Service Specification No.	
Service	Community Pain Service
Commissioner Lead	Mark Sheppard
Provider Lead	Alison Rounce
Period	15th July 2017 to 31st March 2024
Date of Review	*To be reviewed annually*

1. Population Needs

1.1 **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 number of referrals into the service per annum are shown by Place Based Partnership below:-

	Predicted annual referrals
Nottingham North and East	673
Nottingham West	-
Nottingham City	1647
Rushcliffe	428

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.
(note this element of the service is for Nottingham North and East, Rushcliffe and Nottingham West PCB).

2. Outcomes

2.1 <u>NHS Outcomes Framework Domains & Indicators</u>

Domain 1	**Preventing people from dying prematurely**	
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)
- Evidence of patients self-managing their condition
- A reduction in the use of medication (if appropriate) and/or optimisation of medication use
- Fewer patients requiring referral into secondary care pain services.
- 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 service

This service specification sets out the requirements for a Community Pain Service to meet and deliver high quality care to patients in a variety of appropriate community settings. 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 this level 2 community based service will be from a range of health care organisations; though most commonly the GP 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. that 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 aim of the level 2 community based service is to 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 aim of the Community Pain Service is to:-

- Improve the quality of life for patients experiencing chronic pain
- Support and empower patients and their nominated carers to take responsibility for managing their condition
- Provide a biopsychosocial approach to the management of pain, in line with NICE guidance, which utilises evidence based interventions including education, physical and psychological therapies, and pharmacological 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
- Optimising the proportion of patients able to manage pain without the need for surgical intervention, making sure all patients have completed their agreed management pathway before onward referral is considered
- Ensuring patients are reviewed holistically on entering the service to ensure treatment plans remain valid and that they are evidence based
- Improve the quality of life for patients experiencing chronic pain or CFS
- Provide a biopsychosocial approach to the management of pain or CFS, in line with NICE guidance, which utilises evidence based interventions including education, physical and psychological therapies, and pharmacological through a single point of access
- Deliver a service aligned to the NICE guidelines for CFS (last review 2014), including the delivery of Cognitive behavioural therapy (CBT) and/or graded exercise therapy (GET).

The objectives of the service are to:-

- Act as a single point of access for patients with chronic pain or CFS providing an integrated and coherent patient journey regardless of provider.
- Provide a biopsychosocial assessment for all patients as early as possible in the pathway.
- Provide a management approach for patients with chronic pain or CFS to include psychological and physical interventions, using a pain management programme where appropriate
- Support patients living with chronic pain or CFS 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
- Educate carers to continue care and support (where appropriate) learnt through the service post discharge
- 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
- Educate and support other care professionals in the early intervention of pain management techniques
- Optimising the proportion of patients able to manage pain without the need for surgical intervention (i.e. reducing acute elective activity), making sure all patients have completed their agreed management pathway before onward referral is considered

3.2 Service description/care pathway
Pain management services should be delivered through a three level system:-

- Level One - primary care services from GPs, community pharmacists, community psychological therapies, pain self-help organisations/groups and community based physical and psychological therapies.
- Level Two - community based services offering a multi-disciplinary team biopsychosocial approach to CFS or 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.
- Level Three - 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

This specification refers specifically to the delivery of the Level Two community service, with the expectation that efficient pathways between all levels of service will be clearly defined by the Level Two service provider. This provider must also clearly articulate the pathways to other levels of the service and provide support to them as necessary. This communication should include(but not exclusively) clear procedures for:-

- Advice and Guidance to all colleagues,
- Efficient, streamline referral pathways between services at all levels (primary, community and acute/secondary) both into this service and into other appropriate services 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 minimise the need to access primary care or A&E

There are two component parts to the Level Two Community Service.

A comprehensive administrative service and premises
A provider will need to deliver a service that successfully administers a community pain management service for the registered population of Nottingham North and East and Rushcliffe PCB's. This element of the service is already in place for Nottingham West PCB. The Level Two provider must work with the incumbent provider of this administrative function in Nottingham West to ensure the two component parts of the Level Two Community Service work seamlessly.

The already established administrative service in Nottingham West will:-

- Receive referrals from GPs (whether direct from GP practice or via a Clinical Assessment 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.

The service will also 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.

Clinical triage, assessment and treatment
The Level Two 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 biopsychosocial 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 two and three i.e. mild to moderate symptoms.

The service should comprise of 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 and for those patients requiring secondary care, to be referred into an appropriate hospital setting when they need specialist interventions: and to be transferred back to a community setting (if necessary) once Level Three intervention is complete.

It is expected that pain management and CFS therapies including CBT and GET will be delivered within the Level Two service. The community service must be able to provide level 2 and 3 CBT therapies. All interventions must be in line with the local PLCV, the Core Standards for Pain Management in the UK 2015 and latest NICE 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 Two service should build on key principles that underpin bio-psychosocial pain management and the core IAPT programmes.

The model of care is shown in the Appendix 1.

The Community Pain 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.

The service will also:-

- Provide pain management (or CFS specific if appropriate) education sessions to meet patient needs and manage expectations
- 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 patient back into the community service following secondary care intervention
- Encourage and support self-management by patients and/or their carers
- Encourage and support shared decision making involving the patient and/ or their carers

Access to Level Three services will follow a multi-disciplinary review. It is expected that where clinically appropriate, patients will be transferred back to Level Two care for their ongoing management following a secondary care episode. The Level Two 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 optimized before referral
    - Provide direct listing for interventions.

The use of a "never discharged but not followed up" 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 standardised language and terminology to enable colleagues across services to talk to the patient regarding their care plan (where necessary) using common language 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 Service, including outcomes achieved.
- The results of all tests and any fit for surgery/procedure assessment. Recommended procedure(s) or diagnostics where appropriate.
- Full information about any recommended procedure(s).
- Recommendations for ongoing care if the patient has not being referred onwards

3.3 Population covered
This service will cover the population aged 18 years and over, comprising of the PCB's relevant PCB's population

3.4 Any acceptance and exclusion criteria and thresholds
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 Greater Nottingham.

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

- Patients aged less than 18 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

3.5 Interdependence with other services/providers
It is expected that the provider of the Level Two 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 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 service 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.

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 surgery.

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 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 optimize 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 can be part of any MDT discussions when this is deemed appropriate for the client, e.g. substance misuse services.

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.

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) formulary and PLCV

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4A-C)

5.2 Applicable CQUIN goals (See Schedule 4D)

6. Location of Provider Premises

The Provider must hold clinics within each PCB locality, current clinic locations are at:

Cotgrave Surgery, Cotgrave, NG12 3LP
Bay Therapy Centre, West Bridgeford, NG2 5BB
Highcroft Surgery, Arnold, NG5 7BQ
Magnolia Therapy Centre, Carrington, NH5 2EF
Whyburn Medical Practice, Hucknall, NG15 7JE
Humber Therapy Centre, Beeston, NG9 2FD
Oaks Medical Centre, Beeston, NG9 2NY
Hama Medical Centre, Kimberley, NG16 2NB

The Provider's Premises are located at:

Unit H4 Ash Tree Court
Mellors Way
Nottingham
NG8 6PY

APPENDIX 1

Pain Management - Representation of services provided at each level

03 Acute care interventions

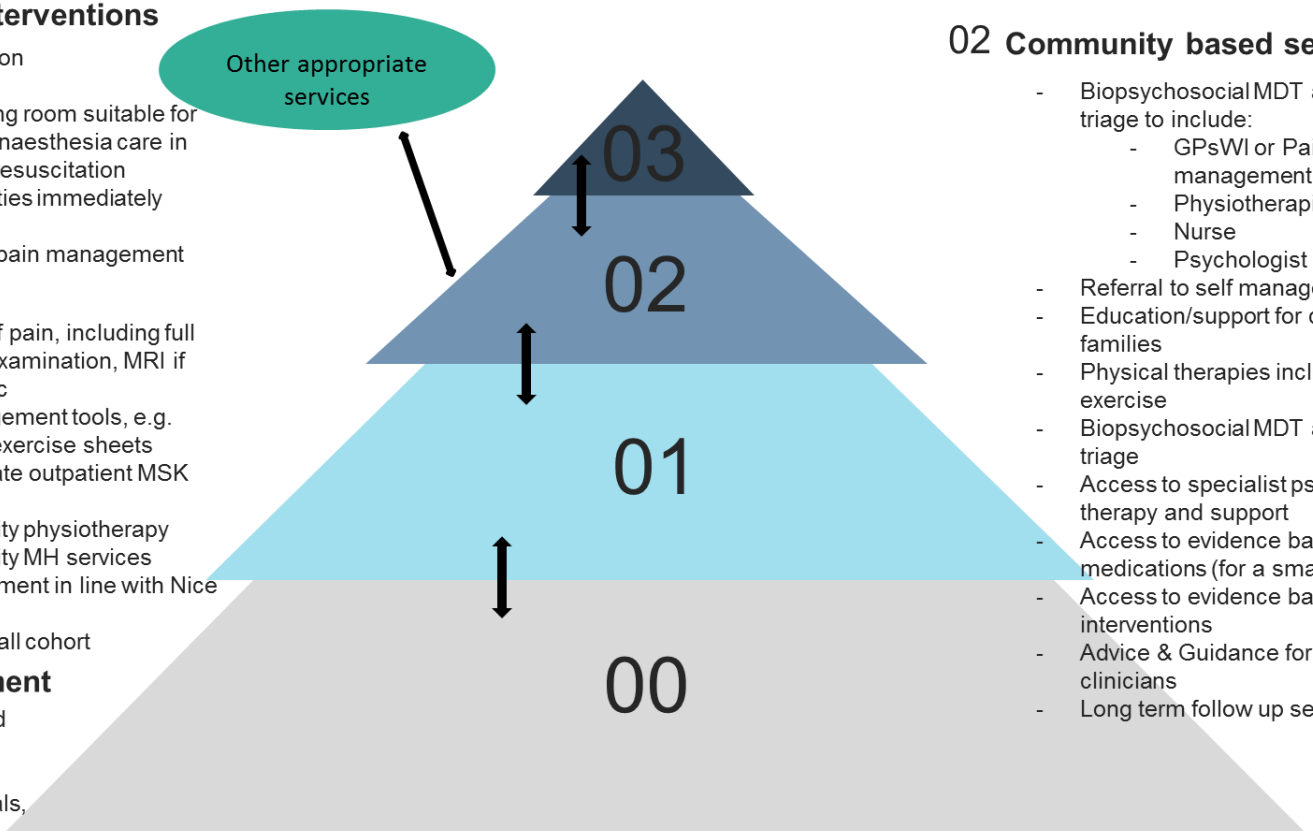
- Spinal cord stimulation
- Spinal surgery
- Interventions requiring room suitable for aseptic procedure, anaesthesia care in close proximity and resuscitation equipment and facilities immediately available if required
- Red listed drugs for pain management

01 Primary Care

- Holistic assessment of pain, including full patient history, MSK examination, MRI if appropriate, bloods etc
- Referral to self management tools, e.g. provision of self help exercise sheets
- Referral into appropriate outpatient MSK services
- Referral into community physiotherapy
- Referral into community MH services
- Pharmacological treatment in line with Nice guidelines
- Joint injections for small cohort

00 Self management

- Using self-sourced tools
- Using community-based professionals, e.g. pharmacist



02 Community based service

- Biopsychosocial MDT approach to triage to include:
  - GPsWI or Pain management consultant
  - Physiotherapist
  - Nurse
  - Psychologist
- Referral to self management tools
- Education/support for carers & families
- Physical therapies including OT, exercise
- Biopsychosocial MDT approach to triage
- Access to specialist psychological therapy and support
- Access to evidence based medications (for a small cohort)
- Access to evidence based interventions
- Advice & Guidance for other clinicians
- Long term follow up service

NB: This diagram does not represent a linear progression to level 3. It lists the activities expected to occur at each level with patients needing to meet referral criteria to progress to level 2 and 3.