

Chronic Low Back Pain Seminar Patient Engagement

NHS North West London CCGs

6th February 2017



Aims and Objectives

- Welcome and introductions
- Why are we here?
 - To hear patient views as CCGs plan to adopt NICE guidance
 - To raise awareness of changes proposed
 - To invite you to the NWL stakeholder session on the 21st of February 2017



Meet the Team

North West London Collaboration of
Clinical Commissioning Groups

- June Farquharson - Associate Director, NWL IFR team
- Dr Lily Wong - General Practitioner and Medical Adviser IFR/PPwT/NWL Policy Development Team
- Facilitators



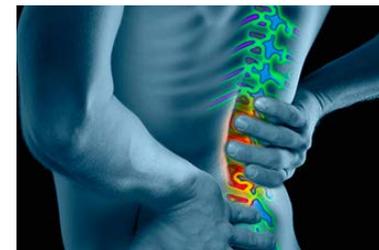
Low back pain

- The lifetime prevalence of non-specific (common) low back pain is estimated at **60% to 70%**
- Low back pain is the most common cause of disability in young adults, with more than **100 million workdays lost per year.**
- Annual total costs due to low back pain are estimated at **£12.3 billion;**
- At present low back pain is treated mainly with analgesics. **The causes of lower back pain are rarely addressed.** Alternative treatments include physical therapy, rehabilitation and spinal manipulation. **Disc surgery remains the last option, but the outcomes are disappointing.**



Why we need a new Low Back Pain Policy

- New NICE guidance, published in November 2016
- It no longer recommends some routine treatments on the basis that they are of limited clinical benefit
- We're drafting a new policy and we want your input



What is NICE?

The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care.



NICE Recommendations



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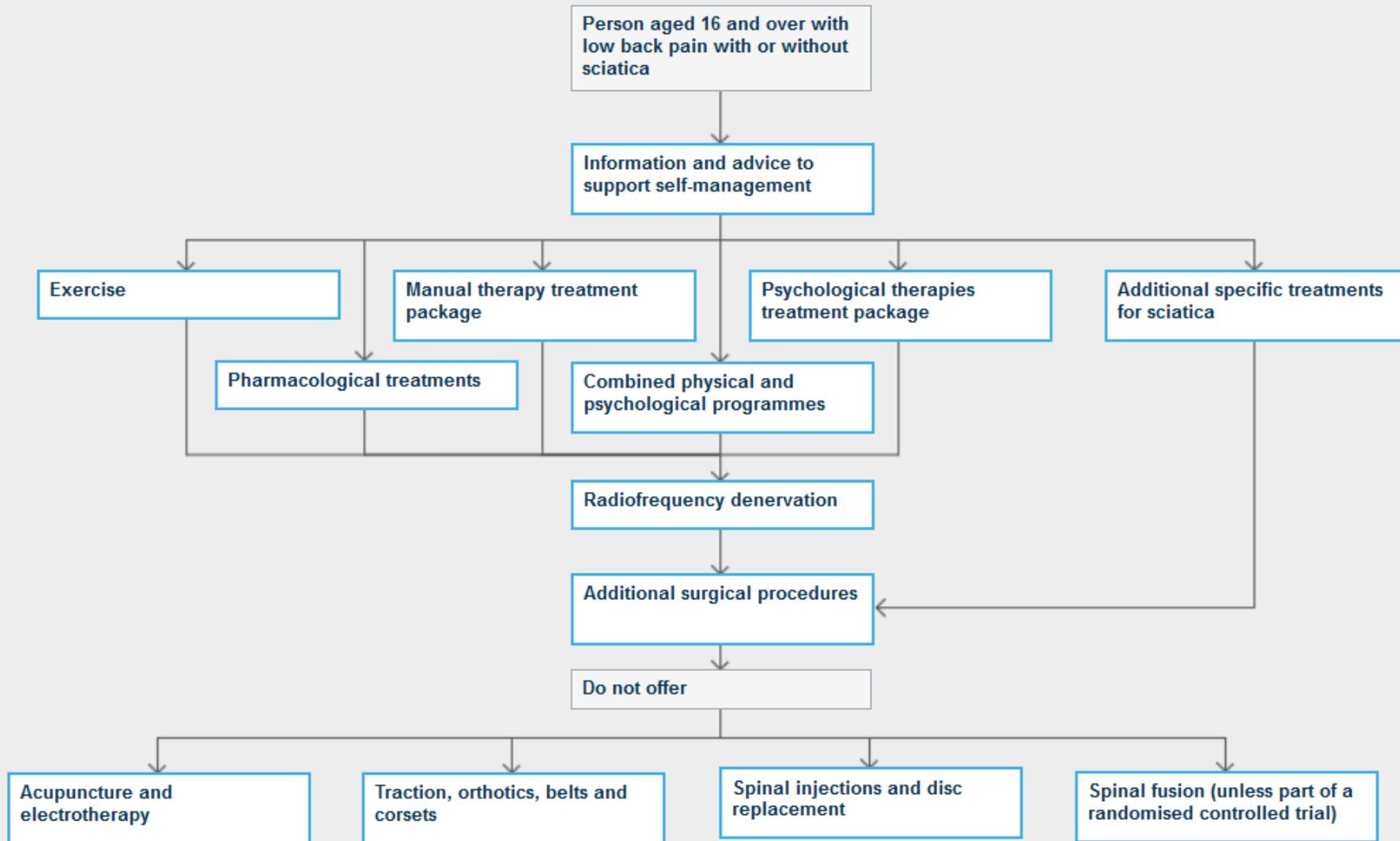
- Invasive procedures currently provided in secondary care lack clinical effectiveness and should not be routinely commissioned.
- More holistic management of patients with chronic low back pain, rather than referral to secondary care where interventions are largely ineffective.
- These interventions are no longer recommended:
 - Acupuncture
 - Discectomy
 - Interlaminar, transformational caudal epidural injection for patients with radicular pain
 - Therapeutic facet joint injection
 - Thermal frequency denervation of lumbar & cervical facet joints



NICE

National Institute for
Health and Care Excellence

Managing low back pain and sciatica



Draft plans

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1. NWL CCGs do NOT commission the following for non radicular spinal pain
 - Facet Joint injections
 - Therapeutic Medial Branch Blocks (cervical, thoracic, lumbar)
 - Intradiscal therapy
 - Prolotherapy
 - Trigger point injections with any agent, including botox
 - Epidural steroid injections (non-radicular pain)
 - Spinal injections not specifically covered above
 - Acupuncture for back pain (with or without radicular symptoms) and osteoarthritis

2. NWL CCGs fund Radiofrequency Denervation for chronic low back pain when:
 - All conservative measures have been tried (see NICE pathway)
 - A diagnostic medial branch block at a single facet joint level provides >80% improvement in pain for the duration of the block
 - The patient has moderate or severe levels of localised back pain (rated as 5 or more on a visual analogue scale, or equivalent) at time of referral
 - Retreatment is not routinely funded unless treatment has provided at least 15months of symptom relief
 - Do not offer imaging for people with low back pain with specific facet joint pain as a prerequisite for radiofrequency denervation (NICE NG59)



Draft plans

North West London Collaboration of
Specialist Pain Relieving Groups

3. NWL CCGs fund **Caudal, Interlaminar and Transforaminal (nerve root) epidural injections** for acute radicular pain and lateral canal stenosis only
4. NWL CCGs will NOT fund the following surgical procedures for nonspecific low back pain. (Specific causes of LBP e.g spondylithesis, scoliosis or severe structural disease are out of scope and not covered by this policy):
 - Spinal fusion, except as part of a randomised controlled trial (RCT)
 - Lumbar disc replacement
5. NWL CCGs recommend that **imaging** for chronic low back pain should not routinely be offered in a non-specialist setting for people with low back pain with or without sciatica.



Evidence base

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- **Acupuncture** was not shown to be any more effective than sham acupuncture
- **Facet joint injections:** no short term clinical effect versus saline, uncertainty of clinically important differences versus active comparators
- **Medial branch blocks:** no clinically important difference
- **Trigger point injections:** Steroid + local anaesth: no short term clinical effect. Botulinum toxin: insufficient evidence
- **Epidural steroid in non specific low back pain:** no clinically important difference



Why should we do this and what are the implications?

- **A greater emphasis on clinically effective treatments** for patients who have chronic low back pain
- **Better use of limited NHS resources** and funds redirected to services which can provide effective treatments
- **Treatments that have been shown to have little clinical effectiveness will not be funded**



Key points to remember

- NWL CCGs would like to use the evidence to develop our policy
- NWL CCGs want to provide effective treatments for their patients
- We want your views – No decisions have been made yet
- If you don't think we should follow the NICE evidence, tell us why.





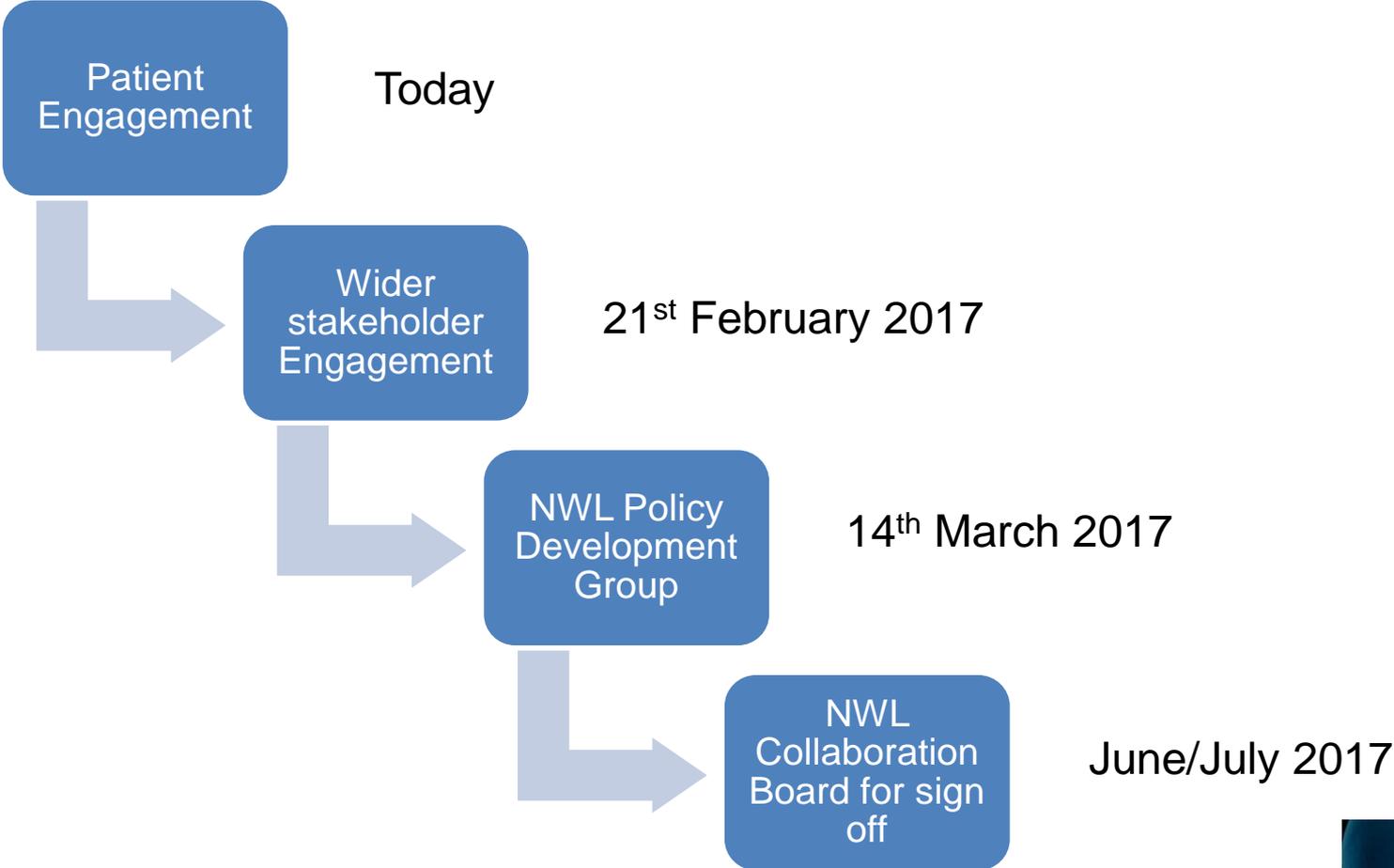
Break Out Sessions

We would like your views and thoughts

- What three key thoughts do you have?



Timelines



Want to carry on the conversation? Save the date!

- We are holding a stakeholder workshop to discuss the proposed policy
- 21st February 2017, 0930-1300, Hellenic Centre, 16-18 Paddington St, Marylebone, London W1U 5AS
- We'd really like people to hear your views first hand so please volunteer to feedback



References

- NICE 2016 Low back pain and sciatica
<https://www.nice.org.uk/guidance/ng59>



Any questions?

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