# Spine, Pain and Neurological treatments Commissioning Policy

<table>
<thead>
<tr>
<th>Version:</th>
<th>2017-20</th>
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| Ratified by:        | NHS Leeds West CCG Assurance Committee on: 16 November 2016  
                      | NHS Leeds North CCG Governance on Performance and Risk Committee on: 17 November 2016  
                      | NHS Leeds South and East CCG Governance and Risk Committee on: 13 November 2016 |
| Name & Title of originator/author(s): | Dr Simon Stockill Medical Director, NHS Leeds West CCG  
                      | Dr Manjit Purewal, Medical Director NHS Leeds North CCG  
                      | Dr David Mitchell, Medical Director NHS Leeds South and East CCG  
                      | Dr Fiona Day, Consultant in Public Health Medicine, Leeds City Council |
| Name of responsible committee/individual: | Dr Simon Stockill Medical Director, NHS Leeds West CCG Governing Body  
                      | Dr Manjit Purewal, Medical Director NHS Leeds North CCG Governing Body  
                      | Dr David Mitchell, Medical Director NHS Leeds South and East CCG Governing Body |
| Date issued:        | July 2017                      |
| Review date:        | December 2020                  |
| Target audience:    | Primary and secondary care clinicians, individual funding request panels, and the public |
| Document History:   | Leeds CCGs Targeted Interventions Policy Feb 2014  
                      | Spine, Pain and Neurological Treatments 2016 |
Executive Summary

This policy applies to all Individual Funding Requests (IFR) for people registered with General Practitioners in the following three Clinical Commissioning Groups (CCGs), where the CCG is the responsible commissioner for this treatment or service:

- NHS Leeds West CCG
- NHS Leeds North CCG
- NHS Leeds South and East CCG

This policy does not apply where any one of the Leeds CCGs is not the responsible commissioner.

The policy updates all previous policies and must (where appropriate) be read in association with the other relevant Clinical Commissioning Groups in Leeds commissioning policies, which are to be applied across all three CCGs, including but not limited to policies on cosmetic exceptions and non-commissioned activity.

All IFR and associated policies will be publically available on the internet for each CCG.

This policy relates specifically to spine and pain commissioning.
Contents

1 Introduction .............................................................................................................. 4
2 Purpose ..................................................................................................................... 4
3 Scope ......................................................................................................................... 5
4 Definitions ................................................................................................................. 7
5 Duties ......................................................................................................................... 7
6 Main Body of Policy .................................................................................................. 7
7 Equality Impact Assessment (EIA) .......................................................................... 13
8 Implications and Associated Risks .......................................................................... 13
9 Education and Training Requirements .................................................................. 13
10 Monitoring Compliance and Effectiveness ............................................................. 13
11 Associated Documentation ...................................................................................... 14
12 Additional References .............................................................................................. 14
Appendices ..................................................................................................................... 17
   A Equality Impact Assessment (where applicable) .................................................. 17
   B Policy Consultation Process: ................................................................................ 20
   C Version Control Sheet ......................................................................................... 21
1 Introduction

The Clinical Commissioning Groups (CCGs) (NHS Leeds West CCG, NHS Leeds North CCG and NHS Leeds South and East CCG) were established on 1 April 2013 under the Health and Social Care Act 2012 as the statutory bodies responsible for commissioning services for the patients for whom they are responsible in accordance with s3 National Health Service Act 2006.

As part of these duties, there is a need to commission services which are evidence based, cost effective, improve health outcomes, reduce health inequalities and represent value for money for the taxpayer. The CCGs in Leeds are accountable to their constituent populations and Member Practices for funding decisions.

In relation to decisions on Individual Funding Requests (IFR), the CCGs in Leeds have a clear and transparent process and policy for decision making. They have a clear CCG specific appeals process to allow patients and their clinicians to be reassured that due process has been followed in IFR decisions made by the Non Commissioned Activity Panel, Cosmetic Exclusions and Exceptions Panel, or Non NICE Non Tariff Drug Panel (the IFR panels).

Due consideration must be given to IFRs for services or treatments which do not form part of core commissioning arrangements, or need to be assessed as exceptions to Leeds CCGs Commissioning Policies. This process must be equitably applied to all IFRs.

All IFR and associated policies will be publically available on the internet for each CCG. Specialist services that are commissioned by NHS England or Public Health England are not included in this policy.

2 Purpose

The purpose of the IFR policy is to enable officers of the Leeds CCGs to exercise their responsibilities properly and transparently in relation to IFRs, and to provide advice to general practitioners, clinicians, patients and members of the public about IFRs. Implementing the policy ensures that commissioning decisions in relation to IFRs are consistent and not taken in an ad-hoc manner without due regard to equitable access and good governance arrangements. Decisions are based on best evidence but made within the funding allocation of the CCGs.

The policy outlines the process for decision making with regard to services/treatments which are not normally commissioned by the CCGs in Leeds, and is designed to ensure consistency in this decision making process.

The policy is underpinned by the following key principles:

- The decisions of the IFR panels outlined in the policy are fair, reasonable and lawful, and are open to external scrutiny.
- Funding decisions are based on clinical evidence and not solely on the budgetary constraints.
Compliance with standing financial instructions / and statutory instruments in the commissioning of healthcare in relation to contractual arrangements with providers.

Whilst the majority of service provision is commissioned through established service agreements with providers, there are occasions when services are excluded or not routinely available within the National Health Service (NHS). This may be due to advances in medicine or the introduction of new treatments and therapies or a new cross-Leeds Clinical Commissioning Group statement. The IFR process therefore provides a mechanism to allow drugs/treatments that are not routinely commissioned by the Leeds CCGs to be considered for individuals in exceptional circumstances.

3 Scope

The CCGs in Leeds have established the processes outlined in this policy to consider and manage IFRs in relation to the following types of requests:

Policy development and review: consultation and engagement

The policy was developed to:

- ensure a clear and transparent approach is in place for exceptional/individual funding request decision making; and
- provide reassurance to patients and clinicians that decisions are made in a fair, open, equitable and consistent manner.

It was originally developed in line with NICE or equivalent guidance where this was available or based on a review of scientific literature. This included engagement with hospital clinicians, general practice, CCG patient advisory groups, and the general public cascaded through a range, mechanisms.

The policy review was undertaken using any updated NICE or equivalent guidance, and input from clinicians was sought where possible. Engagement sessions with patient leaders were undertaken and all policies individually reviewed. Patient leaders were satisfied with the process by which the policy was developed, particularly in light of the robust process (including extensive patient engagement) by which NICE guidance are developed, and acknowledging their own local role in providing assurance. No concerns were raised with regard to the policy

This policy relates specifically to spine and pain commissioning.

Leeds CCGs do not routinely commission aesthetic (cosmetic) surgery and other related procedures that are medically unnecessary.

Providing certain criteria are met, Leeds CCGs will commission aesthetic (cosmetic) surgery and other procedures to improve the functioning of a body part or where medically necessary even if the surgery or procedure also improves or changes the appearance of a portion of the body.

Please note that, whilst this policy addresses many common procedures, it does not address all procedures that might be considered to be cosmetic. Leeds CCGs reserve the right not to commission other procedures considered cosmetic and not
medically necessary. This policy is to be used in conjunction with the Individual Funding Requests (IFR) Policy for Leeds CCGs and other related policies.

Leeds CCGs **routinely commission** interventional procedures where National Institute for Health and Care Excellence (NICE) guidance arrangements indicate “normal” or “offered routinely” or “recommended as option(s)” and the evidence of safety and effectiveness is sufficiently robust.

Leeds CCGs **do not routinely commission** interventional procedures where NICE guidance arrangement indicates “special”, “other”, “research only” and “do not use”.

The commissioning statements for individual procedures are the same as those issued by NICE. ([www.nice.org.uk](http://www.nice.org.uk)).

An individual funding request (IFR) may be submitted for a patient who is felt to be an exception to the commissioning statements as per the Individual Funding Request Policy.

The CCGs accept there are clinical situations that are unique (five or fewer patients) where an IFR is appropriate and exceptionality may be difficult to demonstrate.

Whilst the Leeds CCGs are always interested in innovation that makes more effective use of resources, in year introduction of a procedure does not mean the CCGs will routinely commission the use of the procedure.

An individual funding request is not an appropriate mechanism to introduce a new treatment for a group or cohort of patients. Where treatment is for a cohort larger than five patients, that is a proposal to develop the service, the introduction of a new procedure should go through the usual business planning process. CCGs will not fund interventional procedures for cohorts over 5 patients introduced outside a business planning process.

**Endpoints**

Following completion of the agreed treatment, a proportionate follow up process will lead to a final review appointment with the clinician where both patient and clinician agree that a satisfactory end point has been reached. This should be at the discretion of the individual clinician and based on agreeing reasonable and acceptable clinical and/or cosmetic outcomes.

Once the satisfactory end point has been agreed and achieved, the patient will be discharged from the service.

Requests for treatment for unacceptable outcomes post treatment will only be considered through the Individual Funding Request route. Such requests will only be considered where a) the patient was satisfied with the outcome at the time of discharge and b) becomes dissatisfied at a later date. In these circumstances the patient is not automatically entitled to further treatment. Any further treatment will therefore be at the relevant Leeds Clinical Commissioning Group’s discretion, and will be considered on an exceptional basis in accordance with the IFR policy.

Leeds CCGs are committed to supporting patients to stop smoking in line with NICE guidance in order to improve short and long term patient outcomes and reduce health inequalities. Referring GPs and secondary care clinicians are reminded to
ensure the patient is supported to stop smoking at every step along the elective pathway and especially for flap based procedures (in line with plastic surgery literature: abdominoplasty, panniculectomy, breast reduction, other breast procedures).

4 Definitions

The CCGs in Leeds are not prescriptive in their definitions. Each IFR will be considered on its merits, applying this Policy.

Routinely commissioned – this means that this intervention is routinely commissioned as outlined in the relevant policy, or when a particular threshold is met. Prior approval may or may not be required, refer to the policy for more information.

Exceptionality request – this means that for a service which is not routinely commissioned, or a threshold is not met, the clinician may request funding on the ‘grounds of exceptionality’ through the individual funding request process. Decisions on exceptionality will be made using the framework defined in the overarching policy ‘Individual Funding Requests (IFR) Policy for the Clinical Commissioning Groups in Leeds’.

5 Duties

Whilst this policy and associated decision making policies will be applied on a cross-CCG basis for patients from all three CCGs in Leeds, each individual CCG will retain responsibility for the decision making for its own patients. To this end, each CCG will delegate its decision making in relation to IFRs to a CCG specific decision maker for patients from that specific CCG, in accordance with its own Constitution.

This decision maker will attend the relevant IFR panel and will also have responsibility for approving the triage process for patients from their own CCG population. The triage process is the process of screening requests to see whether the request meets the policy criteria and which referrals need to be considered by an IFR panel; see sections on IFR panels for more information. The decision maker for each CCG is responsible for decision making solely for patients within their own CCG registered population. This will normally be the Medical Director or their designate. This will be detailed in the CCG Constitution as an Appendix.

In exceptional circumstances, when a CCG is unable to send a delegated decision maker to the IFR panel, the panel may discuss the case in their absence and may make a recommendation. However, the decision maker for the specific CCG must make the final decision whether or not to approve the IFR.

6 Main Body of Policy

Exceptionality funding can be applied for in line with the overarching policy through the IFR process if you believe your patient is an exception to the commissioning position. Please refer to the overarching policy for more information.

6.1 Exercise
Leeds CCGs routinely commission group exercise programmes (biomechanical, aerobic, mind–body or a combination of approaches) for people with a specific episode or flare-up of low back pain with or without sciatica. Take people's specific needs, preferences and capabilities into account when choosing the type of exercise.

6.2 Manual Therapy Treatment Package
Status: routinely commissioned

Leeds CCGs routinely commission manual therapy (manipulation, mobilisation or soft tissue techniques (for example, massage)) for managing low back pain with or without sciatica, but only as part of a treatment package including exercise, with or without psychological therapy.

6.3 Psychological Therapies Package
Status: routinely commissioned in specific circumstances

Leeds CCGs routinely commission psychological therapies using a cognitive behavioural approach for managing low back pain with or without sciatica but only as part of a treatment package including exercise, with or without manual therapy (spinal manipulation, mobilisation or soft tissue techniques such as massage).

6.4 Combined Physical and Psychological Programmes
Status: routinely commissioned in specific circumstances

Leeds CCGs routinely commission combined physical and psychological programmes, incorporating a cognitive behavioural approach (preferably in a group context that takes into account a person's specific needs and capabilities), for people with persistent low back pain or sciatica:

- when they have significant psychosocial obstacles to recovery (for example, avoiding normal activities based on inappropriate beliefs about their condition) or
- when previous treatments have not been effective.

6.5 Radiofrequency denervation
Status: routinely commissioned in specific circumstances

Leeds CCGs routinely commission 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.

Only perform radiofrequency denervation in people with chronic low back pain after a positive response to a diagnostic medial branch block.
Imaging for people with low back pain with specific facet joint pain must not be treated as a prerequisite for radiofrequency denervation.

### 6.6 Additional Specific Treatments for Sciatica

**Status:** routinely commissioned in specific circumstances

#### Neuropathic Pain

For information on pharmacological management of sciatica, see NICE recommendations on neuropathic pain.

#### Epidurals

**Leeds CCGs routinely commission** epidural injections of local anaesthetic and steroid in people with acute and severe sciatica.

**Leeds CCGs do not routinely commission** epidural injections for neurogenic claudication in people who have central spinal canal stenosis.

#### Spinal Decompression Surgery

**Leeds CCGs routinely commission** spinal decompression for people with sciatica when non-surgical treatment has not improved pain or function and their radiological findings are consistent with sciatic symptoms.

#### Referral for surgical opinion

**Do not allow** a person's BMI, smoking status or psychological distress to influence the decision to refer them for a surgical opinion for sciatica.

### 6.7 Additional Surgical Procedures

**Status:** routinely commissioned in specific circumstances

#### Spinal cord stimulation for chronic pain of neuropathic or ischaemic origin

The following recommendations are from NICE technology appraisal guidance on spinal cord stimulation for chronic pain of neuropathic or ischaemic origin.

**Leeds CCGs routinely commission** spinal cord stimulation as a treatment option for adults with chronic pain of neuropathic origin who:

- continue to experience chronic pain (measuring at least 50 mm on a 0–100 mm visual analogue scale) for at least 6 months despite appropriate conventional medical management, and
- who have had a successful trial of stimulation as part of the assessment specified below.

**Leeds CCGs do not routinely commission** spinal cord stimulation as a treatment option for adults with chronic pain of ischaemic origin.

Spinal cord stimulation should be provided only after an assessment by a multidisciplinary team experienced in chronic pain assessment and management of people with spinal cord stimulation devices, including experience in the provision of ongoing monitoring and support of the person assessed.
When assessing the severity of pain and the trial of stimulation, the multidisciplinary team should be aware of the need to ensure equality of access to treatment with spinal cord stimulation. Tests to assess pain and response to spinal cord stimulation should take into account a person's disabilities (such as physical or sensory disabilities), or linguistic or other communication difficulties, and may need to be adapted.

If different spinal cord stimulation systems are considered to be equally suitable for a person, the least costly should be used. Assessment of cost should take into account acquisition costs, the anticipated longevity of the system, the stimulation requirements of the person with chronic pain and the support package offered.

People who are currently using spinal cord stimulation for the treatment of chronic pain of ischaemic origin should have the option to continue treatment until they and their clinicians consider it appropriate to stop.

NICE has written information for the public explaining its guidance on spinal cord stimulation for chronic pain of neuropathic or ischaemic origin.

**Other Interventional procedures guidance**

Leeds CCGs commission the following procedures where providers are compliant with the arrangements and indications as set out in the NICE guidance, described in the links below:

- percutaneous coblation of the intervertebral disc for low back pain and sciatica
- non-rigid stabilisation techniques for the treatment of low back pain
- interspinous distraction procedures for lumbar spinal stenosis causing neurogenic claudication
- percutaneous intradiscal laser ablation in the lumbar spine.
- percutaneous intradiscal radiofrequency treatment of the intervertebral disc nucleus for low back pain
- percutaneous electrothermal treatment of the intervertebral disc annulus for low back pain and sciatica
- insertion of an annular disc implant at lumbar discectomy
- peripheral nerve-field stimulation for chronic low back pain
- automated percutaneous mechanical lumbar discectomy.
- lateral interbody fusion in the lumbar spine for low back pain
- transaxial interbody lumbosacral fusion
- prosthetic intervertebral disc replacement in the lumbar spine

NICE has published guidance that epiduroscopic lumbar discectomy through the sacral hiatus for sciatica should only be used in the context of research. This procedure is therefore not routinely commissioned by Leeds CCGs.

**6.8 Acupuncture and Electrotherapy**

Status: Not routinely commissioned

**Acupuncture** - Leeds CCGs do not routinely commission acupuncture for managing low back pain with or without sciatica.

**Electrotherapy** - Leeds CCGs do not routinely commission ultrasound, PENS, TENS or interferential therapy for managing low back pain with or without sciatica.
6.9  **Traction, Orthotics, Belts and Corsets**

*Status: Not routinely commissioned*

**Traction** - Leeds CCGs do not routinely commission traction for managing low back pain with or without sciatica.

**Belts or corsets** - Leeds CCGs do not routinely commission belts or corsets for managing low back pain with or without sciatica.

**Foot Orthotics** – Leeds CCGs do not routinely commission foot orthotics for managing low back pain with or without sciatica.

**Rocker sole shoes** - Leeds CCGs do not routinely commission rocker sole shoes for managing low back pain with or without sciatica.

6.10  **Spinal Injections and disc replacement**

*Status: Not routinely commissioned*

**Spinal Injections**

Leeds CCGs do not routinely commission spinal injections for managing low back pain.

**Disc replacement**

Leeds CCGs do not routinely commission disc replacement in people with low back pain.

6.11  **Spinal Fusion**

*Status: Not routinely commissioned*

**Spinal Fusion** - Leeds CCGs do not routinely commission spinal fusion for people with low back pain unless as part of a randomised controlled trial.

6.12  **Referral to specialist Headache Services**

*Status: routinely commissioned in specific circumstances*

Headache is a very common symptom and can be indicative of many disorders. Headaches can be distinguished into three categories:

- Primary headache disorder in which headache is not indicative of any further conditions (for example, tension-type headache, cluster headaches and migraines)
- Secondary headache disorder in which the headache is the result of underlying pathology. Some examples of secondary headaches are neoplasms, vascular disorders e.g. giant cell arteritis, infections such as meningitis, encephalitis.
- Cranial neuralgias and central causes of face pain such as trigeminal neuralgia and post herpetic neuralgia.

Follow the guidance for referral to specialist services for headache issued by NICE within Clinical Guidelines 150, Headaches in over 12s: diagnosis and management.

NICE Guidelines (CG150): Headaches in over 12s: diagnosis and management
6.13 **Functional Electrical Stimulation for Foot drop of central neurological origin**

Status: routinely commissioned in specific circumstances

Functional Electrical Stimulation (FES) is a technology with stimulates peripheral motor neurones in order to produce muscle contractions which mimic normal voluntary movement. It is in routine clinical use in the UK for treating foot drop.

Foot drop is a common gait abnormality where the forefoot is not lifter during the swing phase of walking. It is often due to an upper motor neurone lesion, which may be associated with a number of conditions including stroke, multiple sclerosis and cerebral palsy. It can cause the forefoot to catch on the floor during walking, which is a common cause of falls, reduced walking speed, and lack of confidence in these populations (Holder et al, 1986; Hausdorff and Ring 2008).

Surface FES for foot drop uses two re-usable electrodes placed over the peroneal nerve, which innervates various muscles dorsiflexing and everting the forefoot. These electrodes are normally activated by a foot-switch which triggers foot lift when the foot leaves the floor. There are three main components to a standard foot-drop system:

- The electrodes where an electrical current is applied to the body. The electrodes are placed on the leg every day and removed overnight;
- A foot-switch, which triggers stimulation; and
- A control box, which co-ordinates stimulation based on the trigger and programmed settings, and also allows user control.

The following criteria have been developed using NICE Interventional procedure guidance (IPG278) and review of the scientific literature.

NICE Interventional Procedure Guidance (IPG278) Functional electrical stimulation for drop foot of central neurological origin

FES can be commissioned if the following conditions is met:

Patient has a documented foot drop which is the result of an upper motor neurone deficit.

FES should be commissioned according to the following guidance:

FES can be provided for people with walking difficulties where there is a demonstrable benefit e.g. reduced trips and falls.

a. Odstock ODFS PACE equipment (1) can be provided to people who have a dropped foot.

b. When difficulties with using (1) are envisaged or experienced associated with dexterity, mental capacity and/or fatigue, an Odstock Cuff (2) can be provided as an accessory to (1)
c. Odstock ODFS2 equipment (3) can be provided to people when both legs are affected or two muscle groups in different parts of the leg.
d. Where a wired Odstock footswitch cannot be set up reliably and professional carers are not available for assistance, an ODFS PACE XL including a wireless footswitch (4) can be provided.
e. When an Odstock footswitch on 1, 3 or 4 cannot be activated reliably or safety a Walkaide (5) can be provided.
f. When existing FES users have a chronic skin reaction to electrodes, a STIMuSTEP with implantable electrodes (6) can be considered. The person must also be willing to travel to Salisbury and meet Odstock criteria (for example, expect benefit over several years, fit enough for surgery, not immune-suppressed).
g. For any person who cannot use 1, 3, 4 and 5 at all for health-related reasons, but who can use a OttoBock MyGait (7) with significant demonstrable orthotic benefit then this can be provided.

NHS stimulator accessories can be self-funded as long as they do not impact on the NHS equipment.

1. ODFS PACE from Odstock Medical
2. ODFS Leg Cuff for PACE from Odstock Medical
3. ODFS2 from Odstock Medical
4. ODFS PACE XL from Odstock Medical
5. Walkaide from Innovative Neurotronics (UK distributor: Trulife)
6. STIMuSTEP from Odstock Medical
7. MyGait from OttoBock

7 Equality Impact Assessment (EIA)

This document has been assessed, using the EIA toolkit, to ensure consideration has been given to the actual or potential impacts on staff, certain communities or population groups, appropriate action has been taken to mitigate or eliminate the negative impacts and maximise the positive impacts and that the and that the implementation plans are appropriate and proportionate.

Include summary of key findings/actions identified as a result of carrying out the EIA. The full EIA is attached as Appendix A.

8 Implications and Associated Risks

This policy and supporting frameworks set evidence based boundaries to interventions available on the NHS. It may conflict with expectations of individual patients and clinicians.

9 Education and Training Requirements

Members of the panels will undergo training at least every three years, particularly in relation to the legal precedents around IFRs. Effective policy dissemination is required for local clinicians.

10 Monitoring Compliance and Effectiveness
Each IFR panel will maintain an accurate database of cases approved and rejected, to enable consideration of amendments to future commissioning intentions and to ensure consistency in the application of the CCGs in Leeds Commissioning Policies.

The financial impact of approvals outside of existing Service Level Agreements will be monitored to ensure the Leeds CCGs identify expenditure and ensure appropriate value for money. Member Practice clinicians need to be aware that all referrals will ultimately be a call on their own CCG budgets.

11 Associated Documentation

This policy must be read in conjunction with the underpinning Leeds CCGs decision making frameworks.

12 Additional References

TENS

NICE Clinical Guidelines (CG177) Osteoarthritis: care and management

NICE Clinical Guidelines (CG88) Low back pain in adults: early management

Facet Joints


**Epidural**


Pain Physician 16 S49-S283


Staal J et al Injection therapy for subacute and chronic low-back pain.. Cochrane Database of Systematic Reviews. 
http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD001824/frame.html Accessed 15/07/16

Zhai et al (2015) Epidural injection with or without steroid in managing chronic low back and lower extremity pain: a meta-analysis of ten randomized controlled trials. 15, 8(6) 8304-8316
Appendices

A Equality Impact Assessment (where applicable)

<table>
<thead>
<tr>
<th>Title of policy</th>
<th>Spine and Pain Policy</th>
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<tbody>
<tr>
<td>Names and roles of people completing the assessment</td>
<td>Fiona Day Consultant in Public Health Medicine, Helen Lewis, Head of Acute Provider Commissioning</td>
</tr>
<tr>
<td>Date assessment started/completed</td>
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1. Outline

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<tr>
<th>Give a brief summary of the policy</th>
<th>The purpose of the commissioning policy is to enable officers of the Leeds CCGs to exercise their responsibilities properly and transparently in relation to commissioned treatments including individual funding requests, and to provide advice to general practitioners, clinicians, patients and members of the public about IFRs. Implementing the policy ensures that commissioning decisions are consistent and not taken in an ad-hoc manner without due regard to equitable access and good governance arrangements. Decisions are based on best evidence but made within the funding allocation of the CCGs. This policy relates to requests for spine and pain services.</th>
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<tr>
<td>What outcomes do you want to achieve</td>
<td>We commission services equitably and only when medically necessary and in line with current evidence on cost effectiveness.</td>
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2. Evidence, data or research

| Give details of evidence, data or research used to inform the analysis of impact | See list of references |
3. Consultation, engagement

Give details of all consultation and engagement activities used to inform the analysis of impact

Discussion with clinicians and patient representatives on the principles of decision making. Discussion with patient leaders relating to changes in the content of the policy and advice on proportionate engagement.

The policy review was undertaken using any updated NICE or equivalent guidance, and input from clinicians was sought where possible. Engagement sessions with patient leaders were undertaken and all policies individually reviewed. Patient leaders were satisfied with the process by which the policy was developed, particularly in light of the robust process (including extensive patient engagement) by which NICE guidance are developed, and acknowledging their own local role in providing assurance. No concerns were raised with regard to the policy.

4. Analysis of impact

This is the core of the assessment, using the information above detail the actual or likely impact on protected groups, with consideration of the general duty to;

- eliminate unlawful discrimination; 
- advance equality of opportunity; 
- foster good relations

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<tr>
<th>Are there any likely impacts?</th>
<th>Are these negative or positive?</th>
<th>What action will be taken to address any negative impacts or enhance positive ones?</th>
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<tbody>
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<td>Age</td>
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<td>Carers</td>
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<td>Disability</td>
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<td>Ensures equitable access based on clinical need</td>
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<td>Pregnancy and maternity</td>
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<td>Other relevant group</td>
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If any negative/positive impacts were identified are they valid, legal and/or justifiable?
Please detail.

5. Monitoring, Review and Publication

<table>
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<tr>
<th>How will you review/monitor the impact and effectiveness of your actions</th>
<th>Annual report of IFR activity reported through relevant committees to Governing Bodies of the 3 CCGs. A limited equity audit is undertaken as part of this. Complaints and appeals monitoring.</th>
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<tbody>
<tr>
<td>Lead Officer</td>
<td>Simon Stockill</td>
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6. Sign off

| Director on behalf of the 3 Leeds CCG Medical Directors | Dr Simon Stockill, Medical Director, Leeds West CCG | Date approved: | 24.8.16 |
### B  Policy Consultation Process:

<table>
<thead>
<tr>
<th>Title of document</th>
<th>Spine and Pain Commissioning Policy</th>
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<tbody>
<tr>
<td>Author</td>
<td>Helen Lewis, Jamie OShea, Steve Laville</td>
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<tr>
<td>New / Revised document</td>
<td>New</td>
</tr>
<tr>
<td>Lists of persons involved in developing the policy</td>
<td>F Day Consultant in Public Health Medicine, M Everitt, Leeds City Council</td>
</tr>
<tr>
<td>List of persons involved in the consultation process:</td>
<td>See appendix A</td>
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<tr>
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