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 24th July 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
Dr Jacky Payne	GP	Berkshire West CCG
Jane Butterworth	Assistant Director Medicines Optimisation	Buckinghamshire CCG
Dr Janet Lippett	Medical Director	Royal Berkshire Hospital Foundation Trust
Linda Collins	Clinical Effectiveness Manager (CCG)	Oxfordshire CCG
Marion Mason	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 Miles Carter	West Locality Clinical Director	Oxfordshire CCG
Shairoz Claridge	Director of Operations	Berkshire West CCG
Tessa Lindfield	Director of Public Health	Berkshire

In Attendance:

Kathryn Markey	Clinical Effectiveness Manager	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 Update: Tonsillectomy		
Mr James Ramsden	Consultant Otolaryngologist	Oxford University Hospital
Item 9 – Evidence Review: Laparoscopic ventral rectopexy for internal rectal prolapse		
Mr Oliver Jones	Consultant Colorectal Surgeon	Oxford University Hospital
Item 10 – Policy Update: Restless legs		
Dr Graham Lennox	Clinical Lead for Neurology	Oxford University Hospital

Apologies:

Andrew Brooks	Clinical Chief Officer	East Berkshire CCG
Fiona Slevin-Brown	Director of Strategy & Operations	East Berkshire CCG
Francis Fairman	Assistant Director – Clinical Strategy	NHS England
Dr Karen West	Clinical Director Integration	Buckinghamshire CCG
Mark Hancock	Medical Director	Oxford Health NHS Trust
Prof. Chris Newdick	Special Advisor – Health Law	University of Reading
Meghana Pandit	Medical Director	Oxford University Hospital
Dr Raju Reddy	Secondary Care Consultant	Berkshire West CCG
Ravi Lukha	Public Health Specialist Registrar	Public Health Services for Berkshire
Robert Majilton	Deputy Chief Officer	Buckinghamshire CCG
Sarah Annetts	IFR Manager (Clinical)	SCW
Tiina Korhonen	Clinical Effectiveness Lead	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. The meeting held on 22nd May 2019 was not quorate. Absent member has reviewed the minutes post meeting and accepted the policy recommendations agreed by the Committee. Tessa Lindfield, Director of Public Health raised the issue of the public health membership for TVPC. It was suggested that being co-opted for discussion of specific issues may be an option rather than being a standing member. The role of public health is changing and there is uncertainty as to how this fits in with the terms of reference for TVPC **ACTION: The Clinical Effectiveness team to discuss with public health lead the status of their membership of the TVPC Committee going forward.**
3.0	**Declarations of Interest**
3.1	Nothing declared.
4.	**Draft Minutes of the Priorities Committee meeting held 22nd May 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 – Public Health representation at 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**
5.2	**Minutes of the Priorities Committee held in May 2019 – Action 6.2 - Paper 19-001 – Policy Update: TVPC13 Ketone Testing** The Clinical Effectiveness team to draft withdrawal paperwork and issue to CCG Governing Bodies for endorsement. **ACTION Complete**
5.3	**Minutes of the Priorities Committee held in May 2019 – Action 7.3 - Paper 19-002 – Pathway for the management of Crohn's disease with biologics** The Clinical Effectiveness team to draft a policy recommendation: Biologic drugs for the management of Crohn's disease and circulate for comment. Comments to be received within the 2 week feedback period following issue. **ACTION Complete**

5.4	**Minutes of the Priorities Committee held in May 2019 – Action 8.5 - Paper 19-003 – Evidence Review: Breast reconstructive surgery post breast cancer** The Clinical Effectiveness team to draft a policy recommendation: Post breast cancer reconstructive surgery and circulate for comment. Comments to be received within the 2 week feedback period following issue. **ACTION Complete**
5.5	**Minutes of the Priorities Committee held in March 2019 – Action 9.3 - Paper 19-004 – Evidence Review: Risk reducing surgery for breast cancer** The Clinical Effectiveness team to draft guidance note to TVPC16 'Aesthetic treatment for adults and children' policy for risk reduction surgery for breast cancer and circulate for comment. Comments to be received within the 2 week feedback period following issue. **ACTION Complete**
5.6	**Minutes of the Priorities Committee held in March 2019 – Action 10.3 - Paper 19-005 – Policy Update: TVPC14 Biological mesh for reconstruction** The Clinical Effectiveness team to draft an update to TVPC14 Biological mesh policy and circulate for comment. Comments to be received within the 2 week period following issue. **ACTION Complete**
5.7	**Minutes of the Priorities Committee held in May 2019 – Action 11.5 - Paper 19-006 – Evidence Review: Sequential use of biologic drugs for ankylosing spondylitis and axial spondylorathritis** The Committee recommended the RBH pathway across the Thames Valley but asked the Clinical Effectiveness team to contact the specialist clinicians to clarify: • The pathway with regard to pregnancy • An adverse drug reaction or injection site reaction where the patient has responded to the first anti-TNF On clarification the Clinical Effectiveness team to draft a policy recommendation for the sequential use of biologic drugs for ankylosing spondylitis and axial spondylorathritis and circulate 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 May 2019 – Action 12.1 – Any Other Business: Hearing aid policy** The Committee agreed to a request by OCCG for the title of TVPC86 to be renamed. The Clinical Effectiveness team to amend the title of policy TVPC86 to 'Hearing aids for hearing loss in adults. **ACTION Complete**
5.9	**Minutes of the Priorities Committee held in May 2019 – Action 12.2 – Any Other Business: TVPC44 Sequential use of a third or subsequent biologic therapy for psoriasis** The Committee discussed and agreed policy TVPC44 should be updated to clarify the policy access criteria in line with new NICE TAGs. The Clinical Effectiveness team to draft an update to TVPC44 Sequential use of third or subsequent biologic therapy for psoriasis and circulate for comment. Comments to be received within the 2 week feedback period following issue. **ACTION Complete**
5.10	**Minutes of the Priorities Committee held in May 2019 – Action 12.2.1 – Any Other Business** The Clinical Effectiveness team to explore the available conflict of interest declarations and add to the standard clinical evidence review and feedback process. **July 2019 Update:** The Committee agreed the Statement (Paper 19-010) produced by the Clinical Effectiveness team together with Russell Carpenter, Head of Governance Buckinghamshire CCG should be included in future evidence reviews. **ACTION Complete** With regard to the Terms of Reference (Paper 19-011) the Chair asked for 'statutory requirements' to be added to section 1. Aim, 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.**

5.11	**Minutes of the Priorities Committee held in May 2019 – Action 12.3 – Any Other Business** The Committee to review the Annual Report and feedback any comments to the Clinical Effectiveness team. **ACTION Complete**
6.	**Paper 19-012 – Evidence Review: Chalazia Surgery**
6.1	Thames Valley Priorities Committee (TVPC) requested a review of surgical treatment of chalazia following publication of new guidance from the NHS England evidence-based intervention (EBI) programme which recommends criteria for assessing patient eligibility for the procedure. Eyelid surgery is covered by TVPC16: Aesthetic treatments for adults and children and is not normally funded, however this does not include treatment of chalazia.
6.2	A chalazion is caused by the obstruction of a Meibomian gland, it is often painless and up to 80% resolve spontaneously although this may take weeks or months. If the chalazion becomes very large it can cause astigmatism, visual disturbance, or ptosis (drooping of the upper eyelid). It can also become infected. Conservative treatment involves daily application of warm compresses and massage to help drain the cyst. Surgical treatment involves incision and curettage; alternatively an injection of a steroid (triamcinolone) may be used.
6.3	The NHS England EBI programme recommends that surgical treatment for chalazia is suitable for patients who meet one of the following criteria: • Has been present for more than 6 months and has been managed conservatively with warm compresses, lid cleaning and massage for 4 weeks • Interferes significantly with vision • Interferes with the protection of the eye by the eyelid due to altered lid closure or lid anatomy • Is a source of infection that has required medical attention twice or more within a six month time frame • Is a source of infection causing an abscess which requires drainage • If malignancy (cancer) is suspected e.g. Madarosis (loss of the eyelashes)/recurrence/other suspicious features in which case the lesion should be removed and sent for histology as for all suspicious lesions
6.4	The clinical evidence base for treatment of chalazion in general is poor; there is a NICE Clinical Knowledge Summary (CKS) (2015) which cites textbooks and clinical opinion. One statement within the NICE CKS guidance, which differs from NHS England criteria states that if the meibomian cyst does not improve or resolve after 4 weeks with conservative treatment, offer the following options (depending on clinical judgement and the person's preference): • No treatment — for example, if the meibomian cyst is small and asymptomatic • Referral to an ophthalmologist The papers identified in the evidence search for TVPC compared steroid injections with surgery, and explored the effectiveness of hot compresses; however, there are serious limitations with the literature.
6.5	Feedback received from Oxford University Hospital (OUH) states that surgery for chalazia is not just done for aesthetic purposes. Chalazia can affect vision, induce astigmatism and can be uncomfortable. The NHS England criteria differ from NICE CKS in that the wait to referral varies between 6 months (NHSE) and 4 weeks (NICE). Ideally it would be preferable to see patients before 6 months as clinical view is that patients are easier to treat at this stage; 4 months would seem a reasonable time period, particularly given that there will be a further wait to get an appointment at the chosen unit. Any local guidance should cover adult chalazia as paediatric

6.5 Cont.	chalazia should be seen sooner, this is not covered by the NHS England guidance.
6.6	The specialist clinician indicated that OUH undertake 5 procedures per week as a minor-op in clinic. Local activity data produced by SCW analysts and also by NHS England does not include outpatients so will not include these minor operations. The average cost of inpatient surgery is considerably higher at £651.24 compared with outpatient costs estimated to be around £107.
6.7	The Committee discussed the potential impact of the policy and noted the uncertainty regarding the procedures carried out in the minor op clinic as these are not captured by the available data. The Committee raised concern that the first criteria (has been present for more than 6 months and has been managed conservatively with warm compresses, lid cleaning and massage for 4 weeks) could lead to treatment of chalazia for cosmetic reasons for asymptomatic cases. There was also discussion around how to define significant interference with vision, whether the policy should apply to both adults and children, and whether there should be a separate statement to address potential malignancy.
6.8	**ACTION: The Clinical Effectiveness team to draft a policy for Chalazia with a summary of the advised conservative treatment, note on malignancy and the following criteria taking account of the EBI policy:** • **Interferes with vision as demonstrated by an opticians report Or** • **Interferes with the protection of the eye by the eyelid due to altered lid closure or lid anatomy Or** • **Is a source of infection that has required medical attention twice or more within a six month time frame Or** • **Is a source of infection causing an abscess which requires drainage** **The Clinical Effectiveness team to circulate for comment. Comments to be received within the 2 week feedback period following issue.**
7.	**Paper 19-013 – Policy Update TVPC22: Tonsillectomy for surgical management of recurrent tonsillitis and obstructive sleep apnoea in children and adults**
7.1	The Committee requested a review of the existing policy TVPC22 following publication of new guidance from NHS England as part of their Evidence Based Interventions (EBI) programme. The EBI recommendations do not include tonsillectomy as a treatment for disordered breathing in children (<16y) or sleep apnoea in adults. The EBI policy referral criteria for recurrent tonsillectomy differ from the current TVPC policy; the main difference being the number of clinically significant, adequately treated sore throat episodes in the preceding year. TVPC22 policy states five episodes, NHS E EBI states seven - this criteria is based on SIGN (Scottish Intercollegiate Guidance) which was reviewed during the original TVPC policy development. The main reason for TVPC originally moving away from 7 episodes to 5 was due to concern over excessive morbidity in patients. EBI state that certain medical conditions should be excluded from the policy. The current TVPC policy also differs from the EBI policy in that it refers to CENTOR scoring criteria, a number of symptoms used to diagnose tonsillitis potentially caused by bacteria.
7.2	There are two systematic reviews that show tonsillectomy to be moderately beneficial for reducing episodes of sore throat in children in the short-term (up to a year). Both raise concern that many children who do not receive surgery improve spontaneously, but that there is a lack of long term data available. There was limited evidence found for the specific medical exclusions mentioned by NHS England.

7.3	Royal College of Surgeons (RCS) guidance 2016 for obstructive sleep disorder breathing (OSDB) states that consideration should be given to weight management services, nasal saline irrigation and/or intranasal steroids and allergy testing prior to considering surgery for children with this condition. Two systematic reviews indicate that for some children with OSDB the condition can improve spontaneously with time. There was very limited evidence that weight loss may be beneficial in particular how much weight loss is useful in children to improve this condition or how best to achieve the weight loss are unclear. There is low level evidence that for adult patients with enlarged tonsils, tonsillectomy can be beneficial for improving sleep apnoea.
7.4	The Committee was provided with local TVPC activity data for acute and chronic tonsillitis (all ages) indicating costs for 2018/19 year of £893k. With regard to sleep apnoea there is more variation between TVPC CCGs with total costs of £337k for the same period.
7.5	The Specialist clinician in attendance advised that the underlying evidence to support the number of episodes of tonsillitis prior to surgery is very poor due to the difficulty in diagnosing tonsillitis and the fact that surgeons do not have the opportunity to see patients when they actually have an episode of tonsillitis. Overall, the studies show that the more often you have tonsillitis the more beneficial the surgery. From the recent OUH Get it Right Review it was shown that the local area had below national rates per head of population for tonsillectomy, grommets, adenoidectomy and tonsillectomy in children. The specialist clinician raised concern that if a patient had tonsillitis 7 times per year, i.e. every 8th week this would likely result in a week off work each time and would have a negative effect on work life and education. . The specialist clinician cited work by Martin Burton, Professor of evidence based medicine and chairman of Cochrane UK who has written a position piece on tonsillectomy summarising the rather poor quality evidence; he performed a study approximately 2 years ago in Oxford where he investigated patient decision making. Whilst he anticipated that half the patients having been given the uncertainty and poor quality of some of the evidence would choose not to have the surgery, however, out of 50 patients, 49 decided they would have a tonsillectomy citing the reason as the barriers for getting to the hospital and seeing a surgeon were so high that by the time they'd been offered the surgery only those that were really determined and unwell remained. The specialist clinician also referred to an on-going national randomised controlled trial based in Newcastle commissioned by NIHR & NHS England, which is investigating tonsillectomy in adults, and due to report in 2020/21. Patients are randomised to a tonsillectomy or a period of observation then a tonsillectomy then followed up for a period of time. He advised that this may lead to a change in practice. The specialist clinician noted that there are papers published in the last 3 years from England, Wales & Scotland which all show substantial increases in the number of admissions to hospital for tonsillitis, quinsy (abscess on the tonsil) and deep neck space infections. It is possible that restricting access to tonsillectomy may mean that more people are being admitted to hospital with serious infections requiring prolonged hospital stays but this is difficult to determine. He also raised concern that the CENTOR scores have caused difficulty for the surgeons as they do not see patients who are experiencing tonsillitis.

7.6	The Committee queried the medical exclusions stated in the EBI policy. The specialist clinician agreed that they should be included but noted that the numbers were likely to be very small. The specialist clinician advised that the new RCS guidance regarding weight management and nasal sprays is already current practice and that tonsillectomy is a last resort treatment for disordered breathing or sleep apnoea.
7.7	The Committee discussed modifying the referral criteria for frequency of tonsillitis from the current TVPC policy of 5 episodes in the preceding year to 7 as recommended by the EBI policy. Taking into consideration local data and feedback received from the attending clinician the Committee felt as the number of interventions across the Thames Valley is low, it was not cost effective to incur transaction costs of changing the guidance referral frequency. The Committee agreed there are a number of medical conditions where episodes of tonsillitis can be damaging to health or where tonsillectomy is required as part of on-going management. The policy is to include the following instances where tonsillectomy may be considered at a lower threshold after specialist assessment: • Acute and chronic renal disease resulting from acute bacterial tonsillitis • As part of the treatment of severe guttate psoriasis • Metabolic disorders where periods of reduced oral intake could be dangerous to health • PFAPA (Periodic fever, Apthous stomatitis, Pharyngitis, Cervical adenitis) • Severe immune deficiency that would make episodes of recurrent tonsillitis dangerous Discussion highlighted a need for the policy to provide details of the CENTOR referral criteria. and the Committee felt that there was no need to add in the new RCS guidance as this would be unlikely to affect current practice. Due to the relatively low numbers of tonsillectomy being performed for adult sleep apnoea, the Committee agreed to retain the current statement. **The Clinical Effectiveness team to draft an update to TVPC22 Tonsillectomy for surgical management of recurrent tonsillitis and obstructive sleep apnoea in children and adults and circulate for comment. Comments to be received within the 2 week feedback period following issue.** **Post-meeting note:** Subsequent to the meeting, the Clinical Effectiveness team has been made aware that the NHS Standard Contract requires both the Commissioner and the Provider to comply with their respective obligations under the EBI Policy. A tonsillectomy for recurrent tonsillitis is a Category 2 intervention as defined in that policy and for the purposes of the NHS Standard Contract. Category 2 Interventions must only be carried out in accordance with the published guidance. This means that a CCG must adhere to the published guidance, and cannot operate a patient administration system (PAS) which is more lenient than the policy requires. It is, on the other hand, permissible to operate a more stringent PAS and nevertheless be in adherence to the policy. **In light this clarification, the Clinical Effectiveness team propose to delay the circulation of the draft update to TVPC22 Tonsillectomy for surgical management of recurrent tonsillitis and obstructive sleep apnoea in children and adults. The topic will be returned to the next meeting in September.**

8.	**Paper 19-014 – Policy Update: TVPC23 Trigger Finger**
8.1	This policy was developed by Thames Valley CCGs four years ago and is being reviewed following NHS England's published recommendations for trigger finger in adults as part of their evidence based intervention programme (EBI).
8.2	EBI recommendations are broadly similar to the current TVPC23 policy, the main differences being: reducing the maximum number of steroid injections given before consideration for surgery, increasing the recommended splinting time, exclusions for people who have had two other unsuccessfully treated trigger digits and exclusions for patient with diabetes.
8.3	Guidance from the British Society for Surgery of the Hand (2016) recommends corticosteroid and local anaesthetic injection is an appropriate first line of treatment for trigger finger with surgical intervention considered for patients that do not adequately respond or do not wish to have injections. Unlike earlier recommendations, these do not include a guide to classifying the severity of the condition. Whilst no studies investigating splinting were eligible for inclusion in the systematic review, a narrative overview concluded that the evidence for splinting was poor. There is no clear recommendation on the number of corticosteroid injections to be trialled prior to consideration of surgery.
8.4	Feedback received from Consultant Hand Surgeon, Oxford University Hospital supported the • Increase in splinting time from 6 to 12 weeks for cases when the mechanical triggering is exclusively or predominantly at night • Reduction in injections from 3 to 2 but suggested that injections can be considered on a repeated basis of no more than 1-2 per year as an alternative to surgical treatment • Preferential surgery for prior cases and patient with diabetes, as long as the recommendations clearly indicated that initial injection treatment (after appropriate counselling) would remain a valid option in community care • Surgery for fingers locked in the palm but recommended that a trial of a flexor sheath injection, performed on the day of clinic attendance, potentially with manipulation would be a reasonable alternative, if only to allow for surgery for any residual symptoms to be delivered in an elective fashion.

8.5	The Committee queried the potential impact of the changes to policy. It was agreed to be minor as the changes were not significant and NHSE has stated that there is no opportunity for savings to be made in the local area.
	
	ACTION: The Clinical Effectiveness team to draft an update to TVPC23: Trigger Finger to align with the NHS England EBI policy as follows:
	• **Reduce the number of maximum recommended steroid injections from 3 to 2**
	• **Increase the maximum recommended period of splinting from 6 to 12 weeks**
	• **Remove the conservative requirement for surgery for:**
	  ○ **A patient who has previously had 2 other trigger digits unsuccessfully treated with appropriate non-operative methods**
	  ○ **Diabetic patients**
	• **Remove reference to the BSSH classification system as this has been discontinued**
	
	The Clinical Effectiveness team to circulate for comment. Comments to be received within the 2 week feedback period following issue.

9.	**Paper 19-015 - Evidence Review: Laparoscopic Ventral Mesh Rectopexy for Internal Rectal Prolapse and Obstructive Defaecation**
9.1	Currently of the Thames Valley CCGs, only Oxfordshire CCG has a policy, dated 2012, and notes that laparoscopic ventral rectopexy (LVR) for internal rectal prolapse is low priority due to the lack of evidence of long term clinical and cost effectiveness. The Thames Valley Priorities Committee requested an evidence review of LVR for internal rectal prolapse to determine whether there is new evidence to support a Thames Valley wide policy.
9.2	Guidance from the American Society of Colon and Rectal Surgeons (2017) states that rectal prolapse cannot be treated non-operatively, however, some symptoms can be palliated medically. In obstructive defaecation syndrome (ODS), pelvic floor retraining was seen as ineffective for patients with high grade internal prolapse and surgery should be considered from the outset. The Italian Association of Hospital Gastroenterologists and Italian Society of Colo-rectal Surgery (2012) state that in cases of repairable anatomical defect and severe symptoms, surgical treatment are indicated. There are a few other surgical options, the American Society of Colon and Rectal Surgeons states that trans-abdominal rectal fixation is the procedure of choice, they feel it has acceptable short and long-term rates of complications but there is insufficient evidence for them to recommend posterior vs. anterior repairs. The Society did feel that rectal mobilisation without rectopexy resulted in higher recurrence and is not recommended. The Italian Association of Hospital Gastroenterologists and Italian Society of Colo-rectal Surgery felt there was no sufficient evidence to be able to recommend one particular approach as a Gold Standard. A randomised control trial (RCT) showed significant increased recurrence with mobilisation without rectopexy (8.6% vs. 1.5%). A recent NICE IPG618 (2018) for laparoscopic ventral mesh rectopexy generally found that there are high levels of patient satisfaction. High levels of anatomical correction were achieved with recurrences at approximately 2-7%. NICE felt the improvements were statistically significant with low rates of recurrence of prolapse to justify it. A NICE IPG351 (2010) Overview of double stapled transanal rectal resection (STARR) procedure for obstructed defaecation syndrome found that not all patients were suitable for this procedure but there was a long history of early good results followed by poorer long term results and felt that further research was needed with a longer follow up. One review found while both laparoscopic ventral mesh rectopexy (LVMR) and STARR are safe, the LVMR has better long-term functional outcome, with less complications and less recurrences. Other reviews were unable to identify statistically significant differences between the various approaches with mixed evidence. In terms of safety generally the procedure appears to be safe and effective however there is limited long-term safety data available. One of the main concerns is regarding the use of mesh. Whilst, there are low rates of synthetic mesh erosion, this may occur a long time after surgery and only short-term safety data are available for the different types of mesh. The NICE IPG618 found that rates of conversion and complications are low. There are several reviews with similar results, these also recommend further research to establish long-term safety. One review found mesh erosion to be more common with synthetic than biological mesh but also recommended further research. Further review found LVMR was safe in elderly patients over the age of 80 years with no significant difference in complications. The Pelvic Floor Society (2017) recommends an international ventral mesh registry to monitor procedures and any complications.

9.2 Cont.	No economic analyses were found. One paper compared laparoscopic costs (€3115.55) with robotic surgery costs (€3672.84). Local data across the Thames Valley for laparoscopic procedures demonstrate low activity levels. For internal rectal prolapse since 2015/16 there appears to have only been one recorded intervention. There were approximately 82 Laparoscopic interventions for all rectal prolapse across Thames valley CCGs since 2015-2016.
9.3	The specialist in attendance raised the following points: • External prolapse can only be fixed surgically, there is no other treatment for it, there are a range of operations broadly keyhole surgery from above, an open operation from above or surgery from below. • Laparoscopic surgery is very low risk. The associated mortality rate is comparable with the mortality rate for hernia, grommet or tonsil surgery. • Internal prolapse is slightly different in that patients have obstructive defaecation and patient may experience difficulty in going to the toilet or patients have incontinence or both. The uptake of STARR internationally has dropped off dramatically whilst at the same time the use of rectopexy has increased rapidly. With STARR there has been a big problem with patients getting morbidity and in particular bad urgency which is difficult to treat and has raised concern among surgeons. • For patients with Obstructive Defaecation Syndrome frequent incontinence should be managed via a robust conservative pathway, partly in the community and partly in hospital. Conservative management includes pelvic floor retraining, irrigation, pelvic floor exercises, dietary manipulation. If a patient fails to improve with conservative management then they should go through a multidisciplinary team meeting (MDT) process for which one of the outcomes might be a discussion about fixing the internal prolapse with preferably a rectopexy, or a STARR. • Documents from the National Pelvic Floor Society should be used to facilitate discussion about enhanced consent, the range of meshes - biological, non-absorbable (prolene) mesh or performing the operation with no mesh. A more permanent mesh may have a slightly higher morbidity where as a biological mesh or no mesh have lower morbidity and a lower risk of erosion.
9.4	The Committee queried the types of mesh used. The specialist in attendance explained that there are three main types of mesh; polypropylene mesh (permanent mesh), permicole and biodesign. Many surgeons use all 3 types of mesh. The specialist felt that it is a complicated discussion with patients as to which mesh is appropriate and should be a discussion between patient and surgeon rather than be determined by finance.
9.5	The Committee agreed that there is no need for TV wide policy and agreed to recommend the withdrawal of the current policy that Oxfordshire CCG holds. It was suggested that an evidence review of mesh, in particular the use of biological mesh (for indications other than that stated in the existing breast reconstruction policy) may be helpful as well as an understanding of its use locally. **ACTION: Oxfordshire CCG to withdraw Policy Statement 228: Laparoscopic ventral rectopexy for internal rectal prolapse.** **ACTION: 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 this year.**
10.	**Paper 19-016 – Evidence Review: Restless Leg Syndrome**
10.1	The TVPC requested a review of local existing policies across TVPC CCGs for primary restless leg syndrome (RLS). Existing policies are held by Berkshire CCGs dated 2007 stating that the use of pramipexole for the management of RLS is considered a low priority due to lack of clinical and cost effectiveness and Oxfordshire CCG holds a policy dated 2008 that states pramipexole and ropinirole for the management of low and moderate RLS are low priority.

	The International RLS rating scale (IRLSRS) assesses the severity of symptoms as follows: 1. Mild (total score 1-10) 2. Moderate (11-20) 3. Severe (21-20) 4. Very severe (31-40) Licensed drug treatments in the UK are currently pramipexole, ropinirole and rotigotine for moderate to severe idiopathic RLS. Naloxone / oxycodone (Targinact®) is licensed as a second line symptomatic treatment of patients with severe to very severe idiopathic RLS after failure of dopaminergic therapy.
10.2	There is little national guidance for the management of primary RLS. A NICE clinical knowledge summary provided details on the background of RLS and principles of management. The Scottish Medicines Consortium (SMC) approved the use of pramipexole, ropinirole and rotigotine in a restricted manner based on the IRLSRS. American guidelines advise that in moderate to severe primary RLS clinicians should consider prescribing a pharmacologic agent to reduce RLS symptoms. For patients who have not responded to other treatments, clinicians may consider prescribing prolonged-release oxycodone/naloxone. European guidelines are in support of rotigotine, ropinirole and pramipexole in specified doses. The use of the three dopamine agonist drugs is supported by systematic reviews but all included placebo controlled trials which showed a higher treatment of efficacy than placebo. The quality of evidence was generally low because of attrition bias and because of studies of too short duration. A Cochrane systematic review (2016) included one well designed randomised, double-blind study that addressed the use of prolonged-release oxycodone preparation which showed a reduction in RLS symptoms however the evidence was regarded to be of low quality. A NICE evidence summary (2015) reviewed the same study and concluded that oxycodone/naloxone is a potential second-line treatment option for people with severe to very severe restless legs syndrome. However, the risk of opioid dependence would need to be considered and people prescribed the treatment would need to be reviewed on a regular basis.
10.3	The Specialist in attendance raised the following points: • RLS is very common particularly in the mild form. It is often not recognised as RLS. Patients are referred with what appears to be peripheral neuropathy when it is actually RLS. • It is quite straightforward to diagnose and treat particularly for mild RLS. A guideline that empowers GPs to treat it in primary care without making a referral to neurology services would be helpful and assist in keeping waiting times down. • The main problem with treatment and why short term studies are possibly misleading is a phenomenon called augmentation particularly in patients with moderate or severe RLS. Very often patients will respond to treatment for the first few months and then gradually the symptoms will start to reappear often at a different time of day. Patients may have their symptoms in the evening or first part of the night then on treatment they start getting it on the second half of the night or in the morning. In this situation increasing the same treatment very often results in escalating symptoms. • Locally, patients have ferritin levels checked first as patients with RLS are often genetically pre-disposed to iron deficiency. Patients may benefit from iron supplements. • If iron supplementation does not work, a patient would normally commence gabapentin or pregabalin. These drugs have become more difficult to prescribe recently as they have become controlled drugs. The reason these are used first line is that less augmentation and fewer adverse psychiatric problems are seen. • Second line drug choice is dopamine agonists. There is not strong evidence to support one drug over another.

	• At particularly high doses of dopamine agonists patients may experience repetitive purposeless activity than can be very alarming for example gambling, sexual compulsions or altered eating habits. • Rotigotine is used as a last choice because it is more expensive but it is more effective than the other drugs in terms of having a lower chance of augmentation. • It is preferred that patients being referred to secondary care have already tried gabapentin and an oral dopamine agonist and therefore the rotigotine patch is then recommended. • The use of opiates is as a last resort.
10.4	Following the discussion the Committee agreed a policy recommendation with referral to secondary care criteria as follows: • Ferritin levels to be checked • Patient to have an IRLS score level of severe or above and • not responded to treatment with at least one dopamine agonist. The prescribing of gabapentin may be considered or • there is diagnostic uncertainty Refer to CKS guidelines as necessary **ACTION: The Clinical Effectiveness team to draft a policy for restless leg syndrome and circulate for comment. Comments to be received within the 2 week period feedback period following issue.**
11.	**Integrated Care System (ICS) and ratification of recommendations across the system**
11.1	Buckinghamshire, Oxfordshire and Berkshire West have formed an Integrated Care System (ICS). There needs to be an investigation and discussion how ratification of the Committee policy recommendations may occur at a higher level at a single point, taking account of affordability and local pathways. **ACTION: Jane Butterworth and Linda Collins to draft a ratification recommendation discussion paper for review by Buckinghamshire Governance team and Clinical Effectiveness.**
12.	**Paper 19-017: Horizon Scanning**
12.1	The Clinical Effectiveness team identified key guidelines or new technologies published between March and June 2019 which may impact on CCG clinical policy or present opportunity for policy development. The paper was accepted by the Committee.
13.	**Any Other Business**
13.1	**Annual training session**
	ACTION: Committee members to indicate if a training session would be needed this year and contact the Clinical Effectiveness team with identified training needs via email to scwcsu.clinicaleffectiveness@nhs.net
13.2	**2020-21 Work programme**
	ACTION: Clinical Effectiveness team to identify a date and venue for the November topic identification workshop for the 2020-21 work programme and send to the Committee.
13.3	**Host CCG for 2020 meetings**
	ACTION: East Berkshire to provide details of prospective venues at or before the next meeting in September 2019.
14.	**Next meeting**
	The next meeting will be **Wednesday 25th September 2019, to be held in Meeting Room GU29/30 Bath Road, Reading RG30 2BA**
15.	**Meeting Close**
	The Chair thanked everyone for their contributions to the discussions and closed the meeting.