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

Thames Valley Priorities Committee (Interim)

Minutes of the meeting held Tuesday 19th May 2020

On-line via Microsoft Teams

Alan Penn	Lay Member Chair	Thames Valley Priorities Committee
Linda Collins	Clinical Effectiveness Manager (CCG)	Oxfordshire CCG
Edward Haxton	Deputy Finance Director	Berkshire West CCG
Dr Megan John	GP, East Berkshire CCG Lead	East Berkshire CCG
Catriona Khetyar	Head of Medicines Optimisation	East Berkshire CCG
Professor Chris Newdick	Specialist Advisor - Law	University of Reading
Dr Jacky Payne	GP	Berkshire West CCG
David Pollock	Interface Lead Pharmacist	Berkshire West CCG
Dr Raju Reddy	Secondary Care Consultant	Berkshire West CCG
Dr Mark Sheehan	Specialist Advisor - Ethics	University of Oxford
Dr Karen West	Clinical Director Integration	Buckinghamshire CCG

In Attendance:

Kathryn Markey	Clinical Effectiveness Manager	SCW
Rachel Finch	Clinical Effectiveness Administrator	SCW

Apologies:

Jane Butterworth	Assistant Director Medicines Optimisation	Buckinghamshire CCG
Shairoz Claridge	Operations Director	Berkshire West CCG

1.	**Welcome & Introductions**
1.1	The Chair opened the meeting, welcomed the Committee members and set out how the on-line meeting is to operate.
2.	**Apologies for Absence**
2.1	Apologies recorded as above.
3.0	**Declarations of Interest**
3.1	None declared.
4.	**Meeting objectives and processes**
4.1	The Clinical Effectiveness team went through the objectives of the interim meetings, to be held once a month until regular face-to-face Committee meetings can resume. The objectives of these meetings will be: • Review old policies and any topics from the original TVPC work schedule that do not, at this stage, require clinical consultation. • Where possible agree an update to current policy, an interim policy or further review, as necessary, when normal TVPC meetings resume. • Record meeting via Microsoft Teams, produce minutes and circulate to TVPC members

4.1 Cont..	• Follow the normal 2 week consultation process with regards to policy development. • Send final recommendations to CCG governing bodies as appropriate. • Until further notice, hold monthly virtual meetings with key CCG representatives. • Include representatives to ensure quoracy as per TVPC ToR. If meeting is not quorate, follow normal TVPC protocol.
5.	**Paper 20-001 - Review: Regional Medicines Optimisation Committee (RMOC) Advisory Statement Sequential Use of Biologic Medicines**
5.1	In January 2020, RMOC published an advisory statement: Sequential Use of Biologic Medicines. The Thames Valley Priorities Committee (TVPC) requested a review of the RMOC statement to understand if current TVPC policies need to be updated.
5.2	<u>Summary of RMOC statement</u> • A policy adopted by a commissioner that would serve to limit patients' access to appropriate treatments based on a number of prior treatments being attempted would be counter to the provisions of the NHS Constitution. • The NHS Constitution pledges that patients have the right to drugs and treatments that have been recommended by NICE, subject to being clinically appropriate, and patients have the right to expect local decisions on the funding of drugs and treatments to be made rationally and following the proper consideration of evidence. • Clinical assessment of the appropriateness of treatments should be the overriding factor rather than the implementation of policies for costs saving reasons. With regard to the status of RMOC advice, there is an expectation that both commissioners and providers of NHS healthcare will have regard to and implement RMOC advice as RMOCs are an integral part of the NHS England and NHS Improvement regional infrastructure The NHS constitution advises patients that they have the right to drugs and treatments that have been recommended by NICE for use in the NHS, if their doctor says they are clinically appropriate. It also states that the NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources. Public funds for healthcare will be devoted solely to the benefit of the people that the NHS serves.
5.3	Currently there are seven TVPC commissioning policies that make statements on sequential use of biologic or high cost immunomodulatory drugs. The policies relate to psoriasis, psoriatic arthritis, Crohn's disease, ulcerative colitis, rheumatoid arthritis, axial spondyloarthritis and ophthalmology. The ophthalmology policy is unlikely to be affected by the RMOC statement as there are currently only two licenced treatments, where the first biologic fails or is stopped due to adverse drug reaction, a second biologic treatment will be funded in patients with wet AMD, RVO and DMO where all NICE criteria are met. Ulcerative colitis has not been considered as part of this review as new NICE guidance is due to be published, date is now to be confirmed. This policy will then be reviewed with local clinicians.
5.4	<u>The Committee had a discussion and raised the following points in the presence of the legal and ethical advisers:</u> • The evidence across all of these disease states generally suggests a diminishing effect with subsequent biologic or immunomodulatory drugs. • The difficulty is the clinical uncertainty with respect to evidence. There may be a case for saying that moving between different categories of biologics makes good clinical logical sense and that if the number of categories in each treatment, whether it is 3 or 4, this would be a good basis for stating that further treatment would no longer be appropriate. This needs to be considered. These treatments can be used to the extent that they cease to be appropriate but their use cannot be limited with respect to appropriate treatment.

5.4 Cont.	• The NICE clinical guideline on psoriasis already advises on limiting the use of biologic drugs. NICE states that: for adults, in whom there is an inadequate response to a second biological drug, seek supra-specialist advice from a clinician with expertise in biological therapy. A discussion was had around the marketing authorisations. A number of the drugs are licensed to say 'following the use of a conventional treatment pathway'; some are licensed for use following a biologic or an anti-TNF. • There is no evidence that suggests for example, that more than 2, 3 or 5 biologic or immunomodulatory drugs cannot be used. A number of Individual Funding Requests (IFRs) suggest that there seems to be an idea that moving within classes benefits patients who have had an adverse drug reaction. • Using a different biologics from a different class may offer the patient benefit. • The current policies can be already considered to offer a reasonable amount of flexibility and there is no blanket ban on the further use of biologics outside of the current policies as the IFR route is available. • If a biologic or immunomodulatory drug is recommended by a NICE TAG then there is not an option to decline treatment unless, there is evidence to suggest further treatment beyond the categories that have been used will not be clinically appropriate. This is endorsed by the RMOC statement. • It is advised to involve clinicians and possibly keep NICE well informed as well seeking their advice as necessary. • There is lack of good quality evidence addressing the sequential use of biologic and immunomodulatory drugs. Published evidence does not appear to be able to draw sound and definite conclusions about the use of a fourth biologic or immunomodulatory drugs in patients who have already tried 3 of these drugs. There appears to be no national or international guidance that advises on sequential use of a 3rd or 4th biologic or immunomodulatory drugs. The American guidance for rheumatology states that if disease activity is moderate or high despite the use of multiple (2+) TNFi therapies (in sequence, not concurrently), non-TNF biologic therapy is conditionally recommended and then conditionally treating with tofacitinib when a non-TNF biologic is not an option. • It is important to recognise that some patients will not tolerate specific biologic drugs and it therefore may be clinically appropriate to move to another biologic in the same class. • An immediate adverse drug reaction (ADR) could be a reason for moving within a class of biologic drugs. • In terms of efficacy, the Committee heard that funding a 5th biologic or immunomodulatory drug via the IFR process would not be against the NHS constitution providing the logic of the policy is explained. • The Committee discussed the need to develop a justification statement. It was agreed that this should be postponed until the Committee is clearer as to the proposed status of the current policies. • A financial estimate is required to assess the potential impact of funding 4 biologic or immunomodulatory drugs across all of the associated policies.
5.5	**ACTION: Clinical Effectiveness team to draft a potential statement to be added onto each policy advising that a 4th biologic or immunomodulatory drug will be funded if it possesses a mode of action previously not tried or if a patient has suffered an adverse drug reaction that necessitates discontinuation. This will be discussed further along with the financial impact and the development of a justification statement. Circulate for comment. Comments to be received within the 2 week period following issue.**

6.	**Paper 20-003 – Standard Operating Procedure**
6.1	The Clinical Effectiveness team has updated the Standard Operating Procedure following discussion and recommendations agreed by the Committee at previous meetings: • Paragraph 2.3: added 'and the wider integrated care system.' • Paragraph 8.2: added 'as necessary' • Evidence Review Methodology point 9: added 'systems' • Review: amendment to 'will be reviewed annually' • Scoping Pro forma: amendment to the scoring system for the number of CCGs requesting this topic to be: 1xCCG scores 2; 2xCCGs score 4; 3xCCGs score 6 and all CCGs 8. The Committee agreed to all the recommended changes. **ACTION: The Clinical Effectiveness team to update the Standard Operating Procedure and submit to the CCG Governing Bodies for their acceptance.**
7.	**Paper 20-004 - Ethical Framework**
7.1	The Clinical Effectiveness team has updated the Ethical Framework to align with discussion and agreement by the Committee at previous meetings: • Background, third paragraph: ten CCGs amended to 'four' • Page 2, footnotes: links updated to be more descriptive The Committee agreed to all the recommended changes. **ACTION: The Clinical Effectiveness team to update the Ethical Framework and submit to the CCG Governing Bodies for their acceptance.**
8.	**Any Other Business**
8.1	**Fertility treatment**
	A question was raised regarding whether any further action is required as a result of the latest government advice on the opening of fertility clinics. It was agreed that no further action was required in addition to the initial amendment of policies at the start of the COVID-19 pandemic.
8.2	**System recovery post COVID-19**
	Oxfordshire CCG on behalf of Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care System approached the chair, committee members and the Clinical Effectiveness team to enquire if TVPC may be able to assist providers and CCGs in developing strategies to prioritise patients and elective care as the system starts to recover post COVID-19. In the first instance, it was agreed that a sub group could be set up to scope this project. **ACTION: The Clinical Effectiveness team to organise a meeting with the Committee working group to consider system recovery post COVID-19.**
9.	**Next meeting**
	The next online meeting will be held on **Wednesday 24th June 2020 from 12-1pm.** Post meeting note, this may be extended until 1.15 if agreeable on acceptance of invitations. The following meeting will be **Wednesday 22nd July 2020 from 2-3pm**
10.	**Meeting close**
	The Chair thanked everyone for their contributions to the discussions and closed the meeting.