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 19th July 2017
Conference Room, 2nd Floor, Albert House, Queen Victoria Road, High Wycombe HP11 1AG

In Attendance:

Alan Penn	Lay Member Chair	Thames Valley Priorities Committee
Laura Tully	Assistant Director of Clinical Quality	SCW
Kate Forbes	Clinical Effectiveness Manager	SCW
Rebecca Hodge	Clinical Effectiveness Manager	SCW
Kathryn Markey	Clinical Effectiveness Manager	SCW
Katie Newens	Clinical Effectiveness Researcher	SCW
Sarah Annetts	IFR Manager (clinical)	SCW
Lindsey Barker	Medical Director	Royal Berkshire NHS Foundation Trust
Jane Butterworth	Associate Director of Long Term Conditions & Medicines Management	Aylesbury Vale CCG & Chiltern CCGs
Linda Collins	Clinical Effectiveness Manager (CCG)	Oxfordshire CCG
Dr Graham Jackson	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
Dr Jacky Payne	GP	Berkshire West CCGs
Sarah Rayfield	Speciality Registrar in Public Health	Berkshire
Amaka Scott	Interface Lead Pharmacist	Berkshire West CCGs
Dr Mark Sheehan	Special Advisor – Ethics	University of Oxford
Jenn Sula-Minns	Prior Approvals Manager	Oxfordshire CCG

Apologies:

Dr Tony Berendt	Medical Director	Oxford University Hospitals NHS Trust
Miles Carter	West Oxfordshire Locality Clinical Director	Oxfordshire CCG
Shairoz Claridge	Operations Director Director for Planned Care	Newbury and District CCG Berkshire West CCGs Federation
Frances Fairman	Medical Director – Clinical Strategy	NHS England – South Central
Rachel Finch	Clinical Effectiveness Administrator	SCW
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
Tiina Korhonen	Clinical Effectiveness Lead	SCW
John Lisle	Chief Officer	Windsor, Ascot & Maidenhead CCG
Dr Anees Pari	Head of Public Health and Wellbeing (Interim)	West Berkshire Council
Louise Patten	Accountable Officer	Aylesbury Vale & Chiltern CCGs
Rosalind Pearce	Executive Director HealthWatch	Oxfordshire
Chandi Ratnatunga	Associate Medical Director, Clinical Networks & Partnership	Oxfordshire
Sarah Robson	Head of IFR	SCW
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.**
3.0	**Declarations of Interest**
3.1	None were declared.
4.0	**Draft Minutes of the Priorities Committee meeting held 24th May 2017 (Paper 17-005) – Confirm Accuracy** The draft minutes were accepted as a true record of the meeting.
4.1	**Committee update**
4.1.1	The Committee welcomed two new members to the Clinical Effectiveness Team; Rebecca Hodge, Clinical Effectiveness Manager and Katie Newens, Clinical Effectiveness Researcher, SCW.
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. **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. **July 2017 Update:** Actions ongoing; potentially an item for the November 2017 TVPC meeting. **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 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. **July 2017 Update: Refer to item 5.6**
5.3	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. **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. 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 Complete**
5.4	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 complete: Refer to item 9.0 below**
5.5	**Minutes of the Priorities Committee held in May 2017 – Action 6.9 - Paper 17-001 – Evidence Review and Policy Update: Snoring and Sleep Apnoea** The Committee discussed the evidence and agreed the Clinical Effectiveness team to develop a draft Sleep Apnoea, CPAP and Snoring policy document. **ACTION Complete.**
5.6	**Minutes of the Priorities Committee held in May 2017 – Action 8.3 - Paper 17-002 – Evidence Review and Policy Update: 'Second Eye' Cataract Removal in Adults** The Committee agreed for the Clinical Effectiveness team to amalgamate the current TV CCGs' Cataract policies and prepare a draft policy to include second eye. It was agreed that the current Buckinghamshire Policy is used with some modifications. 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 **ACTION Complete**
5.7	**Minutes of the Priorities Committee held in May 2017 – Action 7.7 - Paper 16-083 – Policy Update: Hysterectomy and Uterine Artery Embolisation** The Clinical Effectiveness team to withdraw the current Uterine Embolisation of Fibroids policy as the Committee agreed the policy was no longer necessary. The Committee also agreed the hysterectomy policy is to be retained to endorse good practice and to be aligned as one policy across the Thames Valley CCGs. The Clinical Effectiveness team to prepare and circulate a draft hysterectomy policy. **ACTION Complete**
5.8	**Minutes of the Priorities Committee held in May 2017 – Action 9.2 - Paper 17-004 – Gluten Free Foods** The Committee reviewed the Department of Health (DH) consultation documents 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 Committee agreed for the Clinical Effectiveness team to prepare a draft response to the DH and circulate for comment. **ACTION Complete**
5.9	**Minutes of the Priorities Committee held in May 2017 – Action 11.1 – Any Other Business – Erectile Dysfunction.** NHS England will commission penile prosthesis surgery for end stage erectile dysfunction in accordance with criteria outlined in their Clinical Commissioning Policy: Penile Prosthesis surgery for end stage erectile dysfunction (2016). The Committee agreed to amend TVPC 34 Erectile dysfunction policy to include "penile prosthesis is not commissioned by CCGs"; the revised version to be uploaded to the website. **ACTION Complete**
5.10	**Minutes of the Priorities Committee held in May 2017 – Action 11.2 – Any Other Business – Annual Report** The Clinical Effectiveness team to circulate the Annual Report with the minutes of the meeting. The Committee agreed the report could be published on the IFR website. **ACTION Complete**

6.0	**Paper 17-001 – Policy Update: Functional Electrical Stimulation (FES) for Drop Foot and Upper Limb**
6.1	There is currently a policy in place for the use of FES in upper and lower limb dysfunction and a separate policy for the use of FES in drop foot of central neurological origin (CNO). These policies have been adopted by Berkshire East CCG, Berkshire West and Buckinghamshire.
6.2	The Committee were informed there are two types of FES available, implantable and skin surface devices. Due to the extremely low number of implanted FES procedures in the Thames Valley, the review focused on skin surface FES.
6.3	NICE Clinical Guidance CG162 (2013) for Stroke Rehabilitation in Adults indicates that FES can be used for strength training in the upper limbs following stroke, but not routinely. A trial can be considered for patients who have muscle contraction after stoke and are unable to move their arm against resistance. Interventional Procedure Guidance IPG278 (2009) for the use of FES in drop foot of CNO (central neurological origin) states that the current evidence on the safety and efficacy (in terms of improving gait) of FES for drop foot of CNO appears adequate to support the use of this procedure provided that normal arrangements are in place for clinical governance, consent and audit.
6.4	**Drop Foot** There have been a number of systematic reviews and trials published since the publication of NICE IPG278. Evidence for the use of FES in drop foot from one meta-analysis (2016) and one systematic review (2015) suggests that gait speed is similar when using FES vs an ankle foot orthosis (AFO). One trial (2014) suggested that FES induced changes in the sensory-motor cortex area which potentially may lead to improvement in motor function; the authors identify that the majority of studies have a focus on walking speed, rather than changes in the motor cortex. It was noted that the outcome was disease orientated rather than a patient orientated outcome. A study by Dunning 2015 on stoke patients found that satisfaction with the AFO was low.
6.5	**Upper Limbs** A systematic review by Ping (2016) looked at shoulder subluxation, pain, upper arm motor function, daily function and quality of life in patients with stoke when added to conventional therapy. The study found there was statistically significant reduction in shoulder subluxation for FES use in early (less than 6 months) but not late (more than 6 months) after stoke. A review by Vafadar (2015) found there were some short term effects for shoulder subluxation but was inconclusive regarding long term effects of FES on the upper limb. The study sizes were small (17-20 patients) and that 7 of the 10 studies were conducted more than 10 years ago. It was noted that it is difficult to extrapolate evidence for different clinical presentations as FES can be used in a number of neurological conditions. The majority of the studies were looking at stroke patients.
6.6	The Committee reviewed the financial impact by CCG. The activity and associated spend were noted to be relatively small.
6.7	It was identified that there is a variation in usage across the TV, possibly reflecting specialist centres in different areas which may generate larger numbers of referrals. The use of FES after an unsuccessful trial of AFO was discussed; however the evidence does not indicate that FES is any more likely to be successful if an AFO has failed. The Committee noted the limited evidence of significant benefit over alternative therapies to activities of daily living.
6.9	It was agreed, based on the limited evidence, to maintain the current policy position; that the use of functional electrical stimulation for drop foot and impaired upper limbs is not routinely funded. The Committee agreed to amalgamate the 'Upper and Lower Limb Dysfunction' policy with the

	'Drop Foot' Policy. **ACTION: Clinical Effectiveness team to draft a single FES policy document for upper and lower limb dysfunction (rather than drop foot) and circulate for comment. Comments are to be received within the 2 week feedback period following issue.**
7.0	**Paper 17-007 – Policy Update: Female Sterilisation, Reversal of Female Sterilisation and Reversal of Male Sterilisation (Vasectomy)**
7.1	**Female Sterilisation** Currently Berkshire East CCGs, Berkshire West CCGs and Buckinghamshire CCGs have policies for female sterilisation with the same content. All TV CCGs have policies for reversal of female sterilisation and reversal of male sterilisation which state that these procedures will not normally be funded. Berkshire East CCGs, Buckinghamshire CCG and Oxfordshire CCG share a TVPC Commissioning Policy Statement for male sterilisation which sets out the referral criteria for vasectomy. Berkshire West CCGs state that vasectomy is not normally funded.
7.2	Female sterilisation is a permanent method of contraception. In England, reports indicate there has been a decline in female sterilisation numbers. Local activity data indicates that there has been an overall decline since 2014-15. The data does not include salpingectomy or hysterectomy as it is reported that these codes are not normally used for female sterilisation although the procedures will result in female sterilisation.
7.3	Guidance from the Faculty of Sexual & Reproductive Healthcare (FSRH), Royal College of Obstetricians and Gynaecologists (RCOG) and the World Health Organisation (WHO) states that male and female sterilisation should be regarded as permanent methods of contraception. Individuals should be made aware that there are some long acting reversible contraception (LARC) methods that are as effective as sterilisation. However the guidance does state that women should not be pressurised into choosing LARC over female sterilisation. The guidance states that vasectomy or male sterilisation is an effective and permanent form of contraception involving a minor operation usually undertaken under local anaesthetic. The guidance states that an assessment for suitability of female sterilisation should include taking a medical history and assessment of mental capacity to consent to a procedure. Women, post pregnancy and seeking sterilisation should be advised that there needs to be a delay in making the decision for female sterilisation after giving birth particularly following a caesarean or abortion as this increases the level of regret later. There is a lot of evidence cited in the guidance that examines regret, detailing the risk factors associated with female sterilisation for example patients under 30 years old, patients without children or low numbers of children, unhappy relationships, death of a child, coercion by health professional or partner / spouse.
7.4	A 2008 cost-effectiveness analysis concluded that female sterilisation became more cost effective than other LARCs when contraceptive use exceeded six years. The NICE guideline on long-acting reversible contraception summarises that female and male sterilisation are more cost effective than LARC methods at 15 years of contraceptive use. It was noted that the cost-effectiveness analysis is dated 2008 and the NICE guideline was based on 2004 NHS reference costs.
7.5	The Committee requested a review of the male sterilisation (vasectomy) policy at the next TVPC meeting (20th September).
7.6	The Committee considered the evidence and recommendations from the guidance and agreed to adopt a new policy across the Thames Valley CCGs that states female sterilisation will not normally be funded as: • there are other alternative non-invasive options including Long Acting Reversible

	Contraceptives (LARCs) which are as effective or more effective than female sterilisation available. • lack of recent cost-effectiveness data and analyses. • substantial levels of associated regret **7.6.1 ACTION: The Clinical Effectiveness team to draft a policy document for female sterilisation. The Clinical Effectiveness team to hold the draft female sterilisation policy document until after vasectomy (male sterilisation) has been reviewed at the next TVPC meeting (20th September).** **7.6.2 ACTION: The Clinical Effectiveness team to add Vasectomy (male sterilisation) as an agenda item for the TVPC meeting 20th September 2017.**
8.0	**Paper 17-008 – Policy Update: Male Circumcision**
8.1	Current Thames Valley CCG policies were originally developed in 2008 and 2009. Buckinghamshire CCGs and Oxfordshire CCGs have similar policies. The policy for Berkshire CCGs lays out indications as being absolute or relative indications for circumcision. All policies state that circumcision is indicated in pathological phimosis where inability to retract the foreskin is due to permanent scarring. Circumcision may also be indicated for recurrent urinary tract infection (UTIs) (particularly where there is high grade vesico-ureteric reflux) and penile carcinoma.
8.2	The Committee heard that is normal for a boy to be born with non-retractable foreskin and during normal development the foreskin gradually becomes retractile without the need for intervention. By the age of 16 most boys have retractable foreskin.
8.3	Expenditure on circumcision during 2016-2017 across Thames valley CCGs was approximately £750k. Of this, £177k was spent on circumcision in boys under the age of 16. The prior approval requests for Buckinghamshire and Berkshire CCGs indicated that there were 135 requests for circumcision in boys under the age of 16 of which 103 were deemed appropriate to treat and of those 28 were for tight foreskin and phimosis with no specification of any other pathology.
8.4	The Royal College of Surgeons (RCS) Commissioning Guide (2013) on foreskin condition provides guidance on indications for circumcision: • pathological phimosis associated with scarring of the foreskin leading to symptoms and non-retractability of the foreskin, the most common cause is lichen sclerosis (LS), balanitis xerotica obliterans (BXO) • recurrent episodes of balanoposthitis (acute inflammation of the foreskin and glans penis) relative indications for circumcision or other foreskin surgery: • prevention of urinary tract infection in patients with an abnormal urinary tract • recurrent paraphimosis (an emergency condition where the foreskin is retracted and subsequently cannot be reduced back over the glans penis leading to pain and swelling. • traumatic injury • tight foreskin causing pain on arousal / interfering with sexual function • congenital abnormalities. In children up to age 18 years, pathological phimosis must be distinguished from physiological adherence of the foreskin to the glans penis, which is normal. The RCS also state that conservative management of the non-retractile foreskin is under-recognised and practised particularly in the paediatric population. They also state that the role of

	routine circumcision in the population for prevention of urinary tract, HIV, and other sexually transmitted infections at a population level is unclear.
8.5	**Lichen Sclerosus (LS)** The British Association of Dermatologist (BAD) have guidance for the management of lichen sclerosus (2010 - update in progress). LS is an autoimmune, inflammatory dermatosis, that has a predilection for the genital skin in both sexes. Topical steroids have become the mainstay of medical treatment. In men the foreskin and glans penis can be effected and can lead to tightening, which can then lead to phimosis. Scarring can lead to stenosis and obstruction. It has been recognised that a trial of steroids should be used prior to circumcision and that circumcision should be reserved for treatment failures. BAD indicate there is an association between LS and penile squamous cell carcinoma however the risk of malignancy in uncomplicated genital LS that has been diagnosed and treated appropriately is reported to be small. The European Society for Paediatric Urology guidelines 2015, define phimosis as being primary with no scarring or secondary with scarring usually due to LS. In primary phimosis the European Society recommends conservative treatment with a steroid cream to be administered for a period of 20-30 days. For secondary phimosis where there is scarring from LS the guidance states that circumcision is an absolute indication. A systematic review looked at the use of topical steroids in boys up to the age of 18 years. The duration of treatment ranged from 4 to 8 weeks. The authors concluded that topical steroids compared with placebo significantly improved the resolution of the phimosis. There were a number of limitations associated with this systematic review. It is noted that studies included spanned from 1996 to 2011, one study excluded LS and other studies did not report exclusion criteria. Some studies included boys with physiological phimosis.
8.6	**Balanitis and Balanoposthitis** Balanitis is inflammation of the glans penis. Balanoposthitis is acute inflammation of the foreskin and glans penis. There are a number of causes of balanitis and generally in adults it is recommended that the cause is treated for example with an anti-fungal cream or with hydrocortisone cream for up to 14 days together with general hygiene measures. Guidance advises children with recurrent balanitis should be referred to a paediatrician or dermatologist. It was noted that the Clinical Knowledge Summaries (CKS) guidance for does not define recurrent balanitis.
8.7	**Prevention of Urinary Tract Infections (UTIs) and Vesico-ureteric Reflux (VUR)** NICE guidance CG54 (2007) for the management of UTIs in children states that surgical management of VUR is not routinely recommended. VUR is the backflow of urine from the bladder up the ureters to the kidney. NICE CG54 was informed by updated evidence in 2013 from a Cochrane review, this review evaluated several treatments which included surgical management of VUR but circumcision was not referred to in the NICE guidance or the Cochrane review that informed the update. The European Society for Paediatric Urology (2015) state that it is not possible to produce recommendations based on high-quality studies for VUR. With regards to circumcision in children, circumcision during early infancy may be considered as part of the conservative approach because it is effective in reducing the risk of infection in normal children. A Randomised Controlled Trial (RCT) of weak study design followed patients with low-grade VUR and healthy boys. The authors concluded that antibiotics and circumcision was superior to

	antibiotic prophylaxis alone in boys with VUR and circumcision is superior to doing nothing regarding the bacterial colonisation in healthy boys. The clinical significance of the results and conclusions was not explained. The BMA law and ethics of male circumcision Guidance for Doctors (2006) states that all children who are capable of expressing a view should be involved in decisions about whether they should be circumcised, and their wishes taken into account.
8.8	**Penile Lesions** The European Society for Medical Oncology states that that circumcision is considered to be the mainstay treatment for small volume and superficial penile lesions.
8.9	**HIV Prevention** The World Health Organisation (WHO) states there is compelling evidence that male circumcision reduces the risk of heterosexually acquired HIV infection in men by approximately 60%. The evidence appears to have come from three RCTs based in Africa. A Cochrane Clinical Answer states there is low quality evidence from observational studies that suggests that circumcision may be protective among men who have sex with men in HIV acquisition. Cochrane concludes that men who have sex with men should not be excluded from any circumcision programmes and individual requests for circumcision should be considered.
8.10	The Committee discussed the guidance and evidence and agreed to use the current Berkshire CCGs' Male Circumcision policies as a base and expand the criteria as follows: • Recurrent balanitis - circumcision maybe required for balanitis where hygiene measures and other conservative measures such as topical anti-fungals and topical steroids have been considered or tried and failed or contra-indicated. Clinical Effectiveness team to seek specialist advice with regard to defining recurrent balanitis • Recurrent UTIs and VUR – not normally funded due to lack of national guidance and good quality evidence. • Absolute indications for circumcision include penile malignancy, traumatic injury, pathological phimosis after a trial of topical steroid. Clinical Effectiveness team to seek specialist advice regarding the duration of use of steroid. • Lichen Sclerosus must be histologically confirmed. • Age – retain the current policy text regarding non-retractable foreskins. Refer to the BMA guidance regarding obtaining consent of the child. • Non clinical reasons will not normally be funded. **8.10.1 ACTION: Clinical Effectiveness team to seek specialist advice before drafting a male circumcision policy with regard to:** • **defining recurrent balanitis.** • **the length of time a patient can use topical steroids for pathological phimosis before referral for circumcision,** **8.10.2 ACTION: Clinical Effectiveness team to draft a Male Circumcision policy document and circulate for comment. Comments to be received within the 2 week feedback period following issue.**
9.0	**Paper 17-009 – Updated Impact Assessment: Real-time Continuous Glucose Monitors and Flash Glucose Monitors (e.g. Freestyle Libre)**
9.1	The Committee reviewed the estimated resource impact data. As NICE had not provided any costing resources, thus the impact assessment had previously been based on prevalence data.

	At the TVPC meeting in March 2017, the Committee noted financial impact for CCGs is not clear and the impact assessment based on prevalence data varies widely from that predicted by the Oxford University Hospital specialist. The Committee agreed that in the absence of clear data around patient numbers and costings, further investigation would be required. Actions arising as a result of the committee meeting in March were: 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. 2. Dr Anees Pari to provide the Clinical Effectiveness team with the Health Economy Research Unit, University of Oxford contact details. 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.
9.2	1. CCGs with policies in place for Continuous Glucose Monitoring (CGM) Systems: It was noted that Hampshire CCGs (SHIP) have a CGM policy in place. The Committee reviewed Hampshire IFR team prior notification data and expenditure based on invoices received by the SHIP CCGs. It was noted that it is likely that this data also includes insulin pumps and pump consumables. Where reference to a pump was identifiable, this was been removed from the expenditure summary. The Hampshire figures indicated a linear increase in expenditure for CGM and the rate of increase remained consistent prior to and after the introduction of the local CGM policy. 2. Health Economy Research Unit : Dr Anees Pari provided the University of Oxford Health Economy Research Unit contact details. The Health Economics Research Centre advised that the required prevalence / incidence data is not within the remit of the department and was not able to advise us further. 3. Local provider estimations: Local providers were contacted for the number of patients estimated to be eligible for CGM in accordance with NICE guidelines. Clarification was sought from the Royal Berkshire NHS FT as their estimate of patient numbers appears to be significantly higher. The Consultant confirmed that he believes this is not over estimated but has offered to seek further advice from a specialist colleague from Kings College London who has an interest in CGM. The Committee considered that the estimates from other providers have been under estimated. **Post meeting note**: The estimated annual number of patients eligible for CGM in accordance with NICE guidelines for Royal Berkshire NHS FT has been confirmed as believed to be accurate by a specialist from King's College London Diabetes Research Group. The Committee noted that these patients are likely to remain using CGM on a long term basis and are likely to be the numbers of new patients each year. The total number of patients on CGM will therefore be cumulative and increase by this amount year on year. The committee discussed whether or not CGM is included within tariff. It is understood that CGM is in tariff with possible local negotiations. Insulin pumps and consumables are exclusions to tariff. CGM integrated with a pump is considered as PPR excluded e.g. Freestyle Libre.

	The Committee acknowledge that data regarding opportunity costs was not able to be quantified specifically however local provider estimations and the experience of other CCGs which have implemented policy give an indication of additional costs. The Committee agreed to recommend the previously agreed policy which states that CGM may be used in line with NICE Guidance. **ACTION: Clinical Effectiveness team to circulate CGM policy document for comment. Comments to be received within the 2 week feedback period following issue. Previously agreed Insulin pump policy also to be circulated for comment.**
10.	**Paper 17-010 – Eyelid Ptosis**
10.1	The Thames Valley CCGs have requested an amendment to the current local policy 'Aesthetic treatments for adults and children' TVPC16 (March 2015). The Committee was advised that local IFR teams receive requests for ptosis and have expressed a wish to have an additional guidance note to clarify when a request for surgery might be considered. The current policy states that eyelid surgery (blepharoplasty), including ptosis of eyelid is not normally funded. Ptosis describes a drooping of one or both upper eyelids, also referred to as blepharoptosis. The incidence of ptosis increase with age, ptosis can also develop due to an impairment of the nerve which controls the levator muscle. Ptosis does not tend to cause symptoms until the lid impairs a patients visual field (peripheral vision). Skin redundancy of the upper lid, or dermatochalasis, is a separate finding, and may occur in conjunction with blepharoptosis.
10.2	The Committee reviewed and discussed the literature and clinical feedback presented on parameters for ptosis surgery and agreed the following thresholds for undertaking surgery, based on the recommendations from a report by the American Academy of Ophthalmology: • to only fund ptosis or dermatochalasis where there is evidence of the following: o down-gaze ptosis impairing reading and other close-work activities o a chin-up backward head tilt due to visual axis obscuration • OR any one of: o margin reflex distance 1 (MRD(1)) of 2mm or less o eyelid skin fold to reflex distance of 2mm or less o superior visual field loss of at least 12 degrees or 24% o central visual interference due to upper eyelid position **ACTION: Clinical Effectiveness team to draft an amendment to the TVPC16 Aesthetic Treatments policy and circulate for comment. Comments to be received within the 2 week feedback period following issue.**
11.	**Any Other Business**
11.1	**In year requests for Scoping - Lidocaine infusions for chronic pain** Berkshire West CCGs have submitted this topic request for consideration for patients with chronic pain such as fibromyalgia following around 16 procedures per month being undertaken currently with 70-80 patients on the waiting list. The Committee agreed this can be included for scoring on the September meeting agenda. **ACTION: The Clinical Effectiveness team to include Lidocaine infusions for chronic pain relief on the agenda for scoring at the TVPC September meeting (20th September)**
11.2	**Gender Identity –**There is an NHS England consultation on gender identity services for adults which ends on the 30th September. Webinars are being held on the 4th & 5th September. It was agreed a joint response would be submitted on behalf of the Committee. **ACTION: Clinical Effectiveness team to circulate a hard copy of the consultation survey. Comments to be collated and a draft response on behalf of Thames Valley CCGs to be prepared and distributed for agreement at the next meeting (20th September)**

11.3	**Foot and Ankle Surgery –** an Agenda item for 20th September. The numbers of patients having foot and ankle surgery (not including bunion surgery for which there is a separate policy) was reported to be very small. The Committee agreed that the evidence review for this item should not be progressed at this time. **ACTION: Clinical Effectiveness team to remove Foot and Ankle Surgery as an agenda item on the TVPC meeting 20th September 2017.**
11.4	**Gluten Free Foods –** Consultation closed at the end of June with results due for publication at the end of September. **ACTION: Clinical Effectiveness team to update the Committee once the results of the gluten free foods consultation is available.**
11.5	It was raised that NHS CC has been undertaking a lot of work on medicines with NHS England. A 3-month consultation is expected to start on 21st July with 18 drugs proposed or decommission or not used at all and a second part about use of over the counter medicines. The Committee are requested to review the Consultation individually and collectively. **ACTION: The Clinical Effectiveness team to include this item for discussion at the 20th September 2017 meeting.**
11.6	**Adult ADHD –**The Committee discussed the scope of this review for inclusion on the agenda for the next TVPC meeting and agreed that the old policies were drafted to ensure adult AHDH was recognised and that adequate care pathways are in place. It was agreed it remained useful to have a policy for this and to update the current one which is due for review.
11.7	The Committee highlighted that the use of terminology regarding IFR and Prior Approval is not consistent across the TV. This has led to inappropriate requests and confusion for clinicians. The Committee agreed that all Thames Valley CCG websites need to use the same terminology previously agreed by the Committee. **ACTION: Clinical Effectiveness team to arrange for Thames Valley CCG websites to be amended to remove reference to IFR policies and to ensure the term IFR is not used with reference to prior approvals.** **ACTION: The Clinical Effectiveness team to resend the definitions with the minutes of this meeting as a reminder and for information.**
11.8	Note From July 2017 Thames Valley Priorities Committee training workshop: The Committee reviewed the definition of "Exceptional Need" in the TV Ethical Framework in response to the 2016 NHS Wales Independent Patient Funding Request Review. This highlighted that the principle of "exceptionality" requiring a patient to show they will derive more benefit from a treatment than a cohort of similar patients imposes undue burden on those suffering from orphan and rare diseases. The Committee discussed whether the present TV definition needed to be amended in light of this. It was suggested that 'significant benefit at reasonable cost' could be considered as an alternative principle. However the Committee noted that the current TV definition of Exceptional Need expressly refers to "special circumstances" and that this is sufficiently flexible to include the needs and circumstances of patients with orphan/rare diseases and is intended to do so. Given the familiarity of IFR panels with the present definition, the Committee agreed not to amend the current definition.
12.	**Next meeting**
	The next meeting will be **Wednesday 20th September 2017, to be held in Conference Room, Albert House, High Wycombe HP11 1AG.**
13.	**Meeting Close**
	The Chair thanked everyone for their contributions to the discussions and closed the meeting.