*Berkshire West Clinical Commissioning Group*
*Buckinghamshire Clinical Commissioning Group*
*Frimley Clinical Commissioning Group*
*Oxfordshire Clinical Commissioning Group*

# Thames Valley Priorities Committee

## Minutes of the meeting held Wednesday 22nd September 2021

## On-line via Microsoft Teams

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| Alan Penn | Lay Member Chair | Thames Valley Priorities Committee |
| Sue Carter | Clinical Effectiveness Manager (CCG) | NHS Oxfordshire CCG |
| Dr Raju Reddy | Secondary Care Consultant | NHS Berkshire West CCG |
| Edward Haxton | Deputy Finance Director | NHS Berkshire West CCG |
| Emeritus Professor Chris Newdick | Special Advisor – Law | University of Reading |
| David Pollock | Interface Lead Pharmacist | NHS Berkshire West CCG |
| Mark Sheehan | Special Advisor – Ethics | University of Oxford |
| Gill Manning | Lay representative | NHS Frimley CCG |
| Dr Jacky Payne | GP, Berkshire West | NHS Berkshire West CCG |
| Dr Karen West | Clinical Director Integration | NHS Buckinghamshire CCG |
| Dr Megan John | GP, Frimley Lead | NHS Frimley CCG |
| Jenn Sula-Minns | Prior Approvals Manager | NHS Oxfordshire CCG |
| Mohammed Asghar | Prescribing Governance Lead | Frimley Health and Care ICS |

In Attendance:

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| Kathryn Markey | Clinical Effectiveness Manager | SCW CSU |
| Naomi Scott | Clinical Effectiveness Manager | SCW CSU |
| Katie Newens | Clinical Effectiveness Manager | SCW CSU |
| Tiina Korhonen | Clinical Effectiveness Lead | SCW CSU |
| Helen Hicks - minutes | Clinical Effectiveness Administrator | SCW CSU |
| Marion Mason | Interim Head of Prior Approval and Assurance | SCW CSU |

Apologies:

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| Funmi Fajemisin | Clinical Services Programme Lead Clinical Policy Implementation | SCW CSU |
| Dr Janet Lippett | Chief Medical Officer | Royal Berkshire NHS Foundation Trust |
| Matthew Covill | Director of Business Planning | Oxford University Hospital NHS Foundation Trust |
| Andrew McLaren | Deputy Medical Director | Buckinghamshire Health NHS Trust |
| Lalitha Iyer | Medical Director | Frimley CCG |
| Professor Meghana Pandit | Medical Director | Oxford University Hospital NHS Foundation Trust |
| Fiona Slevin-Brown | Director of Strategy and Operations | Frimley CCG |
| Karl Marlowe | Medical Director | Oxford Health NHS Trust |
| Dr Andrew Brent | Director of Clinical Improvement | Oxford University Hospital Foundation NHS Trust |

Topic Specialists in Attendance for Agenda Items:

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| Item – Policy TVPC83 Anterior Cruciate Ligament (ACL) reconstruction |
| Carl Davies, Director of MSK, Berkshire West Integrated Care Partnership (ICP) |
| Item 9 – Benign prostate hyperplasia (BPH) pathway to include review of Evidence based intervention list 2: 2I — Surgical intervention for benign prostatic hyperplasia |
| Stephen Mitchell, Consultant Urological surgeon, Buckinghamshire Healthcare NHS Trust<br>Rob Gray, Consultant Urological surgeon, Buckinghamshire Healthcare NHS Trust<br>Musaab Yassin, Consultant Urologist and Andrologist, Oxford University Hospital NHS Foundation Trust<br>Christopher Blick, Consultant Urological surgeon, Royal Berkshire NHS Foundation Trust<br>Mark Little, Consultant Diagnostic and Interventional Radiologist, Royal Berkshire NHS Foundation Trust |
| Item 10 - Evidence based intervention list 2: 2CC Prostate-specific antigen (PSA) test |
| Simon Brewster, Consultant Urological surgeon, Oxford University Hospital NHS Foundation Trust |
| Item 11 - Evidence based intervention list 2: Surgical removal of kidney stones |
| Kumar Sunil, Consultant Urological Surgeon, Royal Berkshire NHS Foundation trust |
| Item 12 - Evidence based intervention list 2: 2M Endoscopy; 2N & 2O Colonoscopy for cancer surveillance |
| James East, Consultant Gastroenterologist, Oxford University Hospital NHS Foundation Trust |

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| **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.** | **Declarations of Interest** |
| **3.1** | KM declared a ruptured ACL and surgery for meniscal tear damage. |
| **4.** | **Draft Minutes of the online Priorities Committee meeting held 28th July 2021 – Confirm Accuracy** |
| **4.1** | The following amendments are required to the draft minutes:<br>• Attendance - bank staff to be removed for Christina Maslen<br>• Item 8.3 – sentence 'This could equate to approximately £800k per year for Thames Valley CCGs' to be removed as it is inaccurate<br>• Item 8.4 – option 1 and option 2 insertion of the word 'between' to read of between 6/9 and 9/96<br>• Item 8.5 – RR commented that the content is not representative of the concerns and queries raised regarding lack of financial data. No data were available on how many patients are presenting for treatment with an Anti-VEGF agent for one seeing eye. The scale of the issue is currently unknown and therefore the Committee was unable to make a recommendation. This led to the Committee recommending the request for a business case to inform discussions at a future meeting. The Chair suggested that these minutes capture the concern and financial discussions. Further consideration by the Committee will be scheduled when more data are available. This was agreed by the Committee.<br>• Item 10.1 - amend Frimley ICS to Frimley CCG<br>Once amendments have been made the Committee accepted the minutes as a true record of the meeting. |
| **5.** | **Draft Minutes of the online Priorities Committee meeting held 26th May 2021 – Matters Arising** |
| **5.1** | **The July 2021 meeting was not quorate. Draft minutes were circulated and feedback received.** Buckinghamshire CCG accepted the policy recommendations except for proposed Policy 83 Anterior Cruciate Ligament (ACL) reconstruction. This will be discussed at agenda item 7. |
| **5.2** | **Draft Minutes of the online Priorities Committee meeting held 26th May 2021 – Action 4.2 TVPC49 Patients with osteoarthritis (OA); primary hip and knee replacement**<br>Clinical Effectiveness team to update and circulate the policy statement. **Action: Complete** |
| **5.3** | **Draft Minutes of the online Priorities Committee meeting held 26th May 2021 – Action 4.4 Policy 83 Anterior Cruciate Ligament (ACL) reconstruction**<br>Clinical Effectiveness team to update and circulate the draft policy statement as outlined above. **Action: Complete - agenda item 7** |
| **5.4** | **Draft Minutes of the online Priorities Committee meeting held 26th May 2021 – Action 6.6 Posterior tibial nerve stimulation in paediatric patients**<br>Clinical Effectiveness team to contact specialist in attendance (MB) for further evidence and patient data.<br>July 2021 update: KM advised the specialist in attendance of the Committee decisions and requested further evidence and patient data. No response received, KM to follow up within a few months.<br>**September 2021 update**: KM to make further contact with clinicians in due course. |
| **5.5** | **Draft Minutes of the online Priorities Committee meeting held 26th May 2021 – Action 6.11 Policy update programme TVPC20 Otitis Media with effusion in children under 12** |

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| | The Committee queried the financial implications of adopting the wider criteria outlined in EBI phase 2 guidance and requested further information.<br>Action: Clinical Effectiveness team to investigate the financial implications of adopting EBI phase 2 guidance.<br>July 2021 update**:** to be discussed at September 2021 Committee meeting.<br>**September 2021 update: Complete – agenda item 8** |
| **5.6** | **Draft Minutes of the online Priorities Committee meeting held 26th May 2021 – Action 6.13 Horizon scanning.** The following actions were agreed:<br>➢ Medical technologies guidance (update) [MTG53] The PLASMA system for transurethral resection and haemostasis of the prostate<br>Action: To include this as part of the review of a Benign Prostatic Hyperplasia (BPH) pathway as scheduled.<br>➢ Technology appraisal guidance [TA672] Brolucizumab for treating wet age-related macular degeneration<br>This was discussed at the meeting in July 2021 and associated TVPC policy was updated. |
| **5.7** | **Draft Minutes of the online Priorities Committee meeting held 26th May 2021 – Action 7.2 Proposed adoption of interim policy statement: Use of biological and immunodulatory therapies in the treatment of MODERATE Rheumatoid Arthritis (RA)**<br>Clinical Effectiveness team to update and circulate the policy statement as outlined above.<br>**Action: Complete** |
| **5.8** | **Draft Minutes of the online Priorities Committee meeting held 26th May 2021 – Action 8.6 Anti-VEGF for AMD in patients with only 'one seeing eye'**<br>Clinical Effectiveness team to explore the possibility of requesting a business case from the Ophthalmology Consultants.<br>**September 2021 update:** KM has written to the Consultants for further information and the topic will be rescheduled TBC. |
| **5.9** | **Draft Minutes of the online Priorities Committee meeting held 26th May 2021 – Action 9.6 Review of brolucizumab for treating wet age-related macular degeneration and update to TVPC45 Sequential use of biologic therapy in Ophthalmology**<br>Clinical Effectiveness team to update the current policy and circulate the interim policy statement as outlined above. **Action: Complete** |
| **5.10** | **Draft Minutes of the online Priorities Committee meeting held 26th May 2021 – Action 10.1 ToR; SOP; Ethical Framework**<br>Discussions on the documents to be included in the workshop. **Action: Complete**<br>Action: Clinical Effectiveness team to update East Berkshire CCG to Frimley CCG. **Action: Complete** |
| **5.11** | **Draft Minutes of the online Priorities Committee meeting held 26th May 2021 – Action 11.1 Policy update programme: 4 policies to be updated (with/without minor changes) or scheduled for further discussion**<br>TVPC 29 Dilatation and curettage for abnormal uterine bleeding v1.2<br>Clinical Effectiveness team to update and circulate the policy statement as outlined above.<br>**Action: Complete**<br>TVPC 32 Ultrasound guided injections for hip pain<br>Clinical Effectiveness team to update and circulate the policy statement as outlined above.<br>**Action: Complete**<br>TVPC 33 Surgical treatment of femoro acetabular hip impingement surgery v1.1<br>Clinical Effectiveness team to update and circulate the policy statement as outlined above.<br>**Action: Complete**<br>TVPC 76 Arthroscopic Knee Surgery for Meniscal Tears v2<br>Clinical Effectiveness team to update and circulate the policy statement as outlined above.<br>**Action: Complete** |

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| **5.12** | **Draft Minutes of the online Priorities Committee meeting held 26th May 2021 – Action 12.1 Annual Workshop**<br>Clinical Effectiveness team to email potential dates to Committee members. **Action: workshop confirmed for Thursday 2nd December 2021, 2 – 4.30pm. Complete** |
| **6.** | **Declaration of Interest (DOI) Process** |
| **6.1** | The Anti-VEGF for AMD in patients with only 'one seeing eye' paper was presented to the Committee at the July TVPC meeting by a Clinical Effectiveness (CE) manager with 'only one seeing eye'. This was declared during the meeting. Following concerns raised about the potential bias, feedback from the Committee was requested regarding whether a re-presentation of the paper is required or if the paper can be reconsidered as a consequence of the requested business case. Members advised that the paper should be brought back to a future meeting with the business case.<br><br>Discussion Points:<br>• Review paper was written and presented by a member of staff who made a declaration of interest, of which some committee members felt constituted a conflict of interest.<br>• The paper had a different format to that usually presented; it was raised that this could perpetuate the conflict of interest.<br>• Additionally, a committee member shared concern regarding motivational reasoning. This is where one attempts to think through to an obvious particular conclusion. This can be sub-conscious.<br>• There was an opportunity to avoid this conflict by a different team member presenting the item. It is also recognised that people do have different styles of writing.<br>• While personality, style, opinions and views have to be reflected and embraced, the implications and processes of decisions made have to be consistent.<br>• The Committee was advised that the Clinical Effectiveness team has a series of processes in place to ensure Committee reviews are of expected quality and reflect related evidence, including standard operating procedures and internal quality assurance of all draft reports. Members of the team are non-voting members of the Committee as per ToR.<br>• A discussion was held on the materiality and sensitivities of declaration of interests of all Committee members, as well as its recording.<br>• It was noted that DOI by a review paper author and committee members is required.<br>• Previously there have been a variety of declarations in the meeting but it may need to be considered that interests should be declared in advance of the meeting to allow the Chair to review the materiality.<br>• Conflict of interest should not exclude from contribution to meeting, key is how it is managed.<br>• A structure for the DOI can be based on national guidance and CE team will formulate a template which will be circulated with meeting papers.<br><br>The Chair confirmed the Anti-VEGF for AMD in patients with only 'one seeing eye' paper will be required to come back to the Committee for full presentation to be led by a permanent member of the Clinical Effectiveness team with the business case.<br><br>The Chair summarised the discussion regarding the impact and long-term changes for the ToR. Members of the Committee and those who present are to declare any interest in writing prior to the meeting. A DOI form is to be circulated to all attendees as part of the meeting papers for all to state any declarations. The Chair is to view these prior to the meeting.<br>**Action: Terms of reference to be discussed at the workshop on 2nd December 2021.**<br>**Action: Clinical Effectiveness team to produce a DOI form and circulate with meeting papers prior to future meetings.** |

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| **7.** | **Policy TVPC83 Anterior Cruciate Ligament (ACL) reconstruction** |
| **7.1** | At the July meeting CD presented a proposed policy update for ACL reconstruction. Following the meeting, a draft policy was circulated for comments. Representatives from Buckinghamshire CCG expressed concerns about the age thresholds included in the proposed policy. It was decided that for transparency to bring the discussions back to the Committee. The options were to remove age completely and ensure the policy provides a level of clinical decision making or maintain the age thresholds and make it clear that there are differences in prognosis and outcomes for patients depending on age. At the July meeting it was decided to maintain age thresholds to keep the policy as straightforward as possible. |
| **7.2** | Discussion points:<br>The Committee heard that there are only slight differences in proposed criteria for patients under and over 60 yrs. The proposed policy states that patients over 60 years have to undergo a 6 month rehabilitation programme whereas patients under 60 years have to undergo a 3 month rehabilitation programme. The evidence is very clear for ACL rupture that there are good outcomes achieved with rehabilitation. The policy has a purpose of clinically appropriate management which does not necessarily avoid surgery. It was suggested that the proposed policy is amended to include 2 sets of criteria for patients over the age of 18: those who require rapid access to surgery and those who do not. For the latter, a 3-6 month rehabilitation programme is to be undertaken and be determined by the patient and clinician. |
| **7.3** | The Committee reviewed the proposed changes and following a discussion agreed to remove the age groups and include two sets of criteria for those patients over 18 years. For those who do not meet the criteria for rapid access to surgery, the rehabilitation programme is to be amended to 3 – 6 months to allow for decision to be assessed on a case-by-case basis.<br>**Action: Clinical Effectiveness team to update and circulate the policy statement as outlined above.** |
| **8.** | **Policy TVPC20 Otitis Media with effusion in children under 12** |

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| **8.1** | A proposed update to TVPC20 Otitis Media with effusion in children under 12 was first presented to the Committee at the May Priorities Committee. In May, the Committee queried the potential financial implications of adopting wider threshold criteria for adjuvant adenoidectomy as outlined in Evidence based Interventions (EBI) list 2 guidance. The current paper provides cost estimates for funding adjuvant adenoidectomy based on the criteria: 'The child is undergoing surgery for re-insertion of grommets due to recurrence of previously surgically treated otitis media with effusion'. Individual Funding Request (IFR) data suggested that demand for this patient group is low. The estimated additional annual cost of removing adenoids in all patients who are likely to undergo re-insertion of grommets was modest, at £20,234 (<12y) to £30,016 (<18y). As the EBI guidance refers to children under 18 as opposed to under 12 as for the current policy, the Committee was also asked if they wished to broaden the age range of the policy. |
| **8.2** | The Committee reviewed the guidance and following a discussion agreed to adopt the both EBI guidelines in full, broaden the age range of the policy and update the title of the policy to ensure it is aligned with the new guidance.<br>**Action: Clinical Effectiveness team to update and circulate the policy statement as outlined above.** |
| **9.** | **Benign prostate hyperplasia (BPH) pathway to include review of Evidence based intervention list (EBI) 2: 2I — Surgical intervention for benign prostatic hyperplasia;** |
| **9.1** | At present there is no TVPC policy for the treatment of lower urinary tract symptoms (LUTS) caused by Benign prostatic hyperplasia (BPH). The treatment pathway review was requested due to identified demand and capacity issues and recently published national Evidence Based Intervention (EBI) guidance.<br><br>Recommendations for the management of LUTS caused by BPH are included in EBI list 2. This recommends a stepwise approach starting with watchful waiting and conservative management before progressing to drug treatments and then surgery if severe symptoms persisted. In terms of surgical modalities EBI recommends that:<br><br>• Transurethral resection of the prostate (TURP), Transurethral vaporization of the prostate (TUVP, including laser prostatic vaporisation) or Holmium laser enucleation of the prostate (HoLEP) should be offered to men with voiding LUTS presumed secondary to BPH.<br>• HoLEP should be performed within centres specialising in the technique, or where mentorship arrangements are in place.<br>• The UroLift system relieves lower urinary tract symptoms while avoiding the risk to sexual function and should be considered as an alternative to current surgical procedures for use in a day-case setting in men who are aged 50 years and older and who have a prostate of less than 100 ml without an obstructing middle lobe.<br>• Transurethral incision of the prostate (TUIP) should be offered to men with a prostate estimated to be smaller than 30ml.<br>• Open prostatectomy should only be offered as an alternative to endoscopic surgery, to men with prostates estimated to be larger than 80-100ml.<br>• Transurethral needle ablation, transurethral microwave thermotherapy, high-intensity focused ultrasound, transurethral ethanol ablation of the prostate should not be offered as alternative surgical treatments for voiding LUTS presumed secondary to BPH.<br><br>NICE has published Medical Technologies Guidance (MTGs) for Urolift, Greenlight, Rezum and the TURIs system. NICE has published Interventional procedure Guidance (IPGs) for Urolift, Rezum, PAE, HoLEP, Transurethral electrovaporisation of the prostate that support the use of |

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| | the treatment provided that normal arrangements are in place for clinical governance, consent and audit.<br><br>The EBI programme monitors overall surgical activity for the treatment of LUTS caused by BPH, it does not identify activity by specific interventions. Data for TVPC CCGs demonstrates that TURP is the most commonly used procedure. NICE MTG cost-effectiveness analyses found Urolift and Rezum to be cost saving per patient compared to TURP and HoLEP. Comparisons between UroLift, Rezum and Greenlight suggest that they are similar costs. Local data found costs of procedures to be generally similar, with open prostatectomy being the most expensive and TUIP being least expensive.<br><br>There are operational implications for some of the surgical options. Greenlight, UroLift, Rezum and Prostatic arterial embolisation (PAE) have the potential to be performed as day case procedures, potentially reducing demand on bed capacity. PAE is a radiological procedure and therefore does not require a urology theatre. Urolift has the potential to be performed as an outpatient procedure.<br><br>Recommendations were made for a commissioning policy for the treatment of LUTS caused by BPH, including recommendations for surgical treatment options including TURP, open prostatectomy, TUIP, TUVP, HoLEP, Urolift, transurethral needle ablation, transurethral microwave thermotherapy, high-intensity focused ultrasound and transurethral ethanol ablation of the prostate. |
| **9.2** | Options for consideration<br>The Committee considered if the following interventions should be included within the recommended commissioning policy.<br>• **Rezum** - Although mentioned within EBI, no recommendations for Rezum were made. NICE has produced an MTG noting that it may be a cost-effective treatment. It remains under investigation by the EAU. There is currently no trial evidence with an active comparator, all comparative evidence is limited to sham.<br>• **Prostatic artery embolisation (PAE)** – This is not included in recommendations from EBI and current NICE guidance is limited to an IPG. The EAU notes that efficacy evidence for PAE is limited and outcomes are less optimal compared to other treatment options. An evidence review of trial data since NICE published the IPG found PAE to have similar urological outcomes to TURP and may be less likely to result in ejaculatory disorders but is likely to have a higher retreatment rate. It has the advantage of being a radiological procedure that can be performed as a day case with lower anaesthesia requirements<br>• **Urolift** – During consultation local specialists requested that this procedure was not limited to patients over 50 years<br>• **Open prostatectomy –** During consultation local specialists suggested that open prostatectomy was only required for patients with very large prostates |
| **9.3** | The following points were discussed:<br>The Committee heard from local specialists that open prostatectomy is not often performed in current clinical practice as other treatments are now available for larger prostates, but that the option was still valued.<br>➢ The Committee heard from local specialists that PAE is being used regularly for patients with large prostates, especially those with complications such as prostate bleeding and catheter dependency or when they are not suitable for other procedures. Local audits have found that the treatment has good outcomes.<br>➢ The Committee heard from local specialists that Rezum is being offered under local anesthetic and it has the potential to be offered in an outpatient setting. One specialist noted the absence of long-term data, but it was suggested that long term data will be available soon. |

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| | ➢ The committee heard from a local specialist that there are patients under the age of 50 years who request Urolift, but that this is not common.<br>➢ A committee member asked about the financial implications of the proposed policy. Specialists confirmed that the proposed policy reflected current local practice and was not anticipated to result in a significant budget impact.<br>➢ A brief discussion was held regarding alpha-blocker/PDE5is but the appropriate use of these drugs can be managed by a formulary and therefore is considered to be outside of the scope of a policy recommendation. |
| **9.4** | The Committee reviewed the guidance and following a discussion agreed to include PAE and Rezum as surgical treatment options within the proposed policy.<br>**Action: Clinical Effectiveness team to update and circulate the policy statement as outlined above.** |
| **10.** | **Evidence based intervention (EBI) list 2: 2CC Prostate-specific antigen (PSA) test** |
| **10.1** | Recommendations for the use of PSA testing are included within list 2 of the EBI program. This recommended PSA testing for:<br>• Asymptomatic men over age 40 who are at higher risk of prostate cancer due if they are Black and/or have a family history of prostate cancer<br>• Men aged over 50 where there is a clinical suspicion of prostate cancer, such as<br>  • Lower urinary tract symptoms (LUTS)<br>  • Erectile dysfunction.<br>  • Visible haematuria.<br>  • Unexplained symptoms that could be due to advanced prostate cancer<br>It is also recommended that where PSA test results are mildly raised above the age specific range for an individual patient, it may be appropriate to repeat the test within two to three months to monitor the trend.<br><br>PSA testing for prostate cancer is not recommended in asymptomatic men and should be avoided if the man has:<br>  • An active or recent urinary infection (PSA may remain raised for many months).<br>  • Had a prostate biopsy in the previous 6 weeks both of which are likely to raise PSA and give a false positive result.<br><br>The recommendations from EBI are generally in line with current NICE guidelines (CG12 and CG97). The current NICE Clinical Knowledge summary recommends testing any men over the age of 50 who request a PSA test. The British Medical Journal (BMJ) best practice guidelines recommend against PSA testing. The recommendations of the European Association of Urology differ from EBI as it recommends testing for:<br>• All men aged over 50 years - not just those with specific symptoms<br>• Black men, and men with a family history of prostate cancer from 45 years old rather than 40<br>• Men carrying BRCA2 mutations – a criteria not included in EBI<br>The EBI programme was unable to identify coding for the procedure, diagnoses or indications in relation to PSA testing and therefore there is no activity monitoring for this recommendation. Local specialists recommend that a policy should be in line with EBI with minor amendments. |
| **10.2** | Discussion points:<br>➢ A member of the Committee raised concerns that the policy did not specify how frequently men could request a PSA test. A local specialist noted that the Prostate Cancer Risk Management Programme allows men to request a test as long as they are appropriately counselled and was not aware of a limit to this.<br>➢ It was noted that EBI was unable to identify diagnosis and procedure codes and therefore produce activity figures for PSA testing, therefore no financial estimations were possible. |

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| | ➢ The Committee considered that the costs of PSA testing is not limited to the cost of the test, but also included GP and nurse time.<br>➢ It was noted that the recommendations from EBI are national guidelines. |
| **10.3** | The Committee reviewed the guidance and following a discussion agreed to adopt the recommendation to offer PSA testing if requested to men over 50 or if they meet the stated criteria.<br>**Action: Clinical Effectiveness team to update and circulate the policy statement as outlined above.**<br>**Action: Clinical Effectiveness team to review the policy when new evidence and/ or guidance is published that may inform discussions around repeat testing.** |
| **11.** | **Evidence based intervention list (EBI) 2: Surgical removal of kidney stones** |
| **11.1** | The surgical removal of kidney stones is included in list 2 of the EBI recommendations. This refers to NICE Guideline 118 (Renal and ureteric stones: Assessment and management) and gives recommendations for treatment options including watchful waiting, ureteroscopy (URS), shockwave lithotripsy (SWL) and percutaneous nephrolithotomy (PCNL), based on the size of the renal or ureteric stone.<br><br>The coding used to capture activity data by EBI for this intervention captures URS and PCNL but not SWL. Specialists indicate that activity levels reported by EBI under-represent actual activity.<br><br>NICE's economic analysis showed that the cost of a treatment strategy with SWL was less costly than a strategy with URS. Local specialists suggested that URS will still have a place in therapy as URS growth is increasing more than any other urological procedure overtaking SWL.<br><br>Some differences were noted between the EBI recommendations and NG118:<br>• NICE recommends watchful waiting should be considered "if the stone is larger than 5mm and the person agrees to watchful waiting after informed discussion of the possible risks and benefits"<br>• NICE recommends URS should be considered for the treatment of stones less than 10mm, EBI only references the use of SWL<br>• EBI recommends SWL as a first line treatment option for 10-20mm renal stones whereas NICE states URS or SWL may be considered<br>• NICE recommends URS as a treatment option when PCNL is not an option for renal stones over 20mm, this is not included by EBI<br>• EBI recommends watchful waiting with medical therapy for patients with asymptomatic ureteric stones, this is not included in NICE recommendations<br><br>Recommendation for the Committee: Consider the proposed policy, aligning with NG118, for adoption.<br>The specialists consulted indicated that the proposed policy wording, which aligns with NG118, appropriately handles these discrepancies and is in line with current practice. |
| **11.2** | Discussion points:<br>➢ A discussion was had as to why EBI figures do not appear representative of activity estimates from local specialists<br>➢ A committee member asked how asymptomatic renal stones are identified and the treatment of these patients was discussed<br>➢ A committee member raised concerns that the proposed policy format differed from the presentation by NICE and EBI<br>➢ A committee member noted that the policy does not detail the type of PCNL used |
| **11.3** | The Committee reviewed the guidance and following a discussion agreed to adopt the recommendation with the addition of guidance around the different methods of PCNL |

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| | **Action: Clinical Effectiveness team to update and circulate the policy statement as outlined above.**<br>**Action: Clinical Effectiveness team to reformat the policy to guide recommendations by stone size** |
| **12.** | **Evidence based intervention list (EBI) 2: 2M Endoscopy; 2N & 2O Colonoscopy for cancer surveillance** |
| **12.1** | The EBI list 2 recommendation refers to the British Society of Gastroenterology (BSOG) surveillance guidelines for post-polypectomy and post-colorectal cancer resection. The recommendations outline when surveillance colonoscopy should be commissioned after polypectomy, after potentially curative colorectal cancer (CRC) resection and other additional circumstances. During consultation local specialists indicated that the recommendations from EBI are in line with current practice.<br><br>The EBI programme has not been able to set a target activity reduction for these recommendations as it is not possible to differentiate activity from this from other indications for colonoscopy. Age, sex, standardised activity rates for TV CCGs are in the top (lower rate) 50% of CCGs nationally.<br>A local specialist commented that an audit has found the proposed guidelines reduces surveillance by 70-80% compared to guidelines from 2010. It was confirmed that the recommendations had been implemented by local trusts prior to the COVID-19 pandemic.<br><br>The Committee reviewed the guidance and following a discussion agreed to adopt a policy that fully aligns with EBI2 guidelines.<br>**Action: Clinical Effectiveness team to update and circulate the policy statement as outlined above.** |
| **12.2** | The EBI list 2 guidance recommendation for appropriate colonoscopy in the management of hereditary colorectal cancer refers to the BSOG surveillance guidelines for the management of hereditary colorectal cancer<br><br>As EBI was not able to differentiate between colonoscopies for patients for the management of hereditary colorectal cancer and those for patients following post-polypectomy and post-colorectal cancer resection the same data set was used and no targets have been set for this intervention.<br><br>A local specialist noted that the recommendations for patients with Lynch Syndrome are included within the EBI guidance Patients with Lynch Syndrome require specialist care which is most appropriate to be managed in secondary care, although the patient numbers are low. |
| **12.3** | The Committee reviewed the guidance and following a discussion agreed to adopt to recommend a policy that fully aligns with EBI2 guidelines.<br>**Action: Clinical Effectiveness team to update and circulate the policy statement as outlined above.** |
| **12.4** | EBI list 2 makes a number of recommendations regarding the appropriate use of upper gastrointestinal (GI) endoscopy. These are categorised according to when urgent referrals should be made, when referrals for the assessment of upper GI bleeding should be made, when referral should be made for the investigation of symptoms and how specific cases should be managed including H-pylori, Barrett's Oesophagus, Coeliac disease and surveillance endoscopy.<br><br>The current 12 month rolling activity is only above the annual activity goal set by the EBI programme for Berkshire West CCG. It is noted that due to Covid-19 a number of these rates may not accurately reflect standard practice. All CCGs activity rates are below the age sex standardized rate target. |

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| | A number of differences between the recommendations of EBI and NICE clinical guidelines (NG12, CG141, CG184) were noted. As part of a consultation process one specialist indicated a preference to align with EBI to have a wider cohort of patients included in 2 week wait (urgent) referrals. One specialist indicated that it is preferable to still provide endoscopic duodenal biopsy to diagnose coeliac disease where possible.<br><br>It was suggested that the Committee may recommend that the proposed commissioning policy is based on EBI but takes account of the feedback from specialists and some NICE recommendations. |
| **12.5** | Discussion points:<br>➢ A local specialist raised concern over the use of the Edinburgh dysphagia score to prioritise urgent referrals. It was stated that there are concerns that it misses relatively high pre-cell carcinomas in the oesophagus and does not provide sufficient discrimination. As the number of patients presenting with dysphagia is small it is current practice to offer an urgent endoscopy to all patients when they present.<br>➢ A local specialist noted that an ongoing major study may influence future guidelines on the use of endoscopy in patients with Barrett's oesophagus. |
| **12.6** | The Committee reviewed the guidance and following a discussion agreed to adopt the recommendation with an amendment regarding the use of the Edinburgh dysphagia score and bring back to the Committee for discussion following the release of the BOSS study.<br>**Action: Clinical Effectiveness team to update and circulate the policy statement as outlined above.** |
| **13.** | **Horizon scanning** |
| **13.1** | NICE has published three Technology Appraisal Guidelines (TAGs) for biologic agents; one for psoriatic arthritis and two for axial spondyloarthritis. Associated TVPC policies state that the policy applies to all biologic therapies recommended by NICE post policy publication. It is therefore suggested that current TVPC policies are updated with addition of new NICE TAGs when an update to the policy is required according to the policy update programme i.e. every 3 years. The Committee agreed with the recommendation.<br>**Action: NICE TAGs to be added to current TVPC policies when an update is scheduled according to the policy update programme.**<br><br>NICE guideline [NG202] Obstructive sleep apnoea/hypopnoea syndrome and obesity hypoventilation syndrome in over 16s has been published. In addition, NICE TA139 Continuous positive airway pressure for the treatment of obstructive sleep apnoea/hypopnea syndrome has been updated. Various recommendations are stated which may impact the current TVPC policy. The aim of the guidance is to raise awareness of sleep apnoea and may lead to more referrals of patients with mild sleep apnoea. A full review of the current policy is proposed in accordance with the recently published and updated guidance.<br>**Action: Clinical Effectiveness to schedule a full review of TVPC61 Snoring and Obstructive Sleep Apnoea/Hypopnoea Syndrome in Adults** |
| **14.** | **Any Other Business** |
| **14.1** | There was no other business. |
| **15.** | **Date of next meeting** |
| | The next online meeting will be held on Wednesday 24th November 2021 **from 2 - 4.30pm.** |
| **16.** | **Meeting close** |
| | The Chair thanked everyone for their contributions to the discussions and closed the meeting. |