

D08/S/a

**NHS STANDARD CONTRACT  
FOR SPECIALISED PAIN**

**SCHEDULE 2- THE SERVICES- A. SERVICE SPECIFICATIONS**

<b>Service Specification No.</b>	D08/S/a
<b>Service</b>	Specialised Services for Pain Management (Adult)
<b>Commissioner Lead</b>	
<b>Provider Lead</b>	
<b>Period</b>	12 months
<b>Date of Review</b>	

## 1. Population Needs

### 1.1 National/local context and evidence base

#### National Context

Chronic Pain is a long term condition where patients have persistent pain or repeated bouts of intermittent pain and it is a condition in its own right or as a component of other long term conditions. For a small group of people this will prove to be a refractory disabling condition that requires specialised services.

Around 14 million people in the UK, both children and adults suffer with persistent/ chronic pain. The prevalence of pain based on health care records from European studies has shown that of all people consulting in primary care over a one year period approximately 30% of people attend for help with pain, half of these contacts were about chronic or recurring pain and two thirds were about musculoskeletal conditions. These findings align well with self-reported surveys. The burden of chronic pain has recently been emphasised by the Health Survey for England, 2012.

Historical studies of the time trends in pain prevalence have highlighted the increase in prevalence of pain. Harkness et al studied two cross sectional population surveys in the North of England undertaken 40 years apart which showed a significant rise in

musculoskeletal pain. Similarly, a US researcher has found an increase in severe chronic impairing back pain in North Carolina from 4% to 10% in surveys conducted between 1992 and 2006.

With an ageing population, increasing levels of obesity and decreasing levels of physical activity, the need for pain management is expected to rise

The routine assessment and management of pain is a required competency of all healthcare professionals as well as being an important component of health care planning. Persistent pain is frequently accompanied by substantial co-morbidities, such as diabetes, arthritis and heart disease, which makes the clinical management of the patients needs more difficult. Most patients with chronic pain can be well managed in the community or local hospitals by appropriately trained members of interdisciplinary Pain Management Services; these services will be commissioned by the CCGs. However, some patients with more complex chronic pain problems will require management in centres that offer Specialised Pain Management Services. There are currently approximately 6-10 Specialised Pain Management Centres in the UK that provide tertiary specialised services.

The number of tertiary specialised pain patients seen varies by centre, due to local pathways, specialism provided and service capacity available. Centres see between 400 and 2,000 new patients a year. Better coding in the future will give a better picture of activity and demand

The National Pain Audit 2012 demonstrates a paucity of local pain management centres, meeting basic standards, in certain parts of the country.

### **National policy initiatives**

The Pain Summit held in 2011 sets out the key objectives for services for people in pain from health promotion to highly complex care.

The Faculty of Pain Medicine of the Royal College of Anaesthetists is the statutory body that sets standards for pain services nationally. The British Pain Society also sets out standards for this service and unless advised otherwise by commissioners, providers are expected to work to the standards set by these bodies and any successor organisations standards and objectives. As these will change over time, guidance is referenced here, but it is not the expectation of commissioners that this is static and complete but rather it is statement of current policy which evolves.

Chief Medical Officers report of 2008, when pain management was identified as a priority:

[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_096233.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_096233.pdf)

- Chronic Pain Policy Coalition - A report of the Pain Summit 2011  
<http://www.painsummit.org.uk>

National Pain Audit 2012 -

[http://www.britishpainsociety.org/members\\_articles\\_npa\\_2012.pdf](http://www.britishpainsociety.org/members_articles_npa_2012.pdf)

Health Survey for England: [https://catalogue.ic.nhs.uk/publications/public-health/surveys/health-surv-eng-2011/HSE2011-Ch9-Chronic-Pain.pdf](https://catalogue.ic.nhs.uk/publications/public-health/surveys/health-surveys/health-surv-eng-2011/HSE2011-Ch9-Chronic-Pain.pdf)

- British Pain Society (BPS) with Australian and New Zealand College of Anaesthetists (ANZCA) (2010) Acute Pain Management: Scientific Evidence (3rd Edition)
- British Pain Society (2012) Spinal Pain Working Group Consensus Opinion.
- British Pain Society (2010) Best practice in the management of epidural analgesia in the hospital setting
- British Pain Society (2010) Opioids for persistent pain: Good practice
- British Pain Society (2010) Cancer Pain Management
- British Pain Society (2009) 'Spinal cord stimulation for the management of pain'
- British Pain Society (2008) 'Intrathecal drug delivery for the management of pain and spasticity in adults; recommendations for best clinical practice'
- British Pain Society (2007) 'Recommended guidelines for pain management programmes for adults'
- British Pain Society, Royal College of Psychiatrists, Royal College of General Practitioners and Advisory Council on the Misuse of Drugs (2007) joint guidance 'Pain and substance misuse: improving the patient experience' P40-41 section 4.4.2
- The Assessment of Pain in Older People (2007) – Guidance from the British Pain Society
- British Pain Society - the use of drugs beyond license in palliative care and pain management

## 2. Outcomes:

### 2.1 NHS Outcomes Framework Domains & Indicators

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

**Appendix 1 outlines quality and outcome measures for each of the NHS Outcomes Framework Domains and Indicators.**

### **3. Scope**

#### **3.1 Aims and objectives of service**

The aim of the service is to provide patients with persistent disabling pain a service which delivers timely, skilled interventions to reduce or remove the cause(s) of pain and/or to enable patients to manage their pain with psychological and behavioural support that their local secondary pain service or another tertiary service have not been able to achieve. This service specification relates to adults but there are significant overlaps in terms of the tertiary specialisms and in particular in relation to young people and transition.

Objectives of the services are to:

- Promote the highest possible quality of life for patients with persistent pain.
- Provide accurate diagnosis
- Support to clinicians in managing the pain element of their patients care
- Direct interventions to reduce, eradicate or manage the pain
- Provide psychological and behavioural interventions that support patients and their carers in managing their pain, enabling them to lead more normal lives with reduced disability
- Provide inpatient support particularly around the management of pain problems of high medical and psychological complexity, and around the use of controlled drugs
- Reduce recurrent inappropriate admissions and other health care services by promoting self management
- Increase social and physical functioning, promoting return to work and maintaining productivity through employment
- Promote independence and wellbeing for patients through the provision of structured self-management support, with concomitant benefits of fewer inappropriate medical appointments and readmissions.
- To improve the experience of patients who are long-term survivors of cancer and other life-limiting disease.

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

Specialised Pain Management Centres (PMC) are geographically distributed dedicated centres designed for national delivery of services and resourced to provide highly specialist treatments. Generally, they are placed within a teaching hospital environment working in close association with community and local pain management services.

A Specialised Pain Management Centre (PMC) consists of key professionals (clinical and academic) who have a remit to lead and deliver the highest standard of patient care, research, audit output, teaching, and training in the area of complex pain and pain-associated disability, within a dedicated environment.

Complex pain interventions - it is often not the complexity of the treatment alone that requires a specialised service, but the fact that the treatment also requires a multi speciality approach, or some of the time a fully integrated or “interdisciplinary” team approach. Often this is shared care situation with primary and secondary care that requires a dedicated Specialised Pain Management Service.

### **Access**

There is not currently a national specification for pain services at primary and secondary care and not every Clinical Commissioning Group (CCG) commissions this activity explicitly. This specification addresses the tertiary specialised pain services to be commissioned by the NHS England. It will inform the services to be commissioned by CCGs. Differential commissioning arrangements have meant that access to services has not been standardised and although around six centres that meet the criteria for specialised commissioning have been identified, to ensure equity of access this will need to increase to at least one centre in each area.

Treatments involving complex manipulation of medication under consistent supervision in an inpatient setting. This can include opioids. Patients requiring intensively supervised medication management can have excessive lengths of stay and multiple re-admissions if not managed appropriately and usually have pain related psychological and psychosocial problems.

Procedures for patients with complex pain and pain-associated disability that require computerised tomography (CT) scanning or other specialised imaging, supported by multispecialty and interdisciplinary input, that cannot be undertaken using simpler imaging.

Intensive outpatient, residential or inpatient Interdisciplinary Cognitive Behavioural Therapy Pain Management Programs delivered by an interdisciplinary team for patients with persistent pain and pain-associated disability. These services are highly structured and require a high level of competency in delivery. The number of patients requiring that service is relatively small, yet when left untreated the problems caused can be significant. The national focus of these services is a necessity to create efficiencies of scale and maintain required skills. Such services will not be available in less specialised pain management centres. Highly specialised centres may provide dedicated Pain Management Programs for sickle cell disease, facial pain, urogenital pain, hypermobility, children and young people, persistent/refractory angina, and the like.

### **Specialised Pain services must deliver the following key components**

In addition to core requirements, specialised pain services must meet the following:

- Centres with a combined catchment area >1m
- Offering multispecialty and multi disciplinary clinics and pain assessment
- Medical input from more than one specialty and overall more than 3 consultants
- Minimum of 2 specialist nurses
- More than 1 wte Chronic Pain Psychologists
- More than 1 wte Chronic Pain Physiotherapists
- Occupational Therapists
- Pharmacist
- Cognitive Behavioural Therapy assessment and interventions
- Timeliness, patients must be referred within BPS pathways and guidelines.

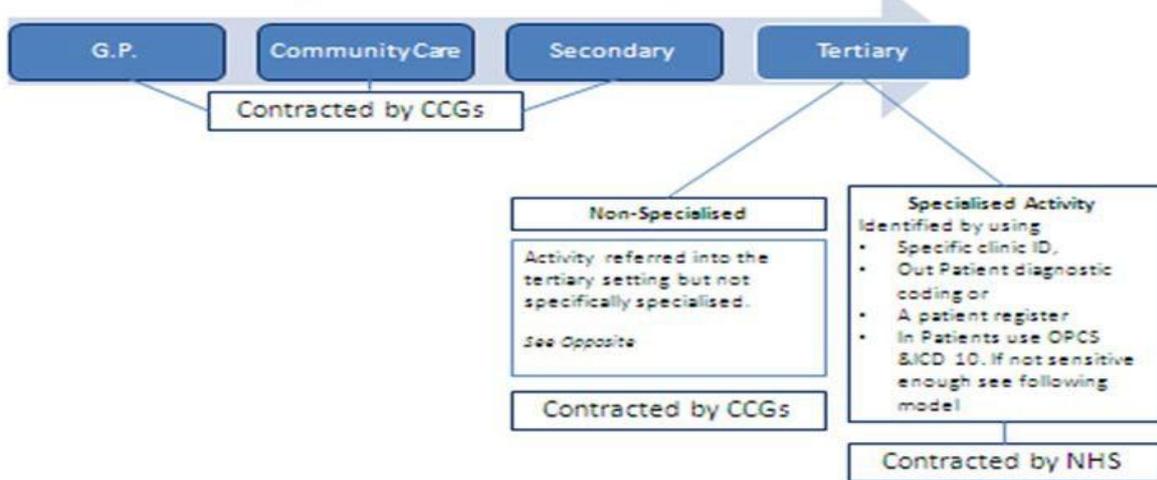
Providers will ensure there is appropriate cross cover for annual leave and absences.

Management and rehabilitation by appropriately trained pain specialists for highly complex pain and pain-associated disability.

Deliver a dedicated Specialised Pain Management Centre, run by one provider, ideally in physical location but a comprehensive service may be provided also in a defined network among a small number of providers if no one Trust has the full range of provision in an area.

Capable of providing complex pain interventions, and works within the context of local Pain Management Services that provide the majority of pain patient assessment and management in England.

### Specialised Pain Management - In Patient and Out patients



The patient care pathway will be:

Referrals only from secondary care services or other tertiary services for very specialised interventions/conditions

Interdisciplinary and multidisciplinary assessments leading to specific:

- Investigations
- Interventions
- Psychological and behavioural assessment
- Psychological and behavioural interventions
- Pharmacological interventions

Referral back to the secondary service for less intensive levels of ongoing support if necessary, often in a shared care role

In commissioning currency terms this pathway will include the following types of activity:

- Outpatients
- Inpatient / Day case episodes, medical and some surgical
- Device implantation
- Prescribing
- Psychological and behavioural interventions for outpatients and as residential

**Definitions of terminology which set out the detail of how the service is to be provided**

**Timely**

There must be a provision to see those with severe unremitting pain in a timely manner according to clinical need, e.g. for trigeminal neuralgia, cancer pain or other pain associated with significant distress and disability urgent referral may be required, from secondary care or above. The service must comply with national targets in relation to referral to treatment targets

### **Interdisciplinary**

An interdisciplinary team is an integrated working group where each individual (which should include: physicians, psychologists, physiotherapists, specialist nurses, and access to others such as pharmacists and occupational therapists, cross cover should be available indicating that there must be at least 2 persons able to provide the service) has a high level of expertise in different aspects of management of patients with complex pain. There is appropriate accommodation, support and administration support for this team. Members of the team would work closely together through joint clinics and interdisciplinary Multidisciplinary Team (MDT) meetings and agree management plans with patients and General Practitioners (GP)s.

### **Minimum Standards**

- Those as defined by the British Pain Society (BPS), Faculty of Pain Medicine, Royal College of Anaesthetists and International Association for the Study of Pain (IASP)
- Proven experience to manage their specific group of specialist patients.
- Service specific competencies for nursing, psychology and other staff working in the specialised Pain Service

### **Multispecialty**

A multispecialty pain team is a team of speciality experts that represent different disciplines involved in the assessment and management of pain, associated illnesses, and consequences for daily functioning. Members of a multispecialty pain team should be determined by the needs of the patients for whom services are designed. Members of the multispecialty team could include:

- pain management specialists with Fellowship of the Faculty of Pain
- Medicine of the Royal College of Anaesthetists (FFPMRCA). or equivalent
- anaesthetists
- neurologists
- oral specialists
- gynaecologists
- uro-gynaecologists
- urologists
- rheumatologists
- psychiatrists
- oncologists
- palliative medicine

- spinal surgeons
- orthopaedic surgeons
- paediatricians
- geriatricians
- diabetologists

The service should be delivered in an integrated fashion, through joint clinics and multispecialty meetings as appropriate; they would develop and agree a pain management plan with the patient, the referral team, and GP, including provisions for ongoing review.

### **Patients requiring complex interventions**

Patients with complex pain and pain-associated disability are those that require access to a multidisciplinary and multispecialty dedicated Specialised Pain Management Centres. Here they can access appropriate support and services for their complex biopsychosocial problems, the types of problems which are particularly persistent in other primary and secondary care treatment contexts. These patients with persistent problems despite their participation in local pain management services may be referred from another tertiary centre for highly specialised input.

Patients who present particular risks for long term outcome:

- Multiple system involvement where symptoms require the input of a team with the skills to manage the complex range of problems presented in parallel to managing the pain, e.g. complex pelvic pain, complex pain associated with neurological disease, complex abdominal pain, complex sickle cell disease, refractory angina, complex diabetes. Sometimes this is managed through shared care
- Drug abuse and dependency associated with drugs of addiction used for pain management, where these issues significantly affect pain management. These patients may require a lot of outpatient support and complex admissions with involvement of both the interdisciplinary and multispecialty teams. Sometimes this is managed through shared care.
- Pain related psychological and psychosocial problems that significantly complicate pain symptoms and rehabilitation (including pain related fear/anxiety, reactive depression and inability to function appropriately), that block treatment success, and contribute to a pattern of excess disability and that cannot be managed without a specific Interdisciplinary Cognitive Behavioural Therapy Pain Management approach by a comprehensive interdisciplinary team delivered by a dedicated specialised Pain Management Service . The case mix might include a population of people in pain where pain is very severe and distressing to carers (including health care professionals) , multiple physical and psychological problems, significant psychopathology (overwhelming depression, addiction, psychosis, bipolar), significant social instability, high physical disability/very limited mobility, persistently high service use, interpersonal problems with providers or consistent treatment dissatisfaction, multiple treatment failures. Such cases require individuality of care provision for pain associated with these complicated and often unusual disorders that is not seen regularly enough in secondary care to

develop treatment protocols. Capacity to benefit demonstrated by engagement with psychological assessment is required.

- Cancer patients that cannot be managed by palliative care without the input of Specialised Pain Medicine. Patients with pain directly associated with malignancy or indirectly from its treatments, which may not fall with the scope or expertise of palliative care or local pain services. These could include late effects of cancer treatment such as post-surgical pain, chemotherapy-induced neuropathy or avascular necrosis in cancer survivors. Patients with complex difficult to manage cancer pain may require specific interventional treatment, e.g. cordotomy, intrathecal neurolytic block, intrathecal pump or coeliac plexus block. Such treatments may require significant resources for pre-procedure assessment and management and post-procedure care within the context of an interdisciplinary and multidisciplinary team delivered by a dedicated Specialised Pain Management Service. Sometimes this is a shared care situation. Shared care through networks should be encouraged to keep services as local as possible and to ensure minimum standards.
- Referral to Specialised Pain Management Centres is from secondary care and above and those procedures that can be safely undertaken locally and that do not need specialised centres are the commissioning responsibility of CGGs as per the Clinical Advisory Group document for the recommendation of prescribed services.
- Patients with complex pain and pain-associated disability who require the provision of the gateway to those procedures/specialised treatments or interventions/very high cost drugs that would not be offered by local clinicians. Patients would require ongoing review. Examples would include neuromodulation and intrathecal pumps. Providing there is appropriate clinical governance, such services do not have to be provided in a Specialised Pain Management Centre but can be managed through shared care managed in secondary care through local network approach, to ensuring minimum standards are met.

## Data Flows

Activity for pain management is usually recorded under Treatment Function Code 191. Activity that is carried out on the treatment of inpatients should also be coded as such as outpatient activity. In tertiary specialised pain centres coding does not currently exist to count activity appropriately, this will be reviewed and patient lists will be used as the basis for commissioning until this has been resolved.

### 3.3 Population covered

The service outlined in this specification is for patients ordinarily resident in England\*; or otherwise the commissioning responsibility of the NHS in England (as defined in *Who Pays?: Establishing the responsible commissioner* and other Department of Health guidance relating to patients entitled to NHS care or exempt from charges).

\* Note: for the purposes of commissioning health services, this EXCLUDES patients who, whilst resident in England, are registered with a General Practitioner (GP) Practice in Wales, but INCLUDES patients resident in Wales who are registered with a GP

Practice in England.

Specifically this service is for adult patients who have been assessed by a secondary care pain management services suffering from chronic refractory pain

### **3.4 Any acceptance and exclusion criteria and thresholds**

#### **Acceptance**

Patients can be referred to tertiary specialised pain services from secondary level care pain management consultants or from other clinicians. The expectation is that the patient must have completed a pain management programme but this may not always be appropriate if its clear that specialised tertiary care is what is required. The referral pathway may be agreed more locally to reflect existing services configuration. Details of this local agreement should be appended to the service specification.

#### **Exclusion**

Referrals from GPs are excluded from this service unless there is a local protocol that requires GPs to make tertiary referrals and patients who have not completed a pain management programme at a secondary level provider will not be accepted with the caveats as described above. Activity within the network not meeting the Identification Rule

Specialised services for Pain Management for Children and Young People are separately defined in Service Specification E2b.

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

As this is a service for people with chronic long term conditions, shared care arrangements are a vital part of the care pathway. Providers will establish robust protocol with referring clinicians in order that the services are able to discharge patients appropriately. It is not envisage that patients will remain in the tertiary specialised service indefinitely but that they will move back to a managed programme/partnership with local services, although they might be reviewed by the tertiary specialised pain service.

## **4. Applicable Service Standards**

### **4.1 Applicable national standards e.g. NICE**

National Institute for Health and Clinical Excellence (NICE) Guidance is as set out below

- NICE (October 2008) 'Spinal cord stimulation for chronic pain of neuropathic or ischaemic origin, NICE Technology Appraisal (TA) TA159', this was reviewed in November 2013 and proposal states this will move to the static list of TAs.
- NICE (2009) Low back pain: Early management of persistent non-specific low

back pain. Clinical guideline 88. London:

- NICE (2009) Management of long-term sickness and incapacity for work. Public Health Guidance 19. London:
- NICE (2010) Neuropathic pain: the pharmacological management of neuropathic pain in adults in non-specialist settings. Clinical Guideline (CGI) 73
- Interventional Procedure Guidance (IPG)382).
- NICE CG 150 (2012) for Headache in Adults and children ; NICE IPG 370 (2010) for Migraine; NICE IPG 381 (2011) for Intractable Trigeminal Autonomic Cephalalgias ; NICE TA 260 for the treatment of Chronic Migraine (2012) The specification does not mention or refer to the relevant Headache centric national policy recommendations, e.g. from the British Association for the Study of Headache Treatment Guidelines (2010) and SIGN 107 (2008) Guidelines for the management of Headache and cranial pain disorders.

#### **Department of Health Guidance is set out below**

- Department of Health (18th March 2011) Enhanced Recovery Events
- Department of Health (2006) 'The musculoskeletal services framework'
- Programme budgeting categories – available at:  
[http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Programmebudgeting/DH\\_4117326](http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Programmebudgeting/DH_4117326)
- '18 weeks cross specialty pathway for chronic non malignant pain' available at:  
<http://www.18weeks.nhs.uk/Content.aspx?path=/achieve-and-sustain/Specialty-focussedareas>

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

Available from the Royal College of Anaesthetists – [www.rcoa.ac.uk](http://www.rcoa.ac.uk);

- Royal College of Anaesthetists (November 2010) Best practice in the management of epidural analgesia in the hospital setting
- Royal College of Anaesthetists (Revised 2009-2011) Guideline for the Provision of Anaesthetic Services
- Royal College of Anaesthetists (2009) 'Guidance on chronic pain management' chapter 7 Guidelines for the provision of anaesthetic services
- Royal College of Anaesthetists (2006) 'Raising the standard: a compendium of audit recipes: chronic pain services'
- Royal College of Anaesthetists (2003) 'Pain management services: good practice'

Available from Royal College of Physicians

Goebel A, Barker C, Turner-Stokes L, Guideline Development Panel. Complex Regional Pain Syndrome in adults: UK guidelines for diagnosis, referral and management in primary and secondary care. London, Royal College of Physicians, May 2012.  
<http://www.rcplondon.ac.uk/resources/complex-regional-pain-syndrome-guidelines>

Available from the Royal College of Obstetricians and Gynaecologists:

[www.rcog.org.uk](http://www.rcog.org.uk)

Royal College of Obstetricians and Gynaecologists (2005) 'Initial management of chronic pelvic pain' Green top guideline No.41 through - available from The British Pain Society – [www.britishpainsociety.org](http://www.britishpainsociety.org); London: BPS; 2005.

The BPS published 5 Pain Patient Pathway Maps using best evidence where available for the care of pain patients in collaboration with Maps of Medicine.

<http://bps.mapofmedicine.com/evidence/bps/index.html> The Pathways are:

- Primary Assessment and Management (focused on community care)
- Spinal pain – low back pain and radicular (community and secondary care, leading into specialised care)
- Musculoskeletal non-inflammatory (community and secondary care, leading into specialised care)
- Neuropathic Pain (community and secondary care, leading into specialised care)
- Pelvic pain in both the male and female. (community and secondary care, leading into specialised care)

Available from the European Association of Urology. EAU Chronic Pelvic Pain Guidelines (2012)

Available from the International Association for the Study of Pain (IASP)– [www.iasp-pain.org](http://www.iasp-pain.org):

- International Association for the Study of Pain (2009) 'Desirable characteristics for pain Treatment Facilities'
- Recommendations for Wait-Times for Treatment of Pain
- Recommendations for Pain Treatment Services
- Ethical Guidelines for Pain Research in Humans
- Development of Clinical Practice Guidelines in the Field of Pain
- Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain
- IASP Classification of Chronic Pain

Available from the National Enquiry into Peri-operative Deaths – [www.ncepod.org.uk](http://www.ncepod.org.uk):

- National Enquiry into Peri-operative Deaths (2008) 'A sickle crisis?' Executive Summary, p3

Available from the Royal College of Paediatrics and Child Health:

- Commissioning Tertiary and Specialised Services for Children and Young People (2004)
- Royal College of Anaesthetists
- A National Strategy for Academic Anaesthesia 2005
- Chronic Pain Policy Coalition
- A report of the Pain Summit 2011
- International Association for the Study of Pain

Desirable Characteristics of National Pain Strategies 2010

<b>5. Applicable quality requirements and CQUIN goals</b>
These are currently in development.
<b>6. Location of Provider Premises</b>
The Provider's Premises are located at:
<b>7. Individual Service User Placement</b>
Not applicable

**Appendix One - Quality standards specific to the service using the following template:**

Quality Requirement	Threshold	Method of Measurement	Consequence of breach
<b>Domain 1: Preventing people dying prematurely (risk factors: cancer/physical fitness/severe pain)</b>			
Targeted and timely Access Ensuring the right people get through a pathway in a timely fashion (from specialist referral to definitive treatment)	Achievement of 18 weeks for elective definitive treatment	Quarterly Service Quality Performance Report	<b>Clause GC9 of General Conditions</b>
<b>Domain 2: Enhancing the quality of life of people with long-term conditions</b>			
People with chronic pain receive a written personalised Care plan appropriate to need that includes local carers (Both lay and healthcare )	70% of patients have plans	Quarterly Service Quality Performance Report	<b>Clause GC9 of General Conditions</b>
<b>Domain 3: Helping people to recover from episodes of ill-health or following injury</b>			
Recurrent admission to A&E are avoided	70% cohort to gather baseline	A & E attendances	<b>Clause GC9 of General Conditions</b>
Acute admission to hospital	70% cohort to gather baseline	Readmission rate	<b>Clause GC9 of General Conditions</b>
<b>Domain 4: Ensuring that people have a positive experience of care</b>			
Monitoring Complaints – number of complaints	Number referred to the	Annual report	<b>Clause GC9 of General Conditions</b>

Quality Requirement	Threshold	Method of Measurement	Consequence of breach
	Ombudsman		
Patients have a positive experience of care.	Initially 70% of all patients to be asked, increasing to 100%  70% of responders answering YES to each question	Questionnaire - patients to be asked 2 questions following initial consultation:  Did you receive a written, personalised long term care plan (or have an existing plan amended)?  Do you feel you were provided with sufficient, appropriate and helpful information about your condition and treatment?  Questionnaire – patients to be asked following question after pre-discharge consultation:  Has the treatment and support you have received helped you to manage your pain better?	<b>Clause GC9 of General Conditions</b>
<b>Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm</b>			
Procedure in place for suicide risk assessment	100%	Production of Protocol in annual report	<b>Clause GC9 of General Conditions</b>
Adverse events reporting for interventional specialised pain procedures	100%	Production of Protocol in line with national RCOA standards  Entry onto registry where they exist	<b>Clause GC9 of General Conditions</b>
Protocol in place for safe practice of intrathecal opioids	100%	Annual report – production of policy In line with ITTD policy	<b>Clause GC9 of General Conditions</b>
Service supports audit in individually and collaboratively	2 local audits and 1 with other specialised service	Demonstration of Regular Audit	<b>Clause GC9 of General Conditions</b>

**References:**

**The National Pain Audit : Clinical Effectiveness and Safety measures including Patient Reported Outcomes: found at:** <http://www.nationalpainaudit.org/methodology>

**IMMPACT recommendations for clinical trials in pain management**

<http://www.immpact.org/static/publications/Dworkin%20et%20al.,%202005.pdf>

## Change Notice for Published Specifications and Products

### developed by Clinical Reference Groups (CRG)

#### Amendment to the Published Products

**Product Name**

Specialised Pain

**Ref No**

D08/S/a

**CRG Lead**

Andrew Baranowski

#### Description of changes required

Describe what was stated in original document	Describe new text in the document	Section/Paragraph to which changes apply	Describe why document change required	Changes made by	Date change made
	Correction of estimated number of people with chronic pain in UK figure from 8 million to 14 million	Page 1		CRG	March 2014
	Inclusion of NHS Outcome Framework measures, as a result of moving to new 2014/15 template	Page 3		CRG	March 2014
	Deleted the word region and replaced with area, as more accurate	Page 5		CRG	March 2014

	Further clarification of the core requirements – this was a result of the previous specification not being specific enough about what was a specialised pain service and what was CCG commissioned service and this had been raised as part of the compliance work. The refined specification means it will be easier to identify specialised centres.	Page 5		CRG	March 2014
	Additional paragraph added by CRG as felt further clarification was needed on complex case mix of patients	Pages 8- 9		CRG	March 2014
	Updates on NICE guidance completed since the last specification was written	Page 11		CRG	March 2014
	New Appendix 1, detailing outcomes linked to Framework Domains as a result of moving to 2014/15 template. These also include 3 measures of patient experience developed by our Patient and Public Voice members.	Pages 13 - 14		CRG	March 2014