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

Minutes of the meeting held Wednesday 23rd November 2022 – FINAL v1.0

On-line via Microsoft Teams

David Clayton-Smith	Chair	NHS Buckinghamshire, Oxfordshire and Berkshire West ICB Integrated Care Board and Frimley Integrated Care Board Priorities Committee (BOBFPC); Review of Priority Committees and IFR processes NHS England and NHS Improvement, South East; Kent Surrey & Sussex Academic Health Science Network
Sue Carter	Clinical Effectiveness Manager and member delegated by BOB CMO; TVPC strategic lead for BOB ICB	NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board
Dr Megan John	Priorities and Policy Lead IFR lead SE priorities and IFR programme Board Lead; TVPC strategic lead for Frimley ICB	NHS Frimley Integrated Care Board
Dr Karen West	Clinical Director Integration	NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board
Mohammed Asghar	Prescribing Governance Lead	Frimley Health and Care Integrated Care System
Emeritus Professor Chris Newdick	Special Advisor, Law	University of Reading
Bhulesh Vadher	Clinical Director of Pharmacy and Medicines Management	Oxford University Hospital NHS Trust
Dr Raju Reddy	Secondary Care Consultant	NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board
Dr Lalitha Iyer	Chief Medical Officer	NHS Frimley Integrated Care Board
Mark Sheehan	Special Advisor, Ethics	University of Oxford
John Seymour	Consultant; Assistant Medical Director	NHS Frimley Integrated Care Board

Jenn Sula-Minns	Prior Approval Manager	NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board
Rosalind Pearce	Executive Director	Healthwatch – Oxfordshire
David Locke	Commissioning Pharmacist	NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board
Alan Cadman	Senior Financial Accountant	NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board
Gill Manning	Lay representative	NHS Frimley Integrated Care Board
Ian Murdock	Finance representative	Frimley Integrated Care Board
Faiza Khan	Chief Pharmacist	Frimley Health Foundation Trust
Dr Karl Marlowe	Medical Director	Oxford Health NHS Foundation Trust
Liza Pazik	Lead Pharmacist Medicines Resource Centre attending on behalf of Kirsty-Joy Habibi-Parker, Associate Director of Pharmacy - Medicines Resource Centre	Buckinghamshire Healthcare NHS Trust
Sakeb Hussain	Chief Pharmacist and Clinical Director for Pharmacy attending on behalf of Will Orr, acting Chief Medical Officer	Royal Berkshire NHS Foundation Trust

In Attendance:

Tiina Korhonen	Clinical Effectiveness Lead	SCW CSU
Kathryn Markey	Clinical Effectiveness Manager	SCW CSU
Naomi Scott	Clinical Effectiveness Manager	SCW CSU
Anna Lyne	Senior Policy Advisor	SCW CSU
Karen Blogg - minutes	Clinical Effectiveness Administrator	SCW CSU
Nicola Goodchild	Clinical Effectiveness Administrator	SCW CSU
Aimee Ashby	Interim Prior Approval and Audit Manager	SCW CSU

Apologies:

Funmi Fajemisin	Clinical Services Programme Lead Clinical Policy Implementation	SCW CSU
Abid Irfan	Deputy Chief Medical Officer	NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board
Dr Andrew Brent	Director of Clinical Improvement	Oxford University Hospital NHS Foundation Trust
Dr Will Orr	Acting Chief Medical Officer	Royal Berkshire NHS Foundation Trust
Kirsty-Joy Habibi-Parker	Associate Director of Pharmacy, Meds Resource Centre	Buckinghamshire Healthcare NHS Trust
Caroline sykes	Business Manager, Medical Director's Office	Oxford University Hospital NHS Foundation Trust
Minoo Irani	Medical Director	Royal Berkshire NHS Foundation Trust

Observers

Sapfo Lignou	University of Oxford
James Hart	University of Reading

Topic specialists in attendance:

Item 8 – Policy Update: TVPC61 Snoring and obstructive sleep apnoea/hypopnea syndrome (OSAHS) in adults Item 9 – Policy update: TVPC 22 – Tonsillectomy for surgical management of recurrent tonsillitis and obstructive sleep apnoea in children and adults. Item 10 – Policy update: Policy statement 76 (TVPC 98) Chronic fatigue syndrome/myalgic encephalomyelitis
Annabel Nickol – Consultant in Respiratory Medicine, Sleep and Ventilation Lead; OSA Alliance co-chair, Oxford Centre for Respiratory Medicine, Oxford University Hospital NHS Foundation Trust **Iain Wheatley** – Nurse Consultant, Sleep and Ventilation, Frimley Health NHS Foundation Trust **Sally Norwood** – Clinical Psychologist for Pain and CFS, Clinical Health Psychology Service (CHPS), Berkshire Healthcare NHS Foundation Trust

1.	**Welcome & introductions**
1.1	The Chair opened the meeting and welcomed members of the Committee and outlined the meeting structure. The Chair notified the meeting that Gill Manning (GM) has agreed to assume responsibility of Deputy Chair for the Committee. The name of the Thames Valley Priorities Committee (TVPC) was raised. It was suggested that the Committee's name should be changed to reflect the ICBs it advises. It was agreed that the committee name would be changed to Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board and Frimley Integrated Care Board Priorities Committee (BOBFPC).
2.	**Apologies for Absence**
2.1	Apologies recorded as above. The meeting was recorded as being quorate.
3.	**Declarations of Interest**
3.1	The Chair reviewed the declarations of interest prior to the meeting. None of the interests declared were considered material for committee decision making.
4.	**Draft Minutes of the Priorities Committee meeting held on 28th September 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 28th September 2022 – Matters arising**
5.1	6.3 Policy review: TVPC 11g Assisted reproduction services for infertile patients and draft policy. Committee decision required for option 2[a] or 2[b]. **Action: See agenda item 7**
5.2	6.6 Policy review: TVPC 11g Assisted reproduction services for infertile patients and draft policy. The Committee agreed to option 2 on defining infertility. Clinical Effectiveness (CE) team to add to the proposed policy. **Action: Complete**
5.3	6.9 Policy review: TVPC 11g Assisted reproduction services for infertile patients and draft policy. The Committee agreed to proposed new wording to confirm how long the ICB should fund storage of surgically retrieved sperm. CE team to add to the proposed policy. **Action: Complete**
5.4	8.1 Review of Terms of Reference (ToR); Ethical Framework (EF); Standard Operating Procedure (SOP).

	• CE team to update minor wording changes within the ToR document • CE team to contact GM regarding continuing membership and possibility of becoming deputy chair **Action: Complete** • CE team to explore recruiting an additional Lay member to represent BOB ICB • Membership and quoracy **Action: See item 6**
5.5	8.2 Review of EF. CE team to update minor wording changes within EF document. **Action: Complete**
5.6	8.3 SOP. CE team to update minor wording changes within SOP document. **Action: Complete**
5.7	10.1 Work plan until March 2023. CE team and SC to meet outside of Priorities Committee to discuss the priority of the topics included on the workplan. **Action: Complete**
5.8	11.1 TVPC Annual Report 2021-2022. CE team to arrange publication of annual report. **Action: Complete**
6.	**Agreement of Terms of Reference including membership and quoracy; Ethical Framework; Standard Operating Procedure**
6.1	<u>Terms of Reference</u> All minor wording changes were agreed in the previous Priorities Committee meeting. Outstanding issues to resolve are: • The name of the Committee • Member organisations, members and number of delegates • Voting members (when consensus is not reached) • Quoracy <u>Agree name of the committee</u> The name of the Committee has been agreed (item 1.1) as Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board and Frimley Integrated Care Board Priorities Committee (BOBF PC). <u>Agree member organisations, members, number of delegates and voting rights</u> The paper circulated prior to the meeting with member organisations and names was displayed and views were sought on whether it was an accurate and an appropriate members list. Discussion and considerations of the Committee: • The direction and work of the Committee should be reviewed as this may drive membership needs. • Membership needs to reflect the combined ICBs. • Clarification was sought on voting rights and how this would work for those deputising for an absent member. • It was agreed that members who are listed as a deputy for voting rights would also be listed as a full member of the committee in their own right. It was explained that all people named on the displayed document and possibly others too would be full members of the committee with contributions important to the work of the committee. • Individual funding request manager – It was noted that the member listed for BOB ICB works for the ICB, however the member listed for Frimley does not. The member currently listed for Frimley is employed by SCW and supports both BOB and Frimley. • In view of the system changes and collaborative nature of working, voting rights would not be needed often. It was considered whether provider organisations should have a

vote. The legal responsibility for decision making on policies and priorities for healthcare services in the Health and Care Act is held by ICBs. The ICB has a responsibility to comprehensively engage with all stakeholders, provider partners and local authorities in relevant ICS areas during decision making. It was agreed that voting rights should remain with ICB representatives. The engagement needs to be communicated with stakeholders and provider partners to encourage collaborative working.

<u>Quoracy</u>

The current quoracy is:

- Chair of the Committee (or deputy)
- Chief Officer or Chief Finance Officer (or designated deputy of CO/CFO)
- At least one member representing each Clinical Commissioning Group /CCG Federation
- At least one lay member
- At least two clinicians (one medical)

The future proposed quoracy

- Chair of Committee (or deputy)
- ICB executive member or Chief Finance Officer (or designated deputy for CO/CFO)
- At least one member representing each ICB
- At least one lay member
- At least two clinicians (one medical)

It was agreed at the last meeting that quoracy would not be based on proportional representation, but that equal representation would be required from each ICB.

Discussion and considerations of the Committee

- The requirement for at least two clinicians (one medical) may need to be explained fully for the benefit of the public (for example the differentiation between pharmacy and physician/surgeon). A question was raised as to whether this also include representation from both ICBs.
- Is there sufficient opportunity to converse adequately between ICB representatives ahead of meetings to ensure members are representing the wider body.
- The work of the Committee is not changing but the way in which the Committee is being asked to work is changing. Public health representation should be a greater consideration if not for quoracy at least for membership. The CE team has engaged with Public Health for BOB ICS and Frimley ICS both of whom are keen to be part of the membership of the Committee but do not have capacity to commit to every meeting and therefore be part of quoracy.
- The Committee currently has one lay member. Another lay member should be recruited. It was suggested that the Ethics and Legal Advisor members could assume a lay member role and this was agreed by the Committee.
- The issue of ICB Executive representation from each ICB at each meeting was raised.
- If an executive member was unable to attend the meeting and had delegated their responsibility, there should be formal written communication of the delegation that could be recorded in minutes.
- It was agreed that either the ICB representative or ICB executive team member is required but there must be one member representing each ICB. One executive member from either ICB will be required for quoracy.
- In the event of non-quoracy, an email will be sent to those unable to attend for quoracy seeking agreement of the meeting actions, as per current post hoc process.

	• The Committee discussed whether members of the Integrated Care Partnerships (ICP) should be invited to the meeting. The Committee understood that members of the ICP were ICB members and vice versa. Additional specific members could be invited for topics where their expertise would be beneficial. • Quoracy was agreed as: ➢ Chair of Committee (or deputy) ➢ One ICB executive member from either ICB (or designated deputy) ➢ At least one member representing each ICB ➢ At least one lay member ➢ At least two clinicians (one medical for example GP, secondary care consultant) **Actions:** • **The voting membership proposed was agreed** • **Deputies listed for voting rights will be committee members in their own right** • **CE team to circulate the draft ToR document with the minutes**
6.2	<u>Ethical Framework</u> Minor changes to Ethical Framework were previously agreed **Action: CE team to circulate the draft Ethical Framework document with the minutes**
6.3	<u>Standard Operating Procedure</u> Minor changes to the Standard Operating Procedure were previously agreed. Addition of a section detailing collaborative working, population health, public health and health inequalities, was not discussed in the meeting but circulated to members prior to the meeting. This will be circulated for comment. **Actions: CE team to circulate the draft Standard Operating Procedure document with the minutes**
7.	**Policy update: BOBFPC 11g (formerly TVPC 11g) Assisted reproduction services for infertile patients**
7.1	This policy review has been ongoing since March 2022. At the September 2022 TVPC meeting it was agreed to recommend: • a proposed policy recommending funding of IUI for patients trying to conceive using partner and donor sperm consistent with NICE Clinical Guideline (CG) 156. • proposed suggested amendments to the wording defining infertility/ expectant management consistent with NICE CG156. • additional suggested changes to improve clarity/ consistency of application of policy. The issue outstanding requiring a decision is in relation to funding of IUI; specifically, the methods through which patients trying to conceive through artificial insemination (AI) need to demonstrate their subfertility prior to NHS funded IUI: • Option [a] – Patients need to undertake 6 self-funded IUI cycles to demonstrate their subfertility; this means patients must undergo 6 IUI cycles at a fertility clinic at their own cost. • Option [b] – Patients need to undertake 6 self-initiated AI cycles to demonstrate their subfertility; this means patients have the option of undergoing 6 AI cycles either at home, using an unregulated sperm donor, or IUI at a fertility clinic at their own cost. It was noted that at the September Committee meeting there was no consensus on whether to recommend option [a] or option [b] and the Chair was to seek the views of the voting members post meeting to obtain decision. However, as this action was not completed, the decision was brough back to the November Committee. The Committee was presented with a summary of

	the differences between the two options and the issues raised at the previous meeting (September 2022).
7.2	Discussion There were detailed discussions on this issue previously which were documented in the approved minutes of 28th September 2022 meeting (item 4). The chair asked that these discussions were not replicated but asked if anyone had any further questions or comments to make. Clarification was requested on which option would have a greater financial impact on both same sex couples and other people trying to conceive using AI. It was confirmed that Option [a] would have a greater financial impact on these groups. Further it was noted that implementing option [a] would mean that a proportion of the population who could not afford to self-fund IUI would not be able to access NHS funded fertility treatment. The Committee noted that regardless of whichever option is chosen, there is the potential for a legal challenge. However, it was agreed that overall option [b] appears to be more defensible in terms of offering equal access to health services and promoting health equality. In addition, the estimated cost impact to ICBs of implementing option [b], calculated by extrapolating activity data from another geographical area which has implemented this policy, is not suggested to be significant.
7.3	The Committee agreed to recommend option [b] Patients need to undertake 6 self-initiated AI cycles to demonstrate their subfertility; this means patients have the option of undergoing 6 AI cycles either at home, using an unregulated sperm donor, or IUI at a fertility clinic at their own cost. The Committee also recommends that signposting information is included in the policy for additional information for patients on the AI options available to them and their implications. The Committee agreed that the draft policy should be sent for independent legal advice before policy ratification. **Actions:** • **CE team to make amendments to policy and circulate draft to the Committee members for comment.** • **CE team to seek independent legal advice on the draft policy.**
8.	**Policy update: BOBFPC 61 (formerly TVPC 61) Snoring and obstructive sleep apnoea/hypopnea syndrome (OSAHS) in adults**
8.1	Background NICE has published guideline 202 - Obstructive sleep apnoea/hypopnoea syndrome and obesity hypoventilation syndrome in over 16s. This makes recommendations on the treatment of OSAHS including continuous positive airway pressure (CPAP), mandibular advancement splints (MAS), positional devices and surgery. The guideline, in part, updates recommendations for the previously published Technology Assessment for CPAP. BOB and Frimley ICBs currently hold a policy recommendation regarding the treatment of OSAHS, TVPC 61. This makes recommendations on: • Referral to specialist sleep unit for further investigation • When continuous positive airway pressure (CPAP) is commissioned • Surgery for OSAHS • Treatments for snoring alone • Recommendations of lifestyle measures • Mandibular advancement devices

	Differences are noted between TVPC61 and NG202 including: • Questionnaires to measure symptoms to inform referrals • Devices used to diagnose OSAHS • TVPC policy requiring previous treatments are trialled before trialling CPAP for patients with mild OSAHS • The use of MAS • The use of positional modifiers The specialists in attendance expressed support for the recommendations within NG202. It was noted that many patients with mild OSAHS are already being treated and as such this change would not result in a significant impact on capacity or demand for CPAP. It was highlighted that there is now wider recognition that OSAHS also affects women who may not be overweight but have symptoms of fatigue and sleep fragmentation. Local specialists supportive of the effectiveness of MAS and the data that the NICE recommendations were based on. It was proposed that MAS are suitable for patients who have symptomatic mild to moderate OSAHS but are unable to tolerate CPAP. The cost of the MAS device is similar to CPAP.
8.2	<u>Discussion</u> The preference of home polygraphy, as the 'gold standard' test, over home oximetry was discussed. As there is good preliminary provision for polygraphy in the area, it was felt this should be encouraged and supported as widely as possible, with the policy wording providing clear direction. The specialists advised that compromising on the diagnostic test used could result in a small proportion of patients being managed inappropriately. It was noted that NICE Technology Assessments are legally mandated, the current policy should be updated with regards to CPAP being recommended for patients with mild OSAHS. There was discussion regarding when it would be appropriate to use MAS or positional devices. Patients requiring MAS are referred to dental services who make the device and titrate them. These patients are then followed up in clinic with a patient questionnaire and home overnight oximetry. Positional devices may be useful for patients with positional OSAHS. Specialists advised that once the costs of MAS were annualised they were similar to CPAP. It was noted that CPAP machines can re-used if not suitable, whereas MAS are custom made. As such it is practical to trial CPAP initially. Clarification was provided on the difference between STOP-BANG questionnaire and the Epworth sleepiness scale. It was noted that the STOP-BANG questionnaire may not identify female patients who are younger and/or not overweight. The Epworth sleepiness scale can be useful to determine how sleepy a person is, and how interventions may change this.
8.3	The Committee agreed • To adopt the NICE TA policy wording for CPAP. • To include information on symptoms of OSAHS and many of these should be required for patients to be referred to secondary care. • To recommend the use of respiratory polygraphy for diagnosis, with oximetry only used when respiratory polygraphy is not available • To maintain reference to the use of the STOP- BANG questionnaire for identifying patients of high risk. • To recommend MAS as a second line treatment option.

	• To recommend the use of positional modifiers for patients who have positional OSA. **Action: CE team to liaise with specialists to develop information on OSAHS symptoms, make amendments to the policy and circulate draft to the Committee members for comment.**
9.	**Policy update: BOBFPC 22 (formerlyTVPC 22) Tonsillectomy for surgical management of recurrent tonsillitis and obstructive sleep apnoea in children and adults**
9.1	Background NICE guideline NG202 makes recommendations on the use of tonsillectomy as a treatment for OSAHS. Currently policy TVPC 22 states that tonsillectomy can be considered for adults with a confirmed diagnosis of OSAHS in the presence of large tonsils. The new NICE guideline recommends that this is restricted to patients with a BMI of less than 35. Local activity data suggests that tonsillectomy is not a common procedure for the treatment of OSAHS. The specialists in attendance advised that there were occasions where tonsillectomy was appropriate for patients with a high BMI, but who are not obese. As such the flexibility to be able to allow treatment is desired. Another specialist agreed with the recommendations from NICE as patients with a higher BMI are more vulnerable to multi-level obstruction.
9.2	Discussion The Committee was in support of adopting the recommendations of NG202. It was noted that treatment for patients falling outside of this could be requested via the individual funding panel.
9.3	The Committee agreed to update the policy to reflect the recommendations of NG202 and to restrict tonsillectomy for OSAHS patients with a BMI less than 35kg/m2 **Action: CE team to make amendments to the policy and circulate draft to the Committee members for comment.**
10.	**Policy update: Policy statement 76 (TVPC 98) Chronic fatigue syndrome (CFS)/myalgic encephalomyelitis (ME)**
10.1	In June 2020, the Committee reviewed the TVPC policies across the Thames Valley CCGs for Chronic fatigue syndrome (CFS). At this time policies promoted the use of Cognitive Behavioural Therapy (CBT) and Graded Exercise T(GET). The current policy is out of line with NICE guidance (NG206) published in 2021. A short summary of NICE is as follows: • Principles of care for ME/CFS including awareness, approach to care, diagnosis, care planning, safeguarding, access to care and managing ME/CFS and its symptoms. • Care for people with CFS/ME should follow a coordinated multidisciplinary approach. • Care for people whose CFS/ME is managed in primary care should be supported by advice and direct clinical consultation from a specialist team. • Primary healthcare professionals should consider seeking advice from an appropriate specialist if there is uncertainty about interpreting signs and symptoms and whether an early referral is needed. For children and young people, consider seeking advice from a paediatrician. • Refer adults directly to an ME/CFS specialist team to confirm their diagnosis and develop a care and support plan • Refer children and young people who have been diagnosed with ME/CFS after assessment by a paediatrician directly to a paediatric ME/CFS specialist team to confirm their diagnosis and develop a care and support plan. • Promotion of 'Energy Management' strategies

	• With regards to physical activity and exercise, do not offer people with ME/CFS any programme that uses fixed incremental increases in physical activity or exercise, for example, graded exercise therapy • Guidance on approaching the use of CBT Activity and financial impact • NICE guideline reinforces best practice. Some of the guideline areas and recommendations may represent a change to current local practice. This may require additional resources to implement, which may be significant at a local level. Benefits derived from the change in practice may help mitigate any additional costs • Lack of robust data on current practice with variation across organisations, services, and country. The size of the resource impact will need to be determined at a local level. • Individual Funding Requests (IFRs) (April 2018-Nov 2022): Only a small number of IFRs received across BOB and Frimley ICBs. These were mainly for outpatient and inpatient treatment; assessment; management including fatigue management, CBT, and psychology. Of the 15 requests, 7 were for out of area treatment. Summary of feedback • Implementation of NICE guidance represents a significant change at local level, indicating that expertise and skills will be needed now more than ever. • The Oxfordshire ME/CFS Service currently provides interventions for children and young people (CYP) over the age of 14. The NICE guideline recommends that after assessment by a Paediatrician, children and young people (CYP) should be referred directly to a paediatric ME/CFS specialist team to confirm their diagnosis and develop a care and support plan. This is not currently possible for CYP under the age of 14 living in Oxfordshire. • There is no specialist ME/CFS service for patients living within East Berkshire. • Specialists are contributing to the Long Covid assessment and rehabilitation pathway in Oxfordshire and that anecdotally we are becoming aware of patients in the long covid clinic with a background history/diagnosis of ME/CFS being triggered into a relapse due to a Covid infection. There is the potential to overload the system going forward. • The specialist in attendance advised that in parts of the local area, there is no specialist input for diagnosing ME/CFS and the service is reliant on the GP to diagnose.
10.2	<u>Discussion</u> The NICE guidance does not refer to stays in private providers offering access to NHS patients. Across the 2 ICBs there is currently little or no details about the volume of ME/CFS patients and therefore cost of existing services and any future provision is difficult to quantify. Policies should reflect NICE guidance unless there is a very good reason why wording should not be updated, and this does not appear to be the case for this policy. Comment was made regarding the availability of staff to deliver the service as suggested by NICE. At present it appears that many areas do not have adequate systems or services in place and would this cause operational difficulties.
10.3	The Committee was asked to consider two options: 1. In consideration of the national guideline NG206, withdraw the current policy statement. (This may not allow for monitoring of individual funding request for treatment potentially not recommended by NICE or referral to out of area specialist centres). 2. Update and maintain the statement to reflect the principles of best practice outlined by NG206 and endorse the position that management in line with NICE guidance within local pathways will be funded. Treatment programmes at out of area specialist inpatient and outpatient units for ME/CFS will not normally be funded.

	The Committee agreed to option 2 with inclusion of local pathways and reason for change. **Action: CE team to make amendments to the policy and circulate draft to the Committee members for comment.**
11.	**Policy update: BOBFPC (formerly TVPC 54) Melatonin treatment in children – chronic fatigue syndrome**
11.1	The current policy (2017, updated 2019) recommends melatonin for sleep disorders in line with NICE guidance in children with: • Learning disabilities and challenging behaviour • Autism • Chronic fatigue syndrome • Children undergoing sleep EEG • Cerebral palsy The policy recommendation for the use of melatonin in patients with chronic fatigue syndrome was based on NICE CG53 (2007): Chronic fatigue syndrome/myalgic encephalomyelitis (or encephalopathy) which stated that melatonin may be considered for children and young people with CFS/ME who have sleep difficulties, but only under specialist supervision because it is not licensed in the UK. • The current NICE guideline (NG206, 2021) makes no recommendation about the use of melatonin for sleep disorders in patients with CFS. • The guideline suggests, if sleep management strategies do not improve the person's sleep and rest, think about the possibility of an underlying sleep disorder or dysfunction and whether to refer to an appropriate specialist. • NICE did not find any evidence for sleep medication (including melatonin) and could not draw conclusions or recommendations for its use. No further evidence published since the search for development of the NICE guideline was found with regards to the use of melatonin in chronic fatigue syndrome.
11.2	<u>Discussion</u> The use of melatonin has been a highly contentious area given the costs attached to its use and there has been lots of work done by medicines optimisation teams to use the most cost-effective preparations where possible. The current impact of the use of melatonin prescribing across the area is not known. It is still considered to be significant and would benefit from some intelligence gathering to establish the current financial impact. As new guidance has been released, the policy wording should be amended to reflect this guidance, which will give better support for clinicians when requests are received.
11.3	The Committee was asked to consider two options: 1. CFS should be removed from the list of indications for which melatonin can be use if a child has a sleep disorder. 2. Withdrawal of current policy due to NICE guidelines, the use of joint formularies and shared care protocols. The Committee agreed to option 1 and the policy wording amended to reflect NICE guidance. **Action: CE team to make amendments to the policy and circulate draft to the Committee members for comment.**
12	**Update on South East Regional Priorities Committee**
12.1	The Chair provided an update on the review undertaken for the South East Regional Office of NHS England and the progress made thus far. The aim is to have a joint committee in place by April 2023, made up of members from each of the 6 ICBs in the South East. Preparation and planning for mapping and aligning policies across the 6 ICBs is currently being discussed.

12.2	**Discussion** It was felt there could be a risk in duplicating work and that there is a need to consider the work being undertaken by medicine optimisation committees, the priorities committees, the area prescribing committees and the Regional Medicines Optimisation Committee (RMOC).
13.	**Policy surveillance and work plan review**
13.1	Hysterectomy for dysplasia The CE team produced a scoping paper following an enquiry from BOB ICB regarding the use of hysterectomy as a treatment for dysplasia. It was noted that the Royal College of Obstetrics and Gynaecology has produced guidance on when hysterectomy is a suitable treatment option for patients with dysplasia of the uterus. Local data suggests that this is not a common procedure will less than 20 spells in any given year. It was proposed that this topic was not put forward for a full review now. Osteoarthritis The policy surveillance process has identified that NICE has published a new guideline (NG266) relating to the diagnosis and management of osteoarthritis in patients over 16 years. BOB and Frimley ICBs hold two related policies: TVPC49 (Patients with osteoarthritis; primary hip and knee replacement) and TVPC6 (Arthroscopic lavage and debridement for patients with osteoarthritis of the knee). The differences between NG266 and the TVPC policies are related to intra-articular steroid injections, paracetamol prescribing, hot and cold therapy and arthroscopic lavage and debridement. The Committee felt that the impact on the TVPC policies was not large, and as this is likely to be affecting many other committees it could be considered when the South East Priorities Committee is in operation Ongoing Committee workplan The workplan was reviewed in the context of releasing CE capacity to support the South East Regional Priorities Committee development. Criteria for prioritisation and risk assessment of planned local topics/updates to address in within the next 3-6 months was: ▪ New or updated national guidance e.g. NICE guidelines that recommend a significant change in policy, a significant financial impact/change in current spend ▪ Issues raised by policy implementation team to suggest increasing/high demand ▪ Clinical concern about policy ▪ Significant reputational risk It was agreed that none of the scheduled topics were high risk. The following items on the workplan were discussed further in view of prioritisation: Denosumab for osteoporosis: it was agreed that the proposed review should be referred initially to BOB ICB for discussion/area prescribing committee. Data indicates the issue is BOB specific. Botulinum Toxin A: differing local policies. Medicines optimisation lead indicated that this could also be referred to area prescribing committee for discussion and standardisation of treatment pathway. The Committee agreed to the revised workplan plan. **Post meeting note for clarity**: Business as usual will continue for: • Policy surveillance for new evidence impacting on local clinical policies. • Policy surveillance for EBI programme updates. • Support to respond to enquiries, FOI/MP letters/complaints related to priority setting and implementation of clinical policies. • Dissemination of monthly NICE updates to include NICE horizon scanning and impact assessment of new guidance. • Production of finalised policies and minutes of the Priorities Committee for publication. • Follow through the current Assisted conception policy review, legal advice and associated Primary Care Pathway review. • Liaison with the policy implementation team on clinical policies.

14.	**Any other business**
14.1	There was no further business raised.
15.	**Date of next meeting**
15.1	The next meeting will be held on Wednesday, 25th January 2023, from 2 – 4.30pm via Microsoft Teams. There is a potential for this meeting to be cancelled and members will be informed as soon as this is known.
16.	**Meeting close**