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 28th November 2018

Cedar Conference Room, Building 55, Whiteknights Campus, University of Reading RG6 6UR

Alan Penn	Lay Member Chair	Thames Valley Priorities Committee
Andrew McLaren	Deputy Medical Director	Buckinghamshire NHS Trust
Chris Newdick	Professor of Health Law	University of Reading
Dr Jacky Payne	GP	Berkshire West 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
Jane Butterworth	Associate Director Medicines Optimisation	Buckinghamshire CCG
Linda Collins	Clinical Effectiveness Manager (CCG)	Oxfordshire CCG
Dr Raju Reddy	Secondary Care Consultant	Berkshire West CCG
Sarah Robson	Head of IFR	SCW
Dr Mark Sheehan	Special Advisor – Ethics	University of Oxford
Marion Mason	Assistant IFR Manager	SCW
Catriona Khetyer	Head of Medicines Optimisation	East Berkshire CCG
Amaka Scott	Commissioning Interfacing Pharmacist	Berkshire West CCG
Lindsey Barker (LB)	Medical Director	Royal Berkshire NHS Foundation Trust
Robert Majilton	Deputy Chief Officer	Buckinghamshire CCG

In Attendance:

Tiina Korhonen	Clinical Effectiveness Lead	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 7 – Evidence Review: Unicompartmental knee replacement Item 8 – Evidence Review: Arthroscopic surgery for Anterior Cruciate Ligament (ACL) Rupture Item 9 – Policy Update: Corticosteroid Injections for Patella Tendinopathy & Evidence Review: Steroid Injections to Joints Item 10 – Policy Clarification: Routine follow-up after primary hip & knee joint replacement surgery Item 11 – Policy Clarification: Hip & knee revision threshold		
Mr Tom Pollard	Clinical Director for Orthopaedics	Royal Berkshire Hospital, Reading
Professor Andrew Price	Knee Surgeon	Nuffield Orthopaedic Centre, Oxford
Mr Nick Bottomley	Consultant Knee Surgeon	Nuffield Orthopaedic Centre, Oxford

Apologies:

Clare Dollery	Acting Medical Director	Oxford University Hospital NHS Foundation Trust
Francis Fairman	Assistant Director – Clinical Strategy	NHS England (TV area)
Jo Jefferies	Consultant in Public Health	Bracknell Forest
Dr Mark Hancock	Medical Director	Oxford Health NHS Foundation Trust
Tessa Lindfield	Strategic Director for Public Health	Berkshire
Tracey Marriott	Director of Innovation Adoption	Oxford Academic Health Science Network
Rosalind Pearce	HealthWatch	Oxfordshire
Dr Karen West	Clinical Director Innovation	Buckinghamshire CCG

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.
2.2	The meeting of 26th September 2018 was not quorate. **Post meeting note:** Tessa Lindfield, Strategic Director of Public Health Berkshire; Dr Megan John, East Berkshire and Robert Majilton Deputy Chief Officer, Buckinghamshire agreed the minutes and recommendations.
3.0	**Declarations of Interest**
3.1	None were declared.
4.	**Draft Minutes of the Priorities Committee meeting held 26th September 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 July 2018 – Action 6.6.2 - Paper 18-006 – Evidence Review: Sequential use and dose escalation of biologics in Crohn's disease** Attending specialist clinicians agreed 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. **September 2018 Update:** Specialist clinician is meeting with colleagues in early October to commence the policy and pathway development process. Committee to be updated at 28th November meeting. **November 2018 Update: ACTION Clinical Effectiveness team to contact specialist clinician for a date when the policy and pathway can be presented to the Committee.**

5.2	**Minutes of the Priorities Committee held in July 2018 – Action 7.6 - Paper 18-007 - Evidence Review: Topical negative pressure for wound therapy (NPWT); vacuum-assisted wound closure dressings** The Clinical Effectiveness (CE) team were asked to review the patient population for diabetic foot ulcers and provide further local data and financial impact for review at the 26th September 2018 meeting. **September 2018 Update:** The Committee acknowledged the lack of accurate local data and evolving evidence base. However, felt a local policy may be helpful in supporting the monitoring of the use of NPWT. Further exploration of the data by the CE team would be helpful. **ACTION: CE team to further review NPWT data, refresh the paper to put forward a recommendation to the Committee at 28th November meeting.** **November 2018 Update:** Due to a full agenda dedicated to orthopaedic topics the Chair agreed to defer this topic until January Committee.
5.3	**Minutes of the Priorities Committee held in July 2018 – Action 9.1 – National evidence based interventions (EBI) programme consultation.** Clinical Effectiveness team to add a point highlighting the need for clear communication to the TVPC CCG EBI joint consultation response document before submitting to NHSE on behalf of the Committee. **ACTION Complete**
5.4	**Minutes of the Priorities Committee held in September 2018 – Action 6.6 – Evidence Review: Iron chelation for myelodysplastic syndromes** The Clinical Effectiveness team to draft a policy recommendation: Iron chelation for myelodysplastic syndrome (MDS) and circulate for comments. Comments to be received within the 2 week feedback period following issue. **ACTION Complete**
5.5	**Minutes of the Priorities Committee held in September 2018 – Action 7.5 – Policy Review: Preservation of fertility** The Clinical Effectiveness team to draft a policy recommendation: Preservation of fertility and circulate for comments. Comments to be received within the 2 week feedback period following issue. **ACTION Complete**
5.6	**Minutes of the Priorities Committee held in September 2018 – Action 8.2 – Evidence Review: Primary care fertility pathway** Specialist Clinicians to provide the Clinical Effectiveness (CE) team a draft recommendation Primary Care Referral Pathway for Subfertility. The Clinical Effectiveness team to circulate for comment. Comments to be received within the 2 week feedback period following issue. **November 2018 Update:** Draft primary referral pathway for subfertility paper has been circulated with no comments received. CE team to issue to Governing Body's with December 2018 policy recommendations. **ACTION Complete**
5.7	**Minutes of the Priorities Committee held in September 2018 – Action 11.1 – Paper 18-016: Standard Operating Procedures (SOP) and Paper 18-017: Terms of Reference (ToR)** The Clinical Effectiveness team to issue SOP and ToR highlighting their suggested minor changes with the draft minutes of this meeting for comment. Comments to be received within the 2 week feedback period following issue. **ACTION Complete**
5.8	**Minutes of the Priorities Committee held in September 2018 – Action 12.1 – Any Other Business – 2019-20 Work Programme Workshop** A TVPC Workshop was held on 5th November 2018 when submitted topics where considered and scored. **ACTION: Clinical Effectiveness team to provide a draft copy of the 2019-2020 work programme with minutes of the 28th November meeting.**
6.0	**Thames Valley Priorities Committee Healthwatch representation**
6.1	The Committee was informed by the Clinical Effectiveness team that the team had received correspondence from the Thames Valley Healthwatch group expressing concern about their representation at TVPC meetings. Healthwatch advised that they will attempt to attend all meetings, however:

6.1 Cont.	1. It is requested that the membership status of Healthwatch on the Committee is changed from voting member to 'in attendance'. 2. It should be acknowledged that the Healthwatch representative will not necessarily be the same person each time. 3. It is recognised that the purpose for attending these meetings is to challenge the Committee that the impact on patients has been taken into account during the review process by asking questions about patient impact, inequality, equality impact, impact on certain groups etc. The role of Healthwatch is to monitor CCGs' implementation of policies particularly regarding significant changes and patient engagement / consultation at a local level. The Committee expressed disappointment at this request and felt that Healthwatch representation is considered to be a core role in the Committee, which would go hand in hand with full commitment in supporting the decision making as a voting member. **ACTION: The Chair and the Clinical Effectiveness team to respond to Healthwatch on behalf of the Committee accepting that the Committee recognises the resource issue and values their membership, however, would like to ask Healthwatch to reconsider the issue of voting rights and the preference for a regular attendee with a deputy, as per Terms of Reference (ToR) of the Committee.** The Committee considered that should Healthwatch no longer commit to regular attendance, alternative lay member representation should be sought. Dr Graham Jackson agreed to approach some existing Buckinghamshire lay representatives to ask them to consider TVPC lay representation. **ACTION: Dr Graham Jackson to approach some existing Buckinghamshire lay representatives to ask them to consider TVPC lay representation.**
7.	**Paper 18-019 – Evidence Review: Unicompartmental knee replacement**
7.1	Thames Valley Clinical Commissioning Groups (TVCCGs) requested a review of unicompartmental knee replacement (UKR) to consider: • The clinical and cost-effectiveness of UKR versus total knee replacement (TKR) • To understand whether conversions from UKR to TKR are performed earlier than revision of TKR. The Thames Valley CCGs do not currently have a policy for UKR. There is, however, policy TVPC49: Patients with osteoarthritis (OA); primary hip and knee replacement, accepted by all CCGs except East Berkshire. TVPC49 does not include UKR. The clinical effectiveness team clarified that when UKRs are converted to a TKR, this is classed as a revision procedure. NHS England specialised commissioning fund the third revision and revision procedures that follow. First and second revisions are the commissioning responsibility of the CCGs. There are no specific NICE or national guidelines for the use or the selection of patients for UKR prosthesis. A NICE clinical guideline for "Joint replacement (primary): hip, knee and shoulder" is currently in development, due for publication in March 2020. Types of knee replacements are one of the specific issues addressed in this guidance.
7.2	Overall, the evidence review found that prosthesis survival for UKR is lower than TKR, but advantages are faster recovery, reduced morbidity, and reduced 90-day mortality. The activity data shows that per 100,000 population, Oxfordshire CCG is an outlier across Thames Valley CCGs, performing significantly more UKRs than other CCGs. However, when TKR and UKR activity is combined, the overall activity is more balanced.

7.2 Cont.	The specialists in attendance raised the following points: • At the Oxford Nuffield Orthopaedic Centre (NOC), for the majority of high volume UKR surgeons, the revision rate is no different between UKR and TKR. • Patient benefits of UKR may include improved speed of recovery, better functional outcomes and fewer complications such as stroke, MI, thrombosis and infection. • Surgeon must be competent to perform a UKR and there are suggested minimum procedure recommendations. For example, for medial partial replacement, 12 cases per year per individual surgeon and 30 per unit as a minimum has been suggested and is supported by the British Association of Knee surgeons. • TKR revisions are usually indicated for loosening, whereas with UKR approximately half may be for disease progression in the other compartments. The threshold for revising a UKR is very different compared to TKR as it is a less complex procedure. The likelihood of a revision of a UKR for pain in the first year is higher compared to TKR. • The specialists in attendance agreed that that including UKR in the current policy TVPC49 would be appropriate, proposing the addition of the minimum numbers of operations per clinician.
7.3	The Committee heard that the GIRFT (2015) national review of adult elective orthopaedic services in England advises that commissioners should consider the introduction of contractual minimum volumes for certain procedure groups. The Committee discussed including UKR in TVPC46, and adding minimum numbers for the procedure per surgeon. The Committee agreed, that there would be challenges in implementing this and therefore, agreed that the policy should include the GIRFT recommendation regarding minimum numbers as opposed to actual set figures of operations per surgeon.
7.4	**ACTION: The Clinical Effectiveness team to update TVPC49: Patients with osteoarthritis (OA); primary hip and knee replacement policy to include unicompartmental knee replacement. The policy is to reflect the GIRFT sentiment that; '**UKR is an option for clinically appropriate patients who meet the criteria above. UKR is a complex procedure and therefore it is recommended that contractual minimum annual volumes for UKR are agreed with providers, in collaboration with the orthopaedic specialist societies, as discussed in the GIRFT (2015) National Review of Adult Elective Orthopaedic Services in England report.' **Comments to be received within the 2 week feedback period following issue.**
8.	**Paper 18-020 – Evidence Review: Arthroscopic surgery for Anterior Cruciate Ligament (ACL) rupture**
8.1	Thames Valley Clinical Commissioning Groups (TVCCGs) requested a review of arthroscopic surgery for ACL rupture. This review aimed to establish the clinical and cost-effectiveness of arthroscopic surgery for ACL rupture compared to conservative treatment and agree thresholds for surgery. Currently Oxfordshire CCG holds a policy for ACL reconstruction.
8.2	ACL injuries are one of the most common types of knee injuries, accounting for around 40% of all sports injuries. The goal of treatment of the injured knee is to return the patient to their desired level of activity without risk of further injury to the joint either by conservative intervention usually via a progressive rehabilitation programme or by surgery which involves reconstruction of the ACL.
8.3	Overall the evidence found for ACL treatment was considered to be of low quality. The Cochrane review 2016 found one study of 121 patients, young adults, and concluded that ACL reconstruction did not offer any benefits over conservative methods. Many patients in the conservative management group opted to have delayed ACL reconstruction. Currently there is an ongoing trial (ACL SNNAP) which aims to compare the clinical and cost effectiveness of two management strategies for non-acute ACL injury: Rehabilitation versus Surgical Reconstruction. Completion date is expected to be 2021.

8.4	In 2017-18 spend on ACL reconstruction was £1.17m across Thames Valley CCGs. There has been a downward trend in expenditure, however 2018-2019 appears to be demonstrating an increase in spend and activity. There may be caveats with this data due to inconsistencies with coding. Buckinghamshire CCG and Oxfordshire CCG are demonstrating a reduction in both activity and spend. This reduction for Oxfordshire may be due to adoption of the local policy.
8.5	The specialists in attendance raised the following points: • For the majority of adults over 25 years it may be more appropriate to rehabilitate the patient and if the patient fails rehabilitation and the knee remains unstable, the patient may have ACL reconstruction. In a younger population under the age of 25 years there is an argument for early ACL reconstruction to avoid damage to the rest of the knee for example damage to the meniscus particularly if a patient is undertaking a lot of sporting activity. • It is reasonable to delay ACL reconstruction in the patient group aged 25 years to 55 years, however, patients over the age of 25 years with significant meniscal damage or loose bone may benefit from ACL reconstruction earlier. The best evidence and clinical consensus suggest waiting 3-4 months to observe the patient after rehabilitation. Clinically 5 months, as stated in the current policy for Oxfordshire CCG, is a long time for a patient to have to wait. A commissioning policy for ACL reconstruction should distinguish between younger and older patients. • The BMI criteria are not particularity relevant in this situation compared to osteoarthritis. Sporty individuals may have a high BMI due to muscle mass. • It would be reasonable within the local guidance to state that paediatric patients should be managed in specialist centres or by specialist surgeons. • It could be recommended that ACL reconstructions are entered onto the National Ligament Registry (NLR) although locally the Committee is informed that there may have been issues in allowing providers to achieve this. • The Oxfordshire CCG policy refers to level 1 and level 2 instability criteria for ACL reconstruction, however, the clinicians advise that this guide is unclear and function and instability affecting quality of life should be at the core at the patient assessment. In the younger group, regardless as to whether the knee is unstable, ACL reconstruction should be considered.
8.6	The Committee considered the points put forward by the Specialist and agreed to progress a policy document based on the Oxfordshire CCG policy with the following amendments: • Remove BMI criteria • Retain smoking criteria • Use functional instability rather than Level 1 & Level 2 knee instability • For age 25-55 years change timescale for rehabilitation to 3 months • ACL reconstruction should be undertaken by specialist surgeons **ACTION: The Clinical Effectiveness team to draft a policy recommendation: Anterior Cruciate Ligament (ACL) Reconstruction and circulate for comment. Comments to be received within the 2 week feedback period following issue.**
9.	**Paper 18-021 – Policy Update: Corticosteroid Injections for Patella Tendinopathy & Evidence Review: Steroid Injections to Joints**
9.1	The Thames Valley Clinical Commissioning Groups (TVCCGs) requested a policy update of ‘Corticosteroid injections for patellar tendinopathy’ and in addition an evidence review of ‘steroid injections to joints’ to inform a potential new policy.

9.2	There are multiple indications for the use of steroid injections in musculoskeletal joint disorders. In order to limit the scope, and due to existing hand policies, only steroid injections to large joints (shoulder, hip, elbow and knee) were reviewed. The majority of guidance for shoulder, elbow, hip and knee pathologies indicate that repeated steroid injections are not recommended, and that long term effectiveness is limited.
9.3	The specialists in attendance raised the following points: • There is a need to separate soft tissue conditions from articular conditions. • That steroid injection is sometimes used diagnostically. • That steroid injection should not be used repeatedly with the purpose of avoiding joint replacement; however for those patients for whom joint replacement is contraindicated, steroid injections can be helpful. • Injecting the patella with a steroid is not good practice. • In osteoarthritis, specifying a number of injections is difficult. Repeating injections should not occur within 3 months. • There is a need to be cautious with restricting shoulder injections as there are a number of patients who have very limited treatment options.
9.4	Discussion was had regarding the need for a policy to assist GP's in advising patients that repeated steroid injections are not advisable, however, concern was raised about over restriction. There was consensus among practising GP's in attendance that 3 per joint per year is widely seen as being appropriate. The Committee agreed the following updates in relation to the use of steroid injections for: **Shoulder pain** • Adhesive capsulitis (Frozen shoulder) – no change to TVPC74 • Shoulder impingement – no change to TVPC50 • Rotator cuff disorders or shoulder osteoarthritis – no policy **Elbow pain** • Lateral and medial elbow tendinopathy – amalgamate CCG policies into one 'Not normally funded' policy which includes patella and Achilles tendinopathy. • Olecranon bursitis –New 'Not normally funded' policy to be amalgamated with pre patellar bursitis **Hip pain** • Trochanteric bursitis – no change to TVPC32 • Hip OA – no change to TVPC49 **Knee pain** • Knee OA – no change to TVPC49 • Patella Tendinopathy – amalgamate CCG policies into one 'Not normally funded' policy which includes lateral and medial elbow tendinopathy and Achilles tendinopathy • Pre patellar bursitis – New 'not normally funded' policy to be amalgamated with olecranon bursitis **ACTION: The Clinical Effectiveness team to amalgamate current separate CCG documents as noted above and draft policy recommendations: TVPC 84 and TVPC 85 and circulate for comment. Comments to be received within the 2 week feedback period following issue.**
10.	**Paper 18-022 – Policy Update: TVPC8: Routine follow-up after Primary Hip & Knee Joint Replacement Surgery**
10.1	The Thames Valley CCGs have a current 2014 policy for routine follow-up of patients after primary hip and knee replacement surgery. The policy states that funding will be available for one routine follow up appointment which is expected to take place 6 to 8 weeks after surgery. Further on going routine follow up was considered to be low priority.

10.1 Cont.	The Committee were asked to consider the updated guidance from Royal College of Surgeons (RCS), Commissioning Guide: Painful Osteoarthritis of the Knee (2017) which suggests that a routine follow-up appointment should be offered within 6 weeks of knee replacement surgery, it also recommends that patients should be followed up in the first year, once at seven years and three yearly thereafter in asymptomatic patients. This latter recommendation is also evident in the RCS guidance of post hip replacement surgery.
	The specialists in attendance raised the following points: • The current limit of one six week follow up appointment does not allow review of patient who is not recovering as expected after their joint replacement, without re-referral to the service. • There should be a mechanism by which any patient after a joint replacement could be seen within the first year without the need for re-referral or for an application for funding for a follow up. • At both local provider units the routine joint replacements are followed up by a specialist physiotherapist, not a consultant surgeon. Regarding the RCS guidance and long term surveillance of joint replacement, it would be helpful to review the recommendation of the NICE guidance in due course, which is due a publication in 2020, as this is a national issue. The suggested timings in the RCS guide are likely to be based on joint replacements in the late 1990's when the polyethylene tended to fail at 7 years. The Getting it Right First Time (GIRFT) report encourages the use of implants that have the ODEP (Orthopaedic Data Evaluation Panel) rating of 10A which is with 10 years with an 'A' level of performance. Units that are not using these are flagged up as an outlier.
10.2	The Committee discussed the role of audit in helping to identify providers that may be outliers in the number of follow-up appointments that patients receive following their joint replacement surgery. The Committee agreed the policy criteria could be amended so that patients can have an additional follow up appointment within a year, if they have symptoms that directly relates to their hip or knee joint replacement. **ACTION: The Clinical Effectiveness team to draft an update to policy recommendation: TVPC8: Routine follow-up after primary hip and knee joint replacement surgery with an amendment that patients can have an additional follow up appointment within a year, if they have symptoms that directly relates to their hip or knee joint replacement, and circulate for comment. Comments to be received within the 2 week feedback period following issue.**
11.	**Policy Clarification: TVPC55: Primary hip and knee replacement revision surgery**
11.1	The current TVPC primary hip and knee replacement revision surgery policy was developed to clarify the commissioning responsibilities of CCGs and NHS England. Although the policy is titled 'primary hip and knee replacement revision surgery' it only includes criteria for knee replacement.
11.2	The attending clinicians highlighted that some clinical scenarios do not fit into the policy, resulting in difficulties with gaining prior approval for procedures. The clinicians recommended the following changes: • The line 'X-ray confirms the presence of aseptic loosening of the prosthesis' should read all polyethylene wear because that is an important reason for revision in hip and knee surgery due to secondary lysis and osteolysis • All metal on metal bearings should be included, because if metal on metal hips that are painful, revising those will rectify this. • 'X-ray' is better rephrased as 'imaging' as patients will also have bone scans, CT's and ultrasounds.

11.2 Cont.	• Instability for knee replacements: Knee replacements which are 'wobbly', not necessarily loose or worn but where the knee is unstable, should be included, • Total hip replacement that dislocate recurrently should be included. Revision following a third dislocation would be reasonable. • Include revision of uni-compartmental to total knee replacement. Patients with progression of OA in the lateral compartment of the knee do not have loose prosthesis or infection but need to be revised to a total.
11.3	The clinicians noted that as there are several indications for revision surgery and if the Committee wish to identify them, they are happy to support in the updating of the policy. Alternatively, the policy treshold could just state that revision is supported if the patient has 'a problem with the joint replacement'. The Committee accepted the specialist offer to help to rewrite the criteria. **ACTION: The Clinical Effectiveness team together with the specialist clinicians to draft an update to policy recommendation TVPC55: Primary hip and knee replacement revision surgery and return to the January meeting for discussion by the committee.**
12.	**Paper 18-023 – Interim Statement: Cannabis based products for medicinal use**
12.1	At the TVPC Workshop on the 5th November an interim statement for cannabis based products was requested following a change in the misuse of drugs regulations to state that use of cannabis based products for medicinal use is not normally funded. The Committee agreed the prescribing of these products will not normally be funded; this position will be reviewed when NICE release their guidance in Autumn 2019. Patients should not be referred into secondary care services solely for this treatment. **ACTION: Clinical Effectiveness team to draft an interim statement: cannabis based products for medicinal use and circulate for comment. Comments to be received within the 2 week feedback period following issue.**
13.	**Paper 18-024: Interim Statement: Bevacizumab (Avastin®) for use in Ophthalmology**
13.1	At the TVPC Workshop on the 5th November the funding of bevacizumab (Avastin®) for use in ophthalmology was raised and an interim statement was requested. Following discussion the Committee considered an interim statement was not required at this time.
14.	**Paper 18-025: Horizon Scanning**
14.1	A copy of the Horizon Scanning report covering key guidelines published between May and October 2018 was circulated to the Committee as part of the meeting pack. The report identified guidelines and new technologies which may impact on CCG clinical policy or present opportunity for policy development.
15.	**Any Other Business**
15.1	No items were raised.
16.	**Next meeting**
	The next meeting will be **Wednesday 23rd January 2019, to be held in Meeting Room GU29/30 Bath Road, Reading RG30 2BA**
17.	**Meeting Close**
	The Chair thanked everyone for their contributions to the discussions and closed the meeting.