervention. Visual acuity is commonly used across CCG policies to determine whether cataract surgery is needed, but it is a crude measure and doesn't detect other visual problems. The draft NICE guideline indicates that visual acuity should not be used as criteria to restrict access to cataract surgery. The draft guideline is not clear on what should be used as an alternative threshold to VA. The draft guideline indicates that limits on the second eye surgery are likely to increase costs due to the increasing demand for 'low vision' services. The draft NICE guideline anticipates only a small increase in referral numbers initially and report that it is unlikely to lead to significant long term changes in commissioning as only the timing of the surgery would be effected by the new recommendations. If patients are referred for surgery because a cataract is seen in the eye but the patient does not have significant problems, their vision could worsen over time. However, if patients are counselled appropriately by surgeons, they are unlikely to progress to have surgery if they do not have any difficulties cause by the cataract. The draft guidance recommends offering second eye cataract surgery with the same criteria as first eye surgery but does not define the criteria. It also suggests that bilateral cataract surgery can be considered for people who are low risk of complications, a potential benefit being that patients would not experience a period of time with refractive errors (i.e difference in vision in between eyes in terms of myopia, astigmatism etc). In terms of measures NICE have identified in the draft guidance that the visual functioning questionnaire and visual acuity are not particularly good measures as thresholds for surgery.
7.3	The specialist advised that New Zealand have a system using a visual functioning questionnaire / tool to measure cataract surgery which identifies priorities in a sensible way; something the team do intuitively when referrals are received.
7.4	The draft NICE guideline has been discussed at the Consultant meeting in Oxford. The specialist stated then it was generally felt that the status quo was their preferred option. The specialist noted that in terms of other evidence not quoted in the evidence review, there is a paper to be published shortly which looked at cataract surgery for veterans in the USA. The study

	looked at the value of second eye surgery in approximately 400 patients, and concluded that second eye surgery did offer significant benefits to symptoms such as stereopsis, mental wellbeing.
7.5	The specialist advised that there are other ways to make efficiency savings than limiting access for second eye surgery, such as reviewing the need for post-operative clinical assessment; this is currently being reviewed in Oxford. The specialist also noted that referrals are still received from optometrists for asymptomatic patients who are found to have a cataract on a routine annual assessment, which seems inappropriate if driving standard vision is still in place. The specialist advised that it is unlikely that surgeons will undertake bilateral surgery frequently due to the risk of serious complications.
7.6	The Committee also discussed the affordability of second eye surgery and the possible deviation form NICE guidance. Concern was raised regarding an escalation in activity and costs should visual acuity not be used as criteria. However, it was also identified that impact on activities of daily living are also included in current policy criteria. The need not to discriminate on the basis of age was raised, as most cataracts occur in the elderly.
7.7	The Committee agreed to support Option 1. To amalgamate Thames Valley CCG's cataract policies and to utilise the same criteria threshold for second eye surgery as for first eye surgery prior to publication of NHS Clinical Guideline in October 2017. It was agreed that the current Buckinghamshire Policy is used with some modifications; that the threshold criterion is to be clarified to read items criteria as 1 and 2 or 3, 4 and 5. The policy is to include the paragraph from the Berkshire West Policy document that cataract surgery should not be performed solely for the purpose of correcting longstanding pre-existing myopia or hypermetropia. 1. The cataract must be sufficient enough to account for the visual symptoms (visual loss or disturbance) experienced by the patient. Alternative causes for the reported visual symptoms should be excluded prior to referring a patient for cataract surgery. AND 2. Visual Acuity 6/12 or worse in either eye. OR 3. The cataract and visual symptoms experienced by the patient should negatively affect the patient's lifestyle. The following are examples for consideration for this threshold: a. Significant glare or dazzle in daylight due to lens opacities b. Difficulty with night vision due to lens opacities particularly if driving c. A requirement for good vision for employment purposes d. Difficulty reading e. Significant Anisopmetropia/ Aniseikonia f. Management of other coexisting eye conditions, including DRSS ungradable photograph g. Refractive error primarily due to cataract 4. The patient must understand the general pros, cons and risks of surgery. AND 5. The patient must want to undertake the surgery when all the above is considered. This information together with a report from the most recent sight test should be included in the referral to secondary care (using the agreed proforma). **ACTION: The Clinical Effectiveness team to amalgamate the current TV CCG's Cataract policies and prepare a draft second eye cataract surgery document and circulate for comment. Comments are to be received within the 2 week feedback period.**
8.0	**Paper 16-083 – Policy Update: Hysterectomy and Uterine Artery Embolisation**
8.1	Currently Thames Valley CCGs have policies for hysterectomy in relation to heavy menstrual bleeding (HMB) and/or dysmenorrhea (painful periods) and for uterine artery embolisation for fibroids (UAE). The CCGs requested a review to consider the latest guidance relevant to the policies and to enable commissions to assess whether the policies are suitable for withdrawal or update as appropriate.

8.2	**Uterine artery embolisation for fibroids (UAE)** Berkshire East and West CCGs share a similar policy statement dated 2003. However, the local policy statements have been superseded by NICE Clinical Guideline (CG) 44 and NICE Quality Statement (QS) 47, supporting UAE as an option as a non-hysterectomy surgery for heavy menstrual bleeding (HMB); 'When surgery for fibroid-related HMB is felt necessary then UAE, myomectomy and hysterectomy must all be considered, discussed and documented. UAE has become part of normal practice in relation to HMB caused by fibroids. This procedure will also be covered by the hysterectomy policy if it adheres to NICE CG, thus the current policies could be withdrawn.
8.3	**Hysterectomy** All local CCGs have a policy statement for hysterectomy surgery. Berkshire East, Berkshire West and Buckinghamshire CCGs share the same statement, Oxfordshire CCG has a separate policy with some additional criteria. Both policies include criteria for when hysterectomy is an appropriate option for HMB, as such both policies are in line with NICE CG 44 for HMB. Both polices also have a criteria for other indications for hysterectomy surgery. The Committee reviewed the current national guidance and considered the clinical feedback received. The Committee agreed that the policy for UAE was no longer necessary and can be withdrawn. The Committee also agreed that the hysterectomy policy is to be retained to endorse good practice and to be aligned as one policy across the Thames Valley CCGs, updated to include indications as follows: NHS funding will be available for hysterectomy for appropriate patients with a diagnosis of: • cancer of the cervix / fallopian tubes / uterus and/or ovaries • severe and debilitating endometriosis or adenomyosis that cannot be managed by non-surgical interventions • uterine prolapse, where non-surgical and non-hysterectomy surgery options are inappropriate or have failed to manage the woman's symptoms • complicated and persistent pelvic inflammatory disease that has not responded to conventional treatment • large fibroids which are causing symptoms and other treatment options have failed or are contraindicated Remove reference to pelvic pain that has not responded to 'chemical hysterectomy' as no longer relevant point. Hysterectomy will be commissioned for heavy menstrual bleeding only when: Other treatment options for heavy menstrual bleeding and/or dysmenorrhoea (with or without fibroids) have failed or are contraindicated; AND There is a wish for amenorrhoea (absence of menstruation); AND The woman no longer wishes to retain her uterus and fertility; AND The woman (who has been fully informed) requests hysterectomy **ACTION: CE team to withdraw the current Uterine Embolisation of Fibroids policy.** **ACTION: CE team to circulate the draft hysterectomy policy update for comment. Comments to be received within the 2 week feedback period following issue.**
9.0	**Paper 17-004 – Gluten Free Foods**
9.1	The CE team highlighted to the Committee the Department of Health Consultation on the availability of gluten free (GF) foods on prescription in Primary Care. The Consultation closes on 22nd June 2017.

9.2	The Committee reviewed the consultation document and considered the wide availability of GF foods and the ability of patients to safely exclude food from their diets that would normally contain gluten. The consultation document contained no evidence of worse outcomes for people in low socioeconomic groups. The Committee agreed to support the Option 2: To add all GF foods to Schedule 1 of the above regulations to end the prescribing of GF foods in primary care. Under this option no GF foods would be available on prescription in primary care. **ACTION: Clinical Effectiveness team to prepare a draft response to the Department of Health Consultation regarding the availability of Gluten Free foods on prescription and circulate for comment. Comments are to be received within the 2 week feedback period following issue as per usual process.** **ACTION: Clinical Effectiveness team to remove Gluten Free Foods from TVPC July Agenda.**
10.	**In year requests for Scoping**
10.1	**Botox use for achalasia, anal achalasia, anismus, gastroparesis, hemifacial spasm, hip abductor spasticity, ophthalmic facial dystonia and spasmodic dysphonia.** Oxfordshire CCG has submitted this topic request for consideration following business case submissions from their consultants about the less common indication for botox use. Currently the local CCGs have a TV wide policy TVPC 12 Botulinum Toxin A, which covers the most common indications for the use of botox, including overactive bladder, chronic migraine, spasticity, chronic anal fissure, long term Bell's Palsy and sialorrhoea (severe drooling). Scoring was undertaken using the scoring sheet template devised in November 2015 to standardise topic selection. Total Score: 12. A score of 12 is low in the context of general topic scores and as such does not meet the threshold for going on the TVPC work programme.
11.	**Any Other Business**
11.1	**Erectile Dysfunction; amendment to current policy.** NHS England has published a Clinical Commissioning Policy: Penile Prosthesis surgery for end stage erectile dysfunction (2016), and will commission penile prosthesis surgery for end stage erectile dysfunction in accordance with the criteria outlined in their policy. The current local policy TVPC34 Erectile Dysfunction states that 'treatment with penile implants is not normally funded' and needs an amendment to clarify that the commissioning responsibility lies now with NHS England. The Committee agreed that the statement can be amended to add that penile prosthesis is not commissioned by the CCG's. **ACTION: Clinical Effectiveness team to amend the TVPC 34 Erectile Dysfunction policy to include "penile prosthesis is not commissioned by CCG's" and upload the revised version to the website.**
11.2	**Annual Report** Annual Report is now available and will be circulated to the Committee with the minutes. The Committee agreed the publishing of the report on the IFR website. **ACTION: Clinical Effectiveness team to circulate the Annual Report with the minutes of this meeting.** **ACTION: Clinical Effectiveness team to publish the Annual Report on the website.**
12.	**Next meeting**
	The next meeting will be **Wednesday 19th July 2017, to be held in Conference Room, Albert House, High Wycombe HP11 1AG.** Please note: the Annual training session will be held also on the 19th July 2017 before the Committee meeting 12:00-13:30 at the same location. Light lunch will be provided.
13.	**Meeting Close**
	The Chair thanked everyone for their contributions to the discussions and closed the meeting.