Quality standards advisory committee 4

Low back pain and chronic kidney disease (update) – post-consultation meeting

Minutes of the meeting held on 26 April 2017 at the NICE offices in Manchester

Attendees	**Standing Quality Standards Advisory committee (QSAC) members** Damien Longson (DL) [Chair], Tim Fielding, Allison Duggal, John Jolly, Jane Bradshaw, Nicola Hobbs, Moyra Amess, David Weaver, Nadim Fazlani, Jane Ingham, Jane Putsey, James Crick, Simon Baudouin, Asma Khalil **Specialist committee members** Low back pain [1-9] Suzanne Blowey, Ian Bernstein, Simon Somerville, Neil O'Connell Chronic kidney disease (update) [7-11] Robert Lewis, Hugh Gallagher, Mark Prentice, Kathryn Griffith, John Roberts **NICE staff** Nick Baillie (NB), Sabina Keane (SK) [1-9] , Julie Kennedy (JK) [1-9], Stacy Wilkinson (SW) [7-11], Nicola Greenway (NG) [7-11] **Topic expert advisers** None **NICE Observers** None
Apologies	**Standing quality standards advisory committee (QSAC) members** Zoe Goodacre, Michael Varrow, Mathew Sewell, Alison Allam **Specialist committee members** Low back pain [1-9] Heather Dempsey, Stephen Ward Chronic kidney disease (update) [7-11] Nicholas Palmer **NICE staff** None **Topic expert advisers** None

Agenda item	Discussions and decisions	Actions
1. Welcome, introductions and plan for the day (private session)	The Chair welcomed the attendees and the quality standards advisory committee (QSAC) members introduced themselves. The Chair informed the committee of the apologies and reviewed the agenda for the day.	
2. 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.	
3. 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: **Specialist committee members** **Suzanne Blowey** • None **Ian Bernstein** • General Practitioner (NHS), Gordon House Surgery, 78 Mattock Lane, London W13 9NZ. 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 adviser (MSk): Arthritis and Musculoskeletal Alliance. (unpaid) • Venue doctor and clinical adviser: Dorney International Rowing (unpaid) • Clinical adviser (MSk) to Royal College of General Practitioners (unpaid)	

Agenda item	Discussions and decisions	Actions
	• Clinical commissioning advisor (MSk) to NHS England (unpaid) • Volunteered 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. Received a bursary of £600 towards travel expenses in April 2016. Food and accommodation were paid. 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 receives commissions as an NGO from the governments in those countries. No commercial sponsorship. • Lectured on the NICE LBP guidelines at the British Institute of Musculoskeletal Medicine, Brighton, 03 December 2016. Received overnight accommodation, travel expenses and an honorarium of £80. • Lectured on the NICE LBP guidelines at the Royal College of General Practitioners, London, 20 January 2017. Received travel expenses, locum costs and an honorarium of £150. • Lead author of a paper commissioned from NICE and published in the BMJ Bernstein IA, Malik Q, Carville S, Ward S. Low back pain and sciatica: summary of NICE guidance. BMJ 2017:i6748. doi:10.1136/bmj.i6748. Received no remuneration for this. **Simon Somerville** • General Practitioner (paid) - some of the patients have back pain • GP Researcher, Keele University (paid) – part of role includes the implementation of STarT Back, education / publication on back pain • GP with Special Interest, MSK clinic (paid) – some of the patients have back pain **Neil O'Connell** • Receives salaried payment from Brunel University London as a healthcare educator to train physiotherapists to assess and treat back pain. Until September 2013 received payment from the NHS to assess and treat patients, in role as a physiotherapist. • Speaker at European Manual Therapy Congress in Belgium in September 2015. Received 500 euro speaker fee and travel and accommodations costs paid by organisers • (Manual Therapy Association of Belgium). 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. Travel and accommodation costs paid by organisers. • In 2014 gave an invited talk for the Council for Allied Health Professions Research London on	

Agenda item	Discussions and decisions	Actions
	evidence interpretation in chronic pain management. Honorarium and travel and accommodation costs paid by organisers. • Spoke at conference on Pain in Physiotherapy in Seville in 2014. Travel, accommodation and meals paid by conference organiser, Sociedad Española de Fisioterapia y Dolor. • Received gift of watch for speaking at conference organised by IlustreColegio Profesional de Fisioterapeutas de Andalucía. **Minutes from the last meeting** The committee reviewed the minutes of the last meeting held on 25 January 2017 and confirmed them as an accurate record.	
4. QSAC updates	NB asked the standing members if they had received details of an 'away day' being held in July when the members will get the chance to meet up following the new model of QSAC coming into effect.	
5. Recap of prioritisation exercise	SK and JK presented a recap of the areas for quality improvement discussed at the first QSAC meeting for low back pain: **At the first QSAC meeting on 25 January 2017 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:** • Assessment – risk stratification and imaging • Non-pharmacological intervention – self-management • Pharmacological intervention – reducing the use of unhelpful medicine • Invasive treatments – non-effective invasive treatments The full rationale for these decisions is available in the prioritisation meeting minutes which can be found here: https://www.nice.org.uk/guidance/indevelopment/gid-qs10027/documents	
5.2 and 5.3 Presentation and discussion of stakeholder feedback and key themes/issues raised	SK and JK presented the committee with a report summarising consultation comments received on low back pain. 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	

Agenda item	Discussions and decisions	Actions
	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	
5.4 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 1	Themes raised by stakeholders	Committee rationale	Statement revised (Y/N)
Primary care services have an approach to risk stratification for young people and adults presenting with a new episode of low back pain with or without sciatica.	General support for risk stratification approach being important for early detection of serious conditions with the following suggested inclusions: • red flag screening tools • x-rays • patient reported outcomes such as sufficient and appropriate intensive support • to be used in all referrals to secondary care.	The committee agreed that as there was support for the statement from stakeholders it should be progressed for inclusion in the final quality standard, with the following amendments: • Possible clarification of wording relating to the definition of risk stratification. Removing the second two sections of the definition as the committee agreed it distracted users from the original intention of the underpinning guideline recommendation.	**Y**
Draft statement 2	**Themes raised by stakeholders**	**Committee rationale**	**Statement revised (Y/N)**

Young people and adults with low back pain with or without sciatica are not referred by primary care services for imaging.	• Support for imaging only being requested by specialists who can interpret the results in their setting.
	• Concerns raised about:-
	  ○ the statement being too broad which could lead to poor outcomes for patients with significant and potentially disabling disc disease
	  ○ altering management may lead to missed diagnoses
		The committee agreed that as there was support for the statement from stakeholders it should be progressed for inclusion in the final quality standard, with the following amendments:
		• Replace the word 'referred' as the committee agreed this could be confusing.
		• Replace 'primary care services' with 'non-specialist services' as there are some services in primary care that have the expertise to offer imaging for this group of patients
		• Consider adding the word 'routinely'.
		• Signposting to the appendix in NG59 which gives an example of when people should be referred to hospital rather than including long list of red flags.
		• Add serious underlying pathology back into the statement as it was felt to be important to include those people who would need imaging for alternative diagnoses. This is stated in NG59 recommendation 1.1.1.
		• Clarification of the rationale around a referral leading to subsequent referrals
		• Consider removing outcome b) Proportion of young people and adults with low back pain with or without sciatica for whom imaging changes management.
			Y

Draft statement 3	**Themes raised by stakeholders**	**Committee rationale**	**Statement revised (Y/N)**
Young people and adults with low back pain with or without sciatica are supported to self-manage their condition.	• Supported as a central part of overall strategy and management plan. • Statement is too broad and could lead to poor outcomes for patients with significant and potentially disabling disc disease.	The committee agreed that as there was support for the statement from stakeholders it should be progressed for inclusion in the final quality standard. The committee agreed that that statement should not advocate specific treatments as it will differ for individuals.	**N**

	• Suggestion to specify the type of support needed • Include Hospital Occupational Health Services as a service provider.	The committee discussed whether there should be greater definition of self-management, and whether the supporting information should signpost to NICE Physical Activity guidance rather than specific activities.	
Draft statement 4	**Themes raised by stakeholders**	**Committee rationale**	**Statement revised (Y/N)**

Young people and adults are not offered anticonvulsants, antidepressants or paracetamol alone to treat low back pain.	• Support for addressing inappropriate prescribing in this group.
	• Concerns raised on not offering these medications as:-
	  ○ it may be appropriate to consider these if there are elements of neuropathic pain
	  ○ paracetamol alone may be appropriate for people with contraindications for NSAIDs
	• appropriate analgesia is needed in the acute phase.
	• This is not helpful in advising GPs on pharmacological strategies.
	• The statement will potentially drive up the use of NSAIDs and benzodiazepines which may lead to adverse effects of NSAIDs and increased benzodiazepine addiction.
	• The healthcare setting focus was queried - primary or secondary care or both?
	• CCG pharmacists could audit and highlight inappropriate prescriptions of these medications.
		The committee agreed that as there was support for the statement from stakeholders it should be progressed for inclusion in the final quality standard, with the following amendments:
		• Add 'without sciatica' for clarity and consistency.
		• Re-word to be clear that it is only paracetamol that that should not be offered alone. Anticonvulsants and antidepressants should not be offered at all.
			Y

Draft statement 5	Themes raised by stakeholders	Committee rationale	Statement revised (Y/N)
Young people and adults are not offered opioids to treat chronic low back pain.	• This is not helpful in advising GPs on pharmacological strategies. • Short term use of opioids in the acute phase may be appropriate whilst the patient awaits definitive interventions. • Avoiding use of opioids for long term pain is important. • A definition of chronic low back pain is needed.	The committee agreed that as there was general support for the statement from stakeholders it should be progressed for inclusion in the final quality standard, with the following amendments: • Add 'without sciatica' for clarity and consistency.	**Y**
Draft statement 6	**Themes raised by stakeholders**	**Committee rationale**	**Statement revised (Y/N)**
Young people and adults are not treated with spinal injections for low back pain.	• It was felt this is achievable with education of those involved with the referral processes. • A better definition of the injections which is supported by NICE guidance is needed as these are all very different. • The statement contradicts NG59 recommendation 1.3.5 which will lead to misinterpretation. • The statement will potentially drive up the use of NSAIDs and benzodiazepines.	The committee agreed that as there was general support for the statement from stakeholders but acknowledged that there was a risk of the current statement being misinterpreted as a steer to decommission all spinal injections. The committee agreed that this statement should be progressed for inclusion in the final quality standard, with the following amendments: • Add the exclusions of people without sciatica except radiofrequency denervation with medial branch blocks and for those who meet criteria.	**Y**

Additional statements suggested	Committee rationale	Statement progressed (Y/N)
Self-management programmes- physical or psychological	This area was not prioritised as a quality improvement area at the prioritisation meeting. The committee agreed that a statement is not needed on this area.	**N**

Manual and psychological therapies	This area was not prioritised as a quality improvement area at the prioritisation meeting. The committee agreed that a statement is not needed on this area.	**N**
Emergency medicine	This area was not prioritised as a quality improvement area as there are no guideline recommendations specifically on this.	**N**
Public awareness education campaign-referral process and spinal degeneration.	This area was not prioritised as a quality improvement area as there are no guideline recommendations specifically on this.	**N**
Schools, colleges and universities	This area was not prioritised as a quality improvement area as there are no guideline recommendations specifically on this.	**N**
Physical and emotional/ mental wellbeing	This area was not prioritised as a quality improvement area as there are no guideline recommendations specifically on this.	**N**
Patient accessible information sources.	This area was not prioritised as a quality improvement area as there are no guideline recommendations specifically on this.	**N**

6. Resource impact	A number of statements will enable cost savings.	
7. 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.	
8. 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.	
9. Next steps and timescales (part 1 – open session)	SK outlined what will happen following the meeting and key dates for the low back pain quality standard.	

10. 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.	

11. 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: **Specialist committee members** **Robert Lewis** • Paid to deliver several (approximately 15) educational sessions for pharma companies: Janssen, Lilly, MSD during 2014-16. • Received sponsored (flights accommodation and registration) to attend educational meetings in USA (Janssen 2014 and 2015) and Europe (Lilly 2016) • Chief investigator on a portfolio clinical trial of Balneum Plus skin cream financed (but not initiated or overseen) by the manufacturer Almiral Ltd. **Hugh Gallagher** • None **Mark Prentice** • None **Kathryn Griffith** • None **John Roberts** • None	
12.1. Recap of prioritisation exercise	SW and NG presented a recap of the areas for quality improvement discussed at the first QSAC meeting for chronic kidney disease (update): **At the first QSAC meeting on 16 December 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:** • Investigations for CKD • Monitoring and progression of CKD • Pharmacotherapy x2 – blood pressure and statins The full rationale for these decisions is available in the prioritisation meeting minutes which can be found	

	here: https://www.nice.org.uk/guidance/indevelopment/gid-qs10028/documents	
12.2 and 12.3 Presentation and discussion of stakeholder feedback and key themes/issues raised	SW and NG presented the committee with a report summarising consultation comments received on chronic kidney disease (update). 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 The significant themes raised during consultation were: • The quality standard overall was well received • General feedback was that the appropriate areas for quality improvement had been identified • How we deal with areas no longer included from the previous QS • Potential savings from a change in emphasis to preventative action The NICE team fed back to the committee that we are reviewing how we present the areas from the previous QS that are no longer prioritised as statements, to make them more visible in an updated QS.	
12.4 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 1	Themes raised by stakeholders	Committee rationale	Statement revised

			(Y/N)
Adults with, or at risk of, chronic kidney disease (CKD) are offered eGFRcreatinine and albumin:creatinine ratio (ACR) testing at an agreed frequency	• Monitoring 'at an agreed frequency' is not precise enough • A personalised approach to monitoring should aid delivery • Distinguish between those with, and at risk of, CKD • People with CKD are not on registers and not having regular testing • Action should be taken in response to monitoring • Emphasise the need for accurate coding • Suggested groups to add to definition of 'adults at risk of CKD' • Add detail to the definition of ACR testing and 'adults with CKD'. Consultation question 5: Is the statement achievable and measurable, or would a narrower and more specific at-risk population be better? • Statement is achievable and measureable • Offer the option of no long-term monitoring to groups with low risk of progression	The committee agreed that as there was support for the statement from stakeholders it should be progressed for inclusion in the final quality standard, with the following amendments: • Change 'an' to 'the' agreed frequency • Add polycystic kidney disease as an example of hereditary kidney disease, and drugs which have an impact on kidney function, to the definition of risk factors for kidney disease. • Add ACR to the definition of adults with CKD to match the guideline (CG182) throughout the quality standard. The committee discussed whether a timeframe could be added to the statement but agreed that as the frequency of monitoring for eGFR varies depending on the stage of CKD and individual circumstances, and frequency of ACR testing is not defined, it would not be possible to add a timeframe to the statement. The committee discussed whether to separate the statement into 2 statements, 1 for people at risk of CKD and 1 for people with CKD. The committee agreed to leave it as 1 statement but to use the measures to separate out the different timeframes for review for each population group and type of test. The committee discussed the responses to the consultation question on narrowing the population of the statement, but was happy that the statement is achievable as it is.	**Y**
Draft statement 2	**Themes raised by stakeholders**	**Committee rationale**	**Statement revised (Y/N)**
Adults with chronic kidney disease (CKD) have their blood pressure maintained below the	• The statement is clear and measurable • It is not achievable for people with CKD who cannot tolerate hypotensive medications	The committee agreed that as there was support for the statement from stakeholders it should be progressed for inclusion in the final quality standard, with the following amendments: • Amend the wording on blood pressure 'target' to a	**Y**

recommended target.	• Frail people risk symptomatic hypotension • Include the lower limit of blood pressure •	recommended 'range'. The committee agreed that the ideal blood pressure falls within the ranges specified in the underpinning guidance (CG182), which includes a lower limit. Including the lower limit ensures that people with CKD do not get over-treated and risk hypotension.	
Draft statement 3	**Themes raised by stakeholders**	**Committee rationale**	**Statement revised (Y/N)**
Adults with chronic kidney disease (CKD) are offered atorvastatin 20 mg	• The statement is clear and measurable • Too restrictive and does not allow personalised treatment • Offer atorvastatin first, then an equivalent statin if not tolerated • Who should be included in the population? • What happens if people with CKD are on a different statin? •	The committee agreed that as there was support for the statement from stakeholders it should be progressed for inclusion in the final quality standard, with the following amendments: • Consider amending wording to 'offer an initial dose of atorvastatin 20mg'. • Add information to the supporting sections for the statement on circumstances where a different statin might be offered, such as adverse effects and inadequate response to treatment. The committee discussed whether the statement could be changed so that a specific statin is not included. As the underpinning recommendation specifies offering atorvastatin 20mg, and there are statements in the lipid modification quality standard that also specify the statin, the committee agreed to leave as worded but to add information to the supporting text to clarify that atorvastatin 20mg is a starting point and other recommended doses or types of statin might be offered, if needed.	**Y**

Additional statements suggested	**Committee rationale**	**Statement progressed (Y/N)**
Psychosocial support	The committee noted that this was discussed at the prioritisation meeting and not	**N**

	progressed as it was agreed that the area was covered by QS15 patient experience in adult NHS services. The committee agreed that a statement is not needed on this area. The NICE team agreed to add more detail on support to the appropriate patient audience descriptor.	
Early testing and monitoring for renal anaemia	This area was not prioritised as a quality improvement area at the prioritisation meeting. The committee agreed that a statement is not needed on this area.	**N**
Provision of personalised information and a documented care plan	The committee noted that this was discussed at the prioritisation meeting and not progressed as it was agreed that the area was covered by QS15 patient experience in adult NHS services. The NICE team agreed to add more detail on patient information to the appropriate patient audience descriptor.	**N**

13. Resource impact	The committee felt that there were no significant resource impact issues with implementing this quality standard.	
14. Overarching outcomes	The NICE team explained that the quality standard would describe overarching outcomes that could be improved by implementing a quality standard on chronic kidney disease. It was agreed that the committee would contribute suggestions as the quality standard was developed. The committee discussed the outcome on CKD progression and agreed to review how this is worded.	
15. 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. No specific equality issues were raised. It was agreed that the committee would contribute suggestions as the quality standard was developed.	
16. Next steps and timescales (part 1 – open session)	SW outlined what will happen following the meeting and key dates for the chronic kidney disease (update) quality standard.	
17. Any other business (part 1 – open session)	The following items of AOB were raised: • No other business.	