

<b>Service Specification No.</b>	
<b>Service</b>	Community Pain Management Service (CPMS)
<b>Commissioner Lead</b>	Mid Notts Place Based Partnership
<b>Provider Lead</b>	
<b>Period</b>	4 year contract period – 4 March 2019 – 31 March 2024
<b>Date of Review</b>	<i>To be reviewed annually</i>

## 1. Population Needs/National Context/Evidence Base

**Chronic Pain** is a long term condition where patients have persistent pain or repeated bouts of intermittent pain. It is a condition in its own right or as a component of other long term conditions. It is defined as a continuous, long-term pain of more than 12 weeks or after the time that healing would have been thought to have occurred in pain after trauma or surgery. For a small group of people this will prove to be a refractory disabling condition that requires specialised services.

The expected annual number of referrals into the service are shown below:-

<b>Mid Notts PCB</b>	<b>Est Annual Referrals</b>
Mansfield & Ashfield	1,455
Newark & Sherwood	1,337
<b>Total – Mid Notts</b>	<b>2,792</b>

### **Chronic Fatigue Syndrome (CFS)**

Chronic fatigue syndrome (CFS)/myalgic encephalomyelitis (or encephalopathy) (ME) is a relatively common illness. There is a lack of epidemiological data for the UK but evidence suggests a population prevalence of at least 0.2–0.4%. This means that a general practice with 10,000 patients is likely to include up to 40 people with CFS/ME; evidence suggests half of these people will need input from specialist services.

Mid Notts Population	Potential CFS patients (0.4%)
328,000	1312

### **Local Context**

Mid Nottinghamshire PCB (Mansfield & Ashfield and Newark & Sherwood) commission services from providers including Community Services, Mental Health Services, Acute, Tertiary Care and private providers. The PCB's are committed to improving the care provided to patients, reducing health inequalities and raising the quality and standards of care whilst achieving a financial balance.

The total registered population in Mid-Nottinghamshire as of April 2018 was 328,000; this is projected to rise to 349,500 by 2033. By 2033, all age groups are projected to grow with the largest increase in the group aged 75 and over. This age group is projected to increase by more than 55% between 2018 and 2033 from 28,300 in 2018 to 43,900 in 2033.

Rightcare data indicates significant opportunity around pain injections across Mid Notts. In addition, review of recent pain activity shows that high volumes of level 1 and 2 activity is currently delivered in a secondary care, which could be provided in a more appropriate setting in the community, either through access to self-management and primary care, or as described in the level 2 community pain management service.

Current delivery of pain services across Mid Notts does not provide equitable provision, and the proposed service will ensure that all patients have opportunity to receive the same level of care.

### **National Context/Evidence Base**

The British Pain Society: Core Standards for Pain Services <https://www.rcoa.ac.uk/system/files/FPM-CSPMS-UK2015.pdf> and Pain Management Services Planning for the Future <https://www.rcoa.ac.uk/system/files/FPM-Pain-Management-Services.pdf> highlight:

- England had 14 million chronic pain sufferers (defined as pain which lasted for more than six months) and in almost one in four, pain had prevented individuals from performing usual activities (including work) on at least 14 days in the previous three months
- 29% of patients with chronic pain experience depression
- In 2004, primary care management of patients with chronic pain was estimated to account for 4.6million appointments per year, this is equivalent to 793 whole time GPs at a cost of approx. £69 million
- 37% of sufferers had used specialist pain services, rising to 57% among those with most severe pain
- Chronic pain had a major impact on employers
- 37% of women and 31% of men reported chronic/persistent pain
- Although chronic pain was more prevalent in older people, one in six 16-34 years olds were affected.
- 24% of pain sufferers lose their jobs.

Our patients tell us that:

- Chronic Pain can provoke further problems such as altered mood, anger, family stress, isolation, confused thinking, financial concerns etc.
- Pain is not static; it changes from moment to moment as do the effects on the individual, their families and friends.

Chronic pain affects up to 28 million adults in the UK. Axial spine pain, arthritis and other musculoskeletal conditions account for 3 of the top 12 disabling conditions globally. Treatment of persistent pain requires a bio-psychosocial approach, where the goal is to improve function and quality of life. Limited service provision is a common obstacle to the optimal management of these conditions. Frequently, patients are seen across a variety of outpatient specialist services, waiting times are long and services disjointed with inadequate communication between specialties in primary, community and secondary care.

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.

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 (2006): 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 work on sick leave 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.

Chronic illness or disability of a parent can present a monumental challenge in the life of dependent children that can alter their development and interfere with normal psychological progression. Census data (2013) revealed the number of five to seven year old young carers in England has increased by around 80% over the last decade. The Children's Society's analysis also reveals that young carers are one and a half times more likely to have a long-standing illness or disability or special educational need than their peers. It is therefore important to ensure that any care plans in relation to adult carers take into account the impact on their parenting capacity and the needs of dependent children.

## 2. Outcomes

### 2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	X
Domain 2	Enhancing quality of life for people with long-term conditions	X
Domain 3	Helping people to recover from episodes of ill-health or following injury	X
Domain 4	Ensuring people have a positive experience of care	X
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	X

### 2.2 Local defined outcomes

- Improvement in the patient's perception of their pain using validated pain perception tools
- An increase in a patient's self-reported quality of life using validated tools e.g. EQ-5D (to be agreed with the commissioner)
- Medication reviews of opioid medication undertaken more frequently
- A reduction in the use of medication (if appropriate) and/or optimisation of medication use
- Improved management of co-morbidities such as drug and alcohol dependence
- Evidence of patients self-managing their condition
- Reduction in referral to secondary care pain services
- Reduction in pain related emergency department attendance
- Increased number of patients managed entirely in a primary/community care setting
- To provide specialist assessment and treatment for adults with moderate/severe CFS/ME

## 3. Scope

### 3.1 Aims and objectives of the service

The aim of the Community Pain Management Service (CPMS) will be to deliver high quality care to patients in a variety of appropriate community settings to improve the quality of life for patients experiencing chronic pain and chronic fatigue syndrome.

**Objectives of the service:-**

- Support and empower patients and their nominated carers to take responsibility for managing their condition and actively participating in their care plan (100% of patients have a jointly agreed care plan)
- Optimising the proportion of patients able to manage pain without the need for surgical intervention or inappropriately managed medication.
- Ensuring patients are reviewed holistically on entering the service to ensure treatment plans remain valid and that they are evidence based (100% of patients will receive a holistic review)
- Consider the impact of adult pain on any dependent children and sign-post to appropriate support services as necessary (100% of impacted patients to have a jointly agreed care plan, accessible to relevant stakeholders and reviewed regularly)
- Ensure all patients are given an bio-psychosocial assessment on entry to and throughout the pathway (100% of patients)
- Provide appropriate access points for patients and carers following discharge to support in the management of flare ups and avoid re-entry into the service where possible
- Optimising the proportion of patients able to manage pain without the need for hospital intervention (i.e. reducing Level 3 activity)
- Act as part of a wider multidisciplinary team to promote the “think family” agenda to promote a holistic approach to family health needs
- Support patients living with chronic pain or chronic fatigue symptom and their nominated carers to manage their own condition and make decisions about self-care and treatment that allows them to live as independent a life as is reasonably possible as possible e.g. through Shared Decision Making, including managing patient expectations
- Engage with local patient groups to develop a mid Notts community group for patients with persistent, long standing chronic pain and provide a supported self-care strategy that can give them and their families a reasonable lifestyle.
- Educate carers to continue care and support (where appropriate)
- Provide appropriate access points for patients and carers following discharge to support in the management of flare ups and avoid re-entry into the service where possible. This would include information about support services, voluntary & statutory
- Educate and support other care professionals in the early intervention of pain management techniques and self-care
- Optimising the proportion of patients able to manage pain without the need for continued medical and surgical intervention (i.e. reducing acute elective activity), making sure all patients have completed their agreed management pathway, and a personal future plan is completed, before onward referral is considered

### **3.2 Service description/care pathway**

The Community Pain Service will deliver high quality care to patients in a variety of appropriate community settings (described as level 2 services below). The service will provide a multi-disciplinary interface service between primary care, other community services and secondary care.

Pain management services may be located in the community, specialist care hospitals or in specialised pain management units, and need to work seamlessly as if in a single unit in order to provide an integrated management plan with the patient. Referral into level 2 community based service will be from a range of health care organisations; though most commonly the GP, MSK Hub or hospital consultant. It is anticipated that on referral, the patients' pain will have been investigated and that either:

1. No cause will have been found

2. The cause will have been identified but no specific treatment can be offered/is acceptable in level 1 services
3. Available level 1 treatments have failed to relieve the pain

The level 2 community based service will provide evidence based 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 a multidisciplinary approach based on a comprehensive bio-psychosocial model.

The Community Pain Management service will:

- Provide a bio-psychosocial approach to the management of pain or chronic fatigue syndrome, in line with national guidance, which utilises evidence based interventions including education, physical and psychological and pharmacological therapies through a single point of access
- Support other providers of pain management care including GPs, community pharmacists and providers of mental health and other equivalent support services through education and advice
- Deliver a service aligned to national guidelines for chronic fatigue symptom, including the delivery of Cognitive behavioural therapy (CBT) and/or graded exercise therapy (GET).
- Act as a single point of access for patients with chronic pain or chronic fatigue symptom providing an integrated and coherent patient journey regardless of provider.
- Provide a management approach for patients with chronic pain or chronic fatigue symptom to include psychological and physical interventions, using a pain management programme where appropriate
- Use primarily evidence based interventions for chronic pain management.
- Support patients living with chronic pain or chronic fatigue syndrome and their nominated carers to manage their own condition and make decisions about self-care and treatment that allow them to live as independently as possible e.g. through Shared Decision Making, including managing patient expectations
- Engage with local patient groups to develop a mid Notts community group for patients with persistent, long standing chronic pain and provide a supported self-care strategy.
- Educate carers to continue care and support (where appropriate) learnt through the service post discharge
- Educate and support other care professionals in the early intervention of pain management techniques

Pain management services should be delivered through a three level system, which is supported by self-care throughout the pathway:-

<b>Self-Management</b>	<p>Using on line self-management tools and resources (with access to non-electronic resources if required). Provider needs to ensure that there is a process in place to identify patients who may require assistance in completing self-management tools, resources and support is provide where necessary.</p> <p>Access to and signposting by community-based professionals, e.g. pharmacist, IAPT, physio self referrals, community social and exercise groups (third sector)</p> <p>Patient led initiatives and community based projects.</p>
<b>Level 1</b>	<p>Primary care services from GPs, community pharmacists, community psychological therapies, pain self-help organisations/groups and community based physical and psychological therapies.</p> <ul style="list-style-type: none"> <li>- Holistic assessment of pain, including full patient history, MSK examination, imaging if appropriate, bloods etc</li> </ul>

	<ul style="list-style-type: none"> <li>- Holistic assessment of family health needs and impact of pain on dependent children</li> <li>- Referral to self-management tools, e.g. provision of self-help exercise sheets</li> <li>- Referral into appropriate outpatient MSK services</li> <li>- Referral to children's 0-19 support services where appropriate</li> <li>- Referral into community physiotherapy</li> <li>- Referral into community mental health services</li> <li>- Pharmacological treatment in line with national guidelines</li> <li>- Injections for a small cohort (in line with Restricted Policy)</li> </ul> <p>It is anticipated that on referral, the patients' pain will have been investigated and that either:</p> <ol style="list-style-type: none"> <li>1. No cause will have been found</li> <li>2. The cause will have been identified but no specific treatment can be offered or is acceptable in level 1 services</li> <li>3. Available level 1 treatments have failed to relieve the pain</li> </ol>
<b>Level 2</b>	<p>Community based services offering a multi-disciplinary team bio-psychosocial approach to chronic fatigue syndrome and pain management in line with the latest NICE guidance and Core Standards for Pain Management in the UK 2015 and with access to self-help resources.</p> <ul style="list-style-type: none"> <li>- Bio-psychosocial /MDT approach to triage to include: <ul style="list-style-type: none"> <li>- GPwSI or Pain management consultant</li> <li>- Physiotherapist/OT</li> <li>- Nurse</li> <li>- Psychologist</li> </ul> </li> <li>- Referral to self-management tools/resources</li> <li>- Education/support for carers, families and patient coaches</li> <li>- Access to physical therapies including occupational therapy</li> <li>- Access to evidence based pain management programmes (face to face and on line)</li> <li>- Access to specialist psychological therapy and support</li> <li>- Access to evidence based medications (for a small cohort)</li> <li>- Access to evidence based medical interventions</li> <li>- Provision of 1:1 and group interventions</li> <li>- Advice &amp; Guidance for other clinicians</li> </ul>

	<ul style="list-style-type: none"> <li>- Contribution to multi-agency care planning meetings</li> <li>- Long term follow up service (including process for “flare ups” and Patient Initiated Follow ups)</li> </ul>
<b>Level 3</b>	<p>Secondary care service for patients requiring surgical interventions that require an acute care setting. Referrals to this service must be in line with the agreed service pathway</p> <ul style="list-style-type: none"> <li>- Spinal cord stimulation</li> <li>- Spinal surgery</li> <li>- Interventions requiring room suitable for aseptic procedure, anaesthesia care in close proximity and resuscitation equipment and facilities immediately available if required</li> <li>- Red listed drugs for pain management (as per APC guidance)</li> </ul>

This specification refers to the delivery of the Level 2 Community Pain Management service, with the expectation that efficient pathways between all levels of service will be clearly defined by the Level 2 service provider. This provider must also clearly articulate the pathways to other levels of the service and to patients/carers, providing support to them as necessary. This should include (but is not exclusive to) clear procedures for:-

- Advice and guidance (throughout the pathway)
- Efficient, streamlined referral pathways between services at all levels (primary, community and acute/secondary) both into this service and into other appropriate services (ie MSK Hub) without the need to return to primary care
- Entry points/processes for patients back into this service from other services without the need to return to primary care
- 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 initiated follow ups (PIFU).

Two key elements of the Level 2 Community Service are described below:

#### **A comprehensive administrative service**

The provider will need to deliver a service that successfully administers a community pain management service for the registered population of Mansfield & Ashfield and Newark & Sherwood (Mid Notts PCBs). There is already a MSK service in place, in which referrals are administered by the MSK Hub. The Level 2 provider must work with this service to ensure seamless pathways between both services.

The Community Pain Management service will:-

- Receive referrals from GPs (whether direct from GP practice or via a Referral Hub/ Service)
- Provide administration of the triage process, including onward referral where necessary
- Book patient appointments

- Provide a reception for the face to face clinic
- Provide post-clinic administration, including onward referral where necessary
- Maintain an activity database, including analysis of patient satisfaction and patient outcome questionnaires.

### **Clinical Triage, Assessment and Treatment**

The Level 2 service will consist of a multi-disciplinary team that can triage all referrals (and thus must include access to an appropriate CFS specialist), manage patient's physical, psychological and social needs associated with pain. The bio-psychosocial approach core to the service must be in line with NICE recommended psychological treatment of depression/anxiety disorders and needs to provide cognitive behavioural therapies (CBT) at levels 2 and 3 i.e. mild to moderate symptoms.

The service will "think family" and consider the impact of the pain management plan on dependent children or adults with care and support needs and refer to specialist support services as necessary

The service should comprise of appropriately trained staff in the following, (but not limited to), a GPwSI or pain management consultant, physiotherapist, nurse, support workers and appropriate psychological support. It will ensure patients experiencing chronic pain or CFS are appropriately managed in a community environment. Patients requiring secondary care will be referred into an appropriate hospital setting when they need specialist interventions: and be transferred back to a community setting (if necessary) once Level 3 intervention is complete.

It is expected that pain management and CFS therapies including CBT and GET will be delivered within the Level 2 service. The community service must be able to provide level 2 and 3 CBT therapies. All interventions must be in line with the local Restricted Policy, the Core Standards for Pain Management in the UK (2015) and latest national guidance. Suitably trained and competent physical and psychological therapists must form part of the multi-disciplinary team. CBT and other psychological therapies delivered within the level 2 service should build on key principles that underpin bio-psychosocial pain management and the core IAPT programmes.

The model of care is shown at section g.

The Community Pain Management Service will provide a multi-disciplinary triage service for all referrals to ensure that patients are placed on the most appropriate pathway within the service depending on their clinical needs. The use of appropriate self-management tools must be considered for all patients to assist in the long term management of their condition.

A care plan will be agreed collaboratively with the patient underpinned by the principle of Shared Decision Making and will include appropriate review

The service will also:-

- Provide pain management (or CFS specific if appropriate) education sessions to meet patient needs and manage expectations. This should be available on an individual and group basis. Patients who are deemed unable to attend group education should be offered 1:1 education.
- Deliver Multi-disciplinary team (MDT) meetings to triage referrals, and to review patients requiring onward referral to secondary care
- Support the integration of care across the primary/community/secondary care interface through the provision of education and advice, and the development of referral protocols
- Facilitate the discharge of patients back into the community service following secondary care intervention
- Encourage and support self-management by patients and/or their carers (ensuring patient participation in the development of self-management resources, ie support groups, health coaching)



- Encourage and support shared decision making involving the patient and/or their carers
- Provide and facilitate an evidence based low back pain pathway across the health care community (all Tiers) focussing on rapid intervention to prevent transition from acute to chronic low back pain

Access to Level 3 services will follow a multi-disciplinary review. It is expected that where clinically appropriate, patients will be transferred back to Level 2 care for their ongoing management following a secondary care episode. The Level 2 service will also:-

- Ensure that service users offered a choice of secondary care provider, are fit for surgery/procedures and are willing to go ahead with the surgery/procedure following shared decision making
- Ensure that patients can be directly listed for surgery/procedures in the secondary care provider
- 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
  - Provide direct listing for interventions.

The use of a Patient Initiated Follow Up (PIFU) Policy is recommended for this service to enable long term follow up of patients at set points determined with the patient using shared decision making, enable the patient to self-refer back into 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.

All patients must have a comprehensive treatment plan which uses plain language to enable colleagues across services to talk to the patient regarding their care plan (where necessary) using common terminology that everyone understands. The treatment plan must include a clear explanation of the circumstances that require them 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.

If discharge is deemed appropriate; at the point of discharge, 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 has not being referred onwards
- Indicators for re-referral into the pain service

### **3.3 Population covered**

This service will be available to patients aged 16 years and over, who are registered (including temporary residents) with a General Practitioner (GP) across the Mid NottsPCB's population.

It is expected that CPMS will specifically align with established and emerging NHS acute, community, and mental health partner trusts community pain services.

The commissioner reserves the right to discuss and agree with the provider other sources of referrals over the term of the contract.

### **3.4 Inclusion/Exclusion Criteria**

This service is for patients suffering with chronic pain or CFS. Chronic pain is continuous, long-term pain of more than 12 weeks or after the time that healing would have been thought to have occurred in

pain after trauma or surgery. Patients will only be accepted into the service if they pass the referral criteria which are to be locally defined and agreed across the Mid Notts PCB's.

The following patients are not eligible for this service and should be excluded:

- Patients aged less than 16 years
- Patients with suspected cancer or cancer related pain
- Patients with severe mental health conditions; addiction or substance misuse
- Patients with moderate-severe cognitive impairment
- Patients with red flags or who require a surgical opinion (e.g. suspected cauda equina syndrome)
- Patients who have an unstable medical condition or undergoing medical investigation

This service is not available for patients outside of the Mid Notts area (Mansfield & Ashfield or Newark & Sherwood PCBs) or who are not registered with a Mid Notts GP practice.

### **3.5 Clinical Service Availability**

As a minimum the service will replicate the core hours of primary care defined as: 8am to 6.30pm, Monday to Friday except Good Friday, Christmas Day or bank holidays.

The service will have a dedicated encrypted email address (NHS.Net) and 0800 Freephone query line to handle enquiries from GPs/consultants and patients.

This will be reviewed after 6 months to ensure the service is working to the optimal operational efficiency and is flexing to meet the needs of patients. Eg. delivering evening and weekend clinics to meet the needs of patients and agreed with commissioners.

### **3.6 Response Times and Prioritisation**

Patients should be seen based on their referral date into the service and not on any other clinical criteria.

Referral criteria as outlined within the specification can be further developed with commissioners prior to mobilisation of contract commencement.

The CPMS:

1. Will respond to any ERS advice and guidance requests within 2 working days of receipt of referral, excluding weekends
2. Will be triaged by a member of the clinical team within 2 working days of receipt of referral (Mon – Fri) excluding weekends.
  - a. Incomplete referrals to be returned to GP within 2 working days with advice and guidance.
  - b. Referrals not on electronic referral form to be returned to GP within 2 working days.
  - c. Inappropriate referrals to be returned to GP with 2 working days with advice and guidance.
  - d. Referrals assessed as a potential 2WW cancer referral to be onward referred within 2 working day, GP to be informed the same day.
3. Will contact patients within 5 working days from referral to arrange an appointment.
4. Will assess within 20 working days of referral (There are no emergency or urgent appointments available within this service). Assessment should be clinically appropriate to meet the needs of the patient.
5. Will commence treatment within 30 working days of referral.
6. Will send a copy of the care/management plan to the GP within 5 working days of discharge from service.

### 3.7 Prior Approval Process/Restricted Policy

The service will adhere to Mid Nottinghamshire PCBs Restricted Policy, following locally determined protocols and processes. This will include receiving referrals, matching them against agreed criteria and onward referral of those that meet the criteria.

Referrals that do not meet the relevant criteria must be returned to the referrer within 2 working days to seek clarity on the incomplete details to enable the service to complete the request.

This process applies regardless of which hospital the patient may be referred to and only applies to referrals to secondary care.

This service is expected to provide primarily evidence based interventions and limit the use of others (such as Botox trigger point injections).

### 3.8 Patient Booking/Referral Process/Patient Choice

Ensuring a single point of access, the system used by the service to book appointments should be either:

- NHS E-referrals (formerly "Choose & Book")
- SystemOne E-Referrals (for referrals into the service, and NHS E-referrals for onward referrals to secondary care (which is the process used by the existing MSK Service). *The PCBs will support the service provider to implement this option.*

The service will contact the patient, carer or appropriate person to offer and agree with the patient, a time, date and place of appointment and discuss any potential needs.

Patient referral data should be sent to the service by secure methods and in line with the following principles:

1. The service must make information available on ERS/S1 to the GP (as per the pathway) and as a minimum this will provide a brief description of the service and how people can access it.
2. Referrals that are not appropriate for the service are to be returned to their source within 2 working days with an explanation as to why the referral has not been accepted.
3. ERS advice & guidance to GPs as part of the standard contract
4. Receipt and administration of all referrals will be the responsibility of the provider.
5. The provider will request that the GP standard electronic referral form (Arden's Referrals) and any supporting information is attached to the request and that it contain details of all relevant previous medical history; the results of any pre-referral examination, tests and investigations, the outcomes of any treatments already tried in primary care and a record of the what patients expectation are.
6. 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.
7. The provider will ensure that any pre-referral requirements are clearly documented. The provider will decline the referral if the requested pre-referral requirements are not reported as complete.
8. The provider will ensure referral arrangements do not cause a delay in access e.g. if ERS is unavailable, there must be contingency arrangements in place to pick up referrals by another method.

9. The provider will inform the GP if they recommend prescription of Opioids for patients; this needs to be fully documented and potential dependency issues addressed. This will need to be reported on.

The service will:

- Ensure that choice has been offered to the patient unless there are specific, documented reasons why this could not happen.
- Provide advice and support to patients with regard to all aspects of their appointment.
- Ensure all onward referrals have the correct demographic and contact information.
- Provide information about the referral service and send reminders of appointment via appropriate means (ie text message) as discussed with commissioners to reduce the incidence of DNAs.
- Establish a means of communication with the patient and/or carer i.e. that the methods of communication meet the needs of the patient.
- The service will maintain a level of expertise in the use of ERS on behalf of the commissioners and will support and advise commissioners and take action on behalf of commissioners where there is a requirement to do so. Non electronic means for receipt and passing on of referrals will be by exception only and approved by the commissioner.
- Direct support (via telephone and/or digital) will be provided to patients who require assistance with booking their appointments. Patients requiring booking assistance will usually be defined by their GP when making a referral. The provider will also apply a process that identifies patients who require booking assistance.

### **3.9 Patient Choice**

When a patient appointment is required, patients will be offered choice at the point of triage 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.

### **3.10 Interdependencies with other services/providers**

It is expected that the provider of the Level 2 service will develop clear criteria for referral between the levels of service on the pathway. It is expected that relationships between the providers of these services will be developed to ensure the optimum outcomes for patients and their families experiencing chronic pain or CFS. Direct referrals between appropriate services must be possible and straightforward. Patients must be able to re-enter this service directly following treatment within other services if this is agreed to be clinically appropriate.

The service shall be dependent on referrals from primary and secondary care professionals and the development of good working relationships with all local acute hospitals, community services and voluntary organizations is essential.

The CPMS will facilitate good working relationships with other services and stakeholders, demonstrated through provision of an evidence based low back pain pathway. This will be especially true of MSK and GP services.

The provider shall develop shared care pathways and joint working across primary and secondary care to enable` (but not limited to) direct access to diagnostics and listing for interventions.

The service shall work as the interface between primary and secondary care. The service shall collaborate with a range of clinicians from primary and secondary care providers and established community providers (including the MSK Service) who will work within a range of locations. This collaborative approach to service user care shall develop and sustain good relationships, ensure that the skills set reflects service user and service need, provide a high quality service and optimise working relationship between primary and secondary care. This shall be reflected in agreements to directly list service users at their chosen provider.

The provider shall have strong links with appropriate wider health & social care colleagues to ensure they “think family” and can be part of any MDT discussions when this is deemed appropriate for the client or their dependents, e.g. substance misuse services, children’s social care.

The service shall possess strong leadership and will ensure the involvement of service users, health and social care staff from all sectors (primary and secondary) and the voluntary sector.

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

1. Provider/key 2. Relationships	3. Suggested Links
Primary Care (including GPs, Local Integrated Care Partnerships (LICPs), local MDT delivery teams)	4. Working with GPs, local integrated care partnerships and other health care professionals to ensure quality of referrals, good understanding and utilisation of the service and how GPs can actively manage patients once discharged. Patient/Peer Support services in the locality.
5. MSK service	6. Establishing close links so that referrals are directed from MSK services appropriately and timely ensuring patients and their GP understand patients’ transfer of care. 7.
Community providers - Local Partnerships (LP)	Establishing close links so that referrals are directed appropriately and timely ensuring patients and their GP understand patients’ transfer of care.
8. Secondary Care providers (Pain Care specialists and other health care clinicians, including Sherwood Forest Hospitals NHS Foundation Trust, Nottingham University Hospitals NHS Trust, etc) 9.	10. 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. 11. Ensure patients have a care plan that includes medication, self-care etc.
12. Mental Health	13. Establishing close links with well-being, mental health services and drug and alcohol services where necessary. 14.
15. Self Care Resources	Using on line self-management tools and resources (with access to non-electronic resources if required). Provider needs to ensure that there is a process in place to identify patients who may require assistance in completing self-management tools, resources and support is provide where necessary.  Access to and signposting by community-based professionals, e.g. pharmacist, IAPT, physio self referrals, community social and exercise groups (third sector)  Patient led initiatives and community based projects.  16.

17. Independent Sector 18. ie. Gyms	19. Establishing links with independent sector providers, working with 20. 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.
21. Local Authority e .g. 22. Leisure services, social care services	23. 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/requesting assessment of the needs of dependent children and utilising the range of services the Local authority (LA) have at their disposal, benefits/advice etc. 24.
25. Employment advice services/ Department of Work and Pensions	26. Establishing links with benefits/employment agencies to ensure pain is not a barrier to returning or finding employment and 'Access to Work' are involved if adaptations need to be made to the work environment etc.
27. External pain/patient support groups	28. 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 (via community initiatives or relevant organisations). 29.
30. Voluntary Community Sector (ie Tai Chi classes, walking groups)	31. Establishing links with relevant sector organisation to complement the pathway of care and ensure patients have access to longer term support.
32. Complementary 33. Therapies	34. Establish links with independent sector providers locally to deliver parts of the pathway not within the capacity of the pathway.

### 3.11 Notification Letter

The provider will inform the patient's referrer/ secondary care when onward referral is required (and copied to the patients GP if s/he is not the referrer) 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 & reason

### 3.12 Discharge Process

Patients will be discharged with a care/management plan. Future access to the service, outside of normal parameters, is to be agreed between providers and patient as appropriate.

The provider will issue a discharge summary to the patient's referrer (and copied to the patients GP if 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 5 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 recommended.
- 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 SystemOne and the provider is responsible to agree with representatives from each GP practice within Mid Notts PCB's and other providers whether they wish to receive this information through SystemOne or by NHS mail. If the provider does not have access to SystemOne then a plan will be submitted to the Commissioner within the first quarter of service commencement to ensure adoption or suitable alternative.

### **3.13 Sub-Contractors**

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

### **3.14 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, patients and Mid Notts PCB's.

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 and physiotherapists. The provider shall also offer guidance for patients on managing chronic pain as developed with the local chronic pain support group.

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.

### **3.15 Patient Support and Information**

Patient engagement, information and support are key components to the successful management and delivery of the service. Self-care/self-management is the corner stone of CPMS. Engagement begins when the patient first presents to their GP and should be weaved throughout the patient pathway and their life living with chronic/persistent pain.

The service will implement "Best Practice" using interactive web based and paper based resources. Many people with persistent pain see their health care professional for treatment, help and support. It has been said that people with health conditions (including pain) may spend less than 3 hours a year on average in contact with a health care professional. For the remaining time they are on their own. The need to learn pain self-management skills and incorporate them in their everyday activities is very important.

The service will consider the wider impact on the patients pain management on their ability to provide safe effective care to any dependent children, and where appropriate refer to family child health teams of children's services for further assessment/support

The service will raise its profile so patients become more involved in their own pain self-management

which is necessary and important. It will promote the message through education and training that patients need to take ownership of their health and that it is not all up to the doctor or health care professional to manage their pain. Patients have to play a vital part as well.

It is important to improve patients understanding of chronic/persistent pain and its management through educational activities and self-management programmes to enable them to get the best from their medication, learn how to better manage disease flares, pain and fatigue, and improve their overall quality of life. It is essential that the offer of educational and self-management activities is not a 'one-off', but is repeated throughout the course of the disease to ensure that people with chronic/persistent have the opportunity to participate at a time, individual to them, that will support them to derive the greatest benefit.

Educational activities and self-management programmes can be provided 1-to-1, through self-study or computer-based interventions or in formal organised group sessions led by pain professionals or trained lay leaders with chronic/persistent pain. Different formats may be used, and should include electronic information supported by written resources, to improve understanding of the condition and its management, and counter any misconceptions people with chronic/persistent pain may have. It will take an educational approach such as lecture or facilitated interactive group discussion sessions to increase knowledge and reduce concerns and a behavioural approach, including regular skills practice, goal setting and use of home programmes to facilitate behavioural change.

The service will support people with chronic/persistent pain by signposting to voluntary organisations such as support groups and charitable organisations (where available) and it may be useful to provide sign-posting information at this point to ensure people know how to access further support once they have been diagnosed.

The opportunity to take part in existing educational activities and self-management programmes should be offered to people with chronic/persistent pain throughout the course of their disease on an ongoing basis.

The Commissioner considers that Shared Decision Making is an essential process in the Service, ensuring that every patient and their carers will be enabled to be an equal partner in the care, and understand their options. Training of MSK staff, opportunities to empower key stakeholders, effective management of the Information Hub, and the relevant decision aids will support, facilitate and embed the Shared Decision Making process.

### **Patient and Carer Information**

The service must provide patient information leaflets in formats and languages to meet the needs of the local population and will make these available to referring clinicians and patients. In addition, the service will provide interpretation facilities (where necessary), the cost of which will be borne by the provider, to enable patients to receive the full benefit of the service. Consideration must be given to literacy needs of the local population.

The service will adopt measures to support patients where their specific needs or circumstances might make it difficult for them to receive the full benefit of the service.

The service must also work with GP practices to ensure that patient information is being delivered consistently across Mid Nottinghamshire to ensure that all patients, wherever seen, are being given the same information.

Information must be presented in a way that enables patients and carers to understand why they are being referred, who has referred them and where they are being referred to and how their information is being shared to support the referral.



### **3.16 Training, Education and research Activities**

The provider will:

14. Provide appropriate levels of access to training, education and research for the staff it employs, or sub-contracts, in order to maintain competence and excel in being able to offer a community based service to a high quality.
15. Provide education and training to others involved in delivery of further service elements for pain conditions, especially clinicians such as GPs, physiotherapists, patient leads, etc so that a fully integrated pain management model is maintained, developed and adopted. No additional payment/tariff for this element is available; providers will work with commissioners to define requirements and ensure that an appropriate level of training is agreed, prior to service commencement.

### **3.17 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 Society 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.

### **3.18 Audit**

The service must undertake quarterly audits to ensure that the referring clinician and the patient's/carers experience of using the service is positive. The provider is expected to report service issues to the lead commissioner. These audits will be part of the reporting suite. To be agreed with the commissioner.

### **3.19 Information Governance**

The service will ensure appointment of a Caldicott Guardian, a Senior Information Risk Owner, and a Data Protection Officer.

The service will affirm compliance to level 2 or above for the Information Governance Toolkit 2017/18, and compliance activities in relation to the Data Security and Protection Toolkit for 2018/19.

The service will ensure that they are aware of and maintain their responsibilities as a Data Controller, and have in place effective and safe data processing contracts with any third party data processors. The service will not engage any third party data processor without the prior agreement of the commissioner, and with the completion of a Data Protection Impact Assessment.

The service will ensure that processing activities are documented within their Records of Processing Activities, Information Flows Mapping, and supported by an assurance of the legal basis for processing under the Data Protection Act 2018.

The service will have in place effective incident reporting procedures in relation to IG, and be equipped to report any IG breaches to the Information Commissioner. The service will be aware that IG incidents can relate to the confidentiality, integrity and availability of identifiable data.

The service will maintain relevant IG Statement of Compliance documentation, in support of the connection to national N3 network and any subsequent providers.

### **3.20 Equality Delivery Scheme**

Ensure the Community Pain Management Service delivers an equitable system to all:

- To make necessary care easily accessible to all those who require it.
- Eliminating unlawful discrimination and harassment
- Eliminating unlawful racial discrimination
- Promoting equal opportunity and good relations between persons of different racial groups
- Eliminating discrimination that is unlawful under the Disability Discrimination Act
- Eliminating the harassment of disabled person that is related to their disabilities
- Promoting the equality of opportunity between disabled and other persons
- Taking steps to take account of a persons' disabilities, even where that involves treating disabled people more favourably
- Promoting positive attitudes towards disabled people
- Encouraging participation by disabled people in public life
- Ensuring the equity of care and treatment for all patients

### **3.21 Quality & Governance**

#### **Patient Experience**

The service will form effective relationships with patients and the public through existing mechanisms. The service will implement patients experience surveys including 'Real Time Patient Surveys'. These surveys will include:

- Regular evaluation reports detailing the results of the surveys including the key themes that are emerging and the delivery of action plans to address concerns and issues raised by patients, service users and carers;
- This will also include the Patient Reported Outcomes Measures (PROMS) or MPROM when available and any other similar tools for other conditions as defined by commissioner (ie ED-5D-5L). The usage and evaluation and further design will be developed on an annual basis;
- Distribution of the report to commissioner, patients and other stakeholders as agreed with the commissioner;
- Evidence of active and continual patient and carer involvement in the review and redesign of service provision;
- Evaluation of Shared Decision Making using CollaboRATE;
- Evaluation of readiness for change and self-management success with the Patient Activation Measure;
- Compliance with requirements of the Friends and Family Test initiative

#### **Complaints & Feedback**

The service must provide robust integrated governance process for patient complaints and feedback and for staff to raise patient safety and CPM Service concerns across all suppliers. Compliance with the standard NHS contract for complaints and plaudits will be required.

#### **Governance and Incident Management**

The provider(s) will have a robust governance process in place monitoring and responding to quality issues. The structure will ensure the quality of care of any sub-contractors is of a high standard and any concerns are identified, reported and acted upon, informing the Commissioner at the earliest opportunity.

The provider(s) will ensure processes are in place for safe management of pathways that may be in place within some sub-contractor organisations. Raising, recording and managing patient safety Incidents (PSIs), Serious Incidents (SI) and Never Events (NE), in line the standard NHS contract, with national and regional policies and frameworks laid out in the NHS England Serious Incident Framework (2015) and NHS England Never Event Framework will be an essential role for the Alliance provider(s). Each SI will be followed up by a formal investigation and action plan with the Commissioner being updated on progress. There will be evidence of Board to floor capacity and capability, measuring quality and safety management practices.

The provider will ensure that there is a process for all SIs either directly or sub-contracted are logged on the national STEIS database. If a provider does not have access to STEIS the commissioner can submit an incident onto STEIS on behalf of the provider (ie Mid Notts Quality Team). Processes and reporting should also cover Never Events.

An annual report of all incidents will be submitted to the Commissioner. This annual report should include evidence of undertaking learning from the incident and how learning from incidents has led to improvement in the quality and standard of care for patients.

### **Safeguarding the needs of Children and Vulnerable Adults**

In line with the standard NHS contract, the Service will demonstrate robust governance processes in meeting the statutory requirements, the national policy drivers and local policy drivers for safeguarding children and adults, including specific roles for named and designated leads.

The service will have processes in place to ensure staff are trained to the required levels and there is a process in place to ensure staff know how to raise Safeguarding alerts, and (for adults) complies with the Multi-Agency Policy and Procedure for Safeguarding Adults at Risk, and equivalent processes for Child Safeguarding.

### **Safety Alerts**

The service will have a system in place to ensure national safety alerts (including medicine alerts, medical devices, estates and facilities) are received, disseminated and implemented in line with the required actions.

### **NICE Guidance**

The service must follow the standard NHS contract and ensure compliance with NICE guidance and that updated technical appraisals relevant to the service are reviewed and applied as appropriate to the service.

### **Infection Prevention and Control**

The CPMS, together with any other sub-contracted services, will ensure risks in relation to the prevention of Health Care Associated Infections and communicable diseases are minimised. There will be effective clinical leadership to ensure required standards are met.

The provider will have responsibility to ensure that:

- any updated guidance on infection control standards are met
- robust audit processes are in place
- staff are trained in infection control
- monitoring of performance including post-operative infection rates is reported

### **Equality, Sustainability (Environmental) and Social Value**

The CPM Service will follow the standard NHS contract and achieve equality, sustainable with social value the CPM Service will need to ensure that it:

- Provides access to the right care in the right place by the right person;
- Establishes standards for quality of care within an effective and integrated service/network;
- Improves patient care and outcomes from the CPM Service;
- Maximises prevention, either as part of the Service or another closely related service;
- Reduces supply induced demand, by ensuring that need has been demonstrated;
- Uses best available evidence of effectiveness in deciding details of service design and local population need

### **Every Contact Counts**

Making Every Contact Count is an approach to behaviour change that utilises the millions of day-to-day interactions organisations and individuals have with other people to support them in making positive changes to their physical and mental health and wellbeing. MECC enables the opportunistic delivery of consistent and concise healthy lifestyle information and enables individuals to engage in conversations about their health at scale across organisations and populations

**For organisations:** MECC means providing their staff with the leadership, environment, training and information they need to deliver the MECC approach.

**For staff:** MECC means having the competence and confidence to deliver healthy lifestyle messages, to encourage people to change their behaviour, and to direct them to local services that can support them.

**For individuals:** MECC means seeking support and taking action to improve their own lifestyle by eating well, maintaining a healthy weight, drinking alcohol sensibly, exercising regularly, not smoking and looking after their wellbeing and mental health.

The Service is to develop and maintain an organisational plan to ensure that staff use every contact that they have with Service Users and the public as an opportunity to maintain or improve health and wellbeing, in accordance with the principles and using the tools comprised in Making Every Contact Count Guidance and make a commitment to the MECC approach as a way of supporting behaviour change

### **3.22 Prescribing**

When making prescribing recommendations, the provider must comply with the Nottinghamshire Area Prescribing Committee (APC) Joint Formulary <http://www.nottinghamshireformulary.nhs.uk/>, clinical guidelines, shared care protocols or traffic light classifications for medicines as identified on the Nottinghamshire APC website <http://www.nottsapc.nhs.uk/>.

The provider must also work with the ICB to reduce the amount of inappropriately prescribed

- antibiotics

- high dose opioids
- Unlicensed medicines/specials

The service will undertake medication reviews of opioid medication and make recommendations for the reduction in the use of medication (if appropriate) and/or optimisation of medication use.

It is essential that prescribing advice is communicated to the patient's GP in a timely manner. Clinic letters should be available to the patient's GP within 5 working days. A standard template will be adopted. Communication will be by electronic means only.

For all prescribing recommendations follow local guidelines for the non-specialist management of pain and National Institute of Clinical Excellence (NICE) guidance for neuropathic pain. All prescribing recommendations must be conducted in accordance with relevant NICE guidance (the following are all listed in NICE guidance CCG97 2014).

Non opioid analgesia	Topical capsaicin
Oral/topical non-steroidal anti-inflammatory drugs (NSAIDs)	Opioid analgesics (care being taken to avoid chronic dependency )
Tricyclic antidepressants and other neuropathic pain agents	Corticosteroid injections

The provider may occasionally be invited to attend the Mid Nottinghamshire Joint Prescribing Sub-Committees, and when required will provide expert input into the development of local guidelines, where necessary attend the Nottinghamshire APC.

### 3.23 Prevention/ Personalised Care

Provision of the Community Pain Management service should support Mid Notts vision to maximise independence, good health and well-being throughout our patients lives. We want to empower local people to make healthier choices that support their own health and wellbeing. We want to ensure that people in our communities live long, healthy and independent lives.

This 'healthy' state of being should be experienced fairly by all our communities. We want to ensure that people living with an existing disability or long-term condition can live as well as possible through access to the right advice, treatment, care and support.

By enabling communities to support people to have a healthy lifestyle, with support from local services to do this, we aim to help people to manage their own health and wellbeing, alongside health and social care services if required.

- Train and support the workforce, to enable a shift in relationships, with a focus on prevention coproduction and promoting self-care for all people.
- Ensure people's lives are made better because the services or interventions they receive add benefit and focus on prevention and promoting self-care to enable them to be as independent as possible
- Embed a strength based approach enabling people to live health and fulfilled lives, increasing life expectancy and reducing disease prevalence.
- A proactive and universal offer of support to people with long term needs to build knowledge, skills and confidence through supported self-care and community-centred approaches.

### 3.24 Indicative Activity

<b>Mid NottsPCB'S</b>	<b>Est Annual Referrals</b>
Mansfield & Ashfield	1,455
Newark & Sherwood	1,337
<b>Total – Mid Notts</b>	<b>2,792</b>

**3.25 Financial Information**

Current financial value of indicative activity is:

	<b>M&amp;A</b>	<b>N&amp;S</b>	<b>Mid Notts Total</b>
	<b>£,000</b>	<b>£,000</b>	<b>£,000</b>
SFH			
NUH			
Circle			
PICS			
Other			

**4. Applicable Service Standards**

4.1 Applicable national standards (e.g. NICE)

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

4.3 Applicable local standards:

The service provider is required to adhere to all relevant national standards including (but not exclusively) the Core Standards for Pain Management in the UK 2015 and the latest NICE guidelines.

The service provider is required to adhere to the most current version of all local policies and guidelines including (but not exclusively) Nottinghamshire Prescribing formulary (APC) and Restricted Policy.

**5. Applicable Quality Requirements and CQUIN**

5.1 Applicable Quality Requirements (See schedule 4a-c)

5.2 Applicable CQUIN goals (See schedule 4d)

**6. Provider Premises/Location**

The service will be responsible for securing and funding the provision of premises for the pain management service to be delivered from, including all associated equipment and facilities such as clinic/treatment rooms.

Services will be located within Mid Notts locality, providing adequate coverage for both Mansfield & Ashfield and Newark & Sherwood PCB'S and ensuring equitable access for patients and carers (ie mobility needs, transport links, car parking and access to buildings, etc).

Location of services will need to align and integrate with the primary care locality hubs (Local Integrated Care Partnerships – LICPs) or those specific locality areas across Mid Notts (Newark: Newark Hospital, Sherwood: Crown Medical, Mansfield: Mansfield Community Hospital, Ashfield: Ashfield Health & Well-being Centre).

Current Mid Notts clinic locations are:

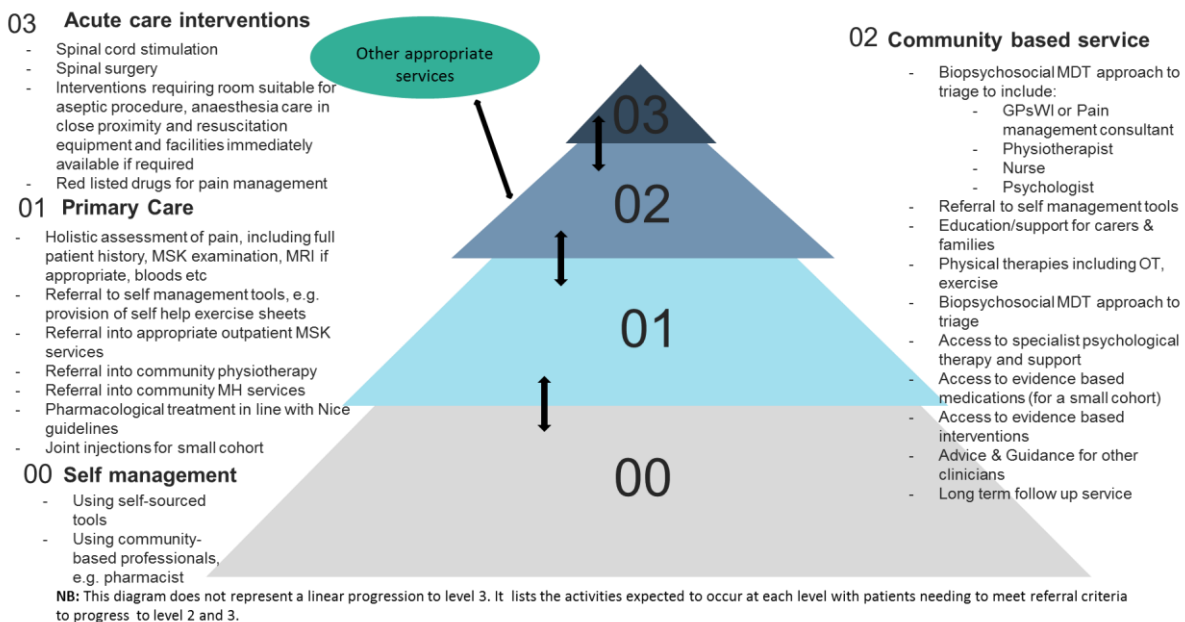
Balderton Primary Care Centre, Balderton, NG24 3HJ  
 Acorn medical Practice, Mansfield, NG18 1QA  
 Oak Tree Health Centre, Mansfield NG18 3RT  
 Oates Hill Health Centre, Sutton In Ashfield, NG17 1BE  
 Warsop Primary care Centre, Warsop, NG20 0BP  
 Rainworth Primary Care Centre, Rainworth, NG21 0AD  
 Bull Farm Primary Care Centre, Mansfield, NG19 7JZ

CPM services must be delivered in an appropriate environment. Specifications for room sizes are contained in the NHS Estates Health Building note 12 (1994). Any provider will be expected to comply with these guidelines. In addition, equipment requirements include:

- Appropriate equipment to assess and treat potential/presented conditions
- The provider must ensure that all equipment is fit for purpose and that all staff are appropriately trained to use the equipment
- The maintenance of equipment will be the responsibility of the service provider

## APPENDIX 1

### Pain Management - Representation of services provided at each level



## APPENDIX 2 – OUTCOME MEASURES/INDICATORS



### 1. Mid Notts CPMS OUTCOME MEASURES