NHS
Derby and Derbyshire
Clinical Commissioning Group

Draft Minutes
Clinical Policy Advisory Group

Thursday 18th June 2020
Microsoft Teams
CONFIRMED

Present Virtually via Teleconference	Initial	Title
Steve Hulme (Chair)	SH	Director of Medicines Management & Clinical Policies (DDCCG)
Dr Carolyn Emslie	CE	GP & Prescribing Lead (DDCCG)
Dr Buk Dhadda	BD	GP Clinical Lead / Governing Body Member (DDCCG)
Slakahan Dhadli	SD	Assistant Director of Medicines Management and Clinical Policies (DDCCG)
Parminder Jutla	PJ	Medicines Management and Clinical Policies Guidelines, Formulary and Policy Manager (DDCCG)
Helen Moss	HM	Individual Decisions & Project Manager (DDCCG)
Tom Goodwin	TG	Head of Medicines Management and Clinical Policies and Decisions (DDCCG)
Helen Wilson	HW	Deputy Director of Contracting and Performance (DDCCG)
Ruth Gooch	RG	GP Clinical Lead (DDCCG)
Siobhan Foxon	SF	Assistant Director of Planned Care & Cancer (DDCCG)
Niki Bridge	NB	Deputy Chief Finance Officer (DDCCG)
Anne Hayes	AH	Consultant in Public Health Derbyshire County Council
Amanda Bradley	AB	Commissioning Support Manager (DDCCG)

Ref:	Item	Action
1	**Declaration of Interest**	
CPAG /20/54	SH reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings that may conflict with the business of the CCG. Declarations made by members of CPAG are listed in the CCG's Register of Interests. The Register is available either via the Secretary to the Governing Body or the CCG's website. SH reminded members there is a new declaration of interest form to be completed and returned (as per attachment). No declarations of interest declared. **Action:** CPAG members to submit annual Conflicts of Interest form CPAG member conflicts of Interest register to be presented at the July CPAG meeting	All AB
2	**Welcome, Introductions, Apologies, Quoracy**	
CPAG /20/55	Apologies were noted for Robyn Dewis (Acting Director of Public Health, Derby City Council), Emma Barrie (Senior Contract Manager – Community, DDCCG), Diane Price (Associate Medical Director – UHDBFT) and Jill Savoury (Assistant Chief Finance Officer, DDCCG).	

3	**Minutes and Key Messages from the last meeting**	
CPAG /20/56	March's CPAG meeting's minutes had been previously agreed as being accurate virtually. SD requested the following amendments: • Page 1 - 'CPAG was not quorate (full Terms of Reference). It was agreed that the minutes would be circulated for virtual agreement and that the Interim Terms of Reference meant that the meeting could take place.' **Action:** Update March's CPAG minutes with minor amendment. Upload updated minutes to the DDCCG Clinical Policies website.	PJ
4	**Matters Arising/Summary**	
CPAG /20/57	**4a. Future CPAG meetings - Interim CPAG Terms of Reference (ToR)** Due to the COVID-19 pandemic CPAG meetings were stood down. Interim CPAG ToR was subsequently devised to ensure the continuity of CPAG meetings whilst the CCG remained at business continuity level 3 and 4, through a skeleton model. This included: a reduction in frequency of meetings to 3 monthly; meetings being conducted virtually through the use of Microsoft Teams and teleconferencing; policies/papers that were non-controversial and required minor amendments would be tabled and reduced quoracy to a single GP member/CCG Medical/Deputy Medical Director and the Director of Medicines Management & Clinical Policy Team/Assistant Director of Medicines Management/Clinical Policies & Decisions or Head of Medicines Management and Clinical Policies & Decisions. Items that would require comprehensive clinician engagement, such as new policies or fundamental changes, have been deferred to future CPAG meetings once the CCG is no longer operating at Business Continuity level 3 or 4 and the meetings are running under the full CPAG ToR. The current CPAG meeting reflects all of the above and is therefore quorate under the interim CPAG ToR. The other key change was in reporting the outputs to the Clinical Cell (CC). Clinical decisions had previously been ratified by the Clinical and Lay Commissioning Committee (CLCC), due to the COVID-19 pandemic these meetings were stood down. In the acute phase the ratification of clinical decisions was undertaken by the Executive Committee. This approach resulted in a backlog of decisions that required ratification. As a result, the CC was formed to ratify these clinical decisions, which included the outputs of CPAG. CLCC has now been reinstated, the CC remains in operation as rapid route of decision making as meetings run weekly if needed. CPAG noted that the CCG is currently operating at Level 3 of the Business Continuity Plan. Based on the interim CPAG ToR the next CPAG meeting would be held in 3 months' time. TG asked the group, given that the CCG is no-longer operating at Business Continuity Level 4, clinicians are available for engagement and that it is possible to hold CPAG meetings that have membership that meet the full CPAG ToR would CPAG still have to be run in accordance to the interim ToR. CPAG acknowledged that the change in Business Continuity Level from 3 to 2 will trigger a different operating structure. NB confirmed that she had discussed at the Joint Area Prescribing Committee (JAPC) meeting the possibility of meetings returning to a monthly frequency. SH agreed that these discussions echoed discussions that were had at JAPC due to CLCC returning to monthly meetings and COVID activity declining. NB also informed the group that she and her team are working on bringing services back online. CPAG agreed that the use of Microsoft Teams during meetings such as CPAG should continue as this capability represents a productivity benefit.	

	BD explained that although CLCC has recommenced the format of the meeting is different. BD added that there is still a pause on elective work in hospitals and asked the group whether the next couple of months should be used to consider how the CCG is going to move forward. CLCC is currently scoping the remit of CLCC for the near future in relation to strategic commissioning decisions. Discussions at CPAG will reflect this over the next few months. SH described how the remit of CLCC fits within the system, and the Joined Up Care Derbyshire (JUCD) review. This included an update on the governance structure relevant to COVID and the restorative and recovery phases as described by NHSE. The group discussed the frequency of CPAG meetings moving forward and agreed to revert back to monthly meetings. The group agreed that the next CPAG meeting would be in July. SH explained that attendance of members for July's meeting might be an issue due to school holidays. Therefore the availability of members should be confirmed before July's meeting goes ahead. SD informed CPAG members that JAPC circulated a questionnaire to members to gauge the capacity of primary and secondary care clinicians. The general feedback was that secondary care clinicians have capacity to engage when reviewing clinical guidelines. TG confirmed that the Clinical Policies Team have received feedback from clinicians regarding the extension of reviews of various policies such as the Tonsillectomy policy and Pinnaplasty Policy. AH informed the group that although there has not been a second surge predicted, Public Health remain extremely busy with meetings regarding Care Homes and Test and Trace. AH explained that she would share any future meetings and associated workload with Robyn Dewis (RD), Acting Director of Public Health Derby City. CPAG would need to be mindful of this with regards to quoracy. AH will manage this with RD outside of the meeting. CPAG agreed to return to monthly meetings but will review as necessary if there was a second wave. **Action:** CPAG agreed to monthly meetings - Inform CLCC Operating arrangements to be reviewed at the July CPAG meeting **4b. Update on prior approval for hip and knee revision (consultant to consultant (C2C) assurance)** Members had previously reviewed the possibility of removing Prior Approval for the hip and knee revision procedure as there was already assurance that referrals were going through the MSK-CATs service. However, BD raised the issue regarding consultant to consultant referrals. HM informed CPAG that although there is a policy in place the CCG cannot pick out specific to consultant to consultant referrals. Therefore HM asked the group whether they would be in agreement of removing Prior Approval from this procedure. BD informed the group that although there is a Consultant to Consultant Policy in place he was unsure whether this policy covered this situation. He explained that there could be a loop hole within the policy allowing consultants to bypass the system by referring to each other and not necessarily adhering to the PLCV criteria.	 AB/HM AB/HM

	SD agreed for the Consultant to Consultant Policy to be returned to next CPAG and so that the group can discuss the issue further. **Action** C2C policy to reviewed at the July CPAG meeting to ensure PLCV is an exclusion Prior Approval to remain for the hip and knee pathway until assurance provided by the change in policy **4c. PLCV financial values 20/21** SD updated members that the CCG has now closed the books for last financial year including any values in challenge. HW informed members that for the period of 20/21 all NHS contracts will be on a block value agreement until the end of July. Although not formally confirmed, there is a possibility that these could be extended until October or even longer. NB explained that the CCG would not be able to challenge and seek reimbursement but would still monitor and work with providers to ensure they are adhering to policies. BD added that this is an ideal opportunity for the CCG to evaluate its broader functions including its role as a strategic commissioner as we are not concentrating purely on the financial efficiencies.	HM
5.	**Workplan/Action Tracker**	
CPAG /20/58	CPAG noted actions on Action Tracker	
6.	**Bulletin**	
CPAG /20/59	**Bulletin -** *Information in the public domain - March Bulletin confirmed virtually – 27/04/20* Bulletin had been virtually agreed by CPAG members and has now been uploaded onto the Clinical Policies website.	
7.	**Clinical Policies Reviewed**	
CPAG /20/60	**7a. Bunions Policy** The policy has come up for review. PJ advised that a literature review had taken place and there was are no significant changes within National guidance since the policy was last reviewed. The policy has been reformatted to reflect the new organisation's clinical policy format, which includes the addition of background information, rationale for recommendations and useful resources. PJ informed the group of the following additional amendments that have been made to the updated policy: ▪ Clarification of restrictive criteria – step-by-step format ▪ Removal of urgent referral criteria (<2/52) ▪ addition of 'Exclusion Criteria' section to the policy PJ added that she has received feedback from clinicians, which has resulted in a number of minor changes to the policy as suggested. CPAG were asked to review the comments and recommended actions. BD agreed that the wording of the restrictive criteria could be more clinically specific. BD explained that	

	although the suggested amendment is a small change, the alteration is clinically appropriate. With regards to the change in wording for private providers, CPAG agreed that the policy should not specifically mention private providers as this suggestion could theoretically apply to all clinical policies. Moving onto the question on how GPs/referrers identify which cases to refer to either surgical podiatry or trauma and orthopaedics, It was suggested whether the querying consultant could provide clarification. PJ will contact the querying consultant for clarification and will provide an update during the next CPAG meeting. SF informed the group that Planned Care is reviewing the MSK-CATs service and this work encompasses the foot and ankle pathway including surgical podiatry and trauma and orthopaedics. CPAG agreed the updates to the policy. **Action:** • Agreed amendments to policy • Policy to go to virtual EQIA panel • Contact querying consultant for clarification of criteria for referrers **7b. Cholecystectomy Policy** The Policy has come up for review. The policy has been reformatted to reflect the new organisation's clinical policy format, which includes the addition of background information, rationale for recommendations and useful resources. PJ explained that both CRH and UHDB clinicians are in agreement with the policy. The group discussed the policy and agreed with the changes. **Action:** • Policy to go to EQIA panel • Policy approved to go to CLCC for ratification	PJ HM PJ HM HM
8.	**Governance Policies**	
CPAG /20/61	**8a. MedTech Funding Mandate** CPAG was assured that the MedTech funding mandate outcome had been paused due to the pandemic. TG had confirmed with NHSE, as such this item can be closed and can be re-started if required, at later date.	
9.	**Contracting and Blueteq queries**	
CPAG /20/62	No update.	
10.	**Individual Funding Request (IFR) – for information**	
CPAG /20/63	**10a Screening Feedback February/March** CPAG noted the screening information. HM confirmed that the cases had been seen and noted by Clinical Cell. SD advised that the purpose of presenting recent IFR cases to CPAG was to enable the group to identify any gaps within the CCG's clinical policies or the need for new clinical policies. SD confirmed that most of the cases listed were covered by pre-existing policies	

	and therefore no further action was required. HM confirmed that IFR cases have reduced since the start of the COVID-19 pandemic. **10b IFR appeal case** HM informed members of a recent IFR case that had been appealed. The case had previously been presented to the IFR panel on three separate occasions with additional information and had been declined. The clinician had then appealed against the decision. In line with the processes stated in the IFR policy, the case was forwarded to the IFR colleagues at Nottingham CCG to determine whether the case was eligible to be considered by a full IFR review panel. Nottingham CCG, independently, came to the decision that the case could be appealed and was sent to a review panel who upheld the appeal. The case returned to the IFR panel for reconsideration. Based on the reconsideration the case was subsequently approved with a note that there were lessons to be learnt from how the case was handled. CPAG agreed that this would be picked up via the proposed virtual IFR training. AH added the need to be stricter on paperwork and to only review IFR requests once the IFR team is assured that they have all the information needed. Formal IFR training had been arranged before the COVID-19 pandemic. It has now been agreed for the training to take place virtually. This training will provide an opportunity to discuss the appeal case further and to takeaway learning from the case. CPAG agreed that the training should be opened to a wider circle of people, such as CPAG members, Governing Body and JAPC members. HM is currently working on organising the remote training and will confirm with members when a date has been confirmed. SD suggested the need for grounds rules for virtually delivered training given that there could be a large number of attendees. HW asked to be included in the IFR training as the finance lead. **Action** • IFR training to take place virtually - confirm at July's meeting • Training to include 'lessons learnt' - from appeal case • Training to invite Nottingham colleagues • Consider different requirements of delegates e.g. panel members, screeners, administrators • Establish a set of ground rules for virtual training sessions	HM
11.	**East Midlands Affiliated Commissioning Committee (EMACC)**	
CPAG /20/64	No updates	
12.	**CLCC updates**	
CPAG /20/65	**12a. Delegated authority summary** CPAG noted the Delegated Authority paper summary that had been agreed by the Clinical Cell. **12b. Update from Clinical Cell - policies ratified** CPAG was informed of the following CPAG approved policies had been ratified by the Clinical Cell and uploaded onto the website:	

- Tonsillectomy Policy
- Breast Augmentation Policy
- Mastopexy (Breast uplift) Policy
- Breast Prosthesis Removal Policy
- Breast Asymmetry Policy
- IPG Policy

The following CPAG approved position statements were also ratified by CC:

- Spinal Cord Stimulation for Chronic Neuropathic Pain Position Statement
- Vaginal Pessaries Position Statement
- Use of Imaging in Management of Morton's Neuroma Position Statement
- Use of imaging in Management of Trochanteric Bursitis/Greater Trochanteric Pain Syndrome (GTOS) Position Statement

Other papers ratified by CC included:

- Removal of Prior Approval for Policy for Injections for non-specific low Back pain without Sciatica including Spinal Fusion for Low Back Pain per
- Gamete Storage Consultation paper
- February's CPAG minutes
- March's CPAG minutes
- March's CPAG Bulletin

CPAG were also asked to note that in response to the COVID-19 pandemic the IFR Policy and IFR ToR were both updated with interim versions. The interim IFR Policy and IFR ToR were approved and ratified by the Executive Committee on 21/04/20 and were uploaded onto the Clinical Policies website.

12c. Extension of review dates for clinical policies – for information

During initial stages of COVID-19 there were four clinical policies identified as requiring a clinical review within the next 6 months. However due to reduced capacity it was proposed that the review dates of these policies would be extended by 6 months if it was clinically safe to do so. Clinicians at CRH and UHDB were asked for their feedback on whether it would be safe and appropriate to extend the review dates of these policies. Clinicians were asked whether there had been publications of evidence that needed to be reflected in these policies, which would otherwise comprise patient safety.

Clinicians confirmed that all of the policies, with the exception of the Pinnaplasty Policy could have their review dates extended. The CCG received confirmation from CRH clinicians that the Pinnaplasty Policy review date could also be extended. However, we did not receive a response from UHDB. It has therefore been agreed that the Pinnaplasty Policy will be reviewed as per original review date.

Action:

- QEIA to be completed and assessed at Virtual panel – assurance to CLCC — HM
- Pinaplasty policy to be reviewed as per the existing CPAG work plan — PJ

12d. CLCC June update

SD submitted the summary of Clinical Cell's outputs to CLCC for information and for assurance. SD also advised that there are no actions outstanding from CLCC.

13.	**IPG updates since last meeting**	
CPAG /20/66	**13a. IPGs, MTGs, DGs and MIBs** CPAG noted the NICE IPG, DTG and MTGs updated in May 2020 **Action:** Send MTG and MIB updates to the Finance Team, Planned Care Team and to the Contracting Team.	AB
14.	**Business Cases**	
CPAG /20/67	No update this month	
15.	**QIPP Pipeline**	
CPAG /20/68	No update this month	
16.	**Key messages for CLCC**	
CPAG /20/69	Key messages to go to CLCC • Inform CLCC that CPAG will be returning to monthly meetings • Cholecystectomy Policy • Bunion Policy • QEIA assurance for policy extensions It was noted that the IFR appeal case would presented to CLCC once the case had been completed.	AB/ HM
17.	**For information**	
CPAG /20/70	No update	
18.	**Any other Business**	
	18a. Options Appraisal paper for the Cosmetics RAS TG/HM provided members with an overview on the current process for cosmetic referrals and the options for the future of this service. **Key matters for consideration included:** • Added benefit from continuing the service • 80% of referrals and 53% of cost relates to benign skin lesions ○ Assured that there is a triage service in place at UHDB and referrals are reviewed against policy at CRH • 87% of costs are covered by four procedures – benign skin lesions, breast reduction, breast implants and rhinoplasty • The current service has been in place since 2005, remaining largely unchanged and unaffected by developments in IT and infrastructure • Service efficiencies in the way of request are dealt with • Alignment to the corporate strategy of the strategic commissioner HM informed CPAG that the preferred option was that the service should sit with Derby Hospitals. SD added that in his opinion the service does not sit with the CCG and asked the group whether there is a potential for PCNs to have a role going into this.	

	SF explained that Dermatology were already overwhelmed with referrals and asked if HM could see if these referrals were just going into Dermatology to be triaged or whether they were going into Plastics. HM confirmed that most referrals were going into Dermatology. BD added that in response to the current pandemic the system has adapted to move forward. For example, in general practice there are systems that allow GPs to run a video conference with patients etc. BD questioned if this technology was available to hospitals. BD added that if the department is feeling overwhelmed then technology could be part of a solution. Members agreed that there is a need for the CAS system to be reviewed and that this would need to be provider led. CPAG also agreed that the provider needs to look at new technology to support this. CE confirmed CRH do not have the service and patients would be referred to Sheffield. HM added that previously Sheffield would return the referrals to DDCCG to confirm if funding had been approved. HM was unsure if this system was still in operation but agreed she would contact Sheffield and will feedback at the next CPAG meeting. The group suggested that the next step in the process would be to link in with Contracting. HW explained that she felt that CPAG was not at that stage yet. SF added that a more appropriate move would be to amend the specification attached to the contract or to even consider removing it. The group also questioned whether there were any work streams around dermatology that could implement the change. CPAG was made aware that there is a Dermatology CIG but is in its early days and is embedding the Consultant connect service. RC chairs the group and therefore could be a possible route for discussion and engagement. CPAG were also informed that there is already a triage service in place in Dermatology but unsure how robust this system is. However, HM clarified that plastic referrals for dermatology were covered and this triage service was more relevant to ENT referrals and rhinoplasty. SD confirmed that he had previously had discussions with Rosalind Puzey, Plastic Surgery specialist Nurse (UHDB) who is employed by the CCG. SH agreed that he felt that the CAS service needs to change but wanted to clarify which approach should be taken.. These services are not classed as a priority under the recovery phase, and the group thought perhaps this sits more with planned care to pick up the conversation. SF agreed to offer help and support. SF suggested that she and HM should discuss this issue outside of the meeting. **Action:** CPAG broadly supported the review • To return to July CPAG meeting for agreement on next steps • HM to clarify the process for North practices (Sheffield referral patterns) 18b. **Options Appraisal paper for Prior Approvals** BD had to leave the meeting and it was therefore agreed to bring this paper back to the next meeting. **Action:** • Paper deferred to July's CPAG meeting	HM HM HM

	18b. Confirm, date, time, duration and media for next meeting Next meeting to be held 16th July 2020 via Microsoft Teams.	

Date of Next meetings

Thursday 16th July 2020 Room 2, Cardinal Square - 09.30 – 12.00
Thursday 20th August 2020 Room 2, Cardinal Square - 09.30 – 12.00
Thursday 17th September 2020 Room 2, Cardinal Square - 09.30 – 12.00
Thursday 15th October 2020 Room 2, Cardinal Square - 09.30 – 12.00
Thursday 19th November 2020 Room 2, Cardinal Square - 09.30 – 12.00
Thursday 17th December 2020 Room 2, Cardinal Square - 09.30 – 12.00
All papers to be sent by 12 noon the week prior please