Date of Meeting: 17 May 2019
Agenda Item: 6.3ii
Subject: Greater Manchester (GM) Effective Use of Resources (EUR) Policies
Reporting Officer: Dr Chris Duffy
Aim of Paper: For Information Only

<table>
<thead>
<tr>
<th>Governance route</th>
<th>Meeting Date</th>
<th>Objective/Outcome</th>
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<tbody>
<tr>
<td>Governing Body</td>
<td>Select date of meeting.</td>
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<tr>
<td>Audit Committee</td>
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<td>Corporate Governance Committee</td>
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<td>Health and Wellbeing Board</td>
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<td>Integrated Commissioning Board</td>
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<td>Locality Engagement Group</td>
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<td>Patient and Public Engagement Committee</td>
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<td>Quality and Safeguarding Committee</td>
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<td>Primary Care Commissioning Committee</td>
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<td>Clinical &amp; Professional Advisory Panel</td>
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<tr>
<td>Other</td>
<td>Approved by Directors of Commissioning (DoCs) on the 21st March 2019</td>
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Resolution Required: For Information Only
Recommendation: Provided for information only.

Link to Strategic Objectives

<table>
<thead>
<tr>
<th>Strategic Objective</th>
<th>Contributes to:</th>
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<tbody>
<tr>
<td>SO1: To be a high performing CCG, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population.</td>
<td>Yes</td>
</tr>
<tr>
<td>SO2: To deliver on the outcomes of the Locality Plan in respect of Prevention and Access (Prevention and Self Care)</td>
<td>No</td>
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<tr>
<td>SO3: To deliver on the outcomes of the Locality Plan in respect of Neighbourhoods &amp; Primary Care (Getting help in the Community)</td>
<td>No</td>
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<td>SO4: To deliver on the outcomes of the Locality Plan in respect of In Hospital - Planned (Getting more help)</td>
<td>No</td>
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<tr>
<td>SO5: To deliver on the outcomes of the Locality Plan in respect of In Hospital - Urgent Care (Getting more help)</td>
<td>No</td>
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<td>SO6: To deliver on the outcomes of the Locality Plan in respect of Children, young people and families</td>
<td>No</td>
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<tr>
<td>SO7: To deliver on the outcomes of the Locality Plan in respect of Mental Health</td>
<td>No</td>
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Risk Level: (To be reviewed in line with Risk Policy) Not Applicable
Comments (Document should detail how the risk will be mitigated) Click here to enter text.
<table>
<thead>
<tr>
<th>Content Approval/Sign Off:</th>
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</thead>
<tbody>
<tr>
<td>The contents of this paper have been reviewed and approved by:</td>
<td>Clinical Chair, Dr Chris Duffy</td>
</tr>
<tr>
<td>Clinical Content signed off by:</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Financial content signed off by:</td>
<td>Not Applicable</td>
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<tr>
<th>Completed:</th>
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<tr>
<td>Clinical Engagement taken place</td>
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<tr>
<td>Patient and Public Involvement</td>
</tr>
<tr>
<td>Patient Data Impact Assessment</td>
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<tr>
<td>Equality Analysis / Human Rights Assessment completed</td>
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**Executive Summary**

In line with delegated authority from the Joint Commissioning Board (JCB), the following Greater Manchester (GM) Effective Use of Resources (EUR) Policies, were approved for implementation by the Directors of Commissioning (DoCs) on the 21st March 2019: -

- Low Back Pain (Revised)
Name of Meeting: Directors of Commissioning

Date of Meeting: XX March 2019

Title of paper: Revised Greater Manchester Effective Use of Resources policy on: Low Back Pain (with or without sciatica)

Reason for Paper: Please tick appropriate box

✓ Decision – The Directors of Commissioning are asked to approve the revised GM EUR policy for implementation.

☐ Discussion

☐ For information

GM Workplan which the subject is supporting. Greater Manchester Effective Use of Resources Policy Development

The Effective Use of Resources (EUR) Policy Team, in conjunction with the GM EUR Steering Group, have developed this revised policy on behalf of Clinical Commissioning Groups (CCGs) within Greater Manchester. The GM EUR Steering Group is made up of a clinical representative from each GM CCG.

Recommendations / Please specify what is the specific aim of the document and what you are seeking to secure from the GM Directors of Commissioning

The Directors of Commissioning are asked to review the attached paperwork and approve the policy for implementation.

Attached documents to aid the decision making process are:-
1. The revised GM Policy for Low Back Pain (with or without sciatica)
2. Costing and Activity Report

Author of paper and contact details

Jane Carr - Effective Use of Resources Policy Manager

Email: jane.carr2@nhs.net  Tel: 0161 212 6212

Governance

The revised policy went out for a period of 7 weeks clinical engagement from the 16 Nov 2018 – 4 Jan 2019. All feedback received during the period of clinical engagement was reviewed by GM EUR Steering Group at their meeting on the 16 Jan 2019 and changes made to the policy where deemed necessary. The group also approved the revised policy to progress through the governance process. The policy has now come to Directors of Commissioning/Chief Finance Officers for approval to implement.
Executive Summary

(please provide no more than a one page summary)

**Brief Background/Rationale**
The aim of the revised policy is to ensure that interventions for back pain with or without sciatica are undertaken in a timely manner and that all alternative treatment options for the individual’s care have been considered and tried where appropriate and are either not indicated or no longer effective. This insures that each individual will gain maximum benefit and potential growth in activity is appropriately managed. It will also bring the local policy in line with the commissioning recommendations suggested by NHS England.

**Key Points**
This policy is slightly more restrictive than its predecessor so there will be a further reduction in activity and associated savings from its implementation supported by the move to zero tariff that will cover epidural injections for back pain. It will also bring the local policy in line with the commissioning recommendations suggested by NHS England.

**Funding Implications**
It is very difficult to collate and tabulate current activity and cost across GM due to the complexity of interventions covered by this policy and interventions for back pain are already restricted under the policies that this one will replace. However as epidural injections for back pain are very restricted by this policy and will be moving to zero tariff as a result of the NHSE evidence based proposals there will be a saving associated with that reduction in activity.

**Level of Engagement (please provide details of who/groups have been involved in the development and if this includes patient/public)**
The revised policy went out for a period of 7 weeks clinical engagement from the 16 Nov 2018 – 4 Jan 2019. All feedback received during the period of clinical engagement was reviewed by GM EUR Steering Group at their meeting on the 16 January 2019 and changes made to the policy where deemed necessary. GM EUR Policies do not go out for patient/public engagement.

**Recommendations/Next Steps (please provide details of the decision making process/the next steps following presentation to DoCs)**
Once approved by DoCs/CFOs the revised policy will be implemented for Bury, HMR, Manchester, Oldham, Salford, Stockport, Tameside and Glossop, Trafford & Wigan CCGs. Later going to their governing body (or equivalent delegated committee) for ratification. For Bolton CCG it will not be implemented until the policy has been ratified by their governing body. The policy will not require to be fully considered by a CCG governing body, but will simply go through a process for ratification. This is because the policy has already been through a rigorous CCG governance process. It is expected that if a CCG had a different opinion regarding a particular policy, then it would have been voiced during the period of clinical engagement or at other meetings where the policy has been considered.

The EUR Policy Team will make the necessary arrangements for this to be varied into the relevant acute trust contract on a quarterly basis.
Greater Manchester CCGs
Policy summary and anticipated activity and cost change report for:
Low back pain (with or without sciatica)
GM Ref: GM046
Version: Revised 1.2 (11 February 2019)

(This policy incorporates GM004: Radiofrequency Denervation for Back Pain)

Expected change in activity Reduction
Expected change in overall cost Reduction
Introduction

This report aims to inform the Greater Manchester Chief Finance Officers and Directors of Commissioning of the likely changes to activity and spend on back pain with or without sciatica and radiofrequency denervation for back pain across the CCGs as a result of the proposed GM EUR policy.

The information contained in this report has been produced to support the policy decision making process across Greater Manchester. The Greater Manchester Chief Finance Officers and Greater Manchester Directors of Commissioning are asked to review this report to assist in the consideration of the revised Greater Manchester EUR Policy for Low Back Pain (with or without sciatica).

Summary of policy impact

The purpose of this policy is to target the most effective interventions for back pain with or without sciatica at those individuals who will gain the most benefit.

This policy document aims to ensure equity, consistency and clarity in the commissioning of treatments/procedures by CCGs in Greater Manchester by:

- reducing the variation in access to treatments/procedures.
- ensuring that treatments/procedures are commissioned where there is acceptable evidence of clinical benefit and cost-effectiveness.
- reducing unacceptable variation in the commissioning of treatments/procedures across Greater Manchester.
- promoting the cost-effective use of healthcare resources.

This policy is designed to support the MSK pathway redesign work already underway and ensure compliance with NICE guidance.

Summary of commissioning recommendations in the policy

Treatments for low back pain with or without sciatica referred to in NICE NG59 as being effective are commissioned.

This includes a single epidural injection for acute (normally of less than 3 months duration) severe sciatica as NICE evidence suggests this may avoid the need for surgery in a proportion of patients and medial branch block as a diagnostic tool prior to consideration of radiofrequency denervation.

NOTE: The following GM policies are still active and should be referred to when specific treatments are being considered:

- GM018: Out of Contract Spinal Procedures
- GM070: Facet Joint Injections

NOTE: The following GM policy have been replaced by this policy:

- GM004: Radiofrequency Denervation for Back Pain

Funding Mechanism

GMEURSG recommendation: Within contract for NICE NG59 approved procedures, including a single epidural for acute severe sciatica and diagnostic medial branch block.
**NOT Commissioned**

In line with NICE NG59, the following are NOT commissioned:

- X-ray of the lumbar spine for the management of non-specific low back pain
- Imaging in a non-specialist setting for people with low back pain with or without sciatica. Imaging, if clinically appropriate should take place in specialist settings of care (for example, a musculoskeletal interface clinic or hospital) for people with low back pain with or without sciatica but only if the result is likely to change management. Imaging can be offered in a community setting if this is part of a locally commissioned pathway of care.
- Belts or corsets for managing low back pain with or without sciatica
- Foot orthotics for managing low back pain with or without sciatica
- Rocker sole shoes for managing low back pain with or without sciatica
- Traction for managing low back pain with or without sciatica
- Acupuncture for managing low back pain with or without sciatica (see Complementary and Alternative Therapies policy for more detail)
- Ultrasound for managing low back pain with or without sciatica
- Percutaneous electrical nerve simulation (PENS) for managing low back pain with or without sciatica
- Transcutaneous electrical nerve simulation (TENS) for managing low back pain with or without sciatica
- Interferential therapy for managing low back pain with or without sciatica
- Opioids for managing acute low back pain unless low potency opioids are being used with Paracetamol in a patient who is intolerant of NSAIDs or where they have been tried with good compliance and are ineffective
- Spinal injections for managing low back pain
- Epidural injections for neurogenic claudication in people who have central spinal canal stenosis
- Repeat epidurals for chronic sciatica (NOTE: Single epidural injections can be given for each discrete episode of acute severe sciatica but cannot be repeated for sciatica that goes on to be chronic / long standing)
- Spinal fusion for people with low back pain unless as part of a randomised controlled trial
- Disc replacement in people with low back pain (disc replacement where indicated is commissioned by NHS England)

In addition to those listed above from NICE NG59, the following are also **NOT** commissioned:

- Therapeutic MBB
- Epidural steroid injections for chronic low back pain
- Alexander Technique
- Massage
- Intradiscal therapy / electrothermal therapy (IDET)
- Prolotherapy
- Trigger point injections with any agent (including botulinum toxin)
• Percutaneous intradiscal radiofrequency thermocoagulation (PIRFT)
• Neuroreflexive therapy
• Any other spinal injections not specifically covered above

**Funding Mechanism**
GMEURSG recommendation: Clinicians can submit an individual funding request outside of this guidance if they feel there is a good case for clinical exceptionality. Requests must be submitted with all relevant supporting evidence.

**Wherever possible, patients should be encouraged to:**
• participate in mobilisation or rehabilitation therapy
• take effective pain relief medication
• where indicated (and where it is available) be referred for weight management

**Lumbar facet joint injections**
• See: [GM070: Facet Joint Injections](#)

Facet joint injection for low back pain with or without sciatica is no longer commissioned (in line with NICE NG59). When determining suitability for radiofrequency denervation a medial branch block is the commissioned diagnostic tool.

**Diagnostic medial branch block**
Diagnostic medial branch block is commissioned for patients who meet the following criteria:
• the back pain has been present for more than 1 year and all chronic pain management pathways have failed
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
AND one of the following:
  o there is no other treatment option available for the patient (i.e. non-surgical treatment has not worked for them)
  OR
  o alternative treatments such as analgesic medication are intolerable or produce undesirable side effects
  OR
  o the patient has demonstrated failure to respond to, or had a loss of response to, other treatment options
  OR
  o other treatment options are contraindicated and this is clearly documented
Wherever possible patients should be encouraged to:

- participate in mobilisation or rehabilitation therapy
- take effective pain relief medication
- where indicated (and where it is available) be referred for weight management support

Patients should NOT have radiofrequency denervation if:

- they are pregnant
- there are any comorbidities present that contraindicate radiofrequency denervation
- they are unable to be positioned in the correct way prior to treatment

Following radiofrequency denervation and where clinically appropriate the patient should be referred for and participate in active rehabilitation support.

Funding Mechanism

GMEURSG recommendation: Monitored approval: Referrals may be made in line with the criteria without seeking funding. **NOTE:** These referrals may be the subject of contract challenges and/or audit of cases against commissioned criteria.

Radiofrequency denervation

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.

AND

- They have chronic low back pain which has shown a positive response to a diagnostic medial branch block.

New patients

If new patients gain relief from medial branch block injections **AND** are suitable for radiofrequency denervation they should be referred for radiofrequency denervation.

Funding Mechanism

GMEURSG recommendation: Monitored approval for patients with a positive response to medial branch block. Referrals may be made in line with the criteria without seeking funding. **NOTE:** These referrals may be the subject of contract challenges and/or audit of cases against commissioned criteria.

Repeat patients

If a patient requires repeat RFD they should have had a **MINIMUM** of 16 months pain relief from the previous treatment.
Funding Mechanism
GMEURSG recommendation: Individual prior approval provided the patient meets the above criteria. Requests must be submitted with all relevant supporting evidence.

Sacroiliac joint pain
If conservative management has failed and sacroiliac joint pain is elicited using a provocation test consider an image guided sacroiliac joint injection of local anaesthetic.

If after the SI injection a further provocation test is negative then the patient can be referred for radiofrequency denervation or consider referral for minimally invasive sacroiliac joint fusion in line with NICE IPG578.

NOTE: Minimally invasive SI joint fusion is a technically challenging procedure and should only be done by surgeons who regularly use image-guided surgery for implant placement. The surgeons should also have had specific training and expertise in minimally invasive SI joint fusion surgery for chronic SI pain.

Funding Mechanism
GMEURSG recommendation: Individual prior approval for image guided SI injection provided the patient meets the above criteria. Requests must be submitted with all relevant supporting evidence. Patients going on to RFD following a successful SI injection are considered to have prior approval for RFD.

NOTE: Clinicians must provide evidence of the result of the provocation test OR evidence of degenerative sacroiliitis.

Policy Exclusions
Appendix 1 of the policy contains a list of ‘red flag’ signs and symptoms requiring urgent referral and therefore excluded from the policy.

Treatment/procedures undertaken as part of an externally funded trial or as a part of locally agreed contracts / or pathways of care are excluded from this policy, i.e. locally agreed pathways take precedent over this policy (the EUR Team should be informed of any local pathway for this exclusion to take effect).

Adherence to NICE Guidance
This policy is compliant with NICE NG59

Current activity and cost
It is very difficult to collate and tabulate current activity and cost across GM due to the complexity of interventions covered by this policy and interventions for back pain are already restricted under the policies that this one will replace. However as epidural injections for back pain are very restricted by this policy and will be moving to zero tariff as a result of the NHSE evidence based proposals there will be a saving associated with that reduction in activity.
Potential costs / savings of implementing the proposed policy

This policy is slightly more restrictive than its predecessor so there will be a further reduction in activity and associated savings from its implementation supported by the move to zero tariff that will cover epidural injections for back pain.

Conclusion

The aim of the policy is to ensure that interventions for back pain with or without sciatica are undertaken in a timely manner and that all alternative treatment options for the individual’s care have been considered and tried where appropriate and are either not indicated or no longer effective. This insures that each individual will gain maximum benefit and potential growth in activity is appropriately managed. It will also bring the local policy in line with the commissioning recommendations suggested by NHS England.
Greater Manchester EUR Policy Statement on:
Low back pain (with or without sciatica)
GM Ref: GM046
Version: Revised 1.2 (11 February 2019)

(This policy incorporates GM004: Radiofrequency Denervation for Back Pain)
## Commissioning Statement

### Low back pain (with or without sciatica)

<table>
<thead>
<tr>
<th>Policy Exclusions (Alternative commissioning arrangements apply)</th>
<th>See <a href="#">Appendix 1</a> for a list of 'red flag' signs and symptoms requiring urgent referral and therefore excluded from this policy.</th>
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<tr>
<th>Policy Inclusion Criteria</th>
<th>Appendix 2 is a quick reference guide to the STarT Back Pain Assessment Tool for use in assessing patients with back pain.</th>
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### Funding Mechanism

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### NOT Commissioned

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Following radiofrequency denervation and where clinically appropriate the patient should be referred for and participate in active rehabilitation support.
Funding Mechanism
GMEURSG recommendation: Monitored approval: Referrals may be made in line with the criteria without seeking funding. NOTE: These referrals may be the subject of contract challenges and/or audit of cases against commissioned criteria.

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

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<table>
<thead>
<tr>
<th>Clinical Exceptionality</th>
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<tbody>
<tr>
<td>Clinicians can submit an Individual Funding Request (IFR) outside of this guidance if they feel there is a good case for exceptionality.</td>
</tr>
<tr>
<td>Exceptionality means ‘a person to which the general rule is not applicable’. Greater Manchester sets out the following guidance in terms of determining exceptionality; however the over-riding question which the IFR process must answer is whether each patient applying for exceptional funding has demonstrated that his/her circumstances are exceptional. A patient may be able to demonstrate exceptionality by showing that s/he is:</td>
</tr>
<tr>
<td>• Significantly different to the general population of patients with the condition in question.</td>
</tr>
<tr>
<td><strong>and as a result of that difference</strong></td>
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<tr>
<td>• They are likely to gain significantly more benefit from the intervention than might be expected from the average patient with the condition.</td>
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<tr>
<th>Best Practice Guidelines</th>
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<tr>
<td>All providers are expected to follow best practice guidelines (where available) in the management of these conditions.</td>
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Policy Statement

Greater Manchester Shared Services (GMSS) Effective Use of Resources (EUR) Policy Team, in conjunction with the GM EUR Steering Group, have developed this policy on behalf of Clinical Commissioning Groups (CCGs) within Greater Manchester, who will commission treatments/procedures in accordance with the criteria outlined in this document.

In creating this policy GMSS/GM EUR Steering Group have reviewed this clinical condition and the options for its treatment. It has considered the place of this treatment in current clinical practice, whether scientific research has shown the treatment to be of benefit to patients, (including how any benefit is balanced against possible risks) and whether its use represents the best use of NHS resources.

This policy document outlines the arrangements for funding of this treatment for the population of Greater Manchester.

This policy follows the principles set out in the ethical framework that govern the commissioning of NHS healthcare and those policies dealing with the approach to experimental treatments and processes for the management of individual funding requests (IFR).

Equality & Equity Statement

GMHCC/CCGs have a duty to have regard to the need to reduce health inequalities in access to health services and health outcomes achieved, as enshrined in the Health and Social Care Act 2012. GMHCC/CCGs are committed to ensuring equality of access and non-discrimination, irrespective of age, gender, disability (including learning disability), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, gender or sexual orientation. In carrying out its functions, GMHCC/CCGs will have due regard to the different needs of protected characteristic groups, in line with the Equality Act 2010. This document is compliant with the NHS Constitution and the Human Rights Act 1998. This applies to all activities for which they are responsible, including policy development, review and implementation.

In developing policy the GMHCC EUR Policy Team will ensure that equity is considered as well as equality. Equity means providing greater resource for those groups of the population with greater needs without disadvantage to any vulnerable group.

The Equality Act 2010 states that we must treat disabled people as more equal than any other protected characteristic group. This is because their ‘starting point’ is considered to be further back than any other group. This will be reflected in GMHCC evidencing taking ‘due regard’ for fair access to healthcare information, services and premises.

An Equality Analysis has been carried out on the policy. For more information about the Equality Analysis, please contact policyfeedback.gmscu@nhs.net.

Governance Arrangements

Greater Manchester EUR policy statements will be ratified by the Greater Manchester Joint Commissioning Board (GMJCB) prior to formal ratification through CCG Governing Bodies. Further details of the governance arrangements can be found in the GM EUR Operational Policy.

Aims and Objectives

This policy document aims to ensure equity, consistency and clarity in the commissioning of treatments/procedures by CCGs in Greater Manchester by:

- reducing the variation in access to treatments/procedures.
• ensuring that treatments/procedures are commissioned where there is acceptable evidence of clinical benefit and cost-effectiveness.

• reducing unacceptable variation in the commissioning of treatments/procedures across Greater Manchester.

• promoting the cost-effective use of healthcare resources.

**Rationale behind the policy statement**

The previous back pain policy (GM021 Persistent non-specific low back pain) was based on old NICE guidance and has therefore been replaced with this one. In addition feedback on the previous policy pointed out that it was complex and difficult to follow. This policy has been simplified in line with NICE NG59 Low back pain and sciatica in over 16s: assessment and management. The policy includes cross references to other relevant policies which are still in effect.

**Treatment / Procedure**

This policy applies to a group of interventions for back pain with or without sciatica that are generally non-specific and where an underlying cause cannot be identified for treatment.

The policy is based on the NICE NG59 and the associated high level pathway, so a further evidence review has not been carried out – the previous evidence review from the earlier back pain policy is available on request but this is now out of date.

Both facet joint injections (FJI) and medial nerve branch blocks (MBB) are diagnostic tests for facet joint pain which will be likely to respond to radiofrequency denervation. NICE advocate the use of medial branch block due to the lower risk of adverse effects associated with MBB compared to FJI.

**Epidemiology and Need**

The lower back is commonly defined as the area between the bottom of the rib cage and the buttock creases.

About 8 in 10 people have one or more bouts of low back pain. Non-specific low back pain is the most common type of back pain. About 19 in 20 cases of sudden-onset (acute) low back pain are classed as non-specific. Non-specific low back pain is tension, soreness and/or stiffness in the lower back region for which it is not possible to identify a specific cause of the pain. Several structures in the back, including the joints, discs and connective tissues, may contribute to symptoms. This is the type of back pain that most people will have at some point in their life. It is called non-specific because it is usually not clear what is actually causing the pain. In other words, there is no specific problem or disease that can be identified as the cause of the pain.

**Adherence to NICE Guidance**

The guidance is produced in line with the recommendations of NICE NG59 Low back pain and sciatica in over 16’s: assessment and management. Published: 30 November 2016

**Audit Requirements**

There is currently no national database. Service providers will be expected to collect and provide audit data on request.
Date of Review

One year from the date of approval of the revised policy (v2.0) by the governance process and thereafter at a date agreed by the Greater Manchester EUR Steering Group, unless new evidence or technology is available sooner.

The evidence base for the policy will be reviewed and any recommendations within the policy will be checked against any new evidence. Any operational issues will also be considered at this time. All available additional data on outcomes will be included in the review and the policy updated accordingly. The policy will be continued, amended or withdrawn subject to the outcome of that review.

Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alexander technique</td>
<td>A system designed to promote well-being by retraining one’s awareness and habits of posture to ensure minimum effort and strain.</td>
</tr>
<tr>
<td>Cauda equina syndrome</td>
<td>A serious neurologic condition in which damage to the cauda equina (the bundle of nerve roots from the lumbar and sacral levels that branch off the bottom of the spinal cord like a &quot;horse's tail.&quot;) causes loss of function of the lumbar plexus (nerve roots) of the spinal canal below the termination (conus medullaris) of the spinal cord.</td>
</tr>
<tr>
<td>Epidural injections</td>
<td>An injection of a local anesthetic into the space outside the dura mater (the tough outermost membrane enveloping the brain and spinal cord of the spinal cord in the lower back region to produce loss of sensation, especially in the abdomen or pelvic region.</td>
</tr>
<tr>
<td>Facet Joint Injections</td>
<td>Facet joints are small joints at each segment of the spine that provide stability and help guide motion. Facet joints can become painful due to arthritis, back injury or mechanical stress. A facet joint injection delivers a steroid medication which anesthetizes the joints and blocks the pain.</td>
</tr>
<tr>
<td>Interferential therapy</td>
<td>A form of electrical stimulation therapy using two or three distinctly different currents that are passed through a tissue from surface electrodes. Portions of each current are canceled by the other, resulting in the application of a different net current to the target tissue.</td>
</tr>
<tr>
<td>Low back pain</td>
<td>Tension, soreness and/or stiffness in the lower back region.</td>
</tr>
<tr>
<td>Non-specific low back pain</td>
<td>Tension soreness and/or stiffness in the lower back region where it is not possible to identify a specific cause.</td>
</tr>
<tr>
<td>Orthotics</td>
<td>The branch of medicine that deals with the provision and use of artificial devices such as splints and braces.</td>
</tr>
<tr>
<td>PENS</td>
<td>Percutaneous electrical nerve stimulation (PENS) and percutaneous neuromodulation therapy (PNT) are therapies that combine the features of electro-acupuncture and transcutaneous electrical nerve stimulation (TENS). PENS is generally reserved for patients who fail to get pain relief from TENS.</td>
</tr>
<tr>
<td>Sciatica</td>
<td>Pain affecting the back, hip, and outer side of the leg, caused by compression of a spinal nerve root in the lower back.</td>
</tr>
<tr>
<td>Spondyloarthritis</td>
<td>A type of arthritis that attacks the spine and, in some people, the joints of the arms and legs. It can also involve the skin, intestines and eyes. The main symptom (what you feel) in most patients is low back pain.</td>
</tr>
</tbody>
</table>
### STarT Back Risk Assessment

The Keele STarT Back Screening Tool (SBST) is a simple prognostic questionnaire that helps clinicians identify modifiable risk factors (biomedical, psychological and social) for back pain disability.

### TENS

Transcutaneous electrical nerve stimulation (TENS) is the use of electric current produced by a device to stimulate the nerves for therapeutic purposes.

### References

1. [GM EUR Operational Policy](#)
2. [NICE NG59: Low back pain and sciatica in over 16s: assessment and management](#)
3. [National Low Back and Radicular Pain Pathway (30 June 2017 3rd Edition v1.0)](#)

### Governance Approvals

<table>
<thead>
<tr>
<th>Name</th>
<th>Date Approved v1.0</th>
<th>Date Approved v2.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater Manchester Effective Use of Resources Steering Group</td>
<td>15/11/2017</td>
<td></td>
</tr>
<tr>
<td>Greater Manchester Chief Finance Officers / Greater Manchester Directors of Commissioning</td>
<td>10/04/2018</td>
<td></td>
</tr>
<tr>
<td>Greater Manchester Association Governing Group</td>
<td>01/05/2018</td>
<td></td>
</tr>
<tr>
<td>Bolton Clinical Commissioning Group</td>
<td>29/06/2018</td>
<td></td>
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<tr>
<td>Bury Clinical Commissioning Group</td>
<td>01/05/2018</td>
<td></td>
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<tr>
<td>Heywood, Middleton &amp; Rochdale Clinical Commissioning Group</td>
<td>01/05/2018</td>
<td></td>
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<tr>
<td>Manchester Clinical Commissioning Group</td>
<td>17/07/2018</td>
<td></td>
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<tr>
<td>Oldham Clinical Commissioning Group</td>
<td>01/05/2018</td>
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<tr>
<td>Salford Clinical Commissioning Group</td>
<td>01/05/2018</td>
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<tr>
<td>Stockport Clinical Commissioning Group</td>
<td>01/05/2018</td>
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<tr>
<td>Tameside &amp; Glossop Clinical Commissioning Group</td>
<td>01/05/2018</td>
<td></td>
</tr>
<tr>
<td>Trafford Clinical Commissioning Group</td>
<td>19/06/2018</td>
<td></td>
</tr>
<tr>
<td>Wigan Borough Clinical Commissioning Group</td>
<td>04/07/2018</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 1 – List of 'red flag' signs and symptoms
Low back pain (with or without sciatica)
GM046

The following are considered 'red flags' and individuals with these signs/symptoms should be referred for URGENT investigation:

**NOTE:** Symptoms suggestive of cauda equina or metastatic spinal cord compression (MSCC) should be treated as a surgical emergency requiring immediate referral.

**Neurological**
- Sphincter and gait disturbance
- Saddle anaesthesia
- Severe or progressive motor loss
- Widespread neurological deficit

**Other: Age <20 or >55 years**
- First episode of back pain occurring after age 50
- Previous malignancy
- Systemic illness
- HIV
- Weight loss
- IV drug use
- Steroid use
- Structural deformity
- Non-mechanical pain (no relief with bed rest)
- Fever
- Thoracic pain
Appendix 2 – The Keele STarT Back Screening Tool
Low back pain (with or without sciatica) 
GM046

Patient name: ___________________________ Date: ________________

Thinking about the last 2 weeks tick your response to the following questions:

<table>
<thead>
<tr>
<th>Question</th>
<th>Disagree</th>
<th>Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My back pain has spread down my leg(s) at some time in the last 2 weeks</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2. I have had pain in the shoulder or neck at some time in the last 2 weeks</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3. I have only walked short distances because of my back pain</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4. In the last 2 weeks, I have dressed more slowly than usual because of back pain</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5. It’s not really safe for a person with a condition like mine to be physically active</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6. Worrying thoughts have been going through my mind a lot of the time</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>7. I feel that my back pain is terrible and it’s never going to get any better</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>8. In general I have not enjoyed all the things I used to enjoy</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>9. Overall, how bothersome has your back pain been in the last 2 weeks?</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Total score (all 9): ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Sub Score (Q5-9): ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Total Score

3 or less
Low risk

4 or more
Sub score Q5-9
3 or less
Medium risk
4 or more
High risk

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Funded by Arthritis Research UK
Appendix 3 – SI Bone - Diagnostic Algorithm for SI Joint Pain

Low back pain (with or without sciatica)

GM046

Chief Complaints:
- Low back pain (below L5)
- Pelvis/buttock pain
- Hip/groin/thigh pain
- Sensation of lower extremity: pain, numbness, tingling, weakness
- Sitting problems
- Pain with position changes or transitional motions (i.e., sit to stand, supine to sit)
- Poor sleep habits due to pain
- Feeling of leg giving way or buckling

History:
- New onset or chronic low back pain +/- trauma
- Previous lumbar surgery
- Post-partum pain
- Description of pain
- Onset and duration of symptoms
- What makes it better/worse
- Treatment to date: PT, meds, spine injections, other

Spine Exam

Hip Exam

SI Joint Exam: Point to pain while standing (Forni finger test) / Tenderness over SIJ sacral / Posterior SIJ tender to palpation / Patient not sitting on affected side. Single leg stance test may induce pain on supporting side.

SIJ Provocative Tests

- Distraction
- Thigh Thrust
- FABER
- Compression
- Gaenslen's

If pain inferior to L5, negative neurological exam, and minimum of 3 positive provocative tests the SIJ is likely a pain generator and image-guided, diagnosis to SIJ injection(s) should be ordered.1 Start with the Distraction Test, which has the highest single positive predictive value.2

Diagnostic SIJ Injection3

- Posterior & inferior approach
- 22 gauge stylletted needle
- 0.25ml contrast medium
- 1.25ml local anesthetic

For more information, please visit www.si-bone.com

3. Fluoroscopically-guided injection photos courtesy of Joseph Seidell, MD

GM Low Back Pain Policy REVISED DRAFT
Appendix 4 – Diagnostic and Procedure Codes

Low back pain (with or without sciatica)
GM046

(All codes have been verified by Mersey Internal Audit’s Clinical Coding Academy)

Please refer to procedure codes in relevant policies below:

- **GM070: Facet Joint Injections**
- **GM018: Out of Contract Spinal Procedures**
## Appendix 5 – Version History

Low back pain (with or without sciatica)  
GM046

The latest version of this policy can be found here: [GM Low Back Pain policy](#)

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Summary of Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.1</td>
<td>31/07/2017</td>
<td>Initial draft statement produced advising low back pain will now be commissioned in line with NICE NG59. This was following discussion of clinical engagement feedback for the draft GM Low Back Pain with or without sciatica policy at GM EUR Steering Group on 19/07/2017. The statement will replace the GM021 Non Specific Low Back Pain Policy once implemented.</td>
</tr>
</tbody>
</table>
| 0.2     | 20/09/2017 | • 'unless part of a national pathway' added on the end of the heading 'Not commissioned'  
• Link to NICE NG59 added  
Following the above amendments, the statement was approved at GM EUR Steering Group to progress through the governance process. |
|         | 15/11/2017 | Statement brought back to GM EUR Steering Group for approval as it was transferred into a policy following feedback from CCG Commissioners.  
• Keele STarT Back Screening Tool added as an appendix for information  
The policy was approved at GM EUR Steering Group to progress through the governance process. |
| 1.0     | 01/05/2018 | Approved by Greater Manchester Association Governing Group |
| 1.1     | 18/07/2018 | The GM EUR Steering agreed that in view of the contradictions between the current Facet Joint Injections Policy, Radiofrequency Denervation Policy, Low Back Pain Policy and NICE NG59 that these policies be reviewed and brought back to the next meeting for further discussion. |
|         | 19/09/2018 | The GM EUR agreed the following changes to the policy in line with NG59:  
Policy Inclusion Criteria:  
• First heading renamed ‘Commissioned’ and criteria updated and amended.  
• Heading ‘In line with NICE NG59 the following are NOT commissioned’ amended to 'NOT Commissioned', bullet point around opioids amended for clarity, and bullet point added to state ‘Repeat epidurals for sciatica’.  
• New sections added for:  
  o Lumbar facet joint injections  
  o Diagnostic medial branch block  
  o Radiofrequency denervation (this policy to replace GM004: Radiofrequency Denervation for Back Pain)  
  o Sacroiliac joint pain  
• Treatment/Procedure: Section reworded for clarity.  
• Appendices renumbered as ‘Appendix 3 - SI Bone - Diagnostic Algorithm for SI Joint Pain’ added  
As these are considered material changes the GM EUR Steering Group requested that the policy go back out for Clinical Engagement. |
|         | 01/10/2018 | Branding changed to reflect change of service from Greater Manchester Shared Services to Greater Manchester Health and Care Commissioning. |
|         | 23/01/2019 | • Links updated as documents have all moved to a new EUR web address.  
• Date of Review: Wording updated due to change of governance arrangements. |
Commissioning Statement:
- ‘(Alternative commissioning arrangements apply)’ added after Policy Exclusions
- ‘Best Practice Guideline’ section added

1.2 11/02/2019 Policy approved at GM EUR Steering Group on 16/01/2019 (after review of the Clinical Engagement feedback) to progress through the governance process once the following amendments have been made:
- Cover page: ‘(and the lumbar section of GM070 Facet Joint Injections for Back Pain)’ removed
- Policy Inclusion Criteria:
  - ‘Appendix 2 is a quick reference guide to the STarT back pain assessment tool for use in assessing patients with back pain.’ added to start of section
  - Under ‘Commissioned’ heading, ‘normally’ added to beginning of ‘(of less than 3 months duration)’ in second paragraph
  - Under ‘NOT Commissioned’ heading, ‘(see Complementary and Alternative Therapies policy for more detail)’ including link added to end of bullet point that reads: ‘Acupuncture for managing low back pain with or without sciatica’ and bullet point; ‘Repeat epidurals for chronic sciatica’ amended to: ‘Repeat epidurals for chronic sciatica (NOTE: Single epidural injections can be given for each discrete episode of acute severe sciatica but cannot be repeated for sciatica that goes on to be chronic / long standing)’
  - Under ‘In addition to those listed above from NICE NG59, the following are also NOT commissioned:’ heading, the bullet point ‘Intradiscal electrothermal therapy (IDET)’ amended to read ‘Intradiscal therapy / electrothermal therapy (IDET)’ and the following bullet points added:
    - ‘Therapeutic MBB’
    - ‘Epidural steroid injections for chronic low back pain’
    - ‘Prolaetherapy’
    - ‘Trigger point injections with any agent (including botulinum toxin)’
    - ‘Any other spinal injections not specifically covered above’
  - Under ‘Diagnostic medial branch block’ heading and ‘Patients should NOT have radiofrequency denervation if:’, the bullet point ‘they are pregnant or breast feeding’ amended to ‘they are pregnant’, and funding mechanism amended to monitored approval from IPA
  - Under ‘Radiofrequency Denervation’ heading and sub-heading ‘New Patients’, funding mechanism amended to monitored approval
  - Under ‘Sacroiliac joint pain’ heading ‘of local anaesthetic’ added to end of first paragraph; start of second paragraph ‘If the SI injection successfully relieves pain for more than 5 months’ amended to ‘If after the SI injection a further provocation test is negative’; and funding mechanism amended from IPA to IPA for ‘image guided SI injection’ and sentence added to read ‘Patients going on to RFD following a successful SI injection are considered to have prior approval for RFD’
- Date of Review: Section amended to state: One year from the date of approval of the revised policy (v2.0) by the governance process and thereafter at a date agreed by the Greater Manchester EUR Steering Group, unless new evidence or technology is available sooner
- Commissioning Statement: ‘Best Practice Guidelines’ section added
- Appendix 1 - List of ‘red flat’ signs and symptoms’: ‘or metastatic spinal cord compression (MSCC)’ added to the note in the second paragraph.
- Appendix 4 - Diagnostic and Procedure Codes: Bullet point for ‘GM004: Radiofrequency Denervation for Back Pain’ removed.