Frequently Asked Questions
A Document to Support GPs and Clinicians with the Implementation of:
NWL Low Back Pain and Sciatica Policy
NWL Cervical and Thoracic Facet Joint Injection Policy

Planned Procedures with a Threshold
Policy Implementation
V7 November 2018
Background

Low Back Pain Policy (from 1st April 2018)

Following a recommendation by the North West London CCGs Policy Development Group on 14th March 2017, North West London CCGs Collaboration Board approved the implementation of a policy for the management of Low Back Pain on 18th May 2017 and the current policy on Low Back Pain and Sciatica was adopted across NWL CCGs on 1st April 2018.

The proposed policy is based on the Low Back Pain NICE guidance published in 2016 and the relevant (evidence-based) feedback taken from the NW London CCGs Clinical workshop. NICE guidance outlines physical, psychological, pharmacological and surgical treatments to help manage low back pain and sciatica.

A multidisciplinary guideline development group undertook systematic searches of the literature, appraised the evidence, conducted meta-analyses and cost-effectiveness analyses and drafted the guidance. The full guidance can be found at https://www.nice.org.uk/guidance/ng59/evidence.

NICE recommended that a number of interventions should not be routinely offered in view of a lack of a clinical evidence base. These recommendations have been included in the NW London CCGs policy.

The list of treatments that NICE recommended ‘do not offer’ are:

- Spinal injections for managing low back pain (without sciatica)
- Acupuncture for managing low back pain with or without sciatica
- Spinal fusion for people with low back pain unless part of a randomised control trial
- Disc replacement for people with low back pain
- MRI imaging in a non-specialist setting for people with low back pain with or without sciatica

Other recommendations by NICE covered in the North West London Policy include:

- Radiofrequency denervation
  - Should be considered as an option for the management of chronic low back pain
- Epidural injections
  - Consider for acute and severe sciatica of less than 3 months’ duration, for people who would be considered for surgery
  - Do not use for claudicant leg pain due to central spinal canal stenosis as there is insufficient evidence of clinical benefit
The Policy Development Group also noted that, given NICE no longer recommends acupuncture for low back pain, there are no other recommended commissioned indications in NW London for acupuncture. NW London CCGs therefore do not commission acupuncture for any indication.

**What does this policy cover?**

The NW London Low Back Pain and Sciatica commissioning policy covers interventions for low back pain with or without sciatica, and was informed not just by the clinical guideline of NICE NG59, but by the systematic reviews carried out as part of NICE NG59 (available in the full guideline and appendices).

- The guideline ‘scope’ is defined in the NICE Guidelines Manual:
  - To provide an overview of what the clinical guideline will include and what will not be covered.
  - To identify the key clinical issues that must be included
  - To set the boundaries of the development work and provide a clear framework to enable the work to stay within the priorities agreed by NICE and the National Collaborating Centre (NCC) or the NICE Internal Clinical Guidelines Programme and the remit from the Department of Health or the NHS Commissioning Board.

In the NICE guideline, it was stated that “The various terms used to describe low back pain reflect our difficulty in accurately identifying discrete causes of low back pain and our inability to accurately define which characteristics might help to identify specific causes.” (p22, Low back pain and sciatica in over 16s: assessment and management Assessment and non-invasive treatments. [https://www.nice.org.uk/guidance/ng59/evidence/full-guideline-assessment-and-noninvasive-treatments-pdf-2726158003](https://www.nice.org.uk/guidance/ng59/evidence/full-guideline-assessment-and-noninvasive-treatments-pdf-2726158003))

The full evidence review supporting NG59 states “This guidance excludes the evaluation and management of serious spinal pathology (infection, malignancy and fractures), inflammatory causes of low back pain and the potentially serious neurological sequelae of sciatica (progressive neurological deficit and cauda equina syndrome), nor does it cover the onward management of patients with suspected serious pathology.”

There were no specific exclusions in the evidence searches for spinal injections for low back pain and sciatica for any of the following conditions: spondylolisthesis, previous back surgery, vertebral fractures, osteoarthritis, degenerative disc disease, facet joint arthropathy or adjacent segment disease. At the review stage, the majority of the 31 final studies included patient populations with such conditions.

The NW London policy applies to all patients presenting clinically with non-specific low back pain. This does not preclude patients who may coincidentally have other structural changes on imaging because such conditions are highly prevalent both in
a majority of patients who suffer non-specific low back pain, as well as those who are asymptomatic.

The below diagram may be helpful in understanding the scope and populations included in the NICE Guideline:

---

The NICE Quality Standard (QS155) makes the following quality statement: “Young people and adults do not have spinal injections for low back pain without sciatica with the exception of radiofrequency denervation for people who meet the criteria.”

The NICE Quality Standard defines examples of serious underlying pathology as including, but not limited to:

- Metastatic spinal cord compression in adults
- Spinal injury
- Spondyloarthritis in over 16s
- Suspected cancer
Should any patients with any specific conditions be identified, the NW London Policy Development Group will review these populations and evaluate any supporting published evidence of clinical effectiveness.

The policy excludes the management of malignancy or cancer-related spinal pain.

**When will this policy be reviewed next?**

The NWL Low Back Pain and Sciatica Policy will be reviewed if new and compelling evidence suggests that there are cohorts of people that can be easily identified, to whom the policy should not apply.

Please note, this policy will be reviewed annually as part of the IFR team’s annual policy review process.

**Cervical and Thoracic Facet Joint Injections and Medial Branch Blocks Policy (from 1st July 2018)**

The NWL policy development group also reviewed the effectiveness of spinal injections for cervical and thoracic facet joint pain. The group agreed that there was a lack of clinical evidence to support these procedures and as such the following policy was adopted across NWL on 1st July 2018.

“NWL CCGs do not commission Facet Joint Injections or therapeutic medial Branch Block Injections for chronic pain in the cervical or thoracic spine. Funding may be considered through the Individual Funding Request (IFR) route in exceptional circumstances”

Please note this policy will be reviewed annually as part of the IFR team’s annual policy review process.

The same exclusion criteria as the Low Back Pain and Sciatica policy applies to this policy.

A link to both policies is found below:

Frequently Asked Questions

Stakeholder engagement

1. What stakeholder engagement has been undertaken before implementation of the new policy?

**Low Back Pain Policy**

Although the implementation of the Low Back Pain policy is based on NICE national guidance there have been opportunities for local stakeholder input and feedback:

**Clinical Engagement -**

A clinical workshop was organised on 21st February 2017 and followed up with an e-group discussion to gather local stakeholder feedback on the implementation of the proposed policy and an opportunity to explore and debate the evidence base. The workshop was multi-disciplinary and included pain management clinicians, orthopaedic surgeons, physiotherapists, community providers, commissioners and lay members (patient representatives).

The workshop included two breakout sessions. The first breakout session focussed on the evidence base of the proposed policy and the second session focussed on the operational service impact of implementing the local policy. Feedback from both sessions fed into the final documents for discussion and decision as appropriate.

**Cervical and Thoracic Spinal Injections Policy**

A clinical workshop was organised in September 2017 and was well attended by pain consultants across NWL. There was a mixed view about the value of these injections but agreement in the lack of clinical evidence. There was wide agreement that physical therapies such as physiotherapy and lifestyle changes were likely to have more impact for patients with chronic pain than providing joint injections.

Further circulation of the draft policy was sent by email to the clinical e-group and no further comments were received.

2. Have GPs been informed about the policy change?

GPs were represented at the NW London CCGs’ clinical workshop, and have also received communications through the CCG Governing Bodies where update papers were presented. GPs have been sent letters advising them of the changes and the rationale behind the changes. The letter has been
accompanied by guidance on the on-going management of patients that are discharged back to primary care.

Feedback to date has been that GPs are broadly supportive. However as part of the wider on-going engagement, the policy changes have also been cascaded through presentations by the GP Champions/Task and Finish Group Leads through the GP Networks. There is a generic inbox, nwlccgs.ppwtifr@nhs.net, which will coordinate any outstanding queries.

3. Has the general public been informed about the policy change and if so, what is their feedback? Is there any written evidence of their views/agreement with the policy?

Patient Engagement for Low Back Pain

To gather feedback on the proposed pathway from a patient experience perspective, a dedicated patient forum was held on 6th February 2017. The forum was attended by patients/carers. There was patient representation at the wider multi-disciplinary clinical workshop held on 21st February 2017 and feedback was also followed up with a survey using ‘survey monkey’.

The feedback from the engagement was documented and incorporated into the papers presented at the NW London CCGs’ Collaboration Board (now Joint Committee).

Healthwatch representatives were part of the Policy Development Group membership which were responsible for making final recommendations regarding the policy, and the Collaborative Board (now Joint Committee) membership which had signed off the policy on behalf of the eight NWL CCGs.

Patient Engagement for Cervical Thoracic spinal injections

The Policy Development Group (which includes a Healthwatch representative) felt that as this group of patients currently receiving these treatments is so small and hard to identify that engagement would be very difficult and instead to identify challenges via local intelligence and complaints monitoring. This and approach was presented to the NWL lay partner forum who also agreed with this way forward.

4. Has an Equality and Health Inequalities Impact Analysis (EHIA) been prepared?

An EHIA screening analysis was undertaken and any identified risks and mitigating actions were built into the implementation plan. The implementation plan is being governed and delivered centrally by the NW London CCGs Low Back Pain Task and Finish Group (T&FG).
5. How do these changes impact consultant-to-consultant referral pathways?

As the NW London CCG policy is evidence-based, the same criteria apply to consultant-to-consultant referrals. Patients who do not meet the NW London CCG policy criteria should be referred back to their GP for on-going management.

6. What local resources and facilities are available to manage patients in the community, if providers discharge them back to GPs? Will there be equity of access and care for all patients across the eight CCGs?

All GPs across NW London have been provided with the same guidance on the on-going management of patients across primary care. CCGs are working at a local level (as part of the Task and Finish Group) to review whether additional alternative provision in the community is available for the management of discharged patients. It is anticipated however that the majority of patients will be managed in primary care or referred for alternative provision as clinically appropriate.
Clinical queries raised by providers

**Spinal injections**

7. What should providers do with the number of referrals for spinal injections from consultants who have historically seen patients with back and leg pain at private providers with NHS contracts?

Clinicians should review the responses to previous treatments (other than injections and acupuncture) on a case-by-case basis. Where other treatments were not clinically effective beyond the end of treatment and where alternative treatments are not both clinically and cost-effective, these patients need to be discharged back to primary care. A care plan template must be completed and has been provided to all relevant provider trusts (or incorporated into any discharge letter) for any patients discharged. The CCGs advise that patients should receive a copy too.

8. Providers currently receive a number of referrals for repeat injections; mainly caudals, nerve root injections and radiofrequency denervations (RFDs), as they have been beneficial for patients in the past. These patients used to have two injections per year either under Radiology, Trauma and Orthopaedics or the Pain service. How should providers now manage these patients? Discharging them to the GPs is going to upset their pain management and quality of life.

It is acknowledged that some interventions may be clinically effective but are not cost-effective, even when taking into account the costs of alternatives such as best supportive care and the side effects of on-going medication. Offering treatments excluded by the Low Back Pain Policy consumes health resources (time, staff, and money) on procedures that are not cost-effective, and therefore denies other patients (possibly with different conditions) timely access to treatment.

Commissioners have had to balance both clinical and cost-effectiveness criteria in formulating the policy. Patients will need to be discharged if there are no alternative treatments that are both clinically and cost-effective.

9. Low Back Pain has been acknowledged as a long term condition requiring long term management. Some clinicians in NW London believe that repeat spinal injections are inevitable for good responders and, provided they are clinically effective, it should be left to the spinal pain Multidisciplinary team (MDT) to decide whether they should be repeated or not. A clinically meaningful reduction in pain is 50% or more according to the International Association for the Society of Pain (IASP). Some clinicians firmly believe that this should be the cut-off point for
repeat injections and injections (other than RFD) should be limited to a maximum of two per year.

The Policy Development Group took into account the clinical evidence, cost-effectiveness evidence, NICE guidelines, NICE Quality Standards, and the context of provision in health care in NW London, including fair allocation of resources. Looking at the weak clinical evidence for injections for low back pain, and the lack of cost-effectiveness, the PDG recommended that injections for low back pain should not continue to be offered in NW London.

In line with NICE guidance, repeated injections will not be commissioned for patients with chronic pain. NICE states that overall the Guidance Decision Group (GDG) agreed that there was no consistent good quality evidence to recommend the use of spinal injections for the management of low back pain. There was minimal evidence of benefit from injections, and reason to believe that there was a risk of harm, even if rare. The GDG consequently agreed that it was appropriate to recommend against the use of spinal injections for people with low back pain.

10. What is the policy if a person re-presents with a recurrence of sciatica following treatment (including epidurals)?

The clinician will need to assess if the person has had a new episode of sciatica, for instance if there is a further disc prolapse at the same or adjacent level, or if the person has had chronic sciatica with a temporary improvement with an injection. If there is clinical recovery that is not simply masked by the first injection and the patient has a genuine recurrence, this can be treated as an acute episode as per NW London CCGs policy.

11. How are providers going to manage the three month clause for radicular pain? Most of the referrals are arriving with the department > 12 months after initial presentation. The recent FPM (Faculty of Pain Medicine) survey showed that most chronic pain patients are referred to the Pain Service four and a half years after initial presentation.

This contractual and trust performance matter should be discussed with the provider’s lead commissioner. The policy advice is that these patients should only be offered treatments that fall within the policy.

The policy states that NWL CCGs fund epidurals (local anaesthetic and steroid) only in patients who have less than three months history of acute and severe lumbar radiculopathy at time of referral.

A discussion about the treatment options for acute sciatica, including the role of injections, would normally occur in community interface services, where these are commissioned.
If an epidural is recommended, the procedure should be completed within three months from the receipt of the referral at the beginning of the musculoskeletal pathway, which includes community and triage services, where these are commissioned.

All providers (GPs, community and hospital) will need to work together to ensure patients are referred for consideration of epidurals at the right time in the pathway. Providers will have to ensure that they can fast-track patients when clinically appropriate to enable access to the right treatment. Your lead commissioner can advise on the development of pathways, including the MSK Sustainability and Transformation Programme (STP).

12. Can the hospital spinal MDT team reject a referral if the GP or MSK service does not provide a comprehensive clinical letter with the reason for the referral and the MRI results where clinically indicated?

All providers are entitled to ensure that they receive adequate information from referrers, without causing any unnecessary delays in seeing patients or starting treatments. If providers feel that it would be helpful to have a referral form with specific information requirements, this can be discussed during pathway development. It is in the patients’ and providers’ best interests that only patients who need to be seen in a given care setting are seen, and that all relevant information to inform a discussion on management options is available.

With regards to prerequisites for MRI scanning, NICE recommends that imaging only be done in specialist settings of care. Not all CCGs have commissioned community specialist services, so in some cases these investigations will need to be done in secondary care. Both the STP diagnostics review programme and MSK transformation programmes will be reviewing where and when imaging should be done.

13. Discharge back to primary care requires a completed ‘care plan template’. What clinical benefit will this add? Most patients will be discharged after completion of treatment or when no treatment is indicated. What will a template actually add?

A completed care plan template will help support GPs by summarising the treatment that the patient has received to date, and providing the GP information about the patient’s on-going management of their condition. E.g. advice about drug treatments and whether further community provided services such as psychological interventions or physical therapy may be beneficial. In addition, the care plan can also inform the GP of when a patient should be re-referred back to secondary care, e.g. for progressive disease or symptoms.
14. Other interventional procedures, for which there is NICE guidance and adequate clinical effectiveness, may be part of the patient pathway. These include spinal cord stimulation, percutaneous coblation of intervertebral disc, and percutaneous intradiscal laser ablation (nucleoplasty).

The NICE Low Back Pain pathway states that other surgical procedures can be considered for the treatment of low back pain.

Some procedures are covered by NICE Interventional Procedures such as:

- Percutaneous coblation of the intervertebral disc for low back pain and sciatica Interventional procedures guidance [IPG543]
- Percutaneous intradiscal laser ablation in the lumbar spine. Interventional procedures guidance [IPG357]

NICE Interventional Procedures Guidance (IPG) requires an assessment of whether these interventions are cost effective, and as such CCGs via the NWL Policy Development group will need to review such requested activity in the first instance.

Spinal Cord stimulation:

There is NICE Technology appraisal guidance for the use of Spinal cord stimulation for chronic pain of neuropathic or ischaemic origin [TA159]. This is commissioned by NHS England as it is a highly specialised area. Please see the NHS England Specialised Commissioning Manual for further details:


15. Can we change facet injections to facet medial branch blocks?

Neither facet joint injections or medial branch block injections are funded for therapeutic reasons.

16. Are diagnostic spinal nerve blocks funded?

Diagnostic medial branch block injections will only be funded in order to determine whether radiofrequency denervation is a suitable treatment option.

17. Is a PPwT form required for radiofrequency denervation?

The submission of a PPwT form is required for the authorisation of Radiofrequency denervation for low back pain, when a diagnostic medial branch block has been shown to be effective. A PPwT form for Radiofrequency denervation for cervical and thoracic pain is not currently required.
18. Are the following procedures commissioned? Please provide clarification

18.1 Sacroiliac joint injections and radiofrequency denervation?

Yes, sacroiliac joint injections and radiofrequency denervation for the sacroiliac joint is routinely commissioned. No PPWT form for sacroiliac joint radiofrequency is required.

18.2 Trigger point injections in an area other than low back pain (lumbar)?

Yes trigger point injections are routinely commissioned except for low back pain.

18.3 Epidurals

- Lateral Canal Stenosis for low back pain

Epidural and transforaminal epidural injections are routinely funded for lateral canal stenosis, only where this is associated with radicular pain. See FAQs 10 and 11.

- Sacral and Caudal epidurals

These injections are not routinely commissioned for the management of low back pain and non-radiccular spinal pain.

- Other epidurals not in the low back (cervical, thoracic)

Yes, these are routinely funded.

18.4 Nerve root injections

Nerve root injections are only commissioned for acute sciatica within 3 months of presentation, or where there is lateral canal stenosis with radicular pain.

18.5 Dorsal Root Ganglion blocks

Dorsal root ganglion blocks are only commissioned for acute sciatica within 3 months of presentation or where there is lateral canal stenosis.

18.6 Piriformis injections

These injections are not approved for low back pain but will be approved for leg pain, but note the lack of clinical and cost-effectiveness evidence.
18.7 *Coccyx injections*

Injections for coccydynia are routinely funded.

18.8 *Acupuncture*

NWL CCGs do not fund acupuncture for any indication.

19. **Are the following conditions treatable under the NWL policy?**

19.1 *Spondylolithesis*

Injections for patients with spondylolithesis with low back pain that is non-radicul in nature will not be routinely funded. Where patients have radicular pain present (with or without back pain), spinal injections will be routinely funded.

19.2 *Failed back surgery syndrome*

Injections for patients with low back pain following failed back surgery that is non-radicul in nature will not be routinely funded. Where patients have radicular pain present (with or without back pain), spinal injections will be routinely funded.

The immediate post-surgical management of pain during the normal healing process is different to failed back surgery. Clinicians should provide treatment based on their clinical judgement.

19.3 *Fractures*

- **Acute fractures**

  The treatment of acute fractures is out of scope of this policy.

- **Chronic fractures**

  If pain is specifically due to the fracture, interventions such as surgery, Orthotics and vertebroplasty should be considered.

  If there is radicular pain due to lateral canal stenosis secondary to the fracture, epidural or nerve root injections will be funded.

  If there is radicular pain due to an acute disc prolapse secondary to the fracture, epidurals or nerve root injections would only be funded during the first three months from initial presentation.

  If as a result of the patient’s fracture they have pain due to altered biomechanics or adjacent segment pain, spinal injections will not be routinely
funded as this group of patients fall into the wider non-specific low back pain group.

20 How does this policy affect patients who have cancer?

This policy does not apply to palliative care patients or to the treatment of patients with cancer-related spinal pain.

Radiofrequency denervation

21 Can radiofrequency denervation be repeated after 16 months?

The “one in a lifetime” radiofrequency denervation (RFD) is not what was discussed in February 2017 at the clinical workshop; this clause has been added recently to the policy. This suggestion clashes with basic science that shows that the nerves recover within 12 months after RFD and can again cause pain.

The clinical evidence is that when RFD works, it usually lasts from three to five years. NICE cost effectiveness threshold analysis shows that the QALY gain needs to last at least 16 months to be cost effective. If the QALY gain (length of pain relief) is less than 16 months, the procedure will not be cost effective, however often it is repeated or indeed if ever repeated. NICE made a research recommendation to review the clinical and cost-effectiveness of repeat RFD.

As such NWL CCGs does not fund repeated treatment of radiofrequency denervation at the same spinal level and laterality.

The Policy Development Group will review the evidence for repeat procedures if new evidence emerges.

The PPwT form for RFD has not been discussed with providers. One would expect that any new points or clauses added to the policy should first be discussed with the providers.

Providers have been engaged with the changes to policy, both via e-group where drafts were emailed around for debate and discussion, and at the NW London CCGs Low Back Pain workshop. A letter was sent out to Trusts to also provide the contractual six months’ notice of intended change.

The policy and PPwT form for RFD for chronic low back pain have been published online at http://www.hounslowccg.nhs.uk/news-publications-and-policies/publications.aspx?n=2010. Trusts are therefore able to access and use these forms for immediate use, where this has been locally agreed.
22 Please clarify whether the CCG commissions radiofrequency denervation for ipsilateral and contralateral sides at the same level

Yes, a separate PPWT form will be required for completion if treatment is not carried out at the same session. NWL CCGs does not fund repeated treatment of radiofrequency denervation at the same spinal level and laterality. Requests for retreatment should be made via the NWL Individual Funding Request (IFR) route in exceptional clinical circumstances.

23 How was 80% decided upon as the threshold for concluding that a diagnostic block was effective in order for radiofrequency denervation to be tried?

This was based on the cost-effectiveness model for RFD produced by NICE which defined a positive diagnostic block as 80% pain relief. (Page 423, para 2.3.3) [https://www.nice.org.uk/guidance/ng59/evidence/appendices-kq-pdf-2726158004](https://www.nice.org.uk/guidance/ng59/evidence/appendices-kq-pdf-2726158004)

24 Are there any exclusions to the radiofrequency denervation for low back pain policy?

The same exclusion criteria as for the Low Back Pain and Sciatica policy applies to this policy.

**Individual Funding Requests**

25 Under what circumstances would an Individual Funding Request (IFR) be considered?

An Individual Funding Request can be made for patients who have clinically exceptional reasons to warrant the consideration of funding of a procedure that is not routinely funded by NWL CCGs.

Secondary care clinicians rather than GPs should complete and submit IFR requests as they are better placed to provide evidence demonstrating clinical exceptionality of the patient’s case.

IFRs are considered on a case by case basis. Funding for treatments for cohorts of similar patients will not warrant consideration by the IFR route.

As per the NWL Clinical Commissioning Groups IFR Operational Policy, there can be no exhaustive definition of the conditions which are likely to come within the definition of a clinically exceptional individual case. The word “exception” means “a person, thing or case to which the general rule is not applicable”
However, to meet the definition of ‘exceptional clinical circumstances’ there must be some unusual or unique clinical factor about the patient that suggests that they are:

- Significantly different clinically to the group of patients with the condition in question and at the same stage of progression of the condition. (I.e. compared with the same age, sex, disease specific cohort of patients). An example would be an exceptionally indolent or other ‘variant’ of the illness or host factors such as an unusual genetic make-up that will make them exceptionally responsive to treatment.

**AND**

- Likely to gain significantly more clinical benefit from the intervention than might be expected from the average patients with the same clinical condition. An example will be where a treatment is likely to be more clinically effective as well as cost effective on an individual patient.

However, the fact that a treatment is likely to be efficacious for a patient is not, in itself, a basis for an exemption.

If a patient's clinical condition matches the 'accepted indications' for a treatment that is not funded, their circumstances are not, by definition, exceptional.

It should be noted that social value judgments are rarely relevant to the consideration of exceptional status.

Further information on the IFR process can be found at the link below: