*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 25th May 2022

## On-line via Microsoft Teams

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| David Clayton-Smith | Chair | Thames Valley Priorities Committee NHS England and NHS Improvement, South East; Kent Surrey & Sussex Academic Health Science Network |
| Diane Hedges | Deputy Chief Executive | NHS Oxfordshire CCG |
| Sue Carter | Clinical Effectiveness Manager (CCG) | NHS Oxfordshire CCG |
| Edward Haxton | Interim Chief Financial Officer | NHS Berkshire West CCG |
| 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 |
| Dr Janet Lippett | Chief Medical Officer | Royal Berkshire NHS Foundation Trust |
| Dr Raju Reddy | Secondary Care Consultant | NHS Berkshire West CCG |
| Dr Jacqueline Payne | GP, Berkshire West | NHS Berkshire West CCG |
| Gill Manning (arrived at 15:45) | Lay representative | NHS Frimley CCG |
| Dr Karen West | Clinical Director Integration | NHS Buckinghamshire CCG |
| Mohammed Asghar | Prescribing Governance Lead | Frimley Health and Care ICS |
| Sapfo Lignou (left at 16:12) | Senior Researcher in Bioethics (Observer with Mark Sheehan) | University of Oxford |

In Attendance:

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| Naomi Scott | Clinical Effectiveness Manager | SCW CSU |
| Katie Newens | Clinical Effectiveness Manager | SCW CSU |
| Tiina Korhonen | Clinical Effectiveness Lead | SCW CSU |
| Karen Blogg - minutes | Clinical Effectiveness Administrator | SCW CSU |
| Marion Mason | Interim Head of Prior Approval and Assurance | SCW CSU |
| Sarah Annetts | Head of IFR | SCW CSU |

Apologies:

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| David Pollock | Interface Lead Pharmacist | NHS Berkshire West CCG |
| Andrew McLaren | Deputy Medical Director | Buckinghamshire Health NHS Trust |
| Professor Meghana Pandit | Medical Director | Oxford University Hospital NHS Foundation Trust |

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| Emeritus Professor Chris Newdick | Special Advisor, Law | University of Reading |
| Shairoz Claridge | Director of Operations, BOB ICS<br>Interim Director Lead for Long Term Conditions | NHS Berkshire West CCG |
| Dr John Fraser | Clinical Lead, Surrey Heath locality | NHS Frimley CCG |
| Dr Timothy Ho | Medical Director | Frimley Health NHS Foundation Trust |
| Dr Karl Marlowe | Medical Director | Oxford Health NHS Trust |
| Kathryn Markey | Clinical Effectiveness Manager | SCW CSU |
| Funmi Fajemisin | Clinical Services Programme Lead<br>Clinical Policy Implementation | SCW CSU |
| Maire Stapleton | Formulary Manager | Buckinghamshire Integrated Care Partnership |

Topic specialists in attendance for agenda Items:

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| Item 6 – Policy update: TVPC 50 Subacromial decompression for shoulder impingement |
| **Professor Steve Gwilym** – Associate Professor in Orthopaedics – University of Oxford and Consultant Trauma and Orthopaedic Surgeon, Oxford Trauma and Emergency Care.<br>**Amar Malhas** – Consultant Orthopaedic Surgeon – Royal Berkshire NHS Foundation Trust |
| Item 7 – Policy update: TVPC 52 Management of low back pain and sciatica |
| **Elaine Buchanan** – Consultant Physiotherapist, Oxford Spinal Surgery Unit, Oxford University Hospitals NHS Foundation Trust |
| Item 8 – New Policy – Ingrown toenail |
| **Rachel Henstridge** – Podiatry Operational Lead, West Berkshire Community Hospital, Berkshire Healthcare NHS Foundation Trust<br>**Penny Garson-Pilbeam** – Head of Podiatry, Buckinghamshire Healthcare NHS 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. |
| **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 23rd March 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 23rd March 2022 – Matters arising** |
| **5.1** | **Draft Minutes of the online Priorities Committee meeting held 23rd March 2022 – Action**<br>**5.2 Policy update feedback: TVPC2 Treatments for Gender Dysphoria**<br>Clinical Effectiveness team to amend the policy and circulate as per usual process with the draft minutes<br>**Action: Complete** |
| **5.2** | **Draft Minutes of the online Priorities Committee meeting held 23rd March 2022 – Action**<br>**6.3 Policy review: TVPC 11g Assisted Reproduction Services for Infertile Patients**<br>Update: Due to the complexity of this policy area and feedback received on the initial circulation of the draft policy update, the specialist adviser for the Committee has proposed that it is important to further explore all of the patient groups affected by the policy and more detail is required, in particular, better understanding of current clinical practice as well as approach to |

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| | services in relation to male infertility. For this reason, it has been suggested and agreed by the strategic lead of the Committee to defer the policy review and convene a dedicated working group to enable more detailed discussion. Updated draft policy to come back to the Committee following the outcome of the working group. Any members of the Committee interested in attending the working group to inform the clinical effectiveness team.<br><br>At the meeting on 23rd March there was an agreement to seek independent legal advice for the draft updated policy once agreed. As the topic has now been deferred to a working group it was suggested that the legal counsel could be part of the working group if possible, to expedite the review process. The Committee agreed with this approach.<br>**Action:**<br>• **Clinical Effectiveness team to convene a working group, to include an independent legal representative (if available).**<br>• **TVPC 11g Assisted Reproduction Services for Infertile Patients to be brought back to the TVPC after referral to working group.**<br>• **TVPC committee members to contact CE Team if they wish to be part of working group.** |
| **5.3** | **Draft Minutes of the online Priorities Committee meeting held 23rd March 2022 – Action**<br>**7.3 Review of NHS Continuing Healthcare (CHC) High Cost and Complex Care Packages**<br>Clinical Effectiveness team to contact the Interim Director of Joint Commissioning at Berkshire West CCG regarding the amalgamation of Oxfordshire, Berkshire and Buckinghamshire Continuing Healthcare Equity and Choice Policies, which could be the basis of a joint BOB statement on funding of CHC home care packages .<br>**Action: Complete** |
| **5.4** | **Draft Minutes of the online Priorities Committee meeting held 23rd March 2022 – Action**<br>**8.1 Recommendation to review TVPC98 Chronic Fatigue Syndrome ahead of schedule due to recent published guidance.**<br>Clinical Effectiveness team to add TVPC 98 Chronic Fatigue Syndrome to the 2022/23 work programme.<br>**Action: Complete** |
| **5.5** | **Draft Minutes of the online Priorities Committee meeting held 23rd March 2022 – Action**<br>**9.1 Amendment to draft minutes of the Priorities Committee meeting held 24th November 2021 – confirm accuracy.**<br>Clinical Effectiveness team to amend the draft minutes.<br>**Action: Complete** |
| **5.6** | **Draft Minutes of the online Priorities Committee meeting held 23rd March 2022 – Action**<br>**13.2 TVPC Work Plan 2022/23.**<br>Clinical Effectiveness team to update the work programme and circulate.<br>**Action: Complete** |
| **6.** | **Policy update: TVPC 50 Subacromial decompression for shoulder impingement** |
| **6.1** | In 2021, the policy was reviewed by the CE team who identified new high-quality evidence in this area. The Committee agreed that this new evidence base requires consideration by the TVPC and noted that due to the potentially large numbers of surgeries being carried out, review of the current policy should be prioritised.<br><br>Subacromial pain syndrome (SAPS), shoulder impingement, or rotator cuff disease each describe similar clinical presentations, and there is inconsistency about how they are defined and overlap between these diagnoses. Patients with SAPS can have degeneration and partial thickness rotator cuff tears or abnormalities in the subacromial bursa on imaging. These imaging findings are also common in people without symptoms. |

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| | Current policy<br>Currently Thames Valley CCGs hold policy statement TVPC 50 Subacromial decompression for shoulder impingement (2018). The policy states that primary care referral for surgical opinion for shoulder decompression in patients with shoulder pain due to shoulder impingement syndrome may be considered in patients where stated criteria are met.<br>National guidance<br>In November 2018, the NHS Evidence-Based Intervention (EBI) programme issued guidance for subacromial decompression surgery, stating that non-operative treatment such as physiotherapy and exercise programmes are effective and safe in many cases and that surgery should be considered for patients who have persistent or progressive symptoms, in spite of adequate non-operative treatment. The term 'Pure subacromial shoulder impingement' was used, this is defined as subacromial pain not caused by associated diagnoses such as rotator cuff tears, acromio-clavicular joint pain, or calcific tendinopathy. The current local policy states more specific criteria for surgery than EBI.<br><br>New evidence, including a Cochrane review (2019), published since the EBI recommendations suggest that surgery did not provide important improvements in pain, function, or quality of life compared with placebo surgery or other options. A BMJ rapid recommendation published in 2019: Subacromial decompression surgery for adults with shoulder pain: a clinical practice guideline makes a strong recommendation against surgery stating that surgery did not provide important improvements in pain, function, or quality of life compared with placebo surgery or other options.<br><br>A 5 year follow up of one of the sham-surgery trials (Paavola et al 2021) reported that there was no clinically significant difference between the groups in pain, function and health related quality of life.<br><br>Local data<br>In 2018/19, 428 subacromial decompression procedures (without repair of rotator cuff tear) were performed across the Thames Valley. This data is reported by NHS England for the Evidence Based Intervention programme. In 2018/2019 there were 83 subacromial decompression procedures performed alongside a surgical repair of a rotator cuff tear. Since this time, there has been a decline in the number of procedures, but this is likely to have been impacted by the COVID-19 pandemic.<br><br>The Committee was asked to consider two options:<br>• Option 1: Maintain the current policy position of primary care referral for surgical opinion for shoulder impingement/syndrome/subacromial pain syndrome based on threshold criteria stated in the policy. Amend the wording to clarify that the indication for referral is pure shoulder impingement syndrome. Amend coding.<br>• Option 2: Update the policy: due to evidence and national guidance not demonstrating the clinical effectiveness of the use of subacromial decompression for shoulder impingement/subacromial pain syndrome compared to non-surgical management, subacromial decompression for subacromial pain syndrome/shoulder impingement syndrome, with or without non-symptomatic partial thickness rotator cuff tears is not normally funded. |
| **6.2** | The specialists in attendance made a number of points:<br>The study selection of the Cochrane systemic review was queried. The review focused on two studies, four studies (500 patients) were excluded due to perceived bias. In addition, it was felt that the Cochrane review was biased against surgery. It was suggested that the policy update |

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| | should be postponed until publication of new guidance from the British Elbow and Shoulder Society (BESS). (Date of publication not yet confirmed)<br><br>The relevance of the data presented in the paper was discussed. A recent GIRFT review at the Royal Berkshire Hospital (RBH) was highlighted, which reported that less than 5% of arthroscopic procedures were subacromial decompressions in isolation. It was suggested that a large number of procedures were related to bicep pathology, and acromial clavicular (AC) joint excisions, both requiring decompression for access.<br><br>An issue with inappropriate referrals was noted with current conversion rates for those referred for surgery at Royal Berkshire Hospital Foundation Trust reported by the specialists to be less than 10%. Many patients have not had physiotherapy input, an injection, or any advice, interventions that should be taking place in the community. The Committee discussed this issue, however as primary care interventions are outlined in the current policy, this may not be able to be further addressed in the policy.<br><br>In the specialist clinician's opinion, option one is the best pathway as this is based upon national EBI guidance, which has a very robust process of development. Option two would have minimal impact, removing around 5% of the shoulder arthroscopy cases. A more cost effective, quality care option would look at maximising primary care support before surgical referral. There was also discussion of what treatments would be available for patients who were not referred for surgery and the impact on other services e.g. chronic pain services.<br><br><u>Further committee discussions</u><br>The potential impact of the two options in relation to specialist clinician/surgical time was queried. Whilst the paper aimed to present data for the number of subacromial decompression procedures being performed in isolation as a treatment for SAPS, it was acknowledged in light of the clinicians' comments above, that further analysis would be required to confirm this dataset. In terms of surgery times, a Committee member suggested that the procedure would take about 1 to 2 hours, depending on what it is being undertaken during the surgery. In a day's surgical list around 4 procedures would be performed. A discussion of clinical priorities was also made. It was proposed that consideration should be given to how debilitating shoulder pain can be, and how it can have an effect on work and quality of life.<br><br>There was concern that there was no timeline for new BESS guidance or an update of EBI guidance. There was acknowledgment that the evidence base showed that the efficacy of the procedure was poor, with a proposal that the policy should be made tighter in line with Option 2 which was supported by several members. However, in contrast, a Committee member proposed supporting the national EBI recommendations as these are referred to in the NHS standard contract. i.e maintaining current position.<br><br>Overall, the discussions did not reach a clear conclusion and concern was raised about the lack of clarity of the options. |
| **6.3** | Decision taken to defer and bring back to Committee.<br>**Action:**<br>• **Clinical Effectiveness team to review the paper particularly in relation to validity of data and clarity of options and bring back to Committee.**<br>• **DH to escalate obtaining specific elective care waiting list data to Matthew Tate and appropriate personnel within ICS.**<br>• **JL to forward contact details for the head of RBH Informatics Department to NS.** |

| 7. | Policy Update: TVPC 52 Management of low back pain and sciatica |
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| 7.1 | This policy update reviews TVPC52 as part of the three-year update programme. This review considered recommendations from the EBI programme and evidence from a literature review.<br><br>**EBI programme recommendations**<br>Radiofrequency denervation – The current policy statement recommendations for radiofrequency denervation are in line with EBI so it was proposed that no amendments are required to the current policy statement.<br><br>Fusion surgery – The current policy statement for fusion surgery is in line with the initial recommendation from EBI. In the recommendations EBI detail a list of "NICE exclusion criteria", and these are therefore outside of the scope of the current commissioning policy. EBI gives a list of cases which spinal fusion is "usually reserved for". These are all considered to be specific cases of back pain, which is also outside of the scope of the current commissioning policy. As such it was proposed that the current commissioning policy statement on spinal fusion is maintained.<br><br>Lumbar discectomy – EBI recommends that in the presence of concordant MRI changes, discectomy may be offered to patients with compressive nerve root signs and symptoms lasting three months (except in severe cases) despite best efforts with non-operative management. This recommendation is more stringent than the current TVPC commissioning policy statement as it requires patients to experience symptoms for at least three months.<br><br>**Literature review**<br>Injections and radiofrequency denervation: There was some evidence that epidural injections are effective in the treatment of sciatica. Two reviews found low quality evidence suggesting there is at least a short-term benefit of radiofrequency denervation for chronic back pain.<br><br>Exercise: A Cochrane review found moderate-certainty evidence that exercise is probably effective for the treatment of back pain compared to no treatment, usual care, or placebo for pain but the effect on functional limitations did were not clinically significant.<br><br>Psychological interventions: One study found that cognitive behavioural therapy (CBT) as an adjunct to other types of therapy may be more effective than CBT, or other therapies alone but that further evidence is required to investigate the long-term benefits. Another study concluded that, compared with physiotherapy care alone, physiotherapy delivered with psychological interventions are more effective in improving physical function and pain intensity. Although, uncertainty remains as to their long-term effectiveness. A third study on meditation found small effect sizes and moderate-certainty evidence, suggesting that meditation is slightly better than minimal intervention in the short term for disability, but not pain.<br><br>Ultrasound: One study concluded that the current evidence does not support the use of therapeutic ultrasound in the management of chronic low back pain.<br><br>Laser treatment: One study concluded that low and high-level laser therapy are suggested to be beneficial to patients in terms of pain severity and functional evaluation, whereas the evidence for laser acupuncture is insufficient.<br><br>The findings of the literature review were generally in line with the TVPC52. However, there is recent evidence of the effectiveness of exercise and psychological interventions, both independently and in combination. It is noted that NICE NG59 recommends consideration of a group exercise programme, psychological therapies using a CBT approach and combined physical and psychological programmes. |

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| | The Committee was asked to consider the following options<br>• Retain the current commissioning policy recommendation.<br>• Add a recommendation to state when exercise may be considered with or without psychological therapies for example:<br>"Consider a supervised exercise programme alone, or in combination with a psychological programme using a cognitive behavioural approach for people with a specific episode or flare-up of low back pain with or without sciatica."<br>• Update the recommendation for spinal decompression for sciatica to require patients to have three months of non-surgical treatment, in line with recommendations from EBI. Early referral is recommended for those with incapacitating radicular pain or major motor radiculopathy. |
| **7.2** | The specialist in attendance noted that Get it Right First Time (GIRFT) has developed back pain pathways and that it is beneficial for policy recommendations to align with these. It was confirmed that the proposals would be in line with these. The specialist suggested that the GIRFT pathways promote cost effectiveness. An example of the cost-effectiveness of stratified care for low back pain was provided.<br><br>It was highlighted that the use of surgery for patients with severe radicular pain, especially where there is neurological deficit, is effective and that a rapid referral to specialists is maintained. The specialist noted that some patients with sciatica are being referred from primary care relatively quickly and often without a full course of physiotherapy. Radicular pain can be incapacitating, and some patients do require support with additional therapies and pharmacology.<br><br>The Committee asked for clarification in the policy regarding medial branch block and radiofrequency denervation. Including the term 'therapeutically' to the recommendation regarding medial branch blocks not being funded for low back pain to reduce ambiguity was discussed. A committee member asked for guidance as to how the individual funding review (IFR) panel should assess repeated radiofrequency denervation. It was noted that the national back and radicular pain pathway provides guidance on this.<br><br>A committee member suggested the need to add "red flags" to the policy to highlight to GPs that there are some serious symptoms that require immediate referral.<br><br>The committee discussed how when one treatment is not recommended, such as lumbar facet joint injections, then other treatments may increase in quantity, such as sacroiliac joint injections. There was discussion about how a pathway approach may help to ensure work saved in one area is not impacting on another and how there is an ongoing shift towards this style of commissioning. |
| **7.3** | The Committee agreed to the following:<br>• Add a recommendation where supervised exercise may be considered with or without psychological therapies<br>• Update the recommendation for spinal decompression for sciatic or require patients to have three months of non-surgical treatment. Early referral is recommended for those with incapacitating radicular pain or major motor radiculopathy.<br>• Add 'red flags' to the policy<br>**Action:**<br>• **Clinical Effectiveness team to liaise with the IFR panel to provide guidance on repeated radiofrequency denervation**<br>• **Clinical Effectiveness team to update the policy as detailed above** |

| 8. | New Policy: Ingrown toenail |
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| **8.1** | A review of treatments of ingrown toenails was requested by the TVPC working group following a scoping and scoring of a CCG topic submission. Thames Valley CCGs do not currently hold a policy for ingrown toenail treatment. Ingrown toenails can be classified into three stages ranging from mild to severe. If left untreated ingrown toenails are likely to get more severe. Conservative management is often used for stage one toenails, but surgical management is a common treatment for more severe ingrown toenails.<br><br>Interventions for ingrown toenails can be split into non-surgical and surgical treatments. A Cochrane review found surgical interventions were better at preventing recurrence than non-surgical interventions.<br><br>Surgical interventions vary in terms of whether all or part of the toenail is removed and whether the nail matrix is removed or destroyed to stop the nail regrowing. A Cochrane review found that it is likely that surgical intervention with chemical ablation is more effective at preventing recurrence than surgical intervention alone. When comparing surgical interventions, more invasive interventions with phenol were found to be more likely to reduce recurrence effectively than less invasive surgical intervention with phenol.<br><br>Local activity suggests that prior to the COVID-19 pandemic around 140 inpatient procedures were performed for ingrown toenails per annum. Due to restrictions in coding, it is not possible to ascertain the severity of the ingrown toenails treated.<br><br>The Committee was asked to consider the following options:<br><br>• Do not routinely commission treatments for ingrown toenails<br>• Commission surgical treatment for ingrown toenails when self-care treatments have failed, and the ingrown toenail has reached stage 2 (inflammatory granuloma tissue, accompanied by seropurulent discharge; infection; and sometimes ulceration of the nail fold)<br>• Commission surgical treatment for ingrown toenails when self-care treatments have failed, and the ingrown toenail has reached stage 3 (chronic inflammation; the formation of epithelialized granulation tissue; and sometimes marked nail-fold hypertrophy)<br><br>The Committee was also asked if it wished to recommend specific surgical treatments. |
| **8.2** | The Committee heard from the specialist in attendance that partial nail avulsion and total nail avulsions with phenolisation are performed by community podiatry across the Thames Valley. This is an effective treatment. There are a small number of patients that do need treatment in secondary care as community treatment is not suitable, e.g. patients with vascular leg issues.<br><br>The Committee discussed whether a policy was required given the limited number of secondary care cases. It was noted that this review was requested due to variation in access and that a policy could provide a framework for decisions and aid consistency in access across the Thames Valley. The specialists in attendance were in support of a policy position to aid consistency.<br><br>It was queried whether, if there is inequality of access across the region, implementing a policy would have a financial impact. It was discussed that, as a significant majority of procedures are undertaken in community, activity data is not available to provide this estimate.<br><br>The Committee discussed whether the policy should require all ingrown toenails to be referred to community podiatry, regardless of severity. Specialists raised concerns over capacity if referral |

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| | rates increased. It was agreed that it would be reasonable, and be in line with current practice, for GPs to trial some conservative management. If symptoms have not resolved after a month then referral to community podiatry would be appropriate. Whether it should be recommended that GPs prescribe antibiotics to patients with infected ingrown toenails, and if conservative management is suitable for these patients was discussed.<br><br>The Committee discussed whether this level of advice would be more suited to a referral and management guideline rather than a policy. It was noted that a policy would help to address any variation across the Thames Valley as management guidelines are often locality led and could result in variation. |
| **8.3** | The Committee agreed to recommend a policy position which includes recommendations for conservative management<br>**Action:**<br>• **Clinical Effectiveness liaise with the podiatry service to develop appropriate conservative management recommendations**<br>• **Clinical Effectiveness team to develop policy and circulate as per usual process.** |
| **9.** | **Policy update programme** |
| **9.1** | The TVPC policy update programme reviews TVPC policies every 3 years and identifies new or updated national guidance and if applicable, clinical and cost effectiveness evidence.<br><br><u>Policy Update: TVPC 23 Trigger Finger</u><br>The current TVPC policy suggests the use of conservative measures including corticosteroid injection where appropriate prior to referral for surgical intervention but certain patient groups may proceed to surgery first. This is generally in line with recently updated current national guidance and two identified systematic reviews. The Committee agreed to maintain the current policy.<br>**Action: Clinical Effectiveness team to update the date of the policy with no other changes.** |
| **9.2** | <u>TVPC 84 – Corticosteroid injections for Patella, elbow and achilles tendinopathy</u><br>Overall, the only evidence found in support for the use of corticosteroids was in achilles tendinopathy, however steroids were administered in combination with high volume injections which may have had a therapeutic effect. As the NICE CKS for this topic still states corticosteroid injections should not be used to Achilles tendinopathy it is recommended the current policy statement is retained. The Committee agreed to maintain the current policy.<br>**Action: Clinical Effectiveness team to update the date of the policy with no other changes.** |
| **9.3** | <u>Policy Update: TVPC 85 – Corticosteroid injections for Pre Patella and olecranon Bursitis</u><br>The BMJ best practice guidance for bursitis recommends corticosteroid injections as a second line treatment option following failure of conservative management and analgesia. However, the guidance does note there is little evidence to support the recommendations in the guidance. No new randomised controlled trials, systematic reviews, or meta-analyses were identified in relation to this topic. It is recommended the current policy statement is retained. The Committee agreed to maintain the current policy.<br>**Action: Clinical Effectiveness team to update the date of the policy with no other changes.** |
| **9.4** | <u>Policy Update: TVPC 20 – Surgical management of otitis media with effusion in children (under the age of 18 years)</u><br>It is suggested that the coding on this policy should be updated to monitor activity for otitis media and adenoidectomy separately, that the ordering of the policy could be updated to make for easier reading and to clarify age ranges. The Committee agreed with the minor changes.<br>**Action: Clinical Effectiveness team to update the policy and circulate the draft update as per usual process.** |
| **10.** | **Any other business** |
| **10.1** | There was no other business. |

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| **11.** | **Date of next meeting** |
| **11.1** | The next meeting will be held on Wednesday, 6th July 2022, from 2 – 4.30pm via Microsoft Teams |
| **12.** | **Meeting close** |