THIS MEETING WAS NON QUORATE

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

Thames Valley Priorities Committee

Minutes of the meeting held Wednesday 22nd January 2020

Conference Room A, Jubilee House, 5510 John Smith Drive, Oxford OX4 2LH

Alan Penn	Lay Member Chair	Thames Valley Priorities Committee
Jane Butterworth	Assistant Director Medicines Optimisation	Buckinghamshire CCG
Linda Collins	Clinical Effectiveness Manager (CCG)	Oxfordshire CCG
Funmi Fajemisin	Interim Head of IFR	SCW
Lindy Hardy	Assistant IFR Manager	SCW
Dr Megan John	GP, East Berkshire CCG Lead	East Berkshire CCG
Andrew McLaren	Deputy Medical Director	Buckinghamshire Healthcare
Bhamini Ramaswamy	Consultant anesthetist (Observer)	Buckinghamshire Healthcare
Dr Raju Reddy	Secondary Care Consultant	Berkshire West CCG
Dr Karen West	Clinical Director Integration	Buckinghamshire CCG

In Attendance:

Tiina Korhonen	Clinical Effectiveness Lead	SCW
Kathryn Markey	Clinical Effectiveness Manager	SCW
Kate Forbes (for FES only)	Clinical Effectiveness Manager	SCW
Jenny Kovalaine-Kwan	Clinical Effectiveness Manager	SCW
Rachel Finch	Clinical Effectiveness Administrator	SCW

Topic Specialists in Attendance via telephone for Agenda Item:

Item 7 – Policy update: Cannabis for medicinal purposes
Maire Stapleton, Formulary Manager, Buckinghamshire Integrated Care System Dr Silvana Trivedi, Consultant, Amersham Hospital Elspeth Wolfenden, MS Specialist Nurse, Buckinghamshire Healthcare

Apologies:

Shairoz Claridge	Operations Director	Berkshire West CCG
Edward Haxton	Deputy Finance Director	Berkshire West CCG
Catriona Khetyar	Head of Medicines Optimisation	East Berkshire CCG
Dr Janet Lippett	Medical Director	Royal Berkshire Hospital Foundation Trust
Professor Chris Newdick	Special Advisor - Law	University of Reading
Meghana Pandit	Medical Director	Oxford University Hospital
Dr Jacky Payne	GP	Berkshire West CCG
Dr Mark Sheehan	Special Advisor - Ethics	University of Oxford
Boo Vadher	Clinical Director of Pharmacy and Medicines Management	Oxford University Hospital

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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	• Dr Megan John declared an interest in item 9, Cannabis for medicinal purposes. Confirmed as not material for the Committee decision making.
4.	**Draft Minutes of the Priorities Committee meeting held 27th November 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 May 2019 – Action 2.1 – Matters Arising** Clinical Effectiveness team to update the Thames Valley Priorities Committee Terms of Reference (ToR) removing Public Health (PH) 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 the Committee reluctantly agreed to remove them from the function. **November 2019 Update:** An amended copy of the ToR has been distributed to the Committee for comment. At present a copy has **not** been issued to CCG Governing Bodies for acceptance pending enquiries with the new Oxford Director of Public Health to ascertain if interest in sending a representative to the Committee. **January 2020 Update: Oxford Director of Public Health acknowledged the importance of the Committee however due to a significant shortfall in capacity are unable at present to provide support. The Clinical Effectiveness team to progress the ToR for Governing Body acceptance. ACTION Closed**
5.2	**Minutes of the Priorities Committee held in May 2019 – Action 13.3 – Any Other Business – Host CCG for 2020 meetings** Clinical Effectiveness team to make enquiries with Wexham Park Hospital (Frimley Health Foundation Trust) and St. Marks Hospital, Maidenhead. **November 2019 Update:** Action is ongoing, alternative venues in East Berkshire are being explored; the fallback position is Jubilee House Oxford. **January 2020 Update:** A room is available at Wexham Park Hospital however will only hold 12 in a boardroom style layout, 25 people can be accommodated theatre style. The Committee agreed meetings the layout was not suitable therefore meetings for 2020 are to take place in Jubilee House, Oxford. Clinical Effectiveness team to make enquires with Wexham Park for 2021 when meeting room bookings are released in October.
5.3	**Minutes of the Priorities Committee held in September 2019 – Action 7.4 – Policy Review: Surrogacy and assisted conception for infertile couples** 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 27th November meeting. **November 2019 Update Paper 19-024:** The Committee agreed that single women should have access to fertility services, with the principle that single woman needs to establish their fertility status as noted already in the policy for same sex couples and couples unable to undertake vaginal intercourse. The policy was discussed in view of amending 'couples' to 'patients' throughout the policy. It was also agreed to add the clinical definition of infertility in the policy for clarity. The Committee confirmed that any other area of the policy remains unchanged, including the number of cycles funded and the age of female at the time of referral to specialist services, acknowledging the current financial position of the CCGs and that no new or additional funds to change the current service provision are available.

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5.3 Cont.	The Clinical Effectiveness team to draft a second draft of policy statement 11g Assisted reproduction services for infertile patients, circulate it to Committee members. Only to come back to TVPC if there are significant changes that require further discussion. **January 2020 Update: Minor comments received with no change to the content. Clinical Effectiveness team to issue to CCG's for Governing Body acceptance. ACTION Closed**
5.4	**Minutes of the Priorities Committee held in November 2019 – Action 6.11 – Policy Update: Circumcision – Paper 19-025** Clinical Effectiveness team to draft an update to policy recommendation: TVPC63 Circumcision, send to the attending clinician for comment before circulating to the Committee members to comment. Comments to be received within the 2 week feedback period following issue. Policy update recommendation to include the following: • Circumcision is not undertaken for social, cultural or religious reasons • Insert separate thresholds for children and adults within the policy • Circumcision will be funded for pre pubertal (under 15) children with LS and balanitis • Circumcision will be funded for patients with a diagnosis of lichen sclerosus (LS) also known as balanitis xerotica obliterans (BXO) Note: where LS is mentioned include reference to the British term BXO • Physiological reasons affecting quality of life or are causing pain • Consider removing 'for 1-3 months' from pathological phimosis section. However, please note the clinician confirmed he would use a steroid potentially in mild disease **January 2020 Update: Refer to agenda item 7**
5.5	**Minutes of the Priorities Committee held in November 2019 – Action 8.3 – Policy Update: Elfornithine and facial hirsutism – Paper 19-022** Clinical Effectiveness team to draft an update to policy recommendation TVPC16 Aesthetic treatments for adults and children to include a 'not normally funded' statement and circulate for comment. Comments to be received within the 2 week period following issue. **January 2020 Update:** Feedback period has ended, Clinical Effectiveness team to issue final recommendation for Governing Body acceptance **ACTION Closed**
5.6	**Minutes of the Priorities Committee held in November 2019 – Action 9.6 – Policy Update: Functional Electrical Stimulation (FES) for upper and lower limb dysfunction of Central Neurological Origin – Paper 19-021** The Committee discussed and agreed more information was required before a decision could be made. **ACTION:** Berkshire West CCG to provide the Clinical Effectiveness team with a copy of their draft threshold criteria for patients who are historic FES users. **ACTION:** Clinical Effectiveness team to draft a policy recommendation: FES for lower limb dysfunction for review at the January 2020 Committee meeting. **January 2020 Update: Refer to agenda item 6.**
5.7	**Minutes of the Priorities Committee held in November 2019 – Action 11.2 – Any Other Business – TVPC12 Botulinum Toxin A – Paper 19-029** The Clinical Effectiveness team to draft an update to TVPC12 policy to reflect NICE TA605 for the use of botulinum toxin A as a treatment option for chronic sialorrhoea (severe drooling) and circulate for comment. Comments to be received within the 2 week feedback period following issue. **January 2020 Update:** Feedback period has ended, no comments received. Clinical Effectiveness team to issue final recommendation for Governing Body acceptance. **ACTION Closed**

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6.	**Paper 19-032 Policy Update: Functional Electrical Stimulation (FES) for Foot Drop in Conditions of Central Neurological Origin (CNO)**
6.1	A policy update evidence review was presented at the TVPC meeting on 27th November 2019. Clinicians from the FES Centre at Salisbury were in attendance. The Committee felt FES was clinically effective for certain groups of patients, but required more information to aid decision making in the following areas; • Predicted cost implications should the current TVPC policy position of 'not normally funded' be replaced by a threshold policy, • Potential starting and stopping criteria, • A scoring system demonstrating patient benefit, • A physiotherapy opinion from an alternative specialist rehabilitation centre which has experience of using FES, Therefore this topic was bought back to the January meeting for further discussion.
6.2	<u>Cost predictions</u> CE highlighted that the number of patients who may be eligible in the event of adopting a threshold policy is very difficult to establish due to: • Number of conditions which may result in foot drop. • Difficulty in identifying when in disease pathways a patient may benefit and for how long. • Difficulty in gaining accurate local incidence / prevalence data for a wide range of conditions which may cause foot drop. Data was obtained from an additional 2 CCGs (which have policies in place), and used to predict the potential cost implications should a threshold policy be adopted by TVPC. There were a number of caveats to the cost predictions, including differences in demographics between the CCGs, lack of clarity regarding individually or 'bundled' appointment costs, and difficulty with interpreting the coded dataset from FES Centre. In the CCGs used for cost modelling; new patients (2018/19) were 2 (CCG population; 236,000) and 0 (CCG population; 193,000). There were 3 discharges. <u>Starting and stopping criteria</u> Potential starting and stopping criteria were discussed based on the FES Centre referral criteria and the evidence review; further action required (6.3) <u>Outcome measures</u> The CE team advised that: • The use of outcome measures requires consideration of the impact of degenerative disease; for example, patients with MS may continue to derive benefit from an FES device but may show deterioration in outcome measures due to disease progression. • Objective measurement of walking quality is difficult; walking speed has previously been used as a proxy measure. • Quality of life measures are not specific to mobility and increases in score may not be attributable to FES • It is likely that a combination of measures will provide the most useful data. Some measures are validated for use in patients with specific conditions.
6.3	The Committee raised the following issues: • The understanding annual fee for FES provision. • The CCGs used for cost modelling have different demographics (and therefore prevalence of foot drop may differ significantly). • Concern that new patient numbers appeared low. • Possible differences in potential provision depending on patient pathway. • Conflict of interest with provider of service (FES Centre) and subsequently the need for views from alternative assessors. • The likelihood of 'pent up' demand due to previous not normally funded position • The difficulty with defining 'continued benefit' in relation to stopping criteria. • The charge for patients who do not complete the assessment process.

6.4	Following discussion the Committee asked the Clinical Effectiveness team to obtain the following information: • Advice from Oxford Centre for Enablement Physiotherapy Service. • Advice from an out of area Centre providing assessment / provision for FES. • Accurate cost data from the FES Centre in relation to fixed annual costs. • Estimates of potential 'pent up demand' due to current not normally funded position. • Duration of assessment period before a decision is made on appropriateness of provision and the related charges. • Referral, starting and stopping criteria. • Definition of 'continued benefit' **Action: The Clinical Effectiveness team to feedback to the Committee at the next meeting.**
7.	**Policy Update: Circumcision**
7.1	Following discussion at the November 2019 Committee meeting the Clinical Effectiveness team issued a draft updated policy recommendation of TVPC63 Circumcision to Committee members and the attending clinician for comment. The draft policy update separated thresholds for children and adults and identified children as being age 14 and under. Following circulation of the draft policy, the attending clinician provided further feedback suggesting the policy should list indications not normally funded rather than a list of indications that are funded. The main restrictions should be in children with a main aim of not performing a circumcision for religious and cultural reasons, for a tight foreskin, preputial adhesions or recurrent UTIs. Paraphimosis in a child is not an indication except under unusual circumstances. Preputioplasty, should probably be treated as the same as circumcision. In adults it is rare to have patients seek circumcision for religious or cultural reasons so all restrictions for circumcision in adults could be lifted with a simple statement that the operation is not being done for cultural and religious reasons. A clinician from Oxfordshire also provided feedback which was noted by the Committee. The Clinical Effectiveness team provided the Committee with a draft policy identifying where male circumcision or preputioplasty for non-therapeutic reasons would not normally be funded in children and young people under the age of 16 years: • Religious or cultural reasons • A tight foreskin that shows no other signs of pathology i.e. physiological phimosis • A foreskin that is adherent to the glans • Pain in the penis without apparent cause • Less than four severe episodes of balanitis or balanoposthitis which can be managed conservatively for example with emollients, topical steroids, anti-fungals, or antibiotics • Paraphimosis where the foreskin is retracted and cannot be returned back to the end of the penis using conservative measures • Recurrent urinary tract infections (UTIs) • Prevention of sexually transmitted infections Adults Circumcision will not normally be funded for the following indications in adults and young people 16 years or older: • Religious or cultural reasons • Recurrent UTIs • Prevention of sexually transmitted infections

7.1 Cont.	For adults the following management will need to be undertaken prior to circumcision: • For mild to moderate signs of LS also known as balanitis xerotica obliterans (BXO), topical steroids should be used • For mild to moderation pathological phimosis where scarring makes it non retractable, topical steroids should be used • For episodes of balanitis or balanoposthitis occurring less than four times per year, appropriate conservative management for example emollients, topical steroids, anti-fungals, oral antibiotics should be tried. **The Committee asked for the Clinical Effectiveness team to draft an update policy recommendation TVPC63 Circumcision and circulate to the Committee members for comment. Comments to be received within the 2 week feedback period following issue.**
8.	**Paper 19-033 Evidence Review: Repair of divarication recti in women**
8.1	The Thames Valley Priorities Committee requested a review of the interventions for the separation of the abdominal muscles in postnatal women. The CCGs receive regular requests for abdominoplasty to correct the condition, and currently these requests are considered via the Individual Funding Request (IFR) process in line with TVPC16 Aesthetic treatments for adults and children. Over the last 30 months there have been 28 applications for the procedure over all Thames Valley CCGs, 7 of which have been approved. There is some local variation in the agreed cases. It was also noted that some applications are embedded as hernia referrals. Divarication or diastasis of the rectus abdominus muscles (DRAM or DRA) describes the separation of the recti, usually as a result of the thinning and stretching of the fibrous structure that runs down the midline of the abdomen (linea alba). It is very common in pregnancy and postnatally and is the result of the hormonal or mechanical stresses of pregnancy. Approximately 50% of women postnatally at 6 weeks still may have it. Divarication may exist with or without the presence of protrusion of the abdominal contents. The abdominal bulge, however, is not a true hernia, with no recognisable risk of strangulation or incarceration of the contents. There are no national guidelines. NICE CG37 (2006, updated 2015) Postnatal care up to 8 weeks after birth and Physical health and wellbeing does not mention the separation of abdominal muscles neither does the NICE Quality Standard for postnatal care QS37 (2013, updated 2015). Evidence for interventions for DRAM was lacking in both quantity and quality. There is lack of consensus on classification of DRAM, methods of measurement and definition of when the condition is pathologic. The natural resolution of DRAM is also not well understood. Impact on physical functioning: One SR found weak evidence that DRAM presence may be associated with pelvic organ prolapse and that DRAM width may be associated with health-related quality of life, abdominal muscle strength and severity of low back pain. There was no significant association between the presence of DRAM and lumbo-pelvic pain or incontinence. The most common complication of surgery noted in the literature was the development of a seroma and superficial would infection. Other common complications included haematomas, minor skin necrosis, dehiscence, post-operative pain, nerve damage and recurrence. However, the reported rate varied greatly in the SR available from 0% to as high as 40%. Regarding exercise there is some evidence that that both standard exercise advice and core and deep core stability focused exercise programme postnatally reduced inter recti distance and prevalence of DRAM.

8.2	The clinical input at the meeting noted that there is no real evidence or literature to support the notion that divarication causes major physical problems but it is a very significant cosmetic issue. This is why there are high levels of patient satisfaction after surgery. Surgeons have huge concerns over this big operation, different repair options, the long term consequences (such as mesh use) and risks of surgery. There is no direct evidence of physical benefits post-surgery other than removing the visual bulge. Surgeons do see divarication in men largely when they have recovered from obesity and we don't normally fund that type of correction surgery either.
8.3	The Committee discussed and recommended that due to the lack of evidence and risk surgery for divarication recti in women is not normally funded. Clinical Effectiveness team to add a statement to existing policy TVPC16 Aesthetics treatments for adults and children. **ACTION: Clinical Effectiveness team to draft an update to policy recommendation TVPC16 Aesthetic treatments for adults and children to include a 'not normally funded' statement.** **Post meeting note:** The updated position on divarication of recti as not normally funded, 'no change in commissioning position', has now been added to the TVPC16 Aesthetic treatments for adults and children policy as the statement was already in the TVPC16. This addition was done concurrently to the agreed amendment of Elfornithine and facial hirsutism to avoid repeated policy updates.
9.	**Paper 19-034 – Policy Update: Cannabis-based medicinal products**
9.1	Dr Megan John declared an interest due to involvement in the development of NICE TAGs: Cannabidiol with clobazam for treating seizures associated with Dravet syndrome and Lennox Gastaut syndrome. Confirmed as not material for the Committee decision making.
9.2	Thames Valley CCGs requested a review of cannabis based products for medicinal use (CBPMs) following the change in Misuse of Drugs Regulations when these products were rescheduled from schedule 1 to schedule 2. In November 2018 Thames Valley Priorities Committee (TVPC) recommended that due to the lack of evidence based national guidance and their unlicensed nature, the prescribing of these products and the licensed preparations including Sativex® and Nabilone will not normally be funded until further national advice has been published. In addition, currently TVPC CCGs hold a South Central Priorities Committees (SCPC) statement dated 2009 which states that SCPC have considered the evidence for clinical and cost effectiveness of medicinal cannabinoids in spasticity, chronic pain and other symptoms associated with MS and considered there was insufficient evidence is currently to support their use for any indication and therefore recommend that medicinal cannabinoids for these indications should be low. Sativex® is non-formulary across all TV CCGs; Nabilone is non-formulary for Berkshire West and Oxfordshire CCGs, for restricted use in Buckinghamshire CCG and restricted to use in palliative care in East Berkshire CCG. The Government has formally agreed a definition of cannabis-based product for medicinal use: 1. It contains cannabis, cannabis resin, cannabinol or a cannabinol derivative. 2. It is produced for medicinal use in humans. 3. It is: i. a medicinal product or ii. a substance or preparation for use as an ingredient of a medicinal product or iii. a substance for use in the preparation or manufacture of an ingredient of a medicinal product This definition includes unlicensed products of varying quantities and ratios of delta-9-tetrahydrocannabinol (THC) and cannabidiol (CBD). The law requires that these products be supplied under either the prescription or direction of a clinician on the General Medical Council's Specialist Register. A number of substances are specifically exempted from this definition. This includes Sativex® as well as synthetic dronabinol and nabilone.

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9.2 Cont.	Licensed preparations in the UK available currently are: • Sativex (exempt from the government definition) THC:CBD spray; treatment for symptom improvement in adult patients with moderate to severe spasticity due to multiple sclerosis (MS) who have not responded adequately to other anti-spasticity medication and who demonstrate clinically significant improvement in spasticity related symptoms during an initial trial of therapy • Nabilone: synthetic cannabinoid, licensed for cytotoxic chemotherapy induced nausea and vomiting • Epidyolex: Each ml of oral solution contains 100 mg cannabidiol, licensed for use in conjunction with clobazam for patients with adjunctive therapy of seizures associated with Lennox-Gastaut syndrome (LGS) or Dravet syndrome (DS).
9.3	NICE guideline (NG144) Cannabis-based medicinal products was published in November 2019 The guideline includes all the products the government has moved from schedule 1 to schedule 2 and also includes sativex®, nabilone, plant-derived cannabinoids and, synthetic compounds which are identical in structure to naturally occurring cannabinoids. NICE recommendations include: • for chronic pain, do not offer the following to manage chronic pain in adults: o nabilone o dronabinol o THC (delta-9-tetrahydrocannabinol) o a combination of cannabidiol (CBD) with THC o do not offer CBD to manage chronic pain in adults unless as part of a clinical trial. • For intractable nausea and vomiting: o Consider nabilone as an add-on treatment for adults (18 years and over) with chemotherapy-induced nausea and vomiting which persists with optimised conventional antiemetics o The rationale for this recommendation is that the studies included in the review were of low to very low quality. The majority of the RCTs were downgraded for the risk of bias. Due to these limitations, the guideline committee did not feel they could make strong recommendations. However, based on the effectiveness data, the guideline committee felt these interventions may still have a place in the treatment pathway as an add-on therapy. • Spasticity: o NICE recommends to offer a 4-week trial of THC:CBD spray to treat moderate to severe spasticity in adults with multiple sclerosis, if: ➢ other pharmacological treatments are not effective. ➢ the company provides THC:CBD spray according to its pay-for-responders scheme. o After the 4-week trial, continue with THC:CBD spray if the person has had at least a 20% reduction in spasticity-related symptoms on a 0 to 10 patient-reported numeric rating scale. o treatment with THC:CBD spray should be initiated and supervised by a physician with specialist expertise in treating spasticity due to multiple sclerosis, in line with its marketing authorisation. o The rationale for this recommendation is that the majority of evidence for THC:CBD spray was from recent studies therefore the guideline committee was satisfied that the treatments used previously reflected current practice. The clinical evidence showed improvements in patient-reported spasticity and could not differentiate between adverse events for THC:CBD spray and placebo. Economic modelling showed that THC:CBD spray would offer sufficient QALY gains if reduction in spasticity led to a halving of management costs and acquisition cost of THC:CBD spray (Sativex®) was also

9.3 Cont.	reduced (in addition to the existing pay-for-responders scheme). NICE concluded that a change in list price and a response to treatment of 20% produced an ICER of £24,992/QALY. This is within the £20-£30k per QALY that NICE use for cost effectiveness. The cost of sativex® is currently £300 per unit and appears to have reduced.
9.4	Prescribing in shared care: Initial prescription of cannabis-based medicinal products should be prescribed by a specialist medical practitioner. The marketing authorisation for both Sativex® and nabilone indicates they must be initiated and supervised by a specialist. NICE makes recommendations on shared care agreements. Subsequent prescriptions of cannabis-based medicinal products may be issued by another prescriber as part of a shared care agreement under the direction of the initiating specialist prescriber, if: • shared care is appropriate and in the person's best interest • the person's clinical condition is stable • the other prescriber is confident to make a fully informed prescribing decision about cannabis-based medicinal products Committee members in attendance reinforced the fact that shared care protocols would need to be developed locally and ultimately if the GP does not feel that it is within their competency to prescribe then shared care should be refused.
9.5	Other NICE guidance are the Technology Appraisal TA614 (2019): Cannabidiol for adjuvant treatment of seizures associated with Dravet syndrome and Technology Appraisal TA615 (2019): Cannabidiol with clobazam for treating seizures associated with Lennox–Gastaut syndrome. These technologies are commissioned by NHS England.
9.6	Local activity for 2018/19 shows some prescribing of sativex® and nabilone in primary care across the Thames Valley CCGs. With regards to the financial impact of funding sativex® for spasticity in accordance with NICE, as a guide, using the NICE resource impact template and their suggested approximate number of patients eligible for sativex® across the Thames Valley post 5 years implementation, total annual cost for the first year is estimated to be £360k (this takes into account no charge for 1 pack of 3 vials). An annual cost for year 2 onwards is estimated to be in the region of £405k. However the NICE model assumes maintenance dose of 6.3-6.5 sprays per day. The maximum recommended dose is 12 sprays per day therefore financial impact may be higher than the NICE model estimates.
9.7	The clinicians in attendance via the telephone raised the following points: ➢ The possibility of shared care should not be excluded and the GPs should be allowed to to make their own decisions. ➢ The patients who would need sativex® would be at the level of moderate to severe spasticity so they would be under regular review. It would be more convenient for patients if the GP could repeat the prescription once it has been initiated if necessary. ➢ There is a patient benefit of sativex ®for a limited number of patients if other anti-spasticity medication is not effective or they cannot tolerate it. There would be a limited group of patients who would benefit from this. ➢ A committee member suggested that there may be a fairly large placebo effect of the cannabis related products. ➢ Data may be obtained in order to gain a trust wide view of patients who are on oral medication prior to requiring sativex®. This was considered to be useful by the Committee.

9.8	The Committee had discussions about affordability and adhering to NICE guidelines. The TVPC ethical framework allows consideration of cost and affordability. The evidence appraisal for NICE guidelines must be regarded. The Committee expressed concern that the financial impact of prescribing sativex® is underestimated. The Committee requested further information before recommendation of a commissioning policy. **The Clinical Effectiveness team to gather further information regarding use of Sativex® spray for MS patients and bring to the March Committee meeting for discussion:** • **patient numbers from providers and CCGs.** • **local prevalence of MS** • **why do patients drop out and the number who have already dropped out** • **scales used to monitor spasticity reduction** • **actual % reduction in spasticity (NICE says 20-40%)**
10.	**Paper 19-035 – Policy Update: Grazax® (allergy vaccine seasonal rhinitis)**
10.1	A Policy Statement on Grazax® allergy vaccine for moderate to severe seasonal rhinitis (grass pollen hay fever) considers Grazax to be a low priority and was originally issued in April 2007. This is currently held by Berkshire West, East Berkshire and Buckinghamshire CCGs. In November 2018 Oxfordshire CCG approved Grazax® for specialist prescribing only for paediatric patients with severe allergic rhinitis where other treatments have failed. A review by the Committee has been requested due to the variation in formulary status of Grazax® across the Thames Valley CCGs.
10.2	NICE clinical knowledge summaries, the British National Formulary (BNF) and British Society for Allergy and Clinical Immunology (BSACI) all have guidance recommending specialist-initiated immunotherapy as an alternative treatment in certain patient groups where there is a history of symptoms on allergen exposure and objective confirmation of IgE sensitivity and persistent symptoms despite optimal anti-allergy treatments. NHS England commissions specialised allergy service for patients with severe allergic rhinoconjunctivitis unresponsive to conventional therapy and requiring immunotherapy.
10.3	Six systematic reviews/ meta-analysis, one economic evaluation and two randomised controlled trials were found. Most were robust in their methodology but the studies within them were of varying quality. However, there may be sufficient evidence to support the use Grazax® in the treatment of seasonal allergic rhinitis in certain patients although the magnitude of clinical effectiveness is unclear. There is also evidence that suggests Grazax® is associated with long-term benefits of symptom remission after the treatment is stopped. Taking this into consideration the clinical benefits and its associated adverse reactions of which there are some, it may be reasonable to recommend Grazax® as a treatment option in selected patients whose symptoms are debilitating and persistent despite optimal standard anti-allergy treatments. No evidence of relevance was found to support the use of Pollinex®, a sub-cutaneous version of Grazax®
10.4	The Committee discussed and recommended not commissioning the use of Grazax® for mild to moderate rhinitis. Management and treatment of patients with severe allergic rhinitis are expected to be commissioned by NHS England specialised allergy services. **ACTION: The Clinical Effectiveness team to update Policy Statement 109 Grazax® allergy vaccine for moderate to severe seasonal rhinitis (grass pollen hay fever) with a statement that mild to moderate rhinitis is not normally funded, severe rhinitis is expected to be covered by NHS England specialist commissioning services and circulate for comment. Comments to be received within the 2 week period following issue.**

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11.	**Any Other Business**
11.1	**Lay member representation**
11.1	The Committee lay member representation needs to be revisited as the current nominated lay member has not been able to attend the meetings and acknowledges that this will continue to be the case due to work commitments. The Committee members put forward two potential lay persons, one from Berkshire West and one East Berkshire. **ACTION: Committee members to provide the Clinical Effectiveness team with contact details of current CCG lay members who may be approached to be lay members on the Thames Valley Priorities committee. CE team for explore further with the nominees.**
11.2	**TVPC76 Knee arthroscopy for meniscal tears**
11.2	In January 2018 the Committee recommended a policy for knee arthroscopy for meniscal tears (TVPC76) which has been adopted across the Thames Valley CCGs. The Clinical Effectiveness team has been made aware that some issues have arisen locally with regard to interpretation of policy and application for funding. The current policy includes a statement: • Funding for arthroscopic surgery will be considered for meniscal tears as a result of trauma, after 3 months of unresolved symptoms. Conservative treatments may include non-steroidal anti-inflammatory analgesics (NSAIDs), physiotherapy and exercise. It was agreed at the 2018 meeting, that the use of conservative measures was not a pre requisite for application for surgery. • Arthroscopic surgery for meniscal tears in the degenerate knee, where there is full thickness cartilage loss on both sides of the respective compartment as evidenced by radiological imaging, if not normally funded. This is due to lack of evidence of positive long term outcomes over conservative treatment. A local clinician has suggested some amendments. Amendments are as follows: • In cases where a twisting injury has resulted in an acute locked knee (i.e. with a fixed flexion deformity), with a clinical diagnosis of a bucket handle meniscal tear, arthroscopic surgery is funded and should be performed on an urgent basis. An MRI scan is not essential if it will delay treatment. • In cases where the knee is not locked and regardless of whether this is a clear history of injury, the diagnosis of a meniscal tear should be made with an MRI scan, and funding for arthroscopic surgery will be considered after 3 months of unresolved symptoms. Conservative treatments undertaken during this period, such NSAIDs, physiotherapy and exercise are not a pre-requisite for funding. • Arthroscopic surgery for meniscal tears in the degenerate knee, where there is full thickness cartilage loss on both sides of the respective compartment as evidenced by radiological imaging, is not normally funded. This is due to lack of evidence of positive long term outcomes over conservative treatment.
11.3	The Committee discussed and agreed to a suggestion put forward by a specialist orthopaedic surgeon for the inclusion of an additional point within policy TVPC76 Knee arthroscopy for meniscal tears, as follows: • In cases where a twisting injury has resulted in an acute locked knee (i.e. with a fixed flexion deformity), with a clinical diagnosis of a bucket handle meniscal tear, arthroscopic surgery is funded and should be performed on an urgent basis. An MRI scan is not essential if it will delay treatment. The Committee also agreed to a change of policy name from Knee arthroscopy for meniscal tears to Arthroscopic knee surgery for meniscal tears as it better reflects the method of surgery. The Clinical Effectiveness team will cross-reference policy TVPC76 to the Anterior Cruciate Ligament (ACL) reconstruction policy and other knee policies.

THIS MEETING WAS NON QUORATE

11.3 Cont.	**ACTION: The Clinical Effectiveness team to draft an update to policy TVPC76 as follows:** • **to include where a twisting injury has resulted in an acute locked knee (fixed flexion deformity) with a clinical diagnosis of a bucket handle meniscal tear, arthroscopic surgery is funded and should be performed on an urgent basis. An MRI scan is not essential if it will delay treatment** • **change the policy name to Arthroscopic knee surgery for meniscal tears** • **cross-reference to TVPC83 Anterior Cruciate Ligament (ACL) reconstruction policy and any other knee policies** **The Clinical Effectiveness team to circulate for comment. Comments to be received within the 2 week feedback period following issue.**
11.4	**Sequential use of biologic drugs**
11.4	Regional Medicines Optimisation Committee (RMOC) has published a statement in January 2020 regarding the sequential use of biologic medicines which could affect current TVPC policies. **ACTION: Clinical Effectiveness team to seek advice from Professor Chris Newdick on the interpretation of NICE TAGS and the NHS constitution by the Regional Medicines Optimisation Committee (RMOC) statement, January 2020, for the sequential use of biologic medicines.** **The Clinical Effectiveness team to add this item to 25th March 2020 meeting agenda.**
12.	**Next meeting**
	The next meeting will be **Wednesday 25th March 2020, Jubilee House, Oxford OX4 2LH**
13.	**Meeting Close**
	The Chair thanked everyone for their contributions to the discussions and closed the meeting.