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Southampton, Hampshire and Isle of Wight Clinical Commissioning Group and Portsmouth Clinical Commissioning Group

HSI+P PRIORITIES COMMITTEE MEETING
Minutes of the meeting held Thursday 19th May 2022, 9:00-12:00
On-line via Microsoft Teams

David Chilvers	GP, Clinical Chair	Fareham and Gosport Local Area Team (LAT)
Genevieve Ryan (left at 10.57am)	Senior Commissioning Manager	Southampton and South West Hampshire Team
David Carpenter	Ethics representative	NHS Health Research Authority
Linda Samuels	Lay member for West Hampshire	West Hampshire LAT
Tracey Gwyther	Service Improvement Manager	North Hampshire LAT
Tai Shodipo (left at 11.30am)	Associate Director of Provider Management	Isle of Wight LAT
Neil Hardy (left at 10.54am)	Associate Director - Medicines Optimisation	West Hampshire LAT
Julia Bowey	IFR Lead, Clinical representative	Southampton City LAT
Anita Bhardwaj	Interface Pharmacist	NHS Hampshire, Southampton and Isle of Wight CCG
Dr Timothy Whelan (left at 11.30am)	GP and Planned Care Clinical Lead	Isle of Wight CCG

In Attendance:

Tiina Korhonen	Clinical Effectiveness (CE) Lead	SCW CSU
Helen Hicks – Minute Taker	Clinical Effectiveness Administrator and Research Support Officer	SCW CSU
Joan Sharp	Clinical Effectiveness Manager	SCW CSU
Marion Mason	Interim Head of Prior Approval and Assurance - Clinical Policy Implementation Service	SCW CSU
Naomi Scott	Clinical Effectiveness Manager	SCW CSU
Karen Blogg	Clinical Effectiveness Administrator	SCW CSU

Apologies:

Cheryl Harding-Trestrail	Associate Director of Commissioning for UEC and Community Services	Isle of Wight Local Delivery System
Kate Forbes	Clinical Effectiveness Manager	SCW CSU
Adrian Higgins	Medical Director (Chair)	West Hampshire LAT
Steve Parker	Medical Director	Isle of Wight NHS Trust.
Linda Collie	Planned Care Clinical Lead	Portsmouth CCG

Topic Specialists in Attendance for Agenda Items:

Items 7 and 8 – Benign Skin Lesions and Keloid Scars
Dr Amy Poyner, GP with an Extended Role Dermatology, IOW Integrated Dermatology Service.

1.0	**Welcome & Introductions**
1.1	The Chair opened the meeting, welcomed the Committee members, and set out how the on-line meeting is to operate.

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2.0	**Apologies for Absence and Quoracy**
	Apologies for absence recorded as above.
3.0	**Declarations of Interest**
	The declarations of interest (DOI) form was circulated to all members prior to the meeting. New system was well received. Submitted declarations were sent to the Chair for review prior to the meeting. No material DOI were noted.
4.0	**Draft Minutes of the Priorities Committee meeting held 17th March 2022 – Confirm Accuracy**
4.1	The Committee agreed the minutes were a true record of the meeting.
5.0	**Draft Minutes of the Priorities Committee meeting held 17th March 2022 – Matters Arising (MA)**
5.1	**Draft Minutes of the Priorities Committee meeting held 17th March 2022 – Item 3 Declarations of Interest** Clinical Effectiveness team to set up a Microsoft Forms for trial prior to the May meeting. **Action: Complete.**
5.2	**Draft Minutes of the Priorities Committee meeting held 17th March 2022 – Item 5.6 Update and Review of Breast surgery policies (cosmetic policy review)** Clinical Effectiveness team to draft an updated policy to reflect the decisions and circulate for comment. **Action: In progress; on hold awaiting publication of EBI list 3. Closed.**
5.3	**Draft Minutes of the Priorities Committee meeting held 17th March 2022 – Item 6.1 Policy 34 Obstructive Sleep Apnoea – Diagnosis using Pulse Oximetry** Final version to be taken to the Clinical Executive Group (CEG) for sign off. **Action: Closed.**
5.4	**Draft Minutes of the Priorities Committee meeting held 17th March 2022 – Item 6.2 Policy 68 Hyperhidrosis** Final version to be taken to the Clinical Executive Group (CEG) for sign off. **Action: Closed.**
5.5	**Draft Minutes of the Priorities Committee meeting held 17th March 2022 – Item 6.3 Policy 25 Anal Fissure** Final version to be taken to the Clinical Executive Group (CEG) for sign off. **Action: Closed.**
5.6	**Draft Minutes of the Priorities Committee meeting held 17th March 2022 – Item 6.4 Policy 40 Management of Haemorrhoids** be taken to the Clinical Executive Group Final version to CEG) for sign off. **Action: Closed.**
5.7	**Draft Minutes of the Priorities Committee meeting held 17th March 2022 – Item 7.3 Policy Update – 41 Management of rotator cuff tears and rotator cuff syndrome** Clinical Effectiveness team to draft policy to reflect the decisions above and circulate for comment. **Action: Complete.** Clinical Physiotherapist Specialist to produce a leaflet to outline the purpose of physiotherapy for rotator cuff tears. **Post meeting note: Feedback received to advise the leaflet is in progress. Action: Closed.**
5.8	**Draft Minutes of the Priorities Committee meeting held 17th March 2022 – Item 8.3 Thuasne Action Reliever Knee Brace (comparison with other knee braces)** Clinical Effectiveness team to draft policy to reflect the decisions above and circulate for comment. **Action: Completed.** Clinical Effectiveness team to review data for Thuasne Action Reliever Knee Brace prescriptions in 6 to 12 months. **Action: Closed.**
5.9	**Draft Minutes of the Priorities Committee meeting held 17th March 2022 – Item 9.3 Policy update: 39 Hysterectomy for heavy and/or painful menstrual bleeding** Clinical Effectiveness team to draft policy to reflect the decisions above and circulate for comment. To be discussed at the April CPOG meeting. **Action: Closed** MM to look into prior approval requests received over the last year. **Action: Complete.**
5.10	**Draft Minutes of the Priorities Committee meeting held 17th March 2022 – Item 10.1 Review of HSIP Priorities Committee Terms of Reference (ToR)** Clinical Effectiveness team to update the membership and quoracy requirements. **Action: Complete.** Agenda item 10 raised as a matter arising (MA): CE team raised a clarification on the Local Delivery System areas to include in the ToR. They were confirmed as Isle of Wight, North and Mid Hampshire, Southampton and South West Hampshire, and South East Hampshire. CE team also queried the inclusion of CE team in the meeting quoracy. It was agreed that CE is removed from quoracy. Quoracy reflects the CCG policy recommendation and decision making process and CE team is a service provider. Quoracy was confirmed as representation from at least three of the four Local Delivery Systems, at least one senior clinician and one lay member.

	Action: CE team to amend the ToR as agreed. It was agreed that the Committee would benefit from having a Standard Operating Procedure (SOP) document to accompany the ToR. **Action: DC and CE team to discuss further and draft the SOP.**
5.11	**Draft Minutes of the Priorities Committee meeting held 17th March 2022 – Item 10.2 Review of Ethical Framework (EF).** DC and KF to meet to discuss further. **Action: Complete.** Clinical Effectiveness team to circulate updated EF for comment. **Action: Complete.** Agenda item 11 raised as a MA: It was noted that the EF did not include reference to principles and legal requirements of the NHS Constitution the Public Sector Equality Duty and it was agreed to add this to the 'purpose' of the Ethical Framework; 'Ensuring that the principles and legal requirements of the NHS Constitution the Public Sector Equality Duty and the requirement to involve the public when making significant changes to the provision of NHS healthcare are adhered to. **Action: CE Team to add to the EF as agreed.** In view of transparency of the Committee decision making, a question was raised if the final minutes of the Priorities Committee should be published on the public facing website. The Committee agreed that this would be beneficial for the public and for the interested stakeholders. **Action:** CE team to pass the final minutes for the Policy Implementation Team for uploading to the policy website.
5.12	**Draft Minutes of the Priorities Committee meeting held 17th March 2022 – Item 10.3 Refresher training for Committee members** DC to investigate training options. May update: King's Fund has been contacted and they will come back to DC with possible options. **Action Closed**.
5.13	**Draft Minutes of the Priorities Committee meeting held 17th March 2022 – Item 10.4 Clinical Executive Group (CEG) sign off of ratified policies** DC to liaise regarding CEG sign off for ratified policies. May update: there will be a CCG close down meeting on 22nd June. Going forward in the policy recommendations will be considered by the Integrated Care Board (ICB) Integrated Assurance Committee who will report to the Clinical Cabinet. Clinical Effectiveness to email DC with a list of policies outstanding CEG sign off with detail on the update to the policy. **Action: Complete.**
5.14	**Draft Minutes of the Priorities Committee meeting held 17th March 2022 – Item 10.5 Ethics Committee** DC to contact David Carpenter. **Action: Complete.**
6.0	**Recommendation for ratification of updated / new policies**
6.1	• Policy 39 Heavy Menstrual Bleeding and Dilation and Curettage • Policy 33 Management of earwax /microsuction • Policy 70 Complementary and Alternative Therapies • Policy 3 Partial Knee Arthroplasty in patients with OA of Knee • Policy 41 Management of rotator cuff tears and rotator cuff syndrome • Policy 69 Knee Pressure Offloading Devices for Osteoarthritis (new policy) • Policy 110 Routine Follow Up after Primary Hip or Knee Surgery – Policy withdrawn All polices agreed for progression to sign off.
7.0	**Policy update: Policy 57 Benign skin lesions**
7.1	<u>Background</u> Policy recommendation 57: Removal of benign skin lesions is due to review as part of the ongoing policy update schedule. A recent audit of referrals under this policy has raised the following concerns: • The term bleeding was ambiguous and in a number of cases bleeding was only minimal spotting or staining of clothing and cases were identified when this only occurred during shaving. • The criterion relating to regular pain and daily function (number 3) and that relating to impacts on functioning (number 5) are duplicated. • The robustness of the threshold for referral of lipomas with a size of >5cm. <u>Recent guidance</u>

	Limited new guidance was identified. A Get it Right First Time (GIRFT) dermatology report was identified which recommended that clinical threshold policies should be developed for the management of benign conditions and that where national guidance exists, it should be followed. <u>Lipomas</u> National guidance related to the use of size as a clinical threshold for differentiating between lipomas and liposarcomas was sought. The British Medical Journal (BMJ) best practice guidance uses a threshold of 5cm, although notes than 10cm is a strong discriminating feature. The UK Guidelines for the management of soft tissue sarcoma also recommends a threshold of 5cm. A literature review identified four publications. Three of these were retrospective reviews which found liposarcomas were generally larger than lipomas. A recent study evaluating the effectiveness of classic 'red flag' signs for differentiating between lipoma and liposarcoma found than these (including size) are of limited value. <u>Local activity</u> Local activity for the removal of benign skin lesions, as defined using the Evidence Based Interventions (EBI) dashboard, decreased between the summer of 2019 and March 2021. Since March 2021, activity has been increasing but it remains below the target activity level set for local sustainability and transformation plans area (STPs) by EBI. When a standardised activity rate is used the STP ranks 8 out of 42 STPs in England, demonstrating activity to be low in comparison to other STPs.
7.2	The committee chair noted that the dermatology departments locally have considerable demand given the elective care recovery drive. This is impacting on capacity for cancer referrals under the two week wait (2WW) pathway and the committee has been asked to review the benign skin lesions policy to reduce unnecessary referrals for benign lesions and free capacity for 2WW referrals. The specialist in attendance informed the committee that the electronic referral system has now been re-introduced post Covid-19. This means that referrals are not physically screened on receipt. This raised concerns that if patients are referred via the benign skin lesions pathway when they have a query on sarcoma that this may lead to a significant wait before being seen. The opportunity for referrals to be returned and the GP to be given advice and a learning opportunity was also seen to be affected by the return of the electronic referral system. The committee were in support of removing the 5cm criteria for differentiating lipoma and liposarcoma. There was agreement that the main areas of concern would be pain and/or rapid growth. There was discussion about how to give GPs information to aid decision making as to whether a lesion is benign or whether it needs to be referred as a sarcoma query via a 2WW pathway. Rapid access advice and guidance service was discussed. The specialist in attendance raised concerns that referrals do not only go to dermatology and a range of departments would need to have the capability to provide rapid advice. The weighted checklist from NICE Guideline 12: Suspected cancer recognition and referral (2021) was discussed as a potential piece of guidance to include within the policy preamble. It was discussed that it could be appropriate to include information about differentiating between lipoma and liposarcoma within this section rather than at the end of the policy. There was consensus that it was important to highlight that GPs should be certain that the lesion is benign before progressing through the benign lesion referral route. The committee discussed the proposal to alter the policy wording regarding 'regular bleeding' to 'significant bleeding', however it was agreed that the term significant was still an ambiguous term and that it is unlikely that a benign skin lesion would result in a considerable amount of bleeding. The committee debated whether it was appropriate to have bleeding as a criterion within the policy. The committee agreed with a preferred focus on including an impact on daily activities within the criterion regarding limiting daily functioning. The committee discussed the use of having two or more courses of antibiotics in a year as an example of the lesion being unavoidably and significantly traumatised on a regular basis. It was agreed that this was reasonable referral threshold. Whether it would be appropriate for a patient who had had antibiotics prescribed once a year for five years was discussed. It was noted that these patients could be referred via Individual Funding Requests (IFR) route.

7.3	Following consideration, the Committee agreed: • To remove the size criterion for the referral of lipomas • To remove criteria relating to bleeding • To expand the criteria relating to affecting or limiting daily functioning to include impacting on daily activities • To include information and guidance, including the weighted checklist from NG12, to help ensure that any patients with a suspected sarcoma are appropriately referred **Action: Clinical Effectiveness team to draft a policy to reflect the decisions above and circulate for comment as per usual process.**
8.0	**Evidence review: Treatment of keloid scars (new topic)**
8.1	<u>Background</u> Requests have been received by the IFR team for keloid scar treatments, particularly for those on the ear following piercing. HSIP CCGs do not currently have a policy position on treatment of keloid scars, and it was felt that the Policy 57: Removal of Benign Skin Lesions was not sufficiently helpful in triaging referrals for keloid scars treatment currently being updated) their treatment would be not routinely funded unless conservative treatment was attempted, and the lesion met at least one criterion in the policy. <u>Keloid scars</u> Large, firm, raised keloid cars can occur after skin injuries such as a surgical procedure, burns or piercings. They are likely to result from a combination of trauma, inflammation and genetics. Keloid scars are benign but can itch, be painful and/or sore to touch. Keloids are different from hypertrophic scars which remain within the area(s) of damaged skin and generally settle in time or respond to treatment. The most common sites for keloid formation are the chest, shoulders, back, and ears. People with a history of keloids are advised to avoid skin piercings, tattoos, and unnecessary surgeries. <u>Traditional treatment approaches</u> If a keloid is forming, early treatment is important, because bigger keloids are often more difficult to treat. Monstrey et al's (2014) Updated Scar Management Practical Guidelines offer advice on prevention and treatment including the use of silicone and compression therapy to a developing scar, plus the addition of intralesional corticosteroid injections if the scar is not resolving after 4 weeks to 6 months. If the keloid does not respond to these treatments after 12 months surgical excision combined with radiotherapy or intralesional cryotherapy can be considered. Surgery can remove the keloid; however, a new keloid (possibly a larger one) may develop in the same site unless additional treatments are done after the surgery. Radiotherapy carries a small risk of causing skin cancer. The UK Primary Care Dermatology Society (PCDS) state that following any given treatment recurrence rates vary from 9-50%. <u>Recent guidance</u> BMJ Best Practice (Last reviewed 10 Feb 2022, Last updated 13 Mar 2018) states the treatment of keloid scarring remains a matter of trial and error, with no predictable outcome. As first-line treatments, they suggest silicone-based therapy, intralesional corticosteroid, topical corticosteroids, laser therapy, cryotherapy and/or pressure therapy. As second-line treatments, they suggest surgery, plus post-operative pressure therapy or radiotherapy or intralesional corticosteroid. They list the following emerging or experimental treatments as including: 5-fluouracil, verapamil, bleomycin, neodermis, interferon, mitomycin C and autologous keratinocyte cell cultures. The 2018, Japan Scar Workshop (JSW) Consensus Document (based on evidence and expert opinion) include the same first and second-line treatments as those listed by BMJ Best Practice, and additionally consider using 5-fluorouracil and botulinum toxin injections. They make site specific recommendations for the selection of treatments. Other options recommended include considering adjunctive therapies such as make-up therapy and/or psychosocial healthcare, or radiation monotherapy (not for young people) to improve pain and itch. The 2013/14 NHS Standard Contract for Specialised Dermatology Services (All Ages) states that NHS England (NHSE) directly commission laser therapy for adults requiring laser for difficult keloid scars and where laser treatment is not available in local services.

	Summary of the literature review and guidance reviewed There are different options in the treatment of keloids; some of which might have a higher efficacy for certain parts of the body. Possible side effects need to be considered when choosing a treatment. Multiple treatments may be needed. It is uncertain whether conventional treatments within the scope of the SCW CE review would successfully reduce the pain, itching and functionality associated with some keloid scars. Surgery with or without adjunctive therapy is likely to be the preferred option for treatment of ear keloids. Some of the emerging therapies might be more effective, safer, tolerable, cost-effective, and/or convenient than those currently used. Local data From April 2018 to December 2021 in HSIP, there were 62 Individual Funding Requests (IFRs) for keloid scar treatments, the number of which increased during the last two years. 32/62 were approved. 19% mentioned the ear and were therefore likely to be caused by ear piercing. Most of the 12 were declined. Treatments requested that were clearly recorded as for treatment of keloid scar(s) were either for scar revision, intralesional steroid injection plus keloid scar revision, radiation therapy, or pulsed dye laser. Public sector equality and equity issues Keloid scars occur most often in patients in their teens and 20s, although they can happen at any age. They may appear or enlarge during pregnancy. Black people are most likely to develop keloids. White ethnicities are much less prone to keloids and hypertrophic scars than Asians, Hispanics and Africans; and if they do develop such scars, they tend not to be as drastic as those in more susceptible populations.
8.2	The specialist attending stated that painful, tender and disfiguring keloids can have a significant impact on a person. The use of Dermatology Life Quality Index (DLQI) is the most widely used questionnaire in dermatology. Although steroid injections are an effective treatment for keloid scars they are generally not offered in primary care. There is need to dilute the steroid injection before administration and failure to do so could significantly risk atrophy and permanent discolouration of skin colour. Locally, NHSE specialised dermatology laser treatment is only commissioned in Salisbury. It was noted that there is an issue around keloids being considered as cosmetic issue and therefore only the large, disfiguring keloids particularly those which cannot be covered by clothing have been approved by the IFR team. The specialist clinician offered that consideration needs to focus on the impact on functionality and quality of life and stated the DLQI would measure such impact. The specialist attending suggested a DLQI score of over 10, a photograph and six months use of silicone gel and pressure/tape (which requires approximately three months use for noticeable improvement) before referral to dermatology. It was stated that although for greatest chance of effectiveness silicone gel and pressure therapy should be used initially after the injury, it may be helpful for a small keloid or if used while waiting for a dermatology appointment. The specialist advised that all keloids have the potential to grow. The questions relating to the threshold of the DLQI score remained uncertain, as did the possibility of an ethnicity bias if keloid scars grew quicker in black and minority ethnic groups. **Post meeting note:** Instructions on how to interpret the DLQI questionnaire state a score of 0 – 1 indicates no effect at all on patient's life, 2 – 5 small effect on patient's life, 6 – 10 moderate effect on a patient's life, 11 – 20 very large effect on patient's life and 21 – 30 extremely large effect on patient's life[1]. The DLQI questionnaire is validated for use in dermatology patients and includes questions which describe symptoms including pain and itch, feelings about the skin problem, difficulties with daily activities (including participation in work, leisure, sport and school), personal relationships (including sexual difficulties) and any problems caused by the current treatment. A 2021 study of 553 Chinese patients aged 18-79 with keloids found the DLQI scores in patients

[1] Microsoft Word - Dermatology Life Quality Iindex DLQI - 01.10.12 (imperial.nhs.uk)

	with keloids were primarily distributed between 3 and 6 (50.29%) and between 6 and 10 (43.13%). Only 6.5% had a DLQI score of 11 to 20[2]. **Post meeting note:** No evidence was found by the Clinical Effectiveness team that indicated differences in growth rates of keloid scars due to ethnicity or skin colour.
8.3	Following consideration, the Committee agreed that the overall position of the policy would be for keloid scar treatment to be not normally funded. It was also agreed that: • A GP should assess the patient's keloid scar, recommend three months silicone gel and pressure (when appropriate). If the patient was then still experiencing problems, a referral for a dermatology review could be made. • Criteria for access to a dermatology review were agreed as a DLQI score (actual score to be agreed), photographic evidence and three months use of silicone gel. • Referral to a dermatology assessment for consideration of treatment should be included in the policy. If dermatologists are consulted, they would decide on the further treatment plan. • The dermatologist would submit an IFR if they considered treatment would likely improve the keloid scar. When drafting the Keloid scar policy, the criterion stated on the current Policy 57: Removal of Benign Skin Lesions: 'If left untreated, more invasive intervention would be required for removal' should not be included or rephrased so that dermatology departments are not overwhelmed. It was also agreed that for the criterion which states '…significantly impacts on function and causes a reduction in their activities of daily living using a recognised scoring measure such as the Barthel ADL Score or EuroQol…' these measures should be substituted with the DLQI. The criteria 'The lesion causes regular pain which affects or limits daily functioning' and 'The lesion is obstructing an orifice or impairing field vision to the extent that the person does not meet DVLA standards for driving' should be removed because these issues of functionality would be recognised in the DLQI scoring. **Action: Clinical Effectiveness team to draft a policy to reflect the decisions above and circulate for comment as per usual process.** **Action: For implementation of the policy there needs to be discussion between DC, HSIP commissioners and SCW CSU outside of this Priorities Committee meeting.** **Post meeting note:** The CE Team circulated a first draft policy to the Clinical Policy Implementation Team. Feedback will be discussed at the June CPOG.
9	**Policy update: Cosmetic policies review (update of several related policies)**
9.1	Background This review aimed to develop a single position on cosmetic procedures. HSIP CCGs have a number of historical statements referencing aesthetic treatments and types of surgery considered to be cosmetic. The review outlined these statements, identified duplications and reviewed national guidance and Cochrane systematic reviews which could impact on statements. Recommendations The primary recommendation was that the majority of HSIP statements relating to cosmetic interventions are amalgamated into one 'interventions not normally funded' (INNF) statement which includes procedure codes. It was also proposed that this policy should include cross-references to relevant standalone polices with thresholds. It was recommended that the ethical guidance notes referenced in some of the policies should be reviewed by the ethics and priorities committees.
9.2	The committee discussed how an overarching policy statement could provide an accessible reference point for patients and clinicians going forward. It was noted that this could be a pragmatic solution to aid policy implementation and the individual funding review (IFR) process. There was discussion regarding the term 'cosmetic' and how this can become a default criterion

[2] Effects on quality of life and psychosocial wellbeing in Chinese patients with keloids - PMC (nih.gov)

	when there is no functional impairment. It was noted that the IFR panel use the term 'purely cosmetic' to aid this distinction. The format of the policy was discussed, with suggestion that it could include an introductory statement, detail what procedures are deemed to be cosmetic and to cross-reference other policies that contain relevant information to aid decisions about whether a treatment is purely cosmetic. It was highlighted that the proposed policy would not be introducing any new statements or altering existing commissioning recommendations but amalgamating existing statements into one place with the aim of making the documentation more accessible and the commissioning position clear. The committee stressed the importance of this being written in plain English to aid accessibility.
9.3	Following consideration, the Committee agreed: • That the following policies/statements should be withdrawn; Policy 121 (2011) – Aesthetic surgery in children; Plastic/ cosmetic procedures statement; Laser removal of skin; Short sight/long sign corrective (laser) surgery (refractive keratoplasty); Removal of skin lesions • That a new INNF policy should be developed which encompasses all current statements referring to purely cosmetic procedures and refers to existing policies that can give further information to aid clinicians and patients as to when a procedure is purely cosmetic. **Action: Clinical Effectiveness team to draft a policy to reflect the decisions above and circulate for comment.**
10	**AOB:**
10.1	Equality Impact Assessment for the clinical policies (EIA). CE team queried the timing of sending out the EIA for the policy reviews going forward. EIA is generally completed once the outcome of the policy consideration is known. It was noted that any evident issues with Public Sector Equality Duty would be raised as part of the policy review, whilst the full EIA is completed after the recommendation is made. However, a concern was raised that the decision-making may be affected by the EIA and thus should be part of the initial review for the Committee to consider. It was agreed that EIA would be brought to the committee with the policy review.
10.2	Glucose monitoring systems policy review. It was agreed that the review of the updated NICE Clinical Guidelines in relation to the glucose monitoring systems would be the agenda item of the July Priorities Committee with no need to be considered in the planning meeting (CPOG) prior to the Committee.
13	**Next meeting**
	The next online meeting will be held via 'Teams' on Thursday 21st July 2022, 9 – 12 noon.
14	**Meeting Close**
	The Chair thanked everyone for their contributions to the discussions and closed the meeting.