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 22nd November 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
Tiina Korhonen	Clinical Effectiveness Lead	SCW
Kathryn Markey	Clinical Effectiveness Manager	SCW
Rebecca Hodge	Clinical Effectiveness Manager	SCW
Gillian Barlow	Clinical Effectiveness Manager	SCW
Katie Newens	Clinical Effectiveness Researcher	SCW
Rachel Finch	Clinical Effectiveness Administrator	SCW
Jane Butterworth	Associate Director of Long Term Conditions & Medicines Management	Buckinghamshire CCGs
Linda Collins	Clinical Effectiveness Manager (CCG)	Oxfordshire CCG
Edward Haxton	Deputy Chief Finance Officer	Berkshire West CCGs
Heather Motion (from 3:30pm)	Medicines Optimisation Lead	Oxfordshire CCG
Dr Jacky Payne	GP	Berkshire West CCGs
Sarah Robson	Head of IFR	SCW
Sangeeta Saran (from 3:30pm)	Head of Operations	Berkshire East CCG
Amaka Scott	Commissioning Pharmacist	Berkshire West CCG
Dr Karen West	Clinical Director Integration	Buckinghamshire CCGs

Topic Specialists in Attendance for Agenda Items:

Mr Tom Pollard	Consultant Orthopaedic Surgeon British Orthopaedic Association Community Champion	Royal Berkshire NHS Foundation Trust
Mr Amar Malhas	Shoulder & Elbow Consultant	Royal Berkshire Hospital
Mr Aniruddha Pendse	Shoulder & Ankle Surgeon	Stoke Mandeville Hospital
Mr Philip Rosell	Shoulder & Elbow Surgeon	Frimley Park Hospital

Mr Chris Little	Orthopaedic Surgeon	Nuffield Orthopaedic Centre
Catherine Owen	Consultant in Diabetes	Oxford University Hospitals Trust
Sarah Roberts	Clinical Diabetes lead TV Cardiovascular Strategic Clinical Network and Diabetes Consultant Wexham Park Hospital Slough	Wexham Park Hospital
Diana Yardley	Chair of Children and Young Persons Diabetes Network	Thames Valley
Dr Ballav	Consultant Diabetologist Type 1 lead	Buckinghamshire HCNHST
Dr Gallen via Webex	Consultant Endocrinologist	Royal Berkshire Hospital NHST
Dr Dutta	Consultant Paediatrician	Buckinghamshire HCTNHST

Apologies:

Lindsey Barker (LB)	Medical Director	Royal Berkshire NHS Foundation Trust
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	Assistant Director Clinical Strategy	NHS England, TV Area Team
Kate Forbes	Clinical Effectiveness Manager	SCW
Dr Mark Hancock	Medical Director	Oxford Health NHS Foundation Trust
Dr Graham Jackson Represented by Dr Karen West	Clinical Chair	Aylesbury Vale CCG
Jo Jefferies	Consultant in Public Health – Health Protection	Public Health Services for Berkshire
Tim Langran	Acting Head of Medicines Optimisation	Berkshire East CCGs
John Lisle	Chief Officer	Berkshire East CCGs
Dr Megan John	GP, Berkshire East CCG Lead	Berkshire East CCGs
Tracey Marriott	Director of Innovation Adoption	Oxford Academic Health Science Network
Eleanor Mitchell	Operations Director	South Reading, Berkshire West CCG
Chris Newdick	Professor of Health Law	University of Reading
Louise Patten (LP)	Accountable Officer	Buckinghamshire CCGs
Rosalind Pearce (RP)	Executive Director HealthWatch	Oxfordshire
Sarah Rayfield	Speciality Registrar in Public Health	Berkshire
Jeremy Servian	IFR Manager	Oxfordshire CCG
John Seymour	Consultant – Chief of Service – Medicine	Frimley Health Foundation Trust
Dr Mark Sheehan	Special Advisor – Ethics	University of Oxford
Fiona Slevin-Brown	Director of Strategy & Operations	Berkshire East CCGs
Bhulesh Vadher	Clinical Director of Pharmacy and Medicines Management	Oxford University Hospital Trust
Sara Wilds	Head of Urgent Care and Medicines Optimisation	Oxfordshire CCG
Cathy Winfield	Chief Officer	Berkshire West CCGs

1.	**Welcome & Introductions**
1.1	The Chair opened the meeting and welcomed the members of the Committee.
2.	**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.	**Draft Minutes of the Priorities Committee meeting held 20th September 2017 (Paper 17-018) – Confirm Accuracy**
4.1	**The draft minutes were accepted as a true record of the meeting.**
5.	**Draft Minutes of the Priorities Committee meetings – Matters Arising**
5.1	**Minutes of the Priorities Committee held in May 2016, Action 10.1 – Fertility care pathway** - **September 2017 Update:** A working group has been formed; an initial meeting is being arranged. **November 2017 Update:** Two GP's, Dr McQuillan from Berkshire West and Dr Iyer form Berkshire East are reviewing the primary care fertility pathway, they will consult with clinicians from all of the relevant localities to produce a final draft. A report will be presented to this Committee, provisionally in March 2018.
5.2	**Minutes of the Priorities Committee held in September 2017 – Action 6.5 – Paper 17-012 Ectropion and Entropion, Indications for Surgery** Clinical Effectiveness team to draft policy statements for referral thresholds for surgery for ectropion and entropion and circulate for comment. **Action Complete**
5.3	**Minutes of the Priorities Committee held in September 2017 – Action 6.5.1 – Paper 17-012 Ectropion and Entropion, Indications for Surgery** Clinical Effectiveness (CE) team to add a note to the Aesthetic Treatments for Adults and Children policy (TVPC16) regarding ectropion and entropion surgery. **November 2017 Update:** Once the Ectropion and Entropion - Indications for Surgery policy (TVPC70) has been adopted by Governing Bodies the CE team will add a statement to policy TVPC16. It is anticipated this action will be completed by March 2018.
5.4	**Minutes of the Priorities Committee held in September 2017 – Action 7.5 – Paper 17-013 Treatment Pathway for Adults with Attention Deficit Hyperactivity Disorder (ADHD)** The Committee noted that shared care pathway protocols vary across the Thames Valley CCGs and agreed it would be of benefit to have a common shared care protocol. Thames Valley Accountable Care System is currently undertaking work to generate an overall shared care protocols; details to be provided to the Committee when available. **November Update:** Lindsay Barker to provide an update at the January 2018 meeting.
5.5	**Minutes of the Priorities Committee held in September 2017 – Action 7.6 – Paper 17-013 Treatment Pathway for Adults with Attention Deficit Hyperactivity Disorder (ADHD)** Clinical Effectiveness team to draft an ADHD policy update to include threshold criteria. Clinical Effectiveness team to seek advice from Special Advisors in ethics and health law regarding patients with a diagnosis given by the private sector, before issuing to the Committee for comment. **ACTION Complete**
5.6	**Minutes of the Priorities Committee held in September 2017 – Action 8.3 – Paper 17-014 – Policy Update: Male Sterilisation – Vasectomy Services** CCG representatives (BE, Bucks and OCCG) to obtain vasectomy activity and cost data for Clinical Effectiveness team to collate for the governing body papers. **November 2017 Update:** No further data was received; governing body papers submitted. **ACTION Complete**

5.7	**Minutes of the Priorities Committee held in September 2017 – Action 8.3.1 – Paper 17-014 – Policy Update: Male Sterilisation – Vasectomy Services** Berkshire West to share their post vasectomy decommissioning review with the Committee when available. **November 2017 Update:** Shairoz Claridge to provide an Update at the January 2018 meeting.
5.8	**Minutes of the Priorities Committee held in September 2017 – Action 8.4 – Paper 17-014 – Policy Update: Male Sterilisation – Vasectomy Services** Clinical Effectiveness team to update TVPC4 Male Sterilisation policy and circulate for comment. **ACTION Complete**
5.9	**Minutes of the Priorities Committee held in September 2017 – Action 8.5 – Paper 17-007 – Policy Update: Female Sterilisation** Clinical Effectiveness team to draft a policy stating that female sterilisation is not normally funded. The CCGs to be made aware that by adopting this policy, patient engagement or consultation may apply. **ACTION Complete**
5.10	**Minutes of the Priorities Committee held in September 2017 – Action 9.1 - Paper 17-015 – NICE 'Do Not Do' Recommendations Proposal for a Policy Statement** Clinical Effectiveness team to prepare a draft NICE 'Do Not Do' policy statement, the statement is to provide a definition for 'NICE' and circulate for comment. **ACTION Complete**
5.11	**Minutes of the Priorities Committee held in September 2017 – Action 10.1 - Paper 17-016 – NHS England Specialised Commissioning Services Proposal for a Policy Statement** Clinical Effectiveness team to draft a NHS England Specialised Services policy statement, define 'Specialised Services' and provide a web link to patient information. **ACTION Complete**
5.12	**Minutes of the Priorities Committee held in September 2017 – Action 11.1 – Gender Identity Consultation** Clinical Effectiveness team to collate CCG responses to the Gender Identity Consultation and provide a draft response on behalf of Thames Valley CCGs for comment. **ACTION Complete**
5.13	**Minutes of the Priorities Committee held in September 2017 – Action 12.1 - NHS England and NHS Clinical Commissioners. Items which should not be prescribed in primary care: A Consultation on guidance for CCGs** Clinical Effectiveness team to collate CCG responses to the NHS England Medicines Consultation and provide a response on behalf of Thames Valley CCGs. **ACTION Complete**
5.14	**Minutes of the Priorities Committee held in September 2017 – Action 13.1 – Clinical Policy Website** Clinical Effectiveness (CE) team to provide a copy of the draft Website Introduction Statement to LP to revise the wording. RP to review and comment on the revised document. The Committee to discuss further at 22nd November 2017 meeting. **November 2017 Update:** Comments received from LP and RP. CE team to circulate the revised wording to the Committee for comment.
5.15	**Minutes of the Priorities Committee held in September 2017 – Action 13.2 - Clinical Policy Website** Clinical Effectiveness team to arrange for paper 17-017b 'Will the NHS pay for my treatment' to be uploaded to Thames Valley CCG IFR websites. To be uploaded with the completed action 13.2 above.
5.16	**Minutes of the Priorities Committee held in September 2017 – Action 14.1 – Any Other Business - In year request for Scoping – Lidocaine Infusions for Chronic Pain** Clinical Effectiveness team to assess the priority level of Lidocaine infusions with a score of 17 in the Committee workshop in November, in context of other topics submitted and scored for the 2018-19 work programme. **ACTION Complete**

5.17	**Minutes of the Priorities Committee held in September 2017 – Action 14.2 – Any Other Business – Sleep Disorders** Clinical Effectiveness team to defer the Sleep Disorders review until the publication of NICE guidance. **November 2017 Update:** An Agenda item for March 2018. **ACTION Complete**
5.18	**Minutes of the Priorities Committee held in September 2017 – Action 14.5 – Any Other Business – Dupuytrens** Clinical Effectiveness team to amend the existing Thames Valley Dupuytrens policy to reflect the change in funding of collagenase and circulate for comment. **ACTION Complete**
6.	**Paper 17-019 – Painful Shoulder – Arthroscopic Surgery for Adhesive Capsulitis (Frozen Shoulder)**
6.1	Thames Valley Clinical Commissioning Groups (CCGs) requested a review of the evidence-based care pathway in orthopaedics related to shoulder complaints and the place for commissioned surgical services. Currently Thames Valley CCGs have one shoulder related policy for subacromial pain developed in 2016. The CCGs asked for further exploration of treatment options for painful shoulder conditions. This review is focused on the management of adhesive capsulitis (frozen shoulder) and the thresholds for referral for arthroscopic surgery.
6.2	Frozen shoulder is a painful condition which leads to stiffness and disability. It is characterised by a progressive restriction of both active and passive shoulder movement and typically affects people aged between 40-60 years. There is loss of external rotation in the presence of a normal X-ray. The underlying fundamental process involves inflammation, scarring and scarring produced in reaction to inflammation. Frozen shoulder progresses through three overlapping phases • Painful phase (lasts 2-9 months). There is progressive pain on movement. The pain can become severe and disturb sleep. • Stiffness phase (lasts 4-12 months). The pain becomes less. Stiffness remains and there is reduction in the range of shoulder movements. Function can be substantially limited. • Resolution phase (lasts 12-42 months). Gradual improvement in range of movement with less stiffness. As there is an overlap between phases, frozen shoulder has been more recently classified into 'pain predominant' and 'stiffness predominant' phases. Interventions suitable for primary care and community triage services, as recommended in the British Elbow & Shoulder Society (BESS) pathway, include analgesics/non-steroidal anti-inflammatory drugs (NSAIDs), corticosteroid injection, domestic exercise programme and supervised physiotherapy or other manual therapy. Symptoms usually of up to 3 months with failure of conservative treatment measures may trigger referral to secondary care for consideration of more invasive treatment. Secondary care interventions: • manipulation under anaesthesia (MUA) • arthroscopic capsular release (ACR) • distension arthrogram (DA) or hydrodilatation • physiotherapy and a corticosteroid injection are usually used to supplement any of these interventions.
6.3	Evidence suggests there may be short-term benefit from adding a single intra-articular steroid injection to home exercise for patients with symptoms of < 6 months' duration. In the same population physiotherapy to a single steroid injection may also produce short-term benefit. A Cochrane review concluded that in the short term a glucocorticosteroid injection is likely to be more effective with regards to pain relief and function than manual therapy and exercise.

6.3 Cont..	A Health Technology Assessment (HTA) identified two case series of more than 50 patients which looked at arthroscopic capsular release (ACR). The best-quality case series had an average length of follow-up of 10 months (range 3 to 29 months). There was evidence of increased benefit of function and disability from both studies. However these studies were at high risk of bias and cannot be used to draw conclusions regarding the efficacy of ACR as a treatment for frozen shoulder. A very small randomised control trial (RCT) looked at ACR and manipulation under anaesthesia, comparing it to a home therapy programme. No statistical differences were found between the two groups. A low quality systematic review found no clear difference between manipulation under anaesthesia and arthroscopic capsular release however, no trials in the review were direct comparisons between the two interventions. There is low quality observational evidence which concludes that ACR is an option in patients that have not responded to conservative treatment.
6.4	Local activity data shows that in 2016-2017, Thames Valley CCGs spent approximately £500k on surgery for frozen shoulder. It was discussed that the expenditure may be higher than this. A post meeting analysis shows that a more accurate estimation of expenditure on arthroscopic capsular release in 2016-2017 is approximately £800k.
6.5	The specialists in attendance raised the following points: • It is important to make a correct diagnosis using an X-ray. Differential diagnoses include cuff tears, loft postural dislocation, arthritis, and bone tumours. • Frozen shoulder is a self-limiting condition. • A significant number of patients will respond to a corticosteroid injection and may not need further treatment. • Patients should have tried physiotherapy and a corticosteroid injection before referral for surgery. Patients should not be referred to secondary care unless symptoms have been present for at 3 to 6 months. • Manipulation under anaesthesia (MAU) and arthroscopic capsular release (ACR) are secondary care options. There is a risk of fracture with MAU. Patients undergoing ACR recover more quickly after 3 months. • Diabetic patients may have a more aggressive onset frozen shoulder. • A longitudinal study looking at patients with frozen shoulder showed that after 4.5 years, 85% of patients were symptom free. • Hydrodilatation with a corticosteroid injection is being used by some secondary care providers. The joint is inflated with larger than normal amount of fluid. A small number of patients may convert to ACR. A local trial of hydrodilatation has demonstrated an 85% success rate. • A corticosteroid injection should be given in conjunction with physiotherapy. • It is preferred that ACR is performed towards the end of the pain dominant phase and during the stiffness dominant phase of frozen shoulder.
6.6	The Committee considered the evidence, specialist feedback and financial impact across the CCGs. The Committee considered the specialists' discussion and the BESS guidance pathway and agreed the referral criteria as: • patient has had symptoms for 3 months • X-ray or equivalent imaging for diagnosis to be done prior to referral • conservative treatment to include NSAIDs, steroid injections and physiotherapy (note the steroid injection must be combined with physiotherapy) • referral to secondary care should not be before 3 months of conservative treatment, where conservative treatment has not been successful • Red flag symptoms require urgent referral to secondary care.

6.6 Cont..	Secondary care intervention may include: • Hydrodilatation with steroid injection where available. ACR will not be considered until 6 months of conservative treatment has failed • Manipulation under anaesthesia (MUA) should only be considered if ACR is not considered the appropriate treatment. The patient is to be made aware and fully informed of the associated risks. **ACTION: Clinical Effectiveness team to draft a painful shoulder – arthroscopic surgery for adhesive capsulitis (frozen shoulder) policy and circulate for comment. Comments to be received within the 2 week feedback period following issue.**
7.	**Paper 17-020 – Evidence Review: Management of Haemorrhoids**
7.1	The Thames Valley Priorities Committee requested an evidence review of the management of haemorrhoids. A benchmarking exercise identified that a number of CCGs nationally have adopted policies for the management of haemorrhoids; at present there are no policies relating to the management of haemorrhoids within the Thames Valley CCGS.
7.2	Haemorrhoids are swellings containing enlarged blood vessels that are found inside or around the anus. Haemorrhoids are classed as external or internal depending on their origin in relation to the dentate line (division of the upper and lower anal canal), both external and internal types can occur at the same time. Haemorrhoids are graded by degree of prolapse 1 to 4 (although classifications do not always reflect the severity of the symptoms). Estimates of the proportion of the UK population affected range from 4.4% to 24.5%.
7.3	There are a range of treatment options available for haemorrhoids. Conservative management includes lifestyle and dietary advice, managing symptoms (oral analgesia or topical haemorrhoid preparations) and ensuring stools are soft and easy to pass. Secondary care options include rubber band ligation, injection sclerotherapy, electrotherapy and infrared photocoagulation. Rubber band ligation is the most common procedure. Surgical interventions are reserved for patients that haven't responded to other treatments, or for patients who have large external haemorrhoids, or who have combined internal and external haemorrhoids with significant prolapse. Surgical procedures include traditional haemorrhoidectomy, stapled haemorrhoidectomy and haemorrhoidal artery ligation.
7.4	The Committee considered the clinical evidence, other CCG policies and the feedback received from clinicians. The committee agreed for a Thames Valley threshold policy for referral to secondary care to be drafted with the following criteria: • Haemorrhoids are prolapsed and incarcerated, and cannot be reduced (grade 4 haemorrhoids) OR • There is frequent and recurrent significant prolapse OR • The haemorrhoids are recurrent and associated with persistent bleeding and/or pain AND • There is failure of documented conservative management techniques including: Ensuring stools are soft and easy to pass (bulk forming laxative), dietary and lifestyle advice (increase fluid and insoluble fibre intake, discourage straining) and symptomatic relief (non-opioid analgesia and/or topical haemorrhoid preparation) NOTE: If the patient presents with rectal bleeding, they need to be appropriately investigated to determine the cause of bleeding. If symptoms are suggestive of malignancy, the patient needs to be referred under the 2 week wait pathway. **ACTION: Clinical Effectiveness team to draft a management of haemorrhoids policy and circulate for comment. Comments to be received within the 2 week feedback period following issue.**

8.	Paper 17-021 – Policies for Potential Withdrawal or Updating
8.1	Following a review of current policies for Thames Valley CCGs that pre date the current TV Priorities Committee recommdations, eight policies were identified as being in need of reconsideration. The Committee was asked to consider whether the policies can be withdrawn or should be updated.
8.2	**Multiple Chemical Sensitivities (MCS) and Clinical Ecology Environmental Medicine (2001)** Berkshire East CCGs and Berkshire West CCGs have policies in place. The policy states that patients with multiple sensitivities or unexplained illness should be treated by local NHS services, which may include medical, psychological and therapeutic assessment and treatment. This is due to the limited evidence of clinical effectiveness of clinical ecology treatments and the uncertainties regarding the diagnosis and management of MCS. The Committee recommended withdrawal of the policy as dated and no longer necessary. **ACTION: Clinical Effectiveness team to draft the paperwork for withdrawal of the Multiple Chemical Sensitivities (MCS) and Clinical Ecology Environmental Medicine (2001) and issue to relevant CCG Governing Bodies for acceptance.**
8.3	**Elfornithine for facial hirsutism (2005)** Berkshire East CCGs, Berkshire West CCGs and Buckinghamshire CCGs share a common policy whilst Oxfordshire CCG has a slightly different version. Both policy versions recommend that Eflornithine cream for facial hirsutism is a low priority treatment, stating that there is no evidence of its efficacy in comparison to existing treatments. After discussion the Committee felt the policy was still helpful in support of prescribers. **ACTION: The Clinical Effectiveness team to review the evidence for Elfornithine for facial hirsutism. If the evidence has not changed, it will be noted that the policy has been reviewed. If the evidence has changed, this item will be scheduled for discussion with TVPC.**
8.4	**Rectal Investigation and Surgery (2006)** Buckinghamshire CCGs have a policy regarding referrals for rectal investigation. The Committee agreed that the policy is no longer required in view of TVPC16 Aesthetic treatments for adults and children which refers to skin tags and the proposed adoption of a management of haemorrhoids policy discussed earlier in the meeting (item 7). **ACTION: Clinical Effectiveness team to draft the paperwork for withdrawal of the Rectal Investigation and Surgery policy and issue to the relevant CCG Governing Body for acceptance.**
8.5	**Prostatism (2006)** Buckinghamshire CCGs have a policy which states referral criteria for prostatism (a blockage of the bladder neck by an enlarged prostate gland). The Committee agreed that the policy could be withdrawn as broader guidance is available on when to refer men with symptoms that are typically associated with this condition. **ACTION: Clinical Effectiveness team to draft the paperwork for withdrawal of the Prostatism policy and issue to the relevant CCG Governing Body for acceptance.**
8.6	**Speech and Language Therapy in Parkinson's Disease (2012)** Policies are in place for all Thames Valley CCGs and refer to NICE guidance that has since been updated. The Committee agreed that in view of more up to date NICE guidance the policy could be withdrawn. **ACTION: Clinical Effectiveness team to draft the paperwork for withdrawal of the Speech and Language Therapy in Parkinson's Disease policy and issue to CCG Governing Bodies for acceptance.**

8.7	The Committee agreed that the following three policies are to be updated in line with most recent guidance and evidence . 1. Chronic Fatigue Syndrome (2008) 2. Short Burst Oxygen Therapy for the Relief of Breathlessness (2008) 3. Non pharmacological services for dementia patients (2011) **ACTION: The Clinical Effectiveness team to add Chronic Fatigue Syndrome, Short Burst Oxygen Therapy for the Relief of Breathlessness and Non pharmacological services for dementia patients to the policy review programme for evidence review, discussion and potential update of policy.**
9.	**Paper 17-022 – Evidence Review: Flash Glucose Monitoring, Freestyle Libre**
9.1	Thames Valley Clinical Commissioning Groups have requested a review of flash glucose monitoring system (FGM) Freestyle Libre (FSL). This review is in the context of recently agreed policy recommendations for Continuous Glucose Monitoring Systems (CGM) for adults with type 1 diabetes by the Priorities Committee in July (TVPC64), which makes a provision for FGM; however, the availability of FGM for the paediatric population also needs to be reviewed. TVPC64 is currently on hold pending further consideration and a joint recommendation by the Committee. The FGM sensor pack (contains 1 sensor, 1 sensor applicator and 1 wipe) was included in the NHS tariff in November, making it available in primary care FP10 prescription across the UK. Concerns raised by local CCGs include the likely high demand for the FGM from November, as well as the potential that availability on FP10 removes the identification of appropriate patients from specialist care setting. In the absence of a national approach many local committees and CCGs have set up interim statements deferring prescribing of FGM pending a local joint recommendation. Note: FGM will in future papers be referred to as FGS (Flash Glucose Systems).
9.2	The key publications currently available for FGM are; NICE Medtech innovation briefing evidence review, the RMOC (NHS England Regional Medicines Optimisation Committee-North) position statement, making recommendations inclusive of both adults and children, ABCD - Association of British Clinical Diabetologists, *Information to help a formulary case for Freestyle Libre System,* making recommendation for adults, and ACDC - Association of Children's Diabetes Clinicians Position Statement (affiliated to ABCD) who have produced recommendations for paediatric population similar to ABCD. East of England Priorities Advisory Committee (PAC) and Health Technology Wales have also produced statements for the use of FGM. All publications are based largely on the same evidence base summarised by the NICE Medtech briefing July 2017. In terms of NICE guidelines, FGM is not discussed, however continuous glucose monitoring (CGM) is discussed in NG17 for adults and NG18 for children. The RMOC statement is using the thresholds from the NICE TA151 insulin pump guideline as part of their recommendations.
9.3	The intended place of FGM in therapy is as a supportive alternative to routine blood glucose monitoring for people aged 4 or over with type 1 or type 2 diabetes, who have multiple daily injections of insulin or who use insulin pumps and are self-managing their diabetes. The Medtech evidence indicates high device accuracy compared with self-monitored blood glucose and that FSL for 6-12 months reduces time spent in hypoglycaemia compared with self-monitoring of blood glucose using finger-prick tests, and reduces the average number of finger-prick blood glucose tests needed. Evidence is limited in that there are only two randomised control trials available and both are company sponsored: One in adults with well controlled type 1 diabetes, and one in adults with type 2 diabetes on intensive insulin therapy or insulin infusion. There is little data comparing FGM to CGM used in unstable patients and very little information for use in pregnancy. In terms of children, there is only one published observational study in young people and children. Currently there is a lack of randomised controlled trials reporting improvements in HbA1c levels.

9.3 Cont..	Economically, based on the NICE Medtech briefing, the resource impact is uncertain, and depends upon the extent to which improved glucose control, through the adoption of FGM, translates into fewer complications in the longer term and reduced emergency admissions. The evidence does indicate that there would be less use of glucose test strips. However, whilst there would be less use of glucose test strips they would still be used in times of unstable blood glucose levels such as during illness and prior to and during driving to meet current DVLA requirements.
9.4	The attending specialists (adult and paediatric) were invited to offer their views and clarify any arising questions. The following points were included in their feedback; Finger prick tests are painful and many people don't check sugar levels as frequently as they need to. FGM technology is helpful in allowing people to monitor their glucose levels throughout the day without invasive testing. The specialists highlighted the issues relating to diabetes complications including morbidity and mortality. Fear of hypoglycaemia and complication relating to hyperglycaemia were discussed. It was noted that there are many factors why people with type 1 diabetes feel unable to control their diabetes at a level that's safe, hypoglycaemia is a big element but there are many others including social isolation, inconvenience of checking levels frequently at work and embarrassment. Improvements in the quality of life as an outcome measure were highlighted. Many people are buying the device privately and the specialists raised concerns about potential health inequalities between people who can and cannot afford the equipment. Differences of outcomes for those who are self-funding have been noted. Reference was made to the evidence of increased frequency of blood sugar testing with FGM, 15 times per day on average, whereas most people who are doing finger prick tests will test 4-6 times per day. Patients are able to give themselves more data on what is happening with their blood sugar overnight and through the day and more data can mean better control of diabetes. The trajectory of blood glucose levels available in FGM is a key feature. Patients can respond to the trajectory and control their blood sugar more effectively by delaying food ingestion, alter food choices and/or exercise if they know whether blood sugar is going up or down. It was noted that from a paediatric perspective, one of the biggest issues is social isolation. Children may not check their blood glucose levels during school as they are at a time in their lives where they want to not stand out from the crowd. Local data from Oxford highlighted that out of 81 of the patients who took part in their survey, 50% missed their insulin on a regular basis, and that the short-term use of FGM increased insulin bolusing and self-confidence in paediatric Type 1 diabetes. It was agreed that patients will still need some finger stick tests in addition to the use of FGM, yet we are unable to quantify the change in use currently. FGM could potentially reduce the number of people needing insulin pump therapy. The specialist supported the notion that FGM use should be initiated by the specialist diabetes care team. It was also agreed that there needs to be clear criteria for starting FGM, a frank discussion and a contract with patients including when to stop its use, for example when patient is not using FGM effectively. Patients need to be trained on effective FGM use. However, it was also acknowledged that not all type 1 diabetic patients engage with the clinics. Guidance for patients who are currently self-funding also needs to be agreed. It was acknowledged that the company estimates that 20-30% of the diabetic population would be eligible for FGM, may be an underestimate. It was noted that the FGM reader (single patient use) is given free to patients by the manufacturer. It has a 3 year life span until service and the manufacturer replaces it free of charge.

9.5	The Committee discussed the available evidence and the clinical feedback as well as the available financial data. It was acknowledged that improved diabetes control is desirable for all patients. It was evident that in order to be affordable, a criteria for the FGM use, continued use and discontinuation needs to be set. Patient outcome data should be collected routinely as recommended by the RMOC position statement. The Committee accepted that the size of the eligible population and the change in glucose strip use was uncertain. The outcomes data of not using CGM or less use of insulin pumps, as well as less hospitalisation due to hypo and hyperglycaemia episodes have not been demonstrated yet. The Committee noted the lack of evidence for FGM use in pregnancy and for type 2 diabetes. The Committee agreed that patients who have obtained FGS through clinical trials or private treatment, or who have been self-funding, must demonstrate that they satisfy the prescribing criteria as per all other patients when they commenced the use of FGM, as well as meet the criteria for continued use.
9.6	The Committee recommended the following criteria for the use of FGM, based in the RMOC position statement: • Type 1 diabetes, age 4 and above • FGM should only be prescribed by a specialist diabetic service and initiated on a 6 month trial basis • Patients who undertake intensive monitoring more than 8 times a day and actively managing their insulin on the results • Those who meet the current NICE criteria for insulin pump therapy (HbA1c greater than or equal to 8.5% (69.4mmol/mol) or Disabling hypoglycemia as described in NICE TA151) where a successful trial of FreeStyle Libre® may avoid the need for pump therapy • Those who have impaired awareness of hypoglycaemia • Frequent admissions (>2 per year) with diabetic ketoacidosis (DKA) or hypoglycaemia • Those who require third parties to carry out monitoring and where conventional blood glucose testing is not possible It was felt that patient education was key to effective use of FGM system and all patients (or carers) must: • have an agreed care plan, and • be willing to attend structured diabetes specialist service training prior to starting the use of FGS to ensure the use and benefit is maximised, and • commit to on-going regular follow-up and monitoring (including remote follow-up where this is offered) Continuation and discontinuation criteria for FGM was agreed to be recommended as per the ABCD guidance (**any** of the following, depending on the indication): Continuation criteria: • Reduction in severe/non- severe hypoglycaemia frequency by >1 episode per week. • Reversal of impaired awareness of hypoglycaemia. • Reduction in DKA events. • HbA1c reduction of 0.5% within 6 months. • PWD performs >4 scans per day, demonstrating evidence of FSL use in self-management. Discontinuation criteria: • Failure to achieve any of the above criteria (dependant on the indication) or • Failure to engage in two consecutive diabetes follow-up appointments.

9.6 Cont..	The need for the service to engage in the data collection of patient outcomes was acknowledged. It was proposed that joint key performance indicators could be agreed, outside of the policy. **ACTION 9.6: Clinical Effectiveness team to draft a Flash Glucose Monitoring policy for type 1 diabetes and circulate for comment. Comments to be received within the 2 week feedback period following issue.** **ACTION 9.6.1: Clinical Effectiveness team to update the draft CGM policy and circulate for comment. Comments to be received within the 2 week feedback period following issue.**
10.	**Paper 17-023 – Assisted Reproductive Services for Infertile Couples - Update**
10.1	Oxfordshire is the lead commissioner for tertiary care fertility services i.e. access to IVF and ICSI. Following a review of the new service specification it has become apparent that in part 2 of the policy, **How to refer eligible couples**, one of the tertiary referral centres is no longer in existence and the policy doesn't include centre's with which contracts are being developed. It was proposed that the policy should be amended to state in view of providers "one of the designated NHS centres listed on the standard referral form and the secondary care clinic." Oxfordshire CCG also propose some updates to the policy wording to reflect the language in the service specification as follows: under **Definitions:** • **Full cycle of IVF/ICSI** wording amended from: "One full fresh cycle" of IVF/ICSI treatment comprises: ovulation induction, egg retrieval, fertilisation and implantation, and include appropriate diagnostic tests, scans and pharmacological therapy. **TO** • "A full cycle of IVF treatment, with or without intracytoplasmic sperm injection (ICSI), should comprise 1 episode of ovarian stimulation and the transfer of any resultant fresh and frozen embryo(s)". • **Abandoned/cancelled cycle of IVF** wording amended from: "An abandoned or cancelled cycle is defined as one where an egg collection procedure is not undertaken. If an egg collection procedure is undertaken, it is considered to be a full cycle". **TO** • "An abandoned" cycle is one which does not reach the stage of embryo transfer. An embryo transfer is from egg retrieval to transfer to the uterus." under **Provider Responsibilities** wording amended from**:** • ".. treatment planning; counselling/advising patients; treatment consent; all drugs; egg collection; semen analysis; embryo transfer; pregnancy test(s); all consumables; pathology tests; scans; and the HFEA fee". **TO** • ".. follow up consultation, and counselling sessions, all ultrasound scans and hormone assessments during the treatment cycle, oocyte recovery, embryo, or blastocyst transfer, all embryology including sperm preparation and sperm retrieval where indicated, a pregnancy test and a maximum of two scans to establish the viability of the pregnancy. The commissioned provider of the IVF service will prescribe and supply the necessary drugs".

10.1 Cont..	Of note is that the content of the policy has not been reviewed and there in no change to the policy tresholds. **ACTION: Clinical Effectiveness team to update the wording of the Assisted Reproduction Services for Infertile Couples (2013) policy adding a footnote to indicate the update is merely to align the wording of the policy document with the service contract specification. The Clinical Effectiveness team to issue the update as per the usual process for comments.**
11.	**Accountable Care Organisations – Update**
11.1	**Topic update deferred until the 24th January 2018 meeting.**
12.	**Any Other Business**
12.1	**Hip Arthroscopy for Femoro-acetabular Impingement Guidelines**
	The attending orthopaedic specialist identified to the Committee that some femoro-acetabular impingement funding applications have been submitted by Basingstoke Hospital. Basingstoke doesn't have clinicians with the required number of annual procedures, agreed as part of the TVPC policy guidelines for hip impingement surgery competence. It was noted that it is a Hampshire policy not a Thames Valley Policy that is applied in Basingstoke Hospital referrals. Patients being referred for treatment from Berkshire West to another lead commissioner's provider are managed under the lead commissioner's contract and policies. It was agreed that there is a need establish whether Hampshire has a policy in place and then consider how these funding requests can be managed. Such requests need to be drawn to the attention of our TVPC Commissioners. **ACTION 12.1: Sarah Robson to review the Hampshire policy website and identify whether there is a hip impingement for arthroscopic femoro-acetabular surgery policy in place and if so provide details.**
12.2	**Referral pro forma**
	The attending orthopaedic specialist also raised an issue with the current prior approval process with the Berkshire West MSK referrals and the pro forma, in relation to a request for an 'opinion' or a request for 'treatment'. Patients are being seen for an opinion where the surgeon recommends surgical treatment, but are not able to forward the patient to the waiting list but are having to send them back to the GPs for referral. GP then completes the required arthritis care, shared decision tool, PDA, etc which should be actioned before the referral. **ACTION 12.2: Sarah Robson to discuss the MSK referral pro forma criteria with Eleanor Mitchell and provide an update to the Clinical Effectiveness team and update the clinical team.**
12.3	**TVPC Work Programme for 2018-19 year**
	Copy of the 2018-19 programme to be circulated with the minutes. **ACTION 12.3: Clinical Effectiveness team to circulate a copy of the TVPC Work Programme for 2018-19 with the draft minutes.**
13.	**Next meeting**
	The next meeting will be **Wednesday 24th January 2018, to be held in Conference Room, Albert House, High Wycombe HP11 1AG.**
14.	**Meeting Close**
	The Chair thanked everyone for their contributions to the discussions and closed the meeting.