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

Thames Valley Priorities Committee

Minutes of the meeting held Wednesday 28th September 2022

On-line via Microsoft Teams

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
Sue Carter	Clinical Effectiveness Manager and delegated (by CMO) TVPC strategic lead for BOB ICB	NHS Buckinghamshire, Oxfordshire and Berkshire West ICB
Dr Megan John	Priorities and policy Lead IFR lead SE priorities and IFR programme Board Lead	NHS Frimley ICB
Dr Karen West	Clinical Director Integration	NHS Buckinghamshire, Oxfordshire and Berkshire West ICB
Mohammed Asghar – attending for 1st and last 30 minutes of meeting	Prescribing Governance Lead	Frimley Health and Care ICS
Emeritus Professor Chris Newdick	Special Advisor, Law	University of Reading
Dr Raju Reddy	Secondary Care Consultant	NHS Buckinghamshire, Oxfordshire and Berkshire West ICB
Dr Jacqueline Payne	GP	NHS Buckinghamshire, Oxfordshire and Berkshire West ICB
Dr Lalitha Iyer	Chief Medical Officer	NHS Frimley ICB
Mark Sheehan	Special Advisor, Ethics	University of Oxford
John Seymour	Consultant Assistant Medical Director	NHS Frimley ICB
Jenn Sula-Minns	Prior Approval Manager	NHS Buckinghamshire, Oxfordshire and Berkshire West ICB
Rosalind Pearce	Executive director	Healthwatch - Oxfordshire
Rachel Alexander		Oxford University Hospitals NHS Foundation Trust

NOT QUORATE

In Attendance:

Tiina Korhonen	Clinical Effectiveness Lead	SCW CSU
Kathryn Markey	Clinical Effectiveness Manager	SCW CSU
Naomi Scott	Clinical Effectiveness Manager	SCW CSU
Anna Lyne	Senior Policy Advisor	SCW CSU
Funmi Fajemisin	Clinical Services Programme Lead Clinical Policy Implementation	SCW CSU
Karen Blogg - minutes	Clinical Effectiveness Administrator	SCW CSU
Nicola Goodchild	Clinical Effectiveness Administrator	SCW CSU

Apologies:

Gill Manning	Lay representative	NHS Frimley ICB
Dr Janet Lippett	Chief Medical Officer	Royal Berkshire NHS Foundation Trust
Andrew McLaren	Deputy Medical Director	Buckinghamshire Health NHS Trust
Professor Meghana Pandit	Medical Director	Oxford University Hospital NHS Foundation Trust
Dr Karl Marlowe	Medical Director	Oxford Health NHS Trust
Rachael De Caux	Chief Medical Officer	NHS Buckinghamshire, Oxfordshire and Berkshire West ICB
Keith Mansfield	Interim Senior Finance Manager	NHS Buckinghamshire, Oxfordshire and Berkshire West ICB
David Pollock	Interface Lead Pharmacist	NHS Buckinghamshire, Oxfordshire and Berkshire West ICB
Abid Irfan	Deputy Chief Medical Officer	NHS Buckinghamshire, Oxfordshire and Berkshire West ICB
Dr Andrew Brent	Director of Clinical Improvement	Oxford University Hospital NHS Foundation Trust

Topic specialists in attendance:

No topic specialists were in attendance

1.	**Welcome & introductions**
1.1	The Chair opened the meeting and welcomed members of the Committee, introduced himself and outlined the meeting structure. Discussion of meeting protocols was deferred until agenda item 6.
2.	**Apologies for Absence**
2.1	Apologies recorded as above. The meeting was recorded as being not quorate. The usual process as per the Terms of Reference will be followed. Post meeting agreement will be sought from absent delegates to endorse 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 Committee decision making.
4.	**Draft Minutes of the Priorities Committee meeting held on 6th July 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 6th July 2022 – Matters arising**

5.1	**Draft Minutes of the online Priorities Committee meeting held 6th July 2022** – 5.1 Policy update: TVPC 50 Subacromial decompression for shoulder impingement **–** Diane Hedges (DH) to escalate obtaining specific elective care waiting list data from Matthew Tate and appropriate personnel within the ICS. **Action: Closed**
5.2	**Draft Minutes of the online Priorities Committee meeting held 6th July 2022** – 5.2 Policy review: TVPC 11g Assisted Reproduction Services for Infertile Patients – Policy review to progress to September meeting. **Action: See item 6**
5.3	**Draft Minutes of the online Priorities Committee meeting held 6th July 2022** – 6.3 Evidence review: treatment with Anti-VEGF agents for neovascular (wet) age-related macular degeneration in patients with one seeing eye – Clinical effectiveness team to prepare draft policy as per option 1 and distribute to committee members for comment as per normal process. **Action: Complete**
5.4	**Draft Minutes of the online Priorities Committee meeting held 6th July 2022 –** 7.2 Policy review: TVPC 5 anti-VEGF treatments and dexamethasone implants for macular oedema caused by central and branch retinal vein occlusion – Clinical effectiveness team to update the date of the policy with no further changes. It is proposed to add the following additional sentence to the document relating to the recent NHSE publication of the national procurement for Anti-VEGF and intravitreal corticosteroids. *'NHS England recommends that clinicians consider ranibizumab biosimilar where the Technology Appraisal criteria are met, it is clinically appropriate and there is capacity to do so.'* **Action: The Committee agreed to the inclusion of this sentence**
5.5	**Draft Minutes of the online Priorities Committee meeting held 6th July 2022** – 9.3 Policy review: TVPC 60 Cataract removal in adults – thresholds for surgery – Clinical effectiveness team to draft policy to include the proposed EBO guidance referral criteria. **Action: Complete** DH to follow up the review of compliance with the referral thresholds across all service providers. There has been some ongoing ICB work monitoring independent sector provider commissioned services. This oversight is required to ensure the work undertaken is appropriate and challenges the breadth and scope of commissioned work. **Action: Closed as being undertaken by the ICB**
5.6	**Draft Minutes of the online Priorities Committee meeting held 6th July 2022** – 11.1 Work programme: DCS and DH to arrange a meeting with relevant personnel to review the work programme going forwards and to report back to the September meeting. The work plan is being reviewed taking account of the way in which the Committee wishes to move forwards. **Action: Closed and covered in agenda items 9 and 10**
6.	**Policy update: Policy Review: TVPC 11g Assisted reproduction services for infertile patients and Draft Policy**
6.1	Following the meeting in May the Committee suggested a working group to address this complex policy. The working group meeting was held on 21st June. Further to this and other discussions a review paper and draft policy is being presented to the committee today. There are three areas which will need agreement. <u>Background and presentation</u> • March 2022: TVPC reviewed TVPC11g assisted reproductive services for infertile patients focusing on: o Review policy on intrauterine insemination (IUI) for patients unable to undertake vaginal intercourse o Clarify definition of infertility/expectant management including point of referral for assessment/investigations

TVPC agreed to maintain the current commissioning position on IUI however it was agreed that the wording of the policy should be reviewed to include the context of the statutory NHS responsibility to remain within budget and the impact this has on funding decisions.

- Subsequently concerns were raised regarding equity of provision of services across different patient groups
- May 2022: TVPC agreed that a Working Group should be convened to discuss clinical detail and current practice to help inform policy development
- June 2022: Working Group* met and agreed policy options for funding of IUI, along with assessment of impact should be worked up, for consideration by TVPC

* Working group members included four NHS fertility specialists, two Integrated Care Board (ICB) representatives (one clinical), two special advisors (law and ethics)

The three areas that will need to be considered by TVPC are:

- Policy options to fund IUI
- Definition of infertility/expectant management
- Additional suggested changes to policy.

Policy options to fund IUI

IUI using partner sperm

- **Option 1**: Maintain the current TVPC11g policy which states that IUI is only funded for patients with social, cultural, or religious objections to IVF.
- **Option 2**: Suggested changes consistent with NICE recommendations; as well as funding IUI for people with social, cultural or religious objections to IVF, funding is made available for two additional patient groups:
    - those who are unable to have vaginal sexual intercourse because of a physical disability or psychosexual problem who have demonstrated subfertility through 6 unsuccessful cycles of artificial insemination (AI)
    - patients with conditions that require specific consideration in relation to methods of conception, for example, men who require electroejaculation because of spinal cord injuries.

  Option 2 has two sub options which define how patients with a physical disability or psychosexual problem demonstrate their subfertility:
    - Option [a] – Patients must undertake 6 self-funded IUI cycles at a fertility clinic
    - Option [b] – Patients must undertake 6 self-initiated AI cycles; this can either be IUI at a fertility clinic or artificial insemination at home using unregulated donor sperm.

Assisted conception treatment using donor sperm

- **Option 1**: Maintain the current TVPC11g policy which indicates that IUI using donor sperm is not funded for any patient groups. However, IVF using donor sperm is funded for:
    - heterosexual couples with male factor infertility, where use of partner sperm is contraindicated, and infertile couples unable to undertake vaginal intercourse and require donor sperm
    - single women and women in same sex relationships who have diagnosed infertility or infertility demonstrated by 12 self-funded AI cycles, 6 of which are IUI
- **Option 2**: Suggested changes consistent with NICE recommendations; offering up to 6 cycles of IUI using donor sperm to patients with:
    - Azoospermia or severe deficits in semen quality who do not want intracytoplasmic sperm injection (ICIS), high risk of transmitting genetic or infectious disorders, or severe rhesus isoimmunisation – it was noted that NICE recommends IUI is tried

before IVF for these patient groups because the female partner will not necessarily have a fertility problem

- People trying to conceive using donor insemination who have demonstrated subfertility through 6 unsuccessful cycles of AI – this suggested change would offer NHS treatment earlier in the pathway, but there would still be a need to demonstrate subfertility by undertaking 6 self-funded AI cycles first. This wording does not specify single women or women in same sex couples but instead defines this group as individuals or couples trying to conceive using donor insemination. This wording is used, as the principle of the pathway would apply to any patient group trying to conceive in this way and is inclusive to people of different gender identities.

Again, Option 2 has two sub options which define how people trying to conceive using donor insemination demonstrate their subfertility:

- Option [a] – Patients must undertake 6 self-funded IUI cycles at a fertility clinic
- Option [b] – Patients must undertake 6 self-initiated AI cycles; this can either be IUI at a fertility clinic or artificial insemination at home using unregulated donor sperm.

Suggested impact of suggested changes

- <u>National guidance</u>
  Option 2 is consistent with NICE guidance. To note, NICE does not specify whether the initial 6 self-funded artificial insemination cycles undertaken to demonstrate subfertility should be in a clinic or whether this can be at home; Option [b] would be more consistent with NICE as it does not necessitate IUI.
- <u>Activity and expenditure</u>
  The estimated cost of funding Option 2 is between £62-£68K per year. These estimates should be treated with caution as they are based on incomplete data and unverifiable assumptions. However, the actual cost impacts may be slightly less as the estimates do not consider activity funded for these patients at baseline. Baseline activity data is unavailable from Northeast Hampshire, Farnham and Surrey Heath, but activity from other areas is estimated as up to £16K per year.
- <u>Patient outcomes</u>
  Option 2 would lead to additional patients accessing IUI and IVF using donor sperm each year. It is unlikely there will be activity for IUI using partner sperm as indicators for this are very rare and other geographical areas implementing this policy have not identified activity.
  HFEA reported live birth rates per cycle are higher for IVF (36%) compared to IUI (19%) using donor sperm. The cumulative live birth rate of 6 IUI cycles is 67%. The indicative cost per live birth is lower for IUI at £6K per live birth versus £9-£11K per live birth for IVF.
- <u>Patient Safety</u>
  Option 1 limits most patient groups requiring donor sperm to having IVF rather than IUI. IVF is more invasive (as requires ovarian stimulation and egg retrieval procedures) and has more complications than unstimulated IUI. Multiple birth rates are also higher for IVF (6%) compared with unstimulated IUI using donor sperm (2%). The HFEA state that multiple pregnancies and births are the single biggest health risk in fertility treatment for patients and babies.
  Option 2 has risks in relation to option [b] which allows patients to demonstrate subfertility using home insemination; this is unregulated and has health, safety and legal risks. Unregulated donor sperm is not screened for disease or quality; there is no legal provision to prevent donors seeking a claim to a relationship with a child; donors may seek sexual intercourse, which could impact on the safety of the patient. Conversely, IUI at a clinic is highly regulated in the UK and everyone involved is offered counselling.

	However, there is a financial cost to the patient of at least £1,800 per cycle plus more for scans, consultations, etc. • Local Specialist view A questionnaire was sent to local specialists to obtain views on the two options. Only one specialist replied, who strongly supported both Options 1 and 2. • Other ICB policies A survey undertaken in 2020 indicates 54% of the commissioning bodies at the time did not fund IUI for same sex couples to demonstrate subfertility, but around 36% did. • Equality and equity The financial barrier to receiving NHS funded treatment for patients who need to demonstrate infertility is highest for option 1, less for option 2[a] followed by 2[b]. • Latest national developments The recently published Women's Health Strategy, sets out 10-year ambitions which include NHS funding of 6 IUI for same sex couples and removal of the financial barrier to accessing NHS treatment (no implementation date confirmed). Option 2[b] would be most aligned to this strategy followed by option 2[a].
6.2	Discussion For the purposes of assessing cost impact, figures quoted in the presentation were for the combined population of BOB and Frimley ICBs; separate estimates were available for the committee within the paper. The estimates were calculated using activity from another ICB which has implemented Option 2b. A rate per 100,000 women aged 18 to 35 was determined from that population and applied to the BOB and Frimley populations. Other than age and gender, it was not possible to control for demographic factors, so there is a potential for variation. It was noted, data from more than one ICB may provide a more robust estimate. The cost differences for patients self-funding AI of between zero and £11,000 for Option 2b, was explained as follows: • A patient trying insemination attempts at home would potentially cost no money. • 6 cycles of IUI performed at a clinic would cost around £11,000, but may be more considering additional costs of scans, appointments etc. • The cost would vary depending on the number of cycles undertaken in a clinical setting vs at home – patients may try both Currently heterosexual couples needing donor sperm would progress straight to IVF. Under the proposed new policy heterosexual couples, who require donor sperm, would need to undertake IUI first. During the working group meeting, attending clinicians generally expressed their support for undertaking IUI rather than progressing directly to IVF, for heterosexual couples who require donor sperm. It was noted that there could be some cost savings from not progressing straight to IVF and conceiving through IUI. A full picture of the baseline activity could not be established, meaning the full cost impact could not be determined. The population data used for this review was from the latest ONS GP registered populations for the historical CCG areas. There was discussion on equality issues, including financial impact, relating to same sex couples demonstrating subfertility. Heterosexual couples must demonstrate their subfertility by trying to conceive through intercourse for two years before accessing NHS funded assisted conception treatment. This is not possible for same sex couples who need to demonstrate infertility through AI cycles. In terms of equality, the policy applies the same principles to same sex couples and heterosexual couples who are unable to have vaginal intercourse.

Options 2[a] and 2[b] determine how patients using artificial insemination to conceive can demonstrate their subfertility. If patients are required to undertake IUI there is objective evidence as this has been undertaken in a clinical setting. For home insemination this would be evidenced by a statement from the patients, in much the same way as for a heterosexual couple would provide a statement of trying to conceive through intercourse for 24 months.

Concerns were raised about heterosexual couples possibly raising an equality issue because IUI under medical supervision is a more effective way of getting pregnant than sexual intercourse. Potentially heterosexual couples would not wish to try to conceive using sexual intercourse for 2 years and would ask for IUI intervention immediately. It was explained that under the policy, heterosexual couples wishing to access IUI would have to pay for six cycles of AI to demonstrate subfertility in the same way as same sex couples. It was noted that the wording of the proposed policy option for IUI using donor sperm has not specified that patients need to be single women or in a same-sex relationship; instead, the policy relates to 'individuals or couples trying to conceive using artificial insemination'.

The proposed policy aligns itself to NICE guidance, the recommendations from which were determined following consideration of equality/ equity issues. It was noted that this would reduce the risk of successful challenge. However, the draft policy should still be referred to counsel after decision is reached by the Committee.

It was agreed to split decision making on the recommendations into two halves. Option 1 versus 2 were considered first. The committee agreed to Option 2.

Option 2 has a further two options [a] or [b]. The Chair asked for a summary of the options. Option 2[a] – would require the patient trying to conceive using AI to demonstrate subfertility by undertaking 6 IUI cycles at a clinic. The patient would need to pay for this at a cost of around £1,800 per cycle, plus additional costs for consultations, scans, etc. Option 2[b] – would **not** require the patient to undertake IUI cycles to demonstrate subfertility. Patients would have the option of home insemination or IUI at a clinic. Home insemination poses risks to the patient including disease transmission, quality of sperm, accuracy of timing and legal challenge around parenthood.

The Committee heard that the setting of the AI to demonstrate subfertility was outside of the scope of the NICE recommendations but the Guideline Development Group, who determined the NICE recommendations, did make a comment in the full guideline that the preference was for patients to have IUI at a clinic. The draft scope for the NICE Clinical Guideline update uses the term AI when defining subfertility (it does not specify IUI) and therefore it seems likely the updated NICE guidance (due to be published in November 2024) will not change the current position.

Comments from members following the summary included:

- Option 2[a] may lead to a cost to the patient of around £11K whereas Option 2[b] potentially has no cost to the patient.
- Option 2[b] offers equality in terms of financial cost to the patient, as it would allow patients who are unable to financially undertake 6 cycles of IUI in a clinic to potentially still access NHS services.
- If option 2[b] is recommended, it was suggested that the majority of patients may opt for the home insemination route with the associated risks.

	• It was queried whether it is for the NHS to accept the potential risks of unregulated artificial insemination at home, or is it for the NHS to mitigate the risk through advice and guidance provided by clinicians. • The risks associated with option 2[b] are not inherent just to home insemination and many of the risks are also inherent in procreation generally. • Both options 2[a] and 2[b] do not prevent patients from trying home insemination, but for 2[a] home insemination would not count towards demonstrating subfertility for access to NHS funded assisted conception treatment. • It was suggested that option 2[b] may be inequitable to people who do not have access to sperm to undertake home insemination. Option 2[a] would be equitable for all in this regard, albeit with a cost attached. • Fertility Network UK was approached for feedback as part of reviews undertaken by other ICBs areas. They were keen for same sex couples to have more access to treatment generally but their views on option [a] vs. option [b] were not requested. • No patient groups were approached about this specific piece of work. Patient views on the current policy have been expressed and considered through the legal challenge of the current policy. At the March 2022 Committee meeting, where the initial paper and considerations were discussed, both legal views, defending and challenging the policy, from a patient perspective, were heard. • There was discussion around the appropriateness of patients being able to progress directly to NHS funded IUI without supporting documentation confirming subfertility. Option 2[a] would address this issue by ensuring that all patient groups trying to conceive through AI are required to undertake IUI in a clinic to demonstrate subfertility. • There was a long discussion about trust between clinicians and patients and the equality issues that result in requiring different groups of patients to evidence their subfertility to access assisted conception treatments. It was noted that the default position should be to trust patients**.** • It was felt that there may be a claim for indirect discrimination with option 2[a] due to the financial burden that this would involve, and if this option is selected, the proposed policy should be referred to counsel to explore how risks could be mitigated. • It was agreed at a prior Priorities Committee meeting, once the draft policy recommendation has been determined by this committee, independent legal advice would be sought. The ICB legal team will need to support approaching an independent advisor. • It was determined that the decision of 2[a] vs. 2[b] needs to be voted on. It was noted that the Terms of Reference and voting rights related to the previous CCGs had not yet been agreed for ICBs. ICBs are the legal, accountable organisation and are responsible for any challenges. The Priorities Committee is an advisory body and makes policy recommendations. The final adoption of policy recommendations has previously been the responsibility of the CCGs' governing bodies. This responsibility now lies with the ICBs Providing the authorising body is clear on how the TVPC reached its recommendation a vote on the recommended options could proceed.
6 .3	**TVPC decision for IUI** The committee were asked to consider whether to recommend: • Option 1 – retain existing policy • Option 2 – recommend adopting proposed policy, in which case further decision needs to be taken on:

	▪ [a] Requiring patients trying to conceive using AI to undertake 6 IUI to demonstrate subfertility OR ▪ [b] Allowing patients trying to conceive using AI to undertake 6 IUI or hone insemination to demonstrate subfertility The Committee agreed to option 2. The Committee was unable to reach agreement on option [a] or [b] and this will need to progress to committee members voting. As the new Terms of Reference and therefore voting rights have not yet been agreed (agenda item 8) it was agreed that the Chair will write to all voting members after the meeting to establish their decision on 2[a] or 2[b] **Actions:** • **Option 2 agreed.** • **DCS to write to all voting members after the meeting to obtain their decision on 2[a] or 2[b] and feed this back to CE Team.**
6.4	**Definition of infertility/expectant management** The focus of this review was to clarify the section of the policy relating to defining infertility/expectant management, specifically: • When patients who have a diagnosed fertility problem/suspected fertility problem can be referred for specialist assessment OR, where patients do not have a current or suspect diagnosed fertility problem, defining the period of expectant management* before they should be referred for specialist assessment • Outlining when patients who have a diagnosed fertility problem can be referred for consideration of IVF OR, where patients do not have a diagnosed fertility problem, defining the period of expectant management* before they should be referred for IVF. *For heterosexual couples, this would be the amount of time they are required to try to conceive through regular sexual intercourse. For single women, people in same sex relationships, people with disabilities/psychosexual problems that means they cannot have sexual intercourse, this would relate to the number of unsuccessful artificial insemination (AI) cycles that need to be completed. <u>Referral for investigations</u> Currently the TVPC11g policy does not address when patients should be referred for investigations. Suggested text is based on NICE recommendations: • Women of reproductive age should be offered clinical assessment and investigation with her partner (where relevant) if: o There is a known clinical cause of infertility or a history of predisposing factors for infertility, OR o In the absence of any known cause of infertility: ▪ The woman is aged <34 and has not conceived after 1 year of unprotected virginal sexual intercourse or 6 cycles of artificial insemination ▪ The woman is aged <u>≥</u>34 and has not conceived after 6 months of unprotected vaginal sexual intercourse or 3 cycles of artificial insemination NICE guidance recommends early referral for women aged 36 years and over. Suggested text for TVPC11g suggests early referral for women aged 34 and over because TVPC11g requires women to start assisted conception treatment before their 35th birthday.

	Referral for consideration of IVF It was noted that this section does not relate to IUI, only IVF. Currently the policy includes two sections which outline how patients must demonstrate their subfertility to be eligible for IVF, summarised as follows: ▪ **Section 5: Diagnosed and unexplained infertility – access to specialist services** People with absolute infertility, which precludes any possibility of natural conception, will have immediate access to IVF, but all other patients must have infertility for at least two years duration. ▪ **Section 6: Women in same sex partnerships, single women, and couples unable to undertake vaginal intercourse** Services will be available to single women, women in same sex partnerships, and couples unable to have vaginal intercourse because of disability, health problems, or psychosexual problems, if they are infertile. Referral can be considered after 12 cycles of artificial insemination (self-funded) 6 of which should be IUI to establish fertility status. It is suggested that these sections are replaced with a single section that addresses both groups of patients. The new proposed text is: ▪ **Demonstrating subfertility to be eligible for IVF** Where investigations show there is no chance of pregnancy with expectant management and where IVF is the only effective treatment, eligible patients can be referred for consideration of NHS funded IVF without delay. All other eligible patients can be offered IVF if they have not conceived after 2 years' duration of regular unprotected intercourse or 12 cycles of artificial insemination (6 of which should be IUI). This text was suggested because: ▪ It is consistent with NICE guidance. ▪ NICE were advised by specialists against using the term 'absolute infertility' in a draft of CG156 and it was removed from the final guideline. ▪ If a patient has a condition which means that expectant management is not appropriate and IVF is the only option, they should be referred directly for IVF. It should be clear in the policy that this applies to both patients trying to conceive through vaginal intercourse and those trying to conceive through artificial insemination.
6.5	Discussion It was questioned whether the revised wording relating to referral for IVF should include earlier referral for women aged over 34 (as per the wording for referral for investigations). It was explained that NICE specifically do not recommend earlier referral for IVF for older women and recommendations for women who are age 40 to 42 include the need to try to conceive for 2 years/ 12 cycles of AI, as per younger patients. It was noted that TVPC11g does no fund IVF for patients within this age group.
6.6	**TVPC decision for defining infertility** The committee were asked to consider whether to recommend • Option 1 – retain existing policy • Option 2 – recommend adopting proposed new wording. **Action: Option 2 agreed. CE team to add to proposed policy.**
6.7	**Additional suggested changes to TVPC11g** The papers included with the agenda details all suggested changes to the current policy. In summary: • Include a 'purpose' section to outline the aim of the policy • Amend scope section to:

	○ Include additional text to confirm the policy relates to people with pathological problems leading to fertility problems. ○ Confirm, in line with the Department of Health Guidance, that the ICB does not partially fund treatments ○ Confirm that the ICB will follow Government guidance on immigration surcharge • Include a new glossary of key terms • Include a new treatment pathway section outlining primary care responsibilities and when to refer for investigations and/or treatment • Amend the following sections to align with NICE CG156: ○ Embryo transfer strategies recommended – this is the number of embryos transferred per IVF cycle, which depends on age and the quality of embryos ○ Not funding natural cycle IVF – which is a specific recommendation made by NICE ○ Clarify indications for IVF/ICSI using donor eggs • Amend the surgical sperm retrieval policy to ensure it is consistent with NHS England policy ○ One outstanding matter to be resolved is how long the ICB should fund storage of surgically retrieved sperm. It was suggested this could be bought in line with storage of embryos and funded for up to 3 years. • Confirm that treatment add-ons with limited evidence as defined by the HFEA are not funded. • Add an appendix with flow chart illustrating patient pathway for assisted conception treatments using donor sperm • Make additional minor changes for clarity/internal consistency.
6.8	Discussion Support was expressed for implementing HFEA guidance around add-on treatments. Historically there have been challenges asking for funding for add-on treatments by service providers as well as patients, so clarification of the commission position is important. It was noted that the HFEA have expertise in this area and review their guidance considering new evidence regularly. In previous discussions on TVPC11g, IVF for social infertility has been broadly discussed and ICBs did not have a desire to include this within the policy statement. The proposed policy does not include funding for assisted conception treatment for social infertility. This could be a future challenge to the ICB. However, NICE guidance is clear that NHS treatment should be limited to people who have a medical or physiological problem that is causing infertility. This has now been clarified in the background section of the scope of the draft policy. If there is a challenge, the challenge would apply to NICE guidance. However, it was noted that by clarifying the scope of the policy towards pathological infertility, there is possibly of challenge that it is bias towards heterosexual couples.
6.9	**TVPC decision for additional suggested changes to TVPC11g** The committee were asked to consider whether to recommend • Option 1 – retain existing wording • Option 2 – recommend adopting proposed new wording ○ Confirm how long the ICB should fund storage of surgically retrieved sperm – suggested 3 years **Action: Option 2 agreed. CE team to make changes to proposed policy.**
7.	**Update on South East Priorities Committee development**
7.1	The Chair provided an update on the review undertaken for the South East Regional Office of NHS England.

8.	**Review of Terms of Reference; Ethical Framework; Standard Operating Procedure**
8.1	Background The Terms of Reference (ToR), Ethical Framework (EF) and Standard Operating Procedures (SOP) are reviewed annually. Minor amendments were previously made and the Committee agreed at this time that all documents would be reviewed again to ensure the Committee is fit for purpose in supporting the work of the ICS/ICB when they became legal entities. Terms of Reference: Actions that need to be considered are: • Agree proposed changes as tracked in the document • Consider whether the name 'Thames Valley Priorities Committee' reflects BOB and Frimley ICBs • Agree the member organisations, members, and number of delegates • Agree voting members (when consensus is not reached), LA member and NHS provider organisations • Agree a named deputy chair • Agree quoracy requirements • Agree the named committee strategic lead for liaison with the clinical effectiveness team to support the effective running of the Committee, to meet its aims and as a point of escalation of any issues as necessary. Previously, Sue Carter stated this role has been delegated to her by the CMO. The Terms of Reference document was displayed, and the Committee was asked if there were any objections to the proposed terminology and general tidying up of the document. There were no objections to the general wording changes within the document. Discussion was held regarding membership: • The Committee heard that Healthwatch would not normally be voting members of a committee. Healthwatch will attend meetings and take full part in the committee discussions, but Healthwatch's role to scrutinise and challenge creates a conflict to being a voting member of a committee. It was considered helpful to have two voting lay members as part of the committee, one from each of the ICBs represented by TVPC. • It was suggested that medicines optimisation representation will be necessary when the agenda has items relating to medicines optimisation. • Consideration needs to be given as to what the committee wishes to achieve in order to ensure the correct IFR representation. • In relation to NHS provider organisations, it was suggested that this should include Frimley ICS provider organisations. If the NHS provider organisations do work in partnership and offer services to the ICB population, it would be appropriate for them to be included. • Regarding voting rights for NHS provider organisations, previously commissioners had sole responsibility for managing resources. This is now a shared responsibility between providers and ICB, so it may be logical for NHS provider organisations to be involved in the decision-making surrounding affordability, activity and clinical policy. • There was discussion on representation from ICBs. Proportional representation was discussed, but it was agreed ICB representation would be 2 from BOB ICB and 2 from Frimley ICB with voting rights. • Under the new ways of working, ICBs and local authorities are required to collaborate and plan for the future. Membership from public health, seeking membership from the integrated care partnership and local authorities was discussed. The Committee will also need to consider pathways, innovation and change. It was agreed as the membership

	includes representation from Public Health this could be something to be reviewed again in the future. Public Health consultant/representative would have one member and one vote. **Actions:** • **CE team to update minor wording changes within the ToR document** • **CE team to explore recruiting an additional Lay member to represent BOB ICB** • **CE team to contact GM regarding continuing membership and possibility of becoming deputy chair** • **It was agreed that the membership and quoracy would be discussed with the TVPC strategic lead outside of the meeting and draft Terms of Reference circulated with the minutes for further comment.** **Post meeting notes:** • **CE team seeking confirmation of ICB members and voting members via email in order to update the ToR** • **Draft ToR will be circulated following agreement of ICB voting members**
8.2	<u>Ethical Framework (EF)</u> Actions that need to be considered for this document include: • Agree proposed changes to the tracked document previously circulated • Inclusion of meaningful reference to population health and public health that ensures the Committee is fit for purpose in supporting the priorities of the ICBs • The Special Advisor in Health Law proposes a slight amendment in how the Committee may assist ICBs to address health inequalities: 'The Committee believes that people should have access to health care on the basis of need. There may also be times when some categories of care are given priority in order to address health inequalities in the community both as to the ability to access services, the experience and outcomes achieved by providing them.' • In order to add the above, it has been suggested to add an additional appendix to the EF document outlining how the Committee will support the ICBs in tackling inequalities in relation to outcomes, experience and access in health care. Items that could be articulated in an appendix to demonstrate the Committee is addressing health inequalities could include: • Topic submissions for TVPC review could identify interventions and pathways where there may be health inequalities. These should link with ICB plans and priorities and take account of joint health and wellbeing strategies published by the health and wellbeing boards. • Assess equality impact of policies to demonstrate the public sector equality duty (PSED) is met • Liaising with Healthwatch and local authorities (LA) to review population health and public health priorities identified in any relevant joint strategic needs assessments (JSNAs). • Review data including: IFR data, activity and expenditure data, indices of deprivation, JSNAs and population health data. **Action: It was agreed minor wording amendments would be made and a draft would be circulated to the committee with the minutes for comment.** **Post meeting note: draft EF will be circulated following on from agreement of proposed wording in an additional appendix**
8.3	<u>Standard Operating Procedure</u> Actions that need to be considered are:

	• Agree or review further tracked proposed minor amendments • Discuss arrangement for an annual workshop. Historically an annual workshop has been held where CCGs submit topics for consideration for review. The timing of the workshop is flexible, but it was suggested it could be held in February or April to give ICBs time to consider priorities and identify health inequalities and link with Healthwatch. Comments included: • It was agreed that the timing of the workshop should be suitable to enable the proactive planning of the work of the Committee • Capacity needs to be built into the work of the Committee to be reactive in meeting arising needs between the planning meetings. This needs to be included in the SOP to enable the Committee to be responsive. It may be that more than one workshop per year is required. There was a suggestion of planning to 80% capacity to leave 20% to address arising needs **Actions:** • **The Committee agreed for workshop meeting to be delayed until 2023** • **It was agreed minor wording amendments would be made and a draft would be circulated to the committee with the minutes for comment.** **Post meeting note: Draft SOP will be circulated with ToR**
9.	**Clinical Policy Updates Surveillance Process; proposed approach and SOP**
9.1	This item relates to the process of the Priorities Committee. The Standard Operating Procedure document outlines how the Thames Valley policies are reviewed, updated and reflect best practice going forwards. At present, individual policies are routinely reviewed on a three-year cycle. The proposal moving forwards is to follow a static policy review process. This means policies would not be routinely reviewed on a three-year basis. Instead, the policy review process would include a monthly surveillance process, exploring specific sources of evidence and guidance. If evidence is identified that is thought to potentially have an impact on a policy, the policy will be reviewed and scoped and if it is felt a full review is required the matter will be raised at a TVPC meeting in order to seek agreement to progress to full review. This is felt to be a more efficient process and will release capacity within the SCW clinical effectiveness team to address the previously raised point of being more reactive. **Action: The Committee agreed to adopt the proposed approach to policy review.**
10.	**Agreement of Work plan until March 2023**
10.1	The previously agreed work plan includes items to be covered for meetings in November, January and March. This has been brought to the meeting to ensure that the Committee remains satisfied with the plan. It was noted that an email has been received from the BESS/BOA group confirming the guidelines for subacromial decompression surgery are due to be published in early 2023. In light of this, it was agreed to delay review of this policy until the publication of this guideline. Workplan explanation: • Policy Statement 76 (TVPC98): Chronic Fatigue Syndrome/Myalgic Encephalomyelitis and TVPC61 Snoring and Obstructive Sleep Apnoea / Hypopnoea Syndrome (OSAHS) in adults

	are included for review due to recent NICE guideline publications and updates which have a significant impact on the current policy proposals. Two other smaller updates in November are included as they crosslink to TVPC98 and TVPC61. • The CE team are still awaiting the publication of EBI list 3. If this is published as expected in October a review will be scheduled for November. • The topics for January include consideration of a policy for Denosumab and an update to the current policy TVPC 12 Botulinum Toxin A, both of which have been requested. The letter will be reviewed alongside TVPC 25 Hyperhidrosis (excessive sweating) – Botulinum Toxin A and Endoscopic Thoracic Sympathectomy. • The others (TVPC 1, 17, 67, 71 and 87) are policy updates, which when scoped were identified as containing some additional published guidance with some impact on TVPC policies. These are flexible for review and could be revisited if another more pressing issue was identified. The reason for identifying work items this far in advance is to ensure that work can start in preparation. Papers are sent to clinicians 5 and 6 weeks ahead of any given meeting. During this point there is time to scope additional pieces of work. This means that if a piece of work does come in two to three weeks ahead of a meeting, there the work could be scoped, and findings brought to the committee for agreement on whether to take the matter forwards. **Actions:** • **The work plan was agreed in principle.** • **CE team and SC to meet outside of Priorities Committee to discuss the imperative of the policies included on the workplan** **Post meeting note: The publication of EBI list 3 may not published in time for discussion at the November meeting.**
11	**TVPC Annual Report 2021-2022**
11.1	This was circulated for information only. The annual report is published on a patient facing website so content approval is sought. **Actions:** • **The Committee agreed the Annual report for 2021-2022.** • **CE team to arrange publication.**
12.	**Any other business**
12.1	The meeting in November may need to be changed from a 2pm start to a 3pm start. The Committee was given advanced warning and informed as much notice will be given as possible if the meeting time needs to be moved. **Action: CE team to notify all members if meeting start time is moved from 2pm to 3pm.**
13.	**Date of next meeting**
13.1	The next meeting will be held on Wednesday, 23rd November 2022, from 2 – 4.30pm via Microsoft Teams
14.	**Meeting close**