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

Thames Valley Priorities Committee

Minutes of the meeting held Wednesday 23rd March 2022

On-line via Microsoft Teams

Alan Penn	Lay Member Chair	Thames Valley Priorities Committee
Diane Hedges	Deputy Chief Executive	NHS Oxfordshire CCG
Sue Carter	Clinical Effectiveness Manager (CCG)	NHS Oxfordshire CCG
Edward Haxton	Interim Chief Financial Officer Berkshire West CCG	NHS Berkshire West CCG
Emeritus Professor Chris Newdick	Special Advisor, Law	University of Reading
Mark Sheehan	Special Advisor, Ethics	University of Oxford
Dr Megan John	GP, Frimley Lead	NHS Frimley CCG
Jenn Sula-Minns	Prior Approvals Manager	NHS Oxfordshire CCG
Robert Majilton (left 14.55)	Deputy Chief Officer	NHS Buckinghamshire CCG
Dr John Fraser	Clinical Lead, Surrey Heath locality	NHS Frimley CCG
Shairoz Claridge	Director of Operations, BOB ICS Interim Director Lead for Long Term Conditions	NHS Berkshire West CCG
Dr Janet Lippett	Chief Medical Officer	Royal Berkshire NHS Foundation Trust
David Clayton-Smith (joined 14.35)	Chair, Review of Priority Committees and IFR processes; Chair	NHS England and NHS Improvement, South East; Kent, Surrey & Sussex Academic Health Science Network
Maire Stapleton	Formulary Manager	Medicines Resource Centre, Bucks Integrated Care Partnership

In Attendance:

Kathryn Markey	Clinical Effectiveness Manager	SCW CSU
Naomi Scott	Clinical Effectiveness Manager	SCW CSU
Kate Forbes	Clinical Effectiveness Manager	SCW CSU
Tiina Korhonen	Clinical Effectiveness Lead	SCW CSU
Helen Hicks - minutes	Clinical Effectiveness Administrator	SCW CSU
Funmi Fajemisin	Clinical Services Programme Lead Clinical Policy Implementation	SCW CSU
Zenzo Ncube	Senior Finance Manager	SCW CSU
Apuuli Ja	Senior Equality Advisor	SCW CSU
Aimee Ashby	Interim Prior Approval and Audit Manager	SCW CSU
Laura Tully	Deputy Director for Clinical Quality	SCW CSU

Apologies:

Dr Raju Reddy	Secondary Care Consultant	NHS Berkshire West CCG
Dr Jacky Payne	GP, Berkshire West	NHS Berkshire West CCG
Gill Manning	Lay representative	NHS Frimley CCG
David Pollock	Interface Lead Pharmacist	NHS Berkshire West CCG
Andrew McLaren	Deputy Medical Director	Buckinghamshire Health NHS Trust
Lalitha Iyer	Medical Director	Frimley CCG
Professor Meghana Pandit	Medical Director	Oxford University Hospital NHS Foundation Trust
Dr Andrew Brent	Director of Clinical Improvement	Oxford University Hospital Foundation NHS Trust
Kate Stephen	Commissioning Manager	Oxford CCG
John Reynolds	Associate Director of Medical Sciences Division	Oxford University Hospital NHS Trust

Topic Specialists in Attendance for Agenda Items:

Item 5 – Policy update feedback: TVPC 2 Treatments for Gender Dysphoria
Dr James McNally, GP and Medical Director – Oxfordshire, Berkshire, Buckinghamshire and Oxfordshire local medical committees (LMCs)
Item 6 – Policy review: TVPC 11g Assisted Reproduction Services for Infertile Patients
Prasanna Supramaniam, Consultant in Obstetrics & Gynecology, Oxford University Hospital NHS Trust Fatima Husain, Consultant in Obstetrics & Gynaecology, Frimley Health NHS Foundation Trust

1.	**Welcome & introductions**
1.1	The Chair opened the meeting and welcomed members of the Committee.
2.	**Apologies for Absence**
2.1	Apologies recorded as above.
3.	**Declarations of Interest**
3.1	The Chair reviewed the declarations of interest prior to the meeting. None of the interests declared were consider material for the Committee decision making.
4.	**TVPC Lay Chair Role**
4.1	A discussion was held at the January Work Prioritisation meeting about the need to appoint a new Chair due to the retirement of Alan Penn. The Committee was informed that discussions have taken place across the South East (SE) region to review Priorities Committees, policy setting and Individual Funding Requests (IFR). David Clayton-Smith (DC-S) is undertaking this work at the request of NHS E South East regional director. The Accountable Officer and Executive ICS Lead for Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care System has proposed that DC-S is appointed as an interim TVPC Chair. It is understood he has relevant expertise and can share learning from the TVPC with the South East regional review. Question was posed that if the proposed Chair is directly employed by the NHS for the regional review, does this fulfil the role description which states the Chair must be a lay person. In response to a concern that working for the NHS to review a regional priorities committee may not fulfil the criteria of a lay chair, it was clarified that DC-S is not employed by a direct stakeholder i.e CCG or ICS within the TVPC Committee membership. The remit of the role of employment for NHS England is to lead the exploration of the South East Priorities Committee and policy implementation process review. It was queried whether the Committee believed the interim appointment would fulfil the lay criteria or should additional lay membership be necessary for the Committee. It was agreed that the Committee would welcome additional lay representation which can be explored further as part of the review of the Terms of Reference (ToR). The role of the deputy lay chair was also

	raised as the ToR refers to a deputy chair role. It was agreed that the Committee membership will need to be reviewed in the autumn once the CCGs transition into ICSs. The Committee agreed to the proposal to appoint David Clayton-Smith as interim TVPC Chair. **Action: Clinical Effectiveness team to progress TVPC Chair recruitment as per usual process for SCW bank staff.**
5.	**Policy update feedback: TVPC 2 Treatments for Gender Dysphoria**
5.1	At the November 2021 the Committee agreed an update to the TVPC2 Treatments for Gender Dysphoria (GD) as part of a routine 3-yearly review. The policy statement mirrors the NHS England Specialised Commissioning Specification in outlining the core and non-core treatments for GD and reiterates that non-core treatments not funded by NHS England (NHSE) are not normally funded by the CCGs. The policy contains notes on the patient pathway, based on the NHSE specification. Post meeting feedback was received relating to the overall patient pathway and the local primary care clinicians expressed their wish to formally raise their concerns over the service provision for this patient group. The clinician in attendance outlined the issues: • GPs should have a good awareness of gender variance and be able to recognise and support this patient group. However, caring for this patient group is complex and the average GP will only have a small number of people presenting to them each year. • GPs are generally advised to refer GD patients to a specialist service for initial assessment and decisions about any treatment necessary, rather than attempt to manage this specialist work themselves. • The local policy, as the NHSE specification, claims these patients remain under some form of "shared care" whereby the GP prescribes with specialist support/supervision. There is an ongoing dispute that GPs should prescribe and monitor patients as there is currently no funding for this from NHSE. • The policy TVPC2 does not reflect that local services are delivering treatment for GD. • There is increasing recognition of the need for ongoing specialist/secondary care input for this patient cohort, for aftercare as well as at initial assessment. National provision for children and young people is currently the subject of an independent review chaired by Dr Hilary Cass OBE. Key points of the report were shared with the Committee and summary of local concerns as follows: • TVPC colleagues should work with NHSE team to ensure delivery of the Cass Review's recommendations. • TVPC /local/regional commissioners should clarify what progress has already been made in light of the May 2021 Cass letter to NHSE. • The care of children and young people with gender dysphoria is everyone's business. • The adult service model will necessarily be influenced by the CYP model. Some suggestions were made to improve the accuracy of the local TVPC2 policy wording in relation to the patient pathway. • The NHS England's Specialised Commissioning team is currently responsible for the provision of specialist care and treatment for people with gender dysphoria. • Note that the NHSE specification is not limited to only Surgical Interventions. • Include in the statement itself, the fact that CCGs are currently, already, commissioning specialist aftercare for this cohort. • Include a note that "there is increasing recognition of the need for ongoing local specialist /secondary care input for this patient cohort, for aftercare as well as at initial assessment. Local models for delivery are in the early stages or in development and funding is under negotiation".

	• Include "The Cass Review" is likely to inform national service developments and local commissioners will work to deliver on its recommendations to ensure best practice for this patient cohort"
5.2	The Committee considered the feedback and whilst agreed on the challenges of the service provision, concern was raised with the proposed change to wording. It was suggested that expectations of patients may be raised of CCG commissioned care by patients and this may increase pressure on GPs beyond their level of competency or time/resource availability. It was acknowledged that differing local commissioning arrangements are in place across Thames Valley. Oxfordshire CCG has commissioned support from Oxford University Hospital at the Endocrinology clinic for transgender management, however, this was abandoned by the service after six months. Buckinghamshire has two GP practices who have GPs with a special interest. They have recently given feedback on Tavistock shared care protocols. This is an agreed interim arrangement within Buckinghamshire for GPs in the commissioned service and for any other GP who would feel competent to prescribe. The shared care agreement can however be rejected if appropriate and patients can be referred to the commissioned practice. In Berkshire West there are no additional clinics, however, with BOB Integrated Care System (ICS) transformation this recognised gap in services will be part of the future workplan when commissioning arrangements change. Following discussion, the Committee agreed for the TVPC2 to be amended with minor points on accuracy of the patient pathway. However, it was agreed that the aspirational points on adding note on local models for delivery will remain outside of the policy remit. Further review to be carried out as relevant once full new national guidance is published. **Action: Clinical Effectiveness team to amend the policy and circulate as per usual process with the draft minutes.**
6.	**Policy review: TVPC 11g Assisted Reproduction Services for Infertile Patients**
6.1	At the January 2022 meeting the Committee agreed to review policy TVPC 11g Assisted Reproduction Services for Infertile Patients. The scope of the review is as follows: • To review the policy position of funding artificial insemination (AI) for patients unable to undertake vaginal intercourse to establish fertility. The current TVPC policy 11g for 'Assisted reproduction services for infertile patients' states that for this policy a couple is expected to be two people in a relationship trying to conceive for over 2 years by regular unprotected intercourse or in case of people unable to have intercourse, over 12 cycles of artificial insemination (AI). It is expected that the 12 cycles of AI are self-funded as part of expectant management. The premise of the policy is the need for the patient to demonstrate healthcare grounds for accessing specialist services for assisted reproduction. The purpose of the policy is to prioritise access based on clinical need (i.e. infertility). • To clarify the related section of the policy for expectant management and the point of referral for initial specialist assessment and investigations for all patients, including female and male same sex couples, single women and other couples unable to have vaginal intercourse. • To note the differing policy thresholds for referral for assisted reproduction / conception services in the current geographical area covered by the TVPC (Buckinghamshire, Oxfordshire and Berkshire West CCGs i.e. BOB and Frimley CCG) and consider whether there is a need to review the core thresholds such as the female age and number of fresh and frozen cycles funded. • Consider the findings of the Human Fertilisation and Embryology Authority (HFEA 2021) report: Ethnic Diversity in Fertility Treatment 2018 UK ethnicity statistics for IVF and DI fertility treatment. This report highlights disparities in access to and outcomes of fertility treatment by ethnic group from 2014-18 and actions for the HFEA and others to undertake in response.

	The HFEA (2020) Family Formations report states that overall, fertility treatment was mostly accessed by patients in heterosexual relationships - 90%; 6.4 % by patients in female same-sex relationships and 3.2% by single patients. It is difficult to estimate the numbers of other patients unable to have vaginal intercourse i.e. people who are unable to, or would find it very difficult to, have vaginal intercourse because of a physical disability or psychosexual problem and people with conditions that require specific consideration in relation to methods of reproduction. Demand by these patients is anticipated to be low. It was noted there were no Individual Funding Requests (IFRs) for Intra uterine insemination (IUI) for BOB, North East Hampshire and Farnham or East Berkshire CCGs, however, this could be due to the long established position as a not normally funded intervention hence no applications to the IFR teams. In Surrey Heath locality, where 6 cycles of IUI is funded, local data indicated that 7.7% of Prior Approvals for assisted conception in services in 2020 were for IUI (all patient groups). NICE Clinical Guideline CG156 'Fertility problems: assessment and treatment' recommendations and advice were summarised regarding chance of conception, access criteria for in vitro fertilisation (IVF) and the funding of IUI. Specialist feedback was shared in support of 6-12 cycles licensed sperm donor insemination rather than self-funding (in relation to female same sex couples), before considering IVF. Feedback was also noted raising the related issues of NHS funding of egg donation and surrogacy. The Committee was reminded of the Public Sector Equality Duty (PSED) and advised to consider direct or indirect discrimination. Information that was presented for the Committee focussed on people in same sex relationships, however, all protected characteristics and patient groups were part of the consideration. The key PSED points were highlighted including: • Addressing all three aims of the duty; eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010; advancing equal opportunity and fostering good relations between people who share a protected characteristic and those who do not. • Whether the Committee has sufficient information in order to make decisions and to have due regard to the duty in considering the options of either maintaining the current policy or amending the policy and any mitigating actions in relation to either maintaining or amending the policy.
6.2	It was noted that the policy TVPC11g does not set any expectations on the duration of relationship for patients seeking assisted reproduction services. A point was raised of the potentially large number of women approaching services who do not have fertility issues and for whom funding approval would amount to the provision of NHS funded IUI for non-clinical reasons. CCGs would need to consider how to fund services for people who may be fertile but have other reasons they cannot conceive a child. This would potentially result in the cessation of other services in order to release funding, which could present ethical issues and further inequality. Additionally, it was highlighted that equity consideration is not just in relation to same sex female couples, but a vulnerability of the policy to be challenged by both heterosexual and male couples if AI for same sex female couples was to be funded. Clinical specialist in attendance noted in relation to efficacy of IUI, that whilst the evidence base had shifted over time, in the context of resources and equity it would be good to reconsider bringing back IUI as a treatment option to fund. Clinical care takes account of broad assessment of suitability for treatment in variety of ways, including consideration such as age, body mass index and lifestyle. It was clarified that NICE will be reviewing the evidence of effectiveness of IUI in the context of IVF. Currently NICE CG156 advises that IUI for unexplained infertility should not be routinely offered as an alternative to expectant management, unless vaginal intercourse is not possible. The scope of the planned NICE CG156 update is yet to defined.

	Concern was highlighted regarding the need for CCGs and ICSs to manage demand within a finite budget. BOB ICS is the lowest funded ICS in the country and is reporting a significant deficit over the next financial year. Any additional costs will have to be met by releasing funds from other services. It was noted that the nature of this policy and any subsequent recommendations innately raises a risk of being challenged. It was suggested that a draft policy recommendation at this stage would be preferable and this should be referred for legal counsel to review to ensure adherence to PSED legislation. This has to be set in the context of the challenges of NHS resource constraints. It must be evidenced that making distinctions between one group and another has to be done in the circumstances that face the local decision makers. It was acknowledged that difficult decisions have been made in relation to this policy previously, for example in regards to not affording to offer full NICE CG156 recommendations such as three full cycles of IVF. It was agreed that the policy update would benefit from outlining the underlying context, affordability of interventions, statutory duty for the CCGs to remain within their allocated budget and the need to be make decisions based on medical need. Whilst this is not normally included in the policy statements it was suggested that for this particular policy it would be beneficial. It was noted that further clarity may be needed with regards to terminology used in the policy statement The difficulty is the category of patients who are fertile but for understandable reasons are not likely to become pregnant through vaginal intercourse. Categories defining fertility status could be included for example: absolute infertility; unexplained fertility; fertile single women and women in same sex relationships. It should be emphasised that the policy position considers all women and patients who are fertile for whom vaginal intercourse is not possible. An issue of fixed capacity was discussed. Question was raised of whether the availability of a fixed number of episodes of fertility support should result in changing the policy position. It was also noted that in some areas of England, fertility services have been withdrawn. The option of widening the policy access for more people was contrasted with the potential need for tighter thresholds for what is funded as well as with the potential option of not funding any assisted reproduction services. The Committee's specialist adviser in ethics suggested that the Committee should consider the value that is attributed to people having children with, for example, the value of treating cancer or giving people the ability to hear using interventions that that would normally be funded. It was acknowledged that holding different policies within an ICS not desirable and that alignment of policies is preferable. Within Frimley CCG there are currently three policies in relation to assisted reproduction services with differences in some of the core referral thresholds. The Frimley CCG representative noted that one of the policies for a locality within Frimley ICS supports funding for wider referral thresholds and echoed the difficult decisions that need to be made in order to align the policies within a limited budget. Inequalities will invariably exist due to the variation on CCG borders. Currently, in the NHS South East region there is work undergoing to review variation in access to care. In view of differing Frimley CCG locality policies, there is potentially a need for local public consultation if a significant change to service provision is agreed as part of alignment to the TVPC11g policy position.
6.3	The Committee noted the points raised and constraints of the funding options for assisted reproduction services. The Committee agreed not to change the thresholds of the current TVPC11g policy or the premise of the policy i.e maintain the need to demonstrate infertility prior to referral to assisted reproduction services with self-funding of AI. It was agreed that the wording of the policy will be reviewed to include context of the statutory NHS CCG responsibility to remain within budget and the impact this has on funding decisions. It was also agreed to add

	clarity for the section on expectant management for all patient groups in regards to the point of referral for initial investigations and referral for IVF. The Committee agreed that the decision was taken with full consideration of the Public Sector Equality Duty and the Health Inequalities legal duties. **Action: Clinical Effectiveness team to:** • **review the TVPC11g policy wording regarding the terminology and the patient groups affected** • **add clarity to the section on expectant management for all patient groups** • **add context of the CCG funding decisions to the policy.** • **Clinical Effectiveness Team to produce a draft policy for the May TVPC and, if approved, the draft policy to be submitted to counsel for a legal opinion.**
7.	**Review of NHS Continuing Healthcare (CHC) High Cost and Complex Care Packages**
7.1	A review was presented to the Thames Valley Priorities Committee (TVPC) in November 2021. This considered whether criteria relating to cost, risk, or level of need could be applied to the provision of domiciliary CHC funded care. The aims of such criteria would be to provide consistency in decision making across the Thames Valley CCGs, reduce variation in access and provision of care, and to support the legal duty of CCGs regarding affordability. Following the November TVPC meeting, a sub-group was convened (with representatives from CHC departments, CCGs, and the specialist adviser in health law) to discuss the possibility of a limit to the cost of CHC domiciliary care to 10% over and above that of a genuine alternative. The Thames Valley CCGs already have Equity & Choice (E&C) policies which include detailed statements regarding the provision of all CHC funded care. Included in Berkshire East and West CCGs and Buckinghamshire CCG E&C policies are statements relating to a 10% uplift for domiciliary care. Oxfordshire CCG does not have a 10% figure in its E&C policy as legal advice previously provided did not support this. Benchmarking CCG Equity and Choice Policies: A high level benchmarking of E&C Policies (or similar) was undertaken prior to the subgroup meeting. This found that of the policies which could be accessed, less than 10 CCGs stated that a domiciliary package of care would not be funded over and above the cost of a registered care setting which could meet the assessed needs of that individual at that time, and less than 10 CCGs included a 10% addition for domiciliary care over and above a genuine alternative. Most policies detailed that exceptional circumstances may exist in which criteria would not be applied. No rationale could be found for setting the figure at 10%. Data: Local data collected in 2021 from CHC teams showed that Oxfordshire CCG had a higher number of clients being provided with domiciliary care costing in excess of £100,000 per annum (11.6 cases per 100,000 population), compared to Berkshire West CCG (3.3) and Buckinghamshire CCG (3.7). No local data were available for Frimley CCG (East Berkshire). Separate data collected as part of the Integrated Care System (ICS) Development Programme suggested differences in activity and spend to that given directly by CHC teams. This data, collected from the council payments team, illustrated that Oxfordshire CCG had 27 domiciliary care packages costing over £100,000 per annum in November 2021 compared to data from Oxfordshire CHC team which showed 87 (June 2021). It was identified during the subgroup meeting that some domiciliary care packages commissioned by Oxfordshire CCG are entirely nurse led. Buckinghamshire CCG funds this level of care on an exceptional basis only, and Berkshire West CCG does not commission. Berkshire West CHC has historically been unable to commission nurse led care due to a lack of available suitably trained personnel and does not consider this level of care in the home to be sustainable. The market in Oxfordshire has evolved to account for this need. Oxfordshire CCG was an NHS England vanguard

	site for personal health budgets and this may be the reason that services have developed to include nurse led care. The Committee was advised that application of a TVPC statement could lead to an increased demand for complex domiciliary care in Berkshire West or a decrease in the number of domiciliary high cost care packages commissioned in Oxfordshire. Management of legacy care packages in Oxfordshire could lead to inequity. Assessing the cost of a 'genuine alternative': the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (2018) states that the starting point for agreeing the package and the setting where NHS Continuing Healthcare services are to be provided should be the individual's preferences. In some situations, a model of support preferred by individuals will be more expensive than other options. CCGs can take comparative costs and value for money into account when determining the model of support to be provided but should consider that the cost comparison has to be on the basis of the genuine costs of alternative models. A comparison with the cost of supporting an individual in a care home should be based on the actual costs that would be incurred in supporting a person with the specific needs in the case and not on an assumed standard care home cost. The Committee was asked to consider how the E&C Policies should be aligned. The Committee was asked to consider whether the 10% should apply (as per Buckinghamshire and Berkshire West CCG policies), or whether to remove this (as per Oxfordshire CCG Policy). The lack of rationale for setting the figure at 10% was highlighted. It was noted that the alignment of the E&C policies may fall within the ICS Development Programme.
7.2	The difficulties with obtaining data were discussed, and whether more accurate data is required prior to further policy development to ensure that any policy is focused on areas of most relevance. At present the numbers of clients domiciled in different settings, and the subsequent cost pressures within individual systems are not clear. It was hypothesised that the 10% cost uplift for domiciliary care was adopted previously to allow for some flexibility in systems. It was discussed that a policy statement could be generated with recognition that this may cause some inequities within the system which would need to be planned for and addressed. The management of high cost packages of domiciliary care already in situ would need to be considered. Any supporting documentation could highlight that the data is incomplete. It was highlighted that the CCG E&C policies detail aspects of care such as risk, cost and sustainability, and that the policies should be aligned by July 2022. The Committee advised that more data is required. This could be accessed via Broadcare when the system is live across the CCGs. It was suggested that it may be more beneficial to review the topic again once the ICSs are fully operational. Additionally, commissioning arrangements may be changing for some CCGs, with a move towards joint commissioning with Local Authorities.
7.3	Following discussion, the Committee requested KF investigate progress with the alignment of E&C policies as part of the ICS Development Programme. **Action: Clinical Effectiveness team to contact the Interim Director of Joint Commissioning at Berkshire West CCG**
8.	**Horizon scanning**
8.1	A recommendation was presented to the Committee to review TVPC 98 Chronic Fatigue Syndrome ahead of scheduled due to recent published guidance. This was agreed by the Committee.

	Action: Clinical Effectiveness team to add TVPC 98 Chronic Fatigue Syndrome to the 2022/23 work programme.
9.	**Draft Minutes of the Priorities Committee meeting held 24th November 2021 - Confirm accuracy**
9.1	The meeting was non-quorate however feedback has been received from Buckinghamshire CCG to confirm acceptance of policy recommendations. Amendments required to: Page 7 – amend to "does not offer unrestricted choice in terms of provider". Page 7 – spelling correction required for Chief financial officers and individuals Once amendments have been actioned the Committee agreed to accept the minutes as an accurate record of the meeting. **Action: Clinical Effectiveness team to amend the draft minutes as outlined above.**
10.	**Draft Minutes of the Priorities Committee meeting held 24th November 2021 – Matters arising**
10.1	**Draft Minutes of the online Priorities Committee meeting held 24th November 2021 - Action 5.5 Benign prostate hyperplasia (BPH) pathway to include review of Evidence based intervention list (EBI) 2: 2I - Surgical intervention for benign prostatic hyperplasia** SC to share wording with Clinical Effectiveness team. CE team to amend policies accordingly. **Action: Complete.**
10.2	**Draft Minutes of the online Priorities Committee meeting held 24th November 2021 – Action 6.3 Review of High Cost and Complex Care Packages** Clinical Effectiveness team to undertake indepth compare and contrast of Equity and Choice policies to note differences across Thames Valley. Post meeting note; this piece of work is being completed by the ICS Development Programme Team. **Action: Complete (agenda item 7)** Clinical Effectiveness team to contact Brighton and Hove for information on recent legal challenges . **Action: Complete** Clinical Effectiveness to investigate reasons for choosing a 10% limitation for home care over and above alternative provision. **Action: Complete** Clinical Effectiveness team to convene a working group. **Action: Complete**
10.3	**Draft Minutes of the online Priorities Committee meeting held 24th November 2021 – Action 7.3 Policy update - TVPC 14 Biological mesh. Review of biological mesh for abdominal surgery** Clinical Effectiveness team to inform relevant specialist that the use of mesh for hiatus hernia was raised. Clinical Effectiveness team is to also facilitate the distribution of the specialist's assessment of the potentially 'preferred meshes' to other Trusts' for consideration in support of more efficient procurement. **Action: Complete** Clinical Effectiveness team to update the current policy to reflect a review of the policy and that the current policy position is maintained. **Action: Complete**
10.4	**Draft Minutes of the online Priorities Committee meeting held 24th November 2021 – Action 8.2 Policy update – TVPC 68 Female sterilisation** Clinical Effectiveness team and Oxfordshire CCG to scope and explore the data. Further discussions should consider the associated ethics and equalities issues. **Action: Complete**
10.5	**Draft Minutes of the online Priorities Committee meeting held 24th November 2021 – Action 9.1 TVPC80 Primary Care Subfertility Pathway** Clinical Effectiveness team to update the date of the pathway with no other changes. **Action: Complete.**
10.6	**Draft Minutes of the online Priorities Committee meeting held 24th November 2021 – Action 9.1 TVPC 2 Treatments for Gender Dysphoria (GD)** Clinical Effectiveness team to update the policy and circulate the draft update as per usual process. **Action: Complete.**
11.0	**Draft Minutes of the Prioritisation of work plan meeting held 26th January 2022 - Confirm accuracy**
11.1	The Committee agreed to accept the minutes as an accurate record of the meeting.

12.	**Draft Minutes of the Prioritisation of work plan meeting held 26th January 2022 – Matters arising**
12.1	**Draft Minutes of the Prioritisation of work plan meeting held 26th January 2022 – Action 3.3 In ye policy review request: TVPC11g Assisted Reproduction Services for Infertile Patients** Clinical Effectiveness team to add the review of TVPC11g Assisted Reproduction Services for Infertile Patients to the agenda for discussion at the TVPC meeting in March. Action: Complete (agenda item 6)
12.2	**Draft Minutes of the Prioritisation of work plan meeting held 26th January 2022 – Action 4.3 TVPC work plan overview 2022-23** SC to raise the TVPC 2022/23 work plan at the BOB Elective Care Board meeting. **Action: Complete.** Clinical Effectiveness team to schedule review of osteoporosis pathway to include the prescribing of denosumab. This will be prioritised alongside topics that may support elective care recovery. **Action: Complete.** Clinical Effectiveness team to remove acne scoping exercise for assessing referral to secondary care and medication to delay menstruation statement from the work plan. **Action: Complete.** Clinical Effectiveness team to remove Sequential use of biologic drugs for Juvenile Idiopathic Arthritis from the work plan. **Action: Complete.** MS to send Bucks Integrated Care Partnership's Fracture prevention and denosumab guidelines to Clinical Effectiveness team. **Action: Complete** Clinical Effectiveness team to send the data to RR. **Action: Complete** Clinical Effectiveness team to remove review of hydrotherapy for people with special educational needs (18 to 25yrs) from the work plan. **Action: Complete** Clinical Effectiveness team to investigate whether review of surgery for ingrowing toenail will suppo the elective care recovery. **Action: Complete**
12.3	**Draft Minutes of the Prioritisation of work plan meeting held 26th January 2022 – Action 5.3 TVPC operational planning: Committee Chair** Clinical Effectiveness team to review the job description and progress the recruitment process. Post meeting note: DH has asked that the recruitment process is temporarily paused. **Action: Complete (agenda item 4)**
12.4	**Draft Minutes of the Prioritisation of work plan meeting held 26th January 2022 – Action 6.2 High cost care packages** Clinical Effectiveness team to investigate further and seek further information from DH. **Action: Complete.**
13.	**Any other business**
13.1	**Alan Penn retirement** AP thanked the Committee and Clinical Effectiveness team for their support, patience and discipline during his time as Committee Chair. The TVPC expressed its gratitude to Alan Penn for his knowledge, tact and skill as chair of the Committee over the past eight years."

13.2	**TVPC Work Plan 2022/23**
	The Clinical Effectiveness team has liaised with the Elective Care Boards in order to support prioritising the TVPC workplan for 2022/23 as previously requested by committee members. Information from the BOB Elective Care Board suggests specialities under pressure include ENT, ophthalmology, gastroenterology, general surgery, and trauma and orthopaedics.
	It is proposed that the work programme for the upcoming TVPC meetings focus on in-demand specialities:
	• May
	  ○ MSK
	  ○ New topic – Ingrowing toenails
	  ○ Policy reviews – Shoulder decompression and lower back pain
	• July
	  ○ Ophthalmology

	○ New topics- Surgery for tear duct obstruction; Anti-VEGF agents for AMD in pts with one seeing eye ○ Policy reviews – Policy review: TVPC 60 Cataract removal in adults - thresholds for surgery including surgery for second eye • September ○ ToR, Ethical Framework, SOP The Committee agreed with the proposed work plan. **Action: Clinical Effectiveness team to update the work programme and circulate.**
14.	**Date of next meeting**
14.1	Thursday 25th May 2022, 2 – 4.30pm, Microsoft Teams
15.	**Meeting close**