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***Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board***
***Frimley Integrated Care Board***

# Thames Valley Priorities Committee

## Minutes of the meeting held Wednesday 6th July 2022

## On-line via Microsoft Teams

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| David Clayton-Smith | Chair | Thames Valley Priorities Committee; Review of Priority Committees and IFR processes NHS England and NHS Improvement, South East; Kent Surrey & Sussex Academic Health Science Network |
| Diane Hedges | TVPC strategic lead | NHS Buckinghamshire, Oxfordshire and Berkshire West ICB |
| Sue Carter | Clinical Effectiveness Manager | NHS Buckinghamshire, Oxfordshire and Berkshire West ICB |
| Keith Mansfield | Interim Senior Finance Manager | NHS Buckinghamshire, Oxfordshire and Berkshire West ICB |
| Dr Megan John | GP | NHS Frimley ICB |
| Dr Jacqueline Payne | GP | NHS Buckinghamshire, Oxfordshire and Berkshire West ICB |
| Dr Karen West | Clinical Director Integration | NHS Buckinghamshire, Oxfordshire and Berkshire West ICB |
| Mohammed Asghar | Prescribing Governance Lead | Frimley Health and Care ICS |
| David Pollock | Interface Lead Pharmacist | Buckinghamshire, Oxfordshire and Berkshire West ICB |
| Emeritus Professor Chris Newdick | Special Advisor, Law | University of Reading |
| Bhulesh Vadher | Clinical Director of Pharmacy and Medicines Management | Oxford University Hospitals NHS Trust |
| Abid Irfan | Deputy Chief Medical Officer | NHS Buckinghamshire, Oxfordshire and Berkshire West ICB |

In Attendance:

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| Naomi Scott | Clinical Effectiveness Manager | SCW CSU |
| Tiina Korhonen | Clinical Effectiveness Lead | SCW CSU |
| Karen Blogg - minutes | Clinical Effectiveness Administrator | SCW CSU |
| Kathryn Markey | Clinical Effectiveness Manager | SCW CSU |
| Funmi Fajemisin | Clinical Services Programme Lead Clinical Policy Implementation | SCW CSU |

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Observers:

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| Claira Ferreira | Audit and Compliance Manager | Bedfordshire, Luton and Milton Keynes, Clinical Policy Review Group |
| Naisha Henry | Audit and Compliance Manager | Bedfordshire, Luton and Milton Keynes, Clinical Policy Review Group |
| Gill Livingstone | Joint lead for best practice assurance, health education, social care and public health | Joint commissioning team across Oxfordshire County Council and Oxfordshire Clinical Commissioning Group |

Apologies:

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| Gill Manning | Lay representative | NHS Frimley ICB |
| Dr Raju Reddy | Secondary Care Consultant | NHS Buckinghamshire, Oxfordshire and Berkshire West ICB |
| Dr Janet Lippett | Chief Medical Officer | Royal Berkshire NHS Foundation Trust |
| Mark Sheehan | Special Advisor, Ethics | University of Oxford |
| Andrew McLaren | Deputy Medical Director | Buckinghamshire Health NHS Trust |
| Professor Meghana Pandit | Medical Director | Oxford University Hospital NHS Foundation Trust |
| Dr John Fraser | Clinical Lead, Surrey Heath locality | NHS Frimley ICB |
| Dr Karl Marlowe | Medical Director | Oxford Health NHS Trust |
| Kirsty Habibi-Parker | Formulary Manager | Buckinghamshire Integrated Care Partnership |
| Rachael De Caux | Chief Medical Officer | NHS Buckinghamshire, Oxfordshire and Berkshire West ICB |
| Sara Wilds | Head of Medicines Optimisation | NHS Buckinghamshire, Oxfordshire and Berkshire West ICB |
| Dr Lalitha Iyer | Chief Medical Officer | NHS Frimley ICB |

Topic specialists in attendance for agenda Items:

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| Item 6 – Evidence review: Treatment with Anti-VEGF agents for neovascular (wet) age-related macular degeneration in patients with one seeing eye<br>Item 7 – Policy review: TVPC5: Anti-VEGF treatments and dexamethasone implants for macular oedema caused by central and branch retinal vein occlusion<br>Item 8 – Evidence review: Surgery for tear duct obstruction (lacrimal surgery)<br>Item 9 – Policy review: TVPC60: Cataract removal in adults – thresholds for surgery |
| **Jonathan Norris** – Consultant Oculoplastic and Ophthalmic surgeon, Oxford University Hospitals NHS Foundation Trust.<br>**Andrew Pearson** – Consultant Ophthalmologist, Royal Berkshire NHS Foundation Trust<br>**Christine Kiire** – Consultant Ophthalmologist and Clinical Lead for Medical Ophthalmology, Oxford University Hospitals NHS Foundation Trust.<br>**Sarah-Lucie Watson** – Clinical lead, Consultant Ophthalmologist, Royal Berkshire NHS Foundation Trust<br>**Ambreen Tunio** – Consultant Ophthalmologist, Buckinghamshire Health NHS Trust<br>**Samantha de Silva** – Consultant Ophthalmic Surgeon, Oxford University Hospitals NHS Foundation Trust |

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| **1.** | **Welcome & introductions** |
| **1.1** | The Chair opened the meeting and welcomed members of the Committee, introduced himself and outlined the meeting structure and protocols. |
| **2.** | **Apologies for Absence** |
| **2.1** | Apologies recorded as above. The meeting was recorded as being not quorate. The usual process as per the ToR will be followed to post meeting to seek agreement of the absent delegate their endorsement of the Committee recommendations. |
| **3.** | **Declarations of Interest** |
| **3.1** | The Chair reviewed the declarations of interest prior to the meeting. None of the interests declared were considered material for the Committee decision making. |
| **4.** | **Draft Minutes of the Priorities Committee meeting held on 25th May 2022 – Confirm accuracy** |
| **4.1** | The Committee agreed to accept the minutes as an accurate record of the meeting |
| **5.** | **Draft Minutes of the Priorities Committee meeting held 25th May 2022 – Matters arising** |
| **5.1** | **Draft Minutes of the online Priorities Committee meeting held 25th May 2022 – Action**<br>**6.3 Policy update: TVPC 50 Subacromial decompression for shoulder impingement**<br>Discussions have taken place with specialists regarding the validity of data and with the SCW informatics department to obtain waiting list data. No contact has yet been made with Matthew Tate and appropriate personnel within ICS to seek advice.<br>**Action: DH to escalate obtaining specific elective care waiting list data from Matthew Tate and appropriate personnel within ICS.** |
| **5.2** | **Draft Minutes of the online Priorities Committee meeting held 25th May 2022 – Action**<br>**7.3 Policy update: TVPC 52 Management of low back pain and sciatica**<br>Liaison with the Berkshire West IFR panel has taken place and the panel are happy with guidance given. The policy has been updated.<br><br>With regards to ratification of policies at this time, the Clinical Effectiveness Manager for Buckinghamshire, Oxfordshire and Berkshire West ICB will be working with the Chief Medical Officer to implement the right ratification processes. Whilst this work is undertaken, it is requested that final policies and governing body papers are distributed as per normal process.<br>**Action: Complete** |
| **5.3** | **Draft Minutes of the online Priorities Committee meeting held 25th May 2022 – Action**<br>**8.3 New policy: Ingrown toenail**<br>Clinical Effectiveness team and podiatry service have added some conservative management recommendations to the policy. Clinical Effectiveness team to update the work programme and circulate.<br>**Action: Complete** |
| **5.4** | **Draft Minutes of the online Priorities Committee meeting held 25th May 2022 – Action**<br>**9.1 Policy update: TVPC 23 Trigger Finger**<br>Clinical Effectiveness team to update the work programme and circulate.<br>**Action: Complete** |
| **5.5** | **Draft Minutes of the online Priorities Committee meeting held 25th May 2022 – Action**<br>**9.2 Policy update: TVPC 84 Corticosteroid injections for patella, elbow and Achilles tendinopathy**<br>Clinical Effectiveness team to update the work programme and circulate.<br>**Action: Complete** |
| **5.6** | **Draft Minutes of the online Priorities Committee meeting held 25th May 2022 – Action**<br>**9.3 Policy update: TVPC 85 Corticosteroid injections for pre patella and olecranon bursitis**<br>Clinical Effectiveness team to update the work programme and circulate.<br>**Action: Complete** |

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| **5.7** | **Draft Minutes of the online Priorities Committee meeting held 25th May 2022 – Action 9.4 Policy update: TVPC 20 Surgical management of otitis media with effusion in children (under the age of 18 years.**<br>Clinical Effectiveness team to update the work programme and circulate.<br>**Action: Complete** |
| **5.8** | **Draft Minutes of the online Priorities Committee meeting held 25th May 2022 – Action 5.2 Policy review: TVPC 11g Assisted Preproduction Services for Infertile Patients**<br>Update: It was agreed there would be a dedicated workshop to seek more clinical input and understanding of clinical preferences around the intrauterine insemination and the patient groups potentially affected by the current policy. The workshop was held on 21st June. The aim is to bring costed options to the September TVPC, including a clear outline of risks and benefits of the options.<br><br>Frimley ICB has alerted the Committee to the likelihood of the legal challenge relating to the current policy progressing to Judicial Review (JR). If the JR did go ahead the review of the policy may benefit from awaiting the outcome of the case. The Committee noted that whatever the outcome of the JR, there is an opportunity to improve the structure of the current TVPC policy. It was agreed that the current workplan should continue, but if the JR should be imminent and before the September meeting, it would to be wise to wait for the review outcome.<br>**Action: TVPC 11g Assisted Preproduction Services for Infertile Patients policy review to progress to September meeting, unless JR has progressed before then.** |
| **6.** | **Evidence review: Treatment with Anti-VEGF agents for neovascular (wet) age-related macular degeneration in patients with one seeing eye** |
| **6.1** | <u>Background</u><br>Treatment of patients with anti-VEGF agents for Neovascular (Wet) Age-Related Macular Degeneration (AMD) was originally discussed at the TVPC meeting in July 2021. At this meeting it was suggested that further information regarding the number of patients affected should be sought from local specialists in order to inform discussions of affordability of commencing treatment earlier than NICE recommends in patients with 'one seeing eye'.<br><br>National guidance states that treating wet AMD when visual acuity is good leads to the eye maintaining good visual acuity over time. There is no standardised definition for one seeing eye. A practical working definition has been suggested as being: An eye where significant loss of vision in this eye would be deemed life-changing with profound impact on the quality of life by both the patient and surgeon.<br><br>From economic analyses, the cost of AMD associated visual impairment in all eye populations, across BOB and Frimley ICBs could be estimated to be £104,776,119. Economic analyses suggested that the loss of quality of life may account for 26% of this.<br><br>The Committee was asked to consider 2 options:<br>• **Option 1 – Earlier access to treatment**.<br>The Committee recommending that treatment with anti-vascular endothelial growth factor (VEGF) treatment should be considered as an option for patients with neovascular (active wet) age-related macular degeneration (AMD) when the fellow eye is **severely sight impaired**.<br><br>Funding is recommended only where the following criteria are met:<br>all of the following circumstances apply in the eye to be treated:<br>o the best-corrected visual acuity is between 6/9 and 6/96 |

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<ul><li style="list-style:none">
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<li>there is no permanent structural damage to the central fovea</li>
<li>the lesion size is less than or equal to 12 disc areas in greatest linear dimension</li>
<li>there is evidence of recent presumed disease progression (blood vessel growth, as indicated by fluorescein angiography, or recent visual acuity changes)</li>
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AND<br>
the manufacturer provides ranibizumab / aflibercept / brolucizumab with the discount agreed in the patient access scheme.<br>
AND<br>
The sight in the fellow eye falls into one of the following categories: (certified blind)
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<li>Visual acuity of less than 3 / 60 with a full visual field.</li>
<li>Visual acuity between 3 / 60 and 6 / 60 with a severe reduction of field of vision, such as tunnel vision.</li>
<li>Visual acuity of 6 / 60 or above but with a very reduced field of vision, especially if a lot of sight is missing in the lower part of the field.</li>
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<li>Option 2 – Treat as per NICE guidance and NICE Technology appraisals and therefore no policy needed.</li>
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<u>The specialists in attendance made the following comments:</u>
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<li>Patients are referred to clinic with suspected wet macular degeneration. When confirmed by the hospital eye service, treatment does not start until visual acuity has deteriorated to a level of 6/12.</li>
<li>There is some very good quality evidence available stating the earlier the treatment the better the outcomes. The need for early intervention is strong for any patient and is even stronger for a patient with one seeing eye. It is a degenerative disease, and although the degeneration continues, early intervention can maintain a patient's quality of life for longer.</li>
<li>At present the patients are monitored in clinic every 4 weeks until they reach the threshold of 6/12 when treatment can begin. In patients with one seeing eye it is essential to retain vision. Biosimilars could be used, the pricing looks positive.</li>
<li>This is a very small cohort of patients, but it is not certain what the frequency of treatment will be. There is now NICE approval and guidance for faricimab, which may require less frequent administration and reduce visits to clinic from 4 weekly to 2 to 3 monthly.</li>
<li>In house trials have taken place using brolucizumab, however due to safety concerns it is not being used in some local hospital trusts.</li>
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Question was raised whether earlier treatment to preserve sight (or health) could relate to other conditions and interventions. Clinicians explained how wet AMD differs from other eye conditions in disease progression and response to treatment. Wet AMD was one of the services that had to continue throughout the pandemic to prevent irreversible patient deterioration.<br>
The Committee requested that a particular note was made that there was a significant opportunity to avoid disability whilst also benefitting from the price change that the use of biosimilars will offer.
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The Committee agreed to recommend option 1 - Earlier access to treatment<br>
Treatment with anti-vascular endothelial growth factor (VEGF) treatment should be considered as an option for patients with neovascular (active wet) age-related macular degeneration (AMD) when the fellow eye is severely sight impaired.<br>
Action: Clinical effectiveness team to prepare draft policy as per option 1 and distribute to committee members for comment as per normal process.
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| 7. | **Policy review: TVPC 5 Anti-VEGF treatments and dexamethasone implants for macular oedema caused by central and branch retinal vein occlusion** |
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| **7.1** | The TVPC policy 'TVPC5: Anti-VEGF treatments and dexamethasone implants for macular oedema (MO) caused by central and branch retinal vein occlusion (RVO) states that the use of anti-VEGF intravitreal injections and dexamethasone implants are recommended in line with the associated NICE technology appraisals. The requirement to use laser therapy before these treatments, as stated in NICE technology appraisal guidance, for the treatment of branch MO due to RVO need not apply.<br><br>Since this policy was last reviewed in 2019, the Royal College of Ophthalmologists has updated its clinical guidelines for retinal vein occlusion, but recommendations relating to anti-VEGF and dexamethasone treatment remain the same. These state that the choice of treatment is dependent on shared decision-making between the clinician and the patient, taking into consideration the frequency of treatment, risk of Intraocular Pressure (IOP) rise and cataract formation. It is noted that macular laser is an option for branch RVO, but the results are not likely to be as good as intravitreal treatment. The current policy is in line with these recommendations.<br><br>A literature review identified a healthcare technology assessment (HTA) which concluded that aflibercept was non-inferior to ranibizumab, but that non-inferiority was not confirmed for the comparison between ranibizumab and bevacizumab. The comparison of aflibercept and bevacizumab was conducted post-hoc, finding bevacizumab to be non-inferior to aflibercept. Over the length of the trial patients received fewer injections of aflibercept than ranibizumab or bevacizumab. Two models were developed in the cost-utility analysis derived from data from this trial. Both models found bevacizumab to dominate ranibizumab and aflibercept, that is it accrued more quality-of-life years (QALYs) for less cost.<br><br>The authors offer words of caution within the conclusions of the report. As the trial was unable to demonstrate that bevacizumab is non-inferior to ranibizumab in the management of macular oedema (MO) due to central RVO, clinicians would have a low level of confidence in recommending that bevacizumab is equivalent in clinical effectiveness to ranibizumab. Only ranibizumab and aflibercept are licenced medications for the management of this condition whereas bevacizumab is not.<br><br>Further evidence found bevacizumab to be non-inferior to ranibizumab in terms of best corrected visual field improvement for RVO regardless of type. A Cochrane SR concluded that anti-VEGF agents provide the most effective treatment in terms of functional (visual acuity) and anatomical (central macular thickness) outcomes when compared with sham, macular laser, or intravitreal steroids for patients with branch RVO. |
| **7.2** | <u>The specialists in attendance made the following comments:</u><br>• Concerns were raised that bevacizumab is an unlicensed drug and that explaining what this means to each patient would take additional time within an already stretched service.<br>• It was raised that the dosing of bevacizumab is more frequent than some licensed treatments. Therefore, using bevacizumab could result in more patient visits, which could result in a worse patient experience and place higher demand on already pressurised ophthalmology and pharmacy services. This could lead to delays in new patients starting treatment.<br>• The clinicians recommended that the current policy is maintained. It was noted that biosimilars are being introduced.<br><br>The Committee discussed the potential usefulness of a whole service review, including wider hospital support services such as pharmacy. It was proposed that this could develop |

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| | understanding of any cross speciality financial cost savings. It was agreed that, as clinicians have advised that changing the current policy could have a detrimental effect on the population, it would be appropriate to maintain the current policy at this time.<br><br>The Committee agreed to maintain the current policy with no changes<br>**Action: Clinical effectiveness team to update the date of the policy with no further changes.** |
| **8.** | **Evidence review: Surgery for tear duct obstruction (lacrimal surgery)** |
| **8.1** | There is currently no Thames Valley Priorities Committee policy recommendation regarding the commissioning of dacryocystorhinostomy (DCR). A review into this procedure was agreed at the TVPC working group noting that ophthalmology is a speciality under considerable pressure at this time. The request queried whether nasolacrimal duct obstruction (NDLO) is an aesthetic or functional problem and what benefits, and harms are associated with DCR.<br><br>Identified literature suggests that DCR is an effective procedure for the treatment of NLDO, with the most recently published comparison estimating it resolves symptoms in 90% of patients. It is suggested by NICE within the Interventional Procedure Guidance IPG113 for endoscopic DCR that patients would be expected to have failed to control their symptoms with conventional treatment, such as warm compresses, massage and probing of the nasolacrimal duct. It is noted that a number of the trials reviewed required patients to have symptoms for 1 year or more before being eligible for treatment. Other, less invasive surgical treatment options are available for NLDO such as balloon dacryoplasty and stenting, however these appear to have much lower success rates. These procedures might be more appropriate for congenital or partial NLDO.<br><br>Local data suggests surgical activity for NLDO reduced between 2018/19 and 2019/20, but the trend beyond this is likely to be significantly affected by the COVID-19 pandemic. There was some recovery in activity levels in 2021/22. On average, DCR costs around £1,650 per procedure. Enlargement of lacrimal punctum is less costly, but likely to be a smaller operation that is more suitable for patients with only partial stenosis.<br><br>The Committee was asked to consider two options:<br>• **Option 1:** Accept the routine commissioning of DCR for patients with symptoms of acquired NLDO that have been refractory to conservative treatment, including warm compresses, massage and probing of the nasolacrimal duct. It may be appropriate to specify a length of time for using conservative treatment before being eligible for referral for surgical opinion.<br>• **Option 2:** Not accepting the routine commissioning of DCR, understanding that the treatment is effective but that ophthalmology is currently under considerable pressure and this is not a priority area. |
| **8.2** | The specialists in attendance made the following comments:<br>• A specialist shared several slides with the Committee. These highlighted that NLDO is a functional problem that impacts on vision, physical activities of daily living, safety, social activities and psychological state. It was stated that DCR is an effective treatment for NLDO and can result in improvements in eye watering, skin soreness, reading, seeing a TV/computer, driving safely, activities at home/work, walking and mood/frustration/embarrassment.<br>• Conservative management techniques are not effective and not appropriate. When patients first present at clinic, a test is undertaken on that day to establish whether the tear duct is obstructed or whether further investigation is needed. If the patient does have an obstructed tear duct the only treatment available is a DCR, no other treatment is effective. |

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| | • The Committee heard that DCR surgery constitutes only a small proportion of ophthalmic procedures and that stopping or restricting lacrimal surgery would have a minimal impact on service pressures. The specialist advised that delays in treatment could cause a higher change of infections (such as acute dacryocystitis) and other complications, which could result in additional treatment time adding pressure to the ophthalmology service.<br><br>The Committee queried whether not having treatment could potentially affect a patient's livelihood and noted how this is a consideration in an integrated care system. Clarification was sought on the options proposed and whether they could result in a threshold/prior approval based policy. It was noted that the NICE IPG113 guideline states that patients would normally have trialled conservative management techniques without success before surgery is offered. This view was not supported by clinical experience.<br><br>The Committee agreed that DCR is a functional problem and continued commissioning is appropriate without the requirement for patients to attempt conservative treatment before referral for specialist assessment. |
| **9.** | **Policy review: TVPC 60 Cataract removal in adults – thresholds for surgery** |
| **9.1** | The current policy TVPC 60 Cataract removal in adults - thresholds for surgery, was recommended by the TVPC in 2017 and updated in 2018 following review of publication of NICE guidance NG77 (Cataracts in adults: management). In 2018 the Committee acknowledged NICE NG77 as national best practice guidance which recommends that access to cataract surgery should not be restricted on the basis of visual acuity however, the Committee agreed to recommend maintaining the current TVPC 60 policy without alteration. This decision was based on affordability, and a recommendation from clinicians to maintain visual acuity criteria in order to support referrers in identifying symptomatic patients. The policy does not restrict access to surgery based on visual acuity alone but emphasises visual symptoms affecting the patient and as such maintains the intent of NICE recommendations.<br><br><u>TVPC policy</u><br>The current TVPC policy states that when considering referral for surgery a patient should have a visual acuity of less than 6/12 in either eye or the cataract and visual symptoms should negatively affect the patient's lifestyle. The current policy also states that the same thresholds apply to referral for surgery for both first and second eye.<br><br><u>National guidance</u><br>Guidance has been produced by the Royal College of Ophthalmologists and Getting It Right First Time (GIRFT) in response to the COVID 19 pandemic and to support the resumption of cataract surgery. National guidance do not recommend that criteria for access to surgery should be tightened or amended in order to reduce pressures on waiting lists. National guidance does suggest that prioritisation should be based on clinical and quality of life criteria, surgical risks, and the risk to the patient of COVID 19, rather than operational targets, to direct care to those most in need. Furthermore, no studies were found that suggest that the criteria within the current policy should be amended.<br><br>Guidance also suggests that certain groups of low risk patients could be managed outside of traditional hospital-based pathways, where this can be delivered without compromising safety and quality of care. This includes patients who have had routine, uncomplicated cataract surgery Royal College of Ophthalmologists and GIRFT have made recommendations in support on the establishment and running of cataract pathways for high flow / low complexity (HFLC) cataract assessment and surgical hubs. |

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| **9.2** | <u>The specialists in attendance made the following points:</u><br>• The service provision of cataract surgery in the region has changed recently as a result of independent providers managing patients who are less likely to have surgical complications. This has an impact on the main local NHS hospital trusts' surgical lists and the provision of a high flow cataract surgery list. (high volume, low complexity )<br>• There are also concerns that the referral criteria for surgery varies between hospitals. It was agreed that the same thresholds should be applied across providers.<br>• Locally, the NHS is not currently looking to do bilateral sequential surgery at this present time.<br><br>One of the suggested options was to maintain the current visual criteria and add guidance from EBI 3 which promotes shared decision-making:<br>Cataract referrals should not be accepted unless a formally documented shared decision-making process has been performed as part of a referral.<br>How the cataract affects the person's vision and quality of life<br>• Whether one or both eyes are affected<br>• What cataract surgery involves<br>• How the person's quality of life may be affected if they choose not to have cataract surgery<br>• Whether the person wants to have cataract surgery – this is particularly important as referral of someone who does not want surgery is not a valuable use of time and resource<br>Clinicians agreed that the list proposed is appropriate and can contribute to a be more efficient service. It was also agreed to remove the reference from the current policy, to an optician discussing risks and benefits of surgery. |
| **9.3** | The Committee agreed to no change to current policy in terms of visual acuity and quality of life. The Committee agreed to include the following guidance in the policy:<br>• Cataract referrals should not be accepted unless a formally documented shared decision-making process has been performed with the patient (and their family members or carers, as appropriate) as part of a referral. This includes but is not limited to:<br>• How the cataract affects the person's vision and quality of life<br>• Whether one or both eyes are affected<br>• What cataract surgery involves<br>• How the person's quality of life may be affected if they choose not to have cataract surgery<br>• Whether the person wants to have cataract surgery – this is particularly important as referral of someone who does not want surgery is not a valuable use of time and resource<br>There is uncertainty about how the issues raised concerning the independent providers may be addressed. Therefore it may be appropriate to investigate this and discuss further with commissioners.<br><br>**Action:**<br>• **Clinical effectiveness team to draft policy to include the proposed EBI guidance referral criteria**<br>• **DH to follow up the review of compliance with the referral thresholds across all service providers.** |
| **10.** | **Horizon Scanning** |
| **10.1** | In March, NICE updated their guidelines around diabetes management for type 1 and type 2. This will have an impact on the Thames Valley commissioning policies and will also have a financial |

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| | implication. David Pollock from the BOB area prescribing committee is reviewing the guidance and liaising with Frimley ICB. The Committee agreed that we can wait for this analysis to have taken place and then review our policy position as necessary. |
| **11.** | **Any other business** |
| **11.1** | Comments were noted about the topic selection process and prioritisation for the Committee work programme going forward. It is anticipated that the Committee will need to work differently to support the work of the ICSs. Up until this point the topic submission and the work plan has been led by the CCGs. The current work programme is open to suggestions from September onwards. The September meeting agenda is reserved for the Committee process review following the ICB formation, including the review of Committee membership, Terms of Reference and Ethical Framework.<br><br>**Action: DCS and DH to arrange a meeting with relevant personnel to review the work programme going forward and to report back to the September meeting.** |
| **12.** | **Date of next meeting** |
| **12.1** | The next meeting will be held on Wednesday, 28th September 2022, from 2 – 4.30pm via Microsoft Teams |
| **13.** | **Meeting close** |