NHS
Leeds
Clinical Commissioning Group

Spine, Pain and Neurological treatments Commissioning Policy

Version:	2019-2022
Ratified by:	NHS Leeds CCG Quality & Performance Committee on: 13 March 2019
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Date issued:	March 2019
Review date:	February 2022
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

Produced on behalf of NHS Leeds Clinical Commissioning Group

Executive Summary

This policy applies to all Individual Funding Requests (IFR) for people registered with General Practitioners in Leeds

This policy does not apply where NHS Leeds CCG is not the responsible commissioner.

The policy updates all previous policies and must (where appropriate) be read in association with the other relevant Leeds Clinical Commissioning Group commissioning policies, which are to be applied across Leeds , 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 the CCG.

This policy relates specifically to spine and pain commissioning.

Contents

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 at 1 April 2018 these three CCGs have merged to become NHS Leeds Clinical Commissioning Group

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. NHS Leeds CCG is accountable to their constituent populations and Member Practices for funding decisions.

In relation to decisions on Individual Funding Requests (IFR), NHS Leeds CCG has 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 CCG Commissioning Policies. This process must be equitably applied to all IFRs.

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

The policy outlines the process for decision making with regard to services/treatments which are not normally commissioned by the CCG 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 NHS Leeds CCG to be considered for individuals in exceptional circumstances.

3 Scope

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

NHS Leeds CCG has established the processes outlined in this policy to consider and manage IFRs in relation to the following types of requests:

This policy relates specifically to spine and pain commissioning.

NHS Leeds CCG *does not routinely commission* aesthetic (cosmetic) surgery and other related procedures that are medically unnecessary.

Providing certain criteria are met, the CCG 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. The CCG 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 NHS Leeds CCG and other related policies.

NHS Leeds CCG 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.

NHS Leeds CCG *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).

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 CCG 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 CCG is always interested in innovation that makes more effective use of resources, in year introduction of a procedure does not mean the CCG 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. CCG 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 the Clinical Commissioning Group's discretion, and will be considered on an exceptional basis in accordance with the IFR policy.

NHS Leeds CCG 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 CCG is 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 Group in Leeds'.

5 Duties

The CCG will delegate its decision making in relation to IFRs to a delegated decision maker/s in accordance with its own scheme of delegation.

A delegated decision maker will attend the relevant IFR panel and will also have responsibility for approving the triage process. 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. This will be detailed in the CCG Scheme of Delegation

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 Use of Spinal MRI

Status: routinely commissioned in specific circumstances
Referral for spinal MRI can only be made by suitably qualified and trained spinal clinicians*, following assessment for appropriate neurological signs in order to confirm diagnosis and inform future treatment (e.g. spinal injection or surgery)

Arrangements for management of Red flag referrals are unaffected by this policy

*suitably qualified and trained spinal clinicians are clinicians who have :-

- Significant experience in the assessment and treatment of a wide range of spinal patients
- Hold recognised post graduate qualifications and can demonstrate experiential learning alongside a range of consultants eg neurosurgical team, MSK consultants and radiological colleagues
- Are working as an integral part of the specialist spinal team
- This includes knowledge of appropriate use of spinal imaging and an up to date evidence base regarding treatment options etc.

6.2 Exercise
Status: routinely commissioned

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

6.3 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.

6.4 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).

6.5 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.

6.6 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.

6.7 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.

Referrals for spinal surgical assessment must only be made if the following criteria are met :-

- The referral includes an attached appropriate spinal MRI demonstrating a suitable surgical target.
- Confirmation that the patient has had a pre-referral face to face review by suitably qualified and skilled spinal clinician such as an Advanced Practice Physiotherapist/other appropriate MSK clinician, incorporating a shared decision making conversation that touches on the pros and cons of surgical intervention, and consideration of peri-operative risk. (Definition of suitably qualified and trained spinal clinicians is contained within section 6.1)
- Confirmation that following the shared decision making discussion, the patient would be willing to consider such a surgical option if they were offered it.
  Note - The requirement for a face to face assessment and shared decision making discussion should only be waived where symptoms, signs and scan results are consistent with pathology where MSK services are unlikely to be able to provide alternative conservative management, and surgery is the only realistic treatment option. Examples could include, but are not limited to:
    - *Cervical spine pathology associated with myelopathy*
    - *Pathology directly related to previous spinal fusion surgery*

  (Whilst face-to-face assessment is not required in such circumstances, the patient should still have had a discussion with a an appropriately skilled spinal clinician such as an Advanced Practice Physiotherapist/other appropriate MSK clinician, so that the patient is clear about the purpose of referral and is able to provide appropriate consent).

Arrangements for management of red flag referrals are unaffected by this policy

6.8 Additional Surgical Procedures

Status: routinely commissioned in specific circumstances

Please note that all referrals for surgical opinion must meet the requirements as set out in section 6.7 – referral for a surgical opinion

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**

6.9 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.

6.10 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.

6.11 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.

6.12 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.

6.13 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

NICE produced pathways to aid diagnosis and management of headaches http://cks.nice.org.uk/headache-assessment#!scenario accessed 14/7/16

6.14 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

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Appendices

A Equality Impact Assessment (where applicable)

Title of policy	Spine and Pain Policy	
Names and roles of people completing the assessment	Fiona Day Consultant in Public Health Medicine, Helen Lewis, Head of Acute Provider Commissioning	
Date assessment started/completed	26.6.16	25.7.16

1. Outline	
Give a brief summary of the policy	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.
What outcomes do you want to achieve	We commission services equitably and only when medically necessary and in line with current evidence on cost effectiveness.

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			
	Are there any likely impacts? **Are any groups going to be affected differently?** **Please describe.**	**Are these negative or positive?**	**What action will be taken to address any negative impacts or enhance positive ones?**
Age	No		
Carers	No		
Disability	yes	Positive	Ensures equitable access based on clinical need
Sex	No		
Race	No		
Religion or belief	No		
Sexual orientation	No		

Gender reassignment	No		
Pregnancy and maternity	No		
Marriage and civil partnership	No		
Other relevant group	No		

If any negative/positive impacts were identified are they valid, legal and/or justifiable? **Please detail.**	

5. Monitoring, Review and Publication			
How will you review/monitor the impact and effectiveness of your actions	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.		
Lead Officer	Simon Stockill	**Review date:**	Dec 2019

6.Sign off			
Lead Officer			
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:

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

C Version Control Sheet

Version	Date	Author	Status	Comment
1.0	14.7.16	F Day, M Everitt	draft	Percutaneous coblation of the intervertebral disc: Previously NOT commissioned, however now recommending in specific circumstances Radiofrequency treatment of the intervertebral disc nucleus: No change in policy Facet Joint Interventions: No change to policy Epidural Injections for back pain: No change to policy Spinal cord stimulation- no change FES- possible change to be in line with NICE (more restrictive) currently discussing with providers Headache – more clear criteria in line with NICE TENS no change
2.0	1.3.17	Helen Lewis, Jamie OShea, Steve Laville	Draft	Updated whole policy in line with new NICE guidance on back pain
3.0	26.02.19	Steve Laville	Draft	Updated sections 6.1, 6.7 and 6.8 to reflect harmonised commissioning policies on spinal services across the West Yorkshire and Harrogate Health and Care Partnership.