Service Specification No.	01
Service	Community Pain Management Referral Assessment and Treatment Service (CPMRATS)
Commissioner Lead	Bassetlaw Place
Provider Lead	
Period	1st August 2022 to 31st March 2024
Date of Review	1st August 2023

1. Population Needs

1.1 Context

Whilst most pain experienced by the general population is infrequent, short-term and manageable through medication or exercise, chronic pain, that which "persists or recurs for more than 3 months", NICE Guidance 193: Chronic Pain (2021)[1], affects around a third of the UK population[2] (British Pain Society, 2022) and tends to be more persistent, significant, difficult to treat and likely to a direct impact on health outcomes.

Other literature breaks down the prevalence of "significant persistent pain" by:

- Age starting at around 23% increasing to 30% in older adults[3] (BMA, 2018); or
- Type: 14.2% for chronic widespread pain and 8.2% for chronic neuropathic[4] (Fayaz A, et al. BMJ Open 2016).

The table below shows the numbers of new patient pain referrals made to the tier 2 and tier 3 (DBTH) services over the last 3 years:

Year / Provider	Tier 2		DBTH (Tier 3)	
	Month	Year	Month	Year
2019/20	11	91 (8 months)	22	266
2020/21	4	45	15	181
2021/22	16	180	16	188

Chronic pain can be either primary or secondary and is defined by NICE Guidance 193: Chronic Pain (2021) as follows:

- Chronic primary pain has "no clear underlying cause" or the pain or its impact "is out of proportion to any observable injury or disease"[5].
- Chronic secondary pain is that which is caused by an underlying condition such as osteoarthritis[6]. Since chronic pain can be complex affecting emotional, cognitive and behavioural components, a multidisciplinary approach is recommended.[7]

Whilst chronic pain can be considered as a long-term condition in its own right; it is frequently accompanied by other long-term conditions such as diabetes, arthritis, heart disease, depression and disability, which can make the clinical management of the patient's needs complex and more difficult.

[1] https://www.nice.org.uk/guidance/ng193
[2] https://www.britishpainsociety.org/about/
[3] https://www.bma.org.uk/media/2100/analgesics-chronic-pain.pdf
[4] https://bmjopen.bmj.com/content/bmjopen/6/6/e010364.full.pdf
[5] https://www.nice.org.uk/guidance/ng193
[6] https://www.nice.org.uk/guidance/ng193
[7] https://fpm.ac.uk/sites/fpm/files/documents/2021-07/FPM-Core-Standards-2021_1.pdf

Publications over recent years have also highlighted the need for efficient primary and community care-based pain management services and NICE guidance recommends effective and timely treatment that includes advice on how patients can self-manage their condition. The 'Core Standards for Pain Management Services' paper[7] emphasises early intervention in the community and a multidisciplinary approach and use of care pathways.

NHS Bassetlaw PCB currently commission a range of pain management services across primary and secondary care, a more detailed breakdown of which can be found in section 3.3.1.

1.2 Evidence base

The British Pain Society National Audit (November 2011) describes pain as "a complex bio-psychosocial experience"[8]. Whilst most people manage their pain successfully, some require specialist input. Specialist pain services are involved with the diagnosis and management of complex pain disorders, utilising 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%.

The importance of community-based services has been a long-standing priority featuring in the White Paper 'Our Health, Our Care, Our Say: a new direction for community services'[9] which supported early intervention, improved access to community-based services, a commitment to address inequalities of care and to move services closer to peoples' homes. More recently this commitment features within the NHS Long Term Plan placing emphasis on boosting 'out-of-hospital' care dissolving "the historic divide between primary and community health services". The outcomes of these recommendations are expected to be more convenience for patients, more cost-efficient service delivery and maintained or indeed improved treatment outcomes.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Table 1: How this service contributes to the NHS Outcomes Framework Domains

Domain 1	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions**	• Ensuring people live well with chronic pain • Ensuring people feel supported to manage their own condition • Improving functional ability in people with chronic pain • Enhancing quality of life for carers • Ensuring people are able to cope emotionally, as well as physically with the impact of chronic pain
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	• Helping people with chronic pain to return to normal activities and maintain their independence • Reducing inappropriate use of healthcare resources
Domain 4	**Ensuring people have a positive experience of care**	• Improving the experience of care for people living with chronic pain

[8] https://www.britishpainsociety.org/static/uploads/resources/files/members_articles_npa_phase1.pdf
[9] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/272238/6737.pdf

Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	• Ensuring effective use of medication for pain management

2.2 Local defined outcomes

The key outcomes of the service will be:

- Patients will have quantifiable improvements in their perception of their pain
- Patients will have increased confidence and ability to self-manage their condition (with evidence to support this)
- Patients will be able to access treatment closer to home (compared to Secondary Care)
- Patients will experience reduced sickness absence from paid work (owing to a decrease in physical and / or emotional disability caused by chronic pain)
- Patients report a positive outcome in their physical, psychological and / or social needs
- Patients will experience an increase in their self-reported levels of physical and social functioning in society
- Reduction in referral to Secondary Care pain services
- Close working relationships between tier 1, 2 and 3 pain providers
- Reduction in the use of medication (if appropriate) and / or optimisation of medication use

3. Service Scope

3.1 Aims of the Service

The aim of the service is to:

- Support patients needing community pain management services between the remits of Primary and Secondary Care
- To have robust referral assessment, onward referral or signposting processes (as appropriate) onto other currently commissioned providers of pain management support, where clinically beneficial for example MSK CATS, physiotherapy, IAPT, Barnsley Premier Leisure, PCN Social Prescribers etc
- Provide clinical assessment, treatment and clinical leadership within a comprehensive community service
- Provide a Community Pain Management Referral Assessment and Treatment Service, building on local pathways and inter-referral to ensure patients get the care they require at a suitable time and at a suitable place
- Provide advice and guidance support to Primary Care where patients can remain in Primary Care
- Contribute to developing a local network for the management of chronic pain
- Work in partnership with Secondary Care providers to identify further pathway development to reduce the need for treatment in acute settings. This may include access to diagnostics to enable appropriate assessment of more complex cases

3.2 Objectives

The main objectives of the service are to:

- Provide a Community Pain Management Referral Assessment and Treatment Service

- Provide L2 pain management services between the remits of Primary Care (L1) and Secondary Care (L3)
- Accept referrals from Primary Care (step-up)
- Develop good knowledge of and effective relationships with supporting pain management service providers
- Provide care in accessible settings around Bassetlaw supporting equity of access addressing health inequalities
- Define a structured approach to the use of therapies in line with latest guidance and Commissioner Policies
- Evidence a reduction in the use of pain management medication where appropriate and where medication is necessary, ensuring that prescribing / recommendations are evidence-based, cost-effective and in line with the PCB's pain management guidelines / formulary
- Provide an approach to ongoing treatment which is based on measurable, progressive patient outcome improvement to the point which they can be safely signposted / referred / discharged as appropriate

3.3 Service Description / Care Pathway

3.3.1 Service Model

Pain management can take various forms and providers of these pain management techniques span primary, secondary, community, third sector, mental health, and potentially tertiary care, each playing an important part in the management of pain. It is important that this service works with these providers to utilise existing commissioned arrangements avoiding duplication and competition and focus on the provision of added value of supporting patients after Primary Care and reducing the number of patients needing to access Secondary Care.

The three-tier model of care is outlined below, and it is expected that duplication, competition and cross-over between the three tiers is minimised:

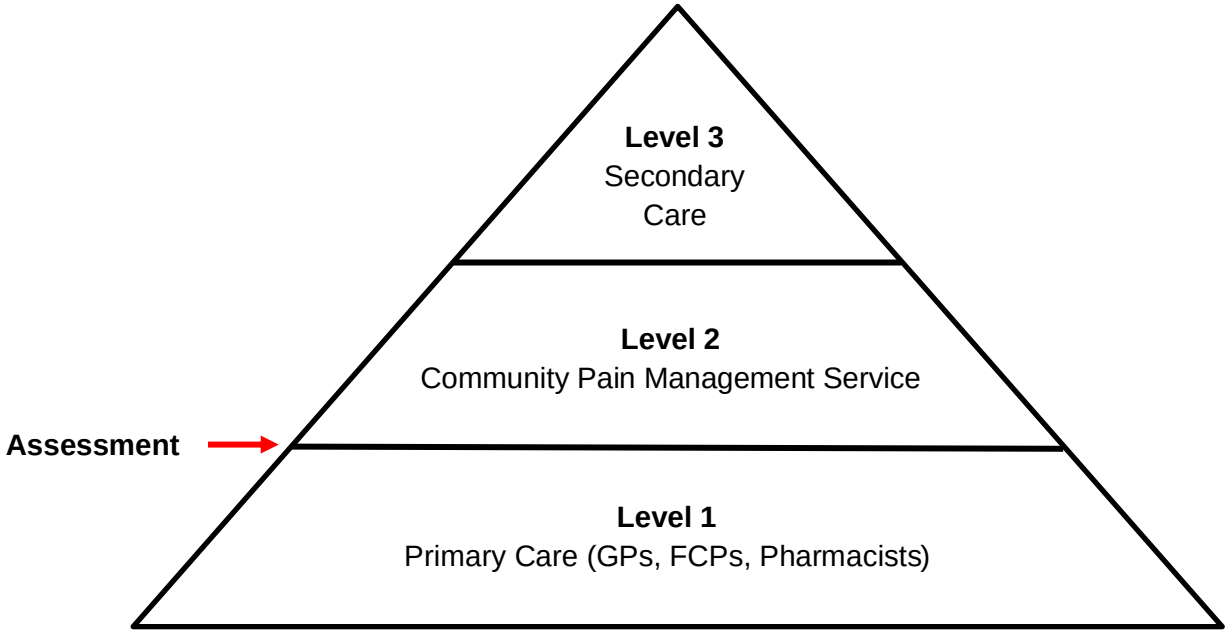


Figure 1: The three-tier model of care.

The following table shows the range of existing pain management techniques / interventions that are currently commissioned, and to which tier they fit within. Where all three tiers look to provide the same technique / intervention, the actual level provided is linked to the tier within which it sits and that's where the value is added, and duplication is minimised. It is expected that services will collaborate to develop appropriate means of stratification.

Table 2: Bassetlaw PCB Commissioned Pain Management techniques / interventions

Pain management technique / intervention	Tier 1 Primary Care	Tier 2 or alternative provider	Tier 3 Secondary Care
Self-management	✓	✓	✓
Holistic assessment of family health needs and impact of pain on dependents	✓	✓	✓
Bio-psychosocial and MDT assessment	✓	✓	✓
Pain medication	✓	This service	✓
Occupational Therapy	✓	✓	
Physiotherapy	✓ FCP	DBTH	Either Specialist or Advanced Practice Physio Nurse Practitioner assessments (both Outpatients only)
Exercise		Barnsley Premier Leisure	
Cognitive Behavioural Therapy		Insight	✓
Acupuncture		This service	✓
Community Support Groups		Various	
Social Prescribing	✓		
Diagnostics	✓	✓	✓
Medicines Optimisation	✓	✓	✓
Injections	✓	Secondary Care	✓
Advice and Guidance to clinicians		This service for inappropriate referrals only	✓
Multi-agency care planning meetings		This service	✓
Spinal cord stimulation			✓
Spinal surgery			✓
Interventions requiring room for aseptic procedures, anaesthesia care in close proximity and resuscitation equipment and facilities immediately available if required			✓
Red listed drugs for pain management as per APC guidance			✓

Tier 1: Primary care services including GPs, First Contact Practitioner Physiotherapists, Pharmacists, Social Prescribers etc

The patient will be primarily supported by the GP. The first line advice and treatment will consist 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 imaging
- Medicines optimisation for the patient

Referral to Tier 2 services can occur where the patient reports increasing pain intensity and distress and / or worsening physical disability and deteriorating emotional role functioning, or the referral criteria for the Community Pain Management Service are met.

Referral criteria are:

- Patients whose pain persists for duration of greater than 3 months
- Patients of less than 3 months with significant pain where the GP potentially following Secondary Care advice and guidance
- The cause has been identified but no specific treatment can be offered within Level 1 services
- Available Level 1 treatments have failed to relieve the pain such as polypharmacy and patient needs expert input in medicine optimisation

The Provider will be expected to draw up clear thresholds for referrals enabling GPs to be clear about why the patient cannot be managed in Primary Care. Pre-templated forms are recommended.

Tier 2 – Community Pain Management Referral Assessment and Treatment Service

This specification refers to the delivery of the Level 2 Community Pain Management Referral Assessment and Treatment Service, with the expectation that efficient pathways between all levels of service will be clearly defined by the Level 2 service provider. This should include (but is not limited to) clear procedures for the provision of:

- **A Referral Assessment Service** to be available on eRS, which NHS Digital explains allows providers to:
  - Assess the Clinical Referral information from the GP / referrer without the need for an appointment being booked
  - Decide on the most appropriate onward clinical pathway
  - Contact the patient to discuss choice (if an elective referral)
  - Arrange an appointment, where needed
  - Return the […] request to the original referrer with advice if an onward referral isn't needed[10]
- **Advice and guidance to patients / carers** (throughout the pathway)
- Efficient, streamlined **referral pathways between services at all levels** (Primary, Community and Acute / Secondary) both into this service (via GPs) and onto other appropriate services from this service (e.g. MSK) without the need to return to Primary Care
- **Entry points / processes for patients back into this service from other services** via Primary Care. Primary Care remains the best place to undertake the referrals but are open to the development of clear pathways and set criteria for this service to support Primary Care in this regard. This will need to be monitored to ensure that it is effective for all parties
- Well defined re-entry / **contact points with the service for patients / carers / family** as part of their long-term management for ongoing support with self-management and during "flare ups" to help minimize the need to access primary care or emergency department.
- **Timely response** to patient, carer, family and GP queries
- **Regular review of the impact of the pain management on family health** with specific consideration of the needs of dependent children
- Transformative approach to delivery of care, to include **virtual appointments** and **patient**

[10] https://digital.nhs.uk/services/e-referral-service/document-library/referral-assessment-services

initiated follow ups[11] (PIFU) in line with the expectations set out in the NHS Long-Term Plan re Outpatient Transformation in so far as:

- expanding the uptake of PIFU, moving or discharging 5% of outpatient attendances to PIFU pathways by March 2023; and
- continue to grow remote outpatient attendances where clinically appropriate with an overall share of at least 25%[12]

Two key elements of the Level 2 Community Pain Management Referral Assessment and Treatment Service are described below:

Part A - A comprehensive administrative service:

- Receive referrals from GPs and Secondary Care via NHS e-Referral Service (e-RS)[13]
- Provide administration of the RAS process, including onward referral with all appropriate demographic and contact details where necessary
- Establish a means of communication with the patient and / or carer i.e. that the methods of communication meet the needs of the patient and help to reduce DNAs. This may also include offering direct support (via telephone and/or digital) for patients who require assistance with booking their appointments. These patients will usually be defined by their GP when making the referral. The Provider will also ensure this information is known to other providers as appropriate if onward referral is made.
- Ensure that a brief description of the service, how it can be accessed, and any pre-referral requirements is available on e-RS. It is the Provider's responsibility to ensure that potential referrers are aware of pre-referral requirements and referral processes. It is also the Provider's responsibility to promote high levels of referral quality and action any poor levels of quality directly with the referrer. The provider will decline the referral if the requested pre-referral requirements are not reported as complete.
- Ensure referral arrangements do not cause a delay in access e.g. if e-RS is unavailable, there must be contingency arrangements in place to pick up referrals by another method.
- The service will contact the patient, carer or appropriate person to offer and agree with the patient, a time, date, type (face-to-face or virtual) and place of appointment and discuss any potential needs.
- Book patient virtual and face-to-face appointments (in accordance with the NHS Long-Term Plan Outpatient Transformation targets)
- Provide a reception for the face-to-face clinic
- Provide post-clinic administration, including onward referral if necessary
- Maintain an activity database, including analysis of patient satisfaction and patient outcome questionnaires

Part B – Referral Assessment and Treatment:

- **Advice:** Support the integration of care across the Primary / Community / Secondary care interface through the provision of education and advice including in the early intervention of pain management techniques and the development of referral protocols.

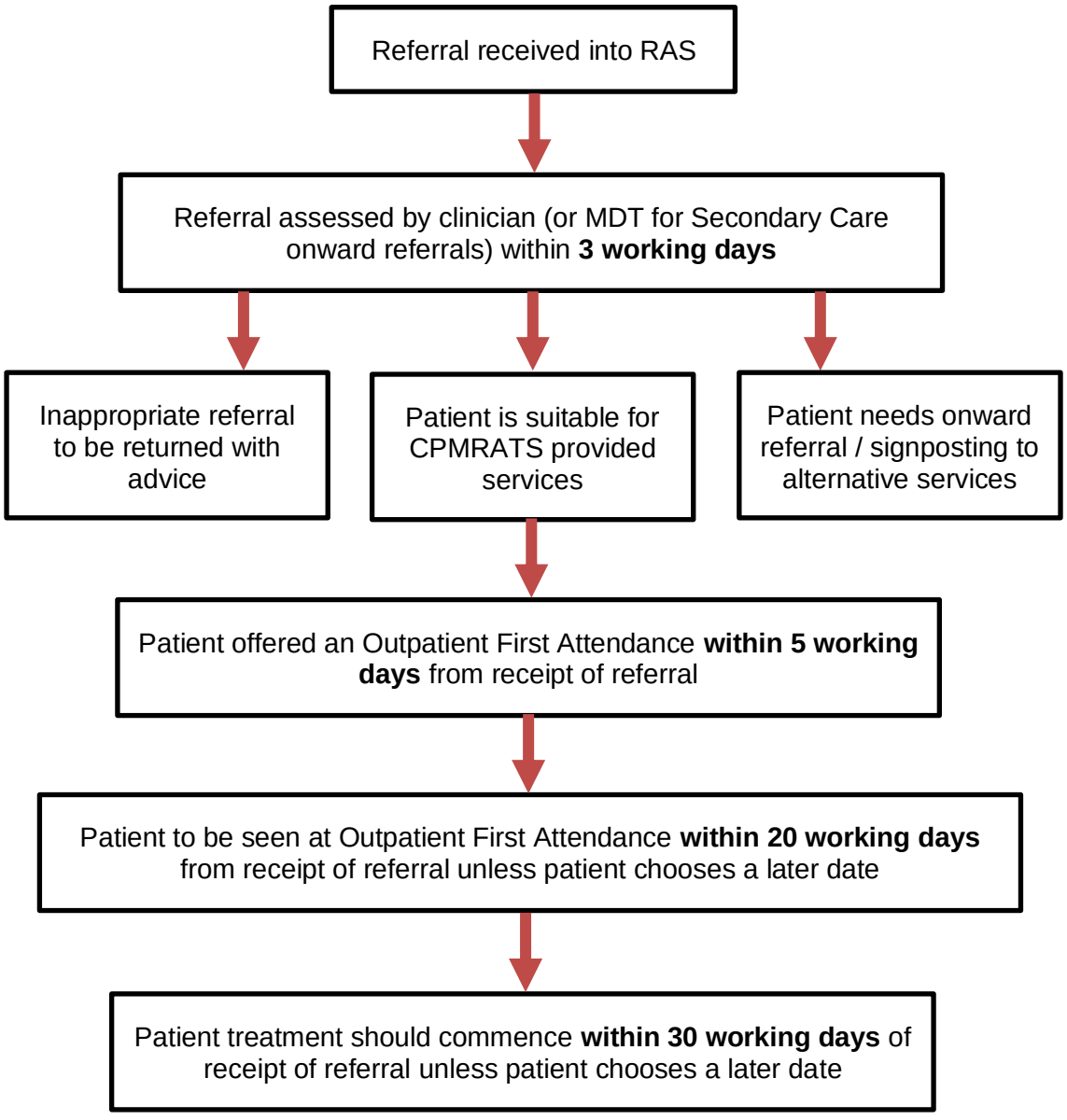
[11] https://www.england.nhs.uk/outpatient-transformation-programme/patient-initiated-follow-up-giving-patients-greater-control-over-their-hospital-follow-up-care/

[12] https://www.england.nhs.uk/wp-content/uploads/2022/02/20211223-B1160-2022-23-priorities-and-operational-planning-guidance-v3.2.pdf

[13] https://digital.nhs.uk/services/e-referral-service

- **Referral Assessment Service:** All referrals will be made into the eRS Referral Assessment Service and shall be assessed by an appropriate clinician within 3 working days. For more complex referrals a multi-disciplinary team (MDT) which includes suitably trained and competent physical and psychological therapists that adhere to the WMQRS Standards for the management of Patients with Chronic Pain will assess the referral.
    - All patients requiring onward referral to secondary care must have been reviewed by the MDT.
    - Incomplete / inappropriate referrals are to be returned to the referrer within 3 working days with advice and guidance.

Diagram 3: Referral Assessment, First Appointment and Treatment Initiation Process and Timeframes



- **Appointments:**
    - Patients to be contacted within 5 working days of referrals to arrange an appointment.
    - Service users shall be seen based on their referral date into the service.
    - Following referral receipt and assessment, the patient will be placed with the most appropriate clinical member(s) of the Community Pain Management Referral Assessment and Treatment Service depending on the individual needs of the patient for management.
    - Patient dependents should also be considered where appropriate.

- Patients to be seen at an Outpatient First Attendance within 20 working days of referral.
- The Keele University "Start back tool" (http://www.keele.ac.uk/sbst/) shall be used as an assessment tool to screen the service users with back pain and to help to stratify their care.

- **Treatment:**
  - The CPMRATS provider will work together in a multi-disciplinary approach to ensure patients are able to access appropriate evidence-based services within the right place and time to manage their physical, psychological and social needs associated with pain.
  - This may include medication management, referral onto other providers of physiotherapy, psychological support, education and promoting self-management tools and techniques.
  - Services will be delivered face-to-face, in group sessions or via the telephone according to the patients' needs and choice.
  - Patient treatment should commence within 30 days of referral.
- **Education:**
  - All patients will be supported with education on pain promoting self-management by patients and / or their carers (ensuring patient participation in the development of self-management resources, i.e. support groups, health coaching).
  - This will be delivered in group sessions unless not appropriate; either web-based or for some patients, face-to-face and include IAPT accredited online programmes specifically for chronic pain patients
- **Psychological support:**
  - The psychological support offer will be to appropriate psychological therapies including Cognitive Behaviour Therapy or Acceptance and Commitment Therapy or Cognitive Analytic Therapy approaches and health training within consultations. A taster session can be initially provided by the CPMRATS before referring onto other providers
  - Further complexities of psychological need will be referred to outside agencies such as IAPT provided by Insight within Bassetlaw.
- **Medicine Reviews and Management:** Working with the PCB Medicine Management team to identify areas of over or poor prescribing and offer education to improve the prescribing of chronic pain medications where appropriate to GPs
- **Signposting:** Patients will be signposted and supported to contact other agencies such as Social Prescribing or Exercise on Referral as appropriate etc.
- **Shared decision making and care planning:** The service should:
  - Encourage and support person-centred shared decision making involving the patient and / or their carers and collaboratively agree a comprehensive care / treatment plan including appropriate review.
  - Use plain language to enable colleagues across services to talk to the patient regarding their care plan (where necessary) using common terminology that everyone understands.
  - Ensure that the treatment plan includes a clear explanation of the circumstances that would require patients to re-engage with the service, how to manage flare ups and the importance of contacting the service at these times in preference to primary care or attending ED where possible.
- **Onward and return referrals:** Patients needing Secondary Care should be referred on and accepted back should community care be appropriate thereafter
- **Episode of care:**
  - The service shall provide an episode of care, not a long-term review of the patient.
  - General follow-ups should be kept to a minimum.
  - **The patient treatment pathway (start to discharge) should not exceed six months although support from the service should be available for a further 12 months**
- **Clinical Feedback / Discharge Summaries:** The service will provide the patient's GP with a updates where any significant decisions have taken place, with a full and detailed report of their

clinical treatment, including problems identified, interventions / treatment received, medications reviewed / prescribed (highlighting any opioid prescriptions and potential dependency issues addressed) and a copy of the patient's personalised management plan within 5 working days of discharge from the service.

- **Patient choice of provider:**
  - Patients will be offered choice of Secondary Care provider at the point of assessment in accordance with the NHS Constitution and given the necessary information and support to make an informed decision as to where they choose to receive their care.
  - Where an onward referral service is directly bookable, the service will book the patient's appointment of choice. The service will support patients with any subsequent queries regarding their appointment and assist in resolving any problems.
- **Work up for onward referral to Secondary Care:**
  - Ensure that service users are fit for surgery / procedures and are willing to go ahead with the surgery / procedure following shared decision making
  - Ensure that the service user understands the nature, aims and expected outcome of surgery / procedure
  - Identify any contraindications for surgery / procedure and make provision for the service users' health to be optimised before referral
- **Patient Initiated Follow Ups:** PIFU are recommended to enable long-term follow up of patients at set points determined with the patient using shared decision making, enabling the patient to self-refer back to the service directly when agreed changes in their condition are noted or if the patient / carer / family need to seek advice to assist in self-management within agreed timeframes.
- **Discharge:** At the point that discharge is deemed appropriate; the provider will be required to produce a discharge plan which includes:
  - Full assessment with summary of findings, including any treatments carried out in the Community Pain Management Service, outcomes achieved and future care plan (with timescales).
  - The results of all tests and any fit for surgery / procedure assessment.
  - Full information about any recommended procedure(s) and diagnostics
  - Recommendations for ongoing care if the patient is not being referred onwards
  - Indicators for re-referral into the pain service

  The service will routinely collect and monitor information about the outcomes of patient's care and treatment including self-discharges and follow up information. The service will also closely monitor all discharges and implement a process where patients who have not fully completed care plans are contacted and reasons for incomplete episodes of care identified and regularly reported
- **Patient interactions:**
  - Staff within the service respect patients and their confidentiality, privacy and dignity at all times
  - The service values the importance of receiving feedback and encourages/supports service users to raise concerns or make complaints to help to improve the quality of the service
  - The service is open and transparent about how complaints and concerns are dealt with and the outcome is appropriately explained to the individual
- **Location and accessibility:**
  - The facilities and premises are located within local communities and appropriate for the service that is planned and delivered e.g. provide a quiet and private environment where patients with limited movement do not feel hampered by a lack of privacy
  - The service engages with people who are in vulnerable circumstances and takes action to remove identified barriers to accessing / using the service
  - Service users have timely access to care and treatment that is delivered at a time to suit them

- The service runs to time and where care and treatment is delayed people are kept informed about disruptions. Cancelled appointments receive and explanation and are supported to access care and treatment again as soon as possible

- **Governance:** The service must:
  - Have an effective governance framework that gives robust assurance and supports delivery good quality care.
  - Regularly report and monitor performance and take action to support improvement which can be evidenced.
  - Actively capture the views and experience of staff and use this to help shape and improve the culture and quality of care.
  - Maintains continuous professional development of all staff as required and support local training and medical education to community care providers. This includes education and training to others involved in the delivery of further service elements for pain conditions, especially clinicians such as GPs so that a fully integrated pain management model is maintained, developed and adopted.
  - All interventions must be in line with the Commissioner's Clinical Policies, Core Standards for Pain Management in the UK (2021) and latest national guidance

Tier 3 – Specialist Pain Management Service

Where patients require specialist pain treatments for severe debilitating pain, MDT discussion will agree action plans for referring onto Secondary Care. Care will be consultant-led.

3.4 Population and Geographical Coverage

Patients registered with a Bassetlaw PCB GP only. The service must also accommodate those who are not registered with any GP but are resident within the District Council boundaries and eligible for NHS Care e.g. members of travelling communities, homeless people. Patients who live in the PCB area but are registered with a GP out of area (i.e. registered with a non-Bassetlaw GP) are not eligible for this service.

3.5 Referrals and Access

The service will provide a Referral Assessment Service for pain referrals. The PCB anticipates that patients will typically be referred by their General Practitioner, although in some circumstances patients may be referred through other community services or hospital consultants.

Bassetlaw PCB requires services to be provided in community settings across Bassetlaw. The Commissioner will need assurance that there is sufficient access to the service. Emphasis is made on the rurality of the county and the requirement for the development of the service to meet patient needs.

The service needs to be available to housebound patients whether that's due to BMI or psychological factors. A definition of housebound patients can be agreed.

3.6 Acceptance and Exclusion Criteria and Thresholds

The Community Pain Service will operate the following access criteria:

- Patients must be a minimum of 16 years old
- Patients must have persistent pain with varying intensity experienced for 3 months as a minimum
- Patients have, where possible, a diagnosis
- Patients have had investigations by the referring GP to ensure diagnosis is of chronic non-malignant pain
- Patients are medically stable

Secondary Care Advice and Guidance to have been sought by GPs where patients have had severe debilitating pain for less than 3 months before onward referral to the CPMRATS.

The following exclusion criteria will apply to:

- Patients with acute pain / pain lasting less than 3 months
- Patients with known pathology requiring further investigation
- Patients with suspected cancer or cancer related pain i.e. pain that is caused by cancer or associated treatment (e.g. surgery, chemotherapy, radiotherapy) or cancer related debility
- Early post-operative or post trauma complications
- Patients suspected with fracture / infection
- Patients with pre-natal back pain / pelvic pain
- Patients with the presence of red flags e.g. Cauda Equina Syndrome
- Patients requiring a surgical opinion
- Patients with acute psychiatric disorder
- Patients with ongoing and chaotic severe mental health conditions, addiction or substance misuse
- Patients with moderate to severe cognitive impairment

3.7 Clinical Staffing

The service will require the correct level of trained staff to ensure a safe and efficient service and as a minimum will include input from:

- Medically qualified consultant / specialist in pain medicine. If the service is not medically led, close working relationships with Secondary Care would be required
- Nurse specialist in chronic pain
- Clinical psychologist / registered practitioner psychologist
- Registered physiotherapists with specialist experience and advanced practice skills in managing people with chronic pain
- Designated clinical and contractual management support

3.8 Days / Hours of Operation

The service shall be primarily provided during core working hours Monday to Friday but also offer out of working hours services at evenings and / or weekends.

The service will have a dedicated encrypted email address (NHS.Net) and telephone query line to handle enquiries from GPs/consultants and patients.

3.9 Discharge Process

The Provider will issue discharge documentation to the patient's GP or referring clinician through secure email (nhs.net) and provide a paper copy to the patient. The discharge documentation shall include:

- Clear information relating to diagnosis, investigations, treatment, medication (highlighting opioids and potential dependency issues addressed)
- A copy of the service user's pain management plan and patient advice
- Any actions to be undertaken by the GP (listed separately at the top of the letter)
- Date of admission into the service and details of any onward referral to another service

3.10 Prescribing

This service is not expected to prescribe therapeutic medication, except for:

- 'Specialist only' drugs
- Where specialist initiation is required and where appropriate prescribing responsibility can be transferred to the GP once the patient's condition / dose is stable
- Where treatment needs to be initiated urgently (i.e. clinically required within 14 days)

On-going management for the majority of service users is expected to be delivered in primary care by GPs. On this basis the service will include prescribing advice for the referring GP following medication reviews.

3.11 Patient Participation:

The Service shall work with service users in ways that foster partnerships and include:

- Views on the location of the services
- Comments and suggestion boxes
- Patient Participation Groups
- Patient surveys
- Local complaints process and annual review
- Promoting self-care – including local education programmes and peer support networks. Providers will be expected to make visits to groups as appropriate / requested.

Regular reporting on patient participation activities will be required by Commissioners.

3.12 Interdependence with other services / providers

Provider / Key Relationship	How

GPs	Working with GPs to ensure quality of referrals / good understanding of the service and how GPs can actively manage patients once discharged
MSK Service	Establishing close links so that referrals are directed via their GP from community MSK services are appropriate and timely. Ensuring patients understand their transfer of care.
Secondary Care Pain Service Providers	Establishing close links so that any specialist pain interventions needed (for patients not within the remit of the specification) can be conducted quickly and effectively and patients transferred back into the service once necessary.
Mental Health	Establishing close links with wellbeing and mental health services, drugs and alcohol services where necessary. Consideration of development / agreement of stratification or measures to ensure joined up patient care. For example, where it is a primary MH problem, it will sit with MH service leads. If it is a primary pain problem, it will sit with pain service leads. Where it is mor complex, a joint care approach may be more appropriate.
Independent Sector	Establishing links with independent sector providers, working with them as part of a package of care to deliver parts of the pathway not within the capacity of the service e.g. access to Exercise on Referral, IAPT
Local Authority	Establishing links with Local Authority working with them as part of a package of care to deliver parts of the pathway not within the capacity of the service e.g. access benefits advice, social care support etc.
Employment advice services	Establishing links with benefits /employment agencies to ensure pain is not a barrier to returning or finding employment
Voluntary Community Sector	Establishing links with relevant Voluntary Sector Organisation to compliment the pathway of care and ensure patients have access to longer term support. Including external pain/patient support groups

The service shall be interdependent on Primary, Community and Secondary Care pain service providers offering access to Bassetlaw patients. The service shall 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 the service users.

4. Applicable Service Standards

4.1 Applicable National Standards (e.g. NICE)

- NICE Clinical Guideline CG173 (2013) Neuropathic pain in adults: pharmacological management in non-specialist settings: https://www.nice.org.uk/guidance/CG173
- NICE Guideline NG59 Low back pain and sciatica in over 16s: assessment and management (2016) https://www.nice.org.uk/guidance/ng59
- NICE Guideline NG193: Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain: https://www.nice.org.uk/guidance/ng193

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

- The British Pain Society – Guidelines for Pain Management Programmes for adults (November 2013): https://www.britishpainsociety.org/static/uploads/resources/files/pmp2013_main_FINAL_v6.pdf

4.3 Applicable local standards

- Commissioning for Value / Evidence Based Interventions Policy (see contract)

5. Applicable Quality Requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4 Parts A-D)

Quality or Performance Indicator	Threshold	Method of Measurement
Referral assessment within 3 working days	**95%**	Date of referral assessment <4 working days of date of referral receipt
Inappropriate referrals to be returned within 3 working days of receipt	**95%**	Date of inappropriate referral advice and guidance return <4 working days of date of referral receipt
Patients to be offered an Outpatient First Appointment within 5 working days of referral receipt	**95%**	Date that patient offered an OPFA <6 working days of date of referral receipt
Patient to be seen at Outpatient First Appointment within 20 working days of referral receipt (excluding occasions where patient chooses to wait longer)	**95%**	Date of patient OPFA <21 working days of date of referral receipt
Patient Treatment to commence within 30 working days of referral receipt (excluding occasions where patient chooses to wait longer)	**95%**	Date of patient treatment <31 working days of date of referral receipt
Number of virtual appointments	**25%**	Number of virtual appointments as a proportion of total outpatient attendances
Number of PIFU appointments	**5%**	Number of PIFU appointments as a proportion of total outpatient attendances
Patient pathway from start to finish should not exceed 6 months (although support can be provided for a further 12 months if necessary)	**95%**	Patient referral date to patient discharge / PIFU date
Clinical Feedback / Discharge Summaries and patient discharge plan to be provided within 5 days of patient discharge	**95%**	Date of clinical feedback / patient discharge summary <6 working days of date of patient significant clinical feedback event / discharge

5.2 Applicable CQUIN Goals (See Schedule 4 Part E)

Not applicable

6. Location of Provider Premises

Regular clinics in various localities across Bassetlaw in clinical and non-clinical settings to meet reasonable patient need

The current clinic location is Harworth Primary Care Centre, Harworth, DN11 8JT