Healthy London Partnership
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FAO: Evidence Based Interventions programme
NHS England
Sent via email: england.EBinterventions@nhs.net

27 September 2018
Our ref: LCW-EBI-001

Dear Sir / Madam,

Evidence Based Interventions: Consultation – response from Healthy London Partnership

As you are aware, in London, CCGs, NHS England and NHS Improvement have had a clinically-led programme, called London Choosing Wisely, that has developed commissioning policies for eight treatment areas, which could be adopted by all 32 London CCGs, to ensure patients across London have consistent access to treatment that improves their health, based on the latest available evidence.

Several conditions / interventions covered by the national review have already been developed by the London Choosing Wisely programme. These are benign skin lesions; knee arthroscopy; low back pain (spinal injections); varicose veins and subacromial shoulder pain. Healthy London Partnership has been commissioned to undertake the programme management for this work. As such, please find this response to the consultation on the national Evidence Based Interventions programme to help inform the development of national policies.

Additionally, the London Choosing Wisely Steering Group has had strong and constructive engagement with the national Evidence Based Interventions programme team who have agreed that a response from Healthy London Partnership to the consultation would be appropriate and is supported by the London Choosing Wisely Steering Group. The importance of individual CCGs responding to the national consultation has also been raised at the London Choosing Wisely Steering Group and Programme Board.

Firstly, Healthy London Partnership agrees with the principle of the Evidence Based Interventions programme that more needs to be done to ensure the least effective

interventions are not routinely performed, or only performed in more clearly defined circumstances.

We believe that the London Choosing Wisely programme has begun to address this in London by drafting a set of commissioning policies which will reduce variation of care for patients across London by providing doctors with the latest evidence on what treatments should be offered to patients to achieve the best health outcome, whilst also seeking to ensure that patients do not receive unnecessary treatment or intervention that will have little impact.

London Choosing Wisely: developing policies through a robust clinically led process

To help inform the development of national policies, we feel it is useful to outline the approach we have taken in London. The programme is being led by a London Choosing Wisely Steering Group which includes clinical leaders representing each of London's Sustainability and Transformation Partnership (STP) areas, primary care clinical leads appointed to the review of each area of care, patient representatives, public health experts and an equality and diversity expert. The Steering Group is chaired by NHS England (London region) medical director, Dr Vin Diwakar.

Six Task and Finish Groups have been established to steer the review process for each treatment (with hip and knee policies being considered together). Each Task and Finish Group is chaired by a primary care lead and that individual also sits on the London Choosing Wisely Steering Group. Membership of the Task and Finish Groups consisted of primary care clinicians from STP patches across London, a secondary care clinical lead(s) for the speciality, and patient representatives. Task and Finish Groups also further consulted with experts locally throughout the review process as necessary.

The six groups met to consider the latest available clinical evidence and the variation in CCG policies across London. The evidence was collated by independent public health experts using agreed search terms, key questions and inclusion/exclusion criteria for each policy. Search terms were agreed and discussed with the Chairs and members of the Task and Finish Group. The Groups discussed how this and current practice should shape a London policy, and reviewed their recommendations against an ethical framework to guide a consistent approach to decision making.

As each policy was developed, a 'sense check' phase was introduced to ensure that each draft policy is clear, easy to follow and use. This was not a consultation. <u>It is important to note that the London Choosing Wisely programme is advisory and the statutory duty for approval of London-wide policies rests with each CCG Governing Body.</u> It will be for CCGs to further engage and consult (if required) locally, prior to any implementation.

Importantly, this phase of the programme allowed the six expert groups to get wider input from interested parties, including clinicians, professional bodies, London's Healthwatch organisations, patients and patient groups. Notice about this phase of the programme was sent to the following groups along with a request that information about the sense check phase be cascaded to local networks:

- Members of the expert working groups;
- Members of the London Choosing Wisely Programme Board, which is made up of London's Sustainability and Transformation Partnership (STP) leads on local CCG policy development;
- London Choosing Wisely programme's two Steering Group patient representatives;
- All relevant royal colleges and professional/clinical associations, including the British Medical Association's London executive;
- All of London's Healthwatch networks, with further support from Healthwatch England in cascading the details;
- All relevant patient-facing organisations, for example including but not limited to Arthritis Research UK (ARUK), the Arthritis and Musculoskeletal Alliance (ARMA) and the British Orthopaedic Association's Patient Development Group.

The response to the sense check was helpful but not comprehensive and the programme will advise CCGs to further engage locally, where appropriate.

It is worth nothing that the London Choosing Wisely programme has received some adverse comment from the BMA's London executive with regard to whether there is a disproportionate impact on older people.

Once agreed by the Task and Finish Groups, each pan London policy is presented to the London Choosing Wisely Steering Group. The Steering Group ensures that a robust and rigorous review process has been carried out. All London Choosing Wisely policies are expected to be presented to London's 32 CCGs by mid-October 2018. It will then be for CCGs to further review, engage and consult (where required) in line with local governance processes, before making a decision on implementation.

Further, this process was endorsed by London's Clinical Senate. Given the extensiveness of this review process and the clinical and patient engagement across London, the London Choosing Wisely Steering Group is hopeful that these pan London policies will be supported by London's CCGs.

The London Choosing Wisely programme is an example of how commissioning policies can be harmonised at a regional level through strong engagement with local CCGs/STP areas, patients, specialist societies and local clinicians.

London Choosing Wisely policies

With this in mind, please find attached to this response the London Choosing Wisely policies drafted in these treatment areas. (Please note the policies for knee arthroscopy and varicose veins will go to the London Choosing Wisely Steering Group on October 2nd to be ratified and therefore are included here in draft form after having completed the sense check and feedback phase of the programme.)

You will note that the pan London policies do not contradict the proposed national criteria undergoing consultation. They also all include an 'Advice for Primary Care' section which has received support as part of sense check, in terms of ease of use and implementation.

We wish to take this opportunity to set out the key considerations of each London Choosing Wisely expert group in order to inform the development of national policies.

Taking each draft pan London policy in turn:

1. Benign skin lesions:

The Task and Finish Group noted that the vast majority of benign skin lesions are harmless but may be unsightly and cause distress for patient. There are occasional circumstances in which a procedure or intervention for benign skin lesions is clinically indicated, these circumstances are listed in this policy. The policy ensures that lesions are not removed for solely cosmetic reasons.

The Task and Finish Group noted that there is generally low level evidence surrounding the interventions for benign skin lesions, and where evidence is available it is focused on the efficacy of intervention, rather than the criteria whereby intervention is supported.

The Task and Finish Group concluded that any malignant and potentially pre-malignant lesions are excluded from this policy which should solely relate to benign skin lesions. For this reason actinic keratosis (AK) are also excluded from this policy. Scars, including keloid and hypertrophic scars, were excluded from this policy as they tend to be included in cosmetic policies. The Task and Finish Group noted that lesions with an uncertain diagnosis or rapid growth present a potential risk to patients and thus these commissioning criteria should only be applied when there is diagnostic confidence.

The Task and Finish Group noted the difficulty in prescribing specific, evidence based criteria for when a lesion should undergo intervention and clinical judgement needs to be applied. However, examples to support this decision making are helpful including recurrent trauma leading to antibiotic requirement, restricted function due to pain, and these are reflected in this policy.

On reviewing the London policy with the national criteria, whilst there are similarities there are also some differences:

- The national policy refers to facial disfigurement and congenital deformity as being within the scope of its policy, whereas the Task and Finish Group agreed that this would be out of scope of a London policy, meaning that it would be up to local CCGs to decide on an individual basis. A congenital deformity could be wide ranging – e.g. an accessory nipple (cosmetic), a haemangioma (large ones could be associated with congenital paediatric syndromes, whereas small ones could be benign and asymptomatic).
- In reference to the >1cm facial lesion criteria causing facial disfigurement, the Task and Finish Group agreed that this a cosmetic issue, and were keen not to widen the scope/lax the criteria of the existing benign skin lesion policies across London.

2. Knee arthroscopy:

The Task and Finish Group agreed that there is no place for diagnostic or therapeutic knee arthroscopy in the routine treatment of painful osteoarthritis (OA).

In addition to discussing the evidence review on arthroscopic partial meniscectomy, the Task and Finish Group reviewed a consensus piece on arthroscopic meniscal surgery due to be published in the coming year by British Association for Surgery of the Knee (BASK) / British Orthopaedic Association (BOA). However, as both the guidance and the underpinning evidence is yet to be published, it could not be formally reviewed by the group and whilst the policy refers to this work, it is has not incorporated into the policy criteria.

The Task and Finish Group noted that there may be local variation in commissioning of both physiotherapy and weight loss services, and so patients across London may not have access to equivalent non-surgical treatment options.

On reviewing the London policy with the national criteria, whilst there are similarities there are also some differences:

- Both the London policy and the national criteria specifically relate to the role of arthroscopic knee lavage (or washout) with or without debridement in patients with osteoarthritis (OA).
- Both are clear that the procedure is not recommended for routine use.
- However, the London criteria recognise one specific exception to this – in the case of a truly locked knee.
- Whilst the London commissioning criteria do not explicitly refer to alternative treatments, the policy does include advice to primary care later in the document:

'For patients who are symptomatic with degenerative disease including OA, first-line treatment should ideally be with a comprehensive programme of non-surgical measures, including education, exercise, physiotherapy, simple analgesia and steroid injection (where acceptable to the patient).'

3. Low back pain (spinal injections):

The Task and Finish Group noted that “radicular pain” and “low back pain” were separate conditions. However, they agreed that pathology in the back is common to both conditions; that they may share similar causation, and thus they should be covered in one single pan London policy. This also aligns with the NHS England National Back Pain Pathway, where the diagnoses are covered in a single policy incorporating two pathways.

The Task and Finish Group noted that there are occasional circumstances in which a procedure or intervention for low back pain is clinically indicated and these circumstances are listed in this policy. It also concluded that patients with malignancy or suspected malignancy, signs or symptoms of neurological deficit (spinal cord compression or cauda equina), fracture or infection are excluded from this policy.

On reviewing the London policy with the national criteria, whilst there are similarities there are also some differences:

- It is noted that the national criteria apply only to non-specific low back pain, whereas the London criteria apply to this and to people with sciatica (radicular pain).
- National criteria only cover spinal injections and note NICE guidance on RFD, whereas the London criteria include a much greater range of interventional treatments.
- On comparing the London criteria against the national criteria, it is noted that the intention is the same, although the wording is different. Both approaches do not recommend the use of spinal injections for patients with low back pain.
- The London wording is more specific and precise about what is included in the category ‘spinal injections’. The detailed text in the London criteria reflects the NICE guidance which is referred to by the national criteria.

4. Varicose veins:

The Task and Finish Group noted that whilst there is some high quality evidence relating to varicose veins, this is mostly focused on the specific efficacy of treatments and not on when to treat patients, the key focus of the commissioning policy.

The group also reviewed the range of scoring systems that exist for varicose veins The group noted that the ‘C’ element of the CEAP classification is broadly most frequently used and is easiest to apply as it gives objective clinical criteria to define stage of varicose vein disease. The group has added additional quality of life criteria around CEAP stages 2 and 3 to make this scale more fit for purpose, and has opted

to use clinical descriptions primarily rather than purely refer to CEAP criteria as these are less well known in primary care.

In addition, the Task and Finish Group discussed whether a reference should be made to treat one leg or both legs in the same procedure but it was agreed that there should not be a reference made within the commissioning policy as there are multiple factors that impact on this decision, that should be clinically led.

The London policy aligns well with the national criteria currently out for consultation, although there are some differences:

- Superficial thrombophlebitis- the draft London policy specifically mentions numbers whereas the national policy includes a description of superficial thrombophlebitis, whilst not specifying any numbers. The wording in relation to thrombophlebitis reflects policy in two of the London STP areas.

- Swelling/ oedema above/below knee/ankle is not specified in national policy.

The Task and Finish Group have opted to commission treatment modalities in line with NICE guidelines. There was no additional evidence to suggest a different treatment option should be first line and surgery still represents the last line of treatment. The group noted that new treatments using glue are starting to evolve but do not yet have a strong evidence base and so should not yet feature in the policy.

5. Subacromial shoulder pain:

Given that there are no CCG policies in place in London, the Task and Finish Group agreed that the South Yorkshire and Bassetlaw CCGs criteria for referral, which appears to be based on the Commissioning Guide produced by the British Elbow and Shoulder Society (BESS) and British Orthopaedic Association (BOA) in 2014, should be used in drafting the London policy.

The Task and Finish Group noted that there is a paucity of high quality evidence demonstrating the effectiveness of any treatment option for subacromial shoulder pain and the evidence for effectiveness of subacromial decompression is conflicting.

The Task and Finish Group highlighted the ongoing Finnish Subacromial Impingement Arthroscopy Controlled Trial (FIMPACT), a randomised trial comparing arthroscopic subacromial decompression vs. diagnostic arthroscopy vs. exercise therapy in participants with shoulder impingement syndrome. The trial will look at pain, arm movement, function, patient satisfaction and reoperations / treatment conversions at two years following randomisation. The results of the trial are currently awaited and due to be published in the coming year.

On reviewing the London policy with the national criteria, whilst there are similarities there are also some differences:

- Whilst the wording in the London policy is different to the national criteria, the criteria are mutually supportive. Both advocate that conservative management is used first and that surgery should only be considered if this fails to provide benefit. This is however phrased differently.
- Policy exclusions are similar but not identical. The national criteria sets out to define shoulder impingement syndrome by excluding rotator cuff tears, acromioclavicular joint pain or calcific tendinopathy; London excludes infection, trauma, malignancy, rotator cuff tears and inflammation.
- The Task and Finish Group members consider the wording in the London policy to be clearer and easier to implement and follow.

Additional considerations

Through the work undertaken as part of the London Choosing Wisely programme, we would also urge you to consider the following points:

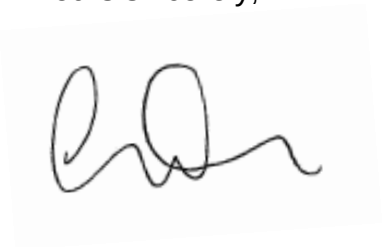
- **National policies should not be mandatory** and there should be flexibility for CCGs to use other policies in these areas that better reflect the local needs and processes. The NHS contract should state that these are minimum expectations but policies are to be agreed locally. For London, the London Choosing Wisely programme has undertaken a significant amount of work to develop eight commissioning policies (five which are also covered by the Evidence Based Interventions programme), the outcomes of which are underpinned with an evidence-based decision making process and strong local engagement. Importantly, all pan London policies have been drafted so that they can easily be managed within current local systems.

- **It is not always appropriate for GPs (primary care) to always submit forms** as this does not reflect current local processes. There will be occasions where decisions on treatment cannot be made until there has been a review undertaken in secondary care. In other words, the London Choosing Wisely Steering Group acknowledges that not all of the information is available in primary care, some patients will need to be reviewed in secondary care in order to have a decision taken on the best course of action to improve their health, therefore it is not always clear at the point of referral if this course of action is a procedure of low clinical effectiveness.

Thank you for accepting this submission to the national consultation on the Evidence Based Interventions programme which we hope you are able to take into consideration.

Please do not hesitate to contact me if you have any further questions about the London Choosing Wisely programme.

Yours sincerely,



Shaun Danielli
Director, Healthy London Partnership

Copied to:

- *Dr Vin Diwakar, Medical Director, NHS England (London region); Chair, London Choosing Wisely Steering Group*
- *Danny Batten, Acting Director of Transformation and Delivery, NHS England (London Region) North East London; Senior Responsible Officer, London Choosing Wisely*
- *Schellion Horn, Director of Operations and Transformation, Healthy London Partnership*

Enclosed:

- *Final pan London policies: benign skin lesions; low back pain (spinal injections); subacromial shoulder pain*
- *Draft pan London policies: knee arthroscopy; varicose veins*
- *Membership of London Choosing Wisely Steering Group*
- *Membership of Task and Finish Groups*
- *Ethical decision making framework and application sheet*