NHS
Derby and Derbyshire
Clinical Commissioning Group

Clinical Policy Advisory Group

Thursday 20th August 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)
Slakahan Dhadli	SD	Assistant Director of Medicines Management and Clinical Policies (DDCCG)
Parminder Jutla	PJ	Medicines Management and Clinical Policy Guidelines, Formulary and Policy Manager
Niki Bridge	NB	Deputy Chief Finance Officer (DDCCG)
Ellie Houlston	EH	Assistant Director of Public Health
Amanda Bradley	AB	Commissioning Support Manager (DDCCG)
Chris Howlett	CH	Acute Contract Manager (DDCCG)
Bernadette O'Donnell	BOD	Commissioning Manager – Planned Care (DDCCG)

Ref:	Item	Action
1	**Declaration of Interest (DOI)**	
CPAG 20/74	SH reminded committee members of their obligation to declare any interest they may have issues arising at committee meetings that may conflict with the business of the CCG. Declarations made by members of the CPAG are listed in the CCG's Register of Interests. The Register is available via the Secretary to the Governing Body or on the CCG's website. SH identified some gaps in the DOI register. AB to contact members and update. No declarations of interest declared.	AB
2	**Welcome, Introductions, Apologies, Quoracy**	
CPAG 20/75	Apologies were noted for Robyn Dewis (Acting Director of Public Health, Derby City Council), Dr Buk Dhadda (GP Clinical Lead / Governing Body Member, DDCCG), Helen Moss (Individual Decisions & Project Manager, DDCCG), Tom Goodwin (Head of Medicines Management and Clinical Policies and Decisions, DDCCG), Ruth Gooch (GP Clinical Lead, DDCCG), Lisa Howlett (Head of Quality Governance, CRHFT), Anne Hayes (Consultant in Public Health Derbyshire County Council), Helen Wilson (Deputy Director of Contracting and Performance, DDCCG). SH asked if members had any objections to the meeting being recorded for the purpose of minute taking, none were noted. SH agreed the meeting was quorate under the Interim TOR but agreed any significant decisions could be deferred if necessary or have virtual agreement.	
3	**Minutes and Key Messages from the last meeting**	

CPAG 20/76	Minutes agreed as a true record of the meeting. **Action:** • Send the approved July minutes to CLCC for ratification • Upload ratified minutes to website	 AB/PJ PJ
4	**Matters Arising/Summary**	
CPAG 20/77	**4a. Tonsillectomy and Adenoidectomy Policy** *EH joined the meeting* The Policy has recently been reviewed and updated. The Consultees from CRH and UHDB were informed of the changes. Feedback has been received from the CRH consultees, who have expressed the need for the policy to include adenoidectomies in adults and chronic rhinosinusitis where the adenoids act as a source of bacteria and biofilm as a criteria for adenoidectomies. Further input was provided from the UHDB consultee and CPAG clinicians. PJ reviewed evidence to support the addition of the two criteria and has also examined policies of neighbouring CCGs. Conclusions: **Adenoidectomies in adults** • Unable to find robust and substantial evidence to support adenoidectomies in adults • There are small number of studies identified that look at adenoidectomy in adults. Therefore it is recognised that some individuals will retain their adenoids into adulthood • ENT UK state that there is no upper age limit for adenoidectomy • UHDB consultee advised that around 4 adult patients requiring adenoidectomies per year • Neighbouring CCGs that do have a restrictive policy on adenoidectomies do not restrict on age. • CPAG was advised that it would seem reasonable to assume that these patient's quality of life would improve similar to that of children with the same inclusion criteria. SD advised CPAG there will be a small cohort of adults who will continue to have adenoids and an even smaller cohort of these adults that will require an adenoidectomy. PJ confirmed these numbers would be low. **Chronic rhinosinusitis where adenoids act as a source of bacteria and biofilm** <u>Adenoidal biofilm</u> • There are a number of small studies that have been published that have found weak evidence suggesting an association of biofilms with the frequency of upper respiratory tract infections (URTI). • No definitive conclusion that can be drawn from this evidence, including the benefits of adenoidectomy on adenoids that act as a source of bacteria and biofilm in chronic rhinosinusitis.	

	Feedback received from CPAG clinicians was that they agreed that the criteria was subjective and lacked evidence. Neighbouring CCGs that do have a restrictive policy on adenoidectomies have not included this specific criterion. Findings from an open randomised controlled trial, submitted by the engaging UHDB consultee, found that immediate adenoidectomy for recurrent URTI confers no clinical benefit over a strategy of watchful waiting. The following recommendations were made. • Policy to include the provision of adenoidectomies for adults • Policy not to include chronic rhinosinusitis where the adenoids act as a source of bacteria and biofilm, due to the lack of substantial and robust supporting evidence • Inform CRH consultees that CPAG have agreed that there insufficient robust evidence to support the inclusion of 'chronic rhinosinusitis where the adenoids act as a source of bacteria and biofilm' as a criteria for adenoidectomy. SD stated we would need to be mindful of the Evidence Based Interventions consultation document that has recently been published. The previous version covered tonsillectomy but did not cover adenoidectomy. PJ confirmed that the new document that is currently under consultation has included adenoidectomy but the specific criteria chronic rhinosinusitis where the adenoids act as a source of bacteria and biofilm has not been included. CPAG members were in agreement with the suggested recommendations. CE suggested the need to monitor numbers of adults going through the service to see if there is an increase. The activity can be monitored via Prior Approval process and any increase in numbers will be flagged. **Action:** • PJ to amend policy as per recommendations • Policy to be submitted to CLCC for ratification **4b. Bunion (Hallux Valgus) Surgery Policy** CPAG are asked to note that the following statement under the Useful Resources section of the policy has now been removed: 'Patients requiring surgical correction of bunions should be referred to the podiatric surgery unless day case management is not appropriate'. This was following the feedback that was received from both CRH and UHDB consultees, who strongly disagreed with the statement. It was accepted that the statement did not add any value to the policy. SD commented that on the back of the policy being updated a query was raised as to where primary care clinicians refer to either surgical podiatry or trauma and orthopaedics. The sentence was added in response to feedback from Consultants during the engagement process and was added to support GPs to refer appropriately into the correct service. CPAG agreed to the removal of the statement from the policy.	PJ PJ/TG

	Actions: • CLCC to be notified of the change to policy. **4c. Clinician stakeholder engagement** CPAG to note Mr Duncan Farquharson (CRH) is the confirmed contact for any queries or updates on future policies. This was following on from a complaint from CRH who had said that some of their Consultants hadn't seen papers or policies. There is an open invite for CRH to attend meetings, AB confirmed Lisa Howlett as the contact PJ agreed to inform Lisa Howlett for reference regarding the above. **Actions:** • PJ to email LH informing her of contact for policies for CRH. **4d. Synthetic Mesh Policy** Paper presented at the previous CPAG meeting in response to the publication of the 'First Do No Harm' review. CPAG agreed that there was a need for a 'do not do' policy but that the Do No Harm recommendations should be kept in a draft form until CPAG is assured that our main providers are aligned to the guidance's recommendations. CPAG is asked to note that assurance has been received from UHDB, Queens Hospital Burton and CRH that they do not use pelvic floor mesh implants. SD explained that it would be good governance to have policy in place just in case there is a clinician who may consider using the mesh. CPAG to also note that this is also covered under an old IPG. CPAG approved the policy with the following amendments:- • Sections A and B to be removed from the policy. Policy will be re-visited when national issues are put in place. **Actions:** • PJ to amend policy • Policy to be submitted to CLCC for ratification **4e. NICE Guidance 157 - Joint replacement (primary): hip, knee and shoulder** Paper was presented at the previous CPAG meeting and has returned for assurance of stakeholder engagement. The NICE guidance on knee, hip and shoulder replacement covers care before, during and after a planned knee, hip or shoulder replacement. Orthopaedic Consultants at UHDB, CRH and Barlborough agreed that no changes were needed to the policy.	PJ PJ PJ PJ

Unrelated to the paper, the lead Orthopaedic Surgeon at Barlborough included within his response that he did not agree with the Arthroscopic Knee Washout for Patients with Osteoarthritis Policy. He explained that the policy is false interpretation of NICE guidance and believes people with meniscal pathology without locking may benefit from arthroscopic surgery. PJ confirmed that there is no restrictive policy/criteria on this procedure and the arthroscopic knee washout policy is specific in that DDCCG commission's arthroscopic knee washout but arthroscopic surgery is not included in the policy. The policy is based on the EBI and NICE recommendations which are both clear in the requirement of knee locking in order to have arthroscopic knee washout for patients with osteoarthritis.

The Consultant suggested the need for a new policy for knees with minor wear and tear with symptomatic MRI confirmed meniscal pathology. It was suggested that in these patients arthroscopy should be funded even if knee locking is not present.

BOD reported that Barlborough had experienced issues when patients are referred into the service. There may be something within their medical history that mentions they have arthritis which Barlborough are picking up on and then they are rejecting the referral because of it. BOD explained that it may be their understanding of the wording within the policy. There have been a lot of patients that have been rejected that have been triaged by the MSK service and because there is a note in their files regarding arthritis they are then being rejected. BOD suggested engagement with the MSK triage team and Barlborough to ensure they understand the policy and are clear on the wording. BOD will provide PJ with contact details.

CE commented that the policy states that washout is not commissioned even if have there is an meniscal tear and can see why Barlborough are confused as the policy does suggests that arthroscopy cannot be provided if the patient has osteoarthritis. CE explained that the policy is wording is confusing.

PJ's understanding of the policy is that DDCCG do not commission knee washout if there is a meniscal tear unless the patient has osteoarthritis with knee locking. There is no mention of any restrictions on arthroscopic surgery as this is a different procedure. CPAG agreed for the DDCCG Arthroscopic Knee Washout for Patients with Osteoarthritis Policy to be clearer and for the policy to be brought back to the next meeting.

CH left the meeting.

SD explained that the Hip and Knee Revision Policy and the Hip and Knee Replacement Policy does not mention arthroscopy at all. The criteria within these policies are not very specific. SD queried whether the Hip and Knee Replacement Policy was even needed due to the criteria not being very specific. SD shared on the screen the Hip and Knee Replacement Policy with the group.

CE confirmed that the key information for GPs is that around exercising, weight loss and physio, which is given to patients prior to being referred to the MSK triage service. The concern is that these elements would be lost if the policy is removed. CE added that she feels that the Hip and Knee policy should remain without any changes.

CPAG members agreed for the Hip and Knee Policy to remain unchanged but for the Arthroscopic Knee Washout Policy wording to reviewed.

Actions:-

	• BOD to provide contact details for Barlborough • Engagement with Barlborough team • PJ to look at wording of Arthroscopic Knee Washout Policy • Policy to return to next meeting **4f. Microsoft Teams Etiquette** CPAG noted paper. SD requested for the paper to be tabled in to future meetings. **Actions:** • AB to add to future agendas	BOD PJ PJ PJ AB
5.	**Workplan/Action Tracker**	
CPAG 20/78	**Action Tracker** CPAG noted actions on Tracker with the following comments • Item 8 has been updated to green as Consultant to Consultant policy has been ratified by CLCC • Prior approval for hip and knee revision has been removed and contracting has been made aware. • Microsuction of earwax to be tabled at November's meeting • IFR training – this has been deferred to November due to trainer having other work commitments. HM to confirm and update tracker • Request update on Hydroxychloroquine from RD, if available	HM PJ
6.	**Bulletin**	
CPAG 20/79	Bulletin was approved by CPAG **Actions:** • Approved Bulletin to go to CLCC for ratification • Bulletin to be uploaded onto website once ratified by CLCC • Bulletin to be circulated to main providers and to Primary Care (via Membership Bulletin)	PJ PJ AB
7.	**Clinical Policies Reviewed**	
CPAG 20/80	**7a. Rhinoplasty and Septo-rhinoplasty** The policy has been re-worded and reformatted to reflect the new organisation's clinical policy format. This includes the addition of background information, rationale for recommendation, useful resources, references, consultation and document version control. It was noted that no feedback had been received from UHDB and therefore the assumption had been made that they are in agreement with the policy. CPAG were informed that feedback had been received from a CRH consultee. CPAG are asked to discuss each comment and to agree on the suggestions made in paper 7ai. **Recommendations** • Suggested that the statement '**Deformities can be secondary to trauma or congenital conditions' should be removed from the policy as it adds little value and was a source for confusion for the engaging clinician. However SD advised that the statement should remain within the policy but should be further clarified. The group agreed with	

	this suggestion • Suggested for the statement 'clinical photographs of post-trauma injury (and pre-trauma where possible)' to remain within the policy. CPAG agreed with the suggestion but requested for the statement to be reworded for clarification to 'and pre-trauma where clinically relevant' • CPAG agreed for the statement ''preoperative photos showing the standard four-way view of the nose: base, anterior-posterior, right and left lateral views' to be amended through the addition of 'as a minimum requirement'. • CPAG agreed that the criteria 'Symptoms persist despite conservative measures for a minimum of three months' should remain within the policy unchanged due to there being a lack of robust evidence published since policy was last reviewed in October 2018 to suggest a need for change. **Actions:** • Policy to be updated with the agreed changes • Policy to be submitted to CLCC for ratification	PJ PJ
8.	**Governance Policies**	
CPAG 20/81	**8a. Evidence-Based Interventions Engagement Document** CPAG to note that there has been a recent publication of a broader, system-wide Evidence-Based Interventions Engagement document. It was noted that CPAG will be unable to co-ordinate a response to the proposed system-wide document that is under consultation by the given deadline of 21/08/20. The recommendation is to inform our providers and stakeholders who are involved in the review of our clinical policies of the recent publication of the document. CPAG were also informed that once the document has been published work will be started on reviewing the DDCCG clinical policies and position statements against the 31 interventions listed. The aim would be to identity the need to develop new policies/position statements or for the modification of existing policies/position statements. NB queried why this had not been brought to their attention in enough time to be able to enable our main provider to feedback. PJ explained that we had recently been made aware of the document. SD added that he too had been recently made aware of the consultation document and that awareness of the publication had not been well circulated when compared to previous EBI papers. SH and SD suggested the need for a brief comparison table. SD advised that the table should not contain a high level of detail as the document is a consultation document and changes to the interventions/recommendations listed are possible CPAG agreed for the comparison table to not contain too much detail until the final document is published. **Action:** • PJ to bring comparison table back to next meeting.	PJ

	8b. EBI ePACT CPAG were asked to note that the EBI dashboard has been refreshed with the May 2020 data and has been redesigned there has been the following extra tabs added • **Providers** - shows the total for providers across all CCG. *Note that the goals and reductions shown on this provider tab are indicative only as they are based on mapping CCG-level goals to providers based on their baseline share of activity.* • **Region** – shows EBI activity at a regional level including comparisons in regional performance and the comparative activity of CCGs, STPs / ICSs and Providers within the selected region. CPAG was also made aware that the NHS has cancelled or postponed many of its elective procedures as part of the response to COVID-19 and this has resulted in a significant drop in EBI activity from March 2020 onwards. SH explained that it would be useful to see the dashboard to help CPAG see if there is a need to review our policies. CPAG agreed that this should be added to the CPAG work plan. **Actions:** • Action to be added to work plan **8c. Restoration and recovery plan** HW was not present at meeting, agenda item deferred. **Actions:** • Agenda item for September meeting	PJ HW
9.	**Contracting and Blueteq queries**	
CPAG	No update.	
10.	**Individual Funding Request (IFR) – for information**	
CPAG 20/82	**10a Screening Feedback July** CPAG noted the screening information.	
11.	**East Midlands Affiliated Commissioning Committee (EMACC)**	
CPAG	No updates	
12.	**CLCC updates**	
CPAG 20/83	SH noted that CLCC accepted all of the updated policies that had been submitted, but confirmed that the Bunion policy had been deferred until formally agreed at CPAG. The CAS/PLCV papers were agreed by CLCC but assurances were required that CPAG would not lose the effectiveness of the clinical policies. **Action:**	

	• Add the risk to the CCG risk register – 1. Increase in volume of PLCV and CAS activity from altering the current process 2. Widening the health inequality from altering the current process • Work with BI, Contracting and Planned Care to transact re • alignment of services to main providers • Inform HR that CLCC approved the paper and be led by them as to communication with staff and next steps at this stage • Send a brief to the Primary Care Leadership Group	TG/HM TG/HM TG TG
13.	**IPG updates since last meeting**	
CPAG 20/84	**13a. IPGs, MTGs, DGs and MIBs** CPAG noted the NICE IPG, DTG and MTGs updated in July 2020 **Action:** - Send IPG, MTG, DG and MIB updates to the Finance Team, Planned Care Team and to the Contracting Team. - Inform CLCC that CPAG have considered and no service development is required	 AB PJ
14.	**Business Cases**	
CPAG	No update this month	
15.	**QIPP Pipeline**	
CPAG	No update this month	
16.	**Key messages for CLCC**	
CPAG	Key messages to go to CLCC • Tonsillectomy and Adenoidectomy Policy • Bunion (Hallux Valgus) Surgery Policy • Synthetic Mesh Policy • NG 157 Joint replacement (primary) hip, knee and shoulder - Assurance • Rhinoplasty and Septo-rhinoplasty Policy • CPAG July 2020 Minutes • CPAG July 2020 Bulletin	 PJ
17.	**For information**	
CPAG	No update	
18.	**Any other Business**	
CPAG 20/85	18a **Website wording clarification (PLCV Vs Other restrictive Policies)** The content of the website makes a distinction between policy based on Procedures of Limited Clinical Value but doesn't distinguish between policies for procedures that have an effective evidence base but have been restricted based on a prioritisation process such as affordability. Therefore the wording on the website requires amendment to reflect this. CPAG agreed to amend the wording on the website accordingly, as proposed in the coversheet. **Action:**	

	• PJ to amend wording on website • CLCC to be informed **18b. September CPAG Meeting** SH informed members that he will be on annual leave for the next CPAG meeting. NB confirmed that she would be available to chair September's CPAG meeting. **Action** Send NB an invitation for September's CPAG pre meet	PJ PJ AB

Date of Next meetings

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