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Hampshire and Isle of Wight

Hampshire and Isle of Wight Integrated Care Board

HIOW PRIORITIES COMMITTEE MEETING
Minutes of the meeting held Thursday 21st July 2022, 9:00-12:00
On-line via Microsoft Teams

David Chilvers	GP, Clinical Lead for Urgent Care and Priorities	Hampshire and Isle of Wight Integrated Care Board (ICB)
David Carpenter	Ethics representative	NHS Health Research Authority
Dr Timothy Whelan (left at 11.27)	GP and Planned Care Clinical Lead	Hampshire and Isle of Wight Integrated Care Board (ICB)
Cheryl Harding-Trestrail	Associate Director of Commissioning for UEC and Community Services (Isle of Wight Local Delivery Team)	Hampshire and Isle of Wight Integrated Care Board (ICB)
Helen Sherred (left at 11:04)	Associate Commissioning Manager, Planned Care Team (South West Hampshire)	Hampshire and Isle of Wight Integrated Care Board (ICB)
Linda Samuels	Lay member	Hampshire and Isle of Wight Integrated Care Board (ICB)
Tracey Gwyther	Senior Commissioning Manager, Planned Care, Working in North and Mid Hampshire	Hampshire and Isle of Wight Integrated Care Board (ICB)
Neil Hardy	Associate Director – Medicines Optimisation, Working in South West Hampshire	Hampshire and Isle of Wight Integrated Care Board (ICB)
Julia Bowey	IFR Lead, Clinical representative, Clinical Associate Planned Care and Covid Vaccine Programme Lead Southampton	Hampshire and Isle of Wight Integrated Care Board (ICB)

In Attendance:

Kate Forbes	Clinical Effectiveness Manager	SCW CSU
Joan Sharp	Clinical Effectiveness Manager	SCW CSU
Naomi Scott	Clinical Effectiveness Manager	SCW CSU
Jenny Kovalaine-Kwan	Clinical Effectiveness Manager	SCW CSU
Marion Mason	Interim Head of Prior Approval and Assurance – Clinical Policy Implementation Service	SCW CSU
Zizi Catovic (joined Meeting 2; Item 10, Policy review - Policy 7 and 28: Glucose monitoring systems)	Prior Approval and Audit Manager	SCW CSU

Apologies:

Russell Swart	GP, Farnborough PCN Clinical Director, NHCCG Clinical Lead, MSK and project support	Hampshire and Isle of Wight Integrated Care Board (ICB)
Lyn Darby	Transformation Programme-Planned Care	Hampshire and Isle of Wight Integrated Care Board (ICB)
Steve Parker	Medical Director	Isle of Wight NHS Trust
Linda Collie	Planned Care Clinical Lead	Hampshire and Isle of Wight Integrated Care Board (ICB)

QUORATE

Topic Specialists in Attendance for Agenda Items:

Item 10– Policy review - Policy 7 and 28: Glucose monitoring systems
Iain Cranston– Consultant Physician, Portsmouth Hospitals NHS Trust Patrick Sharp– Consultant Physician and Clinical Lead, Solent NHS Trust Paul O'Halloran – Senior Clinical Partner and Chair of the Diabetes Programme Board, Hampshire Hospitals NHS Trust Jimmy Chong – Consultant Physician, Diabetologist and Endocrinologist, Hampshire Hospitals NHS Trust Shawndel Nero– Diabetes Specialist Nurse, Hampshire Hospitals NHS Trust Jo Nicholls – Dietician, Hampshire Hospitals NHS Trust Philip Newland-Jones - Consultant Pharmacist Diabetes and Endocrinology; Clinical Director, University Hospital Southampton NHS Foundation Trust Liz Whittingstall, Lead Specialist Nurse, Diabetes and Endocrinology, Isle of Wight.

1	**Welcome & Introductions**
1.1	The Chair opened the meeting, welcomed the Committee members, and set out how the on-line meeting operates.
2	**Apologies for Absence and Quoracy**
2.1	Apologies for absence recorded as above. The meeting was quorate.
3	**Declarations of Interest**
3.1	The declarations of interest (DOI) form was circulated to all members prior to the meeting. Submitted declarations were sent to the Chair for review prior to the meeting. No material DOI were noted.
4	**Draft Minutes of the Priorities Committee meeting held 19th May 2022 – Confirm Accuracy**
4.1	The Committee agreed the minutes were a true record of the meeting, except that Cheryl Harding-Trestrail's job title reflects her old role. **Action**: **CE Team to update CHT's job title for the final copy of the May minutes.** **Post meeting note: Action complete/closed**
5	**Draft Minutes of the Priorities Committee meeting held 19th May 2022 – Review Actions and Matters Arising**
5.1	**Draft Minutes of the Priorities Committee meeting held 19th May 2022 – Item 5.10 Review of HSIP Priorities Committee Terms of Reference (TOR)** Clinical Effectiveness (CE) Team amended the Terms of Reference ensuring that the Local delivery System areas are included correctly, and that the CE Team were not included for quoracy purposes. **Action: Closed.** It was agreed that DC and CE team were to discuss further and draft a Standard Operating Procedure (SOP) document to accompany the ToR. **Action: DC and CE team to discuss further and continue drafting the SOP.**
5.2	**Draft Minutes of the Priorities Committee meeting held 19th May 2022 – Item 5.11 Review of Ethical Framework (EF).** The CE Team have added reference to the principles and legal requirements of the NHS Constitution and the Public Sector Equality Duty, and added to the 'purpose' of the EF: '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: Closed.** Although it was agreed on 19th May that the final minutes of the Priorities Committee would be passed on to the Policy Implementation Team for uploading to the policy website, it was suggested that the ICB Communications Department (Comms) may wish to review the minutes. Meanwhile to avoid delay in the process, it was agreed that the 19th May and 21st July minutes will be uploaded onto the SCW website as planned. **Action: NH to connect MM with the Comms contact.**
5.3	**Draft Minutes of the Priorities Committee meeting held 19th May 2022 – Item 7.3 Policy update: Policy 57 Benign skin lesions** Policy update drafted to reflect the recommendations made at the meeting on 19th May and circulated for comment. Minor reformatting amendment was agreed (see Item 6).
5.4	**Draft Minutes of the Priorities Committee meeting held 19th May 2022 – Item 8.3 Evidence review: Treatment of keloid scars (new topic)** See agenda Item 9.

5.5	**Draft Minutes of the Priorities Committee meeting held 19th May 2022 – Item 9.3 Policy update: Cosmetic policies review** (update of several related policies) Policy update drafted to reflect the recommendations made at the meeting on 19th May and circulated for comment (see Item 6). **Action: Completed.**
5.6	**Draft Minutes of the Priorities Committee meeting held 19th May 2022 – Item 10.1 Equality Impact Assessment for the clinical policies (EIA).** See Item 8.
6	**Recommendation for ratification of updated / new policies:**
6.1	• **Policy 4: Treatments for patients with lymphoedema** Discussion Question was raised if there was a limit on the duration of Complex Decongestive Therapy. It was noted that clinics usually recommend self-care where appropriate and manage more complex patients as required.
6.2	• **Policy 66: Treatment of LUTS as a result of benign prostatic hyperplasia** Discussion An addition to Policy 66 was made to reflect the MedTech mandate requiring inclusion of Rezum.
	• **Policy 57: Removal of benign skin lesions** Discussion The changes were predominantly around trauma and bleeding and subsequently the formatting change. It was noted that the policy states suspected neoplasms were excluded from the policy and would be referred urgently via the two-week wait process.
	• **Policy 72: Cosmetic interventions** Discussion This is a document to collate all the relevant cosmetic policies and their policy positions. No changes were made to referral thresholds/funding criteria.
6.3	**Action: All policies agreed for progression to sign off**. It was also agreed that the new Priorities Committee would be known as "Hampshire and Isle of Wight Integrated Care Board Priorities Committee".
7	**Policy change and amalgamation due to Medtech mandate: Draft Policy 19: Sinus surgery and balloon dilation for chronic rhinosinusitis**
7.1	HSIP Policy 18 'Balloon sinus dilation for chronic sinusitis' was updated in 2021. NICE Medical Technology guidance (MTG30) on the technology (the XprESS multi-sinus dilation system) was published in Dec 2016, and the SHIP8 Priorities Committee recommended in 2017 on policy position of 'intervention not normally funded' and this was maintained in 2021. The 2022/23 MedTech Funding Mandate (MTFM; published in March 2022) however, now mandates commissioners to fund this technology when clinically appropriate. The HSIP June Clinical Policy Operational Group (CPOG) asked the SCW CE team to review HSIP Policy 18 'Balloon sinus dilation for chronic sinusitis' and Policy 19 'Functional endoscopic sinus surgery for chronic rhinosinusitis and nasal polyps' (which was updated in 2021 but was waiting for ratification) with a view to amalgamating the policies and aligning with MTFM. A new draft where the two policies had been merged was presented to the committee, with the following wording added to Policy 19: "Balloon catheter sinus dilation for chronic rhinosinusitis: Balloon catheter sinus dilation involves the endoscopic insertion of a guidewire in the sinuses and the inflation and withdrawal of a balloon, with the aim of widening the ostium and improving drainage. The procedure can often be done under local anaesthesia. MedTech Funding Mandate policy 2022/233 states that use of the XprESS multi-sinus dilation system (a sterile, single-use device for treating chronic sinusitis) should be provided as an option for adults with uncomplicated chronic sinusitis that has worsened despite drug treatment and who have no severe nasal polyposis." Discussion: The committee members noted that balloon dilation can be done as an independent procedure, but also together with endoscopic sinus surgery. It agreed that the MedTech Mandate is clear on the requirement to fund the use of this device for suitable patents. Option to withdraw

	the Policy 18 was discussed and retain Policy 19 as is, as it applies to all referrals for sinus surgery for chronic rhinosinusitis. Balloon dilation will not be directly mentioned in the policy 19, but the choice of technique can be decided by the specialist. Following consideration, it was agreed to retire the Policy 18. The Policy 19 to be renamed 'Sinus surgery for chronic rhinosinusitis'. **Action: CE team to redraft Policy 19 to reflect the recommendation above, circulate for comment as per the usual process and add to the August CPOG agenda.** **Action: MM to withdraw Policy 18.**
8	**Equality Impact Assessments (EIAs)**
8.1	• **Timing of Equality Impact Assessments (EIAs)** The CE Team propose that the EIA is circulated with the final policy. Any issues relating to public sector equality duty are taken into account as part of the evidence review. However, it is not until the policy position has been agreed that the impact assessment can be fully completed. **Action: CE Team to circulate the EIAs with the final policies.**
8.2	• **Process for circulating final policies and EIAs** Once the final policies and EIAs have been agreed by the Priorities Committee for Board ratification, they can be circulated to the whole Committee. At this stage conversation could be had with the providers about new policies which are likely to be introduced to give the providers notice. The EIAs do not need to go to the Board as they will have already been scrutinised by the Priorities Committee. The backlog of policies awaiting CCG agreement were ratified at the CCG close down meeting of the previous amalgamated Board. Implementation of these polices will be discussed at the August Clinical Policy Operational Group Planning Meeting (CPOG). Going forward with the new ICB, there will be a governance process to be specified in the new SOP. **Action: CE team and DC to check the SOP to ensure this process is specified** The version control of the circulated policy needs to be clear. Once policies have been recommended by the Priorities Committee for ratification, they could be marked as "Awaiting ICB Ratification" highlighted at the top/footnote to track as it progresses for agreement. **Action: CE Team to circulate the final policies with the note of "Awaiting ICB Ratification"**
9	**Draft Policy 71: Keloid scars**
9.1	In May priorities committee an initial recommendation was agreed for a new keloid scar policy. Post meeting feedback was received and reviewed in June CPOG. Yet, further comments have been received for discussion and agreement at this committee. Questions for discussion: • Is the criteria for size of ear keloids (>1cm) appropriate? Do we need to specify size(s) for other sites? • Do ear keloids >1cm need to meet the other criteria (except that relating to previous piercings)? Could we note "OR ear keloids greater than 1cm"? • Should we add an additional criterion "OR functional impairment such as impeding joint movement due to thickened scar tissue"? • Do treatment by intralesional corticosteroid injection need prior approval? • Are keloid scars appropriate for direct access to Advice and Guidance (A&G) from Plastic Surgery/Dermatology?
9.2	<u>Discussion</u> There was discussion about the size of keloids that might qualify for treatment under this policy. It was agreed that ear keloids must be symptomatic and need to meet all the stated criteria in the draft policy. There was concern expressed to ensure that treatment of small asymptomatic keloids, those that were below the collarbone and those that were merely uncomfortable should not normally be funded. The Committee recommended that an additional criterion relating to an adverse effect on functionality would be helpful. It was stated that Advice and Guidance (A&G) is available at the Queen Alexandra, the Royal Berkshire, the Royal Hampshire, Alton and Christchurch hospitals and should be sought before referral. More invasive treatments beyond intralesional corticosteroid injection will necessitate secondary care requesting prior approval.

9.3	Following consideration, the Committee agreed that: • The size criteria for an ear keloid to be classified as large is >1cm. • To be considered for treatment the keloid should be symptomatic with pain or itching and causing functional impairment. The threshold of 'uncomfortable' would be removed. • If a plastic surgeon or dermatologist accepts the patient according to the criteria stated in the policy and following A&G, they will not need to seek prior approval for intralesional corticosteroid injection but they will for other treatments such as surgery or laser. **Action: CE team to amend the draft policy to reflect the recommendations above and circulate updated version for comment as per usual process.**
10	**Policy review - Policy 7 and 28: Continuous glucose monitoring systems**
10.1	There are two current policies relating to continuous glucose monitoring systems (CGM). Policy 7 details commissioning criteria for CGM in adults with type 1 diabetes (T1D) and policy 28 details commissioning criteria for 'Flash' glucose monitoring in patients with T1D or pregnant women with T1D or type 2 diabetes (T2D). CGM devices can be categorised by the method used to obtain the glucose readings. Intermittently scanned CGM (isCGM) devices require patients to scan the sensor with a compatible device (smart phone or reader) to view readings. With real-time CGM (rtCGM) a transmitter is attached to the sensor which transmits results to a reader or smart phone. Historically rtCGM has been considerably more expensive than isCGM, but there are now rtCGM devices available on prescription at a similar cost to isCGM. However, these rtCGM devices available on prescription do not have predictive alerts which are beneficial for patients with hypoglycaemia unawareness and/or compatibility with insulin pumps for those who use insulin pumps to administer their insulin. As such, this review considered devices in two groups. Group 1 devices which are available on prescription and cost around £1,000 per patient per year, but do not have predictive alerts or insulin pump compatibility. Examples of these devices include FreeStyle Libre 1 and 2, and Dexcom One. Group 2 devices are only available through specialist services and have predictive alerts and/or insulin pump compatibility but currently cost around £2,500 per patient per year. Examples of Group 2 devices include the Dexcom G6 and the Medtronic Guardian. In March 2022 NICE updated guidelines NG17 (Type 1 diabetes in adults: diagnosis and management) and NG28 (Type 2 diabetes in adults: management), making substantial changes to recommendations regarding when isCGM and rtCGM should be offered to patients. NG17 recommends CGM for all patients with T1D. Shared decision making is recommended, based on patient preference and needs, to determine the type of CGM device (rtCGM or isCGM) offered. Policy 7 recommends rtCGM is only supported for patients with T1D with variable self-monitored blood glucose (SMBG) control with episodic hypoglycaemia impacting on lifestyle, recurrent hypoglycaemia, loss of hypoglycaemia awareness symptoms or persistent elevation of HbA1c despite insulin dose adjustments. Policy 28 recommends isCGM for patients with T1D who are clinically required to test their blood glucose using SMBG more than 8 times a day, who meet the NICE criteria for insulin pump therapy as described in NICE TA151, who have recently developed an impaired awareness of hypoglycaemia, who have frequent admissions with diabetic ketoacidosis or hypoglycaemia or require third parties to carry out monitoring. Local specialists have advised that if the recommendations from NG17 were adopted most patients with T1D would request a device. It was assumed that all patients who require Group 2 CGM devices are prescribed them under the current commissioning policy. The estimated budget impact of prescribing Group 2 devices to the remaining patients with T1D in the locality (who do not currently have a CGM device) was approximately £2 million per year. It was noted that this could be partially offset by a reduction in costs associated with SMBG. It was noted that if the criteria were left open, and all patients had group 2 devices this estimate could rise to £5million. The current commissioning policies (7 and 28) do not recommend the use of CGM in patients living with T2D. NG28 recommends isCGM or rtCGM if it is available at the same or a lower cost)

	for patients with insulin treated T2D who test their glucose more than 8 times a day, have recurrent or severe hypoglycaemia, have impaired awareness of hypoglycaemia or are not able to, or require help from a care worker to self-monitor their blood glucose. Using the assumptions from the NICE impact template that 3.55% of patients with T2D are treated with insulin and that, of these, 48.5% would fulfil one of the recommended NICE criteria, it is estimated that implementing new NICE guidance would cost £1 million per year. Using local estimations for the proportion of patients with T2D who are treated with insulin this rises to £1.8 million per year.
10.2	<u>Discussion</u> The committee noted that the potential budget impact of the new recommendations from NICE is large. Given its current financial position where considerable savings are being required in prescribing, the ICB has a duty to get both best value for money and best patient outcomes possible The committee heard from local specialists that a recent UK based (currently unpublished) trial has presented results suggesting the cost-effectiveness of Group 1 devices in patients with T1D using real world data is more favourable than the analysis from NICE. Local specialists highlighted the use of CGM in pregnant patients and how even small improvements in the percentage of time that glucose levels are in range can have a positive impact on patient outcomes for both mother and child. It was also noted that the SMBG testing regimen in pregnancy is more intensive, and therefore the offset costs of SMGB in these patients is greater. The committee heard that most patients are able to effectively manage their diabetes with Group 1 devices and that it would be appropriate to start patients on Group 1 devices and step up to Group 2 devices if the patient experienced was inadequate glucose control or problems with hypoglycaemia. The committee discussed the potential budget impact of adopting the NICE recommendations for patients living with T2D. The committee heard from local specialists that the wording of recommendations from NICE may be interpreted broadly. It was suggested that patients with T2D and a high risk of severe hypoglycaemia would benefit the most from CGM devices. There were discussions as to how to classify what constitutes a high risk of severe hypoglycaemia, such as previous hospital admissions and renal impairment; and what insulin regimes would be included in “multiple daily injections”. The committee discussed how the current policy included groups of patients not included within NG28, but that have previously been recommended in national guidance for isCGM. This includes patients with insulin treated T2D on haemodialysis. The committee heard from local specialists that these patients are at a high risk of hypoglycaemia and it would be clinically appropriate to continue to offer isCGM to these patients. The committee heard that UK based data suggested group 1 devices could be cost saving in patients with disabilities requiring third party assistance to manage their diabetes due to reductions in admissions and lower levels of support being required. The committee heard that the current evidence of efficacy in patients with T2D and a high HbA1c was lacking. It was noted that there are different models of diabetes services across the ICS. The committee heard from local specialists that community diabetes services are well connected and that utilising these services would aid consistency across the ICS. This would also reduce unnecessary demand on secondary care. There were discussions about capacity, noting that patients would need to be reviewed within a reasonable time frame to ensure the device is being used appropriately and targets met. A follow up after 6 months was deemed reasonable and it was deemed appropriate that the specialist who initiated the treatment to be responsible for this follow up. It was noted that community services would also have a high level of knowledge about the features of differing CGM devices which would enable shared decision making to pick the most appropriate device for the patient. The committee discussed the use of a patient decision aid that would include devices with clinical evidence of accuracy that were agreed locally to ensure consistency across the locality.

QUORATE

	There was discussion about public sector inequality issues and how it is important to ensure a policy does not drive further inequalities. The committee lay member queried whether patients would need to have smart phones to access the technologies.
10.3	Following consideration the committee agreed the following recommendations: • Patients living with T1D – The committee recommended Group 1 CGM devices for all patients with T1D. The committee recommended the use of Group 2 devices to be targeted at patients with a high risk of severe hypoglycaemia or who would benefit from integration with existing insulin pumps. • Patients living with T2D – The committee recommended the use of Group 1 CGM in patients with a high risk of severe hypoglycaemia. • Pregnant patients with insulin treated diabetes – The committee recommended the use of CGM devices in line with the NICE guideline for diabetes in pregnancy (NG3). **Action: CE team to liaise with local specialists to identify patients living with T2D at a high risk of severe hypoglycaemia. CE team to draft a policy position in collaboration with local specialists to be taken to the next CPOG meeting for discussion.** **Action: NH, SP and the Diabetes Specialist Team to draft a table listing the different devices and their merits/drawbacks**
11	**AOB:**
11.1	Topics for September Priorities Committee. It was noted that there are currently no new topics to be reviewed on the work programme. **Action: CE Team to add this to the August CPOG agenda for discussion.**
11.2	Progress with a Regional Priorities Committee and shared IFR Panel. The process of considering this is continuing at pace. The idea for a unified system was initiated by NHS England South East Region hoping to deliver financial savings and a more consistent approach, including a consistency of policy thresholds. It has, however, stalled due to major financial consideration over adopting thresholds for some interventions which could increase costs for some of the ICBs. The possibility of a single shared Regional IFR Panel is also being discussed. The paper outlining the proposals for the South East Region Senior Leadership Team yet to be submitted. **Action: Please email DC with any thoughts or requests relating to this.**
12	**Next meeting**
	The next online meeting will be held via 'Teams' on Thursday 15th September 2022, 9 – 12 noon.
13	**Meeting Close**
	The Chair thanked everyone for their contributions to the discussions and closed the meeting.