NHS
Derby and Derbyshire
Clinical Commissioning Group

Minutes
Clinical Policy Advisory Group

Thursday 20th February 2020
9.30 – 12.00 Room 3, Cardinal Square, Derby

CONFIRMED

Present:	Initial	Title
Steve Hulme (Chair)	SH	Director of Medicines Management & Clinical Policies (DDCCG)
Niki Bridge	NB	Assistant Director of Finance (DDCCG)
Dr Carolyn Emslie	CE	GP & Prescribing Lead (DDCCG)
Dr Buk Dhadda	BD	GP Clinical Lead / Governing Body Member (DDCCG)
Robyn Dewis	RD	Consultant in Public Health Medicine (Derby City Council)
Helen Moss	HM	Individual Decisions & Project Manager (DDCCG)
Parminder Jutla	PJ	Medicines Management and Clinical Policies Guidelines, Formulary and Policy Manager (DDCCG)
Slak Dhadli	SD	Assistant Director of Medicines Management and Clinical Policies (DDCCG)
Helen Wilson	HW	Deputy Director of Contracting and Performance (DDCCG)
Laura Harmer	LH	Administrative Assistant for IFR/clinical policies (DDCCG)

Ref:	Item	Action
1	**Declaration of Interest**	
CPAG /20/19	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. No declarations of interest declared. RD raised a query about Declarations of Interest (DOI) forms for all CCG meetings. Anne Hayes (Consultant in Public Health Derbyshire County Council) and RD have received multiple DOI requests for different meetings. SD confirmed that work has been completed to add all DDCCG meetings to one DOI form, which will be held on a central register. The central register will be managed by Corporate Governance from 1st April 2020.	
2	**Welcome, Introductions, Apologies, Quoracy**	
CPAG /20/20	SH welcomed everyone to the meeting. Apologies noted for Ruth Gooch (GP Clinical Lead), Jill Savoury (Assistant Chief Finance Officer DDCCG), Anne Hayes (Consultant in Public Health Derbyshire County Council) Siobhan Foxon, (Assistant Director of Planned Care & Cancer DDCCG), Lisa Howlett, (Head of Quality Governance, CRHFT) and Tom Goodwin (Head of Medicines Management and Clinical Policies and Decision, DDCCG) Planned Care advised that there is currently very limited capacity within their team and therefore are unable to attend or send a deputy to CPAG. Planned Care have informed CPAG that they will attend if there is a CPAG agenda item	

	that is pressing for Planned Care. HW advised that she is willing to represent Planned Care, as well as Contracting, if deemed satisfactory by CPAG. SH has raised with Craig Cook (Deputy Director of Commissioning Operations/Director of Contracting and Performance) and Zara Jones (Executive Director or Commissioning Operations) as Planned Care are core members under the CPAG terms of reference. LH confirmed the meeting complied with core membership as per CPAG Terms of Reference.	
3	**Minutes and Key Messages from the last meeting**	
CPAG /20/21	January minutes agreed as accurate pending the following amendments noted by SD: • Page 6 - replace the word "happy" with a more professional alternative word • Page 7, 7e Vaginal Pessaries- correction of grammar of first sentence • Page 8, replace "to be included" with "proposed" **Action:** • Send minutes to CLCC for ratification • Upload ratified minutes to website	 AB HB
4	**Matters Arising/Summary**	
CPAG /20/22	**4a. Ardens templates – Alignment with PLCV** HM advised that all of the Electronic Referral System (ERS) templates have been reviewed and uploaded onto the ERS system. During January's CPAG meeting BD raised the uploading of the DDCCG ERS templates to the Ardens system. HM advised CPAG that Ardens have requested the templates. HM added that Tina Pottrell (DDCCG NHS e- Referral Service Manager) has sent communication to practices informing them of the ERS template updates. HM confirmed that all of the ERS forms are up to date and are live for practices to access. **4b. Open Access Gastroscopy: assurance for the Burton site adopting the Derby consultant triage process** HM informed the Group that UHDBFT have not implemented Blueteq and therefore it is not possible to produce Gastroscopy data for the site. Tom Goodwin (DDCCG, Head of Medicines Management and Clinical Policy Decisions) has consulted with various Gastroscopy colleagues including the Gastroscopy Delivery Board. SD confirmed consultant triage is a requirement of the Joint Advisory Group (JAG) endoscopy accreditation. Therefore there is a requirement for a triage service. BD confirmed that there are very few referrals coming through for Gastroscopy. Based on the assurance provided, CPAG agreed to remove the Gastroscopy Policy and the associated Prior Approval. **Action:** Minor update to CLCC to advise removal of the Gastroscopy Policy and the Prior Approval **4b. Burton site** HW reported that Zara Jones (DDCCG, Executive Director or Commissioning Operations) had formerly written to Burton regarding the implementation of Blueteq. Following the letter there had been a delay in progressing due to long term sickness. HW has picked this up with Emily Davies (Head of Locality Commissioning) at Staffordshire, who has prepared a paper for approval at their Governance Committee Meeting. The paper has been deferred to the meeting on the 24th March 2020. HW confirmed she will follow up with Emily Davies after the Governance Meeting and provide an update for April's CPAG meeting. **Action:** Follow up with UHDBFT following Governance meeting on 24th March 2020 **4c. Intrauterine Insemination (IUI) – Queries raised at CLCC**	 AB HW

	PJ reported the policy was presented at CLCC following minor updates, which included: • Removal of 'social' objections to InVitro Fertilisation (IVF) as an exception for IUI for infertility treatment. • Addition of 'People who have social objections to IVF who have an underlying fertility problem' to the policy's exclusion criteria. PJ stated CLCC ratified the minor changes but have raised issues that require further clarification: • 12 month time frame to complete 6 self-funded cycles of IUI unachievable • Policy potentially discriminates against transgender/non-binary people as the policy refers to 'female' same-sex couples PJ advised that the policy has been updated to state couples should have completed their sixth self-funded cycle of IUI within the last twelve months to be eligible for NHS funded IUI. In addition, the policy has been amended to refer to same sex couples where one partner has an intact uterus. SH explained that it is the role of the East Midlands Affiliated Commissioning Committee to tackle these issues raised from the policy (EMACC). HM explained that the EMACC fertility policies are outdated. CPAG was assured that due process was followed as the policy has been presented to the QEIA panel on two occasions. It was agreed that summaries of amendments to policies that fall outside of normal periodic reviews will be noted to future CLCC meetings with the relevant sections of the policy. HW reported that although DDCCG have a policy in IUI, UHDBFT do not provide donor sperm and therefore the IUI procedure cannot be provided to same-sex couples who require donor sperm. Therefore same-sex couples are being referred to NUHFT. HW advised that this issue requires addressing. SD advised that the contract requires reviewing as we have a policy in place with no local service provider being able to provide the procedure. HW confirmed that contracting are looking into this. BD and NB asked if the finances within the contract block and activity levels can be investigated. HW explained that she will review the service specification. The group discussed and agreed the key points to go back to CLCC: • Submission of EQIAs for assurance • CPAG approved updates **Actions:** • Investigate lack of Derby & Derbyshire service provider • Report agreed points relating to the IUI policy above at CLCC • Investigate activity levels and financial impact from the block contract	HM HM HW
5.	**Workplan/Action Tracker**	
CPAG /20/23	CPAG noted the progress on the action tracker.	
6.	**Bulletin**	
CPAG /20/24	CPAG approved the bulletin pending the following amendments noted by SD: Page 1 Hyperhidrosis key changes, amend prior approval wording • Page 2 ERS key changes. Remove word "to" • Hyperhidrosis no longer requires a prior approval process **Action:** Updated bulletin to be presented to CLCC for ratification and then to be uploaded onto the website.	AB
7.	**Clinical Policies Reviewed**	

CPAG /20/25	**7a. Injections for Non-specific Low Back Pain Policy (outcome of SIJ NICE)** PJ advised that the Non-specific Low Back Pain Policy was presented at December's CPAG meeting. The policy returned to CPAG for the group to see the agreed changes for information purposes. In doing so it was identified that the policy is a "do not commission" policy therefore it is questionable whether prior approval is required. The Group agreed to remove prior approval. SH asked if the pre and post policy data could be reviewed before removing Prior Approval to provide assurance on activity levels. **Action:** • Review activity pre and post policy before removing prior approval. To bring to April's CPAG meeting. **7b. Epidural for Acute and Severe Sciatica Policy (new policy)** The Injections for Nonspecific Low Back Pain policy was presented and updated in December's CPAG meeting, which involved the removal of 'A local decision has been made not to offer Epidurals (local anaesthetic and steroid) in patients who have acute and severe lumbar radiculopathy at the time of referral'. This was due to the statement referring to sciatica (lumbar radiculopathy), which is not relevant to the policy as the policy's focus is on 'Nonspecific Low Back Pain without Sciatica'. Instead CPAG agreed for a separate policy on epidurals (local anaesthetic and steroid) for acute and severe lumbar radiculopathy to be devised. PJ advised she has conducted a literature search for new robust evidence around the efficacy of epidurals for sciatica that has been published since the policy was last reviewed in April 2019**.** There was no robust data identified. PJ stated that the UHDBFT Orthopaedic Consultants disagreed with DDCCG's commissioning stance on epidurals for sciatica as they expressed that it goes against NICE guidance and patient's best interests. In light of this the evidence base used by NICE was reviewed. NICE advice "consider epidurals in acute and severe sciatica". NICE refer to "acute" as sciatic symptom's that have lasted less than three months. NICE uses the word "consider" where evidence base is limited. PJ concluded that there is no robust evidence to support the clinical benefit of epidurals for sciatica with regards to pain or function for up to four months when a steroid epidural or steroid and anaesthetic epidural, compared to a placebo or pharmacological interventions. The NICE economic evaluation has also been reviewed and it has been confirmed that epidurals are not cost effective when compared to a placebo. No response has been received from CRHFT clinicians. Therefore the assumption has been made that CRHFT clinicians are agree with DDCCG's commissioning stance. CPAG approved the new draft of the epidural policy. **Action:** Epidural for Acute and Severe Sciatica Policy to be presented to CLCC for ratification and then to be uploaded onto the Clinical Policies website **7c. Hydroxychloroquine** RD reported CPAG discussed Hydroxychloroquine and retinal monitoring approximately 12 months ago. Following this a paper went to CLCC in Summer 2019 outlining the Royal College of Ophthalmologists retinal screening guidance. RD stated the test is not robust enough to detect Hydroxychloroquine toxicity so patients are at risk of being missed, or changes can be detected when no changes are present. CLCC agreed the tests would be renamed "monitoring" in place of "screening" The Royal College of Ophthalmologists have also amended the wording to "monitoring" and not "screening". RD continued, the guidelines stipulate that each patient should receive a baseline retinal	HM HM

	photography and SD-OCT test, with annual monitoring from five years of therapy using SD-OCT/ FAF and visual field testing. Baseline testing can be provided in the community. Annual monitoring must be provided within a specialist secondary care setting. RD advised she had attended 2 Ophthalmology CIG'S (Clinical Improvement Group's), there was little clarity or agreement. The group had a robust discussion around the benefits of performing a baseline test, OCT testing and capacity for baseline testing. Initially CRHFT were undertaking a baseline test, but this has now ceased. UHDBFT are not undertaking baseline testing. Both hospitals are undertaking SD-OCT/ FAF/ Visual fields with patients who are high risk or who have taken the drug for over 5 years. UHDBFT are delivering this service through a virtual clinic and have enabled capacity for this by adding in additional clinical time. CRHFT are reviewing these patients in their retinal clinic and have raised a risk due to the increased workload and extension of waiting times. RD commented she has discussed a risk assessment with CRHFT. SD questioned the test activity and costings. HW commented UHDBFT have a standard charge. It is unclear what the CRHFT charge is. CE queried the numbers of Hydroxychloroquine patients, RD stated around 3000 in Derbyshire, however we are unsure how many are starting and how many have been taking Hydroxychloroquine for five years or more. The group discussed the prevalence of retinopathy, <1% 0 – 5 years, <2% within the first 10 years, but rises to at least 20% after 20 years. The group debated the relevance of the baseline testing. BD queried if the baseline test determines predisposing factors. SD/RD confirmed the test does not. CPAG discussed approaches to testing. SD queried which test has the highest specificity. RD advised there is no gold standard to assess the specificity /sensitivity against, therefore it cannot be accurate. BD expressed concern that Hydroxychloroquine potentially causes retinopathy in a small number of patients, which is not possible to pick up with accurate testing. BD suggested advising potential risks, side effects and alternative DMARD options during the GP consultation to enable the patient to make a choice. SD recommended a review of HCQ and DMARD alternatives. RD commented if Retinopathy is detected early the drug can be stopped and progression is not so severe. RD stated the particular question for CPAG was the value of the baseline test, as in order to achieve the baseline test a new process will need to be commissioned. The group agreed they do not support the baseline given the lack of evidence presented. CPAG went on to discuss the frequency of testing. RD suggested testing at 5, 7.5 and 10 years. Annual testing after 10 years. SH advised we should have a position statement to advise we are awaiting a review; we do not support the baseline testing, an outline of testing frequency and an overview of alternatives. SD advised he has drafted a position statement. The group agreed that due to the complexity of the matter a paper would be prepared for April CLCC to discuss baseline testing and a review of DMARD products. **Action:** • Prepare cover sheet for April CLCC • Conduct a review of HCQ and DMARD alternatives • Circulate drafted position statement to attendees • JAPC to review benefits and risks **7d. Spinal Cord Stimulation** HM explained that the Spinal Cord Stimulation Policy is currently only commissioned in line with the requirements of NICE TAG 159. Data shows that there is limited activity taking	RD SD SD/LH SD

	place. Neither of Derby and Derbyshire's main providers, CRHFT and UHDBFT carry out this procedure. UHDBFT refer to NUHNT and CRHFT refer to STHFT. CRHFT have provided assurance that they have assessed against NICE through a multi-disciplinary team. Since the procedure is only carried out in accordance with NICE Guidance and there are no restrictive criteria, HM queried whether there is a need for a policy and what is the added benefit of the procedure having Prior Approval. SD asked what the level of activity is, HM advised that number were low. The group discussed and agreed to remove Prior Approval. CPAG also agreed for the policy to be removed and replaced with a position statement instead. **Action:** • Remove Prior approval • Spinal Cord Stimulation position statement to be drafted and presented to March's CPAG meeting. **7e Microsuction of Ear Wax** CPAG had previously, removed the prior approval assurance mechanism at the request of contracting and providers. A Service Specification for the 'Treatment and Management of Ear Wax Service' has been finalised and approved, which will be implemented from the 1st April 2020. HM explained that there is an issue with Any Qualified Provider (AQP) commission providers who need to be informed that, as part of the specification, they should be providing information on self-care and management of patients with ears that are compacted with ear wax. HM advised Joint Commissioning would support the removal of the policy as the service specification includes contraindications for ear wax removal. HM explained that if further restrictions are required in the future, then the policy would need to be returned to CPAG. NB reported that issues have been raised at prioritisation of commissioning specification (PCS) around house bound patients as Derbyshire Community Health Services (DCHS) have served notice. A greater understanding is required around access to the procedure within primary care, such as the number of people accessing the service, the number of service users truly housebound etc. for commissioning to then take a view. HW advised that AQP's are in place for audiology but not for the microsuction of ear wax. SH asked if keeping the policy in place would pose any issues for the Service Specification. HM confirmed the Service Specification and the Microsuction of Earwax Policy are aligned. The group agreed that once the Service Specification is in place from1st April 2020 and assurance has been provided CPAG will reconsider the removal of the policy. **Action:** Circulate Service Specification to meeting attendees **7f. Vaginal pessaries position statement** The Vaginal Pessaries Policy was presented to January's CPAG meeting and the group agreed to remove Prior Approval for Vaginal Pessaries and for the policy to be replaced with a position statement. SD/BD/CE advised amendments to the position statement wording. The group agreed to review the position statement following the addition of the suggested amendments. **Action:** Amend position statement and to return to March's CPAG meeting along with the original Vaginal Pessaries Position Statement **7g. Arthroscopic Knee Washout for Patients with Osteoarthritis** **Policy** PJ explained that the Prior Approvals Team have been receiving a number of requests for	HM HM HM HM

	knee arthroscopy for patients with osteoarthritis with meniscal tears, but no mention of mechanical locking. Occasionally the patient's knee may give way. These patients have previously been refused the procedure. PJ stated the NICE definition of mechanical locking is "'not gelling, giving way or X-ray evidence of loose bodies'. PJ asked CPAG whether the Arthroscopic Knee Washout for Patients with Osteoarthritis Policy be should be updated to include NICE's definition. BD and CE both explained that they are unfamiliar with NICE's definition. CPAG agreed for NICE's definition not to be included within the policy. PJ asked the group whether the policy should include meniscal tears for clarification. The group accepted the addition. **Action:** Policy to be updated with the agreed amendments. Updated policy to be presented to CLCC for ratification and then uploaded onto the Clinical Policies website.	HM/HB
8.	**Governance Policies**	
CPAG /20/26	**8a. Difficult Decisions (Staffordshire Consultation)** PJ stated Staffordshire and Stoke-on-Trent CCGs have produced a Difficult Decisions paper which looks at the criteria for five clinical areas with the aim to align polices across the six Staffordshire CCG's. The DDCCG clinical policies team have completed a benchmarking exercise in which the policies and associated criteria have been compared to the Staffordshire polices and the findings have been summarised within the coversheet. The five areas are: 1. Assisted conception 2. Hearing loss in adults 3. Removal of excess skin following significant weight loss 4. Breast augmentation and reconstruction 5. Male and female sterilisation SD commented the difference between DDCCG policies and Staffordshire are minor. BD advised looking at one or two areas where a financial and clinical impact can be made. BD/SD outlined hearing aids as one area to explore, specifically looking at decommissioning or implementing more restrictive criteria. SH added that it would be useful to take relevant parts of the paper to the Prioritisation Panel to form part of the decision making process. **Actions:** • Review evidence around hearing loss and bring back to CPAG • Take relevant parts of paper to be presented to the Prioritisation Panel, once the panel is established to inform decision making	PJ SH/SD
9.	**Contracting and Blueteq queries**	
CPAG /20/27	**9a. Progress update on Clinical Policy Specification** SH asked the group to agree the updated Clinical Policy Specification. RD informed the group of a recent event where a clinician advised that he would refer a patient to an alternative provider for the requested procedure if approval was not given. HW/HM advised that there is no contractual action that can be taken to negate this issue. HW suggested a letter to the provider could be written to advise them not to proceed with the procedure as Prior Approval has not been granted by the CCG. CPAG approved the Clinical Policy Specification. **Action:** • Provide contracting with details of IFR request issue	HM

	• Add update to the February bulletin that the Clinical Policy Specification has been updated **9b. Update on contracting 2020/2021 work and PLCV financial values queried/recovered** **Action:** Deferred to March's CPAG meeting **9c. Update on additional EBI areas for 20/21 - consultation** SD informed the group that both CRHFT and UHDBFT do not provide Helmet Therapy for Plagiocephaly. SD advised that Exercise ECG for screening heart disease is provided by both Trusts. However, NICE currently has a "do not do" recommendation with regards to exercise ECG for diagnosing heart disease. Providers have stated that the preferred alternative treatment would be a (Computerised Tomography) CT scan. However the move to CT scan usage represents a capacity constraint and a potential loss of revenue, hence their objections to the proposal. If the change is implemented following consultation, this will be a national mandate and the providers will be required to comply. At that point, contracting will lead conversations with providers around the constraints and attempt to agree a system approach to resolve this issue. HW advised contracting will update at the next CPAG meeting on the outcome of the consultation. **Action:** • CLCC to be updated	AB LH HM
10.	**Individual Funding Request (IFR) – for information**	
CPAG /20/28	**10a Screening Feedback February** **Action:** Deferred to March's CPAG meeting **10b IFR training update** **Action:** Deferred to March's CPAG meeting **10c. IFR – update IFR policy to reflect additional information timescales** SD advised that the IFR policy has been updated in line with timelines discussed at the February CPAG meeting, specifically pages 14 – 15. CPAG approved amendments to IFR policy. **Action:** • Send updated IFR policy to EMACC • Send updated IFR policy to CLCC for ratification. Ratified policy to be uploaded onto the Clinical Policies webpage. **10d. Output from IFR February meeting re: Assurance business cases** SD and HM provided assurance that IFR cases are analysed to identify cohorts of patients which may require a business case. HM confirmed it is the responsibility of a clinician to submit a business case. CPAG noted the update. **Action:** Add to CLCC for assurance.	LH LH HM HM HM
11.	**East Midlands Affiliated Commissioning Committee (EMACC)**	
CPAG /20/29	**11a. Update on Gamete Storage Consultation** HM confirmed that the Gamete Storage policy is being consulted on. This is on the DDCCG website. The consultation period ends on 3rd March. Feedback will be reviewed by	

	EMACC and a final policy produced.	
12.	**CLCC updates**	
CPAG /20/30	CPAG noted the following papers that were submitted to February's CLCC meeting for ratification: - Scar Reduction Policy - Hyperhidrosis Policy - Intrauterine Insemination Policy - X-Ray and MRI of Back for Low back Pain Position Statement - Spinal Decompression, Spinal Fusion and Disc Replacement Position Statement - Cosmetics and Plastics Policies Assurance Review Summary - Prior Approval (PA)/ Electronic Referral System (ERS) Referral Template for PLCV Assurance - Elective Planned Caesarean Section PLCV Policy - Blueteq at Burton - CPAG Bulletin December 2019 - CPAG Minutes December 2019	
13.	**IPG updates since last meeting**	
CPAG /20/31	**13a. IPGs, MTGs, DGs and MIBs January** CPAG noted the NICE IPG, DTG and MTGs updated in January 2020 **13b. Updated IPG policy – update re: challenges** **Action:** Deferred to March's CPAG meeting	LH
14.	**Business Cases**	
CPAG /20/32	No update this month	
15.	**QIPP Pipeline**	
CPAG /20/33	No update this month	
16.	**Key messages for CLCC**	
CPAG /20/34	CPAG noted the key messages for CLCC	
17.	**For information**	
CPAG /20/35	**17a. IVF Policy minor updates:** CPAG noted that social objections to IVF have been removed from the IVF Policy. **Action:** Minor amendment to be forwarded to CLCC for ratification. Ratified policy to be uploaded onto the website and stakeholders to be informed. **17b. Removal of Benign Skin Lesions** **Action:** Deferred to March's CPAG meeting **17c. Website update – Cranial banding (aka Helmet therapy) for positional plagiocephaly** **Action:** Deferred to March's CPAG meeting	AB LH LH
18.	**Any other Business**	
CPAG /20/36	HM added that the Department of Health and Social Care are reviewing the current 10 year storage limit for eggs, sperm and embryos, to give more people the opportunity to start a family. This has gone out to consultation. The response deadline is 5th May 2020. CPAG discussed and agreed to respond to the consultation.	

	Action: Draft response and bring back to March's CPAG meeting	HM

Date of Next meetings

Thursday 19th March 2020 Room 2, Cardinal Square - 09.30 – 12.00
Thursday 16th April 2020 Room 2, Cardinal Square - 09.30 – 12.00
Thursday 21st May 2020 Room 2, Cardinal Square - 09.30 – 12.00
Thursday 18th June 2020 Room 2, Cardinal Square - 09.30 – 12.00
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