Berkshire West Clinical Commissioning Group
Buckinghamshire Clinical Commissioning Group
East Berkshire Clinical Commissioning Group
Oxfordshire Clinical Commissioning Group

Thames Valley Priorities Committee (Interim)

Minutes of the meeting held Tuesday 23rd September 2020

On-line via Microsoft Teams

Alan Penn	Lay Member Chair	Thames Valley Priorities Committee
Geoffrey Braham	Lay representative	Berkshire West
Linda Collins	Clinical Effectiveness Manager (CCG)	Oxfordshire CCG
Edward Haxton	Deputy Finance Director	Berkshire West CCG
Dr Megan John	GP, East Berkshire CCG Lead	East Berkshire CCG
Catriona Khetyar	Head of Medicines Optimisation	East Berkshire CCG
Gill Manning	Lay representative	East Berkshire
Professor Chris Newdick	Special Advisor – Law	University of Reading
Dr Jacky Payne	GP	Berkshire West CCG
David Pollock	Interface Lead Pharmacist	Berkshire West CCG
Dr Raju Reddy	Secondary Care Consultant	Berkshire West CCG
Dr Mark Sheehan	Special Advisor – Ethics	University of Oxford
Dr Karen West	Clinical Director Integration	Buckinghamshire CCG

In Attendance:

Kathryn Markey	Clinical Effectiveness Manager	SCW
Kate Forbes	Clinical Effectiveness Manager	SCW
Funmi Fajemisin	Clinical Services Programme Lead Clinical Policy Implementation	SCW
Lindy Hardy	PA and Audit Manager	SCW
Rachel Finch – Minute Taker	Clinical Effectiveness Administrator	SCW

Apologies:

Jane Butterworth	Assistant Director Medicines Optimisation	Buckinghamshire CCG
Shairoz Claridge	Operations Director	Berkshire West CCG
Diane Hedges	Deputy Chief Executive TVPC Strategic Lead	Oxfordshire CCG
Lalitha Lyer	Medical Director	East Berkshire CCG

Topic Specialists in Attendance for Agenda Items:

Item 9– Policy Update: Functional Electrical Stimulation for upper and lower limb dysfunction
Ellen Armitage, Senior Neuro Physiotherapist, Oxford Centre for Enablement Emma Dodds, Senior Neuro Physiotherapist, Oxford Centre for Enablement Charlie Winward, Consultant AHP in Neurorehabilitation, Oxford Centre for Enablement
Item 10– Policy Update: Cannabis for medicinal purposes
Dr Anton Pick, Consultant in Rehabilitation Medicine, Clinical Lead, Oxford Centre for Enablement (OCE) Jonathan Mamo, Consultant, Neuro-rehabilitation, Royal Berkshire NHS Foundation Trust

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.
3.0	**Declarations of Interest**
3.1	None declared.
4.	**Draft Minutes of the Priorities Committee meeting held on 22nd January 2020 – Matters Arising**
4.1	**Minutes of the Priorities Committee held in May 2019 – Action 13.3 – Any Other Business – Host CCG for 2020 meetings** **January 2020 Update:** Clinical Effectiveness team to make enquires with Wexham Park Hospital (Frimley Health Foundation Trust) for 2021 when meeting room bookings are released in October. **Action Closed**
4.2	**Minutes of the Priorities Committee held in January 2020 – Action 6.4 - Policy Update: Functional Electrical Stimulation (FES) for Foot Drop in Conditions of Central Neurological Origin - Paper 19-032** Clinical Effectiveness team to obtain additional information and bring to the March Committee meeting for further discussion. **Refer to agenda item 9 – Action Closed**
4.3	**Minutes of the Priorities Committee held in January 2020 – Action 7.1 – Policy Update: Circumcision** Clinical Effectiveness team to draft an update policy recommendation TVPC63 Circumcision and circulate to the Committee members for comment. Comments to be received within the 2 week feedback period following issue. **Action Complete**
4.4	**Minutes of the Priorities Committee held in January 2020 – Action 8.3 – Evidence Review: Repair of divarication recti in women - Paper 19-033** Clinical Effectiveness team to draft an update to policy recommendation TVPC16 Aesthetic treatments for adults and children to include a 'not normally funded' statement. *Post meeting note: The updated position on divarication of recti as not normally funded, 'no change in commissioning position', has now been added to the TVPC16 Aesthetic treatments for adults and children policy as the statement was already in the TVPC16. This addition was done concurrently to the agreed amendment of Elfornithine and facial hirsutism to avoid repeated policy updates.* **Action Complete**
4.5	**Minutes of the Priorities Committee held in January 2020 – Action 9.8 - Policy Update: Cannabis-based medicinal products – Paper 19-034** The Clinical Effectiveness team to gather further information regarding use of THC: CBD spray (Sativex®) spray for MS patients and bring to the March Committee meeting for discussion. **Refer to agenda item 10 – Action Closed**
4.6	**Minutes of the Priorities Committee held in January 2020 – Action 10.4 – Policy Update: Grazax® (allergy vaccine seasonal rhinitis) – Paper 19-035** The Clinical Effectiveness team to update Policy Statement 109 Grazax® allergy vaccine for moderate to severe seasonal rhinitis (grass pollen hay fever) with a statement that mild to moderate rhinitis is not normally funded, severe rhinitis is expected to be covered by NHS England specialist commissioning services and circulate for comment. Comments to be received within the 2 week period following issue. **Action Complete**
4.7	**Minutes of the Priorities Committee held in January 2020 – Action 11.1 – Lay representation** Committee members to provide the Clinical Effectiveness team with contact details of current CCG lay members who may be approached to be lay members on the Thames Valley Priorities committee. CE team to explore further with the nominees. **Action Complete**
4.8	**Minutes of the Priorities Committee held in January 2020 – Action 11.3 - TVPC76 Knee arthroscopy for meniscal tears** The Clinical Effectiveness team to draft an update to policy TVPC76 and circulate for comment. Comments to be received within the 2 week feedback period following issue. **Action Complete**

4.9	**Minutes of the Priorities Committee held in January 2020 – Action 11.4 - Sequential use of biologic drugs** Regional Medicines Optimisation Committee (RMOC) published a statement in January 2020 regarding the sequential use of biologic medicines which could affect current TVPC policies. Clinical Effectiveness team to seek advice from Professor Chris Newdick on the interpretation of NICE TAGS and the NHS constitution by the RMOC statement, January 2020, for the sequential use of biologic medicines. The Clinical Effectiveness team to add this item to 25th March 2020 meeting agenda. **September 2020 Update: Refer to agenda item 7.1 – Action closed**
5.	**Draft Minutes of Priorities Committee meeting held 22nd January 2020 – Confirm Accuracy**
5.1	The draft minutes were accepted as a true record of the meeting.
6.	**Draft Minutes of the online 'Teams' Priorities Committee meeting held 22nd July 2020 – Confirm Accuracy**
6.1	The draft minutes were accepted as a true record of the meeting.
7.	**Draft Minutes of the online 'Teams' Priorities Committee meeting – Matters Arising**
7.1	**Minutes of the Priorities Committee held online in May 2020 – Action 5.5 – Review RMOC Statement sequential use of biologic medicines – Paper 20-001** The Committee to discuss this item further together with the financial impact and the development of a justification statement. **JULY 2020 UPDATE:** CE team experiencing difficulty in obtaining feedback from secondary care providers, most are working on it but are extremely busy at present. CE team to also approach secondary care pharmacists. The CE team will bring back to the November 2020 Committee meeting. **September 2020 Update:** Agenda item for November 2020 meeting
7.2	**Minutes of the Priorities Committee held online in June 2020 – Action 6.6 – Policy Update: Sodium oxybate for cataplexy and excessive daytime sleepiness in narcolepsy in adults – Paper 20-006** The Clinical Effectiveness team to draft a policy recommendation for the use of sodium oxybate for narcolepsy with cataplexy for patients transitioning into adult services. For other adult patients sodium oxybate is not normally funded. The draft policy recommendation is to be circulated for comment. Comments to be received within the 2 week period following issue. **JULY 2020 UPDATE:** Comment received to amend the third bullet point as people may have been on sodium oxybate for longer than 3 months. The Committee agreed to change the wording to read "Discontinue if there is inadequate response to treatment. Expert clinical review and patient history will contribute to this assessment" **Action complete**
7.3	**Minutes of the Priorities Committee held online in June 2020 – Action 8.5 – Policy Update: Chronic Fatigue Syndrome/Myalgic Encephalomyelitis – Paper 20-008** Clinical Effectiveness team to update policy statement 76 and 130: Chronic fatigue syndrome/myalgic encephalomyelitis to note that they have been reviewed by the Committee adding a footnote to indicate that no changes had been made. The footnote should also note that the policy will be reviewed upon publication of new NICE guidance. The Clinical Effectiveness team to circulate for comment. Comments to be received within the 2 week period following issue. **JULY 2020 UPDATE:** Comment received that the draft wording of the footnote gave the impression the evidence was fully reviewed in June 2020 when it wasn't, we didn't make decisions or recommend changes as publication of NICE guidance was expected imminently. The Committee agreed to change the wording to read "In June 2020 the TVPC reviewed the evidence but as NICE guidance is due imminently no decisions were made to change the policy" **Action complete**

7.4	**Minutes of the Priorities Committee held online in July 2020 – Action 6.3 – Defining Activities of daily living (ADL) - Paper 20-011** Clinical Effectiveness team to draft a statement to describe activities of daily living (ADL) for the purposes of individual funding requests (IFR). The draft policy recommendation is to be circulated for comment. Comments to be received within the 2 week period following issue. **Action complete**
7.5	**Minutes of the Priorities Committee held online in July 2020 – Action 7.7 – Policy Update: Complementary and alternative therapies – Paper 20-012** The Clinical Effectiveness team to draft a policy recommendation for complementary and alternative therapies and circulate for comment. Comments to be received within 2 weeks of issue. **Action complete**
7.6	**Minutes of the Priorities Committee held online in July 2020 – Action 8.3 – Policy Update: Management of Pelvic Organ Prolapse (POP)** - **Paper 20-013** Clinical Effectiveness team to draft an update to policy TVPC59 The Management of Female Pelvic Organ Prolapse and circulate to specialist clinicians for comment. On receipt of comments the Clinical Effectiveness team to circulate to the Committee to comment. September 2020 Update: **Refer to agenda item 12**
7.7	**Minutes of the Priorities Committee held online in July 2020 – Action 9.5 - Policy Update: TVPC61 Snoring and obstructive sleep apnoea / hypopnoea syndrome** - **Paper 20-014** Clinical Effectiveness team to update TVPC61 Snoring and obstructive sleep apnoea / hypopnoea syndrome as being reviewed and schedule a further review following publication of NICE guidance. The updated policy to be sent to CCG governing bodies for acceptance. **Action complete**
7.8	**Minutes of the Priorities Committee held online in July 2020 – Action 10.1 – Any Other Business – EBI phase 2 consultation update** Consultation of EBI phase 2 concludes on 21st August 2020. Clinical Effectiveness team to provide the Committee with a link to the EBI consultation document. **Action Complete**
7.9	**Minutes of the Priorities Committee held online in July 2020 – Action 10.4 – Any Other Business – September meeting topics** The Committee discussed the request of the LMC representative to attend future TVPC meetings. It was noted that the Committee has GP representation and further representation of the LMC is not necessary. The LMC may however be included in the consultation process. Clinical Effectiveness team to respond to LMC declining attendance at TVPC meetings. **Action complete**
8.	**Committee recommendations**
8.1	A discussion was held about the TVPC ethical framework and recommendations made by the TVPC in connection with costs and benefits. The Committee heard that it can observe the costs and make recommendations. It can recommend departing from NICE guidelines (not Technology Appraisal Guidance) but needs to articulate the reasons clearly, such as affordability. The legal ruling of the 'Rose and Thanet case' (acknowledge the credibility of the NICE evidence review but note local priorities and costs as possible reasons if not adhering to NICE) should be considered. The Committee needs to be more exact and precise if the recommendation is to depart from NICE guidance.
9.	**Paper 20-015 – Policy Update: Functional Electrical Stimulation (FES) for foot drop**
9.1	**Background** The current TVPC policy for the provision of FES relates to upper and lower limb dysfunction as a result of conditions of central neurological origin (CNO) and states that FES is an intervention not normally funded. A policy update was presented to the Committee in November 2019 with attendance from the National FES Centre. The Committee agreed that although the evidence was limited, for some patients with drop foot the device appeared to be clinically effective; further information was requested by the Committee in relation to:

9.1 Cont..	• Advice from local and out of area services re. benefits/disadvantages due to an acknowledged conflict of interest with the FES Centre • Cost data regarding fixed costs and for those assessed and deemed unsuitable for FES • Estimates of potential 'pent up demand' due to current not normally funded policy • Potential referral, and starting and stopping criteria with clinical input and a definition of 'continued benefit' to aid this criteria.
9.2	**A summary of Addendum Paper was presented to the Committee:** A number of services across the Thames Valley were contacted for clinical opinion on the benefits of FES and current / future referral pathways. More responses were received from Oxfordshire probably due to KF's previous connection with these services. Responses were received prior to COVID lockdown; all indicated the positive benefits for appropriate patients with foot drop. The Committee were shown cost estimates for three scenarios based on different referral rates. In all scenarios, costs were predicted to plateau at 5 years due to drop out rates.
9.3	**<u>Discussion:</u>** **How to assess patients suitability for using the device:** It was reported by the OCE Specialist Physiotherapists that in the last 6 – 7 months out of 10 referrals for FES, 3-4 were suitable for ongoing provision based on assessment and trial of the device. Every patient referred may not be appropriate for FES; patients are screened and assessed for suitability; for example FES does not tend to work for patients with lower motor neuron lesions and this would be picked up at the referral stage. Sometimes a hands on assessment is required, for example the patient may have lower limb weakness affecting their ability to use the device. The National Hospital to Neurology and Neurosurgery provide really clear criteria for any referrers (Appendix 5 of addendum paper). **Starting and Stopping criteria:** The clinicians highlighted the impact of deterioration in cognition; this could affect the patient's ability to apply the device. If a patient was unable to walk more than 5 metres then it is unlikely that FES would be appropriate; it is unlikely that patients would want to apply and remove it for those few steps. Generally OCE referrals are for people who are walking quite long distances. The difficulty of managing stopping criteria for patients with degenerative conditions was highlighted. **Measures of effectiveness:** The clinicians highlighted the importance of the use of quality of life (QoL) measures in addition to objective walking measures, whilst recognising that it is difficulty to fully attribute the effect of the FES to improvement in QoL. **Local referral Pathways:** Discussion regarding referrals; it is difficult to ascertain referral pathways across the TV region. In Oxfordshire patients would usually be referred to Specialist Physiotherapists at the OCE first; it was identified that Specialist Physiotherapists could ensure appropriateness of referrals to Salisbury. **Affordability:** Discussion regarding the potential costs to CCGs of a change to a threshold policy from INNF. Cost below £20-£30k per year per CCG would generally be acceptable if the intervention clarifies clinical pathways or improves equity. Above this cost would need to go via individual CCGs and would involve growth monies. The large demands on the system were highlighted, particularly with increasing elective care following the covid19 restrictions. **Activity estimates**: It was highlighted that activity presented in the paper is based on estimates. A neighbouring CCG has a threshold policy and had 19 patients in 2018/19 (pop. 236,000). Clinical feedback reported that numbers would increase (potentially double) from current numbers at OCE (approx. 5 per year).

9.4	Following discussion the Committee agreed further work was required before a recommendation could be made and asked the Clinical Effectiveness team to: • Establish likely referral pathways across the TVPC locality: who, where, when • Further clarification of starting and stopping criteria with OCE therapists input **ACTION: Clinical Effectiveness team to draft a policy recommendation for Functional Electrical Stimulation for foot drop defining starting / stopping criteria and identifying measurable outcomes, in collaboration with the OCE Specialist Physiotherapists. Clinical Effectiveness team to establish likely referral pathways across the TVPC locality.**
10.	**Paper 20-016 – Policy Update: Cannabis- based medicinal products**
10.1	NICE guideline (NG144) Cannabis-based medicinal products published in November 2019 recommends to consider nabilone as an add-on treatment for adults (18 years and over) with chemotherapy-induced nausea and vomiting which persists with optimised conventional antiemetics. The NICE guideline development committee considered that any resource impact as a result of this recommendation would be unlikely to be significant as nabilone would typically not be offered continuously. NG144 also recommends offering a 4-week trial of THC:CBD spray (Sativex®) to treat moderate to severe spasticity in adults with multiple sclerosis (MS) if: • other pharmacological treatments for spasticity are not effective • the company provides a spray according to its pay-for-responders scheme, essentially offering the first pack free if continued funding is agreed for those that experience at least a 20% reduction in spasticity-related symptoms • after the 4-week trial, continue the spray if the person has had at least a 20% reduction in spasticity-related symptoms on a 0 to 10 patient-reported numeric rating scale. Treatment with THC:CBD spray should be initiated and supervised by a physician with specialist expertise in treating spasticity due to multiple sclerosis, in line with its marketing authorisation
10.2	NICE's rationale for the recommendation is that clinical evidence showed improvements in patient-reported spasticity and could not differentiate between adverse events for the spray and placebo. TVPC recognises that the evidence appraisal for this NICE guideline must be regarded as valid. At the January 2020 TVPC meeting, the Committee agreed that the number of patients eligible for THC:CBD spray (Sativex®) across Thames Valley CCGs, calculated using the NICE resource report and template is likely to be an underestimation and therefore of greater financial impact. At the time TVPC had discussions about affordability in line with our ethical framework and the NHS constitution. The TVPC recognises that the evidence appraisal for NICE guidelines must be regarded as valid albeit the evidence that informed the review was considered to have limitations. Before a recommendation could be agreed the Clinical Effectiveness team was asked to gather further information from Provider Trusts regarding numbers of patients with MS who are eligible for the use of THC:CBD spray (Sativex®) spray and numbers of new patients who would become eligible annually. This information was presented at the September meeting.
10.3	The current numbers of eligible patients and data provided by Thames Valley NHS Trusts are considerably higher than those indicated previously calculated using the NICE resource template. The Clinical Effectiveness team presented a number of cost scenarios using the maximum number of current patients with MS eligible for THC: CBD spray (Sativex®), annual estimates of numbers of new patients becoming eligible, various doses per day (taken from the NICE resource template) with no drop outs and with 24.8% patients dropping out as they did not meet the 20% response rate as stated in the NICE guideline.

10.3 Cont..	The best case scenario, according to the figures presented, is a cost of just under £700k for the first year of treatment across Thames Valley CCGs. Based on the numbers provided, if a patient was to use the maximum of 12 doses per day, the cost in the first year would be just under £1.5m or £1.8m if no patients drop out. Over a 5 year time period of patients using 12 doses per day with no drop out after 4 week the cost is just over £4m. In the resource template and the economic evaluation NICE suggested that by using the THC:CBD spray (Sativex®) , spasticity management costs would be reduced. NICE suggests this will be £123 per patient per year. In year 1 based on the current number of patients using THC:CBD spray (Sativex®) using information given by the providers, it is estimated there would be a savings in the region of £46k across Thames Valley CCGs. The Committee was also provided with costs, for the last 3 financial years, for inpatient admissions where MS was recorded as a primary diagnosis, outpatient admissions where MS is recorded either as a primary diagnosis or comorbidity (not including community providers on a block contract) and A&E attendance.
10.4	The specialist clinicians in attendance made the following points: • The numbers of patients failing to gain a treatment effect from a number of oral anti-spasmodic medications and therefore meeting the criteria for THC:CBD spray (Sativex®) will be small. • By all accounts there appears to be a high dropout rate from other services. • It is very effective for a small number of people. • It is likely to be established if a patient is going to be a responder during the first 4 weeks. • It is unlikely that the use of THC:CBD spray (Sativex®) will reduce hospital admission costs as MS patient will be admitted for many reasons. • THC:CBD spray (Sativex®) may well reduce the inputs required for pain management and spasticity management and this may result in savings. • 'Modified Ashworth Score (MAS) is used locally which means if a patient has dropped from a score 4 or 3 down a level, this is definitely more than a 20% response and the patient will fulfil the criterion to continue the THC:CBD spray (Sativex®). Spasticity management is based on goals. The goal has to be meaningful for the patient and a 0-10 scale is not meaningful for the patient.
10.5	A discussion was held about the inconsistencies in numbers of patients previously provided for analysis and affordability. The Committee heard that East Berkshire currently has 15 historic patients on THC:CBD spray (Sativex®) prescribed by FHFT. The application made in January pre COVID expected approximately 10 pts per 100,000 population to be eligible for THC:CBD spray (Sativex®) so for Frimley ICS alone is potentially 90-100pts. Question was raised regarding the patient characteristic and their context that makes them more likely to benefit from THC:CBD spray: The specialist in attendance advised that in rehabilitation departments, patients generally present on a regular basis having tried different kinds of treatments for spasticity management. Details regarding types of medication, volume given and period of time would be documented. In clinic the amount of tone a patient has will be quantified and scored on a nationally accepted 0-4 system. Once 4 types of medication have been tried, THC:CBD spray (Sativex®) is an option but not everyone will respond to it. Probably about 25% only of patients in that subset are going to respond to THC:CBD spray (Sativex®). The numbers of patients presented in the analysis may be regarded as large as this may include the patients who have not responded. Defining severe spasticity is not easy and there are various physical scales for assessment. Within OCE, spasticity assessment is performed with a physiotherapist and a doctor or two physiotherapists. Sometimes a patient will have very severe spasticity and will not want

10.5 Cont..	treatment. There is not an inevitability for every patient to end up on THC:CBD spray (Sativex®). Some patients, however, may need to be referred to use an intrathecal baclofen pump. A committee member noted via the 'chat' function that it would be really helpful to consider stopping criteria.
10.6	The Committee suggested that if NICE assessed THC:CBD (Sativex®) spray as cost effective, the patient numbers and costs need to be remodelled locally, and that it should reflect the consultant feedback that hospital admissions will not be impacted. It was suggested that following a recalculation, NICE should be contacted for further information regarding its resource impact evaluation. **ACTION: The Clinical Effectiveness team to contact Provider Trusts for more accurate numbers of patients who currently and will fulfil NICE criteria for treatment with THC:CBD spray (Sativex®). Recalculate the financial impact for Thames Valley CCGs. Liaise with CN to contact NICE. Bring back to the Committee for further discussion.**
11.	**Paper 20-017 – Policy Update: Short-burst oxygen therapy (SBOT) for the relief of breathlessness**
11.1	Currently Berkshire West, East Berkshire and Buckinghamshire hold policies regarding the use of short-burst oxygen therapy (SBOT) for the relief of breathlessness. The existing policies dated 2008 all consider SBOT use for this indication to be of low priority due to the lack of evidence of clinical and cost effectiveness. NICE guidance (2018, updated 2019) states SBOT should not be offered to manage breathlessness in people with COPD who have mild or no hypoxaemia at rest. The British Thoracic Society (BTS) guidance (2015) states that SBOT should only be offered in the context of cluster headache.
11.2	The regional home oxygen service lead and local respiratory consultant were consulted and advised that oxygen therapy is rarely used just for breathlessness and alternative support is normally offered. All CCGs have a specialist team responsible for requesting oxygen for respiratory / cardiac and cluster headache relief. GPs will only be prescribing oxygen in exceptional circumstances for example in palliative care. The Committee considered the national guidance, evidence and opinions of the local specialists presented and agreed the policy was no longer required and could be withdrawn. **ACTION: Clinical Effectiveness team to prepare documentation for the withdrawal of the Short Burst Oxygen (SBOT) policy and send to relevant CCG Governing Bodies for acceptance.**
12.	**Paper 20-021: Clinical Feedback: TVPC 59 Policy Update: Management of Female Pelvic Organ Prolapse**
12.1	In July 2020, the TVPC Committee considered the updated evidence (Paper 20-013) for the current policy 'TVPC 59 Management of Female Pelvic Organ Prolapse' (2017). The policy wording was changed to reflect new NICE guidance (2019) and recent publications regarding the use of synthetic mesh in prolapse surgery. The Clinical Effectiveness team circulated a draft policy to clinicians in August. Comments were received from Oxford University Hospital and a Consultant Urogynaecology Lead, Buckinghamshire Healthcare NHS Trust. Clinical feedback was shared with the Committee, which included suggested changes to the policy wording. The Committee felt that further clinical feedback was required from other Thames Valley providers before a policy could be recommended. **ACTION: Clinical Effectiveness team to circulate draft update to policy TVPC59 The Management of Female Pelvic Organ Prolapse, and the underpinning policy update to specialist clinicians for comment and bring back to November Committee.**

13.	**Paper 20-018: Horizon Scanning**
13.1	The Committee was provided with a paper identifying key guidelines and new technologies published which may impact on CCG clinical policy or present opportunity for policy development.
14.	**Any Other Business**
14.1	**None**
15.	**Next meeting**
	The next online meeting will be held on **Wednesday 21st October 2020 from 12-2pm**
16.	**Meeting Close**
	The Chair thanked everyone for their contributions to the discussions and closed the meeting.