



Appendix 2c

Benign Skin Lesions Task and Finish Group meeting, 24 April 2018

Notes of key discussion points

Task and Finish Group members

| Attendees: | | |
|-------------------|--|-----|
| Lily Wong (Chair) | GP North West London Collaboration of CCGs | NWL |
| Nicola Clayton | Consultant Dermatologist | SWL |
| Angelika Razzaque | GP and CCG Clinical Director | SEL |
| Sarah Heyes | Clinical Director | NEL |
| Apologies | | |
| Janet High | GP | NCL |
| Barbara Wall | Patient representative | SEL |
| Ursula Johnston | Patient representative | SEL |

Also in attendance:

| | | |
|-----------------|-------------------|----------------------------|
| Jane Halpin | Director | Deloitte |
| Ronen Gordon | Senior Consultant | Deloitte |
| Mandip Korotana | Programme Manager | Healthy London Partnership |
| Kunle Awosanya | Project Manager | Healthy London Partnership |

1. Welcome from Lily Wong, Chair of the Task and Finish Group

The Chair welcomed members and outlined the purpose of the meeting. The Chair confirmed:

- the meeting was quorate
- there were no conflicts of interest although it was noted that Angelika was Chair in waiting for the Primary Care Dermatology Society (PCDS) and is on the executive committee

2. Presentation of the evidence review from Jane Halpin and Ronen Gordon

Colleagues from Deloitte presented the draft evidence review which had been circulated in advance to Task and Finish Group members. They confirmed that the purpose of the evidence review is to look at the range of policies that exist, the core evidence on which they are based and relevant additional evidence if this has been highlighted through discussion. The purpose of the evidence review is to support Task and Finish Group members in forming a London policy. It was confirmed that whilst all London CCGs have a policy on benign skin lesions, they differ on specifics e.g. definition of functional impairment, definitions of infection. The efficacy of specific interventions for

removing skin lesions is not in the fundamental question, but London CCGs are seeking to determine consistent key clinical criteria for treatment, which reflect available evidence.

Deloitte colleagues confirmed that this evidence review is draft, and will be updated following this Task and Finish Group meeting, following comments from members.

3. Discussion on the evidence: is it robust and of high quality?

The key discussion points were as follows:

- Defining 'harm' – it was acknowledged that there could be either physical or psychological harms from access to or lack of access to interventions, but there was no specific evidence on which to base clinical criteria
- Where patients have an underlying condition that may impair immunity but are stable, other factors would still need to be considered (in relation to some particular treatments reviewed e.g. for warts) and this distinction needs to be pulled through into the main text of the evidence review
- It would be useful to add some context e.g. liposarcoma is very rare
- The evidence review hasn't included cost effectiveness but it would be useful to reflect the overall context of "opportunity cost" into this review.
- The group acknowledged that evidence is largely based on expert opinion.

Janet High's comments were also raised by the Chair and considered as part of the discussions.

With these comments taken on board, the Task and Finish Group members confirmed that they were happy to proceed and the evidence review was sufficiently robust.

4. Drafting the London policy

In terms of the **presentation of the policy**, the key comments were made as follows:

- The policy has to be clear, easy to follow.
- The draft policy should be circulated to others for their input.
- The aims and objectives should make it clear that this is a London policy, referencing CCGs and STPs, and this is about uniformity and equal access across London.
- It should include reference to the opportunity cost, investing funds into other treatments or procedures that have greater benefit for the patient and clinical evidence on effectiveness.

In terms of **content of the London policy**, the following was agreed:

- The policy is about procedures and interventions for benign skin lesions (includes surgery, laser and cryotherapy, conservative management)
- The policy applies to children and adults
- Anything that is solely cosmetic in nature will not be routinely funded
- Out of scope of the policy: anything that is malignant or pre-malignant such as BCCs; scar revision, birthmarks (as many CCGs have separate policies on including management of children)

- The policy should be clear that referral 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 , or where they require advice in order to continue primary care management) are not prevented
- The policy is about criteria for onward referral for intervention for those lesions that have a sufficient level of diagnosis in primary care.
- The policy should include reference to a discussion with the patient that they want intervention and are aware of any issues such as likelihood of recurrence, appropriate to a GP and their knowledge of surgery / treatments risks.
- The diagnostic and intervention codes need to be updated to include what was in scope of the policy, as per discussions.
- The London policy should seek to build upon those London CCGs with the more advanced policies in place.

In terms of the **clinical criteria for treatment**, it was agreed that it should be based on:

- The benign skin lesion is being frequently and unavoidably (due to location) traumatised
- The location of the lesion i.e. obstructing an orifice and / or restricting function, where it is affecting a patient's daily life
- Infection i.e. frequent attendance and more than 2 episodes of infection requiring treatment with antibiotics
- Presence of pain was also a factor, and should be incorporated in the points above, rather than a standalone point.

In discussions on **implementation of this London policy**, the group agreed:

- It would be useful to have a checklist (on one page) that makes it easier for GPs to follow
- The Group would like comments from other colleagues on the draft policy, to ensure that nothing has been missed
- The Group acknowledged that onward referral may result in different routes – for those areas with community services and those where these are no longer in place.

5. Next Steps

- The Group agreed that they should meet again on 1 May, to review the draft policy and review this against the ethical framework
- The Group felt strongly about the need for patient input into the draft policy, and a second meeting would be an opportunity to get this input into the policy.
- It was confirmed that there would be an opportunity for members to circulate the draft policy to colleagues to get further input, as well as a 'soft launch' phase that will involve getting further feedback on the policy, largely in terms of presentation and language.

Benign Skin Lesions Task and Finish Group meeting, 1 May 2018

Notes of key discussion points

Task and Finish Group members

| Attendees: | | |
|-------------------|--|-----|
| Lily Wong (Chair) | GP North West London Collaboration of CCGs | NWL |
| Nicola Clayton | Consultant Dermatologist | SWL |
| Angelika Razzaque | GP and CCG Clinical Director | SEL |
| Janet High | GP | NCL |
| Sarah Heyes | Clinical Director | NEL |
| Rosie Barran | Patient representative | SEL |
| Apologies | | |
| Barbara Wall | Patient representative | SEL |
| Ursula Johnston | Patient representative | SEL |

Also in attendance:

| | | |
|-----------------|-------------------|----------------------------|
| Jane Halpin | Director | Deloitte |
| Ronen Gordon | Senior Consultant | Deloitte |
| Mandip Korotana | Programme Manager | Healthy London Partnership |
| Kunle Awosanya | Project Manager | Healthy London Partnership |

Emailed comments on draft policy from:

| | | |
|---------------------|--------------------------|-----|
| Dr Mark Griffiths | Consultant Dermatologist | NCL |
| Dr Abha Gulati | Consultant Dermatologist | NEL |
| Dr Jennifer Crawley | Consultant Dermatologist | NCL |
| Dr Ben Esdaile | Consultant Dermatologist | NCL |
| Dr Justine Kluk | Consultant Dermatologist | SWL |

6. Welcome from Lily Wong, Chair of the Task and Finish Group

The Chair welcomed members and outlined the purpose of the meeting. The Chair:

- confirmed that the meeting was quorate
- confirmed that there were no conflicts of interest although it was noted, as at the previous meeting, that Angelika was Chair in waiting for the Primary Care Dermatology Society (PCDS) and is on the executive committee
- welcomed Rosie who had stepped in at short notice as the patient representative

7. Agreement and sign off on the notes of the previous meeting

Task and Finish Group members agreed that the notes of the previous meeting were accurate and signed them off as presented.

8. Review of draft policy: presented by Ronen Gordon and Jane Halpin

Ronen outlined key updates following discussions at the Task and Finish Group meeting on 24 April:

- The policy acknowledges that different areas have differing levels of access, so patient pathways will vary.
- 'Diagnostic confidence' has now been included.
- London specific text and opportunity costs have now been included.
- A list of inclusions and exclusions are included, and this is the most significant area for discussion.
- Scars have not been included, to be discussed.
- The evidence on liposarcoma has been included.
- A flowchart has been added to show how the clinical criteria would be applied.
- The evidence review and references are now appended to the policy.

Comments on the draft policy from all members including feedback gathered from colleagues

Discussions first focussed on the inclusion and exclusion tables, including emailed comments from secondary care clinicians, and the Group agreed the following:

- The inclusion and exclusion table need to be more accurately worded to show what will not be funded unless the following clinical criteria apply and what will be funded. The colour coding, where inclusion/exclusion boxes are placed and where the flowchart sits, all need to support ease of use and clarity.
- The following should also appear in the exclusion table to show that the policy does not apply to:
 - Congenital Naevi
 - Vascular birthmarks in children
 - Naevus of Ota / Naevus of Ito
 - Café au lait patches
- The following should appear in the inclusion table i.e. what the policy applies to:
 - Dermatofibroma
 - Campbell de Morgan spots
 - Capillary Haemangioma
 - Xanthelasma
- The policy should make it clear that it is focussed on benign skin lesions, malignant lesions are excluded and follow the 2 week wait.
- On that basis, SCCs, BCCs, melanoma should be removed from the list, including information on BCCs and AKs in the main evidence review and appendix tables, as this could cause confusion.
- It was agreed that skin resurfacing, revision of scars, acne scarring, biopsies should all be removed from the policy as they are not skin lesions.
- Given the range of skin conditions, there was a discussion about what should be named and not named within the policy. It was agreed, given the number of skin conditions, that policy should

not have a long list of exclusions or possible exclusions and should make clear that this is not an exhaustive list.

- For teleangiectasia, it was agreed that the policy should include an example of specific circumstances.
- It was agreed that for warts, there should be an addendum, stating that where warts are multiple or facial or in patients with an underlying condition that may impair immunity or, and where conservative management has failed, treatment will be commissioned with prior approval.
- Coding should reflect the updated list.

Discussions then focussed on the clinical criteria and the Group agreed the following:

- The London policy should follow the clinical criteria used by BHR, it aligns with the criteria that Group members agree upon, and has been tried and tested, is working well, and has begun to be adopted by others.
- It was noted that pain is not mentioned in the clinical criteria. However, Group members agreed that the mention of 'pain' was not explicitly required in the policy. There was no measurement framework for pain, and it was inherent in the first two clinical criteria as reduced function will be most likely related to pain
- The term 'confidence' should be used rather than 'certainty'
- The flow chart should include 'telederm, if available'

Review of the draft policy against the ethical framework

Task and Finish Group members considered the principles as follows:

Rational

- The programme is about ensuring scarce NHS resources are spent on those treatments that have the most benefit for patients.
- The evidence was valid and credible and decisions had been made on the evidence, although it was noted that it was available evidence was low grade, and this is reflected in the policy.
- The policy refers to benign skin lesions that don't ordinarily need to be treated.
- National and local guidelines have been considered but do not exist for these lesions. It was noted that Mark Griffiths who had commented on the draft policy by email, is a member of the British Association of Dermatologists (BAD).

Socially inclusive

- Benign skin lesions are not solely relevant to any one particular group.
- It was flagged that those who do not have the resources cannot go private, or may get themselves in debt in order to get treatment privately.
- Many GPs are not trained in these sorts of minor procedures any more so there is less access for patients.
- The issue is about clinical need, if there was a significant impact on mental health, this would be managed differently.
- Whilst the policy is applicable for London, the patient pathway may vary given services available locally e.g. some have access to telederm and others don't.

Clear and open to scrutiny

- It was noted that there had been a lot of medical terminology used in the meeting, and this may have made it difficult for the patient representative to contribute. It was agreed that further patient input was required as part of the testing / soft launch phase and the patient representative should also circulate the policy to her local patient networks as part of the testing phase.
- It was agreed that the LMC was also an important stakeholder to engage.

Taking economic factors into account

- There was a discussion about 'rationing' given the resources available to the NHS and the need to make difficult choices.
- It was agreed that this applied to all clinicians, secondary care as well as GPs.
- It was agreed that benefits and risks had been considered.
- It was felt that the next criteria was not applicable - low cost treatments with high effectiveness versus high cost treatments with low effectiveness.

Promote health

- It was agreed that this was not applicable to benign skin lesions.

Reviewing of the draft policy considering implementation

Task and Finish Group members agreed the following:

- GPs need to get to the salient points quickly. It was agreed that the commissioning statement on the front will be used to do this.
- The flowchart is very helpful.

Recommendations

A number of recommendations were made by the Task and Finish Group and it was agreed that these would be raised by the Chair at the London Choosing Wisely Steering Group when the draft policy was presented. These recommendations are as follows:

- The standard of education amongst GPs in this area should be increased. CCGs should invest in this as this will have an impact on the successful implementation of the policy.
- Telederm has been very successful and there is inequality of access to this service across London. Those CCGs that do not currently have telederm should consider investing in this. *Ronen to check the statistics on telederm via BAD (Exeter).*
- There should be signposting to the BAD and DermNet New Zealand on GP's intranets across London.
- There is a real need for improved London policies on cosmetic procedures including botox and hyperhidrosis.

9. Agreeing the London policy: next steps

- The policy will be re-drafted following comments made and re-circulated to Task and Finish Group members for final comment, with sign off from the Chair.

- Once signed off, the policy will then move into the 2 week test / soft launch phase which will predominantly focus on testing language used and anything that is open to interpretation, as opposed to testing the content of the policy.
- It will be circulated to Task and Finish Group members who should also circulate it to key colleagues.
- The policy will also be circulated to the Referral Management Centre via STP PoLCE leads, to STP clinical leads, to Healthwatch, and to patient groups.
- Engagement will also be sought with LMC as advised.
- The policy will then be amended (language as opposed to content) as required with sign off from the Chair, and presented at the 4 June London Choosing Wisely Steering Group.