Berkshire West Clinical Commissioning Group
Buckinghamshire Clinical Commissioning Group
East Berkshire (Frimley Clinical Commissioning Group)
Oxfordshire Clinical Commissioning Group

Thames Valley Priorities Committee

Minutes of the meeting held Wednesday 26th May 2021

On-line via Microsoft Teams

Alan Penn	Lay Member Chair	Thames Valley Priorities Committee
Jane Butterworth	Assistant Director Medicines Optimisation	Buckinghamshire CCG
Sue Carter	Clinical Effectiveness Manager (CCG)	Oxfordshire CCG
Dr Raju Reddy	Secondary Care Consultant	Berkshire West CCG
Dr Karen West	Clinical Director Integration	Buckinghamshire CCG
Edward Haxton	Deputy Finance Director	Berkshire West CCG
Mark Sheehan	Special Advisor – Ethics	University of Oxford
Gill Manning	Lay representative	East Berkshire
Professor Chris Newdick	Special Advisor – Law	University of Reading
Dr Jacky Payne	GP	Berkshire West CCG
Catriona Khetyar	Head of Medicines Optimisation	East Berkshire, Frimley CCG
Maire Stapleton	Formulary Manager	Buckingham Healthcare NHS Trust
Louise Davies	Medicines Optimisation Pharmacist	Oxford University Hospital (OUH) NHS Trust/Oxfordshire CCG
Dr Megan John (joined at approximately 4pm)	GP, East Berkshire Lead	East Berkshire, Frimley CCG

In Attendance:

Kathryn Markey	Clinical Effectiveness Manager	SCW CSU
Joan Sharp - Observer	Clinical Effectiveness Manager	SCW CSU
Katie Newens	Clinical Effectiveness Manager	SCW CSU
Helen Hicks - minutes	Clinical Effectiveness Administrator	SCW CSU
Funmi Fajemisin	Clinical Services Programme Lead Clinical Policy Implementation	SCW CSU

Apologies:

Andrew McLaren	Deputy Medical Director	Buckinghamshire Health NHS Trust
David Pollock	Interface Lead Pharmacist	Berkshire West CCG
Dr Andy Brooks	Clinical Chief Officer	NHS Surrey Heath & NHS East Berkshire CCG
Mark Hancock	Medical Director	Oxford Health NHS Trust
Lalitha Iyer	Medical Director	East Berkshire CCG
John Reynolds	Associate Director of Medical Sciences Division (Clinical Affairs)	Oxford University Hospital (OUH) NHS Trust
Professor Meghana Pandit	Medical Director	Oxford University Hospital NHS Trust
Fiona Slevin-Brown	Director of Strategy and Operations	East Berkshire CCG

Tessa Lindfield	Strategic Director of Public Health for Berkshire	Public Health Services for Berkshire

Topic Specialists in Attendance for Agenda Items:

Item 8 – Posterior tibial nerve stimulation in paediatric patients
Angela Downer, Clinical Nurse Specialist in Urology, OUH Mohammad Bader, Consultant Paediatric Urologist, OUH

1.	**Welcome & Introductions**
1.1	The Chair opened the meeting and welcomed members of the Committee. The Chair acknowledged it is JB's last time attending the Committee and thanked her on behalf of the Committee for her support. The Chair noted that there had been little input from Consultants for the topics to be discussed. **Action: Commissioning teams to contact their Medical Directors to confirm papers are being distributed.**
2.	**Apologies for Absence**
2.1	Apologies recorded as above.
3.	**Declarations of Interest**
3.1	None declared.
4.	**Draft Minutes of the online Priorities Committee meeting held 24th March 2021 – 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 24th March 2021 – Matters Arising**
5.1	**Draft Minutes of the online Priorities Committee meeting held 27th January 2021 – Action 5.7 - Policy Update Programme** Regarding TVPC71, the Committee heard that Oxford Health are reviewing the shared care pathway for ADHD for Oxfordshire and may wish to contribute to an update of the current policy. **Actions: Clinical Effectiveness team to liaise with Oxford Health NHS FT regarding a potential update of the ADHD policy and add new dates to TVPC 68, 69 and 70.** **March 2021 update:** KM to contact Juliet Long prior to 1st April when the team moves to Health Education and Social Care for joint commissioning. **May 2021 update**: In progress. ADHD due to be reviewed later in 2021. Clinical Effectiveness team to liaise with Oxfordshire CCG to take forward.
5.2	**Draft Minutes of the online Priorities Committee meeting held 24th March 2021 – Action 6.3 - TVPC43 Use of biologic therapies for ulcerative colitis in adults (18 years and over)** The Committee reviewed the evidence and guidance and following consideration of the potential patient numbers and financial impact, the Committee agreed to recommend an interim statement to state TVPC supports the use of biologic drugs and JAK inhibitors as per algorithm without restricting the number of drugs a patient may try. **Action: CE team to remove all statements regarding 4th and 5th biologic/ JAK inhibitor treatment and recirculate draft policy for comment. ACTION Complete**
5.3	**Draft Minutes of the online Priorities Committee meeting held 24th March 2021 – Action 7.3 Regional Medicines Optimisation Committee (RMOC) Advisory Statement Sequential Use of Biologic Medicines – Amendment to current TVPC policies** The Committee agreed to recommend an interim statement to support sequential use of up to 4 different biologic drugs / JAK inhibitors in total. The Committee was happy with the current wording of the policies for the axial spondyloarthritis, psoriasis and Crohn's disease policies. **Action: CE team to update the Psoriatic Arthritis and Rheumatoid Arthritis policies to state** that **up to 4 biologic drugs or JAK inhibitors can be used as an interim statement.** **Action: CE team to circulate updated draft policies for comment.** **Post meeting note: Following the meeting, it has been agreed that the use of biologic drugs and JAK inhibitors for moderate RA will be reviewed separately due to recently published NICE TAG. ACTION Complete (agenda item 6)**
5.4	**Draft Minutes of the online Priorities Committee meeting held 24th March 2021 – Action 8.1 Evidence Based Interventions List 2** **Action: CE team to add to the forward programme schedule. ACTION Complete**

5.5	**Draft Minutes of the online Priorities Committee meeting held 24th March 2021 – Action 8.2 Chronic Sinusitis** The Committee agreed to adopt the EBI pathway with additions. **Action: CE team to amend the policy with the agreed additions. ACTION Complete**
5.6	**Draft Minutes of the online Priorities Committee meeting held 24th March 2021 – Action 8.3 Hernia** The Committee agreed to add the EBI2 statement and maintain the rest of the policy as it is. **Action: CE team to add EBI2 statement to the policy. ACTION Complete**
5.7	**Draft Minutes of the online Priorities Committee meeting held 24th March 2021 – Action 9.1 Policy Updates** The Committee noted that it would be helpful to cite the new SIGN guidance in the updated policy. **Action: CE team to add a footnote to TVPC 77 to reference SIGN 156 (2019) Children and young people exposed prenatally to alcohol. ACTION Complete**
5.8	**Draft Minutes of the online Priorities Committee meeting held 24th March 2021 – Action 9.2 Management of Haemorrhoids** **Action: CE team to amend TVPC 72 to include a link to the EBI guidance. ACTION Complete**
5.9	**Draft Minutes of the online Priorities Committee meeting held 24th March 2021 – Action 9.3 Adhesive Capsulitis (Frozen Shoulder)** The Committee has previously reviewed the wording of this policy in line with the EBI list 2 guidance and recommended a minor change to the use of imaging in primary/ intermediate care. The current review has also checked national guidance and recently published clinical evidence; no further additions are required. **Action: CE team to amend the policy to reflect EBI list 2 guidance as previously recommended. ACTION Complete**
5.10	**Draft Minutes of the online Priorities Committee meeting held 24th March 2021 – Action 9.4 Management of asymptomatic gallstones** This policy was reviewed in line with the EBI list 2 guidance which recommends that patients admitted to hospital with acute cholecystitis or mild gallstone pancreatitis should have index laparoscopic cholecystectomy performed within that admission. The Committee agreed that this guidance should be added to the current policy. **Action: CE Team to amend the policy to reflect EBI list 2 guidance. ACTION Complete**
5.11	**Draft Minutes of the online Priorities Committee meeting held 24th March 2021 – Action 9.5 Subacromial decompression for Shoulder Impingement** The Committee agreed that this new evidence base requires further consideration and noted that due to the potentially large numbers of surgeries being carried out, that it should be prioritised for a full review. **Action: CE team to schedule TVPC 50 for a full update. ACTION Complete**
5.12	**Draft Minutes of the online Priorities Committee meeting held 24th March 2021 – Action 9.6 Therapeutic use of facet joint injections and medial branch blocks for chronic neck pain** The Committee recommended to update the policy statement on diagnostic and therapeutic facet joints injections and medial branch blocks and maintain the position of not normally funded for chronic neck pain, due to lack of evidence on cost and clinical-effectiveness. **Action: CE team to update the policy statement on diagnostic and therapeutic facet joints injections and medial branch blocks for chronic neck pain. ACTION Complete**
5.13	**Draft Minutes of the online Priorities Committee meeting held 24th March 2021 – Action 10.1 Future meetings location/online** **Action: CE team to liaise with Committee members to ascertain how many meetings they would like to have face to face.**

	May 2021 update: responses from Committee members showed a consensus for the annual workshop to be a face to face meeting. Regarding the Priorities Committee meetings there was a mixed response for all meetings virtual and half virtual / half face to face. The Committee agreed to the recommendation of half of the meetings to be face to face with a dial in option to be made available once a return to office if actioned. **ACTION Complete**
6.	**Paper 21-002: Proposed adoption of policy statement: Use of biological and immunomodulatory therapies in the treatment of MODERATE Rheumatoid Arthritis - Interim statement**
6.1	A proposed draft policy statement has been written by the interface lead pharmacist for Berkshire West CCG, for the use of biological therapies and JAK inhibitors in moderate rheumatoid arthritis (RA). In March 2021, the use of these drugs for severe RA was discussed. The pathway for severe RA was updated with the recently published NICE Technology appraisal guidance [TA676] Filgotinib for treating moderate to severe rheumatoid arthritis. This states that Filgotinib, with methotrexate, is recommended as an option for treating active rheumatoid arthritis in adults whose disease has responded inadequately to intensive therapy with 2 or more conventional disease-modifying antirheumatic drugs (DMARDs), only if: • disease is moderate or severe (a disease activity score [DAS28] of 3.2 or more) and • the company provides filgotinib according to the commercial arrangement. This NICE TA is unique in that it includes a recommendation for moderate RA, currently all other NICE TAs for biologic drugs/ JAK inhibitors for RA specify that the drug is only recommended for severe disease. This, however, is likely to change as NICE review more drugs for moderate RA. An interim policy statement may therefore be required for Thames Valley CCGs for the use of biologic drugs and JAK inhibitors for the management of moderate RA to ensure fair and cost-effective use of these drugs. The proposed pathway for moderate rheumatoid arthritis includes all NICE approved treatments for severe RA which have marketing authorisations for moderate RA, starting first line with the most cost effective as per NICE guidelines. It is proposed that the pathway allows a maximum of 4 treatments in total which is in line with the pathway for severe RA. Feedback received from a consultant rheumatologist suggested that rituximab should be included. A committee member advised that this is only licensed for severe RA. A further query was raised relating to varicella zoster vaccination prior to starting JAK inhibitors. It was suggested that this should be addressed in local areas within their pathways. The Committee noted that based on the assumption that in the first year all patients with moderate RA are prescribed adalimumab, the financial impact will be less than if all patients were to commence on filgotinib, as adalimumab is understood to be the most cost effective treatment.
6.2	Options for consideration The Committee was presented with two possible options for consideration: Option 1 - agree to the proposed pathway. Option 2 -Include only access to those treatments that are less expensive or equal to the cost of filgotinib.
6.3	Committee discussion: The Committee discussed the potential financial implication of the proposed pathway. The Committee noted that funding for filgotinib is mandated as a NICE TA. The proposed pathway includes biologics and JAK inhibitors that all have marketing authorisations for moderate RA and are NICE approved drugs for severe RA.

	The Committee also discussed patient safety as filgotinib is a new drug. Clinicians and patients together may wish to choose a drug that has more experience of being used and a known side effect profile. The Committee agreed that clinicians should make the appropriate choice with the patient for each case. The Committee noted that filgotinib is an oral medication and therefore there would be no administration costs. The costs of day care associated with the administration of biologics was thought likely to be low as this would affect a small number of patients.
6.4	The Committee reviewed the guidance and following consideration agreed to offer filgotinib as a first choice treatment alongside adalimumab and infliximab within the proposed pathway **Action: Clinical Effectiveness team to update and circulate the policy statement as outlined above. Post meeting note: due to the publication of the final appraisal document for partial review of TA375 (Adalimumab, etanercept, infliximab, certolizumab pegol, golimumab, tocilizumab and abatacept for moderate rheumatoid arthritis after conventional DMARDs have failed) and rescheduled date of 14th July for final publication, the proposed pathway for moderate RA will need to be revisited at the the next TVPC meeting.**
7	**Paper 21-003: Policy update: Severe and complex obesity**
7.1	The current interim TVPC policy (2016) is based on former NHS England guidance which was in place before the commissioning of services for bariatric surgery was transferred to CCGs. The policy supports bariatric surgery for adults with a BMI of 40kg/m^2 or more, or between 35 kg/m^2 and 40kg/m^2 in the presence of other significant diseases.
7.2	Guidance for commissioners was published by NHS England in 2016 and refers to NICE CG189 (2014) Obesity: identification, assessment and management. This recommends a broadening of the criteria for bariatric surgery to include consideration of patients with recent onset type 2 diabetes with a BMI 30-34.9 kg/m^2 (with a lower BMI threshold for patients of Asian family origin). NICE also recommends an expedited assessment for bariatric surgery to people with a BMI of 35 or over who have recent-onset type 2 diabetes. The current TVPC policy specifies that patients should have been morbidly obese for 5 years and complied with a local specialist obesity service weight loss programme for 12-24 months (with a shorter duration considered for people with a BMI greater than 50 kg/m^2). However, NICE CG189 does not make recommendations on the length of time a person should have been morbidly obese nor the duration of compliance with a weight loss programme. In 2018, NICE published a surveillance proposal consultation document on obesity. This does not propose an update to the recommendations relating to surgery but the following discussions are of interest: • Topic experts stated that NICE guideline CG189 has made no difference to current practice and noted that the NHS bariatric surgery rate has reduced since publication of the guideline. • Experts considered there to be significant barriers to implementation due to a lack of responsibility for obesity care. • A further barrier to implementation was considered to be the very large numbers (over at least 2.6 million people) that are above the BMI threshold for referral. Guidance was considered necessary to prioritise the referrals into manageable proportions. More recently, The Federation of Surgical Speciality Associations (2021) Clinical Guide to Surgical Prioritisation During the Coronavirus Pandemic has been published to support prioritisation following a large reduction in elective surgery rates due to the Covid-19 pandemic.
7.3	Local activity:

	Primary Bariatric Surgery; Pre Covid data (2018/19) shows TV CCGs' expenditure of £189K to £621K per year. Rates of surgery were higher than the national average in Berkshire West and considerably lower in East Berkshire, Buckinghamshire and Oxfordshire. The impact of COVID-19 was significant and rates of surgery were approximately a third of or less in 2020/21 than 2018/19. Gastric bypass revision surgery rates were relatively low. Estimations of the annual resource impact of adopting the additional NICECG189 criteria for surgery ranged from £196K to £335K. These are based on the NICE resource impact calculator published in 2014 and do not include the costs of pre- or post-surgical care. Overall NICE states that the recommendations will be cost effective in the long-term due to a reduction in medications for diabetes, asthma and sleep apnoea as well as fewer diabetes complications and less contact with health professionals. .
7.4	Options for consideration The Committee was presented with two options for consideration: 1) Update the policy in line with the eligibility criteria from the 2016 NHS England guidance for Commissioners 2) Adopt the recommendations in the current interim statement as standard policy and consider whether any alterations are required based on CG189, specifically: • Offer an expedited assessment for bariatric surgery to people with a BMI of 35 or over who have recent-onset type 2 diabetes as long as they are also receiving or will receive assessment in a Tier 3 service (or equivalent). • Consider an assessment for bariatric surgery for people with a BMI of 30–34.9 who have recent-onset type 2 diabetes as long as they are also receiving or will receive assessment in a Tier 3 service (or equivalent). • Consider an assessment for bariatric surgery for people of Asian family origin who have recent-onset type 2 diabetes at a lower BMI than other populations as long as they are also receiving or will receive assessment in a Tier 3 service (or equivalent). • The requirement for morbid/severe obesity to be present for at least five years. • The duration* of compliance with a local specialist obesity service weight loss programme *The current policy states 12-24 months, except for patients with BMI > 50 (minimum acceptable period of 6 months).
7.5	The Committee discussed the full financial impact of adopting option 1. The Committee heard that calculations produced by Buckinghamshire CCG showed an estimated additional £300K would be required to fund the pre and post surgical support that was not included in the NICE estimations. The Committee also had concerns regarding capacity of tier 3 and 4 services, particularly in light of the long waiting lists that will have developed due to the impact of the COVID-19 pandemic. It was noted that any broadening of the criteria would increase the waiting time for surgery considerably and impact on provider trust capacity. The Committee also discussed the new NICE guidance, TA664 Liraglutide for managing overweight and obesity (2020). The use of this drug is limited to tier 3 services which may impact on capacity but may also help to reduce the numbers of people who consider bariatric surgery. The current TVPC criteria regarding the presence of morbid/severe obesity for at least five years was discussed. It was noted that in general practice, there are increasing numbers of people who have reached the BMI criteria but have not been severely obese for 5 years. The Committee concluded that there was little benefit to waiting five years and recommended that this criteria was removed from the policy.
7.6	The Committee reviewed the guidance and following consideration agreed not to adopt the additional criteria for bariatric surgery recommended by NICE CG189 guidance on the grounds of affordability and capacity for tier 3 services. The criteria regarding the presence of

	morbid/severe obesity for at least five years is to be removed. The policy is to be a standard policy. **Action: Clinical Effectiveness team to update and circulate the policy as outlined above. Comments to be received within the 2 week feedback period following issue.**
8.	**Paper 21-004: Posterior tibial nerve stimulation in paediatric patients**
8.1	Thames Valley Priorities Committee has requested a review of the clinical and cost effectiveness of posterior tibial nerve stimulation for urinary incontinence in children. There are no existing local policies regarding treatments for paediatric urinary incontinence, however, Oxfordshire CCG has received nine Individual Funding Requests (IFRs) during the time period 2017-2021 for posterior tibial nerve stimulation in children with intractable urinary incontinence. Bladder function is regulated by a group of nerves at the base of the spine called the sacral nerve plexus. Stimulation of these nerves through electrical impulses (neurostimulation) may change bladder activity. Posterior tibial nerve stimulation involves the electrical stimulation of the tibial nerve which in turns affects the sacral nerve plexus. Posterior tibial nerve stimulation may be delivered by surface electrodes (transcutaneous posterior nerve stimulation) or using a fine needle inserted close to the actual nerve (percutaneous posterior tibial nerve stimulation).
8.2	NICE IPG362 (2010, 2012 minor maintenance) Percutaneous posterior tibial nerve stimulation for overactive bladder syndrome states that current evidence on percutaneous posterior tibial nerve stimulation for OAB syndrome shows that it is efficacious in reducing symptoms in the short and medium term. There are no major safety concerns. Conclusions on efficacy were drawn based on the results from 2 RCTs and 2 case series studying adults. International Children's Continence Society states the following: In summary, the main indication for neuromodulation in non-organic (i.e. functional) daytime urine incontinence (DUI) is over active bladder syndrome (OAB), and the mode of application can be sacral or tibial nerve transcutaneous electrodes. This option is adjunctive to standard urotherapy and pharmacotherapy or an alternative to antimuscarinic pharmacotherapy in children unable to tolerate their pharmaceutical side effects. EAU Guidelines on Paediatric Urology state the following: ➢ Neurogenic bladder: sacral nerve stimulation and transcutaneous neuromodulation are still experimental and cannot be recommended outside of clinical trials. Day-time lower urinary tract conditions: level of evidence remains low. ➢ Non-neurogenic OAB: these new treatment modalities can only be recommended for standard therapy-resistant cases. ➢ Nocturnal enuresis: present data precludes their use because of its inefficiency, or at least no additional benefit. Two systematic reviews (SR) were found: • Cochrane (2019) SR includes 1 relevant study. The authors of the Cochrane review concluded that the evidence for the comparison of tibial transcutaneous electrical nerve stimulation (TENS) versus placebo (sham TENS) for functional daytime urinary incontinence in children was of low to very low uncertainty. • Gaziev et al (2013) SR included 3 studies that addressed the use of percutaneous posterior tibial nerve stimulation in children. These studies were observational. The authors concluded that promising results have been obtained in non-obstructive urinary retention, chronic pelvic pain/painful bladder syndrome (CPP/PBS) and urinary disorders

	in children. Further studies are needed to assess the exact role of PTNS in these indications and to evaluate the long term.
8.3	The specialist clinicians in attendance made the following points: ➢ The studies available restrict their included patients. ➢ In Oxford patient data and outcomes are being collected. ➢ Currently there are 3 anti-anticholinergics to try, all with different complications. Some have limited use in children and are not licensed. If children fail these therapies, it could be they are not responsive to the medicine or they are not compliant. When children have not been successful with 3 anticholinergics and move to urodynamics, this is an invasive procedure and involves a urinary catheter ➢ Clinicians are selective in what and in which patients percutaneous posterior tibial nerve stimulation (PTNS) is used for. Improvements have been demonstrated locally but this has not been statistically analysed. Feedback from patients demonstrated that they were satisfied and not needing to go back on medications after the 12 sessions. ➢ Complication of side effects for PTNS are low. ➢ PTNS is a 12 week programme. ➢ Options superficially mentioned in the literature include clean intermittent catheterisation (CIC), Botox injections and bladder augmentation. These are considered to be last remaining options for patients. ➢ A Committee member enquired why there is no research from the association of urologists or commissoning guidance. The specialist in attendance advised that the number of patients using percutaneous posterior tibial nerve stimulation is small. The majority of patients respond to urotherapy or simple medication. ➢ Three centres in the UK offer percutaneous posterior tibial nerve stimulation.
8.4	Committee discussion The Committee discussed the evidence, guidance and approach to IFRs. **Action: RR to liaise with Birmingham Centre Urologists to informally ask their views and find out the practices they carry out.**
8.5	The Committee reviewed the evidence and specialist clinical input. Due to the small number of patients and a lack of robust high quality evidence showing positive outcomes compared to usual care, it was agreed to recommend a position of not normally funded as an interim position. **Action: Clinical Effectiveness team to draft a policy recommendation to state intervention is not normally funded and circulate for comment. Comments to be received within the 2 week feedback period following issue.** **Action: Clinical Effectiveness team to contact specialist in attendance (MB) for further evidence and patient data.**
9.	**Paper 21-005: Policy update: Non-pharmacological services for dementia**
9.1	Policy 63 Non-pharmacological services for dementia was developed in 2011 and it is not in line with current NICE guidance (NG97) Dementia: assessment, management and support for people living with dementia and their carers. The policy states that cognitive stimulation groups, music therapy, multisensory stimulation, physical exercise, reminiscence therapy and aromatherapy should be 'Procedures Not Routinely Funded' as there is a lack of evidence that any of these interventions are clinically or cost effective in reducing or delaying the need for long term residential care or acute hospital admission.
9.2	Guidance NICE NG97 (2018): Dementia: assessment, management and support for people living with dementia and their carers • Offer a range of activities to promote wellbeing that are tailored to the person's preferences.

	• Offer group cognitive stimulation therapy to people living with mild to moderate dementia. • Consider group reminiscence therapy for people living with mild to moderate dementia. • Consider cognitive rehabilitation or occupational therapy to support functional ability in people living with mild to moderate dementia. It also includes a range of do not dos: • Do not offer acupuncture to treat dementia. • Do not offer ginseng, vitamin E supplements, or herbal formulations to treat dementia. • Do not offer cognitive training to treat mild to moderate Alzheimer's disease. • Do not offer interpersonal therapy to treat the cognitive symptoms of mild to moderate Alzheimer's disease. • Do not offer non-invasive brain stimulation (including transcranial magnetic stimulation) to treat mild to moderate Alzheimer's disease, except as part of a randomised controlled trial. Evidence that has been published since NICE NG97 (2018): Three Cochrane systematic reviews (SR) were identified addressing aromatherapy, personally tailored activities and cognitive training. In addition, one randomised controlled trial (RCT) that was mentioned by the NICE Committee during development of the guideline has now been published. This found that whilst a four month moderate to high intensity exercise programme improved physical fitness in the short term, there were no improvements in activities of daily living, behavioural outcomes, or health related quality of life. There was a slightly greater cognitive impairment in the exercise group, which also experienced more adverse effects indicating that such a programme is not suitable for people with dementia.
9.3	Local data and services available Across the TVPC area there are 15,075 patients diagnosed with dementia. Data from the Memory Services National Accreditation Programme showed that in 2017/18, 96% of services for people with dementia offered cognitive stimulation training. There are a range of support services available locally. These include activities and therapies offered by the NHS, local authorities and charities • Dementia advisors • Dementia cafes • Music therapy/ singing • Walks and exercise • Reminiscence activities
9.4	Options for consideration The Committee were presented with two options for consideration: • Option 1**:** Due to changes in national guidance which support the use of activities to promote wellbeing for people with dementia and the wide service provision of NHS cognitive stimulation training, current practice and service provision, withdraw the current policy. • Option 2**:** To consider a policy reflecting NICE 'Do not dos' as interventions not normally funded; either as standalone treatments or as part of a package of treatment, due to limited evidence of effectiveness for people with dementia. The Committee is asked to consider whether to include a statement that activities or therapies not provided as part of an agreed support package are not normally funded.

9.5	The Committee reviewed the evidence and following consideration agreed to withdraw the current policy in favor of using available NICE guidance. **Action: Clinical Effectiveness team to withdraw policy 63.**
10.	**Paper 21-006: Policy update programme**
10.1	The TVPC policy update programme reviews all TVPC policies every 3 years and identifies new or updated national guidance and if applicable, clinical and cost effectiveness evidence. TVPC3: Anal Irrigation Systems for the Management of Faecal Incontinence/Constipation NICE is to review NICE MTG36 (2018) Persistent transanal irrigation system for managing bowel dysfunction this year. Three RCTs were found which showed an improvement in bowel function among patients with a range of disorders and improvement in quality of life. Discontinuation rates were high although side effects were common, but equally prevalent among comparative treatments. The Committee agreed to maintain the current policy. **Action: Clinical Effectiveness team to add a new date of recommendation to TVPC3.**
10.2	TVPC 78: Smoking cessation before planned surgery There has been no change to national guidance. A minor change is required due to expired links. The Committee agreed with the minor change. **Action: Clinical Effectiveness team to update TVPC 78 with new links.**
10.3	TVPC6: Arthroscopic lavage & debridement for patients with OA of the knee The current policy is aligned with the statements made by the evidence-based intervention programme (EBI) phase 1 as both are based on NICE CG177: Osteoarthritis: care and management (2014) which is cited in the policy. A minor change was suggested to highlight the EBI guidance. It was advised that EBI have a new website that includes a range of patient resources which may be useful to refer to. The Committee agreed with the minor change. **Action: Clinical Effectiveness team to update TVPC6 with a link to EBI1 guidance.**
10.4	TVPC20: Surgical management of otitis media with effusion in children (under the age of 12 years) The current policy is aligned with the statements made by EBI phase 1 as both are based on the NICE CG60 (2008) guidance: Otitis media with effusion in under 12s: surgery. EBI phase 2 focuses on the removal of adenoids for treatment of glue ear and differs slightly to NICE CG60 with broader criteria. NICE CG60 (and cited by TVPC) state that "Adjuvant adenoidectomy is not normally funded in the absence of persistent and/or frequent upper respiratory tract symptoms". EBI phase 2 guidance states that adenoidectomy for the treatment of glue ear should only be offered when one or more of the following clinical criteria are met: — The child has persistent and / or frequent nasal obstruction which is contributed to by adenoidal hypertrophy (enlargement) — The child is undergoing surgery for re-insertion of grommets due to recurrence of previously surgically treated otitis media with effusion — The child is undergoing grommet surgery for treatment of recurrent acute otitis media It was noted that the NICE guidance (2008) is currently being updated. The Committee queried the financial implications of adopting the wider criteria outlined in EBI phase 2 guidance and requested further information.

	Action: Clinical Effectiveness team to investigate the financial implications of adopting EBI phase 2 guidance.
10.5	TVPC1: Interventional Procedures for Varicose Veins The current policy has stricter criteria for consideration of interventional treatment than EBI phase 1 guidance (which is based on NICE CG168). The TVPC policy also promotes the use of compression stockings, which are not recommended by EBI (or NICE). In addition to EBI phase 1 guidance, a new RCT has been published which shows a benefit in healing time if vascular ulcers are treated early. This study supports the NICE recommendation that patients with leg ulceration not healed within 2 weeks should be referred to a vascular service. The current TVPC policy recommends that patients should be referred if they have "recurrent and persistent leg ulceration secondary to chronic venous insufficiency, despite 6-months of conservative management with compression stockings* for the first ulcer". As the RCT was a large UK trial whose findings conflict with the current policy position, it is suggested that the policy be reviewed in full by the Committee. **Action: Clinical Effectiveness team to add to the work programme for review.**
11.	**Paper 21-007: Horizon scanning**
11.1	The previous three months of published NICE guidance are reviewed to identify opportunity for new policy development or if published guidance impacts on current TVPC policies. The following actions were agreed: ➢ Medical technologies guidance (update) [MTG53] The PLASMA system for transurethral resection and haemostasis of the prostate **Action: To include this as part of the review of a Benign Prostatic Hyperplasia (BPH) pathway as scheduled.** ➢ Technology appraisal guidance [TA672] Brolucizumab for treating wet age-related macular degeneration TV CCGs hold a policy on sequential use of biologic therapy for ophthalmology which states the policy applies to all biologic therapies recommended by NICE. The use of this drug may result in fewer injections than previously available treatments. This may have benefits in terms of increasing capacity and may result in a lower cost impact. **Action: Clinical Effectiveness team to schedule a review into this years' work programme.** NICE guideline [NG193] Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain This gives a positive recommendation to consider a single course of acupuncture or dry needling within a traditional Chinese or Western acupuncture system for people aged 16 or over to manage chronic primary pain within certain criteria. Acupuncture is referred to on 2 TVPC policies: TVPC 52 Management of lower back pain, which states management for lower back pain with or without sciatica is not normally funded; TVPC 100 complementary and alternative therapies, which was reviewed in 2020and states the use of all complementary therapies including acupuncture is not normally funded. This will have a financial impact on the policies. The overall NICE guidelines suggests there is a potential saving in terms of recommendations within the guideline regarding use of expensive drugs for chronic pain. **Action: Clinical Effectiveness team to add to the work programme for review.**
12.	**Any other business**
12.1	Annual report

	The Clinical Effectiveness team have produced an annual report for 2020-21 which details evidence and policies reviewed in 2020-2021. When finalised, this will be circulated to Committee members. **Action: Clinical Effectiveness team to circulate the final version.**
13.	**Date of next meeting**
	The next online meeting will be held on Wednesday 28th July 2021 **from 2 - 4.30pm.**
12.	**Meeting Close**
	The Chair thanked everyone for their contributions to the discussions and closed the meeting.