THIS MEETING WAS NOT QUORATE

Berkshire West Clinical Commissioning Group
Buckinghamshire Clinical Commissioning Group
East Berkshire Clinical Commissioning Group
Oxfordshire Clinical Commissioning Group

Thames Valley Priorities Committee

Minutes of the meeting held Wednesday 25th July 2018

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

Alan Penn	Lay Member Chair	Thames Valley Priorities Committee
Lindsey Barker (LB)	Medical Director	Royal Berkshire NHS Foundation Trust
Linda Collins	Clinical Effectiveness Manager (CCG)	Oxfordshire CCG
Edward Haxton	Deputy Finance Director	Berkshire West CCG
Dr Graham Jackson	Clinical Chair	Buckinghamshire ICS Clinical Lead
Dr Megan John	GP, Berkshire East CCG Lead	East Berkshire CCG
Dr Jacky Payne	GP	Berkshire West CCG
Dr Raju Reddy	Secondary Care Consultant	Berkshire West CCG
Bhulesh Vadher	Clinical Director of Pharmacy and Medicines Management	Oxford University Hospital NHS Foundation Trust

Observers:

Zeshaan Mudassar	Graduate Management Trainee	SCW

In Attendance:

Gillian Barlow	Clinical Effectiveness Manager	SCW
Kathryn Markey	Clinical Effectiveness Manager	SCW
Kate Forbes	Clinical Effectiveness Manager	SCW
Rebecca Hodge	Clinical Effectiveness Manager	SCW
Katie Newens	Clinical Effectiveness Researcher	SCW
Rachel Finch	Clinical Effectiveness Administrator – Minute Taker	SCW

Topic Specialists in Attendance for Agenda Items:

Item 6 – Evidence Review: Sequential use and dose escalation of biologics in Crohn's disease		
Oliver Brain	IBD Specialist	Oxford University Hospitals NHS Foundation Trust
Sarah Cripps	Consultant Pharmacist	Oxford University Hospitals NHS Foundation Trust
Item 7 – Evidence Review: Topical negative pressure for wound closure		
Ria Betteridge	Nurse Consultant Tissue Viability	Oxford University Hospitals NHS Foundation Trust
Lucy Hosie	Training Fellow in Advanced Nursing Practice of Tissue Viability	Oxford University Hospitals NHS Foundation Trust

THIS MEETING WAS NOT QUORATE

Apologies:

Dr Tony Berendt	Medical Director	Oxford University Hospitals NHS Trust
Jane Butterworth (JB)	Associate Director of Long Term Conditions & Medicines Management	Buckinghamshire CCG
Dr Miles Carter	West Oxford Locality Clinical Director	Oxfordshire CCG
Francis Fairman	Assistant Director – Clinical Strategy	NHS England (TV area)
Dr Lalitha Iyer	Medical Director & Women's Health Lead	East Berkshire CCG
Catriona Khetyar	Head of Medicines Optimisation	East Berkshire CCG
Tiina Korhonen	Clinical Effectiveness Lead	SCW
Tracey Marriott	Director of Innovation Adoption	Oxford Academic Health Science Network
Andrew McLaren	Deputy Medical Director	Buckinghamshire CCG
Chris Newdick	Professor of Health Law	University of Reading
Chandi Ratnatunga	Associate Medical Director	Clinical Networks & Partnerships
Sangeeta Saran	Head of Operations – Slough	East Berkshire CCG
Amaka Scott	Commissioning Interfacing Pharmacist	Berkshire West CCG
Dr Mark Sheehan	Special Advisor – Ethics	University of Oxford
Laura Tully	Assistant Director of Clinical Quality	SCW

THIS MEETING WAS NOT QUORATE

1.	**Welcome & Introductions**
1.1	The Chair opened the meeting and welcomed the members of the Committee.
2.	**Apologies for Absence**
2.1	Apologies recorded as above.
3.0	**Declarations of Interest**
3.1	None were declared.
4.	**Draft Minutes of the Priorities Committee meeting held 23rd May 2018 - 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 GPs, from Berkshire East and Berkshire West are looking at 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. **May 2018 Update: Minutes of the Priorities Committee held in May 2018 – Action 8.2 - Paper 18-003a & 18-003b – Fertility Care Pathway for Primary Care** The attending clinicians to provide an Evidence Review: Primary Care referral into Secondary Care for Couples with Infertility to include the Pathway and present to the Committee for consideration at the 25th July 2018 TVPC Meeting **July 2018 Update:** An agenda item for 26th September meeting.
5.2	**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 protocol; details to be provided to the Committee when available. LB to provide an update at the March 2018 meeting. **March 2018 Update:** LB to provide an update at the May 2018 meeting. **May 2018 Update:** Clinical Effectiveness team to correspond with LB via email ***July 2018 Post meeting note****: Developing a common shared care protocol is taking longer than LB first anticipated. In the meantime LB asked for the action to be closed and will bring back to the Committee when a share care protocol is available.* ***ACTION Closed***
5.3	**Minutes of the Priorities Committee held in March 2018 – Action 3.2 – Non-quorate Committee Meeting of 24th January reference Paper 17-026 Draft Policy Review: Flash Glucose Monitoring System (FGS) and proposed Patient Agreement Forms** JB to contact each TVPC CCG representative to discuss and agree the audit criteria and time frame to monitor the use of FGS. **May 2018 Update:** JB to provide an update at the July 2018 meeting. **July 2018 Update:** Action carried forward to September 2018 meeting
5.4	**Minutes of the Priorities Committee held in March 2018 – Action 7.1 – Evidence Review: Iron Chelation for Myelodysplastic Syndromes** Time constraints within the March meeting prevented the evidence review of Iron Chelation for Myelodysplastic Syndromes being presented to the Committee; this item was deferred to the 23rd May 2018 meeting. **May 2018 Update:** Due to other priority items on the May agenda Iron Chelation has been deferred to 25th July 2018 meeting. **July 2018 Update:** An agenda item for September 2018 meeting.

5.5	**Minutes of the Priorities Committee held in March 2018 – Action 8.5 – Paper 17-036 Policy Update: Sequential use of Biologics in Rheumatoid Arthritis (RA)** The Clinical Effectiveness team to draft a policy recommendation update: Use of Biologics in Rheumatoid Arthritis and circulate for comment. **May 2018 Update: Minutes of the Priorities Committee held in May 2018 – Action 5.8.1 - Matters Arising: Paper 17-041 - Use of Biological and Immunomodulatory Therapies in RA** During development of the draft policy specialist clinicians raised further points for Committee consideration, following discussion the Committee agreed the Clinical Effectiveness team to update the draft policy recommendation: Use of Biological and immunomodulatory therapies in RA and circulate for comment. **July 2018 Update:** refer to agenda item 5.8
5.6	**Minutes of the Priorities Committee held in May 2018 – Action 6.6 – Paper 18-001 Evidence Review: Smoking Cessation before Elective Surgery** The Clinical Effectiveness team to draft a policy recommendation: Smoking cessation before elective surgery and circulate for comment. **ACTION Complete**
5.7	**Minutes of the Priorities Committee held in May 2018 – Action 9.1 - Paper 18-004 & 13-016: Preservation of Fertility policy TVPC17 revisit** The Clinical Effectiveness team to provide an Evidence Review: Preservation of Fertility, for consideration by the Committee at the 26th September 2018 meeting.
5.8	**Minutes of the Priorities Committee held in May 2018 – Action 11.2: Any Other Business: Annual Training Event** The Clinical Effectiveness team to arrange a TVPC training event in Jubilee House, Oxford on 28th November 2018 ahead of the TVPC meeting. **July 2018 Update:** The Committee agreed Reading University as a venue for both the TVPC training event and TVPC meeting on 28th November 2018. **ACTION Closed.**
5.9	**Minutes of the Priorities Committee held in May 2018 – Action 11.2.1: Any Other Business: Annual Training Event** Discussion items for the 28th November training event to be sent to the Clinical Effectiveness team for consideration**.**
5.8	**Matters Arising: Paper 17-041 - Use of Biological and Immunomodulatory Therapies in RA**
5.8.1	During development of the draft policy in March 2018, an issue was raised by clinical specialist regarding patients who respond well to treatment but developed severe adverse injection site reactions and for these patients to be switched to an alternative product with the same mode of action. At the subsequent TVPC meeting in May, the Committee recommended the draft policy be amended to allow patients who experience injection site reactions to trial another drug within the same part of the pathway if this was deemed clinically appropriate. On circulating the updated draft policy for comment further specialist feedback was received noting there are other severe adverse reactions such as anaphylaxis, recurrent infections and psoriasis. Additionally the algorithm required amendment to provide clarity regarding contra-indication to Rituximab. A new NICE guideline NG100: Rheumatoid arthritis in adults: management has been published this month replacing NICE clinical guideline CG79. There are no relevant changes in the new guidance with regard to biologic / immunomodulatory therapy. Following discussion the Committee agreed the policy should be amended to include other documented serious adverse reactions that necessitate discontinuation but where the patient is responding well, there is no loss of response and where there has been an opportunity to evaluate the response.

5.8.1 cont..	The Committee agreed for patients who experience severe adverse reactions to the initial biologic, another drug within the same part of the pathway could be trialled and that this would not count as additional to the maximum number of 3 treatments. Patients who have had a serious adverse reaction can trial up to 4 treatments. **ACTION: The Clinical Effectiveness team to update the draft policy recommendation: Use of Biological and immunomodulatory therapies in Rheumatoid Arthritis and circulate to CCG representatives for comment. Comments to be received within the 2 week feedback period following issue.**
6.	**Paper 18-006 – Evidence Review: Sequential use and dose escalation of biologics in Crohn's disease**
6.1	Thames Valley Clinical Commissioning Groups (CCGs) requested a review of the sequential use of biologics and dose escalation of biologics beyond standard doses for adults and children with moderate to severe, active and fistulising action Crohn's Disease (CD) in order to agree a common policy across the Thames Valley CCGs. NHS England commissions paediatric specialised gastroenterology, hepatology and nutritional support services which includes the investigation and management of CD in children and transition to adult care. NHS England does not commission the medical management of CD in adults. This review focused on CD in adults only. There are currently five policies relating to the use of biologic drugs for Crohn's disease within the Thames Valley CCGs.
6.2	There are four biologic drugs approved for CD by NICE: infliximab, adalimumab, ustekinumab and vedolizumab. The Committee was provided with information regarding the mode of action for each biologic drug.
2.24pm	Lindsey Barker joined the meeting
	• NICE TA187 (2010) states that infliximab and adalimumab, within their licensed indications, are recommended as treatment options for adults with severe active CD whose disease has not responded to conventional therapy (including immunosuppressive and/or corticosteroid treatments), or who are intolerant of or have contraindications to conventional therapy. • NICE TA187 (2010) also states that infliximab, within its licensed indication, is recommended as a treatment option for people with active fistulising CD whose disease has not responded to conventional therapy. • NICE TA456 (2017) recommends ustekinumab as an option for treating moderately to severely active CD in patients who have lost response or who are intolerant to either conventional therapy or a TNF-alpha inhibitor. • If more than one treatment is suitable, the least expensive option should be chosen, taking into account administration costs, dosage and drug costs.
6.3	In general there were no robust randomised controlled trials found comparing dose escalation with no dose escalation or sequential use of biologics with conventional therapy. Loss of response was not clearly defined within the studies. In the studies where patients had previously had anti-TNFs, results were not reported according to the number of anti-TNFs previously used. Evidence indicates one third of patients had a loss of response and did require dose intensification in primary anti-TNF α responders. Previous treatment with anti TNF therapy appears to be a factor in predicting loss of response.
6.4	Annual cost of maintenance treatment for adults ranges from £9k to £14k. This does not include administration costs. Costs may vary due to negotiated procurement discounts. Vedolizumab and infliximab are administered via infusion for maintenance treatment and will incur an additional administration cost. It is noted that the data do not quantify dose escalation and sequential use of biologics. The patent for adalimumab expires in October 2018 and this may release some cost savings.

6.5	The clinical specialists in attendance raised the following points: • CD is a lifelong chronic inflammatory disease with a natural progression of inflammation, scarring, fibrosis leading to obstruction, perforation or fistulisation. If inflammation is not controlled it inevitably will progress to bowel damage and the need for surgery. • Basing decision making solely on symptoms can lead to the wrong outcome. Increasingly, decisions are being made by using objective markers of information; for example blood markers, faecal calprotectin, endoscopy, histology and scanning where appropriate. If a patient has active disease, drug levels and antibody levels are both analysed in order to make a decision regarding treatment strategy. • Ustekinumab is appropriate if an anti-TNF has failed to provide a response and there is no straight forward surgical solution. The use of ustekinumab will rise as anti-TNF failure is common. • The specialists also provided details of a virtual anti-TNF clinic which has provided savings of £30k in a year by optimising drug therapy. • NICE is reviewing the management guidelines for CD, due to be published in January 2019. A key area NICE will be addressing is the use of biologics post-surgery.
6.6	The Committee discussed policy development and the points raised by the clinical specialists and agreed, that a Thames Valley wide policy for the use of biologics in CD is required. The Committee welcomed the clinical specialist's offer to work with their colleagues from Oxford, Reading, Buckinghamshire and Frimley to develop a policy and pathway for the use of biologics in CD and present to TVPC for consideration. The Committee recommended that the existing policy statement for paediatric CD should be withdrawn. The Committee asked the Clinical Effectiveness team to propose a timeframe to the specialists in attendance for the policy development working group to bring a draft policy and pathway to the 26th September TVPC meeting. A note of concern was raised regarding the cost data provided as part of the review for Oxfordshire CCG. **ACTION: CE team to check OCCG cost data.** **ACTION: Clinical Effectiveness team to ask the specialist clinicians to develop a policy and pathway for the sequential use of biologics in Crohn's disease with their colleagues from Oxford, Reading, Buckinghamshire and Frimley. The Committee suggested this may be presented to the 26th September TVPC meeting.** **ACTION: Clinical Effectiveness team to recommend withdrawal of MOBB Statement: Dose escalation therapy with infliximab and adalimumab in children (aged 6-17 years) with severe active Crohn's disease to the CCG governing bodies.**
7.	**Paper 18-007 - Evidence Review: Topical negative pressure for wound closure; vacuum-assisted wound closure dressings**
7.1	Thames Valley CCGs requested an evidence review of the use of negative pressure wound therapy (NPWT) as usage appears to be increasing and there are currently no policies in place across the TV CCGs for the use of this therapy. The aim of NPWT is to aid healing by maintaining a moist wound environment, improving blood flow, removing wound exudate, promoting formation of granulation tissue and reducing infection. The review considered whether NPWT delivers improved health outcomes, clinical quality and safer care, its economic impact and indications for use. As there are many indications for use of NWPT, the focus of the review was limited to the use of NPWT in surgical wounds (open abdomen), obstetrics, orthopaedic surgery and chronic wounds relating to diabetic foot ulcers, venous leg ulcers and pressure ulcers.

7.1 cont..	Across the TV CCGs, 287 devices were used over the last three financial years, the main indications have been for debridement of skin, dressing of skin and autograft of skin. There are many NPWT systems available, some portable, single use, 7 day (e.g. PICO) and different makes (VAC, Renasys, Venturi). Comparison of the merits of different types of device was beyond the scope of the evidence review.
7.2	There is no specific NICE Guidance for the use of NPWT, however several NICE documents note its use. NICE NG19 (2015) for Diabetic foot problems recommends that NPWT can be considered after surgical debridement for diabetic foot ulcers, on the advice of the multidisciplinary foot care service. The Guideline Development Group (GDG) was confident that current costs of NPWT are substantially lower than the costs of the intervention assumed by the Guidance cost analysis figures. The Committee were advised that the evidence reviewed to support this guidance was limited and of low quality. NICE CG74 (2013) Prevention and treatment of surgical site infection notes that 'NPWT appears to reduce surgical site infection rates after invasive treatment of lower limb trauma, but may be less effective in other patient groups such as those with multiple comorbidities. Further research is needed'. NICE CG179 (2014) for Pressure ulcers does not recommend routinely offering adults with pressure ulcers NPWT, unless it is necessary to reduce number of dressing changes. NICE IPG467 (2013) considers that current evidence on the safety and efficacy of NPWT for the open abdomen is adequate to support its use. NICE Medtech innovation briefing MIB149 (2018) on PICO NPWT for closed surgical incision wounds states that current evidence suggests that NPWT has been associated with fewer surgical site infections (SSI) compared with standard dressings. Although the difference in costs is significantly greater than standard dressings, costs may be offset by reduced infections and less healthcare resource use in patients at high risk of surgical site complications
7.3	**Evidence for pressure ulcers**: Systematic reviews (SRs) indicate that there is insufficient evidence to support the use of NPWT for pressure ulcers and leg ulcers. **Evidence for venous leg ulcers:** The very limited research identified is not generalisable for the use of NPWT for leg ulcers. **Evidence for diabetic foot ulcers**: Two SR's found that NPWT was more effective than non-negative pressure therapy (moist wound healing treatment) for diabetic foot ulcers and significantly improved proportion of diabetic foot ulcer healing with significantly shorter time to healing and faster formation of granulation tissue. **Evidence for surgical wound healing:** The research indicates that there is no rigorous RCT evidence of effectiveness in surgical wound healing, however some studies suggest a reduction in reoperation rates if NPWT was used and a reduction of median time to healing of 47 days with NPWT when compared with alginate dressing. SR by Liu et al (2018) on open fractures found that NPWT significantly reduced the risk of infection and accelerated wound healing in open fractures. In open abdomen surgery an RCT by Li et al (2017) concluded NPWT can reduce the incidence of surgical site infection (SSI) (surgical site infection) in surgeries with a high risk of infection.
7.4	Data derived from an RCT (2017) indicated that single use NPWT could be considered a cost saving intervention to reduce surgical site complications following hip and knee replacements; The cost per patient was £5,602 for single-use NPWT and £6,713 for standard care respectively resulting in cost-saving of £1,132 in favour of single-use NPWT. The report indicated that savings may be achieved via robust patient selection, minimising waste, timely treatment, appropriate training and monitoring prescribing. An HTA report on NPWT for Wounds (2010) identified there might be potential savings in reduced nurse visits, however concluded there was insufficient evidence on cost effectiveness.

7.4 cont..	Local data indicates that for a PICO single use 7 day system (including adhesive dressings) costs range from £126-£145. An ACTIVAC pump (hospital use only) purchase is over £2k, renting is £23 per day with dressing costs ranging from £10 to over £38 each. NPWT costs across the TV CCGs for surgical and wound debridement has almost doubled to £719k in 2017-18 year from the £430k spent in 2015-16. The average spend per patient appears to be in the region of £10k however costs for NPWT use in the Community are not included in the available data. However, the overall trend indicates the use across the TV CCGs appears to be decreasing with the exception of Oxfordshire; Berkshire West has the least activity. There was a general discussion regarding the acute sector costs and whether NPWT was within tariff.
7.5	The clinical specialist attending queried the data and reported spend at OUH was £231k for the year. The clinical specialists in attendance noted that in OUH the NPWT machines are rented in bulk to ensure availability on site and therefore they pay a reduced charge per unit. OUH pay for the first two weeks of therapy, costs for patients discharged from OUH with NPWT are then transferred to the Community (CCG). Using NPWT for patients who have large wounds means they can be discharged earlier into the community. The specialist clinicians are currently putting together a framework /standard pathway for patients at high risk of SSIs. The specialists noted that NPWT may be used for patients with pressure ulcers with high exudate levels as patients can be discharged to the Community with a twice weekly intervention rather than a three times a day intervention within hospital setting. The Committee raised a concern regarding the training needs for staff managing NPWT in the Community. The local specialists stated that discharge into the community would only be done if the district nursing team were able to continue with the care. Training is provided and more formal training academies are also run. Training is also provided for Nursing Home staff, however, if they were not happy to take the patient under their care, the patient would remain in hospital.
7.6	The Committee noted that there seems to be enough clinical evidence that NPWT is effective for major surgery and diabetic foot ulcer care following debridement, but not for pressure ulcers, nor venous leg ulcers. The Committee agreed that NPWT appears to speed up the transfer time back to community, shortening hospital stay. However, no evidence was available regarding numbers of bed days saved. The Committee considered the evidence provided and felt that more information was required before a policy recommendation could be drafted. The Clinical Effectiveness team were asked to review the patient population for diabetic foot ulcers and provide further local data and financial impact for review at the next meeting on 26th September 2018. **ACTION: Clinical Effectiveness team to:** **1. Provide the Committee with details of the nature of the original request for the evidence review- complete (see below)** **2. Obtain community level data for the numbers of patients in the TVPC locality currently being treated for diabetic foot ulcers.** **3. If available, obtain data re. current spend for treatment of diabetic foot ulcers and projected spend should NWPT be commonly adopted for this indication** **4. Obtain data regarding reduction in bed days for patients discharged from the acute sector with NPWT and potential associated reduction in cost.** **5. Add NPWT as an agenda item for consideration at the 26th September TVPC meeting**

7.6 cont..	***Post meeting note regarding details of the CCG requesting review of NPWT and their reasons for doing so: Berkshire West CCGs submitted a request to review Topical Negative Pressure dressings outlining the issue as follows "At present NPWT therapy is only available from the monopoly supplier Kinetic Concepts Inc (KCI). No policy in place that reviews the evidence base for this. Small numbers but high cost"***
8.	**Paper 18-008 – Current policies update**
8.1	The Clinical Effectiveness (CE) team presented the Committee with the first tranche of 20 policies reviewed under the Policy Update Programme. All TVPC polices will be reviewed every two years to ensure TVPC policies are still relevant, take into account the latest guidance and reflect up to date clinical and cost-effectiveness research. On the basis of the findings the CE team recommends the Committee to endorse the following: 1. Ten policies with no change to the policy – no new guidance or substantial evidence found. Of note: • TVPC2 Treatments for Gender Dysphoria – on hold pending publication of NHSE Consultation findings which closed in October 2017 • TVPC10 Interventions for non-union fracture: Low-intensity pulsed ultrasound – under review by NICE; the policy to be reconsidered following NICE publication. **The Committee agreed the policy 'no change' recommendations for the following:** • TVPC1: Interventional Procedures for Varicose Veins • TVPC2: Treatments for Gender Dysphoria • TVPC6: Arthroscopic lavage and debridement for patients with osteoarthritis of the knee • TVPC10: Interventions for non-union fracture: Low-intensity Pulsed Ultrasound (marketed in the UK as the Exogen®system) and teriparatide • TVPC15: Ganglion Cysts • TVPC20: Surgical management of otitis media (OME) with effusion in children (under the age of 12 years) • TVPC25: Hyperhidrosis (excessive sweating) – Botulinum Toxin A and Endoscopic Thoracic Sympathectomy • TVPC26: Pectus anomaly surgery • TVPC29: Dilatation and curettage for abnormal uterine bleeding • TVPC33: Surgical treatment of femoro acetabular hip impingement (FAI) (open or arthroscopic) 2. Five policies with a minor update – new or updated guidance or substantial evidence is found but makes no impact on the wording of the policy or the context of the policy is not changed. Of note: • TVPC3 Anal Irrigation System – new NICE medical technology Guidance (MTG) has been published and will be added to support the policy. • TVPC21 Rhinosinusitis –new MTG of the XprESS multi sinus dilation system suggests a potential cost saving as an alternative to the endoscopic sinus surgery which is referred to in the policy.

8.1 cont..	**ACTION: CE Team to update links and include new guidance where appropriate for the following policies:** • Ethical Framework • TVPC3: Anal Irrigation Systems for the Management of Faecal Incontinence/Constipation • TVPC19: Carpal Tunnel Syndrome • TVPC21: Rhinosinusitis • TVPC32: Ultrasound guided injections for hip pain (trochanteric bursitis and osteoarthritis of the hip) 3. Five policies where a review of the policy is required at a TVPC meeting – new guidance or substantial evidence found which needs consideration by the Committee which may include the need for specialist clinical expertise. Note: • TVPC5 Anti-VEGF – new NICE TA409 guidance; mandatory and a priority • TVPC12 Botox – new NICE guidance for drooling treatment only • TVPC14 Biological Mesh – clinical concern relating to radiography • TVPC17 Preservation of Fertility – TVPC agenda item for 26th September meeting • TVPC22 Tonsillectomy – new RCS guidance particularly with regard to sleep apnoea in children **ACTION: If not already identified as items for review on the TVPC work programme the CE team to include the policy items identified as requiring review to the Committee work programme.** **ACTION: The CE team to procedure (OPCS) codes to existing TVPC policies being updated.** **ACTION: The CE team to add review of the Ethical Framework as an item for discussion at the TVPC Training session on 28th November 2018.**
8.2	The CE team confirmed the remaining policies will be reviewed in time order. An enquiry was raised as to when Policy Statement 112: Sodium oxybate for cataplexy and narcolepsy, a Berkshire West only policy was to be reviewed, this is an active policy which was commissioned by NHS England but has now returned to CCGs. The CE team advised their review is of existing TVPC interventions policies, PS112 is a medicines policy. In the interim CCGs would need to consider a policy locally or put it forward for scoping at the November programme workshop. *Post meeting note - CE Team clarification re policy updates: There is a question regarding demarcation between medicines policies and clinical interventions. At present the CE team has focused on updating clinical treatment policies as opposed to medicines and therapeutics, such as the Sodium oxybate for cataplexy and narcolepsy policy. There is a need for an STP wide approach to take forward the medicines updates as well as new medicines policies. This is something that needs to be reviewed and agreed and perhaps raised before and at the topic setting working group.*
9.	**National evidence based interventions (EBI) programme consultation**
9.1	Graham Jackson, Buckinghamshire CCG Clinical Lead provided the Committee with an EBI programme update. EBI is a joint venture between NHS England and NHS Clinical Commissioners, NICE, NHS Improvement GIRFT programme and the Academy of Royal Colleges, on 17 clinical treatment policies for a national commissioning position. This first phase was in regard to the items that should not be routinely prescribed in primary care programme. This consultation in in relation to threshold polices and proposed procedures to be not normally funded.

9.1 cont..	GJ asks that all CCGs respond to the consultation independently and that TVPC also respond collectively; consultation closes on 28th September 2018. The CE team offered to co-ordinate and draft a TVPC collective response and requested TVPC members provide their comments by 24th August 2018 to enable a draft response to be prepared. GJ will not participate in the TVPC collective response and asked that his interest as part of the Committee be declared in our response. **ACTION: TVPC Committee members are to provide their response to the EBI consultation to the Clinical Effectiveness team by 24th August 2018.** **ACTION: Clinical Effectiveness team to collate TVPC CCG EBI consultation comments and co-ordinate a joint draft response. Draft joint consultation response to be circulated for comment in mid-September; comments to be returned to CE team in readiness for final sign off at the TVPC meeting of 26th September.**
10.	**Integrated Care System (ICS) Update**
10.1	Graham Jackson, Buckinghamshire CCG Clinical Lead for ICS provided a status update to the Committee. Louise Pattern, Accountable Officer for Buckinghamshire and Oxfordshire is working to bring systems in both CCGs together to provide shared management systems across the two counties. Fiona Wise has been appointed as Executive Lead of the Buckinghamshire, Oxfordshire and Berkshire West Sustainability & Transformation Partnership (STP) . Her remit is to review what the STP boundary should look like. The Commons Select Committee has published a brief on Integrated care partnerships and accountable care organisations in June, a helpful launch and analysis and actives in ICS's across the country. The brief states that 'We recommend that ACOs, if a decision is made to introduce them more widely, should be established in primary legislation as NHS bodies. This will require a fundamental revisiting of the Health and Social Care Act 2012 and other legislation. Whilst we see ACOs as a mechanism to strengthen integration and to roll back the internal market, these organisations should have the freedom to involve, and contract with, non-statutory bodies where that is in the best interests of patients'.
11.	**Any Other Business**
11.1	**Evaluation Form**
	The CE would like the TVPC to evaluate the management of the meetings i.e. meeting structure, presentations, venue etc. It was agreed that an electronic copy of the evaluation form will be issued with the draft minutes of the meeting for completion and return by the next Committee meeting. **ACTION: Clinical Effectiveness team to provide an Evaluation Form to Committee members with the next minutes for completion and return at the 26th September meeting (hard copy will also be provided at the meeting as necessary).**
11.2	**TVPC16 Aesthetic treatments for adults and children**
	Oxfordshire CCG advised that their clinicians have raised an issue with TVPC16 policy under the breast surgery section. The policy does not allow for removal of breast prostheses except as part of the breast cancer pathway. The policy does not, but should, cover ruptured /leaking implants, hardened/painful prosthesis. Oxfordshire CCG has amended their policy to include ruptured/leaking implants, hardened/painful prosthesis, late onset seroma or any suspicion of BIA-ALCL and known PIP-implants as per DoH guidelines The Committee agreed a draft policy recommendation should be prepared as for Oxfordshire CCG and circulated for comment. **ACTION: Clinical Effectiveness team to draft an update to TVPC16 Aesthetic treatments for adults and Children policy and circulate for comment. Comments to be received within the two week feedback period following issue.**

THIS MEETING WAS NOT QUORATE

11.3	**TVPC66 NICE 'do not do' policy**
	TVPC66 policy was adopted by East Berkshire, Buckinghamshire and Oxfordshire CCGs however the link to the NICE 'do not do' database no longer works as NICE no longer maintains a 'do not do' database. NICE has advised that previous 'do not do's' can be viewed in the guidelines in which they were first published. The 'do not do' database has been replaced by a cost saving and resource planning page. NICE advice that guideline recommendations will make it clear when an intervention should not be offered to patients. The Committee agreed that as NICE is no longer maintaining the 'do not do' database the policy was no longer useful and should be withdrawn. **ACTION: Clinical Effectiveness team to prepare papers to CCGs recommending withdrawal of TVPC66 NICE 'do not do'.**
11.4	**Venue for 28th November training session and Committee meeting**
	ACTION: Clinical Effectiveness team to confirm to Professor Chris Newdick of Committee acceptance of his offer of Reading University as a venue for both the TVPC training event and TVPC meeting on 28th November 2018.
12.	**Next meeting**
	The next meeting will be **Wednesday 26th September 2018, to be held in Conference Room A, Jubilee House, 5510 John Smith Drive, Oxford OX4 2LH**
13.	**Meeting Close**
	The Chair thanked everyone for their contributions to the discussions and closed the meeting.