Aylesbury Vale Clinical Commissioning Group
Bracknell and Ascot Clinical Commissioning Group
Chiltern Clinical Commissioning Group
Newbury and District Clinical Commissioning Group
North and West Reading Clinical Commissioning Group
Oxfordshire Clinical Commissioning Group
South Reading Clinical Commissioning Group
Slough Clinical Commissioning Group
Windsor, Ascot and Maidenhead Clinical Commissioning Group
Wokingham Clinical Commissioning Group

Thames Valley Priorities Committee

Minutes of the meeting held Wednesday 20th September 2017

Conference Room, 2nd Floor, Albert House, Queen Victoria Road, High Wycombe HP11 1AG

In Attendance:

Alan Penn	Lay Member Chair	Thames Valley Priorities Committee
Laura Tully	Assistant Director of Clinical Quality	SCW
Tiina Korhonen	Clinical Effectiveness Lead	SCW
Kate Forbes	Clinical Effectiveness Manager	SCW
Rebecca Hodge	Clinical Effectiveness Manager	SCW
Kathryn Markey	Clinical Effectiveness Manager	SCW
Katie Newens	Clinical Effectiveness Researcher	SCW
Rachel Finch	Clinical Effectiveness Administrator	SCW
Lindsey Barker (LB)	Medical Director	Royal Berkshire NHS Foundation Trust
Jane Butterworth	Associate Director of Long Term Conditions & Medicines Management	Aylesbury Vale CCG & Chiltern CCGs
Shairoz Claridge	Operations Director Director for Planned Care	Newbury and District CCG Berkshire West CCGs Federation
Linda Collins	Clinical Effectiveness Manager (CCG)	Oxfordshire CCG
Dr Graham Jackson	Clinical Chair	Aylesbury Vale CCG
Catriona Khetyar	Head of Medicines Optimisation	Berkshire East CCGs
Dr Anees Pari	Head of Public Health and Wellbeing (Interim)	West Berkshire Council
Louise Patten (LP)	Accountable Officer	Aylesbury Vale & Chiltern CCGs
Dr Jacky Payne	GP	Berkshire West CCGs
Rosalind Pearce (RP)	Executive Director HealthWatch	Oxfordshire
Sarah Robson	Head of IFR	SCW

Apologies:

Dr Tony Berendt	Medical Director	Oxford University Hospitals NHS Trust
Miles Carter	West Oxfordshire Locality Clinical Director	Oxfordshire CCG
Chris Newdick	Professor of Health Law	University of Reading
Sarah Rayfield	Speciality Registrar in Public Health	Berkshire
Jeremy Servian	IFR Manager	Oxfordshire CCG
John Seymour	Consultant – Chief of Service - Medicine	Frimley Health Foundation Trust
Dr Mark Sheehan	Special Advisor – Ethics	University of Oxford
Fiona Slevin-Brown	Director of Strategy & Operations	Berkshire East CCGs
Bhulesh Vadher	Clinical Director of Pharmacy and Medicines Management	Oxford University Hospital Trust
Sara Wilds	Head of Urgent Care and Medicines Optimisation	Oxfordshire CCG

1.	**Welcome & Introductions**
1.1	The Chair opened the meeting and welcomed the members of the Committee.
2.	**Apologies for Absence**
2.1	Recorded as above. The meeting of 19th July 2017 was not quorate. **Action:** Clinical Effectiveness team to circulate minutes detailing any policy recommendations made by the Committee to absent members for approval. **Action Complete, Louise Patten Accountable Officer confirmed acceptance of the recommendations made by the committee.**
3.0	**Declarations of Interest**
3.1	Dr Graham Jackson declared an interest in item 12 as he co-chairs the NHS England Medicines Consultation.
4.	**Draft Minutes of the Priorities Committee meeting held 19th July 2017 (Paper 17-011) – Confirm Accuracy**
4.1	**The draft minutes were accepted as a true record of the meeting.**
5.	**Draft Minutes of the Priorities Committee meetings – Matters Arising**
5.1	Minutes of the Priorities Committee held in May 2016, Action 10.1 – Fertility care pathway - CE team were asked to investigate the various providers' referral criteria and liaise with local GPs for further consultation. **May 2017 Update:** Berkshire East report their endeavours to set up a working group to develop a draft patient fertility care pathway have met with very limited response. The Clinical Effectiveness (CE) team agreed to take the pathway review forward. **July 2017 Update:** Actions on-going; potentially an item for the November 2017 TVPC meeting. **September 2017 Update:** A working group has been formed; an initial meeting is being arranged. Clinical Effectiveness team to provide an update at the November meeting.
5.2	**Minutes of the Priorities Committee held in July 2017 – Action 6.9 – Paper 17-001 - Policy Update: Functional Electrical Stimulation (FES) for Drop Foot and Upper Limb** Clinical Effectiveness team to draft a single FES policy document for upper and lower limb dysfunction (rather than drop foot) and circulate for comment. **ACTION Complete.**
5.3	**Minutes of the Priorities Committee held in July 2017 – Action 7.5 – Paper 17-007 – Policy Update: Female Sterilisation, Reversal of Female Sterilisation and Reversal of Male Sterilisation (Vasectomy).** The Committee requested a review of the male sterilisation (vasectomy) policy at the next TVPC meeting (20th September). **September Update: Refer to item 8.**
5.4	**Minutes of the Priorities Committee held in July 2017 – Action 7.6.1 – Paper 17-007 – Policy Update: Female Sterilisation, Reversal of Female Sterilisation and Reversal of Male Sterilisation (Vasectomy).** The Clinical Effectiveness team to hold the draft female sterilisation policy document until after vasectomy (male sterilisation) has been reviewed at the next TVPC meeting (20th September). **September Update: Refer to item 8.**
5.5	**Minutes of the Priorities Committee held in July 2017 – Action 8.10 – Paper 17-008 - Policy Update: Male Circumcision.** 8.10.1. The Clinical Effectiveness team to seek specialist advice before drafting a male circumcision policy. 8.10.2 The Clinical Effectiveness team to draft a Male Circumcision policy document and circulate for comment. **ACTIONS Complete.**
5.6	**Minutes of the Priorities Committee held in July 2017 – Action 9.2 - Paper 17-009 – Updated Impact Assessment: Real-time Continuous Glucose Monitors and Flash Glucose Monitors (e.g. Freestyle Libre).** The Clinical Effectiveness team to circulate CGM policy document for comment. Previously agreed Insulin pump policy also to be circulated for comment. **ACTION Complete.**
5.7	**Minutes of the Priorities Committee held in July 2017 – Action 10.2 - Paper 17-010 – Eyelid Ptosis.** The Clinical Effectiveness team to draft an amendment to the TVPC16 Aesthetic Treatments policy and circulate for comment. **ACTION Complete.**

5.8	**Minutes of the Priorities Committee held in July 2017 – Action 11.1 – Any Other Business - In year requests for Scoping - Lidocaine infusions for chronic pain. September Update: Refer to item 14.**
5.9	**Minutes of the Priorities Committee held in July 2017 – Action 11.2 – Any Other Business Gender Identity.** The Clinical Effectiveness team to circulate a hard copy of the consultation survey. Comments to be collated and a draft response on behalf of Thames Valley CCGs to be prepared and distributed for agreement at the next meeting (20th September). **September Update: Refer to item 11.**
5.10	**Minutes of the Priorities Committee held in July 2017 – Action 11.3 – Any Other Business Foot and Ankle Surgery –** an Agenda item for 20th September. The Committee agreed that the evidence review for this item should not be progressed at this time. **ACTION Complete.**
5.11	**Minutes of the Priorities Committee held in July 2017 – Action 11.4 – Any Other Business Gluten Free Foods –** Consultation closed at the end of June with results due for publication at the end of September. The Clinical Effectiveness team to update the Committee once the results of the gluten free foods consultation is available. **ACTION Complete.**
5.12	**Minutes of the Priorities Committee held in July 2017 – Action 11.5 – Any Other Business -** It was noted that NHS Clinical Commissioners/NHS England Medicines Consultation will take place from July to October 2017. **September Update: Refer to item 12.**
5.13	**Minutes of the Priorities Committee held in July 2017 – Action 11.7 – Any Other Business** The Committee highlighted that the use of terminology regarding IFR and Prior Approval is not consistent across the TV. This has led to inappropriate requests and confusion for clinicians. **September Update: Refer to item 13.**
6.	**Paper 17-012 – Evidence Review: Ectropion and Entropion, Indications for Surgery**
6.1	Thames Valley Clinical Commissioning Groups requested a review of the treatment of ectropion and entropion with a view to defining thresholds for referral for surgical opinion as there are currently no local policies across Thames Valley CCGs for either condition. Ectropion is the outward rotation of the eyelid margin (usually lower eyelid). Entropion is the inward rotation of the tarsus (connective tissue at lid margin) and lid margin, causing the lashes to come into contact with the ocular surface. Involutional (age-related degeneration) is the most common category of both conditions. Treatment depends on severity and the underlying cause. Mild cases may not need any treatment. Minor symptoms can be relieved by conservative treatment. Surgery may be indicated for more severe symptoms.
6.2	There is little high quality research available for the treatment of ectropion and entropion. However, a recent guideline from the Royal College of Optometrists (2017) offers guidance for the treatment and referral thresholds for surgical opinion for both conditions.
6.3	The Committee reviewed the intervention levels and financial impact across the CCGs. Oculoplastic surgery costs range from £900 to £1,300. There is some variation in the number of surgical interventions performed across local CCGs, however, the variation may be rated to population demographics. The Committee felt the local data indicating a relatively low rate of surgery could be related to clinical coding. The Committee discussed the Royal College of Optometrists (2017) guidance for referral thresholds for surgery and agreed that separate thresholds for ectropion and entropion would be appropriate. Referral for surgical opinion for ectropion surgery is indicated for: • ocular surface exposure (increased risk of microbial dermatitis) • chronic epiphora or ocular irritation • recurrent bacterial conjunctivitis

	Referral for surgical opinion for entropion is indicated if any of the following is persistent: • ocular irritation • recurrent bacterial conjunctivitis • reflex tear hypersecretion • superficial keratopathy • risk of ulceration and microbial keratitis **ACTION 6.5: Clinical Effectiveness team to draft policy statements for referral thresholds for surgery for ectropion and entropion and circulate for comment. Comments to be received within the 2 week feedback period following issue.** **ACTION 6.5.1: Clinical Effectiveness team to add a note to the Aesthetic treatments for adults and children policy (TVPC16) re statement for ectropion and entropion surgery.**
7.	**Paper 17-013 – Policy Update: Treatment Pathway for Adults with Attention Deficit Hyperactivity Disorder (ADHD)**
7.1	The Committee requested an update of the current Thames Valley CCGs policy statement for the treatment pathway for adults with attention deficit hyperactivity disorder (ADHD) which was originally developed in 2010. Oxfordshire have recently made some minor amendments to the wording of their policy (2016).
7.2	ADHD is a developmental disorder characterised by symptoms of hyperactivity, impulsivity and inattention. Current evidence suggests that around 15% of children diagnosed with ADHD will retain the diagnosis aged 25. However, some adults may present with symptoms without having been diagnosed as children. Due to a lack of research, symptoms of ADHD in adults can be difficult to define. Additionally, symptoms of adult ADHD tend to be more subtle than childhood symptoms.
7.3	There is limited research available for ADHD in adults as historically the condition has been seen more as a childhood problem rather than an adult one. Prevalence figures are difficult to estimate because of the differences in the diagnostic criteria and the way symptoms are measured. There is, however, evidence to show this is a problem which affects adults and can be associated with significant impairment and difficulties.
7.4	NICE Quality standard 39 (2013) recommends that adults with ADHD have access to a specialist service pathway for assessment, diagnosis and treatment. NICE Clinical guideline 72 (2008) specifies that adults presenting with symptoms of ADHD in primary care or general adult psychiatric services, who do not have a childhood diagnosis of ADHD, should be referred for assessment by a mental health specialist, where symptoms have resulted in, or are associated with moderate or severe psychological, social and/or educational or occupational impairment.
7.5	It was noted by the Committee that shared care pathway protocols vary across the Thames Valley CCGs. The Committee agreed it would be of benefit to have a common shared care protocol. It was noted that TV Accountable Care System is currently undertaking work to generate an overall shared care protocols; details can be provided to the Committee when available. **ACTION: LB to provide details of their overall shared care protocol to the Committee when available.**
7.6	The Committee considered the recommendations from the guidance and the clinical feedback and agreed that current policy should be updated to include the following criteria for referral for specialist assessment: • there must be moderate or severe psychological, social and/or educational or occupational impairment. • in accordance with local shared care arrangements • patients seeking treatment within the NHS, who have an ADHD diagnosis and commenced care privately or abroad, must have their diagnosis confirmed by an NHS specialist.

	ACTION: Clinical Effectiveness team to draft an ADHD policy update to include threshold criteria. Clinical Effectiveness team to seek advice from Special Advisors in ethics and health law regarding patients with a diagnosis given by the private sector, before issuing to the Committee for comment. **POST MEETING NOTE:** The Clinical Effectiveness team sought advice from Special Advisors as agreed. **Summary of feedback**: The Committee was asked to consider whether this problem with private treatment was specific to ADHD or would a more general policy be more appropriate. 'Are there other examples of patients whose treatments have commenced abroad or privately seeking to continue with the same regime in the NHS, but in a way that is inconsistent with existing guidelines? You are entitled to have a different approach with respect to different treatments (eg ADHD and the others), but if this is what you want, have good reasons for doing so. Is there any reason not to have a general policy applicable to all patients in these circumstances'? Additionally, the Specialist Advisors commented that whilst it is preferable for GPs and consultants to agree on suitable treatment protocols, if a GP deems the treatment to be in the patient's best interests, the LMC will remind you about GPs' prescribing responsibilities under the GMS (Contract) Regulations 2002. **CE team note:** TV CCGs already have a policy which considers the private v NHS provision of care: TVPC35 Managing the boundaries of NHS and privately funded healthcare includes the following statement: "Patients who commence care privately can request that further treatment be provided within the NHS. Their clinical needs should be reassessed for NHS treatment within the same regime of priorities applicable to NHS patients with the same condition". This is now added to the draft policy. In view of the patient having received diagnosis and commenced treatment abroad, the CE team referred to DoH guidance and sought further advice from the specialist advisors. The DoH (2017) Guidance on implementing the overseas visitor charging regulations states that "payment of the health surcharge entitles the payer to NHS-funded healthcare on a similar basis as someone who is ordinarily resident. They are entitled to NHS services free at the point of use… from 21 August 2017". In relation to ADHD, the 'similar basis' would infer that a patient from overseas would need to satisfy the same criteria as a UK patient. This may result in them having to access treatment from their home country until their diagnosis can be confirmed by an NHS specialist, subject to the GPs decision about how to manage their care. The Specialist Advisor raised a point about the transition time between: (a) becoming entitled to NHS care and (b) the time taken to confirm the diagnosis and adjust the patient's medicines to the NHS standard. The advisor highlighted that when the process may take time, every effort should be made to reduce this transition. Until the transition is achieved, GPs retain the duty to prescribe the medicines that are needed, so the judgment can be left to GPs in primary care where this is possible.
8.	**Paper 17-014 – Policy Update: Male Sterilisation – Vasectomy Services**
8.1	Thames Valley CCG's have requested a review of the current policy for vasectomy. In July 2017 the Committee reviewed the policy for female sterilisation and agreed that it is advantageous to consider the two policies at the same time in the context of the overall provision of contraceptive services across the TV CCGs. All CCG's within the TV have a policy in place for access for vasectomy, as criteria based intervention, however, in October 2016 Berkshire West CCGs changed their commissioning position on vasectomy to 'intervention not normally funded'.

8.2	Vasectomy is an effective and permanent form of male contraception involving a minor operation, usually under local anaesthetic. There is little evidence of any significant health risks following vasectomy; chronic post vasectomy pain can be an issue for a minority of men. Evidence and guidance suggests that vasectomy is lower risk and more cost effective than female sterilisation. The only alternative male only option is the use of condoms which are less effective than vasectomy. Alternative contraceptives to male sterilisation include female sterilisation, long-acting reversible contraception (LARC), barrier methods and the use of hormonal contraceptives for women. Reasons for generally poor uptake of hormonal methods may include concern of health risks such as increased risk of certain cancers and risk of stroke. Whilst not well evidenced, there appears to be a minority of patients who regret their decision to have vasectomy (based on reversal data). The Faculty of Sexual & Reproductive Healthcare (FSRH) has expressed that regret is an issue for both men and women; however their evidence is based on women's regret rather than men's with the exception of one paper published in 1986. This was likely to have been before pre-vasectomy counselling became widespread. There is some weak evidence that women from lower socio economic backgrounds are less likely to access contraceptives than women from higher economic backgrounds, although the reasons for this are unclear. This is of consideration should vasectomy not be available, as it may result in inequality of access to contraceptive services.
8.3	The Committee considered the likely impact of the potential service charge if provision of vasectomy was decommissioned; the number of terminations and female sterilisation procedures may increase, there may be an increase in cost for alternative contraception/emergency contraception use and there may be longer term implications for health and social care in general following potential increase in number of unplanned births. Cost effectiveness modelling (2013) found that female and male sterilisation is more cost effective than LARC methods at 15 years of contraceptive use. This review did not take account of the management of side-effects of hormonal contraceptives. Concern was raised of the provision of LARCs which are commissioned by Public Health and that this service would need to be able to respond to potentially increasing numbers of service users to ensure it provides robust alternatives to vasectomy. Local community providers charge £250-£300, secondary care £450-£792 on an NHS Contract for vasectomy. Female sterilisation is a more complex procedure and costs approximately £1,000 per procedure. The local data on vasectomy activity and cost across TV CCGs appeared low, but it was generally felt the data extracted represented secondary care only. It was agreed that the CCG representatives will approach the contract teams to obtain more comprehensive activity and spend data and forward to the clinical effectiveness team. The Committee also considered the need for public consultation if decommissioning was recommended. The impact of the service change in Berkshire West was discussed and the Committee agreed to note the outcomes of the year one service review once available from Berkshire West. **ACTION 8.3: CCG representatives (BE, Bucks and OCCG) to obtain vasectomy activity and cost data for Clinical Effectiveness team to collate for the governing body papers.** **ACTION 8.3.1: Berkshire West to share their post vasectomy decommissioning review with the Committee when available.**

8.4	The Committee discussed the evidence, review feedback and the issues raised and proposed the following policy recommendation: • Maintain and update the current TVPC 4 Male sterilisation – vasectomy services statement for reasons of equity, limited alternatives for men, and expectation that in the event of decommissioning vasectomy, women would be solely responsible for any 'no user failure' contraception. • Update the policy to note that vasectomy procedures should take place in primary care, unless there is an identified health need necessitating secondary care referral. **ACTION 8.4: Clinical Effectiveness team to update TVPC4 Male Sterilisation policy and circulate for comment. Comments to be received within the 2 week feedback period following issue.**
8.5	**Female Sterilisation** At the TVPC meeting held on 19th July 2017 the Committee made a recommendation that Female Sterilisation should be decommissioned. The Committee discussed if this was considered to be a significant change to service provision requiring public consultation. It was noted that the role of the Priorities Committee is to make policy recommendations and highlight the potential need for public engagement / consultation in the Governing Body papers for the CCGs. The CCGs will be responsible for deciding whether or not public engagement is required should the policy recommendation be agreed. **ACTION: Clinical Effectiveness team to draft a policy stating that female sterilisation is not normally funded. The CCGs to be made aware that by adopting this policy, patient engagement or consultation may apply. The draft policy to be circulated for comment. Comments to be received within the 2 week feedback period following issue.** **POST MEETING NOTE**: The Clinical Effectiveness team sought advice from Special Advisors in ethics and health law regarding patient consultation and engagement around the decommissioning of female sterilisation services. **The feedback notes** that 'any significant change in the way the NHS provides services must be submitted for consultation. A withdrawal of an NHS service looks significant and should be consulted upon. CCGs should consider consulting on both the male and female policy proposals together to demonstrate fairness and consistency in policy-making. CCGs should consider also describing the financial costs of the existing services and where the savings from the disinvestment may be reinvested. This would help describe the commitment of CCGs to balancing the duty to individuals and to the community as a whole and how the NHS is endeavouring to maximise the benefits available from its finite resources'.
9.	**Paper 17-015 – NICE 'Do Not Do' Recommendations Proposal for a Policy Statement**
9.1	The Committee agreed that the use of any intervention included in the NICE Savings and Productivity database as 'Do Not Do' would not normally funded. The Committee asked for the policy statement to include a definition for 'NICE' and consider rewording the title to a more informative statement. **ACTION: Clinical Effectiveness team to prepare a draft NICE 'Do Not Do' policy statement, the statement is to provide a definition for 'NICE' and circulate for comment. Comments to be received within the 2 week feedback period following issue.**
10.	**Paper 17-016 – NHS England Specialised Commissioning Services Proposal for a Policy Statement**
10.1	Specialised services are those services provided in relatively few hospitals, accessed by comparatively small numbers of patients. These services tend to be located in specialised hospital trusts that can recruit a team of staff with the appropriate expertise and enable them to

	develop their skills. The Specialised Commissioning Directorate of NHS England takes a consistent approach to central planning of specialised services that are delivered locally. Following discussion the Committee agreed that as Thames Valley CCGs do not fund specialised services and treatments that are directly commissioned by NHS England Specialised Commissioning, a policy statement should be helpful to clarify the CCG position. The statement should clearly define 'Specialised Services'. The Committee advised that a web link to patient information will be useful. **ACTION: Clinical Effectiveness team to draft a NHS England Specialised Services policy statement, define 'Specialised Services' and provide a web link to patient information. The policy statement to be circulated for comment. Comments to be received within the 2 week feedback period following issue.**
11.	**Gender Identity Consultation**
11.1	It was agreed at the last meeting a joint response would be submitted on behalf of the Committee. It is noted that the response consultation period has been extended to 16th October 2017. Limited feedback has been received from CCGs so far. **ACTION: Clinical Effectiveness team to collate CCG responses to the Gender Identity Consultation and provide a draft response on behalf of Thames Valley CCGs for comment.**
12.	**NHS England and NHS Clinical Commissioners. Items which should not be prescribed in primary care: A Consultation on guidance for CCGs**
12.1	It was agreed at the last meeting that CCGs would respond to the Consultation individually and a collective CCG response would be send by the Committee. The Committee was reminded that the proposal is to use powers under the NHS Act 2006 for NHS England (NHSE) to give guidance to CCGs under 14Z8 which says: **1.** the board must publish guidance for clinical commissioning groups (CCG) on the discharge of their commissioning options 2. each CCG must have regard to guidance under this section. The Committee discussed that this will not completely remove GPs rights to prescribe within the GMS contracts regulation 2004. The balance of power between CCGs and GPs will need to be observed. This Consultation will not remove the clinical discretion to prescribe. **ACTION: Clinical Effectiveness team to collate CCG responses to the NHS England Medicines Consultation and provide a response on behalf of Thames Valley CCGs.**
13.	**Clinical Policy Website**
13.1	At the last meeting the Committee agreed that all Thames Valley CCG websites where the clinical policies are hosted would benefit from a patient focused introduction to policy funding terminology and for reasons why these policies are developed, in consistent and clear language. The Committee considered the draft proposal for the wording (paper 17-017a) and felt some amendments were needed before publication, to clarify and strengthen the wording. **ACTION: Clinical Effectiveness team to provide a copy of the draft Website Introduction Statement to LP to revise the wording. RP to review and comment on the revised document. The Committee to discuss further at 22nd November 2017 meeting.**
13.2	The Committee reviewed paper 17-017b, plain English 'Will the NHS pay for my treatment?' wording on funding applications and agreed to adopt this item as it would assist those patients with learning difficulties and language barriers. **ACTION: Clinical Effectiveness team to arrange for paper 17-017b 'Will the NHS pay for my treatment' to be uploaded to Thames Valley CCG IFR websites.**

14.	**Any Other Business**
14.1	**In year request for Scoping - Lidocaine Infusions for Chronic Pain** Berkshire West CCGs submitted this topic request for scoping. Lidocaine infusions are being undertaken for patients with chronic pain such as fibromyalgia. Currently approximately 16 procedures per month are being undertaken with 70-80 patients on the waiting list. There is no national guidance for the use of lidocaine infusions. A scoping exercise suggests there is little good quality evidence supporting the use of lidocaine infusions in such patients. The Committee scored the topic with a total of 17. **14.1. ACTION: Clinical Effectiveness team to assess the priority level of Lidocaine infusions with a score of 17 in the Committee workshop in November, in context of other topics submitted and scored for the 2018-19 work programme.**
14.2	**Sleep Disorders –** This item is due to be reviewed by the Committee at the next meeting (22nd November) however, a new NICE guidance is in development for Suspected Neurological Conditions: Recognition and Referral, which is due for publication in January 2018. The new guideline aims to provide information to the non-specialist about referral of the common and important neurological 'presentations', including sleep disorders in adults and children. The Committee agreed this topic is to be deferred until after publication of the NICE guidance. **ACTION: Clinical Effectiveness team to defer the Sleep Disorders review until the publication of NICE guidance.**
14.3	**Immigration Health Surcharge** The Committee were informed that a note has been added to the clinical policy website to advise that the immigration surcharge no longer covers IVF treatment.
14.4	**2018-19 Work Programme** The Workshop is taking place on 8th November in High Wycombe. Topic submission forms with a covering letter will be sent to CCGs shortly.
14.5	**Dupuytrens** – NICE has produced a Technology Appraisal (TA) which supports the use of collagenase**.** Current TVPC policies state that the use of collagenase is not normally funded for this condition. The Committee agreed the wording of the existing policy should be amended to reflect the change. **ACTION: Clinical Effectiveness team to amend the existing Thames Valley Dupuytrens policy to reflect the change in funding of collagenase and circulate with the minutes for comment. Comments to be received within the 2 week feedback period following issue.**
15.	**Next meeting**
	The next meeting will be **Wednesday 22nd November 2017, to be held in Conference Room, Albert House, High Wycombe HP11 1AG.**
16.	**Meeting Close**
	The Chair thanked everyone for their contributions to the discussions and closed the meeting.