

SCHEDULE 2 – THE SERVICES

A. Service Specifications (Full Length Contract)

Service Specification No.	11J/0246
Service	Dorset Pain Management Service
Commissioner Lead	NHS Dorset CCG - Elective Care
Provider Lead	Dorset HealthCare
Period	01 April 2019 – 31 March 2022
Date of Review	Annually

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.

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.

Historically, both nationally and locally, patients have been referred to specialist pain clinics within Secondary Care with limited input from their GP leading to overburdened services which primarily deliver interventional treatments with limited physical, psychological and social assessment, goal setting and personalised care planning.

In 2012, Dorset was innovative in moving to a community based pain service model; this specification further enhances this approach with the Community Pain service offering a multi-disciplinary interface service between primary, community and acute care services.

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	

2.2 Local defined outcomes

1. Provide a single point of access into the service;
2. Work towards developing a triage service within 6 months to ensure patients are triaged within 48 hours of referral;
3. Provide enhanced knowledge and skills within Primary Care in the daily management of persistent pain with particular focus on the provision of optimal pain relief. The service will offer a rolling programme of education and training in accessible formats to 100% of GP Practices.
4. Provide pain education and support service users to achieve an improved quality of life whilst they continue to live with persistent pain. Improvement in confidence, self-care, clinical outcomes, and quality of life outcomes will be evaluated through patient questionnaires and surveys. Including EQ-5D-5L;
5. Appropriate referrals to and from the Community Pain Service in line with MSK, spinal and other relevant pathways;
6. Reduced uptake of interventional therapies for persistent pain;
7. Reduction in the number of patients on opioid medication;
8. Increased uptake of:
 - Pain management programmes;
 - Peer support for service users with persistent pain
 - Self-management strategies and tools.

The service will be expected to adopt an evidence-based method of measuring patient outcomes, utilising where possible any digital solutions.

3. Scope

3.1 Aims and objectives of service

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.

The aim of this service is to enable adults living with persistent pain of at least 3 months' duration with a definitive diagnosis 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 whole 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 to provide enhanced pain management at an appropriate point.

The Community Pain Service will consist of a multi-disciplinary team that can support patient's physical, psychological and social needs associated with pain. It will ensure patients experiencing chronic pain are appropriately managed in a community environment and to refer elsewhere as required and in line with the pathway in Appendix 1.

Health Care Professionals (HCPs) will provide a holistic assessment and formulation including explanation of the cause(s) of an individual patient's pain and its associated effects on psychological, physical, social functioning, wellbeing and the impact on quality of life.

The provider will:

- Act as a single point of access for patients requiring a Community Pain Service;
- Work with and educate GPs to safely optimise the use of analgesia and self-management tools and techniques;
- Support patients in understanding and optimising their quality of life 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 Self-Management 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 Self-Management Plan outside of their contact with the healthcare system;
- Encourage patients to be active partners in reviewing their Personal Self-Management 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

Please find Dorset's Low Back and Radicular Pain Pathway which was agreed in 2018 attached in Appendix 1, services will be delivered in line with this pathway.

PRIMARY CARE

Initially patients will be managed in primary care by their GP where they will be offered first line advice and treatment consisting of:

- Assessment of pain symptoms and pain flare-ups and changes in physical function and / or emotional distress;

- Encourage self-management through education and support including encouraging accessing community pharmacists;
- Diagnostic tests including diagnostic imaging;
- Medicines optimisation for the patient.

If the GP feels the patient should be referred to the Community Pain Service, they will be provided with the details for a patient decision aid tool. This tool will provide patients with an overview of the role of the pain service and the ability to refer themselves and generate a GP referral request to obtain specific information from the patient's GP Practice.

COMMUNITY PAIN SERVICE

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 Self-Management Plans and set realistic goals which are regularly reviewed supporting the ethos of self-care and self-management.

The service will be delivered from community-based venues as far as reasonably possible.

The service will have agreed referral guidelines which will support the provision of all modalities i.e. supported self-management, psychological support, medication advice, physical activity, injection therapy, occupational, educational support and signposting and will be located within community venues across Dorset ensuring equity of provision across the county.

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.

Triage

- Referrals into the Community Pain Service will be managed by a dedicated triage service and completed within 48 hours of receipt (to be developed within the first 6 months);
- Referrals can be accepted from Primary, Community and Secondary Care Services via the e-referrals system in line with the service's referral guidelines in appendix 2;
- Triage will be virtual and based on the information provided on the referral form with no direct contact with the patient at this stage;
- Incomplete or out of date referral forms will be returned to the referrer;
- The outcome of DCPS triage will be:
 - Returned to the GP with advice from the DCPS;
 - Acceptance into the service;
 - Onward referral to secondary care within 1 operational day of triage if required.

The service will:

- Provide a holistic assessment including understanding of 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 persistent pain and the support and self-management options available to them;
- Support delivery of the psychological element of the Combined Physical and , Psychological Programme (CPPP);
- Work collaboratively with individual patients on personalised self-management planning, review and outcome monitoring according to DH best practice guidance. This will include planning for a 'flare up' of pain or acute pain on top of existing chronic, persistent pain;
- Use a motivational interviewing approach within Psychological therapies based on the stepped model of care including cognitive and behavioural therapies, on an individual basis;
- Refer to IAPT (Improving Access to Psychological Therapies) as required via the triage service.
- Provide Pain Management Programmes for groups of patients which include the components of psychological, occupational and physical therapy, advice on medication and injections and an overall understanding of chronic pain;
- Provide advice on safe levels of physical activity, movement and fitness;
- Develop an email / telephone process for offering advice and guidance service to GP Practices during operational hours of the service.
- Co-ordinate the development of a multi-disciplinary management plan for patients who require a reduction in their opioid medication.
- 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.
- Provide a service in line with NHS Dorset's Interventional Procedures in the Management of Low Back and Radicular Pain Policy;
- 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 online and web support for patients;
- Hold regular multidisciplinary team (MDT) meetings to discuss and agree a management plan for complex cases in line with the Terms of Reference for MDT's being developed through the Spinal Steering group.
- Signpost to a menu of options for the provision of associated interventions such as exercise programmes, alternative therapies e.g. 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 Spinal Surgery Service specification;
- Facilitate discharge through a shared decision-making format;
- Undertake clinical audit and research;
- Collect and collate service utilisation, effectiveness, safety and patient experience data.

Access Times

- Waiting times should be in accordance with the standards defined by the International Association for Study of Pain. The service will be monitored against the following:
 - Percentage of patients waiting 8 weeks for their first face to face clinical assessment / treatment following completion of routine triage (this does not include information sessions) with a target of 92%;
 - Number of patients waiting over 26 weeks with a target of 0.
- 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.

Access to Diagnostics

- The service will have access to electronic patient results for x-ray, phlebotomy, MRIs and other diagnostic tests to support a fully informed decision of management and patient acceptance. The Provider shall be responsible for ensuring a manual system is in place in the interim, if required.
- If further diagnostics are required, the service should establish a mechanism by which they are able to access these via the MSK Interface Service without discharging the patient.

Discharge

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

Training

The service will provide a rolling training programme to Dorset GPs and other healthcare professionals on the role and aims of the Community Pain Service including referral criteria and support for opiate management.

3.4 Any acceptance and exclusion criteria.

Please refer to the Referral Guidance in Appendix 2 document for a detailed list of inclusion and exclusions. A summary is provided below.

Inclusion

- Have undergone all appropriate diagnostics and reasonable treatment for their pain;
- Are willing to accept that chronic pain may not go away;
- Are willing and able to engage in supported self-management;
- Are motivated to change patterns of behaviour and learn new techniques of managing their pain.

Exclusion:

- Patients who have not been appropriately investigated with red flags;
- Patients suffering from an acute mental illness at the time of referral;
- Patients actively using illicit substances;
- Patients who are not motivated to engage with the service being offered.

3.5 Interdependence with other services/providers

The provider will need to ensure good communication with other Health Care providers especially GPs, Acute and Community services.

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;
- GP Practices;
- 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 referrers, service users and families/carers.
- Quality of care provided in Primary Care.
- Roll-out of the self-management approaches.

Relevant Clinical Networks and Screening Programmes

- Musculoskeletal Programme.

Subcontracting

In order to make best use of local resources, some or part of the service may be subcontracted to another provider. For example, the triage element of the Community Pain Service is crucial in ensuring the right patients get to the right service at the right time, this could be carried out independently from the main clinical service and therefore not impact on the service's clinical capacity.

4. Applicable Service Standards

- 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**

5. Applicable quality requirements and CQUIN goals

- 5.1 Applicable quality requirements (See Schedule 4 Parts A-D)**
- 5.2 Applicable CQUIN goals (See Schedule 4 Part E)**

6. Location of Provider Premises

The Provider's Premises are located at:

The service must be provided from a variety of community locations throughout Dorset in line with patient demand and ensuring equity of provision.

The locations and times of service operation will be made clear to patients, including information on car parking and public transport options.

7. Individual Service User Placement