NHS
Derby and Derbyshire
Clinical Commissioning Group

Draft Minutes
Clinical Policy Advisory Group

Thursday 19th March 2020
Teleconference
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)
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)
Amanda Bradley	AB	Commissioning Support Manager (DDCCG)

Ref:	Item	Action
1	**Declaration of Interest**	
CPAG /20/37	BD 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.	
2	**Welcome, Introductions, Apologies, Quoracy**	
CPAG /20/38	Apologies were noted for 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) Parminder Jutla (Medicines Management and Clinical Policies Guidelines, Formulary and Policy Manager, DDCCG), Slakahan Dhadli (Assistant Director of Medicines Management and Clinical Policies, DDCCG), Ruth Gooch (GP Clinical Lead, DDCCG), Robyn Dewis (Acting Director of Public Health, Derby City Council), Niki Bridge (Deputy Chief Finance Officer, DDCCG) 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 The meeting was conducted by teleconference. Dr Buk Dhadda (GP Clinical Lead/Governing Body Member) acted as interim chair for the first part of the meeting.	
3	**Minutes and Key Messages from the last meeting**	
CPAG /20/39	March minutes agreed as accurate, pending the following amendments: • Page 3 – Reallocation of action to investigate lack of Derby and Derbyshire IUI service provider from HW/Contracting Team to the Clinical Policies team	

	• Page 4, 7c Hydroxychloroquine – TG asked CPAG members to review this section of the minutes for accuracy. **Action:** • Circulate Hydroxychloroquine paragraph to CPAG members for review • Send minutes to CLCC for ratification • Upload ratified minutes to website	 AB HB AB
4	**Matters Arising/Summary**	
CPAG /20/40	**4a. Injections for non-specific back pain policy – activity data** HM advised that at the February CPAG meeting activity data was requested for spinal injections and fusions before the removal of prior approval could be agreed. CPAG was assured that if prior approval was removed, activity can be monitored through the monthly tracker. BD asked as the policy is a "do not commission policy" why is there activity being reported. HW commented that the coding will not be specific enough for the granularity required to identify the criteria. CPAG agreed to remove prior approval and review activity levels in twelve months. **Actions:** • Remove Prior Approval • Send to CLCC for information • CPAG to assess activity in 12 months **4b. Review of PLCV Policies Requiring Prior Approval: Ophthalmology & Orthopaedics** HM reported that the criteria for PLCV policies requiring prior approval for Ophthalmology and Orthopaedics are aligned to the prior approval forms. CPAG noted the review. **4c. Hydroxychloroquine Stakeholder Update** TG updated the group on the progress made on Hydroxychloroquine related actions from the February CPAG meeting. TG confirmed that the Derby and Derbyshire Joint Area Prescribing Committee (JAPC) have reviewed whether clinicians feel that the therapy is still current practice and is required for patients considering the risks associated with the drug. The clinicians unanimously agreed that Hydroxychloroquine is an effective drug and a required therapy within current treatment pathways. As a result, JAPC approved the drafted interim position statement, which has now been uploaded onto the DDCCG website. **4d. Microsuction of Earwax** HM reported that at the February CPAG meeting the group considered the removal of prior approval for the microsuction of earwax. Work has been completed to align the DDCCG policy to the Service Specification, NICE guidance and Clinical Knowledge Summaries (CKS). BD confirmed that on the whole the DDCCG policy is in alignment with the Service Specification, NICE guidance and TKS. SH joined the meeting and clarified that the Service Specification has not yet been implemented. BD advised that the policy serves as guidance on the microsuction of earwax for GP practices. The group agreed to keep the policy on the website as guidance until the Clinical Pathway (CPATH) Group is set up. NB At this point, BD passed on chairing the meeting to SH.	 PJ/HM AB HM

	SH advised that due to the current Covid-19 situation it is important to prioritise the agenda to ensure that all critical agenda items are discussed. TG listed the agenda items that are regarded as being essential. CPAG agreed that any items not discussed on the teleconference can be agreed virtually through email. **4e. Future of CPAG Meetings during the Covid-19 Pandemic** SH advised that DDCCG is currently at business continuity escalation level two, which signifies that the CCG is starting to show signs of pressure. Chris Clayton (Chief Executive Officer, DDCCG) has advised that DDCCG will move to level 3, major pressures experienced in the CCG, shortly. Therefore some of the CCG's usual business will require prioritisation. SH questioned how level 3 of the CCG's business continuity escalation plan would affect CPAG and how CPAG should plan for this transition. TG advised that as of today all CPAG meetings will be conducted virtually. CPAG agreed to meet every three months going forwards using telephone conferencing and/or virtual meetings. Urgent items can be agreed virtually and an interim CPAG Terms of Reference (ToR) will be put into place to reflect reduced core membership for CPAG quoracy. Agendas are to be prioritised to ensure critical items are presented and discussed at CPAG meetings. **Actions:** • Inform CLCC of the agreed updated interim arrangements for future CPAG meetings • Draft interim ToR and circulate to CPAG members for virtual approval • Submit updated and approved ToR to CLCC for ratification • Investigate Microsoft Teams as a virtual meeting tool **4f. Individual Funding Request Process – Interim Arrangements due to withdrawal of Public Health Resource** HM advised that Public Health input into Individual Funding Requests (IFR's) has been withdrawn due to the current Covid-19 pandemic. Interim measures are required to ensure that the IFR process is still able to function in accordance with the timescales set out in the IFR Policy without Public Health input. It is anticipated that there will be fewer IFR requests due to the reduction in GP consultations. Currently we have four cases awaiting screening due to the lack of Public Health availability. One review panel is due to convene within 20 days which requires Public Health representation. HM advised that IFR Managers are fully trained and competent to triage IFR's, as this was previously undertaken by the IFR Manager, along with a Public Health Representative. In addition to the IFR Manager there are four senior members of the DDCCG Medicines Management team who are fully trained in IFR processing. BD raised concerns that this is a legal process and due process needs to be followed. Having no clinical representation could open the CCG to legal challenge. SH and HM provided assurance that interim representatives do not need to be clinicians as per IFR ToR. Instead the individuals only need to possess the skill set for processing IFRs. SH commented that a staged approach needs to be considered should either the Medicines Management representatives or the IFR Manager be unavailable due to sick leave. This may involve requesting a clinician to replace Public Health representatives as a backup plan. SH suggested buddying up with Nottingham University Hospital Foundation Trust (NUHFT) to support the IFR process, if required, as part of the business continuity plan. HM reported that she had liaised with the Nottingham IFR team to share ideas. Nottingham	AB HM HM HB

	Public Health Representatives are continuing IFR processing duties. SH advised contacting Ian Gibbard (Lay Member and Chair of the IFR panel, DDCCG) for his views. CPAG agreed that the "IFR Manager" can replace the "Public Health representative" and will take on the responsibility of screening cases together with a Medicines Management representative. The "Public Health representative" will be replaced by a "Medicines Management" professional for both the IFR and Review Panel. All panels will take place virtually, which is reflected in the ToR. **Actions:** • Consult Ian Gibbard on his views of IFR panel continuity planning • Approach NUHFT to buddy up for business continuity IFR processing plan • Send IFR process update and updated ToR to CLCC for ratification • Speak to the England National Prescribing Group to share IFR processing management protocols • Confirm with Corporate the input legally required when processing IFR's	HM HM AB SH HM
5.	**Workplan/Action Tracker**	
CPAG /20/41	CPAG noted the progress on the action tracker.	
6.	**Bulletin**	
CPAG /20/42	CPAG approved the bulletin. **Action:** • Updated bulletin to be presented to CLCC for ratification. • Ratified bulletin to be uploaded onto the website and circulated to GP practices via the CCG's Membership Bulletin.	 AB AB
7.	**Clinical Policies Reviewed**	
CPAG /20/43	**7a. Tonsillectomy** TG advised that a literature review has taken place and there are no significant changes to the evidence base since the policy was last reviewed. The policy has been reworded and reformatted to reflect the new CCG organisation. Background information and rationale for recommendations have been added to the policy. The criteria have been clarified further for adults and children. It was identified that criteria A are all indications for emergency hospital admissions. Usually criteria for emergency hospital admissions are not included in clinical policies. CPAG approved the updated policy and the removal of criteria A from the policy, the Prior Approval PLCV Referral form and the Blueteq form. **Action:** • Update PLCV Prior Approval form and Blueteq form. • Send updated policy to CLCC for ratification. • Ratified policy to be uploaded onto the clinical policies website. **7b. Breast Augmentation Cosmetic Policy review** TG reported that the policy has been discussed with consultees in the Derby and Derbyshire area. The policy has been reformatted to reflect the new organisation and has been updated to include the addition of background information, rationale for recommendations and useful resources. The policy has been renamed to better reflect the procedure it covers. Dr Tim Daniel (Consultant in Public Health Medicine Leicestershire County Council & East Leicestershire and Rutland CCG) was involved in the original East Midlands Policy for Cosmetic Procedures and confirmed that the criterion was added following one IFR request that was approved. TG continued that Poland Syndrome is a	 AB AB AB

	rare disorder which would be eligible for IFR screening. When reviewing the literature, no new evidence has been published since the Policy was last reviewed in September 2018. There is limited evidence to suggest which augmentation technique is most cost effective and delivers the best outcome for any individual patient. University Hospital of Derby and Burton Foundation Trust (UHDBFT) have advised that they follow the policy. Chesterfield Royal Hospital Foundation Trust (CRHFT) have provided no response to the request for feedback/comment. Therefore the assumption has been made that CRHFT agree with the policy. CPAG approved the updated policy and asked that Poland Syndrome continued to be an exclusion to avoid potential administration burden. HW raised an issue with the meeting's call quality. It was agreed that the policies would be circulated via email for virtual approval post CPAG meeting to ensure that all attendees agree and are clear on actions. **Action:** • Circulate updated policy to CPAG members for virtual approval. • Submission of approved policy to CLCC for ratification **7c. Mastopexy (Breast Uplift)** TG advised that the policy has been discussed with consultees' at UHDBFT. The policy has been reformatted to reflect the new organisation. The updated policy includes the addition of background information, rationale for recommendations, useful resources and the addition of the "getting it right first time" link for further information. UHDBFT have advised that they follow the policy. CRHFT have provided no response to the CCG's request for feedback/comments. Therefore the assumption has been made that they agree with the policy. CPAG approved the updates to the policy. **Action:** Send policy to CLCC for ratification. **7d. Breast Prosthesis Removal** TG stated that the policy has been discussed with consultees at UHDBFT. The policy has been reworded and reformatted to reflect the new organisation. The updated policy includes the addition of background information, rationale for recommendations and useful resources. UHDBFT have advised that they follow the policy. CRHFT have provided no response and therefore the assumption has been made that they agree with the policy. CPAG approved the updates to the policy. **Action:** Send policy to CLCC for ratification. **7e Breast Asymmetry** TG explained the policy has been discussed with specialists at UHDBFT. The policy has been re-worded and reformatted to reflect the new organisation. The updated policy includes the addition of background information, rationale for recommendations and useful resources. When reviewing the evidence there was no new significant evidence to support/challenge the policy's restrictive criteria as the procedure is cosmetic. There is limited evidence to suggest which asymmetry technique is most cost effective and delivers the best outcome for any individual patient. UHDBFT have advised that they follow the policy. CRHFT have provided no response and therefore the assumption has been made that they are in agreement with the policy. TG advised that there is an issue with one of the criteria, 'Confirmed non-smoker and/or	AB AB AB AB

	documented abstinence for at least 6 months prior to procedure'. The criterion is only listed within two of the seven breast policies. A literature search has been completed and the evidence base has been reviewed. There was no robust evidence to support the restriction and no definitive data to support when to quit, or how long to refrain from smoking to base a recommendation on. HW left the meeting. SH questioned whether there should be smoking criteria given that it is not equally flagged in other clinical policies. BD advised that the criteria should either be included across all surgical procedures or not included in any. CPAG approved the updates to the policy and the removal of the smoking criteria. **Action:** Send updated policy to CLCC for ratification. **7f. Spinal Cord Stimulation Position Statement** HM advised we discussed the removal of Prior Approval at the last CPAG meeting. A position statement has been produced for the approval of CPAG. CPAG approved the position statement. **Action:** Send the position statement to CLCC for ratification. **7g. Vaginal Pessaries Position Statement** HM explained that following the last CPAG meeting the wording on the Vaginal Pessaries Position Statement had been amended as per the group's comments. CPAG approved the position statement. **Action:** Send position statement to CLCC for ratification. **7h. Hip & Knee Revision** HM stated the purpose of the paper is to review the requirement of prior approval in secondary care hip and knee revision. The review of this policy was part of the original DW42 project. Whilst there is a criterion which needs to be met prior to referral to a secondary care provider there is no requirement for prior approval in Primary Care as patients should be referred to the Musculoskeletal Clinical Assessment and Treatment Service (MSK-CATS), which provides the assurance that patients meet the initial criteria, prior to onward referral. HM continued that currently there is an 'ask' for secondary care providers to also complete prior approval via Blueteq, which is a duplication of work since patients should have already been assessed by MSK-CATS. The policy also states that "Prostheses for total hip replacement and resurfacing arthroplasty are recommended as treatment options for people with end stage arthritis of the hip only if the prostheses have rates (or projected rates) of revision of 5% or less at 10 years". Whist this is not reflected on the Blueteq form it is recommended in accordance with NICE Technology Appraisal Guidance 304. BD suggested the inclusion of a caveat which states all referrals that come via MSK CATS do not require prior approval. CPAG are assured that if the referral comes via MSK-CATS prior approval is not required as the service has its separate assurance process to ensure it meets the criteria of DDCCG policies. All referrals from other routes must come through the Prior Approval process. HM confirmed Bernadette O'Donnell (Commissioning Manager	AB AB AB

	– Planned Care, DDCCG) has been consulted and MSK-CATS are in agreement with the proposed changes. CPAG agreed to move the policy to the non-commissioned section of the clinical policies website and to amend the policy to make it clear that prior approval is required. **Action:** • Request confirmation that MSK-CAT's accept policy changes • Review if this can be operationalised. Prior approval should remain until this is reviewed • Move policy to the not commissioned section • Bring activity data back to next meeting **7i. Imaging in Management of Morton's Neuroma (Diagnostic)** HM asked CPAG to consider the removal of Imaging in Management of Morton's Neuroma from PLCV and to replace it with a position statement. This policy was included as a PLCV as it had been identified by the radiologists at UHDBFT as a diagnostic procedure which was being requested by GPs. However the procedure does not alter the clinical management of the condition. Prior approval is not requested and activity is not monitored or challenged as no coding is available for this procedure. The policy states that "referral to MSK–CATS should be undertaken in cases where patient's symptoms are refractory to conservative measures". However MSK-CATS have expressed that these requests should be directed to Podiatry. Therefore CPAG is not assured that the policy provides any added value as a PLCV and should be moved to the non-commissioned section of the website. CPAG have also agreed for the policy to be replaced with a position statement CPAG will virtually agree a position statement. **Action:** • Position statement to be drafted and circulated to CPAG members for virtual approval. • Approved position statement to be submitted to CLCC for ratification. **7j. Use of Imaging in the Management of Trochanteric Bursitis/Greater Trochanteric Pain Syndrome (GTPS) (Diagnostic)** HM stated that this policy was included in as a PLCV as it had been identified by the radiologists as a diagnostic procedure that is being requested by GPs. However, the procedure does not alter the clinical management of the condition. There is currently no requirement for prior approval as the activity cannot be monitored due to a lack of coding granularity. The referral process has been raised with MSK-CATS who have confirmed that "those patients who are not responding to conservative measures should be referred to MSK-CATS for further management". CPAG agree that the policy does not provide any added value as a PLCV and therefore the procedure should be moved to the non-commissioned section of the clinical policies website. CPAG also agree that the policy should be replaced with a position statement. CPAG commented the presented paper is a guideline and not a policy.	HM HM HM HM AB AB

	CPAG agreed to virtually agree a position statement. **Action:** • Position statement to be drafted and circulated to CPAG members for virtual approval. • Approved position statement to be submitted to CLCC for ratification.	 AB AB
8.	**Governance Policies**	
CPAG /20/44	**8a. Benign Skin Lesions – Joint Memo** CPAG approved the Joint Memo following the removal of "and reject" from the second paragraph. **Actions:** • Inform Dermatology • Upload to website • Circulate Memo **8b. Fitness for Surgery** Deferred to June meeting when Public Health representatives present	 HM HB HM
9.	**Contracting and Blueteq queries**	
CPAG /20/45	**9a. Update on contracting 2020/2021 work and PLCV financial values queried/recovered** Deferred to June meeting **9b. Update on Exercise ECG for Heart Disease Testing for 20/21 - consultation** Deferred to June meeting	
10.	**Individual Funding Request (IFR) – for information**	
CPAG /20/46	**10a Screening Feedback February/March** CPAG noted the screening information **10b IFR training update** HM updated that due to the Covid-19 outbreak the IFR training on the 30th May is cancelled. Attendees will be contacted with a new date in due course.	
11.	**East Midlands Affiliated Commissioning Committee (EMACC)**	
CPAG /20/47	**11a. Update on Gamete Storage Consultation** HM advised that there have been no further updates. The consultation period has finished. EMACC have not yet confirmed any changes to the policy. CPAG are assured that the DDCCG Gamete Storage Policy is up to date. **Actions:** Contact Andy Roylance (Planned Care Manager, inc. East Midlands Affiliated Commissioning Committee, Greater Nottingham Clinical Commissioning Partnership) for update at June CPAG meeting.	 HM
12.	**CLCC updates**	
CPAG /20/48	**12a. CPAG noted the following papers that were submitted to March's CLCC meeting:** <u>Clinical Policies Ratified</u> - Epidurals for Acute and Severe Sciatica (Lumbar Radiculopathy)	

	- Injections for Non-specific Low Back Pain with Sciatica including Spinal Fusion for Low Back Pain Policy (minor update) - Arthroscopic Knee washout for patients with Osteoarthritis Policy (minor update) - (InVitro Fertilisation (IVF) Intracytoplasmic Sperm Injection (ICSI) within Tertiary Infertility Services Policy (minor update) - Intrauterine Insemination Policy (minor update) <u>Governance Policy Ratified</u> - Individual Funding Request Policy (minor update) - Removal of Gastroscopy Policy and Prior Approval from PLCV - Clinical Policy Specification <u>Other Items for Ratification</u> - CPAG January bulletin - CPAG January meeting minutes <u>Papers for CLCC Aussurance/Information</u> - IFR Assurance for Business Cases - Update on Proposed New Evidence Based Interventions CLCC noted that the previously used simplified coversheet format was helpful. CPAG agreed to keep this format for future CLCC submissions.	
13.	**IPG updates since last meeting**	
CPAG /20/49	**13a. IPGs, MTGs, DGs and MIBs February** CPAG noted the NICE IPG, DTG and MTGs updated in February 2020 **Action:** Send MTG and MIB updates to finance, planned care and contracting **13b. Updated IPG Policy – update regarding challenges** TG advised that following CPAGs decision not to challenge any standard IPG's a position statement has been sent out to providers detailing the DDCCG's commissioning intentions. The policy has been updated. CPAG noted the update. **Action:** Send to CLCC as a minor update	HM AB
14.	**Business Cases**	
CPAG /20/50	No update this month	
15.	**QIPP Pipeline**	
CPAG /20/51	No update this month	
16.	**Key messages for CLCC**	
CPAG /20/52	CPAG noted the key messages for CLCC: Amended Terms of reference (CPAG, IFR), Updated IFR policy Updated polices - as listed above Updated position statements - as listed above Department of Health and Social Care Review of Gamete Storage Response – as listed below	AB/ HM
17.	**For information**	
CPAG /20/53	**17a. X-Ray and MRI of Back for Low Back Pain Position Statement – MSK CAT assurance** TG provided assurance that the X-Ray and MRI of Back for Low Back Pain Position	

	Statement has been communicated to MSK-CATS. Parminder Jutla (Medicines Management and Clinical Policies Guidelines, Formulary and Policy Manager, DDCCG), has confirmed MSK-CATS are in agreement with the statement. **17b. Spinal Decompression, Spinal Fusion and Disc Replacement Position statement** HM provided assurance that the position statement has been re-named as the Spinal Decompression Position statement. The Spinal Fusion and Disc Replacement procedures have been added to the 'Not routinely commissioned procedures' table on the website. **17c. Removal of Benign Skin Lesions** TG updated that Haematomas are not covered in the Removal of Benign Skin Lesions Policy due the condition not being covered within the NHS England's Evidence Based Intervention guidance. Therefore the DDCCG policy remains unchanged. **17d. Website Update – Cranial Banding (Aka Helmet Therapy) for Positional Plagiocephaly** TG stated that Helmet Therapy has been included in the description of cranial banding for positional plagiocephaly on the clinical policies website as per the 20/21 NHS contract updated wording. **17e. Department of Health and Social Care Review of Gamete Storage Response** SH queried the deadline for the gamete storage consultation. TG confirmed 5th May 2020. TG continued that The Department of Health and Social Care are reviewing the time limits on gamete storage. The current storage limit is ten years. The aim of the review is to give more people the opportunity to start a family. TG presented the background, indications and options. CPAG agreed to support option 2. The group discussed making specific reference to health gain to the population. In the current financial situation where we must prioritise opportunities such as this with many other competing priorities. This is consistent with the approach to that of other developments. **Action:** CPAG to respond to consultation with rationale **17f. Cosmetic Procedures referral pathway** The group accepted the Clinical Assessment Service (CAS) Referral Process document for inclusion on the website. CE advised the need to consult Tina Pottrell (NHS e-Referral Service Manager) regarding the CAS appearing after services closest to the patient's postcode on the electronic referral system (ERS). **Action:** Upload Clinical Assessment Service Referral Process document to website	HM HB
18.	**Any other Business**	
	No other business identified	

Date of Next meetings
Thursday 18th June 2020 Teleconference/Virtual Meeting
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