NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Health and social care directorate

Quality standards and indicators

Briefing paper

Quality standard topic: Low back pain and sciatica

Output: Prioritised quality improvement areas for development.

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Contents

1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for low back pain and sciatica. It provides the committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

1.1 Structure

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the committee in considering potential statements and measures.

1.2 Development source

The key development source(s) referenced in this briefing paper is:

Low back pain and sciatica. NICE guideline 59 (2016)

2 Overview

2.1 Focus of quality standard

This quality standard will cover assessment and management of non-specific low back pain and sciatica in people aged 16 years and over.

2.2 Definition

Non-specific low back pain is a term used to describe pain in the back between the bottom of the rib cage and the buttock creases. It describes low back pain that is not associated with serious or potentially serious causes.

In this context we use 'sciatica' to describe leg pain secondary to lumbosacral nerve root pathology. This is because sciatica is a term that patients and clinicians understand and one that is used widely in the literature to describe neuropathic leg pain secondary to compressive spinal pathology.

2.3 Incidence and prevalence

Serious causes of low back pain are rare (for example, less than 1% of patients presenting with low back pain in primary care will have cancer as the underlying cause and clinicians are usually alerted to the possibility of serious pathology by using clinical screening tools (‘Red flag screening’).

Low back pain causes more disability, worldwide, than any other condition. Episodes of back pain usually do not last long, with rapid improvements in pain and disability seen within a few weeks to a few months. Although most back pain episodes get better with initial primary care management, without the need for investigations or referral to specialist services, up to one-third of people say they have persistent back pain of at least moderate intensity a year after an acute episode needing care, and episodes of back pain often recur.

Prevalence and burden increases with age peaking at around 60 to 70 years, and worldwide prevalence has been reported to be highest in Western Europe. In a large European-wide survey, Breivik reported a prevalence of persistent and intrusive pain of 19%. Of those, 42% reported back pain - by far the most common regional site. Prevalence of back pain is more common in women than men.

Sciatica is a relatively common condition with a lifetime incidence ranging from 13 to 40%. The corresponding annual incidence of an episode of sciatica ranges from 1 to 5%. The incidence of sciatica is related to age - rarely seen before the age of 20, incidence peaks between age 50 to 60 years and then declines. Modifiable factors associated with a first onset of sciatica include smoking, obesity, occupational factors and general health status.

2.4 Management

One of the greatest challenges with low back pain is identifying risk factors that may predict when a single back pain episode will become a long-term, persistent pain condition. When this happens, quality of life is often very low and healthcare resource use high.

A complex and variable interplay between biological, psychological and social factors influences this progression and it is the modification of these factors that has become one of the main focuses of back pain research and treatment over the last decade.

The prognosis for patients with sciatica is good and most patients will find that pain and associated disability improves rapidly without treatment.

Clinical examination of people with back pain or sciatica is routinely performed by primary health care professionals, therapists, specialist physicians and surgeons. Clinical examination serves a number of functions such as corroborating or strengthening the diagnosis made on taking a detailed history. It may also be important for reaching a diagnosis, for example, where the history is unclear or where imaging would not be expected to clarify a diagnosis. Clinical examination might also be important for supporting a management plan, assessing prognosis and assessing the response to treatment.

People consulting healthcare professionals may expect an examination as part of the consultation, and this contributes to satisfaction with the consultation. It is thought that the repercussions of not performing an examination would lead to dissatisfaction and unwarranted demand for tests or further referrals.

There is uncertainty as to whether any of the clinical tests that are commonly used in the examination of people with suspected sciatica are more beneficial than others, or compared to a taking a comprehensive history.

There are recognised risk factors or prognostic features that may make a person more likely to suffer from chronic, disabling back pain. These include demographic/physical factors, for example older age, being female, leg pain, psychological factors such as negative beliefs and behaviours, passive attitude towards treatment, depression and anxiety, and social factors such as poor work environment, job dissatisfaction and unhelpful social support. These risk factors may not always become apparent to a health professional when assessing a person with back pain. Therefore, risk stratification tools that help to support clinical decision-making have emerged.

The use of imaging is considered in specialist settings of care (for example, a musculoskeletal interface clinic or hospital) when the result is likely to change management.

There are numerous treatments for low back pain and sciatica. They fall under 3 main categories: non pharmacological (such as self-management, exercise, manual therapies, psychological programmes and return-to-work programmes), pharmacological and invasive treatments (such as radiofrequency denervation, epidurals). There are also other treatments which are not recommended by NICE, such as acupuncture, electrotherapies, spinal injections, spinal fusion and disc replacement.

See appendix 1 for the algorithms from NICE guideline NG59.

2.5 National outcome frameworks

Tables 1–2 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 NHS outcomes framework 2016–17

Domain	Overarching indicators and improvement areas
2 Enhancing quality of life for people with long-term conditions	***Overarching indicator*** 2 Health-related quality of life for people with long-term conditions** ***Improvement areas***

	Ensuring people feel supported to manage their condition 2.1 Proportion of people feeling supported to manage their condition **Improving functional ability in people with long-term conditions** 2.2 Employment of people with long-term conditions*, ** **Reducing time spent in hospital by people with long-term conditions** **Enhancing quality of life for carers** 2.4 Health-related quality of life for carers**
3 Helping people to recover from episodes of ill health or following injury	***Overarching indicators*** 3a Emergency admissions for acute conditions that should not usually require hospital admission 3b Emergency readmissions within 30 days of discharge from hospital* ***Improvement areas*** **Improving outcomes from planned treatments** 3.1 Total health gain as assessed by patients for elective procedures *i Physical health-related procedures* **Helping older people to recover their independence after illness or injury** 3.6 i Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation service* ii Proportion offered rehabilitation following discharge from acute or community hospital*
4 Ensuring that people have a positive experience of care	***Overarching indicators*** 4a Patient experience of primary care i GP services ii GP Out-of-hours services 4b Patient experience of hospital care 4c *Friends and family test* *4d Patient experience characterised as poor or worse* *I Primary care* *ii Hospital care* ***Improvement areas*** **Improving people's experience of outpatient care** 4.1 Patient experience of outpatient services **Improving hospitals' responsiveness to personal needs** 4.2 Responsiveness to inpatients' personal needs **Improving access to primary care services** 4.4 Access to i GP services

Alignment with Adult Social Care Outcomes Framework and/or Public Health Outcomes Framework
* Indicator is shared
** Indicator is complementary
Indicators in italics in development

Table 2 Public health outcomes framework for England, 2016–2019

Domain	Objectives and indicators
1 Improving the wider determinants of health	***Objective*** Improvements against wider factors which affect health and wellbeing and health inequalities ***Indicators*** 1.09 Sickness absence rate 1.18 Social isolation
2 Health improvement	***Objective*** People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities ***Indicators*** 2.13 Proportion of physically active and inactive adults
4 Healthcare public health and preventing premature mortality	***Objective*** Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities ***Indicators*** 4.11 Emergency readmissions within 30 days of discharge from hospital* 4.13 Health-related quality of life for older people
Alignment with Adult Social Care Outcomes Framework and/or NHS Outcomes Framework * Indicator is shared	

Summary of suggestions

2.6 Responses

In total 12 stakeholders responded to the 2-week engagement exercise 22/11/16 – 6/12/16.

Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table 4 for further consideration by the committee.

Full details of all the suggestions provided are given in appendix 4 for information.

Table 3 Summary of suggested quality improvement areas

Suggested area for improvement	Stakeholders
Assessment • Risk stratification • Imaging • Accurate diagnosis	SPNHSFT, SIS, SCMx4
Non-pharmacological interventions • Self-management • Group exercise programmes • Combined physical and psychological programmes • Return-to-work programmes	SPNHSFT, SIS, PC, YHLBI, NELtd, CSP, CNHC, EPAUK, SCMx5
Pharmacological interventions • Reducing the use of unhelpful medication • Non-steroidal anti-inflammatory drugs	SCMx5
Invasive treatments • Non-effective invasive treatments • Invasive treatments for specific groups • Decision to refer for surgery	SCMx4, SPNHSFT, RCGP
Additional areas • Identify appropriate treatment according to aetiology • Neuromuscular electronic stimulation • Self-referral to physiotherapy • Referral for spinal imaging • Acupuncture • Definition of specialist spinal service • Regulation of professionals	SIS, NELtd, CSP, BSSR, AT

Suggested area for improvement	Stakeholders
AT, Acupuncture Torbay BSSR, British Society of Skeletal Radiology CNHC, Complimentary and Natural Healthcare Council CSP, The Chartered Society of Physiotherapy EPAUK, Esoteric Practitioners Association UK/EU NELtd, Neurocare Europe Ltd PC, Pain Concern RCGP, Royal College of General Practitioners SCM, Specialist Committee Member SIS, Spine Intervention Society SPNHSFT, Somerset Partnership NHS Foundation Trust YHLBI, Yoga for Healthy Lower Backs Institute	

2.7 Identification of current practice evidence

Bibliographic databases were searched to identify examples of current practice in UK health and social care settings; 491 papers were identified for low back pain and sciatica. In addition, 17 papers were suggested by stakeholders at topic engagement and 46 papers internally at project scoping.

Of these papers, 5 have been included in this report and are included in the current practice sections where relevant. Appendix 2 outlines the search process.

3 Suggested improvement areas

3.1 Assessment

3.1.1 Summary of suggestions

Risk stratification

Stakeholders highlighted that healthcare professionals should consider using risk stratification to inform shared decision making about stratified management. This should be done at first point of contact with the healthcare professional for each new episode of low back pain. Risk stratification can identify the patient's risk of ongoing disability from low back pain and determine whether they can be managed in primary care, leading to a reduction of unnecessary treatment and better use of resources.

Imaging

Stakeholders suggested imaging should not be offered in a non-specialist setting for people with low back pain with or without sciatica. This is because imaging in these circumstances does not change initial management, it can raise anxiety and lead to further referral for findings that are not relevant to the clinical presentation.

A stakeholder highlighted the importance of an early MRI scan for people with disabling symptoms and neurology. This can lead to specific indication before chronic pain develops.

Accurate diagnosis

Stakeholders highlighted the importance of establishing an accurate diagnosis of low back pain and sciatica. Without an accurate diagnosis, patients can be subjected to unnecessary procedures and treatments.

3.1.2 Selected recommendations from development source

Table 4 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 4 to help inform the committee's discussion.

Table 4 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Risk stratification	**Assessment** NICE Guideline 59 Recommendation 1.1.2 & 1.1.3

Imaging	**Assessment** NICE Guideline 59 Recommendation 1.1.4, 1.1.5 & 1.1.6
Accurate diagnosis	Not directly covered in NICE Guideline 59 and no recommendations are presented

Assessment

NICE Guideline 59 – Recommendation 1.1.2

Consider using risk stratification (for example, the STarT Back risk assessment tool) at first point of contact with a healthcare professional for each new episode of low back pain with or without sciatica to inform shared decision-making about stratified management.

NICE Guideline 59 – Recommendation 1.1.3

Based on risk stratification, consider:

- simpler and less intensive support for people with low back pain with or without sciatica likely to improve quickly and have a good outcome (for example, reassurance, advice to keep active and guidance on self-management)
- more complex and intensive support for people with low back pain with or without sciatica at higher risk of a poor outcome (for example, exercise programmes with or without manual therapy or using a psychological approach).

NICE Guideline 59 – Recommendation 1.1.4

Do not routinely offer imaging in a non-specialist setting for people with low back pain with or without sciatica.

NICE Guideline 59 – Recommendation 1.1.5

Explain to people with low back pain with or without sciatica that if they are being referred for specialist opinion, they may not need imaging.

NICE Guideline 59 – Recommendation 1.1.6

Consider imaging in specialist settings of care (for example, a musculoskeletal interface clinic or hospital) for people with low back pain with or without sciatica only if the result is likely to change management.

3.1.3 Current UK practice

Risk stratification

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

Imaging

Data provided by NHS North East Quality Observatory Back Pain report[1] shows national trends in the types of procedures undertaken during elective admissions from 2011 until 2015. It is based on the cohort of patients with back and/or radicular pain but does not include patients who have back pain due to specific diagnosis (such as cancer, infection, spinal trauma etc.). The findings of this report show that, in England, from April 2014 until March 2015, there were 1,085 elective admissions to hospital for low back and radicular pain that had imaging undertaken (this accounts for 0.5% of all procedures for this group). There was no significant change in the use of imaging from 2011 to 2015.

Accurate diagnosis

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

3.1.4 Resource impact

No resource impact is anticipated from NG59. This is because it is considered that where clinical practice changes, as a result of this guidance, there will not be a significant change to resource impact, due to small numbers of people or low costs.

[1] North East Observatory Service, Back Pain Report, 2016

3.2 Non-pharmacological interventions

3.2.1 Summary of suggestions

Self-management

Stakeholders suggested that people with non-specific low back pain should be provided with advice and information to help them self-manage their condition. Some stakeholders suggested that the option of increased self-awareness of their role in managing their condition, including self-management courses should be fully explored before referral to specialist services is considered.

Group exercise programmes

Stakeholders highlighted the need for increased provision of group exercise programmes or individual rehabilitation packages. People's specific needs, preferences and capabilities need to be taken into account when choosing the type of exercise. It was suggested that exercise, including yoga, can have benefits in preventing and improving diseases but availability of exercise programmes and rehabilitation services can vary across the UK.

Combined physical and psychological programmes

Stakeholders suggested a combined physical and psychological programme for people with low back pain or sciatica. Stakeholders said that treatments have traditionally focused on the physical aspect of pain, ignoring the psychology of pain. It was also noted that the current provision of psychological services within primary care physiotherapy is limited.

Return-to-work programmes

Stakeholders highlighted the importance of supporting people to return to work or normal activities. One suggestion was to provide access to a musculoskeletal physiotherapy service which can facilitate the return to work.

3.2.2 Selected recommendations from development source

Table 5 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 5 to help inform the committee's discussion.

Table 5 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Self-management	**Non-pharmacological interventions** NICE NG59 Recommendation 1.2.1
Group exercise programmes	**Non-pharmacological interventions** NICE NG59 Recommendation 1.2.2
Combined physical and psychological programmes	**Non-pharmacological interventions** NICE NG59 Recommendation 1.2.13 NICE NG59 Recommendation 1.2.14
Return to work programmes	**Non-pharmacological interventions** NICE NG59 Recommendation 1.2.15

Non-pharmacological interventions

NICE NG59 – Recommendation 1.2.1

Provide people with advice and information, tailored to their needs and capabilities, to help them self-manage their low back pain with or without sciatica, at all steps of the treatment pathway. Include:

- Information on the nature of low back pain and sciatica
- Encouragement to continue with normal activities

NICE NG59 – Recommendation 1.2.2

Consider a group exercise programme (biomechanical, aerobic, mind–body or a combination of approaches) within the NHS for people with a specific episode or flare-up of low back pain with or without sciatica. Take people's specific needs, preferences and capabilities into account when choosing the type of exercise.

NICE NG59 – Recommendation 1.2.13

Consider psychological therapies using a cognitive behavioural approach for managing low back pain with or without sciatica but only as part of a treatment package including exercise, with or without manual therapy (spinal manipulation, mobilisation or soft tissue techniques such as massage).

NICE NG59 – Recommendation 1.2.14

Consider a combined physical and psychological programme, incorporating a cognitive behavioural approach (preferably in a group context that takes into account

a person's specific needs and capabilities), for people with persistent low back pain or sciatica:

- When they have significant psychosocial obstacles to recovery (for example, avoiding normal activities based on inappropriate beliefs about their condition) or
- When previous treatments have not been effective.

NICE NG59 – Recommendation 1.2.15

Promote and facilitate return to work or normal activities of daily living for people with low back pain with or without sciatica.

3.2.3 Current UK practice

Self-management

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

Group exercise programmes

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

Combined physical and psychological programmes

The National Pain Audit[2] surveyed all NHS Trust pain clinics and showed large variations in access to multidisciplinary pain programmes across England. Low back pain and sciatica accounted for 45% of clinical presentations included in the audit. The findings were that 81 out of 204 English clinics could be defined as multidisciplinary by the presence of physiotherapist, psychologist and physician. The same audit also found that 52% of services in England reported having access to a physiotherapist.

Return to work programmes

The Health and Work Development Unit (2012) national audit[3] found that 71% of back pain consultations involved a discussion about the importance of continuing normal activities. This is an increase from the first round of the audit in 2008 which had a score of 68%.

[2] National Pain Audit, 2012

[3] The Health and Work Development Unit (2012) Back pain management: Occupational health practice in the NHS in England. A national clinical audit – round 2

The same audit also found that 86% of back pain consultations included information about the importance of staying at or returning to work. This was slightly lower that in the first round of audit (89%).

The same audit found that, excluding cases in which red flags were present, Occupational Health professionals documented whether the employee was given advice about work for 77% of cases, and 87% of these were encouraged to stay at or return to work despite residual pain. Occupational Health professionals also documented back pain cases that were not encouraged to stay at or return to work. 30% of those cases were deemed to be work-related back pain.

3.2.4 Resource impact

No resource impact is anticipated from NG59. This is because it is considered that where clinical practice changes, as a result of this guidance, there will not be a significant change to resource impact, due to small numbers of people or low costs.

3.3 Pharmacological interventions

3.3.1 Summary of suggestions

Reducing the use of unhelpful medication

Stakeholders suggested the reduction of ineffective medication for managing chronic low back pain is a key area for improvement. They specifically mentioned that opioid prescribing is increasing in the UK despite their poor effectiveness for people with low back pain and the risk of side effects and dependency.

Stakeholders highlighted that paracetamol should not be offered alone for managing low back pain.

Non-steroidal anti-inflammatory drugs

They also suggested that oral non-steroidal anti-inflammatory drugs (NSAIDs) should be considered for managing low back pain. When those drugs are prescribed there should be appropriate clinical assessment, ongoing monitoring of risk factors and the use of gastroprotective treatment. Oral NSAIDs should be prescribed at the lowest dose for the shortest possible period of time.

3.3.2 Selected recommendations from development source

Table 6 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 6 to help inform the committee's discussion.

Table 6 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Reducing the use of unhelpful medication	**Pharmacological interventions** NICE NG59 Recommendation 1.2.16 – 1.2.19 NICE NG59 Recommendation 1.2.21 – 1.2.23
Non-steroidal anti-inflammatory drugs	**Pharmacological interventions** NICE NG59 Recommendation 1.2.17 – 1.2.19

Pharmacological interventions

NICE NG59 – Recommendation 1.2.16

For recommendations on pharmacological management of sciatica, see NICE's guideline on neuropathic pain in adults.

NICE NG59 – Recommendation 1.2.17

Consider oral non-steroidal anti-inflammatory drugs (NSAIDs) for managing low back pain, taking into account potential differences in gastrointestinal, liver and cardio-renal toxicity, and the person's risk factors, including age.

NICE NG59 – Recommendation 1.2.18

When prescribing oral NSAIDs for low back pain, think about inappropriate clinical assessment, ongoing monitoring of risk factors, and the use of gastroprotective treatment.

NICE NG59 – Recommendation 1.2.19

Prescribe oral NSAIDs for low back pain at the lowest effective dose for the shortest possible period of time.

NICE NG59 – Recommendation 1.2.21

Do not offer paracetamol alone for managing low back pain.

NICE NG59 – Recommendation 1.2.22

Do not routinely offer opioids for managing acute low back pain (see recommendation 1.2.20).

NICE NG59 – Recommendation 1.2.23

Do not offer opioids for managing chronic back pain.

3.3.3 Current UK practice

Reducing the need of unhelpful medication

Data from NHS Digital[4] shows that prescriptions for opioid analgesics and non-opioid analgesics (such as paracetamol) increased by 47.3% from 2004 to 2014. The associated cost increase was 80.2%. Use of several opioid analgesics has increased by over 10%. Data from the same report also shows that paracetamol is the highest volume prescribed analgesic. This data is not specific to low back pain.

A cross sectional and longitudinal analysis of 111 primary care practices in Leeds and Bradford has shown that opioid prescribing has risen markedly, even after

[4] Health and Social Care Information Centre. Prescriptions dispensed in the community: Statistics for England 2004-2014. 2015

excluding patients with a code for cancer or drug dependence[5]. More specifically, opioid prescribing almost doubled for weaker opioids over 2005-2012 and rose over sixfold for stronger opioids. Much of this prescribing was for patients with non-malignant pain rather than for those with recorded diagnosis of a specific disease.

Non-steroidal anti-inflammatory drugs

Data from the Health and Social Care Information Centre[6] shows that prescriptions for drugs used in rheumatic diseases and gout (which include NSAIDs) have decreased by 3.5% from 2004 to 2014. The associated cost decreased by 42.6%. This data is not specific to low back pain.

3.3.4 Resource impact

No resource impact is anticipated from NG59. This is because it is considered that where clinical practice changes, as a result of this guidance, there will not be a significant change to resource impact, due to small numbers of people or low costs.

[5] Foy et al Prescribed opioids in primary care: cross-sectional and longitudinal analyses of influence of patient and practice characteristics BMJ 2016;6; e010276 doi:10.1136/bmjopen-2015-010276
[6] Health and Social Care Information Centre. Prescriptions dispensed in the community: Statistics for England 2004-2014. 2015

3.4 Invasive treatments

3.4.1 Summary of suggestions

Non-effective invasive treatments

Stakeholders suggested invasive treatments that are associated with increased risk of harm and are either poorly supported by clinical evidence or lack cost-effectiveness should not be undertaken. Such treatments include:

a) Spinal injections for managing low back pain.

b) Epidural injections for neurogenic claudication in people who have central spinal canal stenosis.

c) Spinal fusion for people with low back pain (unless as part of a randomised controlled trial).

d) Disk replacement in people with low back pain.

Invasive treatments for specific groups

Stakeholders highlighted that evidence-based invasive treatments should be considered. These include:

a) Facet joint radiofrequency denervation for patients who do not respond to the care pathway and who have a positive response to diagnostic medial branch blocks.

b) Spinal decompression for people with sciatica when non-surgical treatment has not improved pain or function and their radiological findings are consistent with sciatic symptoms.

c) Epidural injections of local anaesthetic and steroid in people with acute and severe sciatica.

Decision to refer for surgery

Stakeholders suggested that the decision to refer a person for a surgical opinion for sciatica should not be influenced by their BMI, smoking status or psychological distress.

3.4.2 Selected recommendations from development source

Table 7 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 7 to help inform the committee's discussion.

Table 7 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Non-effective invasive treatments	**Invasive treatments** NICE NG59 Recommendation 1.3.1 NICE NG59 Recommendation 1.3.6 NICE NG59 Recommendation 1.3.9 NICE NG59 Recommendation 1.3.10
Invasive treatments for specific groups	**Invasive treatments** NICE NG59 Recommendation 1.3.2 NICE NG59 Recommendation 1.3.3 NICE NG59 Recommendation 1.3.5 NICE NG59 Recommendation 1.3.8
Decision to refer for surgery	**Invasive treatments** NICE NG59 Recommendation 1.3.7

Invasive treatments

NICE NG59 – Recommendation 1.3.1

Do not offer spinal injections for managing low back pain.

NICE NG59 – Recommendation 1.3.6

Do not use epidural injections for neurogenic claudication in people who have central spinal canal stenosis.

NICE NG59 – Recommendation 1.3.9

Do not offer spinal fusion for people with low back pain unless as part of a randomised controlled trial.

NICE NG59 – Recommendation 1.3.10

Do not offer disc replacement in people with low back pain.

NICE NG59 – Recommendation 1.3.2

Consider referral for assessment for radiofrequency denervation for people with chronic low back pain when:

- Non-surgical treatment has not worked for them and
- The main source of pain is thought to come from structures supplied by the medial branch nerve and
- They have moderate or severe levels of localised back pain (rated as 5 or more on a visual analogue scale, or equivalent) at the time of referral.

NICE NG59 – Recommendation 1.3.3

Only perform radiofrequency denervation in people with chronic low back pain after a positive response to a diagnostic medial branch block.

NICE NG59 – Recommendation 1.3.5

Consider epidural injections of local anaesthetic and steroid in people with acute and severe sciatica.

NICE NG59 – Recommendation 1.3.8

Consider spinal decompression for people with sciatica when non-surgical treatment has not improved pain or function and their radiological findings are consistent with sciatic symptoms.

NICE NG59 – Recommendation 1.3.7

Do not allow a person's BMI, smoking status or psychological distress to influence the decision to refer them for a surgical opinion for sciatica.

3.4.3 Current UK practice

Non-effective invasive treatments

Data provided by NHS North East Quality Observatory Back Pain report[7] shows national trends in the types of procedures undertaken during elective admissions from 2011 till 2015. It is based on the cohort of patients with back and/or radicular pain but does not include patients who have back pain due to specific diagnosis (such as cancer, infection, spinal trauma etc.).The main procedure type undertaken for this cohort of patients was back and radicular pain injections which have increased from a combined total of just under 140,000 to 170,000 episodes over the four year period. This is in contrast to the number of surgical procedures which has remained constant at 30,000 admissions per year while approximately 10,000 admissions had no procedure done. The same data shows that there is variation

[7] North East Observatory Service, Back Pain Report, 2016

between hospital trusts in Greater Manchester in terms of the numbers of patients admitted for injections for back pain. For example, 219 admissions had back pain injections in Stockport and 911 in South Manchester.

The same report shows that from April 2014 till March 2015 there were 3,115 hospital admissions for posterior lumbar fusion, 5,014 for discectomy and 883 for combined decompression and fusion. Posterior lumbar fusion and decompression admissions have been slowly increasing since 2011/12 while discectomy has slowly decreased.

Invasive treatments for specific groups

Data provided by NHS North East Quality Observatory Back Pain report[8] shows that from April 2014 till March 2015 there were 14,509 hospital admissions for decompression, 1,631 for revision decompression and 883 for combined decompression and fusion.

The findings of the report show that Greater Manchester overall has lower rates of spinal surgery compared to the national rate per 100,000 population. There is wide variation in rates across the region with Tameside & Glossop CCG having the highest rate and Central Manchester CCG the lowest rate. Greater Manchester overall has higher rates of injections compared to the national rate per 100,000 population. The proportion of lumbar facet joint injections vary from 25% at Stockport CCG to 63% at Bury CCG.

Epidurals and facet joint injections are those most frequently done within Greater Manchester, constituting 90% of injection activity compared to 73% across England as a whole. The data is shown in two ways, indicating both the proportion and amount of activity relating to each CCG. The proportion of facet joint injections done at Trust level ranges from 19% to 66% compared to the England figure of 37%.

Decision to refer for surgery

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

3.4.4 Resource impact

There may be savings as a result of the recommendations for spinal fusion procedures for low back pain. However, the savings are not anticipated to be significant.

[8] North East Observatory Service, Back Pain Report, 2016

It is not anticipated that there will be a significant increase in costs nationally, with adherence to the recommendations related to radio frequency denervation. There may be regional variation in costs depending on current local practice.

3.5 Additional areas

Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise. However they were felt to be either unsuitable for development as quality statements, outside the remit of this particular quality standard referral or require further discussion by the committee to establish potential for statement development.

There will be an opportunity for the committee to discuss these areas at the end of the session on 25 January 2017.

Identify appropriate treatment according to aetiology

A stakeholder suggested that patients who do not respond to conservative treatment should have access to viable treatment options. These treatment options vary according to the diagnoses. There is variability in the utilisation of the treatment options for patients who have not responded to the conservative treatment. This area is not contained within the development source (NICE NG59).

Neuromuscular electronic stimulation

A stakeholder suggested neuromuscular electronic stimulation (NMES) for non-specific low back pain. This area is not contained within the development source (NICE NG59).

Self-referral to physiotherapy

A stakeholder felt that patients should be able to self-refer to physiotherapy without having to see their GP first. The stakeholder said that only 31% of all Clinical Commissioning Groups commission self-referral physiotherapy. This area is out of scope for this quality standard.

Referral for spinal imaging

A stakeholder felt that patients should be offered imaging before referral to a specialist service. The stakeholder highlighted that a number of specialist services do not accept patients who have not had imaging undertaken. This suggestion is against the recommendations of the development source (NICE NG59).

Acupuncture

Some stakeholders suggested the offer of acupuncture. If the patient responds to acupuncture treatments they can avoid pharmacological treatment or surgery. A

stakeholder also suggested moxibustion. The suggestion for acupuncture is against the recommendations of the development source (NICE NG59) while the suggestion for moxibustion is not contained within the development source.

Definition of specialist spinal service

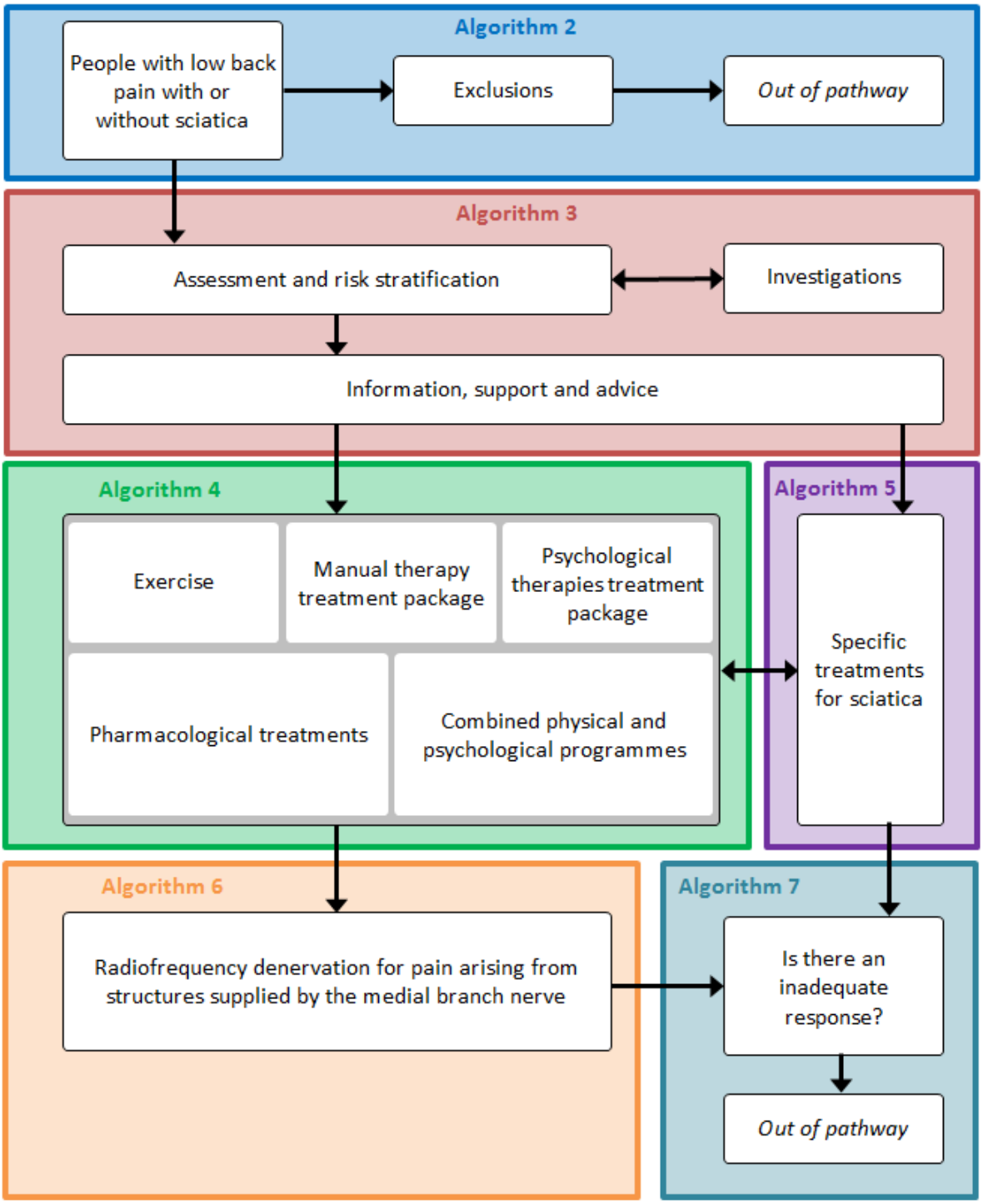
A stakeholder felt that the specialist spinal service should be defined by the guideline committee. It is not in the remit of the quality standard to change the work of the guideline committee.

Regulation of professionals

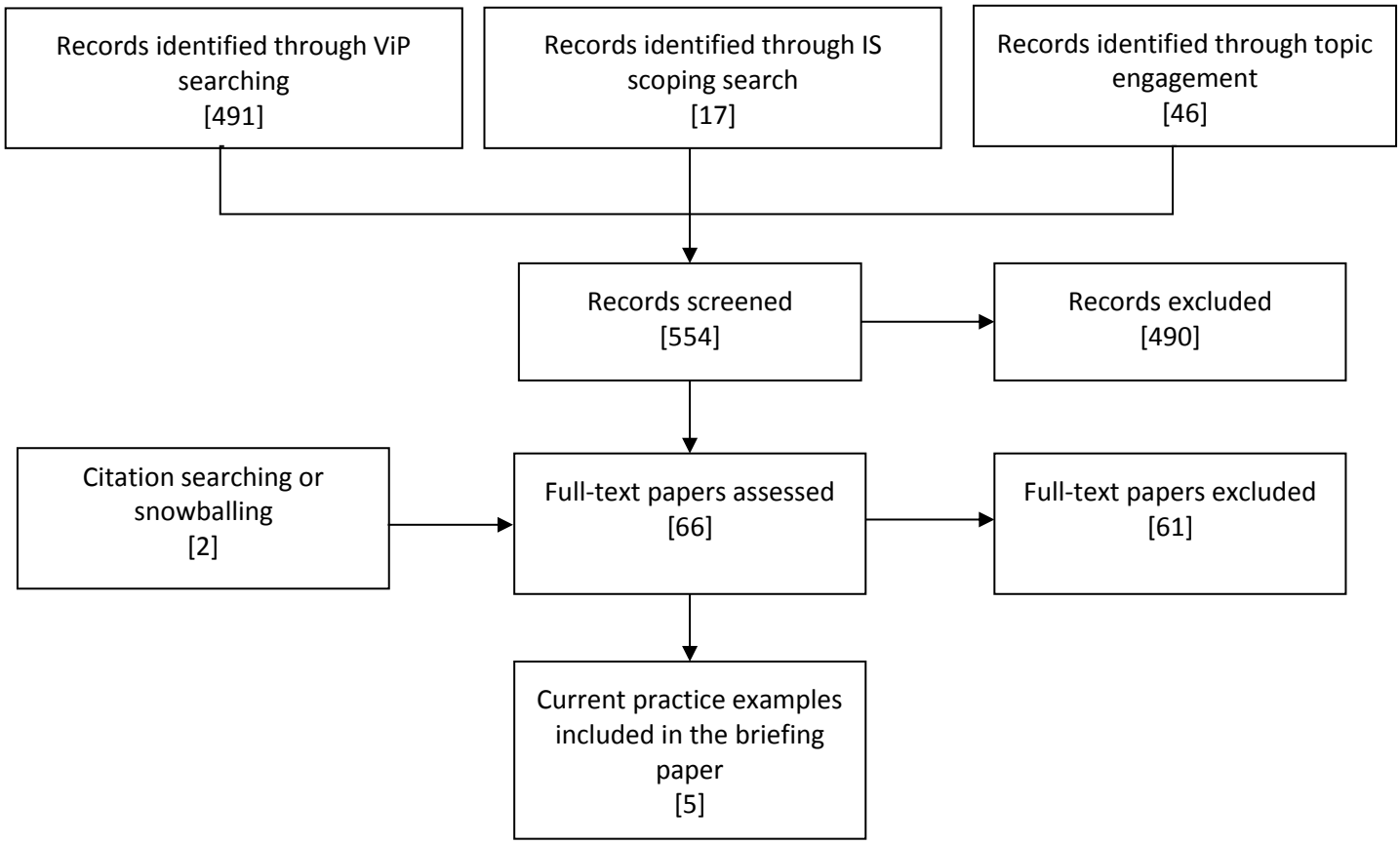
Stakeholders suggested the regulation of professionals delivering massage therapy and yoga. Having registered professionals with and an accredited register means that those professionals meet a required level of standard before practicing. Professional competency can ensure increased patient safety, satisfaction and improved outcomes. This area is not in the remit of NICE.

Appendix 1: Additional information

Low back pain and sciatica management algorithm



Appendix 2: Review flowchart



Appendix 3: Glossary

Acupuncture is a treatment derived from ancient Chinese medicine in which fine needles are inserted at certain sites in the body for therapeutic or preventative purposes.

Epidural injections involve an injection into the epidural space within the spine, using either corticosteroids or anti-TNF agents for their anti-inflammatory and immunosuppressant properties.

Pharmacological interventions are oral/sublingual, rectal, intra-muscular and transdermal drug treatments to relieve low back pain with or without sciatica. This does not include pharmacological treatment for the management of sciatica alone.

Radiofrequency denervation is a minimally invasive and percutaneous procedure performed under local anaesthesia or light intravenous sedation. Radiofrequency energy is delivered along an insulated needle in contact with the target nerves to denature the nerve.

Risk stratification strategies were developed in order to avoid a 'one size fits all' approach. There are many different stratifications and it is appreciated that there can be overlap between groups.

Self-management programmes aim to assist people with low back pain and sciatica returning to normal activities. This includes education and advice for staying active.

Spinal fusion is an operation performed to achieve solid bone union between spinal vertebrae to prevent movement, using either the patient's own bone or artificial bone substitutes.

Spinal injections are variations of injected agents which aim to either reduce inflammation in tissue or induce inflammation to stimulate healthy tissue regrowth. These include facet joint injections, medial branch blocks, intradiscal therapy and prolotherapy.

Appendix 4: Suggestions from stakeholder engagement exercise – registered stakeholders

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
1	SCM1	Consider using risk at first point of contact with a healthcare professional for each new episode of low back pain with or without sciatica to inform shared decision-making about stratified management.	For patients at low risk of a poor outcome intensive treatment may not be needed. Successful use of risk stratification will reduce unnecessary treatment and better target resources	Making this a quality standard raises awareness that many patients do not require intensive treatment and that referrals should be targeted to need. The focus here in my view is on reducing unnecessary referral.	Hill J, D Whitehurst, Lewis M, Bryan S, Dunn K, Foster N, Konstantinou, Main C, Mason E, Somerville S, Sowden G, Vohora K, Hay E. A randomised controlled trial and economic evaluation of stratified primary care management for low back pain compared with current best practice: The STarT Back trial.The Lancet, Volume 378, Issue 9802, Pages 1560 - 1571, 29 October 2011 link
2	SCM2	Risk stratification	Risk stratification is recommended within NICE guidance (NG59). It can be used at the point of consultation with a health care professional to inform clinical decision-making. If a person is characterised as being at low risk of on-going disability from low back pain they can be managed more confidently in	The STarT Back trial (Hill J. et all, Lancet 2011) found that clinical judgement about the need to refer a person with low back pain is not as good as it might be. This means that some patients are not referred treatments that might help them, whilst others are referred for treatments they do not need, which is not good use of resources. By using the Start Back risk stratification it was possible to improve this	STarT Back trial (Lancet 2011) IMPaCT study (Annals of Family Practice 2014)

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			primary care. Conversely those deemed to be at higher risk might benefit from being referred for more intensive management.	situation and more accurately direct patients towards treatment packages that were like to help them. This resulted in improvements in patient outcomes but also cost-efficiency savings for the health service and society in general.	
3	SCM3	Risk stratification for low back pain with or without sciatica	Risk stratification for low back pain with or without sciatica matches interventions to risk of poor outcome. This focuses resources on those least likely to have a good outcome. There are two steps proposed in the NICE guideline NG59 (2016): assessing the risk of poor outcome, and matching the proposed treatments to the risk. 1.1.2 Consider using risk stratification (for example, the STarT Back risk assessment tool) at first point of contact with a healthcare professional for each new episode of low back pain with or without sciatica to inform shared decision-making about stratified management.	Use of the risk assessment and stratification is used in few settings of care in the NHS. Improving uptake will improve outcomes for patients and make better use of resources. Uptake is poor with less than 10% of referrals being accompanied by risk assessment information Uptake of use of risk assessment can be significantly improved by a local implementation programme. https://www.keele.ac.uk/media/keeleuniversity/group/startback/STarT%20Back%20implementation%20presentation.pptx http://www.wmahsn.org/programmes/view/start-back-	Audit of uptake and outcome of using STarT Back in general practice by West Midlands Academic Health Science Network. http://www.wmahsn.org/programmes/view/start-back-

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			1.1.3 Based on risk stratification, consider: • simpler and less intensive support for people with low back pain with or without sciatica likely to improve quickly and have a good outcome (for example, reassurance, advice to keep active and guidance on self-management) • more complex and intensive support for people with low back pain with or without sciatica at higher risk of a poor outcome (for example, exercise programmes with or without manual therapy or using a psychological approach). (NICE Guideline 59)		
4	SCM4	Risk stratification for low back pain with or without sciatica	Risk stratification for low back pain with or without sciatica matches interventions to risk of poor outcome. This focuses resources on those least likely to have a good outcome. There are two steps proposed in the NICE guideline NG59 (2016): assessing the risk of poor outcome, and matching the proposed treatments to the risk.	Use of the risk assessment and stratification is used in few settings of care in the NHS. Improving uptake will improve outcomes for patients and make better use of resources. Uptake is poor with less than 10% of referrals being accompanied by risk assessment information Uptake of use of risk assessment can be significantly improved by a local implementation programme.	Audit of uptake and outcome of using STarT Back in general practice by West Midlands Academic Health Science Network. http://www.wmahsn.org/programmes/view/start-back-

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			1.1.2 Consider using risk stratification (for example, the STarT Back risk assessment tool) at first point of contact with a healthcare professional for each new episode of low back pain with or without sciatica to inform shared decision-making about stratified management. 1.1.3 Based on risk stratification, consider: • simpler and less intensive support for people with low back pain with or without sciatica likely to improve quickly and have a good outcome (for example, reassurance, advice to keep active and guidance on self-management) • more complex and intensive support for people with low back pain with or without sciatica at higher risk of a poor outcome (for example, exercise programmes with or without manual therapy or using a psychological approach). (NICE Guideline 59)	https://www.keele.ac.uk/media/keeleuniversity/group/startback/STarT%20Back%20implementation%20presentation.pptx http://www.wmahsn.org/programmes/view/start-back-	

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
5	SCM1	Do not routinely offer spinal imaging	Incidental findings on imaging can run contrary to the goal of reframing the problem of LBP as benign and usually self-limiting in people's minds.	Imaging is often expensive but confers not benefit in most cases of back pain. In addition the findings, while usually incidental can cause fear and change behaviour in unhelpful ways. Clinicians may find it difficult to not offer imaging in the face of patient requests. To prioritise this as a standard will help raise the profile of this "do not use" recommendation.	See guideline rec and reasoning re: not routinely imaging.
6	SCM3	Imaging for (non-specific) low back pain and sciatica	Imaging for low back pain with or without sciatica in the absence of a clinical picture of an alternative diagnosis including serious underlying pathology (e.g. cancer, infection, fracture) is not required to proceed with initial management. This is because the findings on MRI scan are common and not necessarily related to the patient's symptoms. Performing scanning in these circumstances does not change initial management, and can raise anxiety and further referrals for findings that are not relevant to the clinical presentation. The resources spent on unnecessary	Several papers have identified inappropriate MRI requests for LBP, but not in UK Avoundjian T, Gidwani R, Yao D, Lo J, Sinnott P, Thakur N, Barnett PG. J Am Coll Radiol. 2016 Sep;13(9):1057-66. doi: 10.1016/j.jacr.2016.04.013. Derek J. Emery, MD, FRCPC; Kaveh G. Shojania, MD, FRCPC; Alan J. Forster, MD, FRCPC; et al JAMA Intern Med. 2013;173(9):823-825. doi:10.1001/jamainternmed.2013.3804 And ARUK think is applicable in UK http://www.arthritisresearchuk.org/health-professionals-and-	The National Spinal Taskforce report shows widespread differences in admission and intervention rates for low back pain, with most pts being admitted for only 1 day. Most people admitted or having interventions will be scanned, so this is indirect evidence of overuse of scanning. http://www.sbns.org.uk/index.php/download_file/view/438/87/

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			scans could be spent on therapies recommended in the guideline. 1.1.4 Do not routinely offer imaging in a non-specialist setting for people with low back pain with or without sciatica. 1.1.5 Explain to people with low back pain with or without sciatica that if they are being referred for specialist opinion, they may not need imaging. 1.1.6 Consider imaging in specialist settings of care (for example, a musculoskeletal interface clinic or hospital) for people with low back pain with or without sciatica only if the result is likely to change management. (NICE Guideline 59)	students/reports/synovium/synovium-summer-2013/mri-low-back-pain.aspx	
7	Somerset Partnership NHS Foundation Trust	Reduce excessive imaging in a non-specialist setting for low back pain with or without sciatica.	The over investigation with x-ray and requests from primary care for investigations of non-specific low back pain (LBP) with MRI in particular is at risk of becoming endemic	Radiological imaging for LBP, in the absence of red flags, unresolving radicular pain, progressive neurological deficits and trauma, is often not warranted and may in fact be detrimental.	Brinjikji, W., Luetmer, P.H., Comstock, B., Bresnahan, B.W., Chen, L.E., et al. Systematic Literature Review of Imaging Features of Spinal Degeneration in Asymptomatic

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					Populations. AJNR 2015;36(4):811-16 Deyo RA. Real help and red herrings in spinal imaging. N Engl J Med 2013; 368: 1056-1058
8	Somerset Partnership NHS Foundation Trust	Raising patient expectations of the need for further investigations	As above plus a waste of NHS resources	As above plus the over investigation of simple LBP with MRI is at risk of becoming endemic, and can lead to delays in delivering effective care for the patient with LBP, but also in the management of patients with radicular pain or red flags in whom an MRI scan is necessary. We have a duty to educate patients in the benefits and limitations of imaging and explain that many findings on such tests are commonly found in asymptomatic patients, and thus correlate poorly with pain and disability levels.	Brinjikji, W., Luetmer, P.H., Comstock, B., Bresnahan, B.W., Chen, L.E., et al. Systematic Literature Review of Imaging Features of Spinal Degeneration in Asymptomatic Populations. AJNR 2015;36(4):811-16
9	SCM4	Imaging for (non-specific) low back pain and sciatica	Imaging for low back pain with or without sciatica in the absence of a clinical picture of an alternative diagnosis including serious underlying pathology (e.g. cancer, infection, fracture) is not required to proceed with initial management. This is because the findings on MRI scan are common and not necessarily related to the patient's symptoms.	Several papers have identified inappropriate MRI requests for LBP, but not in UK Avoundjian T, Gidwani R, Yao D, Lo J, Sinnott P, Thakur N, Barnett PG. J Am Coll Radiol. 2016 Sep;13(9):1057-66. doi: 10.1016/j.jacr.2016.04.013. Derek J. Emery, MD, FRCPC; Kaveh G. Shojania, MD, FRCPC; Alan J. Forster, MD, FRCPC; et al JAMA Intern Med.	The National Spinal Taskforce report shows widespread differences in admission and intervention rates for low back pain, with most pts being admitted for only 1 day. Most people admitted or having interventions will be scanned, so this is indirect

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			Performing scanning in these circumstances does not change initial management, and can raise anxiety and further referrals for findings that are not relevant to the clinical presentation. The resources spent on unnecessary scans could be spent on therapies recommended in the guideline. 1.1.4 Do not routinely offer imaging in a non-specialist setting for people with low back pain with or without sciatica. 1.1.5 Explain to people with low back pain with or without sciatica that if they are being referred for specialist opinion, they may not need imaging. 1.1.6 Consider imaging in specialist settings of care (for example, a musculoskeletal interface clinic or hospital) for people with low back pain with or without sciatica only if the result is likely to change management. (NICE Guideline 59)	2013;173(9):823-825. doi:10.1001/jamainternmed.2013.3804 And ARUK think is applicable in UK http://www.arthritisresearchuk.org/health-professionals-and-students/reports/synovium/synovium-summer-2013/mri-low-back-pain.aspx	evidence of overuse of scanning. http://www.sbns.org.uk/index.php/download_file/view/438/87/
10	RCGP	Speed of MRI scan and report	For those with disabling symptoms and neurology and	Long term symptoms lead to a negative spiral that may then lead to 'no wins',	

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			early scan may lead to specific indication before chronic pain develops	chronic pain multiple medications and loss of independence and employment	
11	Spine Intervention Society	Establish an accurate diagnosis/etiology of low back pain and sciatica	The identification of the underlying etiologies of pain is essential as different pathologies have to be treated differently, have varying responses to treatment, and also have different natural histories. Systematic application of controlled anesthetic blocks or provocation procedures can achieve an imperfect, but far more specific diagnosis than simply relying on symptoms or imaging findings. Radiculopathy has specific observable physical examination and electrophysiologic findings. Radicular pain without radiculopathy can be diagnosed by controlled selective nerve blocks. Somatic pain experienced in the lumbar region can be specifically attributed to the facet joints (best diagnosed by dual comparative medial branch blocks) or the intervertebral disc	Without an accurate diagnosis, patients are regularly subjected to unnecessary procedures and treatments that will not reduce their pain or improve their quality of life. Additionally, the evidence base on treatments for low back pain is filled with studies on patients for whom an accurate diagnosis has not been established, and thus would not be expected to benefit from treatments studied. This has done a significant disservice to patients and failed to elucidate the true effectiveness of procedures when performed in appropriately selected patients (those with the diagnosis of interest).	

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			(best diagnosed by disc stimulation). The sacroiliac joint are also potential sources of low back pain and sacroiliac joint pain can be diagnosed with fluoroscopically-guided injections of local anesthetic.		
12	SCM2	Advice to support self-management	NICE guideline (NG59) recommends that people with non-specific back pain should be provided with advice and information to help them self-manage their condition	The latest NICE guideline (NG59) puts greater emphasis on helping people with non-specific low back pain manage their problem through activity promotion. There is also less emphasis on pharmacological and invasive treatments. This presents a challenge for health care professionals who need to explain the reasons for these changes. Appropriate resources are therefore needed to support both patients and health care professionals.	
13	Somerset Partnership NHS Foundation Trus	Self-management should be fully explored and supported in primary care before referral to specialist services	The biomedical l/biomechanical approach to management of LBP still dominates. There is an urgent need to increase patient awareness of their role in management of their condition and not expect a ‘quick fix’	Increasing patient empowerment / education / health promotion and reduced reliance on health care	Zusman, M. Belief reinforcement: one reason why costs for low back pain have not decreased. Journal of Multidisciplinary Healthcare 2013:6 197–204
14	Spine Intervention Society	Identify appropriate treatments for different etiologies/specific	Back pain is a leading cause of disability and a significant detriment to quality of life. While	Patients vary in their level of pain and function and therefore need access to varied treatments ranging from NSAIDs and	

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		diagnoses that cause low back pain and sciatica	many patients with back pain will improve with conservative treatment (e.g. NSAIDs, physical therapy), those who do not must have access to viable treatment options. These treatment options are different for different diagnoses.	physical therapy to interventional procedures and surgery. It is essential that a range of quality interventions is available to providers and patients in order to manage pain, preserve function, minimize opioid abuse, and prevent unnecessary surgeries. The NICE Low Back Pain Guideline has found that good quality evidence exists for many of the treatment options available, yet there is great variability in utilization and understanding of the appropriate use of the different treatment options especially in patients who have not responded to the conservative treatment.	
15	Pain Concern	If the QS is to make a real difference to the way members of Pain Concern, who all have personal experience of living with pain, often back pain, deal with their pain we would like to see priroity given to the following Guidelines. 1.1.2 - Self Management. We are very aware of the need for people being empowered to take control of their back pain at an early stage, to be helped to understand the pain and to be given the tools to help them self manage, for example the Pain Tool kit, and sign posting to voluntary organisations that can provide information and support like Pain Concern and BackCare 1..1.2 Exercise. Exercise is widely recognised as one of the most significant tools in dealing with chronic pain and in the early acute stage people need motivation to help them get started and realise what they can do that will not exacerbate their pain. 1.2.14. Combined physical and psychological programmes . These combined programmes are very important for people who have had back pain for a considerable time and got stuck with a particularly belief about their condition that may be preventing them lead more normal life or returning to work. 1.2.15. Return to Work. There is a strong link between pain and depression and support to return to work or normal activities is so important for physical and psychological health .			
16	SCM5	Measures to improve quality support	Effective education + availability of low cost exercise programmes	Shift in culture to accept that low back pain is a common condition in the current population	Reduction of patients presenting with low back pain

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		to patients with low back pain			
17	Yoga for Healthy Lower Backs Institute (social enterprise Yogaforbacks	Prevention and self-management support.	Many patients want to help themselves to improved health and well-being and they should be encouraged to do so. This will free up resources for those who need it most. It will save costs. It offers value for patients, referrers and the NHS.	GPs are ideally placed to motivate patients to take responsibility for their own health regarding self-care. Health professionals would benefit from more education about exactly how to enable patients to relax, keep active, exercise, reduce stress, i.e. signpost / refer to evidence-based self-management programmes within the NHS, but also within the community.	H. Tilbrook et al Yoga for Healthy Lower Backs programme addresses the multiple layers of successful self-management through the mind/body approach of yoga. www.yogaforbacks.co.uk
18	EPA UK	Thank you for the opportunity to comment on the NICE quality standards and guidelines. We submit the following for your further consideration, our collective feedback outlined under individual headings below on several topical issues which we recommend are included and addressed as part of the NICE quality standards and guidelines for the quality of care for people with Low Back Pain and sciatica. The health system today and the challenges As is widely known, the current health systems struggle to meet patient demand. As a result, quality of care is a subject gaining increasing importance. The current system can neither stop the increasing rates of illness and disease or adequately equip and support health professionals to handle the burden over the long term. Specific medical techniques or interventions are very much needed but to identify the most efficient and cost-effective approach to handle the immediate physical needs we need to consider the bigger picture. Whilst it is undoubtedly important to have strong evidence based modalities and treatment techniques that support people who have lower back pain, high quality of care includes far more than this. A holistic approach to maintaining health and wellbeing			

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		More than just the lumbar spine or just a particular anatomical part of the human body, it is imperative that a holistic approach considering the whole person and their lifestyle is included in any health diagnosis. We referred to the South central Foundation and New Care model vanguards in our previous submission for elderly care. They provide current examples of this approach with evidence of how this works in communities. Hence there are organisations currently open to new ways of working, keeping a vision of high quality patient-centred care whilst considering the working conditions that support health practitioners to sustain their own health in order to provide the very best services. Self-care and responsibility High quality care includes encouraging people to be more responsible for their health and lifestyle (which contributes to their condition) and putting more resources and value into self-care to deal with the underlying causes of a condition such as low back pain, rather than simply managing the symptoms. The way forward in self-care is encouraging 'lifestyle awareness' by empowering people to be more aware of their physical body and how it responds to different lifestyle choices. People can be supported to understand that taking personal responsibility to observe what happens to the physical body, can inform healthier lifestyle choices. This applies to low back pain and sciatica as well as all other areas of our health. Engaging the whole person in the self-care process to support self-healing is a much greater offering to the individual whilst supporting the health care economy. Hence self-care and self-responsibility could be more explicitly stated in the quality standards. As mentioned in our previous submission, NHS England's policy direction, as the major commissioner of health and social care, encourages partner organisations such as the vanguards of the New Care Models programme to directly address self-care and responsibility in local community settings. It is explicitly stated in NHS England's MCP, PACS and Care Homes Frameworks recently published, that patient activation is a key focus through approaches such as health coaching, self-management and education			

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		to build knowledge and citizens' awareness skills and confidence. In section 2.18 to 2.20 of the PACS Framework it specifically mentions two models that support this policy direction. 1. North East Hampshire and Farnham vanguard provides a 'recovery college' offering courses to help people improve their health and wellbeing thereby creating a reduction in service usage. 2. South Somerset Symphony Programme vanguard has implemented health coaching to ensure service users take responsibility for their own health by understanding what is important to them, and offering compassion and challenge. These are just two examples of health care services already recognising the importance of working in this way paving the path forward as models of health care for the future. Unfortunately the vast majority of health care services still operate under a reactive rather than preventative model. The result of this model of health care is that we end up accepting an ever-decreasing quality of health and of health care as the normal, whereby financial resources increasingly get exhausted and inequalities in the quality of treatment services delivered are created. We would like to see more emphasis on 'self-care' and 'health responsibility' for inclusion in the quality standard as a sustainable and holistic way forward for both patients and health professionals. The Biopsychosocial Model of Care We continue to support the draft recommendations for a biopsychosocial model of care for low back pain and sciatica, rather than purely a bio-medical one as this will include all aspects that contribute to this often complex issue. It is becoming increasingly clear that the incidence of lower back pain in the general population is high and is rising, and is placing a considerable strain on our economies both in terms of the impact it has on the ability of a person to contribute actively to society and also the burden on our health resources in managing the condition [1,2,3]. This clearly shows that the current model of care dealing with this condition is inadequate and it is essential to look beyond this approach. In other words, it is not sufficient to simply examine the treatment modalities used and rearrange things based on symptom management (e.g. changing which		

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		drugs are used to manage pain), although this is necessary to a point. A fundamental change in the whole philosophy of how to approach this condition is required to change the quality of care and the quality of life for people who have this condition. Patient choice of care All patients should be entitled to freely explore the possibility that some treatment modalities that for now have limited evidence of their efficacy may provide the support they need. Whilst the treatments may not be recognised because of a lack of informed scientifically accepted research, there is growing anecdotal evidence that people have made significant improvements to their own health through choosing modalities that fall into this category. Hence this calls for the need to improve research into these modalities in an open and transparent way, if there is a possibility that they truly work. Put simply, true quality of care can include the patient's choice of where, when and what treatment they receive and empowers them to engage actively in their own healing process. A multitude of treatment approaches provide a wider range of health care possibilities and potential evidence of the many aetiologies contributing to nonspecific LBP. The standard way of treating this condition continues to currently be a biomedical approach of drug therapy, physical therapy in the form of manual therapy and/or exercise therapy. These treatments have proven to be efficient in managing symptoms and should definitely have their place in the guidelines as they provide much needed physical support to the body. However, as they focus on a specific part of the body, rather than considering the whole person and their lifestyle, they do not appear to be the complete answer to the increasing rates of nonspecific LBP. Hence some hospitals, including Croydon University hospital, have invested in hosting classes with patients that explore the possibility of the person's lifestyle choices. They mention, for example, that depression and poor sleep quality are linked to lower back pain [4,5]. Indeed they explore with patients the possibility that their recovery from low back pain and sciatica is very much linked to lifestyle choices and potentially exacerbated by various other contributing factors.		

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		Hence any planning of future guidelines needs to consider a more holistic approach to help explore and gather a wider evidence base of all possible interventions that can support true quality of care. Indeed many NHS trusts and private health care businesses throughout the UK recognise the importance of preventative medicine and self-care in order to manage the ever-growing rates of illness and disease in our communities. We would therefore advise that more attention is given within the guidelines to preventative programs that prevent lower back pain as well as treat it. Supporting healthcare practitioners One of the areas of great untapped potential to improve quality of care lies in the quality of the health and wellbeing of the practitioner. Hospitals are only relatively recently looking to support the health of their professionals, with the understanding that this a crisis affecting hospital performance overall. Health care practitioner burnout is a widespread issue in our health care systems and directly affects the quality of health care[6]. This too needs to be looked at in the guidelines and quality standards. REFERENCES 1.The Rising Prevalence of Chronic Low Back Pain* Janet K. Freburger, PT, PhD,1,2 George M. Holmes, PhD,1 Robert P. Agans, PhD,3,4 Anne M. Jackman, MSW,1 Jane D. Darter, BA,1 Andrea S. Wallace, RN, PhD,5 Liana D. Castel, PhD,1 William D. Kalsbeek, PhD,3,4 and Timothy S. Carey, MD, MPH1,6 2. Harkness EF, Macfarlane GJ, Silman AJ, McBeth J. Is musculoskeletal pain more common now than 40 years ago?: Two population-based cross-sectional studies. Rheumatology (Oxford) 2005;44(7):890–895. [PubMed] 3. Palmer KT, Walsh K, Bendall H, Cooper C, Coggon D. Back pain in Britain: comparison of two prevalence surveys at an interval of 10 years. BMJ. 2000;320(7249):1577–1578. [PMC free article] [PubMed] 4. Currie SR, Wang J. More data on major depression as an antecedent risk factor for first onset of chronic back pain. Psychol Med. 2005;35(9):1275–1282. [PubMed] 5. Tang NK, Wright KJ, Salkovskis PM. Prevalence and correlates of clinical insomnia co-occurring with chronic back pain. J Sleep Res. 2007;16(1):85–95. PainSci #55909.			

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		6. Reference: Burnout Among Health Professionals and Its Effect on Patient Safety Audrey Lyndon, Phd https://psnet.ahrq.gov/perspectives/perspective/190/burnout-among-health-professionals-and-its-effect-on-patient-safety 7. http://www.nuffieldtrust.org.uk/blog/what-will-be-real-cost-poor-nhs-staff-wellbeing			
19	Neurocare Europe Limited	Rehabilitation for none specific low back pain (LBP) Key area for quality improvement 1	This is a debilitating condition affecting millions and costing millions to treat for which no clinically proven therapies exist. As the current NICE Guideline notes “Your back is a complex structure made up of bones, muscles, nerves and joints. This can often make it difficult to pinpoint the exact cause of the pain. Most cases of back pain aren't caused by serious damage or disease but by minor sprains, strains or injuries, or a pinched or irritated nerve.”	Neither the NHS nor the Private Sector offers effective, reliable therapy for treating low back pain. Diagnosis of underlying causes is often speculative which makes the choice of therapy uncertain. In the treatment of LBP there are very few RCTs of any established therapeutic options which can be said to decisively favour any one approach over any other. This is true of Physiotherapy and also of alternative approaches such as Osteopathy and Chiropractic. Our own experience which we acknowledge is anecdotal with individual patients is that significant relief can be achieved using NMES to improve and balance muscle strength in the lower back.	Neuromuscular electronic stimulation (NMES) has according to the FDA six indications which together address the majority of the possible causes of LBP. These indications are Relaxation of muscle spasms, Maintaining or increasing range of motion, Prevention or retardation of disuse atrophy, Increase local circulation, postsurgical stimulation of calf muscles to prevent venous thrombosis, Muscle Re-education. In treating Knee Osteoarthritis, TKA and Wounds with Electrotherapy (NMES) where pain reduction has been used as an outcome

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					measure, clinical crials have often shown significant reductions in pain and corresponding improvements in HRQoL. These trial results can be found on any of the established Clinical Trial Databases. We cite below two Clinical Trials which illustrate this outcome Clin Interv Aging. 2014 Jul 17;9:1153-61. doi: 10.2147/CIA.S64104. eCollection 2014.The effects of exercise and neuromuscular electrical stimulation in subjects with knee osteoarthritis: a 3-month follow-up study.Laufer Y1, Shtraker H2, Elboim Gabyzon M1. World Journal of Sport Sciences 4 (1): 41-47, 2011 ISSN 2078-4724 © IDOSI Publications, 2011 Corresponding Author: Seham Alsayed Alghamry,

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					Department of Sports Health Sciences, Faculty of Physical Education, Helwan University, Egypt. Effectiveness of Physical Rehabilitation and Electro-Stimulation after Hip Joint Replacement Surgery.
20	SCM1	Key area for quality improvement 2 Provision of group exercise programmes or individual rehab packages for low back	Rehab is at the heart of the recommendations but availability can be piecemeal and many MSK rehab services across the UK(anecdotally) have been pared back in recent years.	Services need to be designed to be able to offer group exercise or individualised rehab, if the guidance is to be successfully delivered.	http://www.csp.org.uk/professional-union/nhs-changes/no-physio-no-way The UK MSK services framework has physio as a frontline service

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		pain with or without sciatica			http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0ahUKEwi--8G87tzQAhXhAsAKHemsDl0QFggbMAA&url=http%3A%2F%2Fwebarchive.nationalarchives.gov.uk%2F20130107105354%2Fhttp%3A%2Fwww.dh.gov.uk%2Fprod_consum_dh%2Fgroups%2Fdh_digitalassets%2F%40dh%2F%40en%2Fdocuments%2Fdigitalasset%2Fdh_4138412.pdf&usg=AFQjCNGayD05-2kHaOAn5-C1SuWC__0sIA&sig2=cuF1A22DqFfjcFpmWoYc0A
21	SCM2	Key area for quality improvement 5 Provision of exercise programmes	NICE guidance (NG59) recommends: Consider a group exercise programme (biomechanical, aerobic, mind–body or a combination of approaches) within the NHS for people with a specific episode or flare-up of low back pain with or without sciatica. Take people's specific needs, preferences and	Exercise has other benefits in both preventing and improving diseases. Despite this being accepted the provision of exercise programmes is patchy across the UK and many areas have withdrawn funding for “exercise on prescription” schemes. The QS can play an important role in highlighting to commissioners that exercise deserves to be placed higher up the funding agenda.	

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			capabilities into account when choosing the type of exercise		
22	SCM3	Provision of group exercise programmes for low back pain with or without sciatica	Provision of group exercise programmes for low back pain with or without sciatica is a key component of four out of five of the core treatments recommended by NICE. 1.2.2 Consider a group exercise programme (biomechanical, aerobic, mind–body or a combination of approaches) within the NHS for people with a specific episode or flare-up of low back pain with or without sciatica. Take people's specific needs, preferences and capabilities into account when choosing the type of exercise. (NICE Guideline 59)	The GDG noted that currently exercise is offered within the NHS, most commonly delivered by physiotherapists. The type of exercise currently offered to people is very variable and depends on the person's preferences, their health care professional's preferences, the local availability of different exercise interventions as well as local commissioning policy. (Extract from full NICE guideline).	National Physiotherapy Low Back Pain Audit Improving Back Care in Scotland http://elearning.scot.nhs.uk:8080/intralibrary/open_virtual_file_path/i41n2005128t/LBPsummary_v6.pdf (Something similar could be set up for England. Please check with Chartered Society of Physiotherapists)
23	Yoga for Healthy Lower Backs Institute	Patient choice of evidence-based long-term self-management courses, including 'yoga' (mind/body) as a 'first-step to managing low back pain'.	Patient choice and a combined physical/ psychological treatment approach will offer improved patient satisfaction. Evidence shows it will affect positive lifestyle and long-term behavioural changes.	There are very few evidence-based exercise programmes available in Primary Care 'as a first step to managing low back pain', as recommended in the new NICE Low Back Pain and Sciatica Guidelines (2016). Yoga for Healthy Lower Backs programme could offer patients and referrers an	1. NICE Guidelines – Low Back Pain and Sciatica Draft Feb 2016 mentions 'self-management' and 'exercise programmes' prominently. 2. NICE Quality Standards QS8 Depression (including

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			Patient Choice can improve outcomes, especially in biopsychological conditions.	innovative, effective, cost-effective and enjoyable evidence-based treatment choice.	those with chronic physical health problem). It is also noted that patient preference and choice need to be taken into account, and practitioners should offer appropriate evidence-based interventions in their consultations with individual service users (Low back pain patients are very often also suffering from depression.) 3. Cost-Savings potential of empowering patients to help themselves with the recurring / episodic condition of low back pain:- London School of Economics and Politics showed that back pain patients cost double that of 'non-back-pain patients' (£1074 v £516 p a) not taking into account indirect costs, nor pain medication costs. Arthritis Research UK funded this research and noted that "it has also

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					established that 'yoga' can help those people who back pain becomes chronic (long-term)". http://www.arthritisresearchuk.org/news/general-news/2013/january/uk-study-shows-high-cost-of-treating-back-pain.aspx 4. www.yogaforbacks.co.uk
24	Yoga for Healthy Lower Backs Institute	Earlier Intervention in Primary Care, alongside GP Care.	More rapid access to locally based community services will aid prevention of persistent/ chronic pain conditions. Ideally, patients could be put on self-management exercise programmes "as a first step" (as per NICE Guidelines).	This will free up Secondary Care resources for those who need it most. Patient-centred care.	"It has been estimated that between 10% to 40% of new orthopaedic referrals do not require a surgical opinion and of patients on a waiting list, between 5% and 15% do not want or need surgery. It has therefore been considered important that General Practitioners (GPs), orthopaedic services and AHP services work in unison to ensure that referrals are appropriately reviewed to ascertain which patients require acute hospital referral and those patients who could

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					benefit from rapid access to more locally based community services. Historically, it was estimated up to 60% of all referrals to an orthopaedic outpatient clinic could be managed safely by a physiotherapist and to the satisfaction of most patients." ALLIED HEALTH PROFESSIONALS MUSCULOSKELETAL PATHWAY MINIMUM STANDARDS – A FRAMEWORK FOR ACTION 2015-2016 | 13
25	Yoga for Healthy Lower Backs Institute	Integration of high quality evidence-based mind/body techniques taught by high quality practitioners	Mind/body programmes should be evidence-based and taught by those trained, skilled and experienced in deliver of the subject. Improved outcomes.	Short trainings and inexperience of delivering mind/body techniques will not be likely to lead to patient/ practitioner satisfaction or best outcomes.	Innovation
26	SCM4	Key area for quality improvement 2 Provision of group exercise programmes for	Provision of group exercise programmes for low back pain with or without sciatica is a key component of four out of five of the core treatments recommended by NICE.	The GDG noted that currently exercise is offered within the NHS, most commonly delivered by physiotherapists. The type of exercise currently offered to people is very variable and depends on the person's preferences, their health care professional's	National Physiotherapy Low Back Pain Audit Improving Back Care in Scotland http://elearning.scot.nhs.uk:8080/intralibrary/open_virt

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		low back pain with or without sciatica	1.2.2 Consider a group exercise programme (biomechanical, aerobic, mind–body or a combination of approaches) within the NHS for people with a specific episode or flare-up of low back pain with or without sciatica. Take people's specific needs, preferences and capabilities into account when choosing the type of exercise. (NICE Guideline 59)	preferences, the local availability of different exercise interventions as well as local commissioning policy. (Extract from full NICE guideline). The National Pain Audit surveyed all NHS Trust pain clinics and showed large variations in access to multidisciplinary pain programmes across England. Low back pain and sciatica accounted for 45% of clinical presentations included in the audit. https://www.britishpainsociety.org/static/uploads/resources/files/members_articles_npa_2012_1.pdf	ual_file_path/i41n2005128t/LBPsummary_v6.pdf (Something similar could be set up for England. Please check with Chartered Society of Physiotherapists)
27	SCM5	Key area for quality improvement 1 Assessment for low back pain with or without sciatica	Key to matching patients to evidence based pathway	Without consistent assessment at the first point of contact variability in provision occurs	Using data collected during Start Back trials as an example
28	SCM2	Key area for quality improvement 4 Combined physical and psychological programmes	NICE guidance (NG59) recommends: consider a combined physical and psychological programme, incorporating a cognitive behavioural approach (preferably in a group context that takes into account a person's specific needs and capabilities), for people with	The latest guideline recommends that people identified (possibly by risk stratification) as potentially at higher risk of disability should be referred for more intensive management. The guideline also indicates that this treatment should be multi-modal with consideration given to physical, psychological and aspects of the back pain experienced by people. Traditionally pain	

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			persistent low back pain or sciatica	clinics in secondary care have had a prominent focus on physical aspects and treatments that are no longer recommended, e.g. spinal injections. This is starting to change and multi-disciplinary pain services are emerging but the coverage around the country is variable.	
29	Yoga for Healthy Lower Backs Institute	Key area for quality improvement 5 Psychology of Pain threaded through the care pathway.	Inappropriate treatment of patients, by focussing on the physical only, can exacerbate or cause long-term chronic conditions. Mind/body programmes offered appropriately at an earlier point in the care pathway can offer a non-invasive and non-pharmacological treatment choice that can positively affect mood, health and wellbeing at the crucial early stages before the psychological impact of pain has become deep-rooted.	The psychology of pain cannot be underestimated. At all levels in the care pathway the psychological impact of being worried / fearful / anxious / depressed about diagnoses, and especially lack of diagnoses, should be addressed. Patient-centred care.	
30	SCM5	Key area for quality improvement 2 Quality of psychological input within physical therapy programmes	Key to moving patients forward in Tier 2	Current provision of psychological services within primary care physiotherapy is absent and patchy	Current skill mix of Back Rehab programmes

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31	The Chartered Society of Physiotherapy	Return to work	All employees having rapid access to a musculoskeletal physiotherapy service that incorporates the promotion and facilitation of returning to work can help ensure that people are able to get back to work as early as possible.	Having timely access to physiotherapy has been found to be effective, and the NHS are currently providing effective services such as Sheffield Hospitals NHS Trust: http://www.nhsemployers.org/~/media/Employers/Publications/Evaluating%20health%20wellbeing%20interventions%20for%20healthcare%20staff%202.pdf (see page 25)	
32	Pain Concern	If the QS is to make a real difference to the way members of Pain Concern, who all have personal experience of living with pain, often back pain, deal with their pain we would like to see priroity given to the following Guidelines. 1.1.2 - Self Management. We are very aware of the need for people being empowered to take control of their back pain at an early stage, to be helped to understand the pain and to be given the tools to help them self manage, for example the Pain Tool kit, and sign posting to voluntary organisations that can provide information and support like Pain Concern and BackCare 1..1.2 Exercise. Exercise is widely recognised as one of the most significant tools in dealing with chronic pain and in the early acute stage people need motivation to help them get started and realise what they can do that will not exacerbate their pain. 1.2.14. Combined physical and psychological programmes . These combined programmes are very important for people who have had back pain for a considerable time and got stuck with a particularly belief about their condition that may be preventing them lead more normal life or returning to work. 1.2.15. Return to Work. There is a strong link between pain and depression and support to return to work or normal activities is so important for physical and psychological health.			
33	SCM1	Reducing prescribing of ineffective and harmful drugs for LBP. Specifically opioid use in chronic low back pain	There is evidence that opioid prescribing for persistent non-cancer pain is increasing in the UK despite their apparently poor effectiveness profile for this clinical group. In addition opioid use is associated with important risks including dependency and death.	Opioid use on chronic pain confers risk but inadequate potential benefit. To prioritise this is a step to reducing potential harm in a large clinical population. Reducing prescription of opioidsi n the face of patient demand will represent a challenge not dissimilar to that presented in reducing antibiotic prescription. To prioritise this as a	Opiod prescribing on the increase nationally: Health and Social Care Information Centre. Prescriptions dispensed in the community: Statistics for England 2002-2012. 2013. www.hscic.gov.uk/searchc

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				standard will help raise the profile of this “do not use” recommendation.	atalogue?productid=12055&returnid=1683. Zin CS, Chen LC, Knaggs RD. Total number of prescriptions and number of patients stratified by non-cancer and cancer pain CPRD 2000-2010. Pharmacoepidemiol Drug Safe2012;21:(suppl 3):403. Commentary of opioid prescribing: Stannard C (2012) Opioid prescribing in the UK: can we avert a public health disaster? Br J Pain. 2012 Feb; 6(1): 7–8. doi: 10.1177/2049463712439131
34	SCM1	Reduction of opiate prescribing for those with chronic non-specific low back	NICE guideline (NG59) recommends that opiates should not be prescribed to those with chronic non-specific low back pain. There is no evidence that are helpful to patients and there	Rates of opiate prescribing have risen for many conditions, including chronic non-specific back pain. There has been an associated increase in the number of people experiencing harm, including death from over dosage. (Deyo R, BMJ 2015).. They are also associated with side effects such	• Prescription data -NHS Business Services Authority • Bedson, J., Belcher, J., Martino, O.I., Ndlovu, M., Rathod, T.,

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			are safety concerns in terms of side effects and dependence.	as drowsiness, constipation and falls. Many people become dependent on these medications.	Walters, K., Dunn, K.M. and Jordan, K.P. (2013). The effectiveness of national guidance in changing analgesic prescribing in primary care from 2002 to 2009: An observational database study. European Journal of Pain, 17: 434–443. doi: 10.1002/j.1532-2149.2012.00189.x • Ruscitto, A., Smith, B.H. and Guthrie, B. (2015). Changes in opioid and other analgesic use 1995–2010: Repeated cross-sectional analysis of dispensed prescribing for a large geographical population in Scotland.

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					European Journal of Pain, 19: 59–66. doi: 10.1002/ejp.520 Zin, C.S., Chen, L.-C. and Knaggs, R.D. (2014). Changes in trends and pattern of strong opioid prescribing in primary care. European Journal of Pain, 18: 1343–1351. doi: 10.1002/j.1532-2149.2014.496
35	SCM5	Key area for quality improvement 3 Current prescribing of opioids for low back pain in primary care	No evidence for effectiveness – evidence of harm	Reduction in opiate prescribing	Data collected by regional pharmacy audits
36	SCM3	Key area for quality improvement 4 Only continue recommended analgesic drugs which are helpful for low back pain and sciatica, and minimise harm such as drug toxicity	Only continue recommended analgesic drugs which are helpful for low back pain and sciatica, and minimise harm such as drug toxicity 1.2.16 For recommendations on pharmacological management of sciatica, see NICE's guideline on neuropathic pain in adults.	Prescribing cost analysis from HSCIC shows paracetamol is highest volume (number of tablets) prescribed analgesic. Paracetamol is not recommended in NICE Guideline 59. http://content.digital.nhs.uk/catalogue/PUB20200/pres-cost-anal-eng-2015-tab.zip The national back pain audit suggests that GPs are referring people to pain services to	Prescribing cost analysis from HSCIC http://content.digital.nhs.uk/catalogue/PUB20200/pres-cost-anal-eng-2015-tab.zip

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			https://www.nice.org.uk/guidance/cg173 1.2.17 Consider oral non-steroidal anti-inflammatory drugs (NSAIDs) for managing low back pain, taking into account potential differences in gastrointestinal, liver and cardio-renal toxicity, and the person's risk factors, including age. 1.2.18 When prescribing oral NSAIDs for low back pain, think about appropriate clinical assessment, ongoing monitoring of risk factors, and the use of gastroprotective treatment. 1.2.19 Prescribe oral NSAIDs for low back pain at the lowest effective dose for the shortest possible period of time 1.2.20 Consider weak opioids (with or without paracetamol) for managing acute low back pain only if an NSAID is contraindicated, not tolerated or has been ineffective. 1.2.21 Do not offer paracetamol alone for managing low back pain. 1.2.22 Do not routinely offer opioids for managing acute low	whom they have prescribed long term opioids. http://www.nationalpainaudit.org/media/files/NationalPainAudit-2012.pdf Also see Foy 2016 http://bmjopen.bmj.com/content/6/5/e010276.full There is evidence that gabapentin and pregabalin are being used beyond their licence and being used as a substance of abuse. https://www2.rcn.org.uk/__data/assets/pdf_file/0009/545751/Gabapentin_and_Pregabalin_Offender_Health_Audit_Report_June_2013_DF_1.pdf A large UK audit (Hearnshaw 2007) showed that NSAIDs are associated with upper GI bleeding, and this is reduced with co-prescription of a PPI. http://gut.bmj.com/content/60/10/1327.long?hwoasp=authn%3A1480581419%3A5531198%3A2455403311%3A0%3A0%3ACYnWpbaBV7ESb72pJWIddw%3D%3D#T3	

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			back pain (see recommendation 1.2.20). 1.2.23 Do not offer opioids for managing chronic low back pain. (NICE Guideline 59)		
37	SCM4	Key area for quality improvement 3 Only continue recommended analgesic drugs which are helpful for low back pain and sciatica, and minimise harm such as drug toxicity	Only continue recommended analgesic drugs which are helpful for low back pain and sciatica, and minimise harm such as drug toxicity 1.2.16 For recommendations on pharmacological management of sciatica, see NICE's guideline on neuropathic pain in adults. https://www.nice.org.uk/guidance/cg173 1.2.17 Consider oral non-steroidal anti-inflammatory drugs (NSAIDs) for managing low back pain, taking into account potential differences in gastrointestinal, liver and cardio-renal toxicity, and the person's risk factors, including age. 1.2.18 When prescribing oral NSAIDs for low back pain, think about appropriate clinical assessment, ongoing monitoring	Prescribing cost analysis from HSCIC shows paracetamol is highest volume (number of tablets) prescribed analgesic. Paracetamol is not recommended in NICE Guideline 59. http://content.digital.nhs.uk/catalogue/PUB20200/pres-cost-anal-eng-2015-tab.zip The national back pain audit suggests that GPs are referring people to pain services to whom they have prescribed long term opioids. http://www.nationalpainaudit.org/media/files/NationalPainAudit-2012.pdf Also see Foy 2016 http://bmjopen.bmj.com/content/6/5/e010276.full There is evidence that gabapentin and pregabalin are being used beyond their licence and being used as a substance of abuse. https://www2.rcn.org.uk/__data/assets/pdf_file/0009/545751/Gabapentin_and_Pregabali	Prescribing cost analysis from HSCIC http://content.digital.nhs.uk/catalogue/PUB20200/pres-cost-anal-eng-2015-tab.zip

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			of risk factors, and the use of gastroprotective treatment. 1.2.19 Prescribe oral NSAIDs for low back pain at the lowest effective dose for the shortest possible period of time 1.2.20 Consider weak opioids (with or without paracetamol) for managing acute low back pain only if an NSAID is contraindicated, not tolerated or has been ineffective. 1.2.21 Do not offer paracetamol alone for managing low back pain. 1.2.22 Do not routinely offer opioids for managing acute low back pain (see recommendation 1.2.20). 1.2.23 Do not offer opioids for managing chronic low back pain. (NICE Guideline 59)	n_Offender_Health_Audit_Report_June_2013_DF_1.pdf A large UK audit (Hearnshaw 2007) showed that NSAIDs are associated with upper GI bleeding, and this is reduced with co-prescription of a PPI. http://gut.bmj.com/content/60/10/1327.long?hwoasp=authn%3A1480581419%3A5531198%3A2455403311%3A0%3A0%3ACYnWpbaBV7ESb72pJWIddw%3D%3D#T3	
38	SCM1	Do not offer injections for back pain	Interventionist spinal treatments like spinal injections likely represent a source of substantial variation in care for LBP. The guidance does not recommend them.	Making this a quality standard sends a clear message out to help change practice and reduce ineffective treatment.	See guideline rec and LETR. I don't have stats on current variation in use but others on the committee may have. Anecdotally they are not uncommon.
39	SCM3	Key area for quality improvement 1	Invasive treatments (injections and surgery) for low back pain	There is considerable variation in injections and surgery for LBP	Data is being collected by Dept of Health under the

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		Invasive treatments (injections and surgery) for low back pain and sciatica	with or without sciatica carry a significantly increased risk of harm compared to non-invasive treatments and are either poorly supported by clinical evidence or lack cost-effectiveness. However, some treatments are evidence based, eg Facet Joint radiofrequency denervations for selected patients who do not respond to the care pathway and who have a positive response to diagnostic medial branch blocks or patients with a six month or less history of sciatica who may respond to epidural steroids plus local anaesthetic. 1.3.1 Do not offer spinal injections for managing low back pain. 1.3.6 Do not use epidural injections for neurogenic claudication in people who have central spinal canal stenosis. 1.3.7 Do not allow a person's BMI, smoking status or psychological distress to influence the decision	The National Spinal Taskforce report http://www.sbns.org.uk/index.php/download_file/view/438/87/ Commissioners should be encouraged to purchase cost effective interventions rather than non-effective ones offered by some secondary services. This should reduce cost, reduce long waiting times and increase efficacy of secondary care.	Getting it Right First Time Initiative. https://www.rnoh.nhs.uk/home/news/16/01/getting-it-right-first-time Prof Briggs has created a dashboard for showing performance at CCG and Trust level. (I can supply contact details) NHS North East Quality Observatory http://www.neqos.nhs.uk/back-pain-profiles-now-available/

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			to refer them for a surgical opinion for sciatica. 1.3.8 Consider spinal decompression for people with sciatica when non-surgical treatment has not improved pain or function and their radiological findings are consistent with sciatic symptoms. 1.3.9 Do not offer spinal fusion for people with low back pain unless as part of a randomised controlled trial. 1.3.10 Do not offer disc replacement in people with low back pain. (NICE Guideline 59)		
40	Somerset Partnership NHS Foundation Trust	Continue to monitor and reduce the use of spinal injections for non-specific LBP	They aren't effective and give patients the incorrect expectation that there may be a reliable invasive solution for their back pain. It can lead to reduced levels of self-management and reliance on healthcare to provide a solution	Waste of NHS resources	

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41	SCM5	Reducing number of spinal injections for low back pain	No evidence for effectiveness and scarce resources	Reduction in payment for associated HRG codes for spinal injections	Monitor regional HRG codes
42	RCGP	Early interventionist review if indicated	As for mri	Early root block may enable mobilisation without side effects of multiple medication. Those not responding or deemed severe may benefit from surgery to resolve radicular symptoms	Current practice of wait and see, physio, analgesia then months later an MRI then months later a review by orthopaedics or neurosurgery may well 'miss the boat and be contributing to the huge burden of chronic discogenic infirmity
43	SCM4	Key area for quality improvement 5 Invasive treatments (injections and surgery) for low back pain and sciatica	Invasive (injections and surgery) and non-invasive treatments for low back pain with or without sciatica should be considered within the context of likely risks and benefits for the individual. Treatments with good evidence of cost effectiveness should readily available to patients for whom they are indicated. NICE recommends radiofrequency denervation for facet joint pain and epidurals for acute sciatica in certain circumstances. Fusion, injections and lumbar disc replacement are not recommended for low back pain	There is considerable variation in provision of injections and surgery for LBP The National Spinal Taskforce report http://www.sbns.org.uk/index.php/download_file/view/438/87/ Commissioners should be encouraged to purchase cost effective interventions rather than non-effective ones. Reallocation of funding will reduce long waiting times, and increase the quality and safety care.	Data is being collected by Dept of Health under the Getting it Right First Time Initiative. https://www.rnoh.nhs.uk/home/news/16/01/getting-it-right-first-time Prof Briggs has created a dashboard for showing performance at CCG and Trust level. (I can supply contact details) NHS North East Quality Observatory

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			because there is either lack of cost-effectiveness or they carry a significantly increased risk of harm. Groups in whom invasive treatments are recommended: 1.3.5 Consider epidural injections of local anaesthetic and steroid in people with acute and severe sciatica. 1.3.2 Consider referral for assessment for radiofrequency denervation for people with chronic low back pain when: non-surgical treatment has not worked for themand the main source of pain is thought to come from structures supplied by the medial branch nerve and they have moderate or severe levels of localised back pain (rated as 5 or more on a visual analogue scale, or equivalent) at the time of referral. 1.3.3 Only perform radiofrequency denervation in people with chronic low back pain after a positive response to a diagnostic medial branch block.		http://www.neqos.nhs.uk/back-pain-profiles-now-available/

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			Groups in whom invasive treatments are NOT recommended: 1.3.1 Do not offer spinal injections for managing low back pain. 1.3.6 Do not use epidural injections for neurogenic claudication in people who have central spinal canal stenosis. 1.3.7 Do not allow a person's BMI, smoking status or psychological distress to influence the decision to refer them for a surgical opinion for sciatica. 1.3.8 Consider spinal decompression for people with sciatica when non-surgical treatment has not improved pain or function and their radiological findings are consistent with sciatic symptoms. 1.3.9 Do not offer spinal fusion for people with low back pain unless as part of a randomised controlled trial. 1.3.10 Do not offer disc replacement in people with low back pain. (NICE Guideline 59)		

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44	RCGP	Use of Caudal Epidural steroid injection for sciatica	Low tech resource suitable for delivery in the community	Traditionally provided in secondary care under imaging & therefore with limited and delayed access	Published evidence suggests imaging is required for this simple procedure but is it?
45	The Chartered Society of Physiotherapy	Direct access to physiotherapy	Initial assessment by an appropriate clinician, utilising all relevant healthcare professionals including physiotherapists. Self-referral to physiotherapy allows patients to access services directly without having to see their GP first. Patients can either refer themselves directly into existing physiotherapy services or see a physiotherapist based in general practice.	The Health Select Committee inquiry into primary care called for self-referral to physiotherapy to be a priority for urgent reform: http://www.publications.parliament.uk/pa/cm201516/cmselect/cmhealth/408/408.pdf	Self-referral to physiotherapy is a tried and tested model, yet in spite of the evidence, and self-referral being available within the private sector for nearly 40 years, only 31% of all Clinical Commissioning Groups commission any self-referral physiotherapy. (Unpublished data from a freedom of information request on patient self-referral to physiotherapy & community rehabilitation services, 2015)
46	British Society of Skeletal Radiology	To be clear I feel these clinical guidelines are much needed and exactly what the spinal radiology services community require. I do however think they could be of greater			

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		clinical use to us with some modification. 1 I think a definition of what constitutes a specialist spinal service is needed, I have come across physiotherapists with less that 12 months post-qualification experience classified as specialist spinal services, if the guidelines committee can give us a lead on this it would make implementation of these changes much more effective by a considerable margin. 2 It would also be worth the committee considering whether they feel a referral for spinal imaging by a specialist service should only be performed after a history and clinical examination of the patient has been undertaken. I think it is frequent that specialist			

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		services no longer accept patients who have not already been imaged which would create a difficult hiatus between the guideline recommendations and spinal.			
47	Acupuncture Torbay	Include Acupuncture and Moxibustion	Because it is a very effective method of treating these illnesses and can combine well with other treatments you have recommended.	Some areas do offer a limited amount of 'Acupuncture' which is provided with Physiotherapists with very little training or understanding of the subject. Any results or research provided by them will be woefully inadequate and not provide a true result	http://acupuncturetorbay.com/further-information/who-acupuncture-list.html/ the above was copied from the WHO list of diseases that can be treated by Acupuncture.
48	Acupuncture Torbay	I know this will be totally ignored and that is sad because you are denying the UK of an effective modality for the treatment of Sciatica and Back Pain. I am only a small organisation but I am at 'the coalface' for Backache and Sciatica it is my everyday treatment for about half of my Patients as are many Acupuncturists in every town and village throughout the UK. It is sad because general medicine is letting down these people, only a few years ago you were making people lay on a board for three months! We have always said the Patients should be up and moving as much as possible and were laughed at. Keep their muscles warm, keep them calm and don't ignore them. So many days are lost from work every year and yet Acupuncture could make a massive difference to these people. Thing is many people are beginning to realise what I am saying is correct and we are fast becoming 'Barefoot Doctors'. We have to deal with the Patients when the NHS has failed them. Unfortunately some people are pushed in to Surgery and then have to suffer for the rest of their lives when, if they had been offered a few Acupuncture treatments it would have been possible to see if the Patient would respond to Acupuncture and avoid Surgery. You really need to open your eyes and think out of the box, forget the politics and the free clocks from the Pharmaceutical companies and do what is right for the Patients.			

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49	Acupuncture Torbay	I cannot believe that you have not included Acupuncture in your guidelines but you include such an invasive and dangerous technique as Epidurals. You talk about Radiofrequency Denervation but Electro-Acupuncture has a similar effect and Acupuncture with Moxibustion also warms the nerves and encourages repair as well as relaxing the surrounding muscles and releasing spasms. Trigger point Acupuncture is very effective for backache and Sciatica especially when used with Moxibustion, Massage, and traditional Acupuncture which will calm the person mentally as well. I treat these problems every working day and have many good results. The Americans are using Battlefield Acupuncture for their troops which is a form of Auricular Therapy and it works very well. I have used it myself for severe Sciatica and managed to get a bed bound Patient out of bed and off on holiday the next day. Why is the UK so Anti-Complementary Therapies and behind the times? I suspect that you are listening to the biased rubbish pseudo research published by Prof. Edzard Ernst and Dr Adrian White of the so called Complementary Therapy Department of Exeter University. Please do not listen to them, do your own research, they are subsidised by Pharmaceutical companies and skew all of their research. If you truly want to help people then give people a choice of true Acupuncture provided by a professional Acupuncturist or is this just a political exercise? I am not that concerned because I am overwhelmed by Patients because of the state of the NHS but you really are failing your Patients by not including Acupuncture.			
50	Complementary and Natural Healthcare Council	Key area for quality improvement 1 The provision of massage under Manual therapies – recommendation 13 (page 452 – FULL)	There is a wide variety of standards of training and practice of massage in the UK. There are also many professional associations in the massage therapy sector, with varying levels of entry requirements. Many of these associations are directly linked to training providers. This creates a risk of patients being referred to massage practitioners who are not suitably trained or qualified to address patients with low back pain and / or sciatica.	In order to address this standards issue, the Department of Health supported the establishment of the Complementary and Natural Healthcare Council (CNHC) in 2008 as the UK voluntary regulator for a number of disciplines including massage therapy. The CNHC is also the holder of an Accredited Register (AR) under the Professional Standard Authority's AR Programme. The area for quality improvement is to require all massage therapists used / employed in such treatment packages under recommendation 13 to be registered with an Accredited Register such as CNHC's. In CNHC's case this would ensure that all practitioners have met recognised UK wide	You can see the following documents here: CNHC's Code of Conduct, Ethics and Performance here: http://www.cnhc.org.uk/assets/pdf/1-058.pdf CNHC's Complaints Procedures: http://www.cnhc.org.uk/assets/pdf/5-003.pdf CNHC's Criteria for Entry to the CNHC Register: http://www.cnhc.org.uk/index.cfm?page_id=20&sid=1

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				standards, abide by CNHC's rigorous Code of Conduct, Ethics and Performance, and can be held to account via CNHC's independent complaints procedure.	
51	Complementary and Natural Healthcare Council	The provision of group yoga (mind-body exercise) under Exercise therapies – recommendation 8, (page 305 – FULL)	Similarly there is a wide variety of training standards and styles of yoga teaching. This leads to a risk of patients being referred to yoga classes held by teachers who are not suitably qualified to address issues of low back pain and sciatica.	As in our point 1 above, the area for quality improvement and to ensure safe practice, is to require all yoga teachers to be registered with an Accredited Register such as CNHC's. All points above apply. CNHC registers yoga therapists who have undertaken training that meets National Occupational Standards for Yoga Therapy.	See above for relevant documents.
52	Yoga for Healthy Lower Backs Institute	Additional developmental areas of emergent practice Yoga for Healthy Lower Backs 12-week Courses. The Yoga for Healthy Lower Backs Institute (nationally-accredited by governing-body British Wheel of Yoga as a Recognized Centre of excellence for training and standards and member of British Council of Yoga Therapy) would welcome working	Patient-centred care. The 'Yoga for Healthy Lower Backs' programme (purposefully identifiable name to show 'best practice'; mentioned in published papers) is a result of a large research and knowledge transfer project with the same quality-assured, well-structured evidence-based, fully-supervised 12-week programme (classes, manuals, hand-outs, relaxation CD, teacher training and support from The Yoga for Healthy Lower Backs Institute). SW Academic Health Science Network support our work, as do Arthritis Research UK (funders of	There is a need for more innovative long-term self-management courses to be accessible to patients within Primary Care. This evidence-based programme is readily available now. It has the advantage of being able to offer a 'combined package' of care that addresses both the physical and psychological aspects of low back pain. It is not just a short-term treatment option. With a self-regulated profession such as yoga, which nevertheless has a significant body of evidence behind it for this condition, NICE and the NHS will benefit from yoga professional advice. NHS Innovations Accelerator applicant with positive feedback re subject knowledge, passion and evidence.	NICE Guidelines for Low Back Pain and Sciatica 2016 recommend group exercise programmes as a first step to managing low back pain. Significant published research evidence for the cost-effectiveness of this approach came from York Trials Unit research (LH Chuang et al, Spine Journal). Significant published research evidence for efficacy of yoga came from York Trials Unit research

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		with NICE or other bodies to enable further developments from its current NHS pilot projects (NHS England Health Education, SW Deanery) in the South West of England.	the original 313-participant randomised controlled trial).	GPs are ideally placed to motivate patients to take responsibility for their own health and can refer to this.	(H Tilbrook et al, Annals of Internal Medicine). Use the research and yoga specialists involved in the above research to help implementation and integration, as well as quality standards. www.yogaforbacks.co.uk http://www.arthritisresearchuk.org/news/press-releases/2012/august/yoga-a-cost-effective-treatment-for-back-pain-sufferers.aspx
53	NHS England	Thank you for asking NHS England to comment on this Quality Standard. NHS England will not be submitting a response in this instance.			