

Appendix 1 - Policy specific points and recommendations

The six expert working groups met on 1 – 3 occasions, with additional discussions online, to review the evidence, share local expertise and draft a London policy. Some key points of their discussions and rationale for the policies drafted are highlighted below.

1. Benign skin lesions

- The available evidence is largely drawn from expert opinion.
- The policy makes clear that it is focussed on benign skin lesions, malignant lesions are excluded and follow the 2 week wait.
- Given the number of skin conditions, the policy should not have a long list of exclusions or possible exclusions and should make clear that this is not an exhaustive list.
- Scar revision, birthmarks, keloids are not included in the policy, as many CCGs have separate policies on these including the management of children.
- The policy is clear that the criteria do not impede primary care in referring for diagnostic advice where a lesion does not fall within the 2 week wait cancer pathways but where a GP needs to confirm that they are not missing something of significance.
- 'Pain' is not explicitly required in the policy, there is no measurement framework for pain, and it is inherent the clinical criteria i.e. reduced function will be most likely related to pain.
- The effectiveness of this policy will partly depend upon recognition and appropriate management of these lesions. GPs and other relevant primary care staff should consider whether they need to increase their skills in this area, for example through education and peer review.
- Teledermatology has been very successful and there is variable access to this service across London. Those CCGs that do not currently have teledermatology should review the case for such services.
- Primary care could signpost to the British Association of Dermatology and DermNet New Zealand for example through their websites
- There is a need for consistent CCG policies across London on cosmetic procedures, including botox and hyperhidrosis.

2. Hip arthroplasty and 3. Knee arthroplasty

- There should be no fixed timeline on duration of conservative management given it is also about levels of patient engagement in the treatment, and accessibility and quality of physiotherapy.
- It is important, particularly at primary care level, to avoid unnecessary surgery whilst noting delays to surgery can lead to poorer clinical outcomes for patients who need treatment.
- There should not be a classification system for severity of pain or functional impairment as there is no standard definition in any guidance. Clinical judgement should be used.
- Whilst smoking cessation and weight reduction support should be offered, smoking should not be a barrier to surgery, in line with NICE guidelines, and there should be no BMI cut off as no specific BMI is referred to in the evidence.
- A shared decision making approach should be incorporated.
- All patients undergoing hip arthroplasty should have had plain radiographs (undertaken in secondary care) prior to the procedure

- Radiological diagnosis of degenerative disease should be included in the criteria for referral (which is included in the policy) given it is the same cohort of patients, the same criteria and the same pathway.

4. Knee arthroscopy

- There is no place for knee arthroscopy for painful osteoarthritis.
- Issues of variable access to physiotherapy across London may mean that patients are referred for surgery when they could have been effectively managed by physiotherapy.
- It was noted that improvements in MRI scanning in interface services could be made to support patients to receive the most appropriate treatment i.e. physiotherapy.
- The draft British Association for Surgery of the Knee (BASK) / British Orthopaedic Association (BOA) Treatment Guidance on the best practice for arthroscopic meniscal surgery should be referenced as a best practice guideline in the policy.

5. Low back pain

- The policy is for lumbar, lower back pain and radicular pain, in line with NHSE National Back Pain Pathway.
- It refers GPs to guidance on lower back pain and the importance of musculoskeletal and physiotherapy services.
- Epidurals: Whilst NICE guidelines state that epidural injections for acute sciatica should be offered to patients within 12 weeks, the pan London Choosing Wisely policy offers epidurals to patients who have had sciatica for 12 weeks or more. The rationale for this is: (i) issues often settle over 12 weeks avoiding the need to carry out invasive procedures such as epidural injections; and (ii) therefore it may not be the most appropriate use of resources.
- Diagnostic blocks: the improvement rate for the second diagnostic injection is based on local expertise and supports secondary care clinicians in managing repeat injections and patient expectations.
- Radiofrequency Denervation: the pan London Choosing Wisely policy states the need for imaging prior to carrying out a procedure based on local expertise. NICE does not refer to imaging pre-operatively and as such, the pan London policy does not contradict NICE guidance. Imaging should be carried out in the acute setting rather than primary care.
- The policy is mindful that there are areas where there is no direct access to MRI in primary care.
- It is important to reference shared decision making.
- Risk factors and successful management of back pain, for example a healthy lifestyle, weight management, smoking cessation; and where relevant, the factors that may reduce the likelihood of successful treatment outcomes, for example, smoking and spinal fusion surgery are included in the policy.
- For patients with uncontrollable pain, referral for assessment should not be delayed.

6. Varicose veins

- Only patients appropriate of consideration for surgical treatment should be referred to secondary care.
- In the absence of a proven “best” scoring system, the pan London Choosing Wisely policy will use relevant descriptors from the “clinical” scale from the Comprehensive

Classification System for Chronic Venous Disorders (CEAP) (grading from 1-6) alongside criteria developed from standard good practice, to support appropriate access to treatment.

- The scoring system will include quality of life criteria, using the treatment hierarchy in NICE guidelines which is widely accepted.
- The policy includes general guideline on lifestyle management such as smoking and BMI.
- The pan London policy has been drafted on the latest available evidence and best practice and may be less restrictive than some current CCG policies in place.

7. Subacromial shoulder pain

- Conservative non operative management should be offered first to all patients presenting with subacromial pain.
- Whilst the term 'appropriate' physiotherapy is open to interpretation in the policy, it is difficult to specify given the nature of the physiotherapy depends on the reason for shoulder pain, the provision of local services, and motivation and engagement of the patient.
- The policy makes clear that some groups such as lower limb amputees and wheelchair users who rely on their shoulders for mobility are an exception and should be referred sooner.
- It was noted that improvements could be made in interface scanning services to support primary care clinicians to ensure that patients receive the most appropriate treatment.
- The policy states that the patient should be involved in shared decisions about their treatment.

8. Cataract surgery

- Whilst there are variations in existing CCG policies, the evidence demonstrates that cataract surgery is both clinically effective and cost effective for both first and second eye.
- Overall, having guidance on visual acuity was useful for commissioners and as guidance for secondary care clinicians, to address any unwarranted variation in practice.
- The pan London policy makes clear that patients with ocular comorbidities and learning disabilities are outside the scope of this policy and will need to be assessed individually on a clinical basis for cataract surgery.
- The criteria are the same for first and second eyes because the evidence suggests they are both clinically effective and cost effective.
- Both visual acuity and quality of life are important criteria. NICE guidance references that visual acuity should not be used alone.
- Where patients have a best corrected visual acuity better than 6/9, surgery should still be considered where there is a clear clinical indication or symptoms affecting lifestyle, subject to mutual agreement between the provider and the responsible (i.e. paying) commissioner about the rationale for cataract surgery prior to undertaking the procedure.
- It is important to include shared decision aides within the pan London policy.
- The pan London policy aims to address variation and protect patients from inappropriate treatment and poor practice; it does not seek to restrict cataract surgery.