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 September 2019

Room G29/G30, 57-59 Bath Road, Reading RG30 2BA

Alan Penn	Lay Member Chair	Thames Valley Priorities Committee
Andrew McLaren	Deputy Medical Director	Buckinghamshire Healthcare
David Pollock	Interface Lead Pharmacist	Berkshire West CCG
Edward Haxton	Deputy Finance Director	Berkshire West CCG
Funmi Fajemisin	Interim Head of IFR	SCW
Dr Jacky Payne	GP	Berkshire West CCG
Dr Karen West	Clinical Director Integration	Buckinghamshire CCG
Linda Collins	Clinical Effectiveness Manager (CCG)	Oxfordshire CCG
Lindy Hardy	Assistant IFR Manager	SCW
Dr Mark Sheehan	Special Advisor - Ethics	University of Oxford
Dr Megan John	GP, East Berkshire CCG Lead	East Berkshire CCG
Dr Raju Reddy	Secondary Care Consultant	Berkshire West CCG
Professor Chris Newdick	Special Advisor - Law	University of Reading
Dr Rachel Horton	Special Advisor - Discrimination Law	University of Reading

In Attendance:

Tiina Korhonen	Clinical Effectiveness Lead	SCW
Shelley Jenkin	Clinical Effectiveness Manager	SCW
Katie Newens	Clinical Effectiveness Researcher	SCW
Rachel Finch	Clinical Effectiveness Administrator	SCW

Topic Specialists in Attendance for Agenda Items:

Item 7 – Policy Review: Surrogacy and assisted conception
Lee Lim Fertility Service Lead Consultant at the Oxford University Hospitals
Item 8 – Evidence Review and Policy Update: Anti-VEGFs for a range of rare eye conditions Item 9 – Policy Update: Verteporfin and photodynamic therapy in chronic central serous chorioretinopathy and idiopathic polypoidal choroidal vasculopathy
Sarah-Lucie Watson Consultant Ophthalmic Surgeon

Apologies:

Andrew Brooks	Clinical Chief Officer	East Berkshire CCG
Jane Butterworth	Assistant Director Medicines Optimisation	Buckinghamshire CCG
Dr Janet Lippett	Medical Director	Royal Berkshire Hospital Foundation Trust
Fiona Slevin-Brown	Director of Strategy & Operations	East Berkshire CCG

Apologies Continued:

Mark Hancock	Medical Director	Oxford Health NHS Trust
Meghana Pandit	Medical Director	Oxford University Hospital
Tessa Lindfield	Strategic Director of Public Health	Berkshire
Dr Tina Kenny	Medical Director	Buckinghamshire
Kathryn Markey	Clinical Effectiveness Manager	SCW

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	Linda Collins declared an interest in item 8, Anti-VEGFs for a range of rare eye conditions. Confirmed not material for the Committee decision-making.
4.	**Draft Minutes of the Priorities Committee meeting held 24th July 2019 - 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 January 2019 – Action 13.1 – Any Other Business – Case Review Committee/equity audits** A question was put to the Committee regarding what equity audits have been carried out about the impacts of our policy recommendations, and whether socio economic status and ethnicity are audited. **March 2019 Update: ACTION:** CCGs to discuss and work with the Head of IFR as to the best method of extracting a report(s) by GP practice over at least two financial years for socio economic status and ethnicity analysis. Review report to be discussed at the Committee Workshop topic scoring event to be held in November 2019. **Action with CCGs and IFR team.** **May 2019 Update: Clinical Effectiveness team to follow up with the IFR team** **September 2019 Update: September 2019 Update:** The IFR team do not have the visibility of a patient's socio economic status or ethnicity within an IFR application; they therefore are not in a position to carry out an audit. The CCGs also do not hold this information. The Committee accepted this and agreed that the action could be closed. **ACTION CLOSED**
5.2	**Minutes of the Priorities Committee held in May 2019 – Action 12.2.1 – Any Other Business** The Chair asked for 'statutory requirements' to be added to section 1 of the Terms of Reference. The Committee agreed and confirmed all the other amendments were accepted. **ACTION: The Clinical Effectiveness team to add 'statutory requirements' to Terms of Reference section 1 and update the ToR. ACTION Complete**
5.3	**Minutes of the Priorities Committee held in May 2019 – Action 2.1 – Matters Arising** The Clinical Effectiveness team to discuss with public health lead the status of their membership of the Thames Valley Priorities Committee going forward. Public health lead e-mailed CE team with the impression that she is now going to be removed from the Terms of Reference (ToR) as core quoracy requirement after the discussion in July meeting. The Committee needs to consider whether we want to change the ToR to remove PH from quoracy and accept that they attend only for specific topics directly related to PH. However, potential review of the function of the Committee, the ToR and the role of the PH team may be pertinent in the near future as the local CCG merger progresses. The timeline of that, however, is uncertain and the Committee is rendered not quorate until we address the PH representation. The Committee felt strongly that PH representation is highly valued for their skills and understanding the population health needs overall. It was agreed that whilst it would be preferable to have PH as part of the core

5.3 Cont.	membership of the Committee, we will remove them from the quoracy requirement for now. **ACTION: Clinical Effectiveness team to update the Thames Valley Priorities Committee Terms of Reference (ToR) removing Public Health representation as a requirement for quoracy. The updated ToR to be issued to CCGs for Governing Body acceptance together with an explanatory note expressing the important and valued input of PH and that Committee reluctantly agreed to remove them from the function.**
5.4	**Minutes of the Priorities Committee held in July 2019 – Action 6.8 – Paper 19-012 – Evidence Review: Chalazia Surgery** The Clinical Effectiveness team to draft a policy for chalazia and circulate for comment. Comments to be received within the 2 week period following issue. **ACTION Complete**
5.5	**Minutes of the Priorities Committee held in July 2019 – Action 7.7 – Paper 19-013 – Policy Update: TVPC22 Tonsillectomy for surgical management of recurrent tonsillitis and obstructive sleep apnoea in children and adults** The Committee agreed to retain TVPC22, the current policy statement, due to the relatively low numbers of tonsillectomy being performed for adult sleep apnoea. However subsequent to the meeting the Clinical Effectiveness team was made aware that the NHS Standard Contract requires both the Commissioner and the Provider to comply with their respective obligations under the EBI policy. **Refer to item 6 below.**
5.6	**Minutes of the Priorities Committee held in July 2019 – Action 8.5 – Paper 19-014 – Policy Update: TVPC23 Trigger Finger** The Clinical effectiveness team to draft an update to TVPC23 Trigger Finger to align with the NHS England EBI policy and circulate for comment. Comments to be received within the 2 week feedback period following issue. **ACTION Complete**
5.7	**Minutes of the Priorities Committee held in July 2019 – Action 9.5 – Paper 19-015 – Evidence Review: Laparoscopic Ventral Mesh Rectopexy for Internal Rectal Prolapse and Obstructive Defaecation** The Committee agreed there was no need for a Thames Valley wide policy and recommended Oxfordshire CCG to withdraw Policy Statement 228: Laparoscopic ventral rectopexy for internal prolapse. **ACTION Complete** The Clinical Effectiveness team to undertake a scoping exercise for biological mesh for scoring at the 2020-21 Thames Valley Programme Workshop to be held later in the year. **September 2019 Update:** On the October 31st workshop programme. **ACTION Complete**
5.8	**Minutes of the Priorities Committee held in July 2019 – Action 10.4 – Paper 19-016 – Evidence Review: Restless Leg Syndrome** The Clinical Effectiveness team to draft a policy for restless leg syndrome and circulate for comment. Comments to be received within the 2 week feedback period following issue. **ACTION Complete**
5.9	**Minutes of the Priorities Committee held in July 2019 – Action 11.1 – Integrated Care System (ICS) and ratification of recommendations across the system** Jane Butterworth, Buckinghamshire and Linda Collins, Oxfordshire CCGs to draft a ratification recommendation discussion paper as to how agreement of the Thames Valley Committee policy recommendations will occur following the merger of the Buckinghamshire, Oxfordshire and Berkshire West CCGs. **September 2019 Update:** The discussion paper written by Bucks and OCCG is currently with the CCG Directors for comment. The outcome should not affect East Berkshire as they can continue to be part of the Committee and receive the policy recommendations as before. Chair suggested that the action is noted as complete with request for Linda to feedback to the Committee when any further progress is made. **ACTION Complete**

5.10	**Minutes of the Priorities Committee held in May 2019 – Action 13.1 – Any Other Business – Annual training session** Committee members to indicate to the Clinical Effectiveness team if a training session is needed this year and if so identify the training required. **September 2019 Update:** No suggestions have been received yet, however, if the Committee members have any further thoughts please forward to the CE team. **ACTION: Topic suggestions to be forwarded to CE team. If sufficient topics are submitted CE to plan a training session for 2020.**
5.11	**Minutes of the Priorities Committee held in May 2019 – Action 13.2 – Any Other Business – 2020-21 Work programme** Clinical Effectiveness team to identify a date and venue for the November topic scoping workshop. **September 2019 Update:** Responses received to date indicate the most suitable date is Thursday 31st October, 2.30pm at Jubilee House, Oxford. **ACTION: The Clinical Effectiveness team to issue 2020/21 work programme meeting invitation and topic submission paperwork**. **Post meeting note: Action complete**
5.12	**Minutes of the Priorities Committee held in May 2019 – Action 13.3 – Any Other Business – Host CCG for 2020 meetings** East Berkshire to provide details of prospective venues at or before the September 2019 meeting**. September 2019 Update**: No suitable venues have been identified as yet in East Berkshire. In Buckinghamshire rooms used by the CCG at Aylesbury Vale Council offices are no longer available as the Council is relocating. **ACTION**: Clinical Effectiveness team to make enquiries with Wexham Park Hospital (Frimley Health Foundation Trust) and St. Marks Hospital, Maidenhead
6.	**Policy Update TVPC22: Tonsillectomy for surgical management of recurrent tonsillitis and obstructive sleep apnoea in children and adults**
6.1	At the meeting in July 2019 the Committee agreed to retain the current policy criteria of 5 episodes in the preceding year rather than 7 as recommended by the NHS England Evidence Based Interventions (EBI) policy, before consideration of tonsillectomy. Subsequent to the July meeting NHS England advises that local policies cannot be more lenient than the recommended baseline under the NHS Standard Contract which requires both the Commissioner and the Provider to comply with their respective obligations under the EBI policy. Policies may have more stringent criteria but may not be more lenient than EBI policies. By changing the number of episodes to 7 in the preceding year and retaining CENTOR referral criteria the TVPC policy will be more stringent. **ACTION: The Clinical Effectiveness team draft an update to TVPC22 Tonsillectomy for surgical management of recurrent tonsillitis and obstructive sleep apnoea in children and adults to align with the EBI and retain the CENTOR criteria and circulate for comment. Comments to be received within the 2 week feedback period following issue.**
7.	**Paper 19-019 – Policy Review: Surrogacy and assisted conception**
7.1	The Thames Valley CCGs have requested a review on the current 'Assisted reproduction services policy for infertile couples' which has been in place since 2013 (last minor update 2017). The aim of the review is to address the current lack of policy for surrogacy, address points in the policy needing clarification and consider possible consolidation of the three related policies to do with fertility;TVPC11g 2013 (OCCG 11h) - Assisted reproduction services for infertile couples. TVPC2 2018 (OCCG 18f) - Treatments for gender dysphoria (references the TVPC17) TVPC17 2018 (OCCG 253a) - Policy for the preservation of fertility. This policy notes that 'Surrogacy is not funded by the Clinical Commissioning Groups'. The premise of the current TVPC11g is based on NICE CG156 (2013) position, supporting assisted conception services for heterosexual or same sex female couples in a relationship. NICE explicitly excluded single people from their guidance at the time. Surrogacy and same sex male relationships were also outside of the NICE guidance at the time.

7.1 Cont.	The Human Fertilisation and Embryology Authority trend and figures (2019) indicates that 91% of fertility treatments are for heterosexual couples with 6% for same sex partnerships, 3% for those with no partner and 0.4% for surrogacy. Overall the highest success rate for fertility treatment continues to be for women aged 35 years and under. The Committee were asked to consider the following: • Definition of infertility; is a person or a couple infertile? • Definition of couple; do they have to be cohabiting? There has been a recent case where the proposed parents lived in different counties. • Clarity on defining infertility for couples who do not have vaginal intercourse. What accounts as evidence of failure to conceive? • Single people and people in non-traditional relationships; possible equalities issue, single people are not protected in the legislation but sexual orientation is a protected characteristic, where does this leave people in a relationship of three or more people? • Possible need to include advice on nicotine replacement therapy (NRT) and e-cigarettes. • Revisit the wording on number of cycles funded, currently open for interpretation. The commissioning position for the number of cycles funded and the patient age range are not part of this review.
7.2	The specialist in attendance noted that they do get enquiries about surrogacy but at the moment it is understood that it is not normally funded. Committee need to think about the patient groups for whom surrogacy may be relevant for, i.e is this treated as a life style option or from the perspective of disease groups involved. There is quite a well-defined disease groups that impact on fertility potentially requiring surrogacy; girls who are born without uterus and/or vagina but have functioning ovaries and eggs, incidence is about 1:4500. The second group is treatment related patient group, those who develop cervical cancer or who have had the uterus removed prematurely. Other groups are less well defined, such as recurrent pregnancy loss, recurrent miscarriage (3% of reproductive population), and recurrent IVF implant failure.
7.3	The Committee noted the clinical definition of infertility is 'a disease of the reproductive system defined by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse'. The Committee also noted current premise of the local policy i.e policy is for couples, and that some of the issues raised were for single people and some for those in unconventional relationships. It was also highlighted that there has been a change in the law earlier this year where single people are now eligible for assisted reproduction services under the Human Embryo Fertilisation Act (HEFA). This however, does not impose any obligations on Commissioners. It was suggested that the discussion starts with the proposition that surrogacy services are not commissioned by CCGs. Surrogacy may be necessary in order to complete an assisted reproduction service for an otherwise infertile couple but extending the current policy to surrogacy may be beyond the CCG responsibility. Surrogacy agreements are not legally enforceable and the intended parent needs to apply for a parental order after their child is born. The legal framework allows for a surrogate to receive reasonable pregnancy-related expenses as assessed by the family court. Surrogacy through commercial means is illegal in the UK. As surrogacy arrangement involves significant legal input and services as well as related costs the Committee agreed surrogacy will not be normally funded by the CCGs. The issue of potential inclusion of single people in the policy was discussed extensively. The Committee heard that from the equalities act perspective relationship status is not protected, thus not funding single people is not an issue under the equality act. The main concern is not to directly or indirectly discriminate against sexual orientation or sex without clear justification. Direct discrimination would mean having a different treatment pathway for a same sex couple and heterosexual couple unless you can show there are clearly relevant differences in their material circumstances. Indirect discrimination is where there is a policy that applies generally

7.3 Cont.	to everyone but disadvantages one of the equalities groups because of their sexual orientation or their sex; if you treat male/male and female/female couples differently. Indirect discrimination could be justified likely on grounds clinical effectiveness and cost. If surrogacy is not funded we are essentially disadvantaging male homosexual couples more than others but not only disadvantaging them but also heterosexual couples. Because it applies to everybody, the fact that it would disadvantage homosexual couples more than others is something the Committee could still justify, being indirect discrimination. The Committee noted that there are occasions when CCGs would agree to harvest eggs or generate embryos as per the 'disease groups discussed'; the current policy for the preservation of fertility includes funding gamete and embryo storage for 'non treatment related genetic conditions'. Women with no reproductive organs but eggs could be considered under this policy. This policy already states that surrogacy is not normally funded. Of note is that the Committee agreed that a surrogate who has concerns about their fertility after expected time of trying to conceive naturally would qualify for services as per normal criteria. The Committee discussed the current policy point re; women with same sex partnerships and couples unable to undertake vaginal intercourse needing to establish their fertility status, the current policy does not define this. It was agreed to adopt the NICE equation that 12 cycles of artificial insemination, 6 of which should be intrauterine insemination (IUI), as equivalent to heterosexual couples referral treshold for specialist services. The Committee discussed the definition of a couple and agreed that clarification should be added to the policy (as per NICE CG) to note that a 'couple' in a relationship should be trying to conceive over 2 years of regular unprotected intercourse or 12 cycles of artificial insemination. Vaginal sexual intercourse every 2 to 3 days optimises the chance of pregnancy. People who are using artificial insemination to conceive should have their insemination timed around ovulation. Lastly, in regards to Electronic Nicotine Delivery Systems (vaping), the Committee agreed not to make any changes to the smoking criteria of the policy. It was acknowledged that the requirement to be a non-smoker at the time of referral to specialised service is a self-declared statement with no testing currently involved. Also the Committee heard that there is not enough evidence that vaping it is detrimental to fertility, whist noting the World Health Organisation caution against vaping for pregnant women and women of reproductive age. It was agreed that the recommendations agreed do not have notable financial impact for the CCGs. The cryopreservation of gametes or embryos for women who have impaired fertility related to treatment or genetic conditions are currently already funded under the cryopreservation policy.
7.4	**ACTION: Clinical Effectiveness team to draft an update to the Assisted reproduction services for infertile couples policy statement and return to the Committee for review at the 27th November meeting addressing the following points agreed:** • Surrogacy is not normally funded. • Women with same sex partnerships and couples unable to undertake vaginal intercourse needing to establish their fertility status; the policy to reflect the NICE definition of 12 cycles for AI 6 of which should be IUI. • Definition of a couple clarifications to note that a 'couple' in a relationship should be trying to conceive over 2 years of regular unprotected intercourse or 12 cycles of artificial insemination. Vaginal sexual intercourse every 2 to 3 days optimises the chance of pregnancy. People who are using artificial insemination to conceive should have their insemination timed around ovulation.

8.	**Paper 19-020 – Evidence Review and Policy Update: Anti-VEGFs for a range of rare eye conditions**
8.1	The Thames Valley Priorities Committee has requested a policy update of anti-vascular endothelial growth factor (anti-VEGF) drugs for eye conditions other than wet age-related macular degeneration (AMD), reflecting both the latest NICE guidance and any other high-quality evidence currently available. The current policy (low priority) is dated 2009 and as such is titled 'South Central Priorities Committees (Berkshire PCTs)' Policy Statement 160: Anti-VEGFs for sight-threatening eye conditions other than 'wet' age related macular degeneration. There is also a Buckinghamshire policy (52b) which has the same content; Oxfordshire CCG does not currently have a policy.
8.2	Although there is a only a small amount of high-level evidence (RCTs, systematic reviews and meta-analyses) focusing on these rare eye conditions, it does appear to indicate that anti-VEGF agents are efficacious in rare eye conditions, by improving vision or stabilising it to reduce visual loss. There is also a lot of lower level evidence (observational studies, case series etc.) that indicates that anti-VEGF agents are likely to be efficacious in rare eye conditions, by improving vision or stabilising it to reduce visual loss. Some eye conditions are so rare no evidence was found. Evidence shows that rates of local and systemic adverse events with intravitreal injections of anti-VEGFs appear to be very low. These drugs appear to have a very acceptable safety profile in ophthalmic disease; however it was not possible to find specific safety data for most of the conditions of interest to this review. Current evidence suggests that there is no significant difference in the effectiveness of the cheaper (off-label) anti-VEGF bevacizumab (Avastin) compared to the significantly more expensive licensed treatments of ranibizumab (Lucentis) and aflibercept (Eylea), however evidence was not found for all of the conditions of interest listed at the beginning of this review.
8.4	The specialist in attendance noted that some of the eye conditions under consideration such as Stargardt's disease and Toxoplasma and Von Hippel-Lindau are extremely rare conditions, seldom needing drug treatment. Most of the conditions involve a crack or an abnormality in the retina, blood vessels grow and leak, they bleed and need a quick hit with an injection. They do not need on-going treatments like the AMD, vein occlusion and diabetic patients, they need short sharp treatment courses and the outcome depends very much on the underlying condition. Neovascular glaucoma is a condition where patients have a sudden onset of pressure due to blood vessels growing on the front of the eye causing a painful eye with extremely high pressure the only treatment for that is an Avastin injection, without an IFR as it is an urgent arrangement. Avastin is generally the treatment of choice. There are no head to head trails of Eylea vs Lucentis vs Avastin, the trials have been done for AMD, vein occlusion and diabetes. None of the agents are licenced for the rare eye conditions. However, we do see that these work extremely effectively and whilst the safety data is not really there, it is an extrapolation from the AMD data.
8.5	Activity and cost data presented showed therapeutic indication and drug, with costs by CCG. The vast majority of indications are for AMD and macular oedema; the numbers are very small for the rare diseases being considered. Following discussion the Committee agreed that a change is in commissioning position is appropriate to support the use of anti-VEGF for these rare conditions. Policy statement to this effect would be helpful as they form a cohort of patients currently going through IFR. The following criteria was agreed: • clinicians to consider using Avastin as the preferred drug particularly with time critical patients • submit an IFR if an alternative drug is to be used

8.5 Cont.	**ACTION: Clinical Effectiveness team to draft a policy recommendation: Rare eye conditions other than age-related macular degeneration (AMD) supporting the treatment of rare eye conditions with anti-VEGF and circulate for comment. Comments to be received within the 2 week feedback period following issue.**
9.	**Paper 19-021 – Policy Update: Verteporfin and photodynamic therapy in chronic central serous chorioretinopathy (CSC) and idiopathic polypoidal choroidal vasculopathy (IPCV)**
9.1	This policy was originally recommended for adoption in 2016 and focuses on two treatments specifically verteporfin and photodynamic therapy (PDT). The Committee agreed that treatment with verteporfin and PDT can be initiated for treatment of CSR where: • there are persistent symptoms and evidence of fluid leakage 6 months after the patients first appointment (unless vision is imminently at risk). • CSR is confirmed by fluorescein angiography (FA) or indocyanine green angiography (ICGA) where necessary • the patient's vision is 6/9 or worse • a maximum of three treatments is provided • treatment should be stopped where response is less than an improvement in vision of 5 or more letters. The Committee agreed that anti-VEGF treatment would be appropriate where the fluid is located at the very centre of the fovea as it would not be appropriate to use PDT treatment due to the potential for damage to eyesight as a result of scarring. Central Serous Chorioretinopathy (CSC) can be self-limiting, typically resolving spontaneously within three to four months. However, approximately 30-50% of patients go on to have the chronic form with long-standing fluid accumulation which can result in a permanent loss of visual function which is addressed in the policy. Treatment is either photodynamic therapy (PDT) or intravitreal injections of anti-vascular endothelial growth factor (anti-VEGF) agents. The policy recommended in 2016 was largely based on clinical consensus policy due to the lack of research. Excluding the acute form, a patient must have had the condition for 6 months, diagnostically confirmed, the patient's vision is 6/9 or worse (based at the time on still working age population consideration for driving), a maximum of 3 treatments is provided. Idiopathic Polypoidal Choroidal Vasculopathy (IPCV) (sub categorisation of wet AMD), the 2016 policy has no statement regarding the use of anti-VEGF treatments for this condition. The local specialist in attendance at the TVPC meeting in 2016 described the condition as aggressive and not self-resolving ; mostly in elderly patients. The policy states that treatment with verteporfin and PDT can be initiated in patients who have been diagnostically confirmed, the patient's vision is 9/12 or worse; a maximum of three treatments is provided.
9.2	Local data indicates that the number of people receiving PDT treatment is declining particularly over the last few years. The specialist in attendance advised that these are two very different conditions. CSC affects typically younger middle aged men and has no known cause. It is a very difficult condition to treat so many treatments may be trialled. IPCV is a disease with 2 different forms. IPCV can result in a very aggressive form of wet macular degeneration that affects between 9-22% of the Caucasian population. Laser treatment is no longer used as previously when the only treatment available for any condition was laser. The number of patients needing laser is low; patients requiring on-going injections are between 10-20% of those with AMD.
9.3	New NICE guidance has been published for age-related macular degeneration; however this doesn't contain any new recommendations for either chronic CSC or IPCV. NICE guidance recommends 'do not do' for the use PDT as a monotherapy. There was limited evidence available for CSC, a Cochrane review and two RCTs. The numbers were very small for CSC's with very limited conclusions.

9.4	Due to the complexity of this topic, limited new evidence, evolvement of disease management and low activity, the Committee recommends the withdrawal of this policy. **ACTION: Clinical Effectiveness team to draft governing body paper to recommend withdrawal of policy TVPC42 Verteporfin and photodynamic therapy in chronic central serous chorioretinopathy (CSC) and idiopathic polypoidal choroidal vasculopathy (IPCV)**
10.	**Paper 19-022 – Policy Update: Elfornithine and facial hirsutism**
10.1	Due to time constraints this paper will be discussed at November Committee meeting.
11.	**Any Other Business**
11.1	**Management of Ear Wax**
11.2	This Committee has recommended an earwax policy based on NICE with self-treat criteria and instructions on how to do it, acknowledged there was a limited group of people who should be seen in secondary care with referral thresholds. There is also a group of people in the policy who 'may have access to' management of earwax by a professional but not within secondary care. The issue in Buckinghamshire and Oxfordshire is the lack of community services, thus the CCGs cannot ratify the policy. The committee agreed that the 'may' in the policy implies that the service is expected, but if we attempt to add clarification that 'the services may not be available in all CCG areas' we would just endorse the local variation in service provision even further. Further conversation suggested that perhaps we should look at this category of patients again in view of treatment tresholds, numbers of patients and services required. **ACTION: Clinical Effectiveness team to undertake further review for the management of earwax for the specific group of patients that may need community services and return a paper to the Thames Valley Priorities Committee for discussion.** **Post meeting note: This is now scheduled for January 2020 Committee.**
11.2.	**Use of EBI decision aids**
12.1	The next set of Evidence Based Interventions are due to be issued at the beginning of November, we should have sight of them for the next meeting and can discuss the patient leaflets and videos to go with them at the same time.
13.	**Next meeting**
	The next meeting will be **Wednesday 27th November 2019, to be held in Meeting Room GU29/30 Bath Road, Reading RG30 2BA**
14.	**Meeting Close**
	The Chair thanked everyone for their contributions to the discussions and closed the meeting.