NHS
Derby and Derbyshire
Integrated Care Board

Clinical Policy Advisory Group (CPAG)

MINUTES OF THE CLINICAL POLICY ADVISORY GROUP (CPAG) MEETING HELD ON THURSDAY 4TH JULY 2024 AT 9:30AM VIA MICROSOFT TEAMS

CONFIRMED MINUTES

Present:		
Derby and Derbyshire ICB (DDICB)		
Dr Buk Dhadda	BD	GP (Chair)
Dr Jonathan Burton	JB	GP Prescribing and Clinical Policy Lead
Slakahan Dhadli	SD	Associate Director of Clinical Policies & Evidence Based Medicine
Dr Ruth Gooch	RG	GP
Tom Goodwin	TG	Head of Clinical Policies & Evidence Based Medicine
Helen Moss	HM	Individual Decisions & Project Manager
Claire Warner	CWa	Senior Public Equality and Diversity Manager
Craig West	CW	Associate Director of Finance
Derby City Council		
Derbyshire County Council		
Simon Harvey	SHa	Consultant in Public Health
Chesterfield Royal Hospital NHS Foundation Trust (CRHFT)		
Derby and Derbyshire Local Medical Committee (DDLMC)		
In Attendance:		
Apologies:		
Steve Hulme	SH	Chief Pharmacy Officer (DDICB)
Ben Milton	BM	GP and Medical Director (DDLMC)
Allan Reid	AR	Consultant in Public Health (Derby City Council)

Ref:	Item	Action
1	**Welcome, Introductions and Apologies**	
	Apologies were noted from Steve Hulme, Chief Pharmacy Officer (DDICB), Ben Milton, GP and Medical Director (DDLMC) and Allan Reid, Consultant in Public Health (Derby City Council). Dr Buk Dhadda introduced himself and informed the committee he would be chairing the meeting in Steve Hulme's absence. <u>Confirmation of Quoracy</u> CPAG was quorate under the Terms of Reference. <u>Pre-election Period Guidance</u> Further to the Prime Minster's announcement of the General Election on 4th July, the 'Pre-Election Period' will commence from 25th May 2024 until at least 5th July 2024. During this time, specific restrictions are placed on the use of public	

	resources and the communication activities of public bodies including the NHS, civil servants and local government officials. The Pre-Election Period is designed to avoid the actions of public bodies distracting from or having influence on election campaigns. During the Pre-Election Period, there should be no new announcements of policy or strategy or on large and/or contentious procurement contracts, and no participation by NHS representatives in debates and events that may be politically controversial, whether at national or local level. These restrictions apply in all cases other than where postponement would be detrimental to the effective running of the local NHS, or wasteful of public money. As a result, this CPAG meeting has a reduced agenda.	
2	**Declarations of Interest**	
	BD referred to the Register of Interest and the Declaration of Interest Checklist which all committee members should be acquainted with. BD 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**	
	BD 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 24/50	The June 2024 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 24/51	**<u>5a. CPAG Actions and Decisions Log</u>** CPAG noted the Actions and Decisions Log. **<u>5ai. CPAG Workplan</u>** CPAG noted the progress to date and items pending review on the workplan.	
6	**Matters Arising/Summary**	
CPAG 24/52	**<u>6a. New Ways of Working Post ICB Restructuring</u>**	

	<u>CPAG Operating Model</u> It is proposed that there be no change to the CPAG frequency of meetings. However following the ICB restructure, there is reduced capacity to produce detailed minutes for CPAG meetings. DDICB Directors recognise that there are a limited number of meetings where detailed minutes are required, for meetings that do not fall into this category, there should be clear records of decisions and the rational for the decisions made. It is suggested that alongside the CPAG Bulletin, a decision and justification log be produced which will document decisions made at CPAG MS Teams meetings. The meeting transcript will also be retained within the ICB as an (unpublished) record of the conversations which have taken place at CPAG meetings. The CPAG meeting in July will continue to have formal minutes and a decision and justification log will be produced and tabled at August CPAG meeting. This will allow members the opportunity to review and feedback on how meeting decisions will be documented going forwards. A discussion took place and members felt it would be helpful to see the new decision and justification log completed following July's CPAG meeting. The importance of logging the decision and the justification for this was highlighted. A minute taker has the skill to identify those key areas within a discussion, therefore it is important that when the decision and justification log is completed, both the decision and justification are clearly stated. Additionally the Chair will summarise at the end of each agenda item to support record keeping within this log. A draft version of the decision and justification log will be circulated to the Chair of CPAG and members of the Clinical Policies and Evidence Based Medicine team for comment, before being circulated to CPAG members for agreement. A question was raised as to how the decision making process will be relayed to sub-committees. The decision and justification log will act as a record of the meeting and the CPAG Bulletin will support this. If a topic requires escalating, this will be done via a separate paper to the committee. It was noted that the bi-monthly CPAG meetings – papers for agreement by email do not have minutes, it only applies to MS Teams meetings where outcomes from discussions are minuted. CPAG noted the proposed changes to how the minutes will be recorded and agreed to review the new decision and justification log at a future meeting, to ensure that members are in agreement and assured by this process. **Actions:** • Complete formal CPAG minutes for July meeting • Complete meeting decision and justification log to circulate to August CPAG meeting for feedback • Save (unpublished) meeting transcript for future CPAG MS Teams meetings • Add to CPAG Bulletin <u>CPAG Chair Stepping Down and New Chair Appointment</u> The Chief Pharmaceutical Officer (Steve Hulme) will be stepping down as CPAG Chair and options were discussed for a clinical chair until the Deputy Medical Director has been appointed.	KR KR KR KR

	Dr Jonathan Burton (GP) nominated and accepted the role of CPAG Chair as of August 2024, Dr Ruth Gooch (GP) will be taking up the role of Deputy Chair for CPAG meetings as of August 2024. **<u>Actions</u>** • Arrange handover to JB • Thanks to outgoing chair • Update PHSCC • Confirm Pharmacy Directorate rep in CPAG ToR <u>Individual Funding Request (IFR) Record Keeping</u> DDICB acknowledges that IFR meetings require accurate minutes due to the nature and frequency of the meetings. The Clinical Policies and Evidence Based Medicine team are to look internally within their team for capacity, before exploring external options of support. CPAG noted and agreed with this.	KR TG HM HM
CPAG 24/53	**<u>6b. Update & Review Following the Removal of National EBI Guidance including local implications e.g. Benign Skin Lesions and links to existing operational support.</u>** <u>Benign Skin Lesions</u> SD advised that the purpose of the paper is to inform CPAG of the rationale for the withdrawal of the national EBI guidance for Benign Skin Lesions and review of EBI interventions. The Academy of Medical Royal Colleges (AOMRC) Clinical Governance group retired five guidance documents, four of which CPAG had previously agreed as pathways: • Upper GI Endoscopy • Liver function, creatinine kinase and lipid level tests (Lipid lowering therapy) • Prostate-specific antigen (PSA) test • Troponin test The other one of which was the 'Removal of Benign Skin Lesions'. Following the decision made by AOMRC to withdraw the EBI Guidance for the Removal of Benign Skin Lesions, clarification has been sought as to the rationale for this decision. There were two reasons why this decision was taken: • Specialist clinicians suggested that the initial criteria could lead to a degree of subjectivity in the interpretation resulting in variation in care. Whilst not causing patient harm, the guidance was potentially too permissive (or could be interpreted that way) which may lead to unnecessary system pressure as well as further variation in the quality of care. • Having reviewed the guidance from the clinical perspective, and having considered expert opinion it was judged that correcting the guidance would require disproportionate effect when reviewed against the likely gain made in terms of improving the quality of care or resources saved. The Clinical Policies and Evidence Based Medicine team have engaged with local	

	stakeholders (which included Consultant Dermatologists at University Hospitals of Derby and Burton NHS Foundation Trust (UHDBFT)) regarding the withdrawal of the EBI Guidance, and they have confirmed that they are in agreement to formally adopt a local position based on the guidance already written. CPAG agreed that as no concerns were raised by stakeholders, the Removal of Benign Skin Lesions policy criteria will remain unchanged and be adopted as local policy. <u>National EBI review</u> A review of the clinical evidence base for interventions published between 2019-2020 has also been undertaken by AOMRC, with the aim of determining if the evidence is up to date and whether any of the guidance requires updating to reflect any of the changes. This exercise was completed in March 2024 and of the original publications, 10 were found to need minor amendments. AOMRC are in the process of updating these interventions and hope to conclude this work by January 2025 when the updated guidance will be published. CPAG noted the 10 interventions currently being updated by AOMRC, planned to be completed/published by January 2025 <u>Operational Issues</u> In addition, it was highlighted that there is no longer access to the Clinical Policies via the GP system 'Pathfinder', following the removal of Prior Approval. It was noted that GP's need to be able to find and access these policies within a timely manner, Pathfinder is a system that most use. HM will liaise with the DDICB Pathfinder team to ensure there is a link to DDICB Clinical Policies within Pathfinder. **Actions:** • Removal of Benign Skin Lesions policy to be updated – all references to EBI to be removed • Clinical Policies website to be updated to reflect that "Removal of Benign Skin Lesions" policy is no longer an EBI intervention, it is now a local policy • Inform Contracting, Planned Care, Pathology of decision. • Add to CPAG Bulletin • Liaise with DDICB Pathfinder Team to ensure link to Clinical Policies on the Pathfinder system	HM KR KR KR HM
CPAG 24/54	**<u>6c. Updates to Cosmetic Policies Following Close Down of the Cosmetic Referral Assessment Service</u>** The purpose of the paper is for CPAG to acknowledge various cosmetic policies still make reference to the decommissioned prior approval process. CPAG noted this and the action to remove said reference to agree a minor update to the wording of cosmetic policies that require amending to reflect the closure of the Cosmetic Referral Assessment Service. Following the decision made by DDICB as part of the new organisational structures to close the Prior Approval service for cosmetic surgery, an exercise has been undertaken to review and identify any cosmetic policies that refer to the former	

	Cosmetic Referral Assessment Service. As a result minor amendments have been made to 5 clinical policies: • Pinnaplasty (Surgical correction of prominent ears) • Abdominoplasty (Apronectomy, Panniculectomy) • Blepharoplasty • Brow Lift • Rhinoplasty and Septo-rhinoplasty The Clinical Policies and Evidence Based Medicine team has informed the Cosmetic Surgery Department of the intended changes and no concerns have been raised. CPAG agreed to the minor changes to the policies to reflect the cessation of the Cosmetic Referral Assessment Service. **Actions:** • Stakeholders to be informed of minor amendment to policies • Cosmetic Policies to be updated on Clinical Policies website • Add to CPAG Bulletin	HM/KR KR KR
7	**Clinical Policies Reviewed**	
CPAG 24/55	**<u>7a. Principles for Reviewing Date Extensions for Clinical Policies</u>** HM advised that the purpose of the paper is for CPAG to discuss the principles for reviewing and extending clinical policies in the absence of a policy writer. Due to a pause in recruitment across the ICB, this has resulted in reduced capacity within the Clinical Policies Team which includes the temporary loss of the Policy writer. The earliest expected dated the policy writer is due to return is the end of 2024. CPAG agreed to implement a temporary measure to extend the review period for policies due for review in the next 6 months for a further 12 months if the following principle applies: • It is clinically safe to extend policies, in line with current practice, as confirmed with stakeholders via email, taking into account if: ○ Information within the existing policies infringes on patient safety. ○ Has any new or significant evidence been published since the policies were last reviewed that would need to be reflected within the policies. Clinical concerns have been raised that the extension of policies for a further 12 months has created a significant backlog. 23 clinical policies have been extended since November 2023, a further 10 policies are due to be extended until November 2024. CPAG are asked to consider the following options: • Escalate recruitment for an interim policy writer – to be discussed with DDICB Finance team • Prioritise Clinical Policies for review once full capacity restored and categorise by risk as opposed to date with following: ○ Low ○ Medium ○ High This may lead to a delay in the workplan for local DDICB policies	

	• CPAG to endorse a longer extension period i.e. 2 years for areas where there is unlikely to be a significant change in evidence base e.g. cosmetic procedures, review of sterilisation A discussion took place and the importance of a risk register for Clinical Policies due for review/extension was highlighted. A table of clinical policies which have been extended/due to be extended will be circulated post meeting and the Clinical Policies and Evidence Based Medicine team will suggest a (clinical) risk for each one. CPAG clinicians and Public Health representatives are asked to categorise their own risk next to this. The outcome will be tabled at August 2024 CPAG meeting for consensus and agreement on which to prioritise for updating. CPAG asked for previous stakeholder engagement comments from when the policy was last extended to be included within the risk table to assist with their decisions. CPAG agreed that Clinical Policies should be prioritised for review by risk as opposed to date, once full capacity is restored. **Actions:** • Circulate a table of clinical policies which have been extended/due to be extended and ask CPAG clinicians and Public Health representatives to categorise the level of risk. To be tabled at August 2024 CPAG meeting. Following this, start working on high risk areas. • Add to CPAG Bulletin • Discuss with DDICB Finance team recruitment for an interim policy writer	HM KR TG
CPAG 24/56	**7b. Clinical Policies Extension Date Review** Whilst awaiting the risk register (item 7a), HM advised the purpose of the paper is to provide assurance that the policies extended by 12 months are safe and align to the current evidence base in agreement with relevant consultees. The Clinical Policies Team identified a number of policies which were due to expire in the next 6 months. Item 7a provides the rationale and background. Policies extended for 12 months with assurance from clinical stakeholders are: • Photodynamic Therapy for Management of Central Serous Chorioretinopathy (CSCR) Policy • Trigger Finger Release in Adults Policy • Circumcision in Adults Policy • Circumcision in Childrens Policy • Non-standard MRI Scans Policy • Cosmetic Procedures for Gender Dysphoria Position Statement A discussion took place, and it was advised that where a nil response has been received from stakeholders specific to clinical policies, a follow up email is sent to the identified relevant stakeholders of CPAG that are from the providers to inform them of this. CPAG agreed to review this process. CPAG noted the assurance provided above and agreed a temporary extension of	

	12 months for those clinical policies which are due for review in the next six months. These policy extensions will form part of the risk register (discussed in item 7a). **Actions:** • Add to CPAG Bulletin • Add updated policies to the Clinical Policies website • Provide feedback to clinicians/stakeholders	 KR KR KR
8	**Governance Policies**	
CPAG 24/57	**8a. MedTech Pathway Proposals** TG advised the purpose of the paper is to inform CPAG of the proposal for an integrated, rules-based medical technology (medtech) pathway. NICE propose moving towards a more integrated, rules-based, and predictable pathway for the evaluation, funding, and commissioning of medical technology (medtech) in the NHS. The pathway will apply across the entire lifecycle from promising early-stage technologies; to groups of new, innovative products; as well as existing technologies in widespread use where there is scope to drive greater value. A set of principles have been developed to help ensure that the pathway as described can deliver the strategic aims of improving outcomes for patients, providing greater certainty for medtech innovators and suppliers, and driving better value for money for taxpayers and the NHS. A proposed integrated, rules based pathway has also been set out. NICE has introduced several different routes to assess the clinical benefit of a technology after topic selection which span the lifecycle of technology development: Early Value Assessment (EVA), multi-technology guidance (MTG) and late-stage assessment (LSA). There are clear, rules-based eligibility criteria for each. NICE committees have used different medtech evaluation methods to the approach in this pathway. The current criteria for the Medtech Funding Mandate Policy (MTFM) requires technology to demonstrate cost-saving potential within three years to be supported by MTFM for use within the NHS. In future, NICE will consider the cost-effectiveness and value offered by both cost-incurring as well as cost-saving medtech, using the developed principles. NICE will use their standard cost-effectiveness threshold. In general interventions with an incremental cost-effectiveness ratio of less than £20,000 per quality-adjusted life year gained are considered to be cost effective by NICE. The outcome of MTG will be a recommendation from NICE on the cost-effectiveness of a category of technologies. NICE may also issue a negative MTG recommendation which means that the case for adoption is not supported, or a 'research only' recommendation which means that further evidence is needed. Based on this, for those technologies that have received a positive MTG recommendation for routine use in the NHS, NHS England will engage in a commercial negotiation and procurement exercise. Technologies positively recommended should have a budget impact of no more than £10 million per year (considering commercial negotiations and cost savings from introducing the technology) to be eligible for automatic identification of funding to support routine commissioning. For MTG-recommended products with a greater budget impact, the commercial negotiation and procurement exercise may consider how best to support more gradual adoption over time, balanced against affordability constraints.	

	Decommissioning will be a key activity linked to NICE's LSA guidance to maximise the value of medtech for the NHS. This will be informed by benefits and value realisation from medtech implementation and the extent to which it is embedded over time. For ICB-commissioned services, ICBs will be expected to update their own service specifications and clinical commissioning policies in line with NICE guidance. CPAG suggested the ICB Innovation lead to be made aware. A discussion took place, and CPAG asked for further clarification on the following: • Is this going to be a mandated technology? It isn't clear whether this is to replace the current Medtech Funding Mandate • What is on the horizon for 2024-25 • Which DDICB clinical policies might be affected CPAG asked for the medtech pathway proposals to be tabled at a future CPAG meeting once clarification has been received in regard to the questions raised. Following this, it can then be escalated to the Population Health Strategic Commissioning Committee (PHSCC). **Actions:** • Draft policy in preparation of January 2025 • Notify commissioners • Contact DDICB Innovation Lead • Add to CPAG Bulletin	TG/HM HM TG KR
CPAG 24/58	**8b. MedTech Funding Mandate Policy Update 24/25** TG advised the purpose of the paper is to inform CPAG that an updated version of the Medical Technology (MedTech) Funding Mandate (MTFM) Policy has been published which includes the adoption of a new technology for 2024. For the 2024/25 financial year, an updated version of the guidance document has been published which includes the addition of one new technology: AposHealth (MTG76) - a device worn on the foot that improves pain measurement scores, stiffness and function for patients with symptomatic knee osteoarthritis. It is a Class I medical device and is recommended as a cost-saving option to manage knee osteoarthritis. Summary of the MTFM: • Aims to ensure patients and the NHS benefit from clinically effective and cost saving medical technologies faster and more equitably. • Technologies covered are typically funded by commissioners from their existing allocations and resources and make a return on investment within three years ((costs not exceeding £20 million), • Systems should continue to prioritise the appropriate adoption of all supported technologies which offer cost savings and improved patient outcomes and experiences.	

	• The policy does not provide additional funding for the technologies it supports. Instead, it mandates commissioners to fund the technologies when clinically appropriate. • The policy has a 'pass through' payment approach, where the commissioner is required to pay for the cost of technologies from existing allocations on a 'cost and volume' basis, where clinically appropriate. The technologies are excluded from core payment mechanisms. A discussion took place around the financials for MTFM technologies. Further conversations with DDICB Finance department will need to be held if/when future technologies become part of the MTFM. CPAG Finance noted this. A question was asked as to whether there is any way to model eligibility for AposHealth. CPAG noted that the proposed savings are cost avoidance, and as part of the horizon scan should form part of the contract conversations. CPAG noted the updated guidance which includes the addition of a new technology. **Actions:** • Inform Commissioners, Contracting and Finance of the update • Add updated MedTech Funding Mandate Policy to Clinical Policies website • Add to CPAG Bulletin	 HM KR KR
8c	**East Midlands Fertility Policy Review**	
CPAG 24/59	**8c. Update - Assisted Fertility Policy Review for East Midlands ICBs** HM advised the purpose of the paper is to update CPAG on the progress of the East Midlands ICB policy review for fertility. An assisted fertility review of policies and options appraisals for East Midlands ICBs' has been undertaken by the Public Health arm of Arden & Gem CSU, Solutions for Public Health (SPH). A collaborate approach to the commissioning of fertility services across the five East Midlands ICBs, with Nottingham ICB acting as Lead Commissioner. A policy working group has been formed with representatives from across the five East Midlands ICBs. The aim of the working group is to have an East Midlands wide policy to reduce inequalities across local borders. East Midlands ICBs Working Group meeting update – June 2024 • A Case for change final proposal has been agreed in principle prior to pre-engagement • The Chair of the working group will draft an executive summary ready for circulation • The Senior Planning Manager at Leicestershire ICB will draft a committee front sheet to be used by all East Midlands ICB's • Each ICB should confirm a timeline for the paper to be presented at internal committees in August 2024 The first phase of the engagement process has been completed; the second phase	

	is still in progress. CPAG noted the progress to date. **Actions:** • A separate update to be tabled at PHSCC <u>for discussion</u> • Final version of proposed 'Case for Change' to be tabled at August 2024 CPAG meeting	 HM HM
8d	**Glossop Transition**	
CPAG 24/60	**<u>8d. Glossop Transition for Clinical Policies – Update</u>** HM advised that the purpose of this paper is for CPAG to note the progress to date for the Glossop transition programme for EBI Clinical Policies and note policies extended for July 2024. The background and agreed engagement process have been outlined previously see item 8b of the March 2024 CPAG minutes available at: [CPAG_Minutes_March_2024.pdf (derbyshiremedicinesmanagement.nhs.uk)] For 'Photodynamic Therapy for Management of Central Serous Chorioretinopathy (CSCR)', there is no GM policy in place. Business Intelligence (BI) were asked if any activity has been undertaken for this procedure within Greater Manchester, BI have confirmed that there is no coding for this and therefore they cannot report on levels of activity. None of the reviewed policies require a Public Patient Involvement (PPI) assessment form completing. A discussion took place, and it was noted that the Glossop representative does need to respond as part of the engagement process. A question was asked in regard to the timeline for this programme of work and it was felt that this could be ongoing for a further 6 months. The ongoing work in regard to IVF was also noted. The following approach was approved by CPAG in July 2023 and ratified by PHSCC in September 2023: • To continue with the disparity whilst awaiting the outcome of the East Midlands assisted conception policy review • Patient and Public Involvement (PPI) form to be completed – Corporate to assess if the legal duty is triggered. The latest update on the East Midlands Review Group was presented to CPAG in July 2024 (item 8c). CPAG noted the update to the Glossop transition programme. **Actions:** • Table at PHSCC for information • Follow up with Glossop representative re engagement process	 HM HM
9	**Contracting and Blueteq Queries**	
	No update this month.	

10	**Individual Funding Request (IFR) – For Information**	
CPAG 24/61	**10a. IFR Screening/Panel Cases May 2024** CPAG reviewed the IFR Screening/Panel cases for May 2024 and were assured that no areas for service development have been identified. **Actions:** • Add to CPAG Bulletin	 KR
11	**PHSCC Updates**	
CPAG 24/62	Papers submitted to PHSCC tabled in June 2024 were noted: • CPAG Minutes March 2024 • CPAG Bulletin March 2024 • CPAG Bulletin April 2024 • Clinical Policies review date extension and clinical assurance • Updated CPAG Terms of Reference and Stakeholder Map and agreed review date extension • IFR Terms of Reference 3 yearly review date • Update on East Midlands Assisted Fertility Policy Review • Glossop Transition PPI Backlog	
12	**IPG Updates Since Last Meeting**	
CPAG 24/63	**12a. IPGs, MTGs, DGs, HTEs and MIBs** CPAG noted the NICE IPGs, MTGs, DGs, HTEs and MIBs updated in May 2024. 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 24/64	Papers to be submitted to PHSCC to be tabled in August 2024 (no meeting in July 2024) were noted: • CPAG Bulletin June 2024 • Clinical Policies review date extension and clinical assurance, clinical policies risk assessment • Update on East Midlands Assisted Fertility Policy Review • Glossop Transition for Clinical Policies • Change of CPAG Chair	
16	**For Information**	
CPAG 24/65	**15a. Blueteq Contract Extension for High-Cost Drugs and Individual Funding Requests (HCD and IFR)** The purpose of the paper is to inform CPAG of the proposal to agree a one-year extension for the Blueteq contract for High-cost Drugs and IFR for 2024 and note the arrangements for 2025 procurement.	

	A procurement exercise was undertaken in September 2021 and the contract awarded to Blueteq for an initial two-year period (until 2023) with an option to extend for a further 2 years (2024/2025), which could be extended without the need for any formal tendering process. In June 2024 a confirmation email has been sent to the provider, Blueteq, confirming the extension of the contract for a further and final year (2024/2025). Blueteq is now only used for HCD and IFR, as PLCV is no longer in place within the ICB. In 2025, a formal tender process must be completed for the procurement of Blueteq. Currently there is no alternative provider, therefore the procurement will fall under a Direct Award A process with a maximum 8-week timeline. Since the PLCV function has been removed, the majority of Blueteq usage is High-Cost drugs compared to IFR. The procurement will be undertaken by the Policy Team within the Pharmacy Directorate. The contract extension has been approved at a Senior Management Team (SMT) meeting. CPAG noted the agreed Blueteq contract extension for High Cost Drugs and Individual Funding Requests and the responsibility for future commissioning to be led by the Pharmacy Directorate.	
17	**Any Other Business**	
CPAG 24/66	It has been raised by the DDICB Commissioning team that following a regional meeting, it was felt that there is some increased activity around particular DDICB Clinical Policies which are aligned to EBI most notably varicose veins, and that Derby appears to be an outlier in certain areas compared to other regions. CPAG noted the issue maybe more by implementation and agreed that this should be investigated further. Questions to be raised with the Contracting team for consideration are as follows; is the issue policy related or operational. Has the volume of referrals increased or are secondary care carrying out procedures that do not meet policy criteria? A question was also raised as to whether IPG's and MTG's are being contractually followed up to ensure there is no provider activity on those. It was highlighted that contracting/commissioning used to form part of CPAG and it may be useful to link in with them in the future. To be tabled at the next CPAG meeting in August 2024. **Actions:** • Meet with the DDICB Commissioning Team for further discussion	SD
18	**Date of Next Meeting**	
	Thursday 1st August 2024, papers to be circulated for agreement by email. Agenda items for August meeting to be received by 12 noon on 15th July 2024 please.	