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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 24th November 2021

On-line via Microsoft Teams

Alan Penn	Lay Member Chair	Thames Valley Priorities Committee
Sue Carter	Clinical Effectiveness Manager (CCG)	NHS Oxfordshire CCG
Dr Raju Reddy	Secondary Care Consultant	NHS Berkshire West CCG
Edward Haxton	Deputy Finance Director	NHS Berkshire West CCG
Emeritus Professor Chris Newdick	Special Advisor – Law	University of Reading
David Pollock	Interface Lead Pharmacist	NHS Berkshire West CCG
Mark Sheehan	Special Advisor – Ethics	University of Oxford
Gill Manning	Lay representative	NHS Frimley CCG
Dr Jacky Payne	GP, Berkshire West	NHS Berkshire West CCG
Dr Megan John	GP, Frimley Lead	NHS Frimley CCG
Jenn Sula-Minns	Prior Approvals Manager	NHS Oxfordshire CCG
Mohammed Asghar	Prescribing Governance Lead	Frimley Health and Care ICS

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
Rebecca Stephenson - Observer	Clinical Effectiveness Manager	SCW CSU

Apologies:

Marion Mason	Interim Head of Prior Approval and Assurance	SCW CSU
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
Fiona Slevin-Brown	Director of Strategy and Operations	Frimley CCG
Dr Andrew Brent	Director of Clinical Improvement	Oxford University Hospital Foundation NHS Trust
Kate Stephen	Commissioning Manager	Oxford CCG

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Topic Specialists in Attendance for Agenda Items:

Item –
Amanda Walsh, CHC Business Manager, Oxford Health Suzanne Awadallah, Service Lead for Bucks, Oxford Health Ian Bottomley, Lead for CHC Commissioning, Oxford CCG/Oxfordshire County Council
Item
Sakina Bi, Senior Commissioning Officer, Oxford CCG Alexandra Murray, Plastics Consultant, Buckinghamshire Healthcare NHS Trust Stephen Baxter, Consultant surgeon, Frimley Health NHS Foundation Trust

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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. The meeting was not quorate due lack of representation from Buckinghamshire CCG. CE team will follow up as per usual process, endorsement (or not) of the Committee's recommendations via the minutes of the meeting post hoc.
3.	**Declarations of Interest**
3.1	The Chair reviewed the declarations of interest prior to the meeting. One indirect interest was declared for agenda item 7.
4.	**Draft Minutes of the online Priorities Committee meeting held 22nd September 2021 – Confirm Accuracy**
4.1	The Committee accepted the minutes as a true record of the meeting.
5.	**Draft Minutes of the online Priorities Committee meeting held 22nd September 2021 – Matters Arising**
5.1	**Draft Minutes of the online Priorities Committee meeting held 22nd September 2021 – Action 5.4 Posterior tibial nerve stimulation in paediatric patients** **July 2021 update**: KM advised the specialist in attendance of the Committee decisions and requested further evidence and patient data. No response received, KM to follow up within a few months. **September 2021 update**: KM to make further contact with clinicians in due course. November 2021 update: KM has made further contact with clinicians and will bring updates to the Committee for discussion when received. **Action: Closed.**
5.2	**Draft Minutes of the online Priorities Committee meeting held 22nd September 2021 - Action 6.1 Declaration of Interest (DOI) Process** Terms of reference to be discussed at the workshop on 2nd December 2021. **November 2021 update:** Terms of reference have been added to the workshop agenda. **Action: Complete.** Clinical Effectiveness team to produce a DOI form and circulate with meeting papers prior to future meetings. **November 2021 update:** the Committee agreed with the new process for DOI to be captured in advance of meetings via an online form. **Action: Complete.**
5.3	**Draft Minutes of the online Priorities Committee meeting held 22nd September 2021 - Action 7.3 Policy TVPC83 Anterior Cruciate Ligament (ACL) reconstruction** Clinical Effectiveness team to update and circulate the policy statement as outlined above. **Action: Complete.**
5.4	**Draft Minutes of the online Priorities Committee meeting held 22nd September 2021 - Action 8.2 Policy TVPC20 Otitis Media with effusion in children under 12:** Clinical Effectiveness team to update and circulate the policy statement as outlined above. **Action: Complete.**
5.5	**Draft Minutes of the online Priorities Committee meeting held 22nd September 2021 - Action 9.4 Benign prostate hyperplasia (BPH) pathway to include review of Evidence based intervention list (EBI) 2: 2I - Surgical intervention for benign prostatic hyperplasia** Clinical Effectiveness team to update and circulate the policy statement as outlined above. **November 2021 update:** It was shared that the OCCG Board discussed the policy phrasing of the at-risk population with regards to specific and appropriately inclusive terminology. Naming men only in the policy may exclude female patients who retain a prostate. Oxfordshire CCG has amended the policy wording as well as the wording of the other associated policies; treatment of voiding lower urinary tract symptoms and prostate specific antigen testing. **Action: SC to share wording with Clinical Effectiveness team. CE team to amend policies accordingly.**

5.6	**Draft Minutes of the online Priorities Committee meeting held 22nd September 2021 - Action 10.3 Evidence based intervention (EBI) list 2: 2CC Prostate-specific antigen (PSA) test** Clinical Effectiveness team to update and circulate the policy statement as outlined above. **Action: Complete.** **November 2021 update:** SC to share wording with Clinical Effectiveness team for proposed wording changes to policy as outlined in item 5.5. Clinical Effectiveness team to review the policy when new evidence and/ or guidance is published that may inform discussions around repeat testing. **Action: Complete.**
5.7	**Draft Minutes of the online Priorities Committee meeting held 22nd September 2021 - Action 11.3 Evidence based intervention list (EBI) 2: Surgical removal of kidney stones** Clinical Effectiveness team to update and circulate the policy statement as outlined above. **Action: Complete.** Clinical Effectiveness team to reformat the policy to guide recommendations by stone size. **Action: Complete.**
5.8	**Draft Minutes of the online Priorities Committee meeting held 22nd September 2021 - Action 12.1 Evidence based intervention list (EBI) 2: 2M Endoscopy; 2N & 2O Colonoscopy for cancer surveillance** Clinical Effectiveness team to update and circulate the policy statement as outlined. **Action: Complete.**
5.9	**Draft Minutes of the online Priorities Committee meeting held 22nd September 2021 - Action 12.3 Evidence based intervention list (EBI) 2: 2M Endoscopy; 2N & 2O Colonoscopy for cancer surveillance** Clinical Effectiveness team to update and circulate the policy statement as outlined. **Action: Complete.**
5.10	**Draft Minutes of the online Priorities Committee meeting held 22nd September 2021 - Action 12.6 Evidence based intervention list (EBI) 2: 2M Endoscopy; 2N & 2O Colonoscopy for cancer surveillance** Clinical Effectiveness team to update and circulate the policy statement as outlined above. **Action: Complete.**
5.11	**Draft Minutes of the online Priorities Committee meeting held 22nd September 2021 - Action 13.1 Horizon Scanning** NICE TAGs to be added to current TVPC policies when an update is scheduled according to the policy update programme. **Action: Complete.** Clinical Effectiveness to schedule a full review of TVPC61 Snoring and Obstructive Sleep Apnoea/Hypopnoea Syndrome in Adults. A**ction: Complete.**
6.	**Review of High Cost and Complex Care Packages**
6.1	Background: A review of high cost and complex care packages was requested as a topic at the 2020 TVPC workshop. The Thames Valley CCGs wished to explore the possibility of a TVPC statement regarding the delivery of high cost and complex care to particularly: • Explore whether such a statement could provide consistency to decision making for patients and staff and reduce variation in access and provision of care across the ICS. • Consider a suggested upper limit for care provision in the home environment. Cost, risk, or level of need were identified as topics for discussion. The review focused on individuals eligible for NHS CHC (NHS Continuing Healthcare) as they have needs more likely to be considered 'complex' and care is directly funded by CCGs/ICS. There has been year on year increases in the number of those found eligible for CHC nationally (excluding 2020 due to the impact of Covid-19) and it is anticipated that demand will continue to increase.

Home care packages for patients with highly complex needs may cost over £100,000 per annum and availability of care is often very limited. Limited availability and poor sustainability can lead to delayed hospital discharges, increased risk and unnecessary hospital admissions.

Fast track (end of life) CHC and children's services were excluded from the review.

NHS Continuing Healthcare eligibility (CHC): An individual is eligible for NHS CHC if they have a 'primary health need'. A patient's multi-disciplinary team is required to make a recommendation regarding this using a decision support tool (DST). The DST and eligibility are based on need and are not condition specific. A recommendation should also include consideration of the nature, intensity, complexity and/or unpredictability of a person's needs. Patients can move between local authority (LA) and CHC funding if their needs change, for example if they are deemed to no longer demonstrate a primary health need.

NHS Continuing Healthcare funding: Where an individual is eligible for CHC, the NHS is responsible for commissioning a care package that meets all health and associated social care needs. CCGs must have regard to the National Service Framework (NSF) for CHC which states that the the starting point for agreeing the care package, and the setting where CHC services are to be provided, should be based on the individual's preferences. The framework states that CCGs can take comparative costs and value for money into account when determining the model of support to be provided, but should consider the following factors when doing so:

- The cost comparison must be based on 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.
- Where a person prefers to be supported in their own home, the actual costs of doing this should be identified based on the individual's assessed needs and agreed desired outcomes.

CCG Equity and Choice (E&C) Policies: CHC departments across Thames Valley have developed E&C policies which have commonalities. These offer examples of levels of need which may be more suitable to be managed in a care home setting. All outline a need for risk assessment for patients, GP support if a patient remains at home and the need to consider the psychological impact of moving to a different setting. Oxfordshire CCG states it will consider a 2-week temporary increase of care if there is a temporary deterioration in a patient's condition.

Personalisation: The NSF states CCGs should operate a person-centred approach to all aspects of NHS CHC, using models that maximise personalisation and individual control, and that reflect an individual's preferences. Personal Health Budgets (PHB) should be offered. The Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care System (2019) Draft Strategic Delivery Plan supports the use of PHBs as the default delivery process.

Risk assessment: Some risks may be considered too high to be managed within the home environment following a comprehensive risk assessment. Generally, a CHC risk assessment would involve reviewing risks and mitigation within the care domains of the DST, and an environmental and/or hazards risk assessment. Involved individuals may all have different views about assessing and responding to risk and as such there will often be a level of subjectivity in agreeing an 'acceptable' risk. Quantifying a level of risk to either an individual or those caring for them, which would precipitate a move to a 24-hour care setting is challenging and involves ethical decision making. Risks may not necessarily be wholly mitigated by a move to a 24-hour setting.

	National Data: NHS CHC data is collated by NHS England. Snapshot data for Quarter 1 (2020/21): • Nationally the number eligible for (all) CHC funding per 50,000 population was 54.99 • Locally the figures were; Oxfordshire = 41.6, Buckinghamshire = 41.7, Berkshire West =11.4, Frimley (whole) = 40.4 per 50,000 population. • Year to date eligibility per 50,000 population: Oxfordshire CCG = 65, Buckinghamshire CCG = 46, Berkshire West CCG = 16, Frimley (whole) CCG = 50 • Nationally the total number of people no longer eligible for NHS CHC was 23,461 in Q1 2021-22. Of these, 2,958 were standard NHS CHC cases Variation in the data may be for a variety of reasons including age dispersion within the local population, variations between geographical areas in terms of their levels of health needs, and the availability of other local services. These factors need to be taken into consideration when viewing the data and care should be taken when attempting to make comparisons and draw potential conclusions. Local Data: Data was requested from the four CHC departments of the CCGs supported by TVPC; this showed that Oxfordshire has a higher proportion of home care packages over £100,000 per annum (11.6 per 100,000 population), compared to Berkshire West (3.3 per 100,000 population) and Buckinghamshire (3.7 per 100,000 population). The average costs of CHC nursing home provision varies across the ICS (Oxfordshire - £1957.53 per week, Berkshire West - £1957.53 per week and Buckinghamshire - £2570.33 per week). No local data was received from East Berkshire. Considerations • CCG level guidance (E&C) offers examples of levels of need which may be more suitable to be managed in a care home setting including: excess of 8 hours care required a day, the need for waking night care, registered nurse required to provide supervision or intervention throughout the 24 hours. • Some policies outside of the TVPC locality recommend that home care will only be funded up to a given percentage higher than providing the same level of care in a different setting. • Collaborative decision making regarding where a CHC funded patient is domiciled can be complex, highly individualised, and multifaceted. • For individuals with priority needs in domains such as breathing, care may be more difficult to source and less sustainable. In these instances, contingency care may also be challenging to put in place. • Alternatives to home care may be some distance from family and friends affecting a patient's 'right to respect for private and family life'. • Nursing home costs can also be very variable as individuals may require 1:1 supervision or have highly specialised needs requiring increased levels of staffing and training. • Options and choice for patients may be severely constrained by availability in the local care market. Patients with very similar needs may have very different levels of sustainability in their care packages depending on where they live. • Any TVPC statement / policy recommendation will need to consider patients transitioning from children to adult services.
6.2	**Discussion** Data: Dicussion was held regarding variation in the national data as Berkshire West appears to be an outlier in terms of numbers found eligible for CHC funding. Conversion rate from referral to eligiblility nationally is circa 20%, but it is unclear what the conversion rate is for Berkshire West and whether lower numbers of patients are referred or lower numbers found eligible. It

	was acknowledged that more understanding of the reason for differences in numbers found eligible is required. Cost: The very high cost of some home care packages that are well in excess of £100,000 per year was raised. It was highlighted that one of the Chief Financial Officer's lines of enquiry for the 22/23 planning process is to review CHC costs, which amount to £153 million across the area. If the spend currently seen in Oxfordshire and Buckinghamshires was replicated in Berkshire West, there would be a cost pressure in the region £30 million. It was highlighted that the cost of actually managing individuals' preferences on a case by case basis should be considered. A legally sound ICS framework would save time and resource. Risk: The risk and poor sustainability of 24 hour care for those with complex needs in a home setting was discussed. It was identified that CHC undertakes review of needs at 3 months and then annually to ensure needs are met safely and sustainability. Financial risk to CCGs due to increasing costs was discussed. Choice: Although an individual's choice and preferences should be taken into account in line with the NSF, it was highlighted that the current care market often does not offer unrestricted choice in terms of provider. Legal aspects: Special Advisor for Law provided advice. The NSF states that patient choice comes first, however it also discusses CCG resources. There is a balance between patient choice and the requirement to stay within financial resources. There have been several legal challenges. The CCGs need to establish what is affordable and set a framework for this. Such a framework could be subject to legal challenge; therefore it must balance all considerations carefully. Patients best interests need to be recognised. It was highlighted that diverting care to individuals in their own home may impact the workforce in other service areas and that this is a higly relevant consideration. A framework agreed throughout the ICS will be more robust, and easier to explain and defend. From April, BOB ICS should be one legal entity taking decisions; BOB is looking at the alignment across CHC systems. On the ICP board there will be a Local Authority member and collaboration will be a duty. Local Authority (LA): A possible need to engage with the LAs on this specific topic was raised. Different CHC departments have different arrangements with LAs in terms of brokering and providing care. The possibility of care being costed higher for CHC patients simply because they fall under the umbrella of health as opposed to social care was highlighted. Equity and Choice Policies (E&C) and % caps on home care over and above a reasonable alternative: Each of the CCGs hold an E&C Policy which have many similarities but some differences. Out of area policies reviewed include statements that provision of home care a percentage cost above a reasonable alternative (i.e nursing home) will not usually be considered. Brighton and Hove have a E&C policy with limitations to home care provision, which has withstood some legal challenges. Buckinghamshire does put a 10% threshold on with Bevan Brittans (Legal Firm) support. It was highlighted that the reason for the choice of 10% was unknown, but seems to be a figure consistently used by CCGs. Discussion was had as to whether a percentage cap would be compatible with the NSF; it was highlighted that an arbitary cap couldn't be set without taking into account an individuals needs, but that CCGs have a responsibility to maintain financial stability.

6.3	Following consideration the Committee agreed to an indepth compare and contrast of Equity and Choice policies to note differences across Thames Valley. The Committee requested further exploration of out of area policies with a percentage spend limitation for home care, over and above that of alternatives. Following this, a working group to be set up with expertise from NHS and Local Authory to review. **Action: 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: Clinical Effectiveness team to contact Brighton and Hove for information on recent legal challenges .** **Action: Clinical Effectiveness to investigate reasons for choosing a 10% limitation for home care over and above alternative provision.** **Action: Clinical Effectiveness team to convene a working group.**
7.	**Policy update - TVPC 14 Biological mesh. Review of biological mesh for abdominal surgery**
7.1	TVPC 14 for Biological mesh (2015, minor update 2019) recommends biological mesh as an option for suitable patients undergoing breast reconstructive surgery. The use of biological mesh is not funded for any other indications. At the time of the policy development the Committee also considered an evidence review for the use of biological mesh for complex abdominal wall repair and concluded that there was not sufficient evidence of clinical or cost effectiveness to recommend the use of biological mesh for this indication. <u>Guidance and clinical evidence</u>: No new national guidance has been released in relation to biological mesh for complex abdominal wall repair. A review of clinical evidence found three randomised control trials (RCT) published within the last year addressing the use of biological mesh for repair of ventral and incisional hernia. Significant methodological issues were apparent with all studies. One concluded that patients with biological mesh were significantly more likely to experience hernia recurrence or re-operation than those with synthetic mesh. Although, it was noted that less than half the required patients were recruited and 24% of patients were not treated in line with protocol. A second RCT concluded that patients were significantly more likely to experience hernia recurrence than those with synthetic mesh. However, again patients recruited fell short of the number required and a large number of patients dropped out of the trial. The third RCT was a pilot study with a small sample size. This trial concluded that patients with biological mesh had twice the rate of mesh infection, recurrence, or re-operation than those with synthetic mesh, but the result was not statistically significant. <u>Acquisition costs:</u> Biological mesh are high-cost CCG commissioned devices with costs ranging from approximately £160 to £17,000 per mesh. In comparison, the cost of standard flat mesh ranges from approximately £16 to £660. Individual funding requests (IFR) received since policy implementation in 2015 were in majority for incisional hernias.
7.2	<u>Discussion</u>: The specialists in attendance raised the following points: • Biological mesh is used in specific and rare operations for abdominal wall reconstruction and its use is discussed by a multi-disciplinary team. • The evidence for biological mesh is poor, but it is difficult to design a trial to assess its efficacy as it is not suitable to use synthetic mesh for patients with contaminated hernias. The literature is limited, and the trials are heterogenous with regards to included hernia patients. • Conclusions drawn however indicate that: biological meshes are not as strong as synthetic meshes so should be avoided where possible; biological meshes are essential

	where contact with the gastrointestinal tract cannot be avoided or when the wound is heavily contaminated, and a synthetic mesh would not be suitable. • Multidisciplinary approach and joint decision making with these complex patients allows there to be a governance trail, ensuring that the process of decision making is open and transparent. There was discussion as to whether this process would fit with the current IFR process. It was estimated that 6 cases per year require biological mesh and thus the IFR route would be manageable. The specialists highlighted that local NHS provider trusts currently stock a considerable number of meshes and that this could be optimised to reduce unnecessary spend. The Committee noted that whilst it is important to review this, it would be appropriate to highlight to the trusts' procurement teams.
7.3	Following consideration, due to the small of affected patients and low-quality evidence, the Committee agreed to recommend no changes to the current policy and that the use of biological mesh will continue to be not normally funded. **Action: 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: Clinical Effectiveness team to update the current policy to reflect a review of the policy and that the current policy position is maintained.**
8.	**Policy update – TVPC 68 Female sterilisation**

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8.1	A review of TVPC 68 Female sterilisation has been undertaken due to local concerns regarding the policy implementation. The current policy was recommended in 2017 (updated 2021) and states female sterilisation will not normally be funded. This position was taken because there are other alternative non-invasive options including Long Acting Reversible Contraceptives (LARCs) available which are as, or more, effective than female sterilisation. At the time of policy development, it was noted that there was a lack of recent cost-effectiveness data and analyses. In addition, the literature suggested that female sterilisation is associated with high levels of associated regret. Berkshire West CCG receives a number of Individual funding requests (IFRs) for sterilisation at caesarean section, often when the patient has already had multiple caesarean sections. In addition, it is understood that Oxford University Hospitals (OUH) Foundation Trust is performing immediate female sterilisation following caesarean section. Local data indicates that across Buckinghamshire, Oxfordshire and Berkshire West (BOB) CCGs there is activity for elective caesarean sections and associated female sterilisations. National guidance suggests women should be advised that some LARC methods are as, or more, effective than female sterilisation and may confer non-contraceptive benefits. However, women should not feel pressured into choosing LARC over female sterilisation. Tubal occlusion should ideally be performed after some time has elapsed following childbirth. Women who request tubal occlusion to be performed at the time of a delivery should be advised of the possible increased risk of regret and clinicians should ensure that written consent to be sterilised at caesarean section is obtained and documented. The Committee was asked to comment on whether the current position, that female sterilisation is not normally funded, should be maintained or if the policy should be reviewed further to consider the provision of female sterilisation to certain groups of women, for example those who cannot tolerate any other contraception, have had multiple caesarean sections, or for whom a further pregnancy is contraindicated.
8.2	Discussion: Discussion was held around the need for further review to understand whether activity is based in specific subgroups of women, for example those who have had multiple caesarean sections. Concern was raised about potential inequalities and access to sterilisation. The issue of ensuring informed consent and patient information was raised. Following consideration, the Committee agreed for the Clinical Effectiveness team and Oxfordshire CCG to undertake work to explore the data further and consider the ethics and equalities issues associated with access to female sterilisation and caesarean section. This review will be discussed at a future committee meeting when further information and data is gathered. Date to be confirmed. The Committee agreed no amendment to policy at this time. **Action: Clinical Effectiveness team and Oxfordshire CCG to scope and explore the data. Further discussions should consider the associated ethics and equalities issues.**
9.	**Policy update programme: Two policies to be updated (with/without minor changes) or scheduled for further discussion.** • **TVPC 80 Primary Care Subfertility Pathway** • **TVPC 2 Treatments for Gender Dysphoria**
9.1	TVPC80 Primary Care Subfertility Pathway The pathway was developed by the local clinicians in 2018. The aim of the pathway is to ensure consistency in thresholds for secondary care referrals, standardisation of the primary care investigations and avoidance of duplication of tests and to reiterate that secondary care referral is not just about access to assisted conception services but also for specialist advice and guidance on options for management of subfertility.

	The pathway is based on the NICE Clinical Guideline CG156 (2013) Fertility problems: assessment and treatment (updated in 2017). There has been no new national guidance has been published since the adoption of the pathway. Feedback was sought from the clinicians who developed the original pathway. OCCG advised of no significant clinical changes to this pathway. Policy date to be updated as reviewed. **Action: Clinical Effectiveness team to update the date of the pathway with no other changes.** <u>TVPC 2 Treatments for Gender Dysphoria (GD)</u> The policy was originally agreed when Specialised Commissioning became responsible for the provision of care for people with gender dysphoria in 2013 (last updated in 2018). The policy statement mirrors the Specialised Commissioning Specification in outlining the core and non-core treatments for GD and reiterates that non-core treatments not funded by NHS England are not normally funded by the CCGs. NHS England Gender Identity Services for Adults (Surgical Interventions) Specification was updated in 2019. It was proposed to update the policy to reflect the current Specification and maintain not normally funded position for non-core procedures. IFR data for those seeking non-core procedures in Thames Valley CCGS reflects the relatively low numbers of patients having core surgery. The committee agreed to the proposal to update the policy to reflect the current Specification and maintain not normally funded position for non-core procedures. **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.
11.	**Date of next meeting**
11.1	The next online meeting will be held on Wednesday 26th January 2022 **from 2 - 4.30pm.**
12.	**Meeting close**
12.1	The Chair thanked everyone for their contributions to the discussions and closed the meeting.