NICE National Institute for Health and Care Excellence

Quality Standards Advisory Committee 4

1. Low back pain– prioritisation

2. Osteoporosis post consultation

Minutes of the meeting held on Wednesday 25 January 2017 at the NICE offices in Manchester

Attendees	**Standing Quality Standards Advisory Committee (QSAC) members** Damien Longson (DL) [Chair], Zoe Goodacre, Alison Allam, John Jolly, Michael Varrow, Jane Bradshaw, Nicola Hobbs, Moyra Amess, David Weaver, Asma Khalil, Nadim Fazlani, Jane Ingham, Jane Putsey, James Crick, Mathew Sewell and Simon Baudouin **Specialist committee members** Suzanne Blowey [1-6], Ian Bernstein [1-6] , Simon Somerville [1-6], Neil O'Connell [1-6], Stephen Ward [1-6] , Frances Dockery [7-11], Angela Thornhill [7-11], Juliet Compston [7-11], Terry Aspray [7-11], Sheila Ruddick [7-11] and David Stephens [7-11] **NICE staff** Nick Baillie (NB), Julie Kennedy (JK) [1-6], Karyo Angeloudis (KA) [1-6], Stacy Wilkinson (SW) [7-11], Kirsty Pitt (KP) [7-11], Joanne Ekeledo (JE) **Topic expert advisers** None **NICE Observers** Sabina Keane [1-6]
Apologies	**Standing Quality Standards Advisory Committee (QSAC) members** Tim Fielding, Allison Duggal and Alaster Rutherford

Agenda item	Discussions and decisions	Actions
1. Welcome and code of conduct for members of the public attending the meeting (public session)	The Chair welcomed the public observers and reminded them of the code of conduct that they were required to follow. It was stressed that they were not able to contribute to the meeting but were there to observe only. They were also reminded that the committee is independent and advisory therefore the discussions and decisions made today may change following final validation by NICE's guidance executive.	
2. Committee business (public session)	**Declarations of interest** The Chair asked standing QSAC members to declare any interests that were either in addition to their previously submitted declaration or specific to the topic(s) under consideration at the meeting today. The Chair asked the specialist committee members to declare all interests. The following interests were declared: <u>Standing committee members</u> • Jane Ingham participated in healthcare quality improvement partnership audit. <u>Specialist committee members</u> • Dr Ian Bernstein [agenda item 1-6] Author of a paper published in the BMJ. The paper was a summary on low back pain General Practitioner (NHS), Gordon House Surgery, London. Ealing CCG. Musculoskeletal Physician, London North West Healthcare NHS Trust (self-employed, service agreement LNWHT). GP Clinical Lead, Ealing CCG, with responsibility for musculoskeletal services NICE Guidelines Development Groups for Osteoarthritis, and Low Back Pain and Sciatica and NICE Quality Standards Committee Specialist Member (Expenses and locum cover) NICE Technology Appraisal Committee (Expenses and locum cover) Clinical advisor (MSk): Arthritis and Musculoskeletal Alliance. (unpaid) Venue doctor and clinical advisor: Dorney International Rowing (unpaid) Clinical advisor (MSk) to Royal College of General Practitioners (unpaid) Clinical commissioning advisor (MSk) to NHS England (unpaid) He volunteers with a charity, Operation Wallacea, in Mexico on a biodiversity project as a GP to a team of 60 scientists and students looking at the effect of tourism on damage to coral reefs and turtle populations. He received a bursary of £600 towards travel expenses in April 2016. His food and accommodation were paid for. The charity is not involved with the NHS. The charity raises funds from the researchers and assistants who pay to work/study on the projects. The charity also	

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	receives commissions as an NGO from the governments in those countries. He was advised there was no commercial sponsorship. He lectured on the NICE LBP guidelines at the British Institute of Musculoskeletal Medicine in December 2016. He was offered overnight accommodation, travel expenses and an honorarium fee of £80. • Neil O'Connell [agenda item 1-6] He received salaried payment from Brunel University London as a healthcare educator to train physiotherapists to assess and treat back pain. Until September 2013 he received payment from the NHS to assess and treat patients, in his role as a physiotherapist. He was a speaker at European Manual Therapy Congress in Belgium in September 2015. The congress is organised by the Manual Therapy Association of Belgium who covered travel and accommodation costs and paid a 500 Euro speakers fee. In addition the congress organisers paid for 2 speakers dinners. He has no prior or ongoing commitments with, or membership of the organisation. He was a speaker at the conference of Le Comité Scientifique de la Société Française d'Evaluation et de Traitement de la Douleur (SFETD) in Nantes, France in November 2015 on the management of complex regional pain syndrome. There was no speaker's fee but flights, accommodation and conference registration costs were covered by the organising committee. In 2014 he gave an invited talk for the Council for Allied Health Professions Research London (on evidence interpretation in chronic pain management) on Weds 26/11/14. He was paid a speaker fee of £300 plus transport costs. He has no ongoing commitments with the organisation. He attended and spoke at a conference on Pain in Physiotherapy in Seville on 17/18th October 2014 (previously declared). The conference was organised by the Sociedad Española de Fisioterapia y Dolor, a physio special interest group in pain management and Colfisio -Ilustre Colegio Profesional de Fisioterapeutas de Andalucía. My contact was with these professional organisations. He had no contact with any medical companies or industry representatives related to this conference. The conference organisers paid for his travel accommodation and meals. In	

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	thanks for giving the talk he was gifted of a watch worth around £150. He has no ongoing commitments with the organisations. The Association which sponsored the conference and paid for the gifts is Ilustre Colegio Profesional de Fisioterapeutas de Andalucía. He has published a number of papers on this topic. These include a debate paper that critiqued the assertion that poor performance of therapies in clinical trials may be due to inadequate subgrouping of back pain patients. He has also published narrative reviews and original research papers relating to the evidence of altered central nervous system function in chronic non-specific low back pain. He has argued against the recommendation of acupuncture for treating low back pain in earlier NICE guidance, and other painful disorders based on its lack of meaningful superiority over sham acupuncture, he has always argued from an evidence based position. He has made regular contributions related to back pain to the science blog www.bodyinmind,org where he is the senior commissioning editor and where he has presented critical summaries of contemporary back pain research for a clinical and lay audience, including blog posts relating to research that was not positive about the effectiveness of manual therapy for spinal pain. • Dr Simon Somerville [agenda item 1-6] General Practitioner (paid) - some of the patients he sees have back pain GP Researcher, Keele University (paid) – part of his role includes the implementation of STarT Back, education / publication on back pain. GP with Special Interest, MSK clinic (paid) – some of the patients he sees have back pain • Dr Stephen Ward [agenda item 1-6] Chair – NICE Guideline on Back Pain and Sciatica He is paid to provide pain management services (which include many of the areas covered by the NICE low back pain guideline) in both the NHS and private sectors. He was a director of Back@work LTD (community pain clinic) until Jan 2016. He has resigned this position and has no involvement with the company • Prof Juliet Compston [agenda item 7-11] Advisory Board Gilead – development of new antiretroviral drug tenofovir alafenamide 2015-2016 • Sheila Ruddick [agenda item 7-11] Eli Lilly funded her attendance at a conference in November 2015	

Agenda item	Discussions and decisions	Actions
	Minutes from the last meeting The committee reviewed the minutes of the last meeting held on 16 December 2016 and confirmed them as an accurate record	
3. QSAC updates	None	
4 and 4.1 Topic overview and summary of engagement responses	KA presented the topic overview and a summary of responses received during engagement on the topic.	
4.2 Prioritisation of quality improvement areas	The Chair and KA led a discussion in which areas for quality improvement were prioritised. The QSAC considered the draft areas as outlined in the briefing paper prepared by the NICE team. The outcome of discussions is detailed below.	

Suggested quality improvement area	Prioritised (yes/no)	Rationale for prioritisation decision	If prioritised, which specific areas to be included?
Assessment a) Risk stratification b) Imaging c) Accurate diagnosis	 Yes Yes No	<u>Risk stratification</u> The committee considered the NICE guidance recommendations on risk stratification. There are various risk stratification tools but a specific one is not recommended. The STarT Back tool is given as an example of a tool that could be used in the recommendation. The committee recognised the importance of early intervention to reduce incidence of low back pain and assist people with low back pain at an early stage to receive the most appropriate treatment. The committee asked why the risk stratification recommendations are 'consider recommendations'.	**NICE team to draft a structural statement on risk stratification based on NG59 recommendations 1.1.2 & 1.1.3.**

		The specialist committee members advised that this is because the tools have a success rate of approximately 70% for accurately identifying if people are at low or high risk of poor outcomes. The main value of using the tools is to identify people at high risk of disability resulting from the condition. Although the tools are not accurate approximately 30% of the time the success rate is better than when they are not used. Due to the large volume of people with the condition a lot of people benefit from the use of risk stratification. The committee felt it was important to prioritise risk stratification as it will help to ensure that psychological assessment is undertaken when assessing people with low back pain. Use of the tool will also help to drive people through the different pathways in the guideline which will lead to improved quality of care. The NICE team suggested that a structural statement aimed at organisations in first contact with people with low back pain could be drafted to ensure that the statement is measurable. <u>Imaging</u> The committee discussed imaging for people with low back pain and it was suggested that imaging is being done inappropriately for this group. Reducing inappropriate imaging has a number of benefits including reducing waiting times for people who do need imaging and reducing costs for the NHS. The committee agreed that it was important that when imaging is appropriate it should be undertaken in a specialist setting. When it is not undertaken in a specialist setting imaging does not change initial	**NICE team to draft a statement on not offering imaging in non-specialist settings based on NG59 recommendation 1.1.4**

		management, it can also cause anxiety and further referrals for findings that are not relevant to the clinical presentation. <u>Accurate diagnosis</u> The committee agreed that it would not be appropriate to draft a statement on accurate diagnosis of low back pain.	
Non-pharmacological interventions a) Self-management b) Group exercise programmes c) Combined physical and psychological programmes d) Return-to-work programmes	 Yes No No No	<u>Self-management</u> The committee discussed helping patients to self-manage their low back pain by providing information on their condition and encouraging them to continue with normal activities. They agreed that across the country there is significant variability in the provision of support for people with low back pain to self-manage their condition. Concerns were raised that encouraging self-management will mean that psychological support will be lost. However, self-management does not mean that the person is on their own rather it empowers them to cope when they are not with a clinician. The committee agreed that self-management is a priority area as it can be effective in helping people to return to normal activities and to cope with their condition outside of a clinical setting. <u>Group exercise programmes</u> The committee agreed this was not a key area for quality improvement. <u>Combined physical and psychological programmes</u> The committee agreed that combined physical and psychological programmes are important and	**NICE team to draft a statement on self-management based on recommendation 1.2.1.**

		discussed the issues with access to these services. There is significant variation in waiting times across the country. However, as the format of the programmes is not defined in the guideline it would be difficult to have a meaningful statement for this area. <u>Return-to-work programmes</u> The committee discussed that this is driven by risk stratification which leads to it becoming a treatment outcome. The committee felt this area is an outcome measure for the quality standard rather than a statement and is therefore not a key area for quality improvement. It was agreed that return to work would be included as an outcome measure under the relevant statements.	
Pharmacological interventions a) Reducing the use of unhelpful medication b) Non-steroidal anti-inflammatory drugs	Yes	The committee discussed the issue of inappropriate prescribing of opioids for people with low back pain. They agreed that stopping the prescribing of opioids for people with chronic low back pain is an area for improvement. They also discussed the use of anticonvulsants, antidepressants and paracetamol for managing low back pain. The NICE team asked the committee which of the drugs discussed should be the focus of the statement. The committee felt that it was important to stop the prescription of all of the drugs highlighted in order to drive up quality in this area. It is important to reduce the use of these drugs in specific populations as they are ineffective and can cause side effects and dependency. Concerns were raised that by including antidepressants in the statement there is potential for people with depression to have these drugs	**NICE team to draft a statement on not offering ineffective pharmacological interventions.**

		stopped inappropriately if they have low back pain as a secondary issue. However, the NICE team advised that the measures could be worded in a way to ensure it is clear this only applies when back pain is the primary issue.	
Invasive treatments a) Non-effective invasive treatments b) Invasive treatments for specific groups c) Decision to refer to surgery	Yes	Non-effective invasive treatments The committee discussed the issue of spinal injections. The specialist committee members advised that there are specific spinal injections that shouldn't be offered for people with low back pain. They agreed that having a statement on not offering these specific injections for people with low back pain (not including people with sciatica) is a priority as they are associated with increased risk of harm. The NICE team agreed to list the relevant type of injections in the definitions section. Invasive treatments for specific groups The committee agreed that this is not a priority area. Decision to refer to surgery The committee discussed having a statement on not allowing a person's BMI, smoking status or psychological distress to influence the decision to refer them for surgical opinion for sciatica. Some committee members felt this was a priority area but other members were uncertain if it was appropriate to develop a statement about this issue. The committee agreed that this area would not be prioritised but that the issue could be discussed again at the second meeting taking any relevant consultation comments into account.	**NICE team to draft a statement on not offering ineffective spinal injections for low back pain based on recommendation 1.3.1.**

Additional areas suggested	Committee rationale	Area progressed (Y/N)
Identify appropriate treatment according to aetiology	This area is not covered in the source guidance or NICE accredited guidance.	**N**
Neuromuscular electronic stimulation	No recommendations	**N**
Self-referral to physiotherapy	No recommendations	**N**
Referral for spinal imaging	Against the recommendations of current NICE guideline	**N**
Acupuncture	No recommendations	**N**
Definition of specialist spinal service	Not within the remit of Quality Standards	**N**
Regulation of professionals	Not within the remit of Quality Standards	**N**

5. 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. The statements highlighted are anticipated to result in some savings as a result of reducing or stopping the interventions highlighted.	
6.1 Overarching outcomes	The NICE team explained that the quality standard would describe overarching outcomes that could be improved by implementing a quality standard on low back pain. It was agreed that the committee would contribute suggestions as the quality standard was developed.	
6.2 Equality and diversity	The NICE team explained that equality and diversity considerations should inform the development of the quality standard, and asked the committee to consider any relevant issues. It was agreed that the committee would contribute suggestions as the quality standard was developed.	
7. QSAC specialist committee members (part 1 – open session)	NB asked the QSAC to consider the constituency of specialist committee members on the group and whether any additional specialist members were required. **Specialist members**: It was agreed that no additional expertise is required.	
8. Recap of	SW presented a recap of the areas for quality improvement discussed at the first QSAC meeting for	**5. Recap of prioritisation**

prioritisation exercise	osteoporosis: **At the first QSAC meeting on 28 September 2016 the QSAC agreed that the following areas for quality improvement should be progressed for further consideration by the NICE team for potential inclusion in the draft quality standard:** • Who to assess for fragility fracture - progressed • How to assess for fragility fracture risk – not progressed • Management for people at risk of fragility fracture - progressed The full rationale for these decisions is available in the prioritisation meeting minutes which can be found here: https://www.nice.org.uk/guidance/GID-QS10020/documents/minutes	**exercise**
8.2 and 8.3 Presentation and discussion of stakeholder feedback and key themes/issues raised	SW presented the committee with a report summarising consultation comments received on osteoporosis. The committee was reminded that this document provided a high level summary of the consultation comments, prepared by the NICE quality standards team, and was intended to provide an initial basis for discussion. The committee was therefore reminded to also refer to the full list of consultation comments provided throughout the meeting. The committee was informed that comments which may result in changes to the quality standard had been highlighted in the summary report. Those comments which suggested changes which were outside of the process, were not included in the summary but had been included within the full list of comments, which was within the appendix. These included the following types of comment: • Relating to source guidance recommendations • Suggestions for non-accredited source guidance • Request to broaden statements out of scope • Inclusion of overarching thresholds or targets • Requests to include large volumes of supporting information, provision of detailed implementation advice • General comments on role and purpose of quality standards • Requests to change NICE templates	**5.2 and 5.3 Presentation and discussion of stakeholder feedback and key themes/issues raised**
8.4 Discussion and agreement of final statements	The committee discussed each statement in turn and agreed upon a revised set. **These statements are not final and may change as a result of the editorial and validation processes.**	

Draft statement	Themes raised by stakeholders and discussed	Committee rationale	Statement revised (Y/N)
Adults who have had a fragility fracture, or who have other high-risk factors for fragility fracture, have an assessment of their fracture risk.	• Define 'fragility fracture' • Mention primary prevention before secondary prevention in the statement • Definitions: additions were suggested • The resource impact of the statement in terms of primary care capacity	The committee discussed whether the term 'fragility fracture' could be interpreted differently by users and agreed to adding a definition for clarity. The committee discussed whether primary or secondary prevention of fragility fractures should be mentioned first in the statement. They agreed to leave the statement as it is, as previous fracture should be the focus. The committee discussed the definitions and asked the NICE team to add a definition of 'frequent use of steroids' based on the definition used in FRAX. The committee discussed whether the statement is achievable in terms of the resource impact on general practice. They considered whether to leave the statement broad and with a large at-risk population, or whether to narrow the focus of the statement to specific at-risk groups. The committee agreed that a more focused statement would avoid the concerns around available resources, and decided to focus the statement on 3 risk factors: steroid use, previous fragility fracture and previous falls.	**Y** **NICE team to:** – **add a definition of 'fragility fracture'** – **define frequent use of steroids** – **draft a statement that focuses on specific risk factors (steroid use, previous fragility fracture and previous falls).**
Adults assessed as at high or intermediate risk of fragility fracture and diagnosed with osteoporosis are offered bone-sparing drug treatment.	• Adding bone-forming treatment and interventions to reduce modifiable risk factors to the statement • Who is covered by the statement • The lack of intervention thresholds, conflicting guidance on when to offer treatment and different results from different assessment tools	The committee considered whether to add bone-forming treatment and lifestyle interventions to the statement. It was agreed to leave it as 'bone-sparing' treatment and not to add lifestyle interventions, as the evidence base for these is low. The committee discussed what it would be possible to include in a statement on treatment with the available guidance. A specialist committee member highlighted that the National Osteoporosis Guideline Group (NOGG) is close to receiving NICE accreditation and their guidance covers treatment thresholds. The committee agreed to the NICE team checking whether the NOGG guidance can be used to draft a statement	**Y** **NICE team to check if NOGG guidance can be used to draft a statement with a better defined population, or consider including a placeholder statement if not.**

		with a clearer population and treatment thresholds, and if not, to consider including a placeholder statement.	
Adults with osteoporosis prescribed bone-sparing drug treatment are asked about adverse effects and adherence to treatment at each routine medication review.	• Including timeframes in the statement • Add actions needed if adherence issues and adverse effects are found • Suggestions to change the definition of the medication review	The committee discussed whether the statement should include a timeframe. The committee stated that annually reviewing people with long-term conditions is general good practice and discussed that timeframes in the national standards for Fracture Liaison Services were to ensure that people received treatment within a certain timeframe after the decision to treat. The focus of this statement is ensuring people adhere to treatment so that they reduce their fracture risk, not around the frequency of the review, so a timeframe can remain in the definition but does not need to be included in the statement. The committee discussed adding information on offering alternative treatment if adherence issues or adverse effects are found. They agreed that this information would be useful and could be included in the audience descriptors. A committee member also suggested that dentists can carry out the reviews. The committee discussed whether to change the definition of the medication review. The specialist committee members stated that the symptoms that the definition suggests asking about are included in the Summary of Product Characteristics and the definition does not need to be changed.	**Y** **NICE team to add information to the audience descriptors on what to do if issues with medication are discovered and who can do the reviews.**
Adults with osteoporosis who have been taking bisphosphonates for at least 3 years have a review of the risks and benefits of continuing treatment.	• The statement wording should match the multimorbidity guidance. • The frequency of the review	The committee discussed the source guidance for the statement and stated that the multimorbidity guideline is specifically for people with multiple conditions, so might not be appropriate. The NICE team agreed to look at whether a different source would be more suitable, and consider rewording the statement to match the source guidance. The committee considered the timescale for reviewing bisphosphonates. The committee suggested that 5 years should be the upper time limit for review, and that review	**Y** **NICE team to check source guidance and consider rewording the statement to match.** **NICE team to review the wording relating**

		should not be sooner than 3 years after starting treatment. The NICE team agreed to review the statement wording.	**to the time scale.**

9. Overarching outcomes	The NICE team explained that the quality standard would describe overarching outcomes that could be improved by implementing a quality standard on osteoporosis. It was agreed that the committee would contribute suggestions as the quality standard was developed.	
10. Equality and diversity	The NICE team explained that equality and diversity considerations should inform the development of the quality standard, and asked the committee to consider any relevant issues. It was agreed that the committee would contribute suggestions as the quality standard was developed. Lower treatment rates for men was highlighted and a specialist committee member mentioned that older men with hip fracture are under-treated.	
11. Next steps and timescales (part 1 – open session)	The NICE team outlined what will happen following the meeting and key dates for the osteoporosis quality standard.	
12. Any other business (part 1 – open session)	The following items of AOB were raised: • None **Date of next meeting for low back pain: 26 April 2017** **Date of next QSAC 4 meeting: 26 April 2017**	