Clinical Policy Advisory Group (CPAG)

MINUTES OF THE CLINICAL POLICY ADVISORY GROUP (CPAG) MEETING HELD ON THURSDAY 2ND MARCH 2023 AT 9:30AM VIA MICROSOFT TEAMS

CONFIRMED MINUTES

Present:		
Derby and Derbyshire ICB (DDICB)		
Steve Hulme	SH	Director of Medicines Management & Clinical Policies (Chair)
Lana Davidson	LD	Head of Contracts (Acute)
Dr Buk Dhadda	BD	GP
Slakahan Dhadli	SD	Assistant Director of Medicines Management and Clinical Policies
Tom Goodwin	TG	Head of Medicines Management and Clinical Policies and Decisions
Helen Moss	HM	Individual Decisions & Project Manager
Dr Andy Mott	AM	GP & Prescribing Lead
Craig West	CW	Acting Associate Chief Finance Officer
Derby City Council		
Derbyshire County Council		
Thom Dunn	TD	Assistant Director of Public Health
Chesterfield Royal Hospital NHS Foundation Trust (CRHFT)		
Hannah Doody	HD	Trust Policy Lead
In Attendance:		
Lara McKean	LM	Senior Pharmacy Technician (DDICB)
Sean Thornton	ST	Deputy Director Communications and Engagement (DDICB)
Karielle Webster	KW	Public Health Registrar (Derby City Council)
Kate Rogers	KR	Individual Decisions and Projects Officer (DDICB) (Minutes)
Apologies:		
Dr Ruth Gooch	RG	GP (DDICB)
Parminder Jutla	PJ	Medicines Management and Clinical Policy Guidelines, Formulary and Policy Manager (DDICB)
Ben Milton	BM	Medical Director (Derby & Derbyshire Local Medical Committee (DDLMC))

Ref:	Item	Action
1	**Welcome, Introductions and Apologies**	
	Apologies were noted from Dr Ruth Gooch, GP (DDICB), Parminder Jutla, Medicines Management and Clinical Policy Guidelines, Formulary and Policy Manager (DDICB), Ben Milton, Medical Director (DDLMC). • ST left the meeting at 9.56am, following discussion of agenda item 'Patient and Public Involvement' which was brought forward to be tabled at the start of the meeting. • BD left the meeting at 10.57am <u>Confirmation of Quoracy</u> CPAG was quorate under the Terms of Reference.	

	SH informed the committee that this will be Dr Andy Mott's last CPAG meeting, as he will be stepping down from his prescribing lead role to take on a new substantive role for the GP Provider Board (GPPB). Andy was thanked by the Chair on behalf of CPAG and the Clinical Policies team, for his hard work and contributions. Ben Milton from Derby and Derbyshire Local Medical Committee (DDLMC) will be welcomed to future CPAG meetings. He will represent DDLMC and also the GP Provider Board. SH confirmed that in time, there will be new representation at CPAG for the GP Prescribing Lead role.	
2	**Declarations of Interest**	
	SH reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the ICB. Declarations declared by members of the Clinical Policy Advisory Group (CPAG) are listed in the ICB's Register of Interests and included with the meeting papers. The Register is also available either via the Executive Assistant to the Board or the ICB website. <u>Declarations of interest for today's meeting</u> No declarations of interest were made.	
3	**Minutes and Key Messages from the Last Meeting**	
	SH confirmed that no minutes were available for the previous meeting, as papers were circulated and agreed by email, with the CPAG Bulletin replacing the formal minutes. The next CPAG MS Teams meeting is due to be held in May 2023, with papers circulated for agreement by email in April 2023.	
4	**Matters Arising/Summary**	
CPAG 23/20	**<u>4a. Benign Skin Lesions</u>** HM advised that the purpose of the paper is to inform CPAG of the issue raised by Joined Up Care Derbyshire (JUCD) Urology Expert Advisory Forum (EAF) regarding the Removal of Benign Skin Lesions Policy and genital lesions. The JUCD Urology Expert Advisory Forum, ask that genital lesions be considered separately from other skin lesions. Whilst the EAF acknowledge that some genital lesions may be cosmetic, they can significantly affect sexual function and it is felt that they should either be exempt or specifically considered within the policy. As the policy is not due for renewal until 2025 the EAF have asked if an understanding can be reached whereby, they can continue to remove lesions from the genital area if they affect sexual function. The Academy of Medical Royal Colleges (AOMRC) have been contacted to request clarification on whether the removal of genital benign skin lesions is exempt from the restrictive criteria, on the basis that genital lesions can significantly affect sexual function. There has been no response to date. Public Health have advised that they feel the policy covers genital warts/molluscum where criteria within the policy is met. Where criteria within the policy is not met, the	

	other possibility would be psychological impact, however, cosmetic treatments are not commissioned for that indication. CPAG agreed the proposed actions. **Actions:** • Planned Care, Contracting and Quality Teams to be kept up to date with issue raised. Colleagues were emailed on 10/01/2023 informing them of the issue raised with a request for them to input into the CPAG coversheet where appropriate. • Clinical Policies website to be updated to include a statement clarifying that the removal of benign skin lesions will not be commissioned on the grounds of psychological impact • Add to CPAG Bulletin • Clinician stakeholders to be informed of CPAG's decision	HM KR KR HM/KR
CPAG 23/21	**4b. Tonsillitis in Children** TG presented the paper Diagnosis and Management of Tonsillitis in Children aged 3-15 years. CPAG had been requested to review by the Clinical and Professional Leadership Group (CPLG) following the review by the Joined Up Care Derbyshire (JUCD) Children's Urgent Care Group. A change is proposed to the clinical assessment tool, to include symptom onset ≤3 days in the JUCD guideline for Diagnosis and Management of Tonsillitis in Children aged 3-15 years. The DDICB Tonsillectomy and Adenoidectomy Policy is due for review in May 2023, the policy is aligned with Evidence Based Interventions (EBI). CPAG acknowledged the guideline and that the impact on local policy is currently unaffected by it. CPAG will consider the assessment tool during the next routine review. CPAG noted that CPLG have been informed of this. It was recommended that the JUCD guideline goes through CPLG for completeness. **Actions:** • Add to CPAG Bulletin • Stakeholders to be informed of any updates • JUCD guideline for Diagnosis and Management of Tonsillitis in Children aged 3-15 years to go through CPLG • Inform the Derbyshire Joint Area Prescribing Committee (JAPC), for review where appropriate	KR HM HM HM
CPAG 23/22	**4c. IVF Policy**	

	HM advised that the purpose of the paper is for CPAG to note and approve a minor amendment to the wording of the recommendation section in the IVF Policy, to provide clarification that funding is available for heterosexual couples. South Yorkshire ICB have requested clarification that the Derbyshire policy appeared on reading to only offer IVF to same sex couples, single women, and people with a physical disability with proven infertility. Although the IVF policy infers that treatment is available for heterosexual couples and is referred to in the background section, the current wording of the recommendation section could be misinterpreted as excluding heterosexual couples from treatment for IVF. Following this request for clarification, the recommendation section within the IVF policy has been reworded. Heterosexual couples have been added as one of the groups that IVF will be funded for if they meet the criteria. CPAG approved the rewording of the recommendation section, to provide clarity that IVF is available to heterosexual couples. **Actions:** • Add updated policy to Clinical Policies website • Add to CPAG Bulletin • Inform stakeholders	 KR KR HM
CPAG 23/23	**4d. Glossop Update** HM advised that the purpose of the paper is to update CPAG on the Glossop transition process to date. Following the Secretary of State's announcement in July 2021, the boundary of the Derbyshire Integrated Care System (ICS) has been amended to incorporate the area of Glossop. Nothing is expected to change, until a transaction date of 1st July 2023, when Glossop patients will be treated as Derby & Derbyshire patients. Individual Funding Requests are to be assessed against DDICB policies for Glossop patients with the exception of host policies where DDICB have no contractual levers. The Clinical Policies and Decisions (CPD) team are asked by the Director of Corporate Delivery to provide assurance of the governance process for clinical policies to date. HM presented the following principles, that have previously been agreed by CPAG/Population Health and Strategic Commissioning Committee (PHSCC): • Legal Advice – a previous exercise identified that the majority of policies are aligned to EBI which would not cause a major impact. The two areas that were identified as potentially contentious are Gluten Free (for Derbyshire	

Joint Area Prescribing Committee (JAPC) consideration) and IVF due to differences in commissioning arrangements.

- Public Health – advised on equitable decision making, if DDICB do not have a contract with the provider, patients are entitled to access treatment against the lead commissioner's policy.
- Contracting – Out of Area requests for treatment where DDICB is not the host commissioner will continue to fall within the lead commissioner contracting arrangements. When Glossop patients become part of Derbyshire, their direction of referral for acute services will not change and they will therefore remain subject to the policies of the lead commissioner of any trust they attend, even though they will be Derbyshire patients.
- Strategy and Planning – there will be no changes to services e.g. contracts without due process and appropriate governance.
- Glossop Meetings – four workstreams were set up to support the overarching Transition Steering Group. An internal review (led by contracting) identified 200+ service lines specific to Glossop where there may be a variation, this output is pending. Following the review, a communication and engagement plan for Glossop service integration is to be agreed, including the scope of public input required and timelines.

CPAG noted and agreed the following:

- Transaction date of 1st July 2023 (expected) when Glossop patients will be treated as Derby & Derbyshire patients, with the caveat that the 12 months from the 1st July 2022 should only be seen as a minimum date, given the amount of work required for any consultation and the number of policies.
- CPAG to agree any significant and substantial policies, i.e. not aligned to EBI, NICE which sit outside of the host commissioner arrangement and are clinically different and may have a major impact/risk i.e. IVF.
- When Clinical policies come up for review the CPD team will consider the impact for Glossop patients, where appropriate. This will include contractual mechanisms, risk, EBI and NICE guidance and Public Health principles. IVF to be excluded from this process, due to differing commissioning arrangements. Gluten Free policy noted to sit with the Joint Area Prescribing Committee (JAPC).
- CPAG have agreed to follow the ICB position on the Glossop transfer and adhere to the ICB corporate plan on integration, including following agreed principles, timeframe, scope, any legal considerations, and content of the engagement plan for due diligence to be observed.
- The CPD team have asked corporate to provide clarity on strategy containing a Communications and Engagement plan for Glossop Service Integration, which agrees the scope of public input required and outlines timelines, for example a stepwise approach to implementation.

Clarification was requested around contracting arrangements for Glossop patients. A discussion took place, and it was confirmed that this has not yet been agreed.

CPAG noted the Glossop transition process to date.

CPAG agreed that this was a useful summary and asked that this paper go to the Glossop Working Group to discuss CPAG's role and position in this.

	Actions: • Send a copy of 'Glossop transition process to date' paper to the Glossop Working Group	HM
CPAG 23/24	**4e. Ethical Framework** HM advised that the purpose of the paper is for CPAG to note the adapted Ethical Framework policy document to include the Seven Principles of Public Life 'Nolan principles' for its decision making. Mandatory Individual Funding Request (IFR) training identified that the ICB have an Ethical Framework to underpin all ICB decision making made at a population level which would include IFR requests. A document produced by the CPD team, approved by CPAG in October 2022 was sent to the November 2022 PHSCC meeting for information. The framework, which was discussed at Senior Leadership Team (SLT) in November was not fully supported and SLT asked that the framework be consulted on a wider basis within the ICB for it to be a corporate approach. Following actions agreed at a meeting in December 2022 between members of the CPD team, the Assistant Director of Communications and Engagement and the Head of Governance, the policy has been adapted by corporate to include the Nolan principles. The framework will be taken to the Audit and Governance Committee on 23rd March 2023 for ICB approval and adoption. SH asked that the CPD team consider how the Ethical Framework will interlink with the Patient and Public involvement QEIA's/PPI assessments. CPAG noted the addition of the Nolan Principles for non-clinical decision making in the Ethical Framework. **Actions:** • To be tabled at PHSCC for information • Update the CPAG Terms of Reference and Stakeholder map • Add to CPAG Bulletin	 HM HM KR
5	**Work Plan/Action Tracker**	
CPAG 23/25	**5a. CPAG Action Tracker** CPAG noted the Action Tracker. **5ai. CPAG Workplan** CPAG noted the progress to date and items pending review on the workplan.	

6	**Bulletin**	
CPAG 23/26	The February 2023 Bulletin was noted and approved by CPAG. **Actions:** • Approved Bulletin to be tabled at PHSCC for information • Bulletin to be uploaded to Clinical Policies website • Bulletin to be circulated to main providers and to Primary Care (via Membership Bulletin)	 HM KR KR
7	**Clinical Policies Reviewed**	
CPAG 23/27	**<u>7a. Epidurals for all forms of Sciatica (Lumbar Radiculopathy) Position Statement</u>** TG presented the epidurals for all forms of sciatica paper to CPAG members. The position statement is due for routine review and has received extensive clinician/stakeholder/national engagement. NICE Clinical Guideline [CG59] states 'consider epidural injections of local anaesthetic and steroid in people with acute and severe sciatica'. NICE have clarified that the word 'consider' when used in recommendations is based on there being limited evidence supporting the recommendation. The position statement is based on NICE NG59 Low Back Pain and Sciatica in over 16s: assessment and management (published November 2016 and updated December 2020). There has been no publication of substantial robust evidence since the position statement was last reviewed in February 2020. The position statement has been re-worded to reflect the new ICB organisation. In response to the volume of queries received, a short life working group (SLWG) involving the CPD team and Public Health met to discuss the issues raised by the clinician stakeholders. Comments were received from a Consultant in Anaesthesia and Pain, Medicine Clinical Director at Chesterfield Royal Hospital NHS Foundation Trust (CRHFT), a Consultant Trauma, Orthopaedic and Spine Surgeon, and a Consultant Spinal and Orthopaedic Surgeon at University Hospitals of Derby and Burton NHS Foundation Trust (UHDBFT), who did not agree with the current stance. DDICB commissioning stance is evidence-based and aligned to NICE NG59. NICE have been contacted to enquire when the next review of NG59 will take place, NICE were unable to provide a review date for this. Stakeholder feedback followed by the position statement rational/SLWG actions are included below: • Epidural in this context includes intralaminar epidural and "nerve root injection" more properly called transforaminal epidural injection. ○ The position statement includes epidurals by any route. Nerve root injections, interlaminar and transforaminal terminology are already reflected in the position statement. • The position statement is not equally applied and enforced across providers. ○ This issue has been raised with the Senior Clinical Quality Manager (DDICB), as well as colleagues in Planned Care and Contracting as this issue falls outside of CPAG's remit.	

- Orthopaedic surgeons seek virtual advice on patients being admitted to CRHFT along the cauda equina/acute or chronic spinal pathway.
  - Cauda equina syndrome is a medical emergency and therefore is an indication that is excluded from this position statement. This is in line with NICE NG59.
  - DDICB Clinical Policies website has been updated with a new 'Medical Emergencies and Red Flags' section, advising that conditions that are medical emergencies and red flags are excluded from all DDICB clinical policies and position statements. Clinicians will be informed of the statement during feedback.
- Suggestion for commissioners to allow a block contract.
  - The position statement is in line with NICE NG59 recommendations based on the interpretation of the term 'consider' as being used in recommendations that are supported by limited evidence. The position statement is evidence-based.
  - Given the above, a block contract would not be appropriate. The Head of Provider Management in Acute Contracts (DDICB) was consulted, who confirmed that Contracting would not support the request. To adopt a block contract would require a change in the current commissioning stance, which is unlikely to happen given that there has not been significant new evidence since the position statement was last reviewed.
- Feedback that Neuro and Orthopaedic Spinal Surgeons cannot understand the position statement and feel that these are necessary management techniques.
  - The position statement's rationale behind CPAG's interpretation of NICE's use of the word 'consider' has been linked to DDICB Clinical Policies webpage section on NICE Guidance, which expands on the use of the word 'consider' by NICE recommendations.
- Transforaminal epidurals and the other listed injections are used to treat patients who have failed other conservative options and for whom surgery is not an option or may not be their preferred first treatment choice. Although there is no high-quality evidence to support their widespread use there is good evidence to support their use in specific situations e.g. severe radicular pain due to disc prolapse.
- Transforaminal epidural injections done properly with contrast are essential to the management of lumbar radiculopathy. Some patients have significant pain but cannot have decompressive procedures for several reasons.
  - The position statement is evidence-based and is aligned to NICE NG59. Publication of substantial robust evidence is required in order for the commissioning stance to be revised. There has been no significant publication of evidence since the position statement was last reviewed in February 2020.
  - CPD team contacted NICE to confirm whether there is a growing long term evidence base that would suggest that the use of epidurals could replace surgery. NICE responded to say they are unable to advise on this, as it is not something that they have looked at within the guideline.

As part of the engagement, the CPD team contacted clinician stakeholders, requesting evidence base to support the use of epidurals for all forms of sciatica. The following was provided:

- Surgical microdiscectomy versus transforaminal epidural steroid injection in patients with sciatica secondary to herniated lumbar disc (NERVES): a phase 3, multicentre, open-label, randomised controlled trial and economic evaluation. *By Martin John Wilby, Ashley Best, Eifiona Wood, Girvan*

	Burnside, Emma Bedson, Hannah Short, Dianne Wheatley, Daniel Hill-McManus, Manohar Sharma,et.al. Published Online March 18, 2021. Lancet Rheumatology 2021; 3: e347–56. (accessed 25/01/23) TG presented the findings from the evidence provided in the Randomised Controlled Trial (RCT). The study has been critically appraised which concluded that there were several limitations, including the potential risk of findings being subject to bias and a low number of participants. Due to this, it was unable to be used to support a change in the ICB commissioning stance. A discussion took place and CPAG agreed that clinician and commissioner interpretation reflect a misalignment which could result in a potential inequitable service, the terminology in national guidance contributes to ambiguity for clinicians. CPAG acknowledged that the absence of evidence does not mean that there is no value, or a cohort of patients that may benefit from this treatment. However, members agreed that commissioning decisions are led by the evidence base available. If in the future, there is significant new evidence in support of benefit vs risk and further studies available, DDICB could consider reassessing the position statement. A suggestion was made to consider specific circumstances or exceptionality within the position statement. Whilst the ICB are committed to maintaining the current position statement, CPAG are open to a policy approach provided clinical criteria can be aligned to National guidance, addresses any inequality, and considers learning from neighbouring areas policies. **Actions:** • Business Informatics to provide data on inequity within neighbouring areas • Review national professional guidance for clinical definitions/criteria used by Multidisciplinary Teams. • Draw comparison with other areas policy criteria if available • Findings of the above to be tabled at a future CPAG meeting • Add updated position statement to Clinical Policies website • Add to CPAG Bulletin • Provide feedback to clinicians/stakeholders	 TG/HM TG/HM TG/HM TG/HM KR KR HM
CPAG 23/28	<u>**7b. Gamete Storage Policy**</u> HM advised that the purpose of the paper is for CPAG to note the review of the Gamete Storage policy. In November 2022 CPAG agreed to consult fully with local stakeholders, with partial adoption of the East Midlands Affiliated Commissioning Committee (EMACC) policy as follows: • 'Additional groups of patients who are eligible for Gamete Storage'. This has been recommended by EMACC based on NHS England Guidance 'Formation of clinical commissioning policies for fertility preservation'. The following are examples of conditions that have been included and considered appropriate for gamete storage: o Patients with autoimmune conditions requiring chemotherapy o Rare mitochondrial disorders which may cause infertility o Conditions requiring special endocrinology services which may result in infertility	

These examples have been added to the updated DDICB Gamete Storage policy.

- Current ICB Fertility Policies are based on the idea of providing the opportunity for one child. Although the Gamete Storage Policy does not guarantee eligibility for fertility treatment, it is in line with DDICB existing policies. CPAG have previously agreed to maintain this stance. The following criteria has not been removed from the updated DICCB policy to align with EMACC:
  - "The patient has no living children. This includes a child adopted by the patient. Continued storage will not be funded if the patient subsequently adopts a child or achieves a pregnancy leading to a live birth"

The policy has been re-worded to reflect the new ICB organisation, references and rationale sections have been added and the policy has been updated to reflect stakeholder feedback.

Stakeholder feedback followed by the outcomes are included below (guidance was sought from the Director of Public Health at Derby City Council and Senior Public Equality and Diversity Manager at DDICB):

- Gamete Storage should be offered to patients irrespective of whether they have children already. This would put Derbyshire in line with the EMACC criteria.
  - CPAG agreed to consult fully with stakeholders with partial adoption of the EMACC policy, CPAG accept that policy positions are different and base the DDICB policy on the rational provided by Public Health.
- The current policy discriminates against non-transgender patients
  - The policy has been amended to reflect the EMACC statement as this would eliminate the potential issue of discrimination.
- Male patients should not have funding for sperm storage withdrawn if a subsequent semen analysis one year after chemotherapy shows a sperm count in the normal range following viable reasons (outlined during the meeting).
  - The policy has been amended to reflect EMACCs policy position: "Sperm will normally be stored for a maximum period of 10 years, or until a man reaches the age of 56 years old, whichever is sooner".
- There may be young women who need to store longer than 10 years and there should be provision for making an IFR application for continued storage in these situations.
  - CPAG agreed that storage should remain at 10 years with a check at 5 years, which is aligned to the EMACC policy.
- Not in agreement that funding for storage should cease at the age of 42 for women and the rationale.
  - Storage age limits for men and women aligned to EMACC policy so that the accepted criteria for entry into the storage pathway are applied equally to men and women e.g. "Sperm will normally be stored for a maximum period of 10 years, or until a man reaches the age of 56 years old, whichever is sooner. Eggs and embryos will normally be stored for a maximum period of 10 years, or until a woman reaches the age of 43 years old, whichever is sooner."
    Gamete storage to remain as 10 years, this is aligned to the EMACC Policy.

	• Not in agreement with the statement that gametes should not be frozen for infertility as a result of congenital disorder. Unclear what this actually means or what conditions that it would refer to.
	  ○ CPAG agreed to remove this statement.
	• Query received regarding EMACC consultation process.
	  ○ Stakeholder signposted to Leicestershire ICB as the former Leicestershire CCG undertook the 2020 consultation on behalf of EMACC for all East Midlands CCG's.
	• There should be a gamete Storage policy for Oocytes or Sperm as per EMACC policy not embryos.
	  ○ DDICB policy has always allowed for the creation and storage of embryos for patients and is aligned to the EMACC policy.
	
	A discussion took place and CPAG approved the Gamete Storage policy with the following amendments:
	• People with living children should not be eligible for gamete storage
	• Inclusion of additional groups of patients who are eligible for gamete storage
	• Removal of statement " gametes should not be frozen for infertility as a result of congenital disorders"
	• Removal of statement that "male patients should have funding for sperm storage withdrawn if a subsequent semen analysis one year after chemotherapy shows a sperm count in the normal range"
	• Removal of statement which discriminates against non-transgender patients access to fertility only if a pregnancy is viable
	• Storage age limits for men and women to be aligned to EMACC policy so that the accepted criteria for entry into the storage pathway are applied equally to men and women
	• Gamete storage to remain as 10 years, this is aligned to the EMACC Policy
	
	CPAG noted that the Gamete Storage policy should be for ongoing review, pending updates to DDICB fertility policies.
	
	Actions:
	• Cross reference wording used by Human Fertilisation and Embryology Authority (HFEA) and wording in Gamete Storage policy where policy states: Sperm will normally be stored for a maximum period of 10 years, or until a man reaches the age of 56 years old, whichever is sooner. Eggs and embryos will normally be stored for a maximum period of 10 years, or until a woman reaches the age of 43 years old, whichever is sooner.
	To be tabled under 'Matters Arising' at May 2023 CPAG meeting
	• Add updated policy to Clinical Policies website
	• Add to CPAG Bulletin
	• Provide feedback to clinicians/stakeholders
	• Contracting to inform providers
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8	**Governance Policies**	
CPAG 23/29	**<u>8a. Patient & Public Involvement</u>** The paper was presented by Sean Thornton (ST), Deputy Director for Communications and Engagement (DDICB). The purpose is to define the CPAG operating model for Patient and Public Involvement, standardise good practice and align accountability for pathway change.	

	The ICB has recently released guidance to ensure that commissioners and NHS Trust's working within Derby and Derbyshire ICB meet legal obligations to inform, involve or consult with patients and members of the public in any change that takes place to frontline service provision. The legal duties and the risk of noncompliance was outlined. There are also a number of other principles and tests set out in the guidance. The CPAG proposed operating model as set out below, was discussed. • Where there is a medical intervention change with an alternative, CPAG should continue as is with an alternative available. Medicine swaps are usually undertaken by the Derbyshire Joint Area Prescribing Committee (JAPC). • Where there is a medical intervention change with no alternative, or an alternative that could have implications on any of the 9 protected characteristics, then a Quality and Equality Impact Assessment (QEIA) will be needed. From this, a referral could/would be made for a Public Patient Involvement (PPI) assessment in most cases. Medicine changes are usually undertaken by the Derbyshire JAPC. • Where there is a policy change with minimal change, CPAG should continue with a virtual QEIA assessment, with escalation to full panel and/or PPI assessment if required. • Where there is a policy change with impact on patients in any way, the QEIA panel should review in the first instance, with onward referral to PPI as appropriate. • Any 'removal/decommissioning' triggers QEIA/PPI processes and awareness of an 18-month process as a minimum. A query was raised as to whether legal advice has been sought on this position. CPAG were assured that the operating model represents good practice, is proportionate and aligns to both statutory law/guidance and common/case law. A recommendation was made that the broader process should receive board level sign off, as assurance to decision making groups that this is the agreed way of working within DDICB. CPAG were informed that it will be put to the board via an assurance report and agreed as part of the PPI process. This forms part of corporate governance and processes are reviewed on an ongoing basis. A question was asked as to how the decommissioning of a service through National Guidance might affect the process. CPAG were advised that this varies in engagement and local approach required, and each one is considered on a case by case basis. It was suggested that further information be incorporated into the CPAG coversheet template with regard to consideration of protected characteristics, and whether a full QEIA or PPI assessment should be undertaken. CPAG agreed with this addition. **Actions:** • Update CPAG coversheet template with further information in regard to protected characteristics and whether a full QEIA/PPI assessment should be undertaken.	KR
9	**Contracting and Blueteq Queries**	
	No update this month.	

10	**Individual Funding Request (IFR) – For Information**	
CPAG 23/30	**10a. IFR Screening/Panel Cases January 2023** CPAG reviewed the IFR Screening/Panel cases for January 2023 and were assured that no areas for service development have been identified.	
11	**PHSCC Updates**	
CPAG 23/31	Papers submitted to PHSCC and tabled on 9th February 2023 were noted: • CPAG Bulletin January 2023	
12	**IPG Updates Since Last Meeting**	
CPAG 23/32	**12a. IPGs, MTGs, DGs and MIBs** CPAG noted the NICE IPGs, MTGs, DGs and MIBs updated in January 2023. It was confirmed that no business cases have been received for any IPG's. **Action:** • Send IPG, MTG, DG and MIB updates to the Finance Team, Planned Care Team and to the Contracting Team	KR
13	**Business Cases**	
	No update this month.	
14	**QIPP Pipeline**	
	No update this month.	
15	**Key Messages For PHSCC**	
CPAG 23/33	Papers to be submitted to March 2023 PHSCC were noted: • CPAG Bulletin February 2023 • Ethical Framework	
16	**For Information**	
	No update this month.	
17	**Any Other Business**	
	No other business was raised.	
18	**Date of Next Meeting**	
	Thursday 6th April 2023, papers to be circulated for agreement by email. Agenda items for April meeting to be received by 12 noon on 20th March 2023 please.	