NHS
Derby and Derbyshire
Integrated Care Board

Clinical Policy Advisory Group (CPAG)

MINUTES OF THE CLINICAL POLICY ADVISORY GROUP (CPAG) MEETING HELD ON THURSDAY 7TH SEPTEMBER 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)
Dr Jonathan Burton	JB	GP Prescribing and Clinical Policy Lead (DDICB)
Lana Davidson	LD	Head of Contracts (Acute)
Slakahan Dhadli	SD	Assistant Director of Medicines Management and Clinical Policies
Dr Ruth Gooch	RG	GP
Tom Goodwin	TG	Head of Medicines Management and Clinical Policies and Decisions
Chris Howlett	CH	Senior Clinical Quality Manager
Craig West	CW	Acting Associate Chief Finance Officer (DDICB)
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
Derby and Derbyshire Local Medical Committee (DDLMC)		
Ben Milton	BM	GP and Medical Director
In Attendance:		
Sophie Mason	SM	Senior Innovation Lead (East Midlands Academic Health Science Network)
Lara McKean	LM	Senior Pharmacy Technician (DDICB)
Hannah Morton	HMo	Public Involvement Manager (DDICB)
Mandy Phillips	MP	Individual Decisions Approvals Senior Administrator (DDICB)
Claire Warner	CW	Senior Public Equality and Diversity Manager (DDICB)
Robyn Wight	RW	Public Health Specialty Registrar (Derby City Council)
Kate Rogers	KR	Individual Decisions and Projects Officer (DDICB) (Minutes)
Apologies:		
Dr Buk Dhadda	BD	GP (DDICB)
Parminder Jutla	PJ	Medicines Management and Clinical Policy Guidelines, Formulary and Policy Manager (DDICB)
Helen Moss	HM	Individual Decisions & Project Manager (DDICB)
Allan Reid	AR	Consultant in Public Health (Derby City Council)

Ref:	**Item**	**Action**
1	**Welcome, Introductions and Apologies**	
	Apologies were noted from Dr Buk Dhadda, GP (DDICB), Parminder Jutla, Medicines Management and Clinical Policy Guidelines, Formulary and Policy Manager (DDICB), Helen Moss, Individual Decisions and Project Manager (DDICB), Allan Reid, Consultant in Public Health (Derby City Council).	

	• CW joined the meeting at 9.45am • CH left the meeting at 9.50am and re-joined at 10.12am • LD joined at 10.02am and left the meeting at 11.18am • SM left the meeting at 10.19am, following discussion of agenda item 'MedTech Funding Mandate – update to operating model ' which was brought forward to be tabled at the start of the meeting. • HMo left the meeting at 10.28am following discussion of agenda item 'Update to QEIA Operating Model & PPI process'. <u>Confirmation of Quoracy</u> CPAG was quorate under the Terms of Reference. SH informed the committee that this will be Parminder Jutla's last CPAG meeting before she commences her maternity leave. Parminder was wished well by the Chair on behalf of CPAG and the Clinical Policies team and thanked for her hard work and contributions.	
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.	
4	**Bulletin**	
CPAG 23/99	The August 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, Derbyshire Primary Care Networks (PCNs) Clinical Directors, and to Primary Care (via Membership Bulletin).	 HM KR KR
5	**Work Plan/Action Tracker**	
CPAG 23/100	**<u>5a. CPAG Action Tracker</u>** CPAG noted the Action Tracker. **<u>5ai. CPAG Workplan</u>** CPAG noted the progress to date and items pending review on the workplan.	

6	Matters Arising/Summary	

CPAG 23/101	**6a. Update to QEIA Operating Model & PPI process**
	
	TG advised that the purpose of the paper is for CPAG to review the process for Quality and Equality Impact Assessments (QEIA's) and Public Patient Involvement (PPI) assessments and approve the changes.
	
	The QEIA Impact Assessment policy states for services that directly impact patients the ICB is responsible for ensuring that Quality and Equality Impact Assessments are effectively considered as part of discussions and decisions regarding Cost Improvement Programmes (CIPs), business cases and other service developments or change arising from commissioning activity.
	Staff who are involved in the development of policies, commissioning cases and service redesign initiatives are responsible for ensuring that QEIA assessments are conducted at an early stage and then any subsequent key stages of programme management.
	
	CPAG advised for clinical polices that come up for review there is no further requirement to complete a Quality Impact Assessment (QIA). Where aligned to NHSE/National Guidance and/or there is alignment to Evidence Based practice, the quality aspect is covered nationally, therefore there is a reduced requirement for quality assessment.
	
	Requirement for Equality remains part of the ICB statutory duties and still needs to be completed. It ensures that public bodies consider the needs of all individuals in their day-to-day work – in shaping policy, in delivering services and in relation to their own employees.
	
	Proposed changes to the operating model for QEIA include:
	• Equality
	  ○ Senior Public Equality and Diversity Manager to become core member of CPAG.
	  ○ EIA only to be completed if there are any significant issues/concerns raised by the Senior Public Equality and Diversity Manager at a CPAG meeting.
	  ○ Outcome of EIA decision to be recorded in the minutes/action tracker.
	• Quality
	  ○ Quality representative to remain as a core member of CPAG.
	  ○ QIA to be submitted for new local polices/significant changes
	
	The PPI operating model has been updated and the following process was noted:
	Glossop Process
	• Once the policy has been reviewed by the CPD team, the Medical Director Derbyshire Local Medical Committee (LMC) and Glossop representative will assess the differences in policy between DDICB and Greater Manchester and provide CPAG with a view i.e. minor or significant change.
	• PPI form to be completed for individual policies and included as part of the CPAG agenda and papers. To be sent to Head of Engagement for assessment purposes.
	• PPI team will assess and provide an opinion prior to the CPAG meeting date (if there are any significant issues/concerns, a member of the PPI team will attend CPAG). PPI forms require assessment prior to decisions being ratified at CPAG. If 'involvement' is identified as being a legal duty, decisions are not able to be ratified until that 'involvement' has taken place.	

	• For policy variations where the legal duty is triggered and "inform" is the recommendation, this will be communicated via the CPAG Bulletin which is sent out on a monthly basis to providers, primary care colleagues, PCNs. As the majority of Glossop patients will continue to be seen by Manchester providers, the change of policy criteria will not have a significant impact on the Glossop population, as they will continue to be assessed against the lead commissioner policy (Greater Manchester). CPAG agreed the updated operating model for QIA, EIA and PPI. **Actions:** • Clinical Policies Coversheet to be updated to reflect changes in QIA/PPI process • CPAG Terms of Reference to be updated to reflect change in membership • Senior Public Equality and Diversity Manager to be added to CPAG email distribution list • Record EIA/PPI recommendations for relevant items tabled at CPAG meetings i.e. CPAG Minutes/Action Tracker	KR HM/KR KR KR
CPAG 23/102	**6b. Evidence Based Interventions (EBI) 3 Guidance – Updated Policies and New Policy** TG advised that the purpose of the paper is for CPAG to review and agree the outstanding updated/new DDICB policies to align to the publication of the National Evidence Based Interventions EBI3 guidance published in May 2023. The EBI 3 document published in May 2023 sets out 10 interventions. The interventions were split for members of CPAG by CPD into the following three categories: • Section 1: 3 interventions that are covered by pre-existing DDICB policies/position statements that require updating. • Section 2: 1 intervention requires the development of a new DDICB clinical policy. • Section 3: 6 interventions that are pathways and require no further action by the Clinical Policies team. These interventions will be forwarded on to the appropriate teams for actioning and included in an overarching position statement. CPD team has agreed a plan to review the 10 EBI Interventions in sections and engage with stakeholders to provide assurance that Derby & Derbyshire providers are aligned to EBI3. During August CPAG, the Breast Prosthesis (Implant) Removal Policy update in line with EBI was presented and approved. The paper presented to CPAG at the September 2023 meeting considers the remaining three EBI3 interventions: • Penile circumcision in under 16 years of age (policy update) • Referral for bariatric surgery (policy update) • Angioplasty for PCI (percutaneous coronary intervention) in stable angina (new policy)	

Circumcision Policy

CPAG agreed with the following recommendations:

- Current policy separated into two:
  - Circumcision in Adults Policy
    - Minor changes to criteria wording in line with EBI3 recommendations:
      - Clarified policy applies to adults aged 16 years and over
      - Use of umbrella term 'pathological phimosis'
      - Traumatic foreskin injury criteria updated with 'Acquired trauma where reconstruction is not feasible, for example, following zipper trauma or dorsal slit for paraphimosis'
    - Section 5. References updated to include EBI3 reference.
    - Policy wording also updated to reflect the new DDICB organisation.
  - Circumcision in Children Policy
    - Criteria to align to EBI3 recommendations including clarification that the policy applies to children aged under 16 years.
    - EBI3 recommends the following as a criteria:
      'persistent phimosis in children approaching puberty, following an attempted a trial of non-operative interventions e.g. a six-week course of high-dose topical steroid. A prescription of this would not normally exceed three months and should have achieved maximal therapeutic benefit within this time. A topical steroid such as Betamethasone (0.025-0.1%) is commonly prescribed'.

CPAG noted that the EBI3 recommendation for penile circumcision also contains information that is regarded as falling under pathway, which is not typically included within DDICB clinical policies.

Complex and Specialised Obesity Surgery Policy

CPAG were asked to consider the following recommendations:

- to align policy wording to EBI3 recommendations by removing the DDICB criteria regarding the patient needing to be morbidly obese for at least 5 years, noting that this will potentially increase activity.
- to align policy criteria to EBI3 recommendations by adding criteria 'BMI of 30 kg/m2 or more with type 2 diabetes of less than 10 years duration. This BMI threshold should be reduced to 27.5 kg/m2 if the patient is of Asian family origin'. This change will potentially lead to an increase in activity.
- to agree to align policy wording to EBI3 recommendations by including the following additional criteria 'After surgery, the host bariatric surgery unit should follow up with the patient for two years. Thereafter, responsibility for follow up should be handed over to either the local nonsurgical Tier 3 service or the patient's GP, who should conduct yearly appointments. These appointments should include weight measurement and a request for nutritional blood tests. See British Obesity & Metabolic Surgery Society (BOMSS) guidance for more details. Please note that this guidance is intended as a standard threshold for access'.

CPAG noted that EBI3 justify the potential increase in activity with the following rationale:

- Evidence shows that when commissioned as recommended, surgery is highly effective in causing weight loss, reduces the long-term impact of poor health and reduces the risk of premature death from obesity-related conditions.
- When commissioned appropriately, obesity surgery is highly effective in promoting weight loss, and more importantly, reducing mortality and morbidity

	burden. It is also one of the most cost-effective treatments in the field of surgery. CPAG were assured that the University Hospitals of Derby and Burton NHS Foundation Trust (UHDBFT) are aligned to the EBI3 recommendations. Chesterfield Royal Hospital NHS Foundation Trust (CRHFT) do not provide the service. EBI3 is embedded within the National Contract. The Contracting team within DDICB have been contacted to confirm if the National Contract has been adopted locally, currently awaiting a response. A discussion took place, CPAG supported clinical changes, however it was noted that there are financial implications. A question was raised as to the role within the obesity management pathway and the availability of Tier 3 and Tier 4 services to patients in the county. Concerns were raised in regard to the responsibility for long term follow up of these patients, and whether this will be carried out by the local nonsurgical Tier 3 service or the patient's GP. If it is the responsibility of the GP Practice, will there be an enhanced service to support it. Further concerns were highlighted in regard to the potential volume of people and increase in activity. A question was asked as to who is providing a Tier 3 service for patients within Derby and Derbyshire. CPAG agreed that wider stakeholder engagement should take place to further understand the impact. This should include discussions with the Contracting and Planned Care Teams within DDICB. <u>Angioplasty for Percutaneous Coronary Intervention (PCI) in Stable Angina Policy</u> This is a new proposed policy, CPAG agreed with the following recommendations: • DDICB policy to be aligned to EBI3 criteria, with the exception of the criteria 'The patient is participating in clinical research in stable coronary artery disease'. • CPAG to note that the policy contains information that falls under a pathway, which is not typically included within DDICB clinical policies. CPAG were assured that UHDBFT and CRHFT are aligned to EBI3 recommendations. CPAG agreed on the criteria and suggestions made in Appendix 1 regarding the updated policies. CPAG approved the draft updated policies for Circumcision and Angioplasty for Percutaneous Coronary Intervention (PCI) in Stable Angina. No issues were highlighted in regard to protected characteristics (EIA). **Actions:** 'Circumcision Policy' and 'Angioplasty for Percutaneous Coronary Intervention (PCI) in Stable Angina Policy' • Upload each policy to Clinical Policies website • Add to CPAG Bulletin • Provide feedback to clinicians/stakeholders 'Complex and Specialised Obesity Surgery Policy' • Further Stakeholder engagement required, outcome to be tabled at a future CPAG meeting	KR KR KR PJ/HM/ LM

CPAG 23/103	**6c. Evidence Based Interventions (EBI) 3 Guidance – Pathways & Overarching Position Statement** TG advised that the purpose of the paper is for CPAG to review and agree that the six EBI3 interventions considered as pathways do not require a policy/position statement and no further action by CPAG is required. The paper presented to CPAG covered section 3; 6 Interventions that are classed as pathways and require no further action by CPAG and an Overarching Position Statement to include all 10 EBI3 Interventions. CPAG were assured that stakeholder engagement has been completed for the following interventions: 1. Asymptomatic Carotid Artery Stenosis Screening 2. Needle Biopsy of Prostate 3. Non visible Haematuria 4. Glaucoma Referral criteria 5. Optical coherence tomography (OCT) use in Diabetic Retinopathy Referral 6. Shared Decision-making for Cataracts CPAG agreed that no further action is required for the six interventions, as assurance of compliance has been provided. CPAG noted that Planned Care, Long term Conditions, Primary Care and Contracting will be informed of the work that CPAG has carried out with main providers to provide assurance that their practices are aligned to EBI3 and to consider the implications for existing and future pathways relating to the interventions, to ensure consistency throughout the wider system for efficient implementation in line with the ICBs priorities. CPAG approved the Overarching Position Statement – EBI3 **Actions:** • Overarching Position Statement to be updated with a statement – Complex and Specialised Obesity Surgery Policy – alignment TBC pending assurance re: activity increase and funding (Primary Care, Contracting, Finance) Update wording from CCG to ICB • Overarching Position Statement to be forwarded to appropriate teams i.e. Planned Care, Contracting, Long Term Conditions, Shared Care Pathology for actioning. • Upload Overarching Position Statement to Clinical Policies website • Add to CPAG Bulletin • Provide feedback to clinicians/stakeholders	HM HM/KR KR KR LM/KR
CPAG 23/104	**6d. Evidence Based Interventions (EBI) 3 Additional Areas – Urology** TG gave a verbal update to inform CPAG of the EBI current engagement process for three urological conditions to be added to the EBI suite of clinical best practice guidance. The three urological conditions are: • Transurethral Resection of Bladder Tumour (TURBT) Single Post Instillation of Mitomycin C (SPI-MMC) • Investigation and onward referral of women with recurrent Urinary Tract Infections (rUTIs)	

	• PSA Testing for men aged 80 years and above This has been shared with Urology and Pathology leads. CPD team are currently awaiting a response from AMROC to confirm whether this is ad hoc (reduced EBI3 output) or a change in operating model. CPAG noted the EBI engagement process for the three Urological conditions. **Actions:** • Add to Action Tracker for 2024 • Add to CPAG Bulletin	 KR KR
CPAG 23/105	**<u>6e. Renaming of PLCV (Procedures of Limited Clinical Value) Policies</u>** TG advised that the purpose of the paper is for CPAG to review options for the renaming of PLCV (Procedures of Limited Clinical Value). As part of Clinical Policies stakeholder engagement, feedback was received from stakeholders disagreeing with the use and interpretation of the term "PLCV" for ICB Clinical Policies. CPAG members agreed that they would consider renaming to align more closely to the Evidence Based Interventions (EBI) programme. Options for renaming PLCV were considered at the July 2023 CPAG meeting. It was recommended that the renaming options be based on EBI but encompass all other local policies, including affordability. CPAG agreed that additional consideration should be given to the name, as further variation maybe required. The renaming of PLCV was discussed at the GP Provider Board who were happy to support what was considered the most appropriate option. CPAG agreed on the <u>name 'Evidence Based Interventions' (EBI) based on national direction, however, local policies that have been agreed on other grounds e.g. affordability, cost effectiveness or a combination will be separated out from EBI.</u> **Actions:** • Review and follow the implementation guidance for renaming of PLCV, which was included within the paper tabled at July 2023 CPAG meeting. • Add to CPAG Bulletin	TG/HM/ KR KR
CPAG 23/106	**<u>6f. Review of BMI Criteria Related to Removal of Excess Skin/Tissue</u>** TG advised that the purpose of the paper is for CPAG to agree a policy statement regarding BMI criteria for policies relating to excess skin/tissue removal (e.g. breast reduction and abdominoplasty). This request has been received from the Individual Funding Request (IFR) Screening Pair following a recent IFR request, and further historical requests where the weight of breast tissue or an abdominal flap, is perceived to impact on achieving a normal BMI. It was suggested that a statement is added to the policy which states either:	

	• The BMI requirement is fixed and does not relate to the weight of the tissue to be removed OR • If the excess tissue is so significant that a normal BMI cannot be achieved, then the case will be considered if removal of the tissue is estimated to reduce the BMI to a normal range This would provide clarity on whether the weight of the excess skin could be considered, and to reduce the number of IFR requests for this reason. CPAG considered a range of factors and acknowledged that assessment to calculate if excess tissue would result in a normal BMI following surgery would be challenging and subjective, as there is no reliable way to measure. A discussion took place and CPAG were in favour of adding a statement which considers cases where excess tissue is significant, and a normal BMI could only be achieved following removal of this. However, members felt that further research and engagement with clinicians should take place, to ask how they would assess/measure if excess tissue removal would result in a normal BMI following surgery. A literature search will also be requested, to consider further evidence base. It was highlighted that patients with a higher BMI could carry a higher clinical risk of surgery, and this should be explored. If after further research/clinician engagement this statement is added to the policy, a suggestion was made to consider collecting the BMI 6 months after surgery on requests that are approved, to evaluate the outcome. A question was asked as to the number of people who have been referred through the Cosmetic Referral Assessment Service who want/require the surgery. **Actions:** • Engage with Clinicians/stakeholders to ask how they would assess/measure if excess tissue removal would result in a normal BMI following surgery and how a higher BMI links to clinical outcomes. • Request a literature search to research the reliable measurement of removable tissue related to cosmetic procedures • Request current activity data via Business Informatics (BI)	HM PJ/HM/ LM PJ/HM/ LM
CPAG 23/107	**<u>6g. Gamete Storage Stakeholder Feedback</u>** TG gave a verbal update to inform CPAG that a correspondence letter agreed by the Chair and CPAG, has been sent to a stakeholder in response to a query received in regard to the Gamete Storage Policy. It confirms the ICB's current stance and that there is an East Midlands wide review of Assisted conception currently being undertaken across the region. CPAG acknowledged that the letter has been sent.	
7	**Clinical Policies Reviewed**	
	No update this month.	
8	**Governance Policies**	
CPAG 23/108	**<u>8a. MedTech Funding Mandate – update to operating model</u>**	

	TG advised that the purpose of the paper is to update CPAG on changes to the operating model for the MedTech Funding Mandate. The MedTech Funding Mandate is an NHS Long Term Plan commitment to get selected NICE approved cost-saving devices, diagnostics and digital products to NHS patients more quickly. It consists of a mandatory policy document ensuring ICB funding for selected products, so healthcare providers can make these available to NHS patients. It is implemented within the NHS and supported by the Academic Health Science Networks (AHSN's). It was proposed to update the current CPAG operating model following the submission of a paper to the Clinical and Professional Leadership Group (CPLG) from the ICS Innovation Lead and representative from the East Midlands AHSN asking CPLG to support system wide engagement to review each technology and provide rationale for adoption or non-adoption. Sophie Mason, Senior Innovation Lead from East Midlands AHSN gave a short presentation on the MedTech Funding Mandate programme. It was clarified the recommended blended payment model between commissioners and providers is made up of a fixed payment, a variable activity-based payment (e.g. for elective care) and a low volume activity block payment for activity with an annual value of less than £0.5 million. The cost of the policies supported MTFM technologies is excluded from all of these payments. Use of fixed payments with no variable or additional elements has posed a barrier to MTFM supported technology adoption, particularly where systems are financially challenged. There have been no technologies introduced in 23/24 to ensure that systems have the time to build in adoption costs into the next financial year. A discussion took place, the recommendation is for CPAG to confirm delegated authority for MedTech Funding Mandates, all ICS proposals are to be reviewed by CPAG to provide assurance that internal governance is undertaken and a systemwide implementation plan exists. For assurance purposes, a document (appendix 1 included within the CPAG papers) has been produced to support system wide engagement, to review each technology and provide rationale for adoption or non-adoption. A suggestion was made to ensure that actions are ordered by priority area. CW confirmed that the impact on financial processes/risks is an additional cost of activity which has not been accounted for. A question was raised in regard to the long term efficacy of these treatments. SM confirmed that they are long standing technologies supported by NICE guidance in terms of cost effectiveness and minimally invasive equivalent efficacy. However, SM advised that following the meeting, further detail of the long term efficacy data will be provided to CPAG members. CPAG agreed delegated authority for MedTech Funding Mandates and approved Appendix 1 – 'MedTech Funding Mandate DDICB CPAG Checklist for Service/Innovation Manager'. **Actions:** • SM to provide CPAG members with further detail of the long term efficacy data for current MedTech Technologies being considered for use • Update Appendix 1 to ensure it is ordered by priority area	SM TG/HM

	• Upload Appendix 1 to Clinical Policies website • Add to CPAG Bulletin • Notify stakeholders within ICB/ICS of approved process for MedTech Funding Mandates • Add to CPAG Terms of Reference - agreed delegated authority to CPAG for MedTech Funding Mandates • CPD team to confirm stakeholders' details with SM • Add MedTech Funding Mandate to CPAG Action Tracker for 2024	KR KR LM HM/LM TG KR
8b	**East Midlands Fertility Policy Review**	
CPAG 23/109	**<u>8b. Update - Assisted Fertility Policy Review for East Midlands ICBs</u>** TG advised that the purpose of the paper is to update CPAG on the progress of the fertility: review of policies and options appraisals for East Midlands ICBs. A collaborate approach to the commissioning of fertility services has been proposed across the five East Midlands ICBs, with Nottingham ICB acting as Lead Commissioner. Taking this approach minimises inequity of access based on geography and also supports providers with service delivery across a wide geographical area. The final report is to be submitted to the joint chief executives (subject to key dependencies). CPAG were advised of progress to date and meeting attendees. A discussion took place, and a question was asked as to whether CPAG members would be able to view the draft assisted fertility policy review report before it was sent to the Chief Executive within the ICB, as it was felt that the Chief Executive would welcome the perspective of CPAG. Confirmation has been received from Nottingham ICB, that fertility preservation (gamete storage) is included in the specification. DDICB has asked that the issue of living children and length of storage are also considered. Comments from both Public Health and Equality (DDICB) included as part of the paper on Gamete storage limits, which was submitted to the August CPAG meeting, have also been forwarded to the reviewers who have confirmed that living children will be included as part of the recommendations along with evidence on duration of storage and whether it has an impact on the effectiveness of IVF. Following the publication of the Women's Health Strategy, Public Health have advised that there is a national workstream looking at IVF, including access for female same sex couples, as there is a desire to make treatment access equal nationally, however this would need to be funded. A national database, which provides data showing how many IVF cycles are funded by the NHS in each area of the country is now available to access via the government website. The entry for Derbyshire has been corrected to reflect the Derbyshire position. CPAG noted the paper and progress to date. **Actions:** • Add to CPAG Bulletin • A draft copy of the Assisted Fertility Policy Review Report to be circulated to CPAG members	KR LD

9	**Contracting and Blueteq Queries**	
	No update this month.	
10	**Individual Funding Request (IFR) – For Information**	
CPAG 23/110	**<u>10a. IFR Screening/Panel Cases July 2023</u>** CPAG reviewed the IFR Screening/Panel cases for July 2023 and were assured that no areas for service development have been identified.	
CPAG 23/111	**<u>10b. Review of DDICB Individual Funding Request Policy to align to NHSE IFR Policy and Standard Operating Procedure (SOP)</u>** TG advised that the purpose of the paper is for CPAG to review and approve changes to the current DDICB IFR Policy and SOP to align to NHSE IFR documentation. The IFR policy was originally agreed on an East Midlands wide basis. As no East Midlands wide review has taken place, the DDICB IFR policy has been updated to align to the NHS England IFR policy, which includes a separate SOP. NHSE updated their policy and SOP in February 2023. CPAG noted the differences between the NHSE IFR Policy and SOP and DDICB IFR policy. As part of stakeholder engagement, Public Health have been consulted and their comments incorporated. IFR's are a statutory function, advice was sought from the Director of Corporate at DDICB in regard to legal advice, who confirmed that as there is no material change, legal advice is not required. CPAG agreed the proposed changes to the DDICB IFR Policy to align to NHSE documentation. **Actions:** • Upload to Clinical Policies website • Add to CPAG Bulletin • Inform stakeholders/providers/IFR Panel Members	 KR KR HM
11	**PHSCC Updates**	
CPAG 23/112	Papers submitted to PHSCC to be tabled in September 2023 (no meeting in August 2023) were noted: • CPAG Bulletin June 2023 • Glossop Transition for Clinical Policies • CPAG Bulletin July 2023 • CPAG Minutes July 2023	
12	**IPG Updates Since Last Meeting**	
CPAG 23/113	**<u>12a. IPGs, MTGs, DGs, HTEs and MIBs</u>** CPAG noted the NICE IPGs, MTGs, DGs, HTEs and MIBs updated in July 2023. It was confirmed that no business cases have been received for any of the above NICE outputs. **Action:**	

	• Send IPG, MTG, DG, HTE and MIB updates to the Finance Team, Planned Care Team, Mental Health 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 23/114	Papers to be submitted to PHSCC to be tabled in November 2023 (no meeting in October 2023) were noted: • CPAG Bulletin August 2023 • NICE MedTech Mandate Operating Model for CPAG	
16	**For Information**	
	No update this month.	
17	**Any Other Business**	
	Addition to CPAG Terms of Reference to include delegated authority of 'Chair' to an ICB clinician who is a member of CPAG, should the nominated Chair and Deputy Chair be unavailable.	LM
18	**Date of Next Meeting**	
	Thursday 5th October 2023, papers to be circulated for agreement by email. Agenda items for October meeting to be received by 12 noon on 18th September 2023 please.	