SCHEDULE 2 – THE SERVICES

A. Service Specifications (Full Length Contract)

Mandatory headings 1-4. Mandatory but detail for local determination and agreement
Optional heading 5-7. Optional to use, detail for local determination and agreement.

NHS England guidance on completion is in red italics

Service Specification No.	
Service	*Community Persistent Pain Service*
Commissioner Lead	*Service Delivery and Transformation Directorate*
Provider Lead	
Period	*3 years*
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

Chronic pain is pain affecting any part of the body which lasts beyond the expected time for healing. It may occur when no obvious cause can be found and may be accompanied by changes in the central or peripheral nervous system. The Department of Health recognises pain as a Long Term Condition (LTC) in its own right and as a component of other LTCs.

The British Pain Society report that chronic pain affects 43 per cent of adults, just under 28 million people currently live with chronic pain in the UK. Prevalence is higher in older age groups with 62% of those affected aged 75 and 30% of young adults aged 18-39 years are affected.

Healthcare utilisation increases as chronic pain accounts for 4.6 million GP appointments per year, which is 15-22% of all GP consultations. The social cost is estimated at £12.3 billion per annum with 119 million working days lost per year to back pain.

The Chief Medical Officers report (2008) tells us that 16% of sufferers feel that their chronic pain is so bad they sometimes want to die. Low back pain is ranked highest out of 291 conditions studied by the Global Burden of Disease study and ranked number one for years lost to disability worldwide.

In summary, 1.6 million people in UK and 18,000 people in Dorset move from acute to chronic back pain each year (Chronic Pain Policy Coalition). In Dorset, two people every hour slip into chronic pain, adding to the 125,000 people in Dorset who already live with persistent pain.

Evidence suggests that the most effective care for patients with chronic, persistent pain is that which enables the patient to understand and come to terms with their pain and to adopt strategies for living, which allow them to lead as fulfilling and independent lives as possible. This is to be achieved throughout the pathway beginning with the integrated provision of supported self-care and optimised medical therapy delivered in Primary Care at the onset of pain and onward referral, at an agreed time to a Community Pain Management Service which will provide enhanced pain management.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

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

Any relevant indicators from the NHS Outcomes Framework may be added here. If the Provider is to be held accountable for them, they should be included in the locally agreed quality requirements.

2.2 Local defined outcomes

Any broad outcomes to which the service should be working should be inserted here.

3. Scope

3.1 Aims and objectives of service

The aim of this service is to enable adults living with persistent pain (of at least 3 months' duration with a definitive diagnosis, including Medically Unexplained Symptoms, and/or when the patient and GP agree and accept that the pain has become chronic/persistent) to understand and come to terms with their pain and to adopt strategies for living, which allow them to lead as fulfilling and independent lives as possible.

This is to be achieved throughout the pathway beginning with the provision of supported self-care and optimised medical therapy delivered in Primary Care at the onset of pain and onward referral to a Community Pain Service which will provide enhanced pain management.

The accountable provider will offer all modalities of the service i.e. GP training and the Clinical service including specialist pain management medical, nursing, clinical psychology, physiotherapy and occupational therapy provision.

The service will;

- Work with and educate GPs to safely optimise the use of analgesia and self-management tools and techniques.
- Act as a Single Point of Access for patients referred with persistent pain of at least 3 months duration with an acceptance that the pain has become chronic i.e. persistent.
- Support patients in understanding their quality of life issues in the context of their persistent pain.
- Support and signpost patients to gain a good level of information and health literacy about persistent pain and its associated manifestations.
- Encourage and support patients to become actively involved, in developing and taking forward the strategies that they will adopt in response to their persistent pain – as detailed in a jointly developed Personal Care Plan.

- Support and empower patients to gain or regain self-belief and confidence.
- Promote patients in taking as much responsibility as possible for implementing their Personal Care Plan outside of their contact with the healthcare system.
- Encourage patients to be active partners in reviewing their Personal Care Plan at agreed intervals.
- Reduce dependency and enhance quality of life for patients and families/carers.
- Promote peer support amongst patients and their families within the service and independent of the service.
- Encourage patients to play an active role in delivering the service as a mentor or as a group facilitator.
- Ensure all staff actively promote best practice, evidence-based, person-centered pain management support to service users and other professionals.
- Review and redesign the service in response to feedback from service users, key partners and evidence based best practice.
- Implement opportunities for ongoing pain management training and development of healthcare professionals.

3.2 Service description/care pathway

- The Community Pain Management Service will receive referrals from Primary Care via E-referrals and from Secondary Care with written consent from the patient's GP.
- The service will work directly with people who live with persistent pain of more than 3 months duration with an acceptance that the pain has become chronic i.e. persistent, to mutually agree, develop and implement Personal Care Plans and set realistic goals which are regularly reviewed supporting the ethos of self-care and self-management.
- The service will hold regular multidisciplinary and inter-speciality team meetings to discuss complex patients and their needs.
- The service will provide 'outcome' targeted Wessex Deanery and Faculty of Pain Medicine accredited training and support for GPs and other frontline staff about how best to support people who live with persistent pain. Training will be delivered at a level which will be clinically effective and may take the form of a 1:1 teaching clinic, GP training Forum and by electronic means as appropriate.
- The service will facilitate health supplied group programmes e.g. intensive pain management programmes and signpost to non-health supplied group programmes e.g. expert patient pain programmes as required.
- The service will provide psychological support to patients, their family and carers within a stepped model of care up to step 2 interventions and refer to Improving Access to Psychological Therapy (IAPT) / talking therapies as required.
- The service will provide interventional procedures in line with the NHS Bournemouth and Poole and NHS Dorset Interventional Procedures in the Management of Spinal Pain Policy.

- The service will distribute relevant information and signpost service users and families to robust pain management information, both written and electronic and to other appropriate services such as return to work programmes or physical activity programmes.

- The service will work closely with agencies who promote return to work or volunteering, weight loss, alcohol and substance misuse support and support for increased physical activity.

The integrated service will provide all modalities i.e. supported self-management, psychological support, medication advice, physical activity, injection therapy and signposting and will be located within community venues across Dorset, Bournemouth and Poole.

The service will be underpinned by the evidence which suggests that optimal pain management is achieved by a combination of optimal pain relief and optimal self-management with psychological and peer support playing a major role in the service provision.

The service will be provided by a multidisciplinary team of professionals including doctors who have been trained and have appropriate competencies in pain medicine as defined by the Faculty of Pain Medicine, nursing, clinical psychology, physiotherapy and occupational therapy services with specialist pain management skills. The doctor's role will be to provide medicines management and pharmaceutical advice to GPs, the prescription of medications according to the traffic light status and performing interventional therapy in line with the NHS Dorset CCG Interventional Procedures in the Management of Spinal Pain Policy.

All staff will be competent in motivational interviewing. Specific skills in delivering cognitive and behavioural therapies, exercise therapy and joint protection for patients with chronic, persistent pain will be encompassed within the service. The team will be managed with a strong multidisciplinary team ethos which includes the patient and their GP.

The key factors are to ensure that:

- Patients understand their condition and are able to achieve realistic expectations.

- Patients make informed and personally relevant decisions about the use of analgesia including injection therapy.

- Patients are supported to optimally self-manage their condition.

- The principles of optimal pain management become widely understood and embedded within Primary Care and social services.

To achieve the model, the service will provide the clinical service plus Wessex Deanery and Faculty of Pain Medicine accredited training for GPs. The success of the service will depend on the quality of referral and work up of patients in Primary Care.

The clinical service will;

- Triage referrals and return those who do not meet the referral criteria, referring patients on promptly where other pathologies are suspected. (returned referrals will be accompanied by guidance and further training will be offered).
- Provide a holistic assessment including explanation of the cause(s) of an individual patient's pain and its associated effects on psychological, physical and social functioning and wellbeing and the impact on the patient's quality of life.
- Provide up-to-date, relevant information about the individual patient's pain and the support and self-management options available to them.

- Work collaboratively with individual patients on personalised care planning, review and outcome monitoring according to best practice guidance. This will include planning for a 'flare up' of pain or acute pain on top of existing chronic, persistent pain.
- Provide motivational interviewing and counselling type interventions based on the stepped model of care including cognitive and behavioural therapies, on an individual basis.
- Refer to IAPT (Improving access to Psychological Therapies)/ talking therapies as required.
- Provide intensive Pain Management Programmes for groups of patients which include psychological, physical/exercise and social elements.
- Provide advice on safe levels of physical activity and joint protection.
- Perform medication reviews (conducting or facilitating according to 2009 NICE guidance re: concordant interviewing) within current formulary offering advice and guidance to individual patient's GP. Medication will be prescribed according to the traffic light status.
- Consider the need for specialist injection therapy where required in accordance with the NHS Bournemouth and Poole and NHS Dorset Interventional Procedures in the Management of Spinal Pain Policy and taking patient choice into consideration.
- Deliver interventional therapy in a safe environment in line with national and local guidelines (Interventional therapy should be provided in conjunction with other pain management techniques to enable the patient to live as full a life as possible following intervention).
- Arrange and coordinate access to patient led Pain Management Programmes and individual mentors.
- Provide telephone support to the patient either from a member of the service or expert patient/mentor as appropriate.
- Provide on line and web support for patients.
- Hold regular multidisciplinary team meetings to discuss and agree a management plan for complex cases. Inter specialty meetings will be called as needed and may include orthopaedic and spinal surgeons, neurologists, oncologists, rheumatologists, gynaecologists etc.
- Hold a menu of options for the provision of associated interventions such as exercise programmes, alternative therapies e.g. aromatherapy and massage, local walking groups and sports and leisure opportunities that are provided locally by other agencies.
- Signpost or refer and support patients to other services such as weight loss programmes, drug and alcohol misuse support, voluntary agencies and social services.
- Liaise with return to work, voluntary and benefits agencies enabling patients who have been medically signed off work to understand the personal and financial implications of returning to work, either paid or voluntary.
- Assess, triage and refer patients who would benefit from a spinal surgical opinion and potential surgical intervention in line with the Pan Dorset Low Back and Radicular Pain Pathway.
- Consider and advise the patient's GP of the need to be referred to an inpatient pain management services.
- Facilitate discharge through a shared decision making format.
- Undertake clinical audit and research.

- Collect and collate service utilisation, effectiveness, safety and patient experience data.

Training

The service will provide training and information to referring GPs on the role and aims of the Community Pain Service including referral criteria. This will ensure patient engagement and realistic expectations of the service with referral in a timely manner.

The service will provide an ongoing and rolling Wessex Deanery and Faculty of Pain Medicine accredited and nationally recognised training programme with CEPD for GPs which aims to increase the knowledge and skills in supporting patients to manage their persistent pain on a day to day basis.

The training programme will cover the following:

- Education on the causes and types of persistent pain.
- Definitions, myths and misconceptions about persistent pain.
- Service user perspectives.
- The cost of pain to individuals and the health economy.
- The importance of service user empowerment, activation and self-management.
- Effective Primary Care management including optimal analgesia within current formulary.
- The utilisation of assessment and risk stratification tools.
- The utilisation of motivational interviewing.
- The role of specialist injections.
- The role of counselling and psychological support.
- Advice and guidance on particular cases throughout the pathway.
- Clinical audit and research in Primary Care.
- Mentorship, clinical governance and clinical supervision.

The training programme may be delivered individually but will primarily be delivered within a GP forum setting.

GPs with special interest in persistent pain will be identified from within two to three localities and will deliver further education and training to locality GPs. They will also take the lead for assessing and treating more complex patients within the community.

GPs will be encouraged to attend the Community Pain Service to shadow a clinician or a patient.

On request, a Community Pain Service clinician will attend a joint GP clinic appointment for complex patient assessment, review and treatment advice.

The service will ensure that patient feedback is collected and that this is used to inform the ongoing development of GP training.

3.3 Population Covered

The service is available to people who are:

- Adults aged 18 years or over or in transition from paediatric services (16 – 18);
- Registered with a Dorset GP and eligible for NHS treatment;
- Meet the referral criteria detailed in this service specification.

The service is also available to adults aged 18 years or over who are registered with non-Dorset, Bournemouth or Poole PCT GPs or foreign nationals provided the relevant cross-charging mechanisms are put in place.

The service will be underpinned by the evidence which suggests that optimal pain management is achieved by a combination of optimal pain relief and optimal self-management.

3.4 Any acceptance and exclusion criteria.

People referred to the Dorset Community Pain Management service will have:

- Experienced high levels of pain-related distress or disability and/or with low levels of confidence to self-manage.
- Experienced daily pain of more than 3 months duration and undergone an appropriate diagnostic screen.
- Continued to suffer from pain-related distress or disability despite taking optimal analgesics and have made an informed choice to engage with the service.

or

- Made an informed choice not to undergo specific treatment of any underlying condition if available).

and/ or

- Are considered likely to benefit from enhanced self-management strategies.
- Are unlikely to benefit from other medical or surgical-based management.

and/or

- Advice and guidance i.e. the GP requests advice and guidance on the day-to-day management and strategies for an individual patient.

Referral will be accepted where a patient has:

- Accepted that their pain will not be cured;
- Been optimised on medication within Primary care or the GP requests advice and guidance regarding medication issues;
- Other interventions have had no or a limited effect;
- The risk of surgical/medical intervention outweighs the benefits e.g. joint surgery with high surgical risk;
- Curable causes have been excluded.

Exclusion Criteria

- Patients who have not been appropriately investigated or with red flags.
- Patients (and their families) who are not motivated to be referred to the service.

Interdependence with other services/providers

The service will maintain and develop constructive working relationships with a range of relevant staff and organisations particularly:

- Acute hospital consultants and other acute hospital staff from the NHS and Independent sectors e.g. orthopaedics, rheumatology, oncology and neurology.
- Community services particularly physiotherapy, interface services including substance misuse services, occupational rehabilitation and return to work agencies and voluntary organisations.
- GPs and practice staff.
- Community pharmacies and Medicines Management Services.
- Social Services.
- Service user groups.
- Carers and family members.
- Leisure centres and exercise instructors.

Interdependencies

The successful delivery of this service is dependent on the:

- Number and quality of referrals from GPs.
- Expectations of service users and families/carers.
- Quality of care provided in Primary Care.

Relevant Clinical Networks and Screening Programmes

Musculoskeletal Commissioning Programme.

4. Applicable Service Standards

To be confirmed.

4.1 Applicable national standards (eg NICE)

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

4.3 Applicable local standards

This section may be used to identify NICE standards, other national standards and any locally agreed standards that are relevant to the service.

5. Applicable quality requirements and CQUIN goals

To be confirmed.

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

The reference numbers for quality requirements and CQUIN goals which apply to the service can be listed here. This allows clarity about the requirements relating to specific services.

6. Location of Provider Premises

The Provider's Premises are located at:

Geographic coverage/boundaries

The service will be entirely provided in non-acute hospital settings across at least 5 main sites including: Bournemouth, Poole, West Dorset, Weymouth and Portland, North and mid Dorset.

Location(s) of Service Delivery

The service will be delivered in a variety of locations which facilitate convenient and prompt access for patients, to minimise disruptions to their personal commitments or those of their carers and family members, and to support their recovery.

The service will be located and available at times and places which reflect the relative population demographics and anticipated needs of a particular geographical area.

The locations and times of service operation will be made as simple, straightforward and as clear as possible to patients, their families and carers.

Days/Hours of operation

The service is to be provided at times which optimise the patient's ability to attend and minimise disruption to their personal commitments or those of their carers or family members. The operating times should reflect and accommodate wherever possible patient's personal circumstances and commitments and their choice of venue and time of appointment.

Group interventions will preferably be delivered in a non-medical site e.g. leisure centre, community centre, village hall.

7. Individual Service User Placement

This section may be used to include details of any individual service user placements (eg for care homes). This is likely to be relevant where the service provides tailored specialist placements. It may also be used to record any specialist equipment that is provided as part of an individual care pathway.