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

Thames Valley Priorities Committee

Minutes of the meeting held Wednesday 25th November 2020

On-line via Microsoft Teams

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
Edward Haxton	Deputy Finance Director	Berkshire West CCG
Diane Hedges	Deputy Chief Executive TVPC Strategic Lead	Oxfordshire CCG
Dr Megan John	GP, East Berkshire CCG Lead	East Berkshire CCG
Catriona Khetyar	Head of Medicines Optimisation	East Berkshire CCG
Gill Manning	Lay representative	East Berkshire
Professor Chris Newdick	Special Advisor – Law	University of Reading
Dr Jacky Payne	GP	Berkshire West CCG
David Pollock	Interface Lead Pharmacist	Berkshire West CCG
Dr Raju Reddy	Secondary Care Consultant	Berkshire West CCG
Dr Karen West	Clinical Director Integration	Buckinghamshire CCG
Jenn Sula-Minns	Observer	Oxfordshire CCG

In Attendance:

Kathryn Markey	Clinical Effectiveness Manager	SCW
Kate Forbes	Clinical Effectiveness Manager	SCW
Funmi Fajemisin	Clinical Services Programme Lead Clinical Policy Implementation	SCW
Aimee Ashby	Assistant Manager: IFR & Case Management	SCW
Rachel Finch – Minute Taker	Clinical Effectiveness Administrator	SCW
Helen Hicks	Observer	SCW

Apologies:

Geoffrey Braham	Lay representative	Berkshire West
Mark Hancock	Medical Director	Oxfordshire Health NHS Foundation Trust
Dr Tina Kenny	Medical Director	Buckinghamshire Healthcare Trust
Dr Janet Lippett	Medical Director	Royal Berkshire Hospital
Lalitha Iyer	Medical Director	East Berkshire CCG
Meghana Pandit	Medical Director	Oxford University Hospital
Dr Mark Sheehan	Special Advisor – Ethics	University of Oxford

Topic Specialists in Attendance for Agenda Items:

Item 6 – Policy Statement: Pelvic Organ Prolapse
Avanti Patil, Consultant, Obs/Gynaecology Urogynaecology Lead, Buckinghamshire Healthcare NHS Trust Matthew Izett, Registrar, Urogynaecology, Oxford University Hospitals NHS Foundation Trust Beverley White, Urogynaecology Specialist Nurse, Oxford University Hospitals NHS Foundation Trust Tiana Howard, Urogynaecology, Specialist Nurse, Oxford University Hospitals NHS Foundation Trust
Item 7 – Policy Update: Ulcerative colitis
Nishant Patodi, Consultant Gastroenterologist, Royal Berkshire NHS Foundation Trust Annamaria di Felice, Senior Pharmacist, Frimley Health NHS Foundation Trust Sarah Cripps, Consultant, Oxford University Hospitals NHS Foundation Trust Dr Oliver Brain, Consultant Gastroenterologist, Oxford University Hospitals NHS Foundation Trust Maire Stapleton, Formulary Manager, Buckinghamshire Healthcare NHS Trust
Item 9 – Functional Electrical Stimulation (FES)
Ellen Armitage, Specialist Physiotherapist, Oxford Centre for Enablement Emma Dodds, Specialist Physiotherapist, Oxford Centre for Enablement Gemma Shuter, Berkshire Healthcare Karen Evans, Berkshire Healthcare

1.	**Welcome & Introductions**
1.1	The Chair opened the meeting and welcomed members of the Committee.
2.	**Apologies for Absence**
2.1	Apologies recorded as above.
3.0	**Declarations of Interest**
3.1	None declared.
4.	**Draft Minutes of the online Priorities Committee meeting held 21st October 2020 – Confirm Accuracy**
4.1	The draft minutes were accepted as a true record of the meeting.
5.	**Draft Minutes of the online Priorities Committee meeting held 21st October 2020 – Matters Arising**
5.1	**Minutes of the Priorities Committee held online in May 2020 – Action 5.5 – Review RMOC Statement sequential use of biologic medicines – Paper 20-001** The Committee to discuss this item further together with the financial impact and the development of a justification statement. **JULY 2020 UPDATE:** CE team experiencing difficulty in obtaining feedback from secondary care providers, most are working on it but are extremely busy at present. CE team to also approach secondary care pharmacists. **September 2020 Update:** Agenda item for November 2020 meeting **October 2020 Update:** Obtaining patient number data for all TVPC CCGs is proving difficult at present. A Berkshire West clinician has indicated offering a 4th biologic provides sufficient flexibility for RA patients. The CE team to provide an update at November 2020 meeting however this item is likely to be deferred until January 2021. **November 2020 Update: Refer to item 8 below**
5.2	**Minutes of the Priorities Committee held online in June 2020 – Action 9.4 – Paper 20-015 – Policy Update: Functional Electrical Stimulation (FES) for foot drop** Clinical Effectiveness team to draft a policy recommendation for Functional Electrical Stimulation for foot drop defining starting / stopping criteria and identifying measurable outcomes, in collaboration with the OCE Specialist Physiotherapists. Clinical Effectiveness team to establish likely referral pathways across the TVPC locality. **October 2020 Update:** In progress, anticipate bringing back to November 2020 meeting. **November 2020 Update: Refer to item 9 below. ACTION Closed**
5.3	**Minutes of the Priorities Committee held online in June 2020 – Action 10.6 – Paper 20-016 – Policy Update: Cannabis- based medicinal products** The Clinical Effectiveness team to contact Provider Trusts for more accurate numbers of patients who currently and will fulfil NICE criteria for treatment with THC:CBD spray (Sativex®). Recalculate the financial impact for Thames Valley CCGs. Liaise with CN to contact NICE. Bring back to the Committee for further discussion. **October 2020 Update:** In progress, revised data being obtained and anticipate being able to provide an update to November 2020 meeting. **November 2020 Update**: Awaiting data from Royal Berkshire Hospital.
5.4	**Minutes of the Priorities Committee held online in July 2020 – Action 8.3 – Paper 20-013: Clinical Feedback: TVPC 59 Policy Update: Management of Female Pelvic Organ Prolapse** Clinical Effectiveness team to circulate draft update to policy TVPC59 The Management of Female Pelvic Organ Prolapse, and the underpinning policy update to specialist clinicians for comment and bring back to November Committee. **October 2020 Update:** In progress, anticipate being back to November 2020 meeting. **November 2020 Update**: Refer to agenda item 6. **ACTION Closed**

5.5	**Minutes of the Priorities Committee held online in October 2020 – Action 12.1 - Paper 20-022: Policy Update: TVPC49 Patients with osteoarthritis (OA); primary hip and knee replacement** The Clinical Effectiveness team to draft an update to policy recommendation TVPC49 Patients with osteoarthritis (OA); primary hip and knee replacement to include reference to MRI as per EBI and circulate for comment. Comments to be received within 2 weeks following issue. **ACTION Complete**
5.6	**Minutes of the Priorities Committee held online in October 2020 – Action 7.5 - Paper 20-023: Policy Update: TVPC15 Ganglion cysts** The Clinical Effectiveness team to draft an update to TVPC15 Ganglion Cysts policy recommendation criteria in line with NHSE EBI recommendation and circulate for comment. Comments to be received within the two week period following issue. **ACTION Complete**
5.7	**Minutes of the Priorities Committee held online in October 2020 – Action 8.6 - Paper 20-024: Policy Update: TVPC 18 Dupuytren's Contracture** The Clinical Effectiveness team to draft an update to TVPC18 Dupuytren's Contracture policy recommendation to include NHSE EBI criteria. Reference to collagenase clostridium histolyticum (CCH) to be removed as it is no longer available in the UK. The TVPC18 position regarding radiation therapy as 'not normally funded' is to be retained. The Clinical Effectiveness team to circulate the draft update for comment. Comments to be received within the two week period following issue. **ACTION Complete**
5.8	**Minutes of the Priorities Committee held online in October 2020 – Action 9.4 - Paper 20-025: Policy Update: TVPC19 Carpal Tunnel Syndrome** The Clinical Effectiveness team to draft an update to TVPC19 Carpal Tunnel Syndrome policy recommendation to reflect the NHSE EBI criteria, with physiotherapy included as an option (but not mandated) intervention. The current TVPC position on NCSs as being not routinely necessary is to remain. The Clinical Effectiveness team to circulate the draft update for comment. Comments to be received within the two week period following issue. **ACTION Complete**
5.9	**Minutes of the Priorities Committee held online in October 2020 – Action 10.1 – Any Other Business - TVPC11g Assisted reproduction policy; point 13.3** The Clinical Effectiveness team to update policy TVPC11g Assisted reproduction; point 13.3 to reflect NHS England specialist commissioning for surgical sperm retrieval and issue for upload to CCG IFR websites on acceptance of the meeting minutes. **ACTION Complete**
5.10	**Minutes of the Priorities Committee held online in October 2020 – Action 10.2 – Any Other Business - Continuous glucose monitoring (CGM) in pregnancy** NHS England long term plan states that by 2021, CGM will be offered to all pregnant women with type 1 diabetes, because of improved neonatal outcomes, deliverable by March 2021. More understanding of the funding mechanism is required in order to update TVPC CGM policy. The Clinical Effectiveness team to add CGM as an item for review at January 2021 meeting. **November 2020 Update:** Local maternity systems will hold the funding and lead this work. The funding has been released to lead CCGs and Neil Lester, Head of Strategic Finance, NHS E and NHS Improvements confirms the money sits with LMS. Funding is available until 2023/24 year on the NHS long term plan. The three maternity providers across BOB will invoice Oxfordshire CCG for their shares once it has been agreed by the local maternity system.

	ACTION: Clinical Effectiveness team to draft an update to policy recommendation TVPC64 Continuous Glucose Monitors and issue to the Committee for comment via email. Comments to be received within 2 weeks of issue.
5.11	**Minutes of the Priorities Committee held online in October 2020 – Action 10.3 – Any Other Business - Future Committee meeting dates** Clinical Effectiveness team to arrange an additional Committee meeting for 24th February 2021. **November 2020 Update:** Proposals for the February meeting are cancelled. Committee meetings for January and March 2021 will be extended by half an hour to 4.30pm**. ACTION Closed**
6.	**Paper 20-027: Clinical Feedback: TVPC 59 Policy Update: Management of Female Pelvic Organ Prolapse**
6.1	In July 2020, the Committee considered a policy update (Paper 20-013) for policy 'TVPC 59 Management of Female Pelvic Organ Prolapse' (2017). A draft policy was subsequently circulated to the Committee which reflected new NICE guidance (2019) and recent publications regarding the use of synthetic mesh in prolapse surgery. The draft policy also included a 'not normally funded' statement for the treatment of pelvic organ prolapse with laser, due to a lack of evidence of clinical and cost effectiveness. Due to the changes, the Committee requested that the draft policy be circulated to specialist clinicians for comment. Following receipt of clinician comments the Committee requested that the draft policy should discussed further at a TVPC meeting.
6.2	Discussion with specialist clinicians: <u>Pelvic floor muscle training (PFMT):</u> NICE guidance differentiates treatment for pelvic organ prolapse depending on the stage. For stages 1 and 2 conservative management is suggested. Feedback from a local clinician suggests that PFMT may only be effective for stage 1. Other clinicians in attendance advised that the evidence base suggests the efficacy of PFMT extends to stage 2. Evidence from Cochrane systematic reviews (SR) and randomised controlled trials (RCT) reviewing cost effectiveness used a cut off of within or around the hymeneal ring to stage prolapse (depending on the classification system this is generally stage 2). The clinicians in attendance raised concern regarding women being referred to secondary care, who had not received physiotherapy from a specialist. Half to a third of prolapse referrals re-triaged during COVID-19 pandemic were diverted to physio services. It was highlighted that women with stage 3-4 prolapse may be inappropriately on waiting lists for PFMT, due to reduced effectiveness in greater stages of prolapse. However the importance of PFMT post operatively was highlighted by the attending clinicians, and that it therefore may be helpful for women with stage 3-4 prolapse to learn PFMT preoperatively. The attending clinicians advised that PFMT should be taught by a specialist women's health physiotherapist. Currently there is not this provision across all Thames Valle CCGs. <u>Pessary:</u> The clinicians in attendance advised that NICE recommends that women's wishes should to be taken into consideration; sexually active women may not wish to trial a pessary. <u>Topical Oestrogen</u>: The Committee were advised that topical oestrogen has a positive impact on the quality of the tissues, recovery and suture healing post operatively. An attending clinician advised that some women are concerned about the risk of cancer and the use of oestrogens. One clinician stated that topical oestrogen should be offered but not mandated due to the limited evidence base and patient concerns regarding cancer. <u>Mesh:</u> Buckinghamshire Healthcare Trust does not offer any mesh procedures for prolapse following guidance published in 2018. The Committee was advised that mesh continues to be used for some prolapse surgery at the OUH.

	Patient decision aids: BW advised that these should be used in secondary care only as they are dependent on the procedure. In addition BW advised that options should be discussed with women in secondary care as staff are best placed to advise regarding procedures involving mesh. Laser procedures: Due to low quality evidence and laser not being current practice, the Committee decided that the 'not normally funded' statement in the draft policy should remain.
6.3	The Committee reviewed the evidence and following consideration of the specialist clinical input, the Committee agreed an update to TVPC 59 Policy Update: Management of Female Pelvic Organ Prolapse (POP) was recommended as follows: • Topical oestrogen to be offered • Pelvic floor muscle training to be provided by Specialist Physiotherapy • Laser treatment is an intervention 'not normally funded' • Maintain statement regarding the use of Mesh in prolapse surgery **ACTION: The Clinical Effectiveness team to draft an update to policy recommendation TVPC 59 Policy Update: Management of Female Pelvic Organ Prolapse and circulate for comment. Comments to be received within 2 weeks following issue.**
7.	**Paper 20-028 – Policy Update: TVPC43: Use of biologic therapies for ulcerative colitis in adults (18 years and over)**
7.1	TVPC43: Use of biologic therapies for ulcerative colitis in adults (18 years and over) (2016) was identified for review. The current policy supports the use initially of one of adalimumab, golimumab and infliximab (anti-TNFs) and after this vedolizumab (targets α4β7 integrin) may be tried. The most cost-effective anti-TNF therapy option is to be offered first line. Due to the lack of evidence to support switching between the therapies, the use of a second anti-TNF is only supported following a documented adverse drug reaction to the first line anti-TNF.
7.2	Since the policy was issued in 2016, two new anti-TNFs have been introduced: ustekinumab and tofacitinib. There are therefore currently 3 anti-TNFs (adalimumab, golimumab, infliximab), 1 inhibitor of IL12 and IL23 (ustekinumab); 1 JAK inhibitor (tofacitinib); vedolizumab (targets α4β7 integrin) with associated NICE Technology Appraisal Guidelines (TAGs) for moderately to severely active ulcerative colitis.
7.3	The British Society of Gastroenterology (BSG) consensus guidelines (2019) suggests that surgery should be discussed as an option for any patient on any therapeutic agent at any part of the pathway. The BSG recommends thatvedolizumab and tofacitinib can be used in induction and maintenance of remission of ulcerative colitis in patients where anti-TNF treatment has failed. It is noted that this guidance was published before ustekinumab was approved by NICE. The BSG suggests that treatment options with failure of an anti-TNF therapy could be to increase the dose, shorten the dosage interval, switch to an alternative anti-TNF, or switch to different class. Decisions will need to be informed by the clinical context and by measurement of serum drug and anti-drug antibody concentrations. The guidelines also suggest that patients with secondary loss of response to anti-TNF therapy may have serum drug and anti-drug antibodies measured to inform appropriate changes in treatment. The pathway produced by the society makes recommendations regarding when to intensify the anti-TNF or when to switch within or out of class.
7.4	Evidence A Healthcare Advanced Database Search (HDAS) for studies published since 2016 only found observational studies and data collected from registries. The studies suggest clinical remission is more likely in patients who have not had an anti-TNF previously. The literature suggests that switching within the class, between class and dose escalation are all strategies for managing treatment failure. Dose escalation is less likely to be required in patients who anti-TNF naive. The studies also suggest that withdrawal of an anti-TNF due to primary and secondary failure was associated with a lower probability of achieving remission with a subsequent anti-TNF.

7.5	Local activity High cost drug data recorded by the provider organisations for 2019/20 total suggests expenditure on biologics and JAK inhibitors for gastroenterology indications is approximately £8m.
7.6	Discussion with the clinicians in attendance Dr Oliver Brain provided an overview of the simplified pathway developed by Royal Berkshire Hospital (RBH) and Oxford University Hospital (OUH). The notes that accompany the pathway indicate that where possible the cheapest drug should be used. Anti-TNF therapy for most patients, but not all, is the first line agent. Buckinghamshire Healthcare Trust pathway is currently draft and attempts to adhere to NICE guidelines and orders drug choice where appropriate in order of cost. The pathway requires further update. Feedback from a Consultant Gastroenterologist, Clinical Director Abdominal Surgery, supports the use of the proposed RBFT/OUH pathway. Since the original policy was written, newer drugs including tofacitinib and ustekinumab are now available and these have a useful place in the management of select patients with difficult ulcerative colitis. Usually these drugs are used in young people who have severe persistent ulcerative colitis and in whom surgery, which is potentially disfiguring and has its own set of long-term complications, is undesirable. The option of third or fourth line therapy is considered in a small number of patients who are exceptional and treatment decisions like these are taken by a multidisciplinary team with IBD consultants present. Discussion in the presence of specialists raised the following points: • intolerance which prevents ongoing treatment is relatively uncommon; most biologics are very well tolerated. This is slightly less clear for tofacitinib. Intolerances are related to the development of antidrug antibodies and the higher risk of infusion reactions that occur due to this. • intolerances to anti-TNFs may be generic or specific to that particular anti-TNF. An infusion reaction to infliximab does not indicate that another anti-TNF is unsuitable. If a patient has had a primary non-response and their drug levels are good it is not effective to switch within class. If a patient has had a primary response, secondary loss of response or an intolerance then drug and antibody levels need to be analysed to ascertain whether the patient is tolerant to immunomodulators. This will enable a decision to be made regarding a switch within class or out of class. Another anti-TNF should definitely not be used when a patient has had a primary non-response to the first anti-TNF. • to note, none of these pathways (RBH/OUH) reflect current concerns about the use of immunomodulators and COVID-19. • it is important that any guidance states that accurate monitoring is performed whenever a drug is commenced, to ascertain effectiveness and that stopping it is based on objective parameters. A subsequent biologic is less cost effective against the original drug; whichever drug is used first is statistically, is the more effective. This does not mean a 2nd, 3rd or 4th drug is not going to be effective, it just means it is slightly less likely to work. The costs of surgery are not inconsiderable, plus there are costs to personal quality of life. Acute/severe patients are at the highest risk of colectomy and the way the biologic drugs are being used has definitely reduced the colectomy rate. The Committee heard from the local specialists that locally this is not going to impact on cost as clinicians are ensuring that appropriate decisions are being made for patients.
7.7	Committee discussion A discussion was held regarding the options for policy recommendations. The Committee suggested that a pragmatic view should be taken and if the costs are not going to increase significantly the option to transfer between different categories of drugs could be allowed.

	The policy should state that if there is no clinical reason for specific drug selection, then the most cost effective should be chosen. The policy should also indicate that ustekinumab cannot be used 1st line and be used as recommended by NICE. The policy could make a recommendation about the number of drug types that can be used i.e. no more than one drug from each class unless there are extenuating circumstances, for example, an injection reaction. A Committee member suggested that a policy stating when dose escalation is appropriate will be useful as such requests are received via the individual funding request (IFR) process.
7.8	Having reviewed the evidence and considered the specialist clinician feedback, the Committee agreed to recommend that a modified version of a combination of the presented pathways is drafted, taking account of Committee considerations and send to local consultants for comment. **ACTION: The Clinical Effectiveness team to draft an update to TVPC43: Use of biologic therapies for ulcerative colitis in adults (18 years and over) policy recommendation and circulate to local consultants for comment in the first instance. Post meeting note, this will be discussed at a subsequent TVPC meeting.**
8.	**Paper 20-029 – RMOC Policy Statement for the sequential use of biologic medicines**
8.1	Unfortunately due to time constraints this item is deferred until January 2021. **ACTION: The Clinical Effectiveness team to add RMOC Policy Statement for the sequential use of biologic medicines as an agenda item for 27th January 2021 meeting.**
9.	**Paper 20-030 – Policy Update: TVPC62 Functional Electrical Stimulation (FES)**
9.1	The current TVPC policy for the provision of FES relates to upper and lower limb dysfunction of Central Neurological Origin (CNO); the policy position is that FES is not normally funded. In November 2019 a policy update review was presented to the Committee. The Committee agreed that although the evidence was limited, for some patients with drop foot the device appears to be clinically effective. At the TVPC meeting in September 2020 the Committee was presented with cost estimates for three scenarios based on different referral rates. In all scenarios, costs were predicted to plateau at 5 years due to drop out rates. The Committee asked the Oxford Centre for Enablement (OCE) Specialist Physiotherapists in collaboration with the Clinical Effectiveness Team (CE) to draft a threshold policy recommendation for the provision of FES for foot drop that defines starting / stopping criteria and measurable outcomes. In addition, the Committee requested information on possible referral pathways across the TVPC locality. Contact with services across Thames Valley CCGs highlighted that that staff training in FES has lapsed and assessment devices are dated. Additionally both Community Neurological Rehabilitation Service (Buckinghamshire) and Neurological Rehabilitation & Specialist Physiotherapist (West Berkshire) highlight that whilst existing patients could be accommodated for FES assessment, new work streams solely for assessment of FES could not be managed with existing staff arrangements.
9.2	Discussion with specialist clinicians: The clinicians gave feedback regarding their services: Oxford Centre for Enablement (OCE) have 2 trained clinicians and 3 devices. It was reported that Berkshire Healthcare NHS Foundation Trust has no devices that are useable and training is out of date. Additionally the service covers a wide geographical area. For service set up, the costs are: £200 for the FES training course; £700 for the wired device; £900 for the wireless device(excluding VAT).

	The draft policy was discussed. It was highlighted that 'aesthetics' as a reason for an ankle foot orthosis (AFO) being discontinued should be removed, as this would infer that an FES could be provided on aesthetic grounds. It was highlighted that there were differences in the referral criteria and starting and stopping criteria in relation to the wording of walking difficulty. The cost implication of setting up new clinical pathways for assessment and provision was discussed. Clinical pathways were originally reviewed in an attempt to anticipate demand should the policy change from 'not normally funded' to threshold criteria and to review whether specialist physiotherapists would ensure appropriateness of referrals to the Salisbury Centre (thus reducing cost to CCGs). The Committee agreed that the setting up of clinical pathways across the Thames Valley CCGs was considered to be implementation rather than a policy recommendation. However the Committee acknowledged that differences in local pathways and resulting costs could result in the CCGs adopting a different stance from the TVPC policy recommendation for provision of FES for foot drop. The Committee acknowledged that this was a risk and that co-ordination across the system should be considered. The Committee agreed that the current policy should be changed from an intervention not normally funded to threshold criteria for those with foot drop as a result of a condition of neurological origin
9.3	The Committee considered the evidence and specialist clinical feedback and agreed an update to TVPC62 Functional Electrical Stimulation (FES) for Upper and Lower Limb Dysfunction of Central Neurological Origin (CNO) in line with the draft policy recommendation circulated to the Committee, to be amended as follows: • Removal of aesthetics as a reason for discontinuation of AFO • Revision of wording of walking ability to ensure consistency with starting and stopping criteria. In addition when submitting the updated policy recommendation for governing body ratification the accompanying paperwork is to highlight that there is a risk that TVPC CCGs may reach different decisions regarding the implementation of the policy and that co-ordination across the system should be considered. **ACTION: The Clinical Effectiveness team to draft an update to TVPC62 Functional Electrical Stimulation (FES) for Upper and Lower Limb Dysfunction of Central Neurological Origin (CNO) policy recommendation and starting and stopping criteria and circulate for comment. Comments to be received within the 2 week period following issue.**
10.	**Any Other Business**
10.1	**Flash Glucose Monitors (Flash) for people living with diabetes and a learning disability**
10.1	New directive from NHS England (NHSE) states that all patients with a learning disability and diabetes and using insulin should be offered a flash glucose monitor. NHS E states that funding has been identified until the end of March 2021 when the responsibility for providing Flash will revert to CCGs. A Committee member suggested that patients with autism with diabetes and no learning disability will also need to be referred to in the updated policy. **ACTION: The Clinical Effectiveness team to draft an update to TVPC73 Flash Glucose Monitoring System (Freestyle Libre®) policy recommendation and circulate via email for comment. Comments to be received within the 2 week period following issue.**
10.2	**TVPC scoping workshop and draft work programme schedule for 2021/22**
10.2	A copy of the scoping workshop output together with a copy of the draft work programme for 2021/22 year is to be distributed with the draft minutes of this meeting.

	ACTION: The Clinical Effectiveness team to distribute the draft TVPC work programme for 2021/22 with the draft minutes of this meeting.
10.3	**Evidence Based Intervention (EBI) phase 2 (Draft)**
10.3	**ACTION: The Clinical Effectiveness team to draft updates to TVPC policies with reference to EBI list 2 diagnostic guidance. The Clinical Effectiveness team to draft an interim statement for the remaining EBI list 2 diagnostic policies.** **Post meeting note, EBI 2 guidance has been published in December ,therefore further discussion will be scheduled at a TVPC meeting.**
11.	**Next meeting**
	The next online meeting will be held on **Wednesday 27th January 2020 from 2-4.30pm**
12.	**Meeting Close**
	The Chair thanked everyone for their contributions to the discussions and closed the meeting.