SCHEDULE 2 – THE SERVICES

A. Service Specifications

<table>
<thead>
<tr>
<th>Service</th>
<th>New Pain Service Model of Care for West Suffolk/ Tier 2 Community Pain Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioner Lead</td>
<td>West Suffolk Clinical Commissioning Group (WSCCG)</td>
</tr>
<tr>
<td>Provider Lead</td>
<td>TBA</td>
</tr>
<tr>
<td>Period</td>
<td>2014-2017</td>
</tr>
</tbody>
</table>

1.1 Purpose

The Community Pain Management Service (CPMS) will provide a multi-disciplinary interface service between GP practices, community services and an acute setting in West Suffolk.

The philosophy of the service is to provide the best options of care, ensuring patients are seen by the most appropriate healthcare professional, at the appropriate time and in the appropriate place, whilst optimising the best health outcome for the patient. This will be managed through effective collaborative clinical triage and delivery of the management of chronic pain through a comprehensive bio-psychosocial model. The service promotes long-term self-management and less dependency on the wider health care services such as: A&E, GPs secondary care, ambulance services and mainstream physiotherapy.

Pain management services should be delivered through a three tier system:

- Tier one - primary care services from GPs, community pharmacists, pain self-help organisations/groups and community based physical therapy;
- Tier two - community services offering pain management programmes, IAPT (Improving Access to Psychological Therapies) services, web based and paper based self-management resources and;
- Tier three - secondary care service for patients with complex needs, pain relief, web and paper based self-management resources.

An expert screening team is advised between tier one and two.

The comprehensive CPMS Tier 2 service in West Suffolk will consist of a multi-disciplinary team that can manage patient’s physical, psychological and social needs associated with pain. It will ensure patients experiencing chronic pain are appropriately managed in a community environment and for those patients requiring secondary care, to be referred into an appropriate hospital setting when they need specialist interventions: and to be transferred back to a community setting (if necessary) once Tier 3 intervention is complete.

The service will act as a single point of access for patients referred with chronic pain of at least 3 months duration with an acceptance that the pain has become chronic pain not of a short term nature. Health Care Professionals (HCPs) will provide a holistic assessment

---

1 -Chronic Pain – Pain of slow progression and long duration which causes continuous or episodic periods of incapacity of three months or longer.
including explanation of the cause(s) of an individual patient’s pain and its associated effects on psychological, physical, social functioning, wellbeing and the impact on quality of life.

1.2 Aims

The Provider shall provide a community based pain management service that:

- Supports and empowers patients through shared decision making to gain or regain self-belief and confidence.
- Reduces dependency on healthcare systems and enhances the quality of life for service users and carers/families.
- Offers improved access to high quality pain interventions which will include education, physical therapy and psychological support that improve health and wellbeing.
- Works with, and educate, clinical colleagues to safely optimise the use of analgesia and self-management tools and techniques.
- Works with a range of different organisations including the contract parties, local authorities, private and voluntary sectors.

1.3 Evidence base

The British Pain Society National Audit (November 2011) describes pain as “a complex bio-psychosocial experience”. Pain that persists longer than expected can be difficult to accept, and, therefore, to treat. Whilst most people are able to manage their pain successfully, some require referral to specialist pain services. The definition of a specialist pain service for the purpose of coding in the UK is described as the diagnosis and management of complex pain disorders, requiring a multidisciplinary approach”. The British Society National Pain Audit estimated prevalence of chronic pain at 6.4%, annual incidence of 8.3% and annual recovery of 5.4%.

Research evidence and the resultant policy guidance that has emerged in the last 30 years for pain services in the UK have clearly indicated that the most effective approach for pain services is multidisciplinary working. Recent health policy has encouraged the move for such services from traditional settings in specialist secondary care centres, into a community setting. The White Paper ‘Our Health, Our Care, Our Say: a new direction for community services’ included recommendations around early intervention, improved access to community-based services, a commitment to address inequalities of care and to move services closer to peoples’ homes. These recommendations were accompanied by an expectation that the relocated services would improve the patient journey, result in cost-savings and achieve similar treatment outcomes.

There is also evidence that demonstrates the benefits of early intervention, preventing people with low back pain remaining off sick for long periods and avoiding the detrimental effects associated with long-term sickness absence. Reflecting this understanding, over the last ten years health policy in England has increasingly emphasised the need for health and social care services to act proactively in the management of long-term health conditions of which chronic pain is identified.

Public Health Suffolk reviewed the literature on the prevalence of chronic pain looking at pain prevalence rates from three studies. The details of these can be seen in Appendix 3.

Available research indicates that around one in five adults suffers from an appreciable level of pain at any one time. There is however wide variance in prevalence estimates across studies and the availability of robust data on the incidence and prevalence of chronic pain in England and elsewhere is limited. A pragmatic approach to estimating the prevalence of chronic pain in the West Suffolk population was undertaken by applying the prevalence rates reported in three contemporary studies to the local population. The three studies reported period prevalence rates that range from 13% to 50.4% with further within study variation between sex and age groups, socio-economic status and other variables. This equates to between 24,500 and 88,000 adults in the West Suffolk population. These prevalence rates are
anticipated to increase due to predicted population growth in the catchment area and the impact of an aging population. Data from Scotland looking at multi-morbidity indicate that most people with chronic pain have at least 3 other long term conditions, only 19% have pain alone.

The wide variance reflects some of the limitations within the studies including the absence of a consistent definition of chronic pain; the difficulties in finding reliable and valid ways to measure pain and the differing cultural interpretations of pain that are evident in the studies.

The audit stresses the importance of multidisciplinary care, covering medical, rehabilitation and psychological expertise. This has been strengthened by the work from the British Pain Society who has recently published pain management pathways within their portfolio and on the Map of Medicine Website. It recommends patient management programmes in the community for patients with chronic pain.

A review of other pain models across the UK (East Riding, Sheffield & Kent) was undertaken identifying the successful outcomes of a three tier approach. The services have demonstrated that provision of level 2 services resulted in a 50% reduction in secondary care elective pain activity.

1.4 Policy Guidance and Regulatory Framework

Best practice guidelines and information have been used in the design of this specification:

- NHS England Outcomes Framework 2013/14: Domain 2 “Enhancing peoples quality of life with long-term conditions” Domain 2.2 “Ensuring people feel supported to manage their condition” and Domain 4 “Ensuring that people have a positive experience of care”;

Full reference lists are included in Appendix 1.

1.5 Local Policy

The Suffolk Health and Wellbeing Strategy for Suffolk list four priorities of which this pain service meets two areas:

- Suffolk residents have access to a healthy environment and take responsibility for their own health and wellbeing;
- Older people in Suffolk have a good quality of life.

WSCCG’s ambition is to deliver the highest quality health services in West Suffolk through integrated working by:

- Developing clinical leadership;
- Demonstrating excellence in patient experience and patient engagement;
- Improving health and care of older people;
- Improving access to mental health services;
- Improving health and wellbeing through partnership working;
- Delivering financial sustainability through quality improvement;
1.6 General Overview

Historically, patients have been referred to specialist pain clinics within secondary care after initial management from GPs. This can overburden services which primarily deliver interventional treatments with limited physical, psychological and social assessment, goal setting and personalised care planning (Poole and Dorset PCT 2012).

Evidence suggests that the most effective care for patients with chronic pain is that which enables the patient to understand and come to terms with their pain and to adopt strategies for living, which allow them to lead as fulfilling and independent lives as possible. This is to be achieved throughout the pathway beginning with the integrated provision of supported self-care, optimised medical therapy delivered in primary care at the onset of pain and onward referral to a community pain service which will provide a bio-psychosocial assessment of pain and collaborative management with appropriate specialists.

1.7 Objectives

The objectives of the new service are to:

• Act as a single point of access for patients with chronic pain.
• Support the referring clinician/health professional in identifying and actively managing patients at high risk of chronic pain becoming chronic.
• Provide a bio-psychosocial assessment to patients referred with chronic pain (i.e. of at least 3 months duration).
• Use shared decision making to deliver support and programmes to patients living with chronic pain enabling them to understand and come to terms with their pain.
• Enable patients to take ownership and to adopt strategies of living, which allow them to lead as fulfilling and independent lives as possible with less reliance on the health care system.
• Educate and support other health care professionals in the early intervention of pain management techniques and encourage collaborative and cross boundary working with other contracted parties.
• Reduce elective care activity within acute hospital setting.

1.8 Expected Outcomes

The service will deliver and evidence the following key outcomes:

• Quantifiable improvements in the patient’s perception of their pain.
• Evidence of patients self-managing their condition.
• A reduction in the use of medication (if appropriate) and/or optimisation of medication use.
• Fewer patients in the west of Suffolk requiring referral onto secondary care pain (internal service referral and GP referral) through earlier recognition and management of patients developing chronic pain.
• A positive outcome in their physical, psychological and/or social needs.
• An increase in individual’s self-reported levels of physical and social functioning in society.

1.9 Service Description

A three tier model of care has been developed for the patients in West Suffolk and is shown below.
2.1 **Tier 1 – Primary Care** *(For information only and is not part of the specification)*

Primary care services – Patient primarily supported by GP. First line advice and treatment consisting of:

- Assessment of pain symptoms and pain flare-ups and changes in physical function and/or emotional distress.
- Bio-psychosocial assessment.
- Encourage self-management through education and support including community pharmacists.
- Diagnostic tests including diagnostic imagining.
- Medicines optimisation for the patient supported by the West Suffolk Pain Medication Ladder (Appendix 4).

Referral to tier 2 services should occur where the patient reports increasing pain intensity and distress +/- or worsening physical disability and deteriorating emotional role functioning, or the referral criteria (as set out at Section 4.3 of this service specification) for the CPMS are met. The detailed tier 1 Primary Care agreed pathway can be found in Appendix 1.

The level of initial pain consultations with GPs is expected to remain unchanged. GPs will manage patients in line with the new tier 1 pathway (Appendix 1).

Patients whose pain persists for duration of greater than 3 months,

Patients of less than 3 months where the GP may need additional support can be referred into the community pain management service following the referral criteria for advice and guidance (as set out in section 4.3 of this service specification).

2.2 **Tier 2 – Community Pain Management Service (CPMS)**

Referrals sources are set out in Section 4.4. All referrals into the service shall be triaged by a Nurse Consultant. Following triage, the patient will be placed with the most appropriate member of the community pain management service (CPMS) depending on the individual needs of the patient. Patients meeting the criteria for tier 3 will be directly referred into secondary care.

CPMS will work together in a multi-disciplinary approach to deliver services which may include medication management, physiotherapy, psychological support education and promoting self-management techniques. Patients will be signposted and supported to contact other agencies such as Wellbeing Service or Job Centre Plus.
A treatment plan (pain management plan) will be agreed in collaboration with the patient and any education and support delivered through a community based programme.

The service will be provided as a minimum for 5 operational days (Monday – Friday between the hours of 9:00-17:30 excluding bank holidays) each week and provide the following:

- Daily triage.
- Daily 1:1 clinics including medication management and provision of Transcutaneous Electrical Nerve Stimulation (TENS) instruction/review where appropriate.
- Daily telephone clinics.
- Daily SOS appointment slots to meet patient need.

The service will also provide:

- Regular pain management education sessions to meet patient needs (see Appendix 5).
- Multi-disciplinary team (MDT) meetings as required but on at least a monthly basis. The MDT team will consist of all of the Healthcare Professionals (HCP) Groups of staff as set out at section 3.4 of this service specification.

2.3 The Role of the CPMS

The key areas for which the CPMS will have responsibility include:

- Integration of service provision at the acute/community interface, and to further develop services at this interface.
- Provision of a triage process providing assessment to patients within 3 operational days of receipt of referral for routine referrals and within 1 operational day for urgent referrals.
- Delivering evidence based pain management education for patients based on improving person centred outcomes specific to the individual.
- Provision of SOS appointments to patients discharged from West Suffolk Hospital NHS Foundation Trust Emergency Department (ED) and supporting departments. Referral criteria are to be developed and agreed within three months of contract commencement and these discussions will be initiated by the Provider. Such appointments are to be provided by the CPMS within 1 operational day of discharge to prevent re-admission to hospital with chronic pain.
- Supporting the discharge of patients from West Suffolk Hospital Pain Clinic (criteria to be developed within one month after contract commencement) to maintain self-management and confidence with pain management techniques.
- Promotion of the use of community based assessment tools in conjunction with the MDT.
- Providing leadership and advisory support to Primary Care and community services (including GP’s).

2.4 Secondary Care Tier 3 (For information only-not part of the specification)

Tier 3 services will be accessed via the CPMS (tier 2) for elective patients. These treatments are hospital based and are aimed at patients with severe debilitating pain and patients for whom Tier 2 services are either not appropriate or the tier two service have agreed the need to onward referral. These will include:

- Identification of a patient who is failing to progress through the agreed pathway and an MDT discussion has taken place concluding that there is need for secondary care interventions/education;
- changes in presenting pathology that necessitates MDT discussion and onward referral;
- concerns based on clinical judgement by the Health Care Professional (HCP) managing the patient that requires MDT discussion and onward referral and
- referrals triaged with a suggested diagnosis of Complex Regional Pain Syndrome (CRPS) and facial pain with anorexia.

2.5 Whole System Relationships and Interdependencies
The service shall offer an integrated model of service delivery and should fully utilise the skills of other providers to provide a high quality service.

The table below highlights some of the key relationships and how these could be utilised.

<table>
<thead>
<tr>
<th>Provider/key relationships</th>
<th>How utilised</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP’s</td>
<td>Working with GP’s and other health care professionals to ensure quality of referrals/good understanding of the service and how GP’s can actively manage patients once discharged.</td>
</tr>
<tr>
<td>MSK service</td>
<td>Establishing close links so that referrals are directed from MSK services appropriately and timely ensuring patients and their GP understand patients’ transfer of care.</td>
</tr>
<tr>
<td>Secondary Care Service Providers</td>
<td>Establishing close links so that any specialist pain interventions needed for the patients can be conducted quickly when transferred into secondary care and ensure step-down services from secondary care.</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Establishing close links with wellbeing and mental health services, drug and alcohol services where necessary.</td>
</tr>
<tr>
<td>Independent Sector e.g. gyms</td>
<td>Establishing links with independent sector providers, working with them as part of care to deliver parts of the pathway not within capacity of the service e.g. access to gym equipment/swimming pools etc.</td>
</tr>
<tr>
<td>Local Authority e.g. leisure services/benefits</td>
<td>Establishing links with local authority to facilitate and support packages of care to deliver parts of the pathway not within the capacity of the service e.g. access to gym equipment/swimming pools and utilising the range of services the Local authority (LA) have at their disposal, benefits/advise etc.</td>
</tr>
<tr>
<td>Employment advice services</td>
<td>Establishing links with benefits/employment agencies to ensure pain is not a barrier to returning or finding employment.</td>
</tr>
<tr>
<td>External pain/patient support groups</td>
<td>Using external support groups (with different expertise in pain conditions) to compliment the pathway of care and ensure patients have access to longer term support.</td>
</tr>
<tr>
<td>Voluntary Community Sector e.g. Tai Chi classes</td>
<td>Establishing links with relevant sector organisation to complement the pathway of care and ensure patients have access to longer term support.</td>
</tr>
<tr>
<td>Complementary therapies</td>
<td>Establish links with independent sector providers locally to deliver parts of the pathway not within the capacity of the pathway.</td>
</tr>
</tbody>
</table>

The CPMS will work in a multidisciplinary method in order to achieve optimum outcomes for each patient. This will require the development of collaborative working relationships and communication protocols (and associated processes, including clear line of Clinical Governance, Management Accountability, and Information Governance) with other local services including:
- West Suffolk Hospital NHS Foundation Trust pain management consultants and other health professionals;
- Cambridge University Hospitals Trust (Addenbrookes) and other health professionals;
- Suffolk Community Healthcare (SCH/Serco Ltd);
- musculoskeletal services;
- General Practitioners including local MDT delivery teams;
- Social care services (provided or commissioned by Suffolk County Council);
- West Suffolk CCG
- Norfolk and Suffolk Foundation Trust;
- Department of Work and Pensions.

The Provider will need to ensure pathways of care provide high quality levels of care with clear clinical governance arrangements including referral mechanisms.

The service will have access to electronic patient results for x-ray, phlebotomy, MRIs and other diagnostic tests to support a fully informed decision of management and patient acceptance. The Provider shall be responsible for ensuring a manual system is in place in the interim, if required.

2.7 Integrated Care Pathways

This service(s) will be interdependent of secondary care pain service providers and community providers therefore; the Provider should ensure it has a clear understanding of all the services available to patients with chronic pain. The Provider must establish strong integrated operational links with each service to ensure collaborative working and seamless pathways for patients.

2.8 Relevant Clinical Networks and Screening Programmes

The Provider will actively participate as a full member in all relevant clinical networks, including those already existing and those developed during the time of the contract.

2.9 Sub-contractors

The Provider shall be the prime contractor for the community pain management service. Sub-contracting where required, shall be undertaken under the terms and conditions of the contract.

2.10 Communication

The Provider will be responsible for developing and maintaining a website of pain resources for professionals and patients, developed in conjunction with local providers and the WSCCG.

Within the first month of service commencement, the Provider will develop and distribute a patient leaflet detailing the service, opening hours and access routes including contact details to key contacts such as GP Surgeries, community providers, acute hospitals, the mental health services Provider (NSFT) and physiotherapists. The Provider shall also offer guidance for patients on managing chronic pain as developed with the local chronic pain support group and WSCCG.

This service will be provided through a partnership model; this service design has been specifically developed to facilitate integrated working across the community/primary care and acute trust interface. The Provider is expected to establish and maintain strong working relations with all relevant providers and stakeholders.

3.1 Service Intervention

The CPMS is a ‘step-up’ elective service for GPs, Physiotherapists and BANS and a ‘step down’ elective service from the pain clinic (tier 3).
The community pain service shall provide the following:

- A paper based or electronic triage of all referrals by the nurse consultant of patients whom have had pain of longer than 3 months duration and where interventions in primary care / MSK have failed. Triage will take place within three Operational Days of receipt of referral for routine referrals and within one Operational Day for urgent referrals. Urgent referrals protocols will be developed by the Provider although the Commissioner expects that this will include patients whose symptoms are severe and would otherwise be urgently referred as an elective patient to secondary care (excluding red flag patients where admission is entirely appropriate). These will be developed with one month of service commencement and shared with the Commissioner for sign off.
- Triage of all referrals from the secondary care provider pain clinic for additional support to the patient to maintain self-management.
- Triage of patients from ED within 24 hours where a patient requires pain assessment with the implementation of a management plan to prevent attendance/readmission. This applies to patients who have had 2 or more admissions to ED within 12 months with the same complaint and area of pain who have been clinically investigated and no cause found (criteria to be developed in Quarter 3).

The outcome of CPMS triage will be:

- Returned to the GP with advice from the CPMS
- Acceptance into the service
- Onward referrals to secondary care within 1 operational day of triage if required.

Once accepted into the service, patients will complete a self-assessment form which will be part of the initial assessment. (Assessment form to be generated electronically).

Patients will be offered a first appointment with one of the following healthcare professionals; GP with special interest/pain consultant, nurse consultant, pain nurses or extended scope physiotherapist. A full bio-psychosocial assessment using the Brief Pain Inventory (BPI) and EQ-5D-5L or other patient activation assessment (as agreed with the Commissioner) will take place. Patient’s expectations will be explored and discussions of realistic goals/outcomes will be reviewed within the assessment.

An individualised individual pain management plan will be developed with patient containing the patient goals and outcomes including summary of health needs, social needs, day to day management, crisis management, the agreed plan with the patient and contact details of the CPMS and other stakeholder/agencies along with any other elements that are relevant to the patient. The pain management plan that has been agreed in collaboration with patients and their health care professional will be given to the patient with a copy being sent to the GP.

All patients will be supported with education on a pain promoting a self-management approach. This will be delivered in group sessions, web based or for some patients face to face appointments.

An evidence-based education programme will be delivered to support patients on all self-management aspects of their pain along with specific exercise advice to improve physical functioning (see appendix 5 for roles of staff and list of presenting topics). The Provider should ensure these are available at a range of times i.e. including evenings/weekends.

Support and advice will also be given about work related aspects and accessing employment support services.

Health care professionals will signpost patients towards external support groups as appropriate to meet their needs.

All patients will have as appropriate regular medication reviews and full optimisation of pain medications with the nurse consultant/specialist using agreed pathways and following NICE guidelines.
Psychological support offer will be:

- Appropriate psychological therapies: Cognitive Behaviour Therapy or Acceptance and Commitment Therapy or Cognitive Analytic Therapy approaches and health training within consultations;
- guided self-help and or;
- assessment, signposting and onward referral as required.

Further complexities of psychological need will be referred to outside agencies such as Wellbeing Service or Mental Health Services.

The Provider may determine that aspects of health coaching can be delivered by the nurse and physiotherapist with the appointment of a clinical psychologist for clinical supervision. This will be based on individual patient need and health coaching requirements/support.

The CPMS will offer procedural support such as acupuncture (within the competencies of the HCP) and access to Transcutaneous Electrical Nerve Stimulation (TENS) if considered appropriate for the patient.

There will be monthly and ad-hoc multi-disciplinary meetings with a significant emphasis on self-care and progress for patients with complex needs, patient who are not making expected progress or for patients who the health profession has concerns.

If available within the local health system, health care trainers can support the needs of patients in the community and encourage patients to work alongside their Pain Management Plans. They can be the first point of contact for patients who need some basic pain management advice. This element of the service will need to be developed as the project evolves if the Provider identifies benefits from provision of health trainers.

The CPMS will have access to ‘complementary therapies’ and/or work closely (or in partnership) with other agencies to offer patients a range of choices to assist in the management of their pain and symptoms (gymnasiums, yoga centres etc.) The CPMS will support correct identification of patients and subsequent referral sources to follow the correct pathway.

For patients referred to the service who are already known or under the care of the substance misuse service, the CPMS will be expected to liaise with these services to ensure consistency of treatment and management approach (each case should be considered individually and consent issues need to be discussed). This will be reflected in the Pain Management Plan, if applicable.

The patient’s treatment pathway (start to discharge) within the CPMS should not exceed six months although patients/other HCP’s may be supported by the service for a further 12 months after completion of the Pain Management Plan.

All patients who are unable to progress with their Pain Management Plan will be discussed at MDT. The CPMS are able to liaise or refer directly on to secondary care services when clinically appropriate though the use of Choose and Book including the advice and guidance or by contacting the service directly by email or telephone as appropriate. Provision of this tier two service is however, expected to result in a reduction of elective activity within secondary care settings. This will primarily be within secondary care Pain specialty but also within Rheumatology and Trauma & Orthopaedics. The quality requirement regarding reduction in secondary care elective activity set out within this specification below relates solely to pain services in the first instance. The Commissioner will also monitor activity within T&O/Rheumatology with an expectation that there will also be a reduction of first outpatient activity within these specialties for pain related referrals.

The CPMS would be expected to provide telephone support/advice to GPs and community allied health professionals via the nurses and directed to the appropriate person as determined by the nurse. This service will be available during operational hours as set out at Section 4.2 of this service specification.
Some aspects of pain management education can be supported through web-based courses which will need to be linked into the service delivery and specifically referred to in the patients Pain Management Plan where relevant.

The detailed tier 2 CPMS agreed pathway can be seen in Appendix 2

This service(s) will be interdependent with secondary care pain service providers and the MSK service. The Provider should therefore ensure it has an effective understanding of all the providers working within the chronic pain pathway(s) and be able to establish operational links with each service to ensure smooth transfers of patients, via the GP’s.

### 3.2 Training and Education

The CPMS is expected to maintain continuing professional development of all staff as required and support local training and medical education as community care providers. This will be in addition to roles outlined in section 2.3.1.

The service shall:
- Provide appropriate levels of access to training, education and research for the staff it employs in order to maintain competence and excel in being able to offer a community based services to a high quality;
- Provide education and training to others involved in delivery of further service elements for pain conditions, especially clinicians such as GPs, so that a fully integrated MSK and pain management model is maintained, developed and adopted.

### 3.3 Professional Qualifications and Governance

The Provider shall meet all necessary information and clinical governance standards, in particular NICE guidelines, NHS standards and the British Pain Society or other relevant, accredited bodies.

The Provider shall ensure:
- All clinicians shall have current professional clinical registration relevant to their role.
- They are a member of the British Pain and/or other relevant bodies.
- They are able to demonstrate an appropriate level of clinical education and specialisation in pain management.
- They carry adequate professional indemnity for the duration of the contract.

### 3.4 Staffing Requirements

The following staff are seen as key to the service and are required to be employed within the service to fully deliver the specification. All clinical staff are required to be trained to provide appropriate psychological support (CBT, ACT, or CAT) and health training

- GP with Special Interest in pain or Consultant in pain;
- Nurse Consultant with demonstrated and extensive experience in pain services and evidence of continuing further development focused on pain management;
- Pain Specialist nurses;
- Extended Scope Physiotherapists with demonstrated and extensive experience in pain and evidence of continuing further development focused on pain management;
- Clinical Psychologist with demonstrated and extensive experience including in pain management and evidence of continuing further development including pain management;
- Administration;

### 4.1 Geographic coverage/boundaries

Patient’s registered with a West Suffolk CCG practice.
4.2 Location(s) of Service Delivery for Community Model

WSCCG require services to be provided in community settings across West Suffolk. The Commissioner will need assurance that there is sufficient access to the service for patients.

The pain education programme should be provided in a range of locations across West Suffolk.

The service will operate, as a minimum, between the hours of 9 am-5.30 pm Monday – Friday, excluding bank holidays. For the avoidance of doubt this will be referred to as an Operational Day.

4.3 Referral criteria & sources

Access Criteria:

Initial access into the CPMS shall be via the West Suffolk GPs, Physiotherapists or secondary care based on the following criteria:

- Diagnosis made by referring clinician and provided.
- Pain experienced for longer than 3 months/ or from advice within CPMS when a patient has significant pain preventing sleep, work and has been maximally treated in primary care with medication as described in the pain medication ladder (Appendix 5).
- Investigations undertaken by the referring GP to ensure diagnosis is of chronic non-malignant pain.
- Not receiving care/ treatment from an alternative pain team/provider for the same problem unless considered appropriate and core to the patients Pain Management Plan.
- Patients must be a minimum of 18 years old.
- Pain must be of benign origin, present most of the time with varying intensity.
- Patients that have been through a full pain management programme e.g. Bath or Input within the last 5 years will be considered case by case at MDT discussion.
- Patients with on-going litigation may not be suitable but should be reviewed case by case at MDT meetings.
- Patients should be medically stable.

Exclusion Criteria including Red Flags:

- Patients with an MSK condition that have not been triaged by MSK service (Patients do not need to have had a full Pain Management Plan within this service if early access is deemed appropriate).
- Known pathology requiring further investigation.
- Suspected cancer or cancer related pain.
- Palliative pain.
- Complex regional pain syndrome.
- Facial pain with anorexia.
- BANS patients with pathology unsuitable for surgical intervention.
- Post-operative or post traumatic complications.
- Suspected Fracture/Infection.
- Cauda Equina Syndrome or other condition requiring emergency treatment.
- Patients receiving care from another pain management service.
- Patients under 18 years of age.
- Patients not registered with a West Suffolk CCG GP.
- Patients requiring a surgical opinion.

4.4 Accessibility/acceptability

Referral Sources:

- GP’s in West Suffolk Clinical Commissioning Group.
- Community MSK services.
• Back and Neck Service (BANS).
• Secondary care pain management service.
• WSFT ED and supporting departments (using criteria to be developed with local providers and the Commissioner).

For clinical safety reasons, self-referral by patients is not an option and accordingly the Provider shall not accept self-referrals.

Patients having been initially referred by one of the above health professionals and within a period of 12 months after being discharged from the service as per their agreed management plan

The content of the self-assessment form will be co-produced with the Commissioner and voluntary group during the mobilisation period

The Provider will use electronic record systems that can be integrated with other providers and the use of national electronic systems such as Choose and Book and its replacement e-Referral. The patient self-assessment form should be available in both electronic and paper copies and will need to link into the electronic systems for the service.

Patients will be discharged back to their GP with support offered from the CPMS for 12 months or referred into secondary care. Any appointment with a patient within 12 months of a previous appointment will be considered a follow up.

Patients should be discharged to their GP with a clear pain management plan. This should include clear information on how to self-manage their condition, how to access services in the community and how to gain future access to this service, as appropriate.

Patients will be referred into secondary care when:
• The CPMS identifies the need for Secondary Care at triage or at MDT for a specific reason such as consideration for nerve blocks or intensive rehabilitation.

4.5 Notification Letter

The Provider will inform the patient's referrer/secondary care when onward referral (and copied to the patients GP if s/he is not the referrer) on each occasion that the patient is seen in the service by issuing a Notification Letter within 3 operational days of the contact with the patient. The Notification letter shall be generated electronically using a template agreed with the Commissioner and contains relevant information and as a minimum shall cover:
• Patient's name, date of birth and NHS number
• Summary of treatment
• Outcome of treatment
• Pain management plan (treatment plan or recommendations for management).
• Any changes in medication including details of any medications that have been stopped giving the reason why

4.6 Discharge processes

The Provider will issue a discharge summary to the patients referrer (and copied to the patients GP if s/he is not the referrer) through e-transfer and provide a paper copy to the patient.

The discharge summary shall include a copy of the pain management plan, if relevant, and be sent to the GP/referrer within 3 Operational Days of discharge. The discharge summary will clearly specify any actions required to be undertaken by the GP/referrer at the top of the form and will contain as a minimum the following information:
• Date of admission into service.
• Date of discharge.
• Summary of treatment.
• Medication changes prescribed.
• Patient management plan.
• Name of responsible clinician/key worker at the time of the service user discharge.
• Details of any onward referral to another service.

All notification letters and discharge summaries including any Pain Management Plans will be created in SystmOne and the Provider is responsible to agree with representatives from each GP Practice within WSCCG and other providers whether they wish to receive this information through SystmOne or by NHS mail. If the Provider does not have access to SystmOne then a plan will be submitted to the Commissioner within the first quarter of service commencement to ensure adoption or suitable alternative.

A minimum of 14 days medication/dressings/appliances/feeds will be provided to the patient on discharge.

4.7 QUALITY REQUIREMENTS

<table>
<thead>
<tr>
<th>7. Quality and Performance Indicators</th>
<th>Threshold</th>
<th>Method of Measurement</th>
<th>Consequence of Breach</th>
<th>Reports Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in Elective Secondary Care (total Inpatient Speciality 191 Pain; within the following Providers):</td>
<td>a) Greater than a 50% reduction from 13/14 baseline activity: Maximum of 34 total Inpatient episodes/ month b) Greater than a 30% reduction from 13/14 baseline activity: Maximum of 50 total Inpatient episodes/ month c) No reduction from baseline – activity 67 total Inpatient episodes/ month</td>
<td>SUS /DESCRO and Provider return) In-patient episodes-Pain Management Speciality code 191 for Provider: West Suffolk CCG patients only accessing Provider organisations: Monthly</td>
<td>a) no consequence b) 2% deduction from monthly payments c) 5% deduction from monthly payments</td>
<td>The Provider shall be exempt to the Consequence of Breach for the first 3 months of the Contract delivery</td>
</tr>
<tr>
<td>Reduction in Secondary Care total Outpatient First attendances (Speciality 191 Pain: within the following Providers)</td>
<td>a) Greater than a 50% reduction from 13/14 baseline activity: Maximum of 26 total Outpatient First attendances / month</td>
<td>a) no consequence</td>
<td>b) Greater than a 30% reduction from 13/14 baseline activity: Maximum of 52 total Outpatient First attendances / month</td>
<td>b) 2% deduction from monthly payments</td>
</tr>
<tr>
<td>West Suffolk Hospital Foundation Trust</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cambridge University Hospital Foundation Trust</td>
<td>Outpatient first attendance - Pain Management Speciality code 191 for Provider: West Suffolk CCG patients only accessing Provider organisations: Monthly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ipswich Hospital Trust</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Norfolk and Norwich University Hospital Foundation Trust</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colchester Hospital University NHS Foundation Trust</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Royal National Orthopaedic Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mid Essex Hospital Services NHS Trust</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non Contract Activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Percentage of patients having a BPI, EQ-5D-5L and or other patient activation measure (as agreed with the Commissioner) on entry and on discharge from the service who reported an improvement in their scores.

| a) >75% of Patients reporting an improvement in scores (of a sample size which must be 90% of referral activity) | Monthly Provider monthly survey/ and or British Pain Inventory and EQ-5D-5L (or agreed equivalent) | a) no consequence of breach | b) 2% deduction from monthly payments | c) 5% deduction from monthly payments | The Provider shall be exempt to the Consequence of Breach for the first 3 months of the Contract delivery |
| b) 65%-75% of Patients reporting an improvement in scores (of a sample size which must be 90% of referral activity) | | | | | |
| c) <65% of Patients reporting an improvement in scores (of a sample size which must be 90% of referral activity) | | | | | |

<p>| Percentage of patients waiting 3 Operational Days or less (from Monthly Provider return) | 98% | GC9 | | | | |</p>
<table>
<thead>
<tr>
<th>Category</th>
<th>Target %</th>
<th>Frequency</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of patients waiting 1 Operational Days or less (from receipt of referral) for routine triage by the CPMS service</td>
<td>98%</td>
<td>Monthly Provider return</td>
<td>GC9</td>
</tr>
<tr>
<td>Percentage of patients waiting 1 Operational Days or less (from receipt of referral) for urgent triage by the CPMS service</td>
<td>98%</td>
<td>Monthly Provider return</td>
<td>GC9</td>
</tr>
<tr>
<td>Percentage of patients triaged from Secondary Care Emergency Department (ED) within 1 Operational Day of discharge/referal</td>
<td>98%</td>
<td>Monthly Provider return</td>
<td>GC9</td>
</tr>
<tr>
<td>Referral shall be for patients who have had 2 or more admissions to ED within 12 months with the same complaint and area of pain who have been clinically investigated and no cause found (detailed criteria to be developed in Month 1 to support a reduction in readmissions).</td>
<td></td>
<td></td>
<td>The Provider shall be exempt to the Consequence of Breach for the first 6 months of the Contract delivery</td>
</tr>
<tr>
<td>Percentage of patients waiting 4 weeks (20 Operational Days or less) for their first face to face clinical assessment/treatment following completion of routine triage</td>
<td>95%</td>
<td>Monthly Provider return</td>
<td>GC9</td>
</tr>
<tr>
<td>Percentage of patients waiting 1 Operational Days or less for their first face to face clinical assessment/treatment following completion of urgent triage</td>
<td>98%</td>
<td>Monthly Provider return</td>
<td>GC9</td>
</tr>
<tr>
<td>Percentage of first follow up appointments taking place no later than 4 weeks after initial direct contact clinical assessment/treatment</td>
<td>95%</td>
<td>Monthly Provider return</td>
<td>GC9</td>
</tr>
</tbody>
</table>

This Quality Requirement only applies to those patients who are not accessing and/or who have been
<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Target</th>
<th>Frequency</th>
<th>Reporting</th>
<th>Consequence of Breach</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percentage of patients waiting less that 4 weeks (20 Operational Days) to commence Pain Management Programme (sessional) from date referred</td>
<td>98%</td>
<td>Monthly</td>
<td>Provider return</td>
<td>GC9</td>
</tr>
<tr>
<td></td>
<td>Percentage of Notification Letters sent to GPs / referrer/ secondary care within 3 Operational Days of contact with the patient</td>
<td>95%</td>
<td>Monthly</td>
<td>Provider return</td>
<td>GC9</td>
</tr>
<tr>
<td></td>
<td>Percentage of Discharge Summaries/ sent to GPs / referrer/ secondary care within 3 Operational Days of discharge</td>
<td>95%</td>
<td>Monthly</td>
<td>provider return</td>
<td>GC9</td>
</tr>
<tr>
<td></td>
<td>Percentage of patients who are re-referred into the service within 3 months after discharge</td>
<td>Maximum of 10% of all patients discharged</td>
<td>Monthly</td>
<td>Provider return</td>
<td>GC9</td>
</tr>
<tr>
<td></td>
<td>Percentage of patients with chronic pain that receive an appointment within the CPMS SOS service within 24 hours (1 Operational Day) of discharge from Secondary care</td>
<td>95%</td>
<td>Monthly</td>
<td>Provider return</td>
<td>GC9</td>
</tr>
<tr>
<td></td>
<td>The Provider shall be exempt to the Consequence of Breach for the first 6 months of the Contract delivery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Experience:</td>
<td>Percentage of Patients reporting having a positive outcome in either their physical, psychological or social needs</td>
<td>75% (of a sample size which must =&gt;50% of referral activity)</td>
<td>Quarterly</td>
<td>Provider survey</td>
<td>GC9</td>
</tr>
<tr>
<td>Patient Experience:</td>
<td>Patients reporting that they feel more in control in the use of medication and are compliant in the</td>
<td>75% (of a sample size which must =&gt;50% of referral activity)</td>
<td>Quarterly</td>
<td>Provider survey</td>
<td>GC9</td>
</tr>
</tbody>
</table>
### Patient Experience

Percentage of patients followed-up 6 months after discharge from CPMS who report an increase in their levels of physical and social functioning in society compared to when entered in to service

<table>
<thead>
<tr>
<th>Percentage of patients followed-up 6 months after discharge from CPMS who report an increase in their levels of physical and social functioning in society compared to when entered in to service</th>
<th>Quarterly Provider survey</th>
<th>GC9</th>
</tr>
</thead>
<tbody>
<tr>
<td>75% (of a sample size which must =&gt;50% of referral activity)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Participation in Group Education courses to promote self-management of pain.

- **a)** 95% of patients to be offered opportunity to participate in group Pain Education Programme
- **b)** 50% of patients who are offered, undertake a face to face group Pain Education Programme
- **d)** 95% of patients who accept a referral to a group Pain Education Programme who complete the prescribed course

<table>
<thead>
<tr>
<th>Monthly Provider return</th>
<th>GC9</th>
</tr>
</thead>
</table>

### 9. Prices & Costs

<table>
<thead>
<tr>
<th>Estimated First outpatient activity Year 1</th>
<th>1092</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ratio of Nurse First</td>
<td>0.3</td>
</tr>
<tr>
<td>Ratio of Physician First</td>
<td>0.2</td>
</tr>
<tr>
<td>Ratio of Psychological First</td>
<td>0.2</td>
</tr>
<tr>
<td>Ratio of Physiotherapist First</td>
<td>0.3</td>
</tr>
<tr>
<td>F:FUP ratio (other excl. group activity)</td>
<td>4.0</td>
</tr>
<tr>
<td>F:FUP ratio (Physician)</td>
<td>2.0</td>
</tr>
<tr>
<td><strong>Group Activity (additional to activity specified above)</strong></td>
<td></td>
</tr>
<tr>
<td>Percentage of 1st outpatients attending group activity</td>
<td>50%</td>
</tr>
<tr>
<td>Max number of patients in group</td>
<td>15</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>----</td>
</tr>
<tr>
<td>Time per session including set up (hours)</td>
<td>5</td>
</tr>
<tr>
<td>Number of sessions per programme</td>
<td>6</td>
</tr>
<tr>
<td><strong>Patient time excl. MDT and triage and including any direct patient administration</strong></td>
<td><strong>minutes</strong></td>
</tr>
<tr>
<td>Medical (Nurse and Physician):</td>
<td></td>
</tr>
<tr>
<td>First Appt</td>
<td>40 minutes</td>
</tr>
<tr>
<td>F:UP</td>
<td>30 minutes</td>
</tr>
<tr>
<td>Psychology:</td>
<td></td>
</tr>
<tr>
<td>First Appt</td>
<td>40 minutes</td>
</tr>
<tr>
<td>F:UP</td>
<td>40 minutes</td>
</tr>
<tr>
<td>Physio:</td>
<td></td>
</tr>
<tr>
<td>First Appt</td>
<td>40 minutes</td>
</tr>
<tr>
<td>F:UP</td>
<td>30 minutes</td>
</tr>
</tbody>
</table>

Note: The time excludes any triage, MDT and advice and guidance time.
APPENDIX ONE - References


Clear guidance for what is required to deliver an effective pain self-management support programme.


11. Multi-morbidity in Scotland, The Scottish School of Primary Care’s Multi-morbidity Research Programme. The Scottish School of Primary Care.


13. National Pain Audit. Phase 1 Report: Organisational Audit of NHS Chronic pain Services, British Pain Society and Dr Foster Intelligence


Department of Health (2009) ` Annual report of the Chief Medical Officer`


Dr Foster (2004) ‘Adult Chronic Pain Management Services in Primary Care’.

NICE (2009) CG88 Early management of chronic low back pain. (Currently under review)


The British Pain Society and Royal College of General Practitioners (2008) A case of neuropathic pain
Appendix 2a

Community Pain Service

Patients referred from primary care should have had their cause for pain thoroughly investigated and appropriate analgesics trialled. Consider the 4 “D”s as pain is likely to become chronic/chronic and/or persistent and these patients may benefit from earlier intervention from the community service. Patients should be encouraged to treat any significant pain whilst investigations are being performed.

Patient presents with pain

History and examination
- Somatic pain
- Neuropathic pain
- Nociceptive pain
- Visceral pain

Where possible treat cause for pain

Treat with appropriate analgesics as per pain ladder. Consider mixed pain.

Investigations as appropriate
- To explore cause for pain
- Refer to appropriate specialty if diagnostic uncertainty

Investigations complete
- Provide on-going review of pain medications

Musculoskeletal pain

Physiotherapy
- Provide on-going review of pain medications

Serious pathology suspected
- Investigate and refer as appropriate

Pain persists > 2 weeks

Check compliance / side effects
- Manage patient expectations

Non-musculoskeletal pain

Continue primary care management & r/v in 2wks

• Pain persists > 3 months
• *Analgesia escalated in line with west Suffolk pain medication ladder
• Depression
• Disability
• Drug use
• Diagnostic uncertainty

Criteria not met

Refer to Community pain management service for assessment

Refer to secondary care pain clinic if:

Facial pain and anorexia or

Chronic regional pain syndrome

Consider the 4 “D”s: Depression, Disability, Drug use problematic, Diagnostic uncertainty.

If these are present then the pain is more likely to become chronic/chronic and/or persistent and earlier referral to the pain community service may be required.
Serious pathology suspected
May include acute medical conditions such as:
Ischaemia: MI / PE, Acute peripheral Ischaemia
Infection
Acute Abdomen
Metastasis

Urgent referral may also be required for psychiatric morbidity such as severe mental health issues.

Pain should be treated alongside these

4 “A”s Principles of on-going analgesic therapy

**Analgesia** – is the medicine still providing useful pain relief?

**Adverse effects** – What side effects are being experienced and can these be managed more effectively?

**Activity** – does the patient maintain suitable physical and psychosocial functioning?

**Adherence** – is the patient taking medication as agreed in the management plan?

---

Not suitable for Community pain management service

**Spinal pain (Should be referred to BANS)**

**Cancer pain / palliative pain control**

**Possible fracture / injury / infection**

---

www.paintoolkit.org

www.arthritis.org

www.nationalmigrainecentre.org.uk

www.fibromyalgia-associationuk.org
<table>
<thead>
<tr>
<th>Study</th>
<th>Cohort</th>
<th>Prevalence of chronic pain</th>
<th>Estimated WSCCG population with chronic pain.</th>
</tr>
</thead>
</table>
| Elliot et al (1999)                            | Sample drawn from general practices. 43% practices. 5036 patients age >25. | General population = 46.5% (95% CI 44.8 – 48.2). | Male – 41,859 (39,707 – 44,017)  
|                                                |                                                                        |                                             | Female – 46,295 (44,112 – 48,470)          |
|                                                |                                                                        |                                             | Adults - 88,187 (79,349 – 93,979)          |
| Health Survey for England (HSE) Volume 1, Chapter 9 (2011) | Sample of the UK adult population                                      | Men 30.9% (95% CI 29.1%– 32.6%)  
Women 37.5%(95%CI 35.9% – 39.1%) | Male – 30,434 (28,661–32,109)  
Female – 38,201 (36,571–39,831)  
Adults – 68,224 (65,232–71,939) |
| The Pain in Europe Survey (PIE). Breivik et al, (2006) | 46,324 respondents undertaken in 2003 across 15 European countries and Israel. | Europe 19% (range 12% to 30%)  
UK 13% (95%CI 12% - 14%) | Adults – 24,347 (22,414 - 26,419) (based on UK responses) |
### Pain Ladder (non-cancer)

**Guidance on analgesic choice for adults in primary care**

<table>
<thead>
<tr>
<th>Acute pain</th>
<th>Chronic pain</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Short-term pain &lt;3 months</strong></td>
<td><strong>Continuous, long-term pain &gt;3 months</strong></td>
</tr>
</tbody>
</table>

#### MILD PAIN

**Paracetamol** [1g QDS oral/rectal]

- +

**Ibuprofen** [400mg TDS oral/5% gel TDS topical] OR **Naproxen** [250–500mg BD oral]

Consider a proton pump inhibitor in patients at increased risk of gastrointestinal adverse effects with an NSAID**

As for Mild pain +

Consider possibility of neuropathic/mixed pain; treat with neuropathic agent as appropriate (see overleaf) +/

**Morphine sulphate***

Oral solution/immediate-release tablets

- [moderate pain: initially 2.5–5mg 4-hourly; severe pain: initially 5–10mg 4-hourly]
- For up to 5 days or for occasional use <3 days/week

#### MODERATE TO SEVERE PAIN

In patients intolerant of morphine consider:

**Oxycodone hydrochloride***

Oral solution/immediate-release capsules

- [moderate pain: initially 1.5–3mg 4–6 hourly; severe pain: initially 3–5mg 4–6 hourly]
- For up to 5 days or for occasional use <3 days/week

- If regular opioid required, convert to equivalent modified-release 12-hourly preparation
- If pain remains poorly controlled, or if opioid dose increases >60mg/24hours morphine equivalent, review diagnosis and treatment plan and seek advice if necessary; opioid dose >120mg/24hours morphine equivalent should only be prescribed on the advice of the specialist pain service

**Diclofenac sodium** suppositories

- [75-150mg daily in divided doses]
- Consider for short-term use as an alternative to ibuprofen or naproxen for severe acute pain

**Buprenorphine** transdermal patches

- Only for severe chronic pain in patients with severe dysphagia or on advice of specialist pain service; not suitable for rapid dose titration or acute pain

- Pain should respond to an opioid within 48 hours, & to other treatments within 6 weeks; ineffective medicines should be stopped, diagnosis reviewed & alternative treatment sought
- During long-term treatment, review patient at least monthly for the first 6 months after stable dosing achieved
- Seek advice on dose adjustment before prescribing to patients with renal or hepatic impairment, and on dose equivalence if switching opioids
- Fentanyl preparations are not recommended for initiation in primary care & should generally be reserved for palliative care (risk of serious adverse effects & inappropriate use of transdermal preparations has caused fatalities)
- Cost-effective preparations should be prescribed

---

* Alternatives to morphine/oxycodone in moderate pain

**Morphine sulphate***

Oral solution/immediate-release tablets

- [moderate pain: initially 2.5–5mg 4-hourly; severe pain: initially 5–10mg 4-hourly]
- For up to 5 days or for occasional use <3 days/week

**Codeine phosphate** [oral, 30–60mg QDS]

- Contra-indicated in all patients of any age known to be ultra-rapid metabolisers of the CYP2D6 enzyme
- Metabolism to morphine can vary significantly & ultra-rapid metabolisers have a marked increase in toxicity
- Abrupt withdrawal precipitates a withdrawal syndrome (especially if used at high doses for >2 weeks)

**Meptazinol** [oral, 200mg every 3–6 hours as required]

**Tramadol hydrochloride** [oral, 50–100mg TDS-QDS]

- Risk of serotonin syndrome with concomitant use of SSRI’s (serious & potentially fatal if undetected); symptoms include neuromuscular and autonomic hyperactivity and altered mental state

---

* Increased risk of gastrointestinal (GI) adverse effects if: on the maximum recommended dose of an NSAID, aged ≥ 65 years, history of GI bleeding/ulcer/perforation, on concomitant medicines with a risk of GI effects (e.g. anticoagulants, aspirin, corticosteroids, antidepressants), cardiovascular disease, hepatic/renal impairment, dehydration, diabetes, hypertension, prolonged NSAID use (e.g. for arthritis or chronic lower back pain in those aged over 45 years), H. pylori infection, excessive alcohol intake, or heavy smoker.
APPENDIX 5 – COMMUNITY PAIN MANAGEMENT EDUCATION PROGRAMME

All patients accepted into the CPMS from triage should be positively encouraged to attend the pain education programme.

Direct referral into the education programme from GP’s and patients will not be accepted although referrals will be accepted from the pain clinic in secondary care if it is deemed that the patient will benefit from the programme.

The purpose and benefits of pain management education will be discussed with each patient at their initial face to face appointment with their HCP and entered on their Pain Management Plan.

Before completing the education programme, all patients must agree to and accept their Pain Management Plan. Those patients who are still in conflict with acceptance should be offered additional 1:1 appointments with the clinical nurse specialist to open up and explore barriers with acceptance. If necessary, the patient may need a review appointment with the consultant/GPWSI to reinforce diagnosis.

Inclusion Criteria - Community Pain Education Programme

The pain management education programme aims to help patients with pain to understand the physiology and psychological distress this may cause. The programme focuses on improving health and wellbeing with emphasis on self-management at its core; as well as patient empowerment and minimising the impact of pain on quality of life.

Inclusion criteria

Patients will have:

- A stable analgesic medication regime
- Independence in self-care
- Willingness to contribute to a group
- Physical fitness to take part in rehabilitation and no health condition that would prevent the patient from making gains
- Willingness to risk loss of income/time-off work.(note the provider should ensure weekend/evening sessions are offered)

Exclusion criteria

- On-going medical investigations
- Current plans for surgical or injectable pain therapies
- Active suicidal ideation
- Active psychosis
- Drug or substance misuse or cognitive impairment as a result of current medication (with reduction plan carried out before programme)
- Patient diagnosed with a primary psychiatric illness or disorder that may predict disruption of treatment for themselves or others
- Primary psychological problems (also checked at multidisciplinary assessment – primary psychological problems should either be treated or resolved before taking part as they may affect ability to make gains from the programme e.g. complex bereavement response)

General guidelines
• Baseline measures will be recorded at the start and end of the programme (to be agreed with physiotherapists) using recognised assessments such as EQ 5D 5L, BPI or other patient activation measures as agreed between the provider, commissioner and Chronic Pain Support Group.
• The whole programme should be attended and those who are in employment should discuss time off from work with their employer. Note the provider should ensure weekend/evening sessions are offered.
• There will be a clinical nurse specialist present on each of the sessions who will work alongside the other members of the MDT.
• The recommended group size will be no more than 15 patients.
• Patients will be responsible for their own transport arrangements to and from the sessions.
• The pain management education sessions will be delivered over a 6 week period.
• The sessions will be held weekly and each session will last for 4 hours.

The sessions will be delivered by the MDT and roles are outlined below:

**Nurses**

• Bridge between biomedical and psychosocial aspects of pain management.
• GP and other medical liaison and referral management.
• Liaison including development and implementation of policies and guidelines with other organisations and agencies as appropriate such as medication management and infection control.
• Assessment and formulation of personal goals and personal management plan with the patient (and/or carers).
• Programme organisation.
• Using the principles of cognitive behavioural therapy (CBT) or acceptance and commitment therapy (ACT) enabling individuals to understand pain mechanisms, managing medication and side effects, sleep and stress management, relationships, relaxation, and flare-up planning.
• Healthy living promotion.
• Family/carer involvement.
• Clinical supervision.
• Educating other health professionals regarding rehabilitative pain management.
• Contributing to research and audit.

**Psychologists**

• Interpretation and application of therapeutic models including CBT, ACT and motivational techniques.
• Facilitating multidisciplinary working – consultancy, supervision, formulation and conceptualisation, understanding of systems and groups, facilitating reflection, cohesion.
• Psychopathology and psychology of normal functioning.
• Organisation, assessment and treatment.
• Patient experience perspectives.
• Skills including group dynamics, CBT, change, development and culture.
• Risk management.
• Research and audit.
• Using evaluation to support service change.

**Occupational Therapists**

• Promoting awareness of the workability of activity management strategies and providing opportunities to practise alternative approaches.
• Advice regarding work retention with patients in employment, including liaison with employers.
• Facilitate return to work interventions and signposting/liaison with appropriate agencies.

Physiotherapists

• Determine whether physiotherapy alone or Pain Management Plan is appropriate.
• Identify PMP exclusion factors including low functional level, medical instability and lack of readiness to change, including willingness to exercise.
• Deliver the exercise component within a psychological model and facilitate interdisciplinary contribution to the component.
• Assimilation of physical and psychological skills into specific activities.
• Analysis and interventions to optimise the balance between work, rest and leisure.
• Commitment to goal-orientated action and value-driven targets.
• Teaching of activity management strategies to initiate and maintain engagement in meaningful activity.
• Reassessment of change in performance following PMP intervention.
• Assess when specific exercises are required in the case of certain pathologies and prescribe appropriate programme.
• Identify and challenge barriers to exercise and rehabilitation through appropriate communication and exercise exposure.
• Apply fear avoidance models, motivational techniques and educational models.
• Education regarding pain mechanisms.
• Outcome assessment of change in physical conditioning, function and activity.
• Group supervision.
• On-going assessment of changes in physical conditioning, function and activity.
• Group supervision.
• Outcome measurement including administration of self-report questionnaires, physical function tests, video feedback, and values-specific measures, monitoring of healthcare and medication use.
• Promotion of skills development including problem solving.
• Provide advice on the appropriate use of environmental adaptations.
• Delivery of interventions that promote relaxation and stress management in daily life.
• Assessment of the impact of chronic pain on performance

Subject Sessions:

• Chronic pain-multimodal approach.
• Health and wellbeing...diet and weight.
• Relaxation.
• Deep breathing techniques.
• Explaining and understanding chronic pain.
• Principles of pacing.
• Active exercise participation.
• Goal setting completed.
• Communication and breaking the cycle of pain.
• How to communicate effectively with health care professionals.
• Stress and negative thinking...its effects on pain.
• Medication management.
• Goal practice.
• Goal reviews.
• Sleep and sleep management.
• Dealing with setbacks and flare ups.
• Ergonomics.
• Return to work....what's available to help.
• Managing negative thoughts and behaviours.
• Plan and provision for pain flares, return to work and pacing.
Follow up appointments will be given for review of progress in line with objectives/timescales set out within the individual PMPS and recording of outcomes measures as agreed with the commissioner and Chronic Pain Support Group as described previously as being an agreed patient outcome measure such as EQ 5D 5L, BPI or other patient activation measures.

Quality and Safety

Governance

The service will put in place an effective clinical governance framework. This must have in place appropriate and effective arrangements for quality assurance, continuous quality improvement and risk management.

The service shall nominate a person who will have responsibility for ensuring the effective operation of the system of clinical governance. The person nominated shall be a person who performs or manages the services.

Patient Safety, Clinical Quality and Clinical Effectiveness

The Provider will comply with national and local policies and procedures on:

- Infection Prevention and Control
- Patient Advice and Liaison (PALS)
- Complaints and compliments
- Management and reporting of all incidents, including serious incidences (SI’s) and near misses
- Never Events occurrences
- Risk assessment and risk management
- Information Governance
- Safeguarding Adults
- Data protection
- Quality Assurance/ maintaining good practice
- Clinical and Professional Development (CPD), supervision and training
- Clinical audit
- Harm Free Care
- 6C’s
- National Quality Board and NICE standards
- Adherence to the recommendations of patient safety reports both national and local. For example the Francis Inquiry (February 2013), and Berwick Review (August 2013)

In addition to the scope of the service and its aims, the Provider will ensure the following:

- All equipment used is maintained and serviced to manufacturer’s instructions.
- Quality Control and calibration of the equipment is carried out by trained staff following manufacturer’s instruction and stated limits.
- Patients and or carers receive relevant information in a format that is appropriate for the patient’s individual needs.
- Patients are satisfied with the access to the service, information given and their management.

Patient Experience

West Suffolk CCG aim to ensure that information about patient experience is used systematically to support the review of services provided to patients. We expect that the Provider will give patients the opportunity to comment on their experience of using services on an on-going basis, through patient surveys, Patient and Public Involvement work, PALS, complaints and other activities.

Safeguarding Adults
Health services have a duty to safeguard all patients and provide additional measures for patients who are less able to protect themselves from harm or abuse.

People who use services should be protected from abuse, or the risk of abuse, and their human rights respected and upheld.

To achieve this all responsible agencies and individuals must work together to prevent abuse and safeguard adults where possible, and where preventative measures fail, to deal sensitively and effectively with incidents of abuse.

The Provider shall work to the Care Quality Commission guidance Essential Standards of Quality and Safety and in particular Outcome 7, Safeguarding people who use services from abuse.

In order to comply with these requirements the Provider shall ensure:

- Senior management commitment to the importance of safeguarding and promoting the welfare of vulnerable adults
- A clear line of accountability within the organisation for safeguarding and promoting the welfare of vulnerable adults
- Safeguarding adults as an integral part of patient care
- Safeguarding measures are understood, assured and improved
- Service development that takes into account the need to safeguard and promote welfare and is informed by the views of service users, families and carers
- Effective interagency working to safeguard and promote the welfare of vulnerable adults
- They comply with either Norfolk County Council or Suffolk County Council’s policies as set out below
- Suffolk Multi-Agency Safeguarding Adults Policy (2010)

Legislative Guidance (2010)

- Suffolk County Council’s Adult Safeguarding Policy and Operational Guidance (2010)
- Arrangements for appropriate and proportional information sharing in response to safeguarding concerns.