1. **Background**

1.1 Chronic pain has a prevalence of approximately 10% of the general adult population. For the population of Central Cheshire this equates to approximately 18,000 people.

1.2 Chronic pain is that which either persists beyond the point at which healing would be expected or that occurs in diseases in which healing does not take place. Chronic pain may be accompanied by severe psychological and social disturbance, and can be experienced by those who do not have evidence of tissue damage.

1.3 Chronic pain is not simply an acute pain which persists for a longer period of time; although by convention and for research and pragmatic reasons it is generally considered that the pain has been present for more than three months. Rather, it is a model (or construct) consisting of nociceptive (organic), cognitive (thoughts and ideas) and behavioural (adaptive and maladaptive) dimensions.

1.4 The effective approach to the management of chronic pain deploys the biopsychosocial model of care rather than the acute biomedical model. Whilst an individual health care professional may provide a multi-dimensional assessment of a patient, it is well recognised that for many patients with chronic pain and disability, a multi-disciplinary approach will also be essential.

1.5 Historically, chronic pain services have been led by Consultant Anaesthetists. This tradition can be traced back to nerve block and other invasive treatments which anaesthetists began to offer patients with the pain of terminal cancer in the 1940’s and 1950’s. Nowadays it is recognised that for a service to be categorised as a “Multi-disciplinary Pain Centre (MPC)”, a range of health care specialists is required, such as physicians, psychological therapists, nurses, physiotherapists, occupational therapists, vocational counsellors and social workers.

1.6 In 2008 Spinal Surgical Service (SSS) was re-configured. The CECPCT (the “PCT”) determined that this development would have to be supported by the provision of a community- based Chronic Pain Management Service (CPMS) similar to that being offered in Eastern Cheshire. This was both in accordance with “Implementing Care Closer to Home – DH April 2007” and a first step in providing equity across the PCT area.
2. Introduction

2.1 The original proposal that a Central Cheshire Pain Management Service (CCPMS or the “Service”) should be established was made in a presentation to the CECPCT Board on 27th April 2007. The concept of achieving equity of service across the “patch” was endorsed and the quality of the service in Eastern Cheshire was described in terms of the model of care deployed, patient and referrer feedback, audit of outcome, research and teaching activity, and links with primary and secondary care.

2.2 A Primary Care Specialist (experienced General Practitioner) in chronic pain management (RP) had experience of setting up and running a primary care-based CPMS. This model (see Appendix 1) has been used to create the CCPMS. The team delivering the Service comprises RP (also director of IML), three clinical specialist physiotherapists (CC, SR, SW) and a nurse (DB), a senior Cognitive Behavioural Psychotherapist (VW), and supported by a project manager (JP, a director of IML) and potentially a medical secretary.

2.3 The team may refer to the Consultant Anaesthetist Pain Service at Leighton Hospital, Mid Cheshire Hospital Trust for advice on secondary care technical procedures. The Service will develop links with other services caring for patients with pain especially the general practices, the interface musculoskeletal services and other therapists.

2.4 The contracting for and provision of the Service continues between the PCT and Interface Medical Ltd under the “Any Willing Provider” arrangements. The service is compliant with PbR and tariff prices are based on HRG4 for 1:1 and negotiated for the group Pain Management Programme (PMP).

2.5 The evidence base is referenced from the Clinical Standards Advisory Group Report “Services for Patients with Pain” (1999), the joint publication by the Royal College of Anaesthetists and the Pain Society “Pain Management Services: Good Practice” (2003) and the DrFoster organisation’s audit and report “Adult Chronic Pain Management Services in the UK” (2003).
3. **Strategic Direction**

The Service Specification sits within both national and local policy contexts. From a national perspective the overarching policies are The NHS Plan (2000), The NHS Improvement Plan (2004) and Implementing Care Closer to Home (2007). From current **national** policy the key drivers for change in the local health economy relevant to the future development of CPMS’s include:-

* Choosing Health  
* Supporting people with long term conditions  
* Practice Based Commissioning  
* Payment by Results  
* Choose and Book  
* 18 week referral to treatment pathway  
* Financial balance  

From a **local** perspective the underpinning principles within which the specification sits are:-

* Personalised treatment and care for patients  
* Providing care closer to peoples homes – development  
* Improved access to Health Services  
* Improved health and well-being  
* Service redevelopment and redesign  
* Patient service and quality standards to be continually improved  
* Improved patient satisfaction  
* Improved satisfaction levels of staff
4. Why a Chronic Pain Management Service?

4.1 The high prevalence of chronic non-malignant pain in the community includes common conditions such as spinal pain, headache, arthritis, neuropathy and nerve damage pain. No other service can combine the range of generalist and specialist skills and devote the amount of time required to address the complex needs of patients with physical and psychological components to their condition. The service allows a development from the biomedical model of care to the biopsychosocial approach, which is the hallmark of good Primary Care, but in greater depth.

4.2 Unrelieved chronic pain causes patients mounting problems including: physical disability, psychological distress, behavioural maladaptation, family dysharmony, employment difficulties and the inappropriate use of drugs and healthcare services. The latter involves significant unnecessary costs to the NHS with multiple specialist referrals, investigations and interventions. There are further costs to the economy and to business with days lost from work.

4.2 The objectives of the Central Cheshire Chronic Pain Service are:

4.3.1 Reduction in the patient’s overall experience of pain including physical, psychological and behavioural components.

4.3.2 Reduction of inappropriate disability and optimisation of function and roles.

4.3.3 Rationalisation of medication to optimise pain relief and to avoid inappropriate use.

4.3.4 To reduce inappropriate utilisation of Secondary Care services, to support patients who have been assessed by the SSS as not being candidates for surgery and to optimize the subsequent care delivered in General Practice by the development of a “pain plan”.

4.3.5 Attention to social, family and occupational issues.

4.3.6 An educational role acting as a resource to the healthcare services of Central Cheshire with the aim or appropriate and timely referral to the Chronic Pain Service and a wider role in the prevention of chronicity through optimal management of the acute phase.

4.3.7 Continuing audit and evaluation of the service and the needs of patients.
4.3.8 Facilitating research into the epidemiology, causes and management of chronic pain.

4.4 It is now widely accepted that the interdisciplinary approach using the principles of CBT is the most effective clinical model for pain management services. Within the Service, priority should be given to those treatments and approaches for which there is a good evidence base. However, there is also room for an empirical approach in those patients who may idiosyncratically respond to an individual treatment (e.g. trigger-point injection or acupuncture) especially if pain relief is linked to functional gain. All treatments within the service will be delivered within the biopsychosocial chronic pain model.

4.5 Nationally chronic pain services are delivered in the following arenas:

a. Outpatient or outreach clinics
b. Inpatient ward referrals
c. Palliative care services for cancer patients

This Service is only concerned with a.
5. Characteristics of a Primary Care based Service

5.1 Chronic pain services have traditionally been based within an Acute Trust (or larger) hospital. The hectic environment of a busy outpatient department may provide a less than conducive atmosphere for the chronic pain patient to give their “pain story”. Outreach clinics in general practices are accessible to and comfortable for patients.

5.2 All patients attending for assessment have a multi-dimensional exploration of their problem by a generalist physician. Sufficient doctor time (40mins) is allowed to give patients space to explain their experience of pain.

5.3 All patients receive the pain management approach even when they do not see all members of the team. This means that if a patient is to be given a specific treatment (e.g. drug, injection, TENS, acupuncture) this is not seen as an end in itself. Rather, the specific treatment is a “key” with which to access the patient’s pain problem allowing progress towards improved coping strategies and an optimisation of day-to-day functioning.

5.4 The patient is intimately involved with the treatment orchestrated by the pain service. A brief questionnaire is completed by the patient prior to initial assessment and this is incorporated into the medical record. A consultation with a healthcare professional is presented as a discussion between equal partners; the patient is expert on his or her pain experience and the clinician is expert in the management of chronic pain. Correspondence from the service is in the form of a report addressed to the patient and copied to the referrer and the General Practitioner.

5.5 The reports prepared by the service represent a ”pain plan” describing an agreed strategy in the management of the patient’s condition. On discharge from the service the aim is to facilitate a seamless transition of care to the General Practitioner. The pain plan remains a working document for use by the patient and the doctor in the future, for instance, during the management of relapses. There may also be further immediate work to be done with the patient especially in the future with regard to occupational issues.

5.6 The full advantages of having a General Practitioner as the physician within the service will be exploited. Frequently patients referred with chronic pain will have other conditions relevant to their pain but which a traditional service would feel is outside its remit to treat. As a Primary Care based service it may be justifiable for the clinician to act in the place of the General Practitioner especially in treating any mental health problems which have a significant effect on the presenting pain. 50% of patients seen within any chronic pain service may have a significant depressive illness: when the mood disturbance is the main determinant of the pain (such as some cases of chronic daily headache) it
will often be appropriate to treat the mood disturbance in the CPS either pharmacologically or with Cognitive Behavioural Therapy (CBT).

6. **Components of the Service**

6.1 **The initial driver for the Service** was the anticipated needs of patients with spinal pain declined for surgical treatment by the re-configured SSS. However after wider consultation through Practice Based Commissioning (PBC) it was determined that the service should be made more widely available to referral from General Practitioners. The initial anticipated referral rate was 6/ week which was exceeded by some margin (see Summary of Accreditation, Appendix 3) but after 12-18 month the rate had settled back to 8/ week.

6.2 **The accommodation for the Service** is at two sites: Eagle Bridge Health & Well-being Centre in Crewe and Dene Drive Primary Care Centre in Winsford. These two areas are the more deprived areas in the PCT suggesting both a high level of need and the desirability of a very local service. The overall requirement is for 10 consulting room sessions and 1 group room session per week. The clinical service runs on Mondays, Tuesdays and Fridays with telephone access Monday to Friday 9am – 5pm.

6.3 **Personnel:**

All clinicians individually and the Service as a whole will be subject to appraisal and accreditation as described by the Department of Health (see Appendix 3). This process should ensure both robust clinical and corporate governance.

6.3.1 **PCT Commissioner** A link person to monitor performance of the service.

6.3.2 **Service Co-ordinator** (JP) Organiser of clinics(appointments, notes etc.). Communication with patients. Telephone line to receive queries from patients. Collector of data for audit incl patient satisfaction. Holiday cover for secretary.

6.3.3 **Service secretary** Typing of letters. Holiday cover for co-ordinator.

6.3.4 **A Primary Care Physician/Generalist** (RP) Lead Clinician. Medical assessment of all patients & setting the agenda (initial pain plan). Ultimate clinical and managerial responsibility for service. Preparation of audit reports.

6.3.5 **Clinical Specialist Physiotherapists** (SR,CC,SW) 1:1 and group CP physiotherapy.

6.3.6 **Cognitive Behavioural Psychotherapist** (VW) A senior professional with extensive clinical and managerial experience. 1:1 and group therapy. A training role underpinning the Service especially with regard to the PMP.

6.3.7 **A Clinical Nurse Specialist** (DB) 1:1 and group intervention. Neuromodulation (TENS) service. Liaison between team members. Responsible for the patient discharge pain plan.
6.4 The service has developed a **drug formulary** for analgesic, co-analgesic and other drugs (see Appendix 2). Parallels between the formulary and that for palliative care services are deliberate.

6.5 **Clinical equipment** for the service includes: TENS machines for loan to patients, skeleton, exercise mats, timers and patient and professional educational aids.

6.6 **Invasive procedures**: The range of procedures which can be safely performed in an outpatient setting is limited. Trigger-point and joint injections can be performed and some nerve-blocks, e.g. ilioinguinal nerve. Invasive and complex procedures requiring image intensification, patient monitoring, theatre equipment, or the ability to deal with serious complications will be referred to Leighton Hospital.

6.7 The Service will use a manual version of an **audit** process which is nationally recognised and led by a sub-group of the UK Pain Society: The Pain Audit Collection System (PACS) (see Appendix 4).

6.8 The total **capacity** of the Service has been calculated by formalising the appointment system for each of the Team members, and now represents in excess of 400 New Patient referrals and attendant follow-up treatment per annum.

6.9 A **patient satisfaction** survey (see Appendix 5) is incorporated into the discharge procedure of the Service.
7. **Referral and Discharge Procedures**

7.1 The capacity the Eastern Cheshire is 320 new patients per year (1 for each 625 head population). The initial capacity of the CCPMS was 246 per year (1 for each 952 head of population) but has now grown to 400 pa (1 for 562 pop.).

7.2.1 Referrals will be taken from General Practitioners, Consultants or the musculoskeletal CATS. In the first instance the Service will develop a particular relationship with the Spinal Surgeons involved in the new SSS at Hope Hospital, although patients referred from the SSS will not be prioritised over other referrals. Referral pathways will be concordant with the National Library for Health “Map of Medicine” flowcharts especially those concerning spinal pain. Other patients may have specific pain syndromes such as post-herpetic neuralgia, CRPS, atypical visceral pain or fibromyalgia (widespread pain syndrome).

7.2.2 Referrals should ideally contain the following information:

- Patient bio-data
- History of the pain problem
- Copies of specialist opinions sought on the problem
- Copies of the reports of relevant investigations performed
- Previous treatments which have been effective/ineffective/not tolerated
- Current medication/treatment

7.2.3 Inclusion Criteria

- Age – 18 years and over.
- Persistent or episodic pain of greater than three months duration.
- Patient has been comprehensively investigated by the General Practitioner and/or specialist.
- All specific curative treatment options aimed at the pathology underlying the pain have either been excluded or attempted without benefit.
- The patient is satisfied that all appropriate investigations or specialist opinions have been sought at the time of referral.

7.2.4 Exclusion Criteria

- Cancer related pain unless referred by the Palliative Care Cancer Service.
• A hospital inpatient.
• The patient has currently been referred to or is being seen by another Chronic Pain Service.
• Uncontrolled alcohol or substance abuse.
• Uncontrolled psychotic or other major psychiatric illness.
• Housebound/unable to attend outpatient clinic.

7.3 When the patient has been stabilised within the Chronic Pain Service and/or treatment options have either been deployed (with success or not) or excluded, the patient is discharged back to the General Practitioner. On discharge the audit questionnaires and (anonymized) patient satisfaction surveys are completed. The treatment in the Service will culminate in a “pain plan” describing the interventions given, ongoing prescriptions, self-management techniques, strategies for the management of flares etc. The patient and the GP will having copies of this “living” document. The long-term follow-up is provided by the primary health care team.

7.4 On discharge the patient is also engaged with both the audit of outcome and anonymised assessment of patient satisfaction processes (see Appendices 4 & 5).
8. Audit and Clinical Governance

8.1 Introduction

Clinical Governance was introduced in the NHS White Paper in 1997 and created the framework through which NHS organisations continuously monitor the quality of service delivered, safeguarded high standards of care and create an environment in which excellence in clinical care is more likely to flourish. Chronic pain services address the health concerns of a group of patients whose needs are not met elsewhere in the Health Service. In relation to chronic pain services both the Audit Commission and the Clinical Standards Advisory Group have called for better assessment practices. The Service intends to utilise the Pain Audit Collection System (PACS) database to capture basic service data.

8.2 Background

The clinical information special interest group of the UK Pain Society was set up in 1997 to promote the collection of clinical information in chronic pain management for the purpose of audit, research and resource management as well as to measure clinical effectiveness.

The PACS database satisfied the demands of clinical governance to collect data on clinic activity including diagnosis, treatments performed, information on outcomes achieved and complications from treatments. A simple and economic system is essential to be of practical use to busy clinicians.

An unrestricted educational grant was obtained from Searle (Pharmacia) which has allowed the database to be distributed and technically supported free of charge and available to those clinicians interested in being involved. To date, the system is being used by 100 pain clinics and has generated data on 80,000 patients.

8.3 Data Collected

8.3.1 The individual patient data set includes:

- Patient identifier, age, sex
- Duration of symptoms in months
- Responsible clinician
- Diagnosis
- Treatments
- Clinician/s undertaking treatment
• Drug utilisation and adverse drug reactions
• Pain assessment using the Brief Pain Inventory
• Complications of treatment indicator
• Discharge or end of plan/treatment indicator.

The database has the ability to produce summary reports of patient visits for sending to referrers as well as a graphical and data display of changes in outcome, measures of pain, function and mood between baseline and discharge. The clinician has only to generate the diagnosis and treatment information that may be completed on a tick box form, see page 5 of Appendix 4. The remaining information is collected from two brief patient questionnaires and the Co-ordinator enters all information into the database.

It is essential that those involved with entering date and using the database are able to extract data from it. To this end, a number of standard reports are available. These reports allow the clinician to interrogate the data with the results being produced in a simple readable format.

To allow multi-centre data to be collected and analysed, there is a data export facility within the database allowing data from all centres to be pooled. This information can then be fed back to the users allowing comparison of case mix, etc. to be made.

The database can act as a means of evidence based practice, allowing audit, both for the purposes of quality control and also a source of data for research. The principal aim of audit is to monitor outcomes for evidence of effective or, indeed, ineffective practice. This acts as a safeguard against unchecked error and is intended to promote increasing standards of clinical service. Beyond this, and particularly in the case of chronic pain services, there is an opportunity to introduce improved services through empirical evidence.

8.3.2 The Service data set includes:

• Number of new patients seen
• Waiting time
• Number of follow-up patents seen
• Transit time in service
• Breakdown by clinician
• DNA rates
• Wasted appointment rates
• Referrals to secondary care
• Re-referral rate
• Complaints
• Patient satisfaction

8.4 Governance Assurance

Appendix 6 gives more detailed information in relation to:

• Clinical Governance
• Healthcare Standards
8.5 Conclusions

Clinical Governance demands high standards of care and therefore the ability to produce evidence through accurate collection and evaluation of clinical data is paramount. The PACS database allows clinicians to quickly and easily obtain the necessary data, detailed workload, treatments, complications and outcomes which are obtained from their work and detailed in the personal portfolio report of the database.

The speciality of pain management is still relatively new and the meaningful analysis from individual pain centres in difficult. The download capability of PACS potentially allows multi-centre data collection and standardisation of clinical terms and outcome measures although this is not possible until a computerised version of PACS comes into operation.

9. Insurance and Indemnity

9.1 Clinical negligence – all clinicians subcontracted to the service will be responsible for and carry their own insurance against negligence either with their own professional body or a separate defence organisation as appropriate. Evidence of such insurance will be held by IML and can be produced at any time.

9.2 Environmental hazards and faulty equipment – all patients will be seen at approved NHS medical premises. In renting accommodation for the service a condition of the contract will be the provision of public liability and other appropriate insurance.

9.3 Data protection – IML is registered with the Data Protection Agency.

9.4 Criminal records bureau – all clinicians will have been CRB checked.

9.5 Clinical and corporate governance assurance is described elsewhere.
Appendix 1  Flow of patients through the CCPMS and communication with primary care

A1  Inappropriate referrals

A1.1 Each referral letter will be reviewed by the lead clinician (RP) to check for the appropriateness of the referral especially with reference to “red flags” (CSAG Report on Low Back Pain 1994) and the services own criteria (see 7.2.3/4).

A1.2 In the event of an inappropriate referral a letter of explanation will be sent to the referrer and copied to the GP. A separate letter will be sent to the patient to explain briefly why an appointment is not being offered and requesting the patient to consult the GP, with this letter also being copied to the GP. In cases where the appropriateness is uncertain the case may be discussed over the telephone.

A2  Failed appointments

Patients who fail their appointments will receive a letter from the Service Co-ordinator (JP) advising them of the fact in a respectful way and inviting them to telephone the service to make a further appointment within four weeks. The letter is copied to the GP. If nothing more is heard from the patient the GP will be informed that the patient is discharged from the service.

A3  Information flow to patients in the service and to GP’s
A3.1 It is a novel feature of the service that after the first assessment appointment with the physician in the service a report is sent addressed to the patient and copied to the referrer and the GP. The report summarises the history, investigation results and diagnosis of the patient and sets out the initial medication changes/treatments given together with some self-help advice and the future options for treatment. The concept has worked well with patients feeling understood, engaged with their own management and clear on medication instructions.

A3.2 All follow-up consultations with the pain physician will result in a letter to the GP especially to request repeat prescriptions and to clarify the revised “pain plan” and these letters are copied to the patient.

A3.3 Consultations with other team members may or may not result in a letter to the GP. Any changes of medication will be communicated to the GP.

A3.4 Patients entering the PMP will have a letter sent to the GP informing the doctor of this and asking him to consider carefully any change to the patient’s management whilst this treatment is given. All patients on the PMP will have discussed with the team the need to keep other interventions to a minimum.

A4 Patients discharged

A4.1 Patients who are discharged through default will have no agreed “pain plan” and so their care will continue ad hoc in primary care.

A4.2 Patients who are formally discharged on completion of their treatment will have a discharge letter from the physician describing their ongoing treatment and self-management plan. Alternatively patients who have received multidisciplinary care, including PMP, will have an appointment with the nurse specialist to formulate the discharge “pain plan”.

A4.3 Occasionally patients may be unable to continue with their treatment in the service because of other psychological or physical problems. These patients may be discharged but with criteria described for future potential referral back to the CCPMS to complete their treatment.

A5 Referrals onto secondary/tertiary care

A5.1 If it is felt that a patient requires onward referral to a different specialty (e.g., rheumatology, psychiatry) the CCPMS will not make this referral but, rather advise the GP and patient of this opinion. It will be made clear to the GP that they will need to make the referral if they agree.

A5.2 Occasionally patients will need referral to secondary care – based pain service (e.g., for nerve blocks not available in the CCPMS) and in this circumstance the referral letter will be sent from the CCPMS directly.
Appendix 2

PAIN SERVICE DRUG FORMULARY

Introduction

This formulary aim to act as a guide to prescribing the relatively limited range of drugs used within the Chronic Pain Service. It is intended that prescribing practice reflects national guidelines (such as those produced by the British Pain Society), is consistent where appropriate with palliative care practice and can be seamlessly matched with the prescribing habits and skills of local General Practitioners.

Anti-inflammatory drugs

These have been removed from the “step ladder” as they are not primarily analgesics and are associated with gastrointestinal and cardiovascular side effects. Many patients referred to the pain service are taking NSAID’s (with or without gastroprotection) or Cox 2’s and in the absence of a clear inflammatory lesion we frequently suggest a trial off the drug whilst prescribing an analgesic in its place.

Where we recommend an anti-inflammatory:

**Oral:**
- IBUPROFEN 600mg tds
- DICLOFENAC 50mg tds
- NAPROXEN 500mg bd
- MELOXICAM 15mg od
- ETORICOXIB 60mg od

**Topical:**
- INTRALGIN gel qds
- DICLOFENAC gel qds
- DIFFLAM cream qds

Anti-depressant medication

In the clinic we see patients who score significantly for depression on the HAD (>11) where this is not just a response to pain (a common occurrence) but it becomes clear that depression is the main determinant of the pain in which case we will consider prescribing medication in the clinic rather than referring back to the GP.

Our preference is:
- CITALOPRAM 20-40mg od
- FLUOXETINE 20mg od

Somatic pain

An updated interpretation of the WHO model.

**Step 1**
PARACETAMOL 1000mg qds (regular regime)

**Step 2a**
Paracetamol plus CODEINE 60mg qds (or dihydrocodeine)

**Step 2b**
Paracetamol plus TRAMADOL 50mg two qds (or MR form)

Or “low dose” strong opioid:
- MORPHINE 10-20mg bd
- OXYCODONE MR 5-10mg bd
Step 3 Paracetamol plus “higher dose” strong opioid:

- MORPHINE 30mg bd +
- OXYCODONE MR 20mg bd +
- BUPRENORPHINE patch 35mcg/h +
- FENTANYL patch 25mcg/h +

Co-prescription of medication to prevent side-effects of opioids may be required including: topical steroid preparations, anti-emetics and constipation remedies.

The BPS is updating its guidelines on opioid prescribing and we are contributing. Key points include:

- Investigation of the organic lesion
- Baseline measurement of pain intensity
- Screening for anxiety/ depression
- Patient information on adverse effects (short/ long term)
- Monitoring analgesic response
- Avoiding short acting opioids where possible
- Having a plan for flare-ups of pain
- Avoiding dose escalation after stabilisation
- Specialist referral for complex cases/ higher doses
- Consider use of a “patient contract”
- Seamless transitions of care
- Named doctor responsible for repeat prescribing

**Neuropathic pain (NeP)**

One of our important roles in the Pain Service is breaking a patient’s pain complaints down into the component parts often with the result of identifying a neuropathic component.

**TCAD’s:**
- AMITRIPTYLINE 10-50mg on
- DOSULEPIN 25-50mg on
- NORTRIPTYLINE 10-50mg on

**Topical:**
- CAPSAICIN cream 0.025%/ 0.075%
- LIDOCAINE 5% plasters od
- EMLA cream with occlusion

**SNRI:**
- DULOXETINE 60mg od

**Anticonvulsants:**
- GABAPENTIN caps 100-600mg tds
- PREGABALIN 25-300mg bd
- CLONAZEPAM 500mcg 1-2 on or bd

**Extraordinary:**
- KETAMINE liq 10mg qds
  (METHADONE)

With the more difficult cases, combination therapy will be necessary typically starting with a TCAD +/- a topical treatment, then adding an anticonvulsant and then a strong opioid. A separate protocol will apply for use of drugs in the “Extraordinary” group. The specialist nurse is planning to qualify as a “supplementary prescriber” and an additional protocol will be required to support that role.

August 2008
Appendix 3  Appraisal & Accreditation

ACCREDITATION OF CCPMS 2009

Introduction

The Central Cheshire Pain Management Service (CCPMS) was established in April 2008 in response to the requirements of Practice-based Commissioning and the re-design of the Spinal Surgical Service. The pain service proposed is described in the service specification. It was anticipated that the progress and performance of the service would be reviewed after 12 months.

The method of accreditation of the service is summarised below and is based on the DH document “Providing Care Closer to Home” Part 3 (2007) as this is an interface service between primary and traditional secondary care led by a generalist physician (GP). The emphasis is on evaluation of the service as a whole although an element of individual accreditation is necessarily included. The latter should not be taken to replace other appraisal processes within the individual’s own discipline.

The accreditors of the service will include a recognised medical specialist/ consultant in pain management from outside central/east Cheshire and a senior commissioner from CECPCT. Each will be provided with copies of the individual professionals’ and the service's supporting paperwork as described below at least two weeks in advance of a team meeting. The half day meeting will involve all the service staff and the accreditors to complete the face-to-face component of the process.

The accreditors will prepare a concise report focusing on the performance of the service, its compliance with the service specification, the identification of problems or difficulties and any recommendations for change.

Accreditation of individual professionals working in the service

Whilst the overall purpose of the exercise is to evaluate the quality of the service as a whole, some consideration of the skills, experience and personal development activity and future needs is relevant.

The key requirements for an individual being accredited to work within the service would be:

- Appropriate level of skill and competence to fulfil the role
- Understanding of the role within the service
- Familiarity with the local clinical pathways
- A written Personal Development Plan (PDP)
- Professional indemnity insurance
- Peer review arrangements
• How the role fits in the work portfolio
• Evidence of appropriate professional registration

A concise draft pro forma is attached for completion by team members within the service. It is proposed that unless specifically requested by the individual or the service accreditors (ie either identify a significant problem specific to that individual) no 1:1 interviews will occur. Rather, any issues arising of importance to the functioning of the team are discussed in a non-personalised way within the accreditation meeting. The completed individual accreditation documents will be submitted to the accreditors at least two weeks before the meeting.

Accreditation of the service

Having considered the competence and experience of the professionals delivering the service the assessment will be of the functioning of the multidisciplinary service as a whole. The Service Specification was considered and approved by an independent specialist in pain medicine and senior commissioners within the PCT in the process of establishing and contracting the service. These precepts may be reviewed and revised for 2009-10 after the concordance of the day-to-day working of the service with the current specification has been determined.

The component parts of accrediting the service as a whole are as follows:

• Referral criteria
• Referral rate
• Clinical interventions being delivered
• Supporting infrastructure of the service – staff, premises etc
• Clinical audit
• Patient satisfaction
• Professional indemnity
• Corporate/ financial governance

It is suggested that the majority of the above is described within an Annual Report of the service following the accreditation meeting and subsequently being available to PCT commissioners, PBC groups and referrers to the service.

The exception will be the financial data/ governance considerations which will be reviewed with PCT commissioners at other meetings relevant to the negotiation of the ongoing contracting of the service.

RP/March 09
### Pro forma for the individual component of the appraisal process

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<td><strong>Any issues you wish to raise individually or collectively</strong></td>
<td></td>
</tr>
</tbody>
</table>
Accreditation Summary

Tuesday 24th March 2009

Introduction

1. A half-day meeting took place, as envisaged in the service specification and business contract, to review the progress of the service over its first year since being commissioned.

2. The principles of this process are set out in the attached documentation.

3. Present:
   - Dr Mark Dickinson, Associate Medical Director, CECPCT.
   - Alison Dwyer, Consultant Pain Nurse, SRFT
   - Dr Richard Potter, Lead Clinician CCPMS
   - Dr Verina Wilde, CBT Psychotherapist
   - Shivaun Rackham, Specialist Physiotherapist
   - Carol Chaddock, Specialist Physiotherapist
   - Suzanne Watson, Specialist Physiotherapist
   - Dan Barlow, Specialist Nurse
   - Julie Potter, Service Co-ordinator

Summary points

4. The history, and skills and evidence base of the service were presented.

5. Local care pathways and referral criteria for the CCPMS were reviewed.

6. The case management of patients within the service was highlighted as an asset and represented good clinical and corporate governance.

7. Moving patients through the service, avoiding “log-jamming”, as demonstrated by the flow chart maximises capacity and efficiency whilst giving individual patients a sense of momentum and the consolidation of gains at each step of their care.

8. The commissioning expectation (especially PBC) that the service was required to satisfy a considerable unmet need was vindicated by a referral rate of 45% over that predicted (353 vs 242 in 11 months).

9. Having established that potential referrers had gained awareness of the service and demonstrated a confidence in the style of treatment on offer and a willingness to refer patients, the next point of consideration was the activity levels attained within the service.

10. An indication of the expected activity appears in the Service Agreement. It was intended that patients would be offered a first assessment appointment (also the start of their treatment) within two months of receipt of the referral letter: therefore comfortably within the 18 week pathway requirement. This requirement together with the greater than expected early demand has resulted in a significantly greater volume of clinical activity (and cost to the PCT).

11. A tariff system based on 90% of HRG3.5 ensured efficiency of resource utilisation with the losses from failed appointments being borne by the company. DNA rates overall were 13.5%.

12. Activity rates over the 7 months of established operation (Aug 08 – Feb 09) were 224 New Patient appointments (45% over expectation) and 683 Follow-up appointments (85% below). This differential indicates some inappropriate referring (e.g. further investigation required), some patients only needing medical attention and some time lag in patients filtering through to the team.

13. The multidisciplinary nature of the service anticipated a greater use of physical and psychological rehabilitation through the group Pain Management Programme than in other pain clinics. The conversion rate to the PMP was approximately 20% of patients assessed (the average hospital pain clinic might involve 8%). This rate is consistent with the clinical and business models proposed.
14. All patients unless excepted (usually through ultimately proving unsuitable as per our referral criteria) were sent audit questionnaires (BPQ + HAD) with a SAE. The response rate was 42/76 = 55%.

15. Of patients returning audit questionnaires 100% were assessed by the pain physician, 71% by the nurse, 52% by the physiotherapists and 36% by the CBT therapist.

16. Of these patients the treatments given were: opioids 24%, anticonvulsant drugs 21%, tricyclics 45%, topical therapy 19%, TENS 36%, and PMP 29%.

17. Overall improvement was rated as “Good” (40-60% improved) or “Very Good” (70%+) by 76% of patients.

18. Of the 24% who indicated a 0-30% improvement or did not complete that scale a further 5 patients showed significant improvement in another scale eg pain intensity, anxiety or depression – if these were added to the 32 patients with good or better %age improvement this would be 88% of patients gaining objective benefit.

19. The cost of the PMP makes this intervention especially important to audit both process and outcome. The compliance rate after 3 cycles of the PMP was 76% of patients completing 4 or more sessions (59% completed 6+).

20. Outcome of the PMP is not yet clear due to the low number of figures available so far. However 10/17(59%) patients have so far returned questionnaires with 80% indicating at least a 40% improvement in their condition.

21. With the audit questionnaires all eligible patients were also sent anonymised patient satisfaction questionnaires (PSQ) and a separate SAE. The response rate was 45/76 = 59%.

22. Satisfaction with the running of the service (waiting, contacting the service, location, information) was 91-98%. For the clinical care satisfaction was 87-91% rating “Good” or “Very Good”. 89% felt that they had benefited from treatment within the service.

23. Half of patients returning the PSQ took the opportunity to offer a comment with 69% of these being positive, 9% being negative and 22% were judged neutral. The verbatim comments were viewed by the group.

Conclusions

24. It was evident that the service has exceeded expectation with regard to demand and clinical activity.

25. The company has complied with and achieved all that was demanded in the contract with the PCT: Central Cheshire Pain Management Service 2008 Service Agreement 18th February 2008.

26. It was suggested that a 30% self rated improvement (rather than 40%) could be accepted as a satisfactory response. (30% is accepted elsewhere when increasing the dosage of analgesia).

27. Robustness of the service should be considered. Training within the service will be developed to provide future clinicians. The nurse involvement in the PMP is already partly a learning exercise. One extra physiotherapist was recruited in the first year and it would be desirable for that therapist to gain experience running the PMP. Another potential pain physician (qualified and experienced GP) will be sought for training at some stage.

28. Links with other services (eg Salford) could be developed especially with training in mind.

28. Referrer satisfaction should be surveyed either by the company and/or the PCT. This document will be shared with GP practices through their manager and a brief questionnaire (with SAE) will be attached to give a preliminary view.

29. Longer term follow-up especially of PMP patients would ideally be undertaken to identify health care utilisation cost savings after treatment.

30. Expansion of the service will be needed to meet the current and increasing demand. This cannot occur until a new contract compliant with HRG4, covering a 3 year period (and currently in advanced negotiation) with the PCT is signed.
31. The **accreditors** of the service have agreed to provide feedback on the written submissions and the afternoon’s discussion. The external clinical accreditor (AD) has explicitly approved this summary and it has been sent to the PCT commissioning accreditor (MD) who has made no further comment.

RP 26/04/09
Appendix 4 Audit Tools (PACS)

Central Cheshire Chronic Pain Management Service
Patient information sheet

Please read the following carefully:

Dear Patient

The Pain Clinic is striving to improve standards of Clinical Service in Pain Management. We therefore need to collect as much information as possible regarding our clinical activity.

Your help in completing the various questionnaires and consent to input clinical data into our database would be greatly appreciated.

Data Collected
On your first visit to the pain clinic you will be asked to complete a ‘new patient’ assessment form and a hospital anxiety and depression scale questionnaire. On your final visit you will be asked to complete a follow-up questionnaire. In addition, details of your pain condition and treatment will be provided by the doctor or nurse seeing you in clinic and then entered in to the database.

Data Controller
The Data Controller is Julie Potter.
The development of the database was financed by an educational grant from Pharmacia, a Pharmaceutical company. However, no clinical data will be passed on to Pharmacia or any other commercial firm.

What happens to the data?

The data collected will be used to provide:-

- Information about your care will be used by the Service to monitor your progress. It is good clinical practice for Services to audit themselves and this data (with your name attached) will be used for this purpose, strictly within the Central Cheshire Chronic Pain Service.

- The Service also wishes to compare itself with Chronic Pain Services in the U.K. To this end, we would like to send anonymized (i.e. without your name on it) data to a National Database to see how we are performing.

We believe that both these processes are important for the development of a high quality chronic pain service in Central Cheshire.

Please do not hesitate to ask the nursing or medical staff if you have any queries or concerns regarding the database.

Many thanks in anticipation of your help.
Please circle your response or ask for help if you are having problems

1. Please rate your pain by circling the one number that best describes your pain at its **WORST** in the past week.

<table>
<thead>
<tr>
<th>NO PAIN</th>
<th>0</th>
<th>1</th>
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<th>WORST PAIN YOU</th>
</tr>
</thead>
</table>

2. Please rate your pain by circling the one number that best describes your pain at its **LEAST** in the past week.

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<thead>
<tr>
<th>NO PAIN</th>
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<th>WORST PAIN YOU</th>
</tr>
</thead>
</table>

3. Please rate your pain by circling the one number that best describes your pain on the **AVERAGE**.

<table>
<thead>
<tr>
<th>NO PAIN</th>
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<th>WORST PAIN YOU</th>
</tr>
</thead>
</table>

4. Please rate your pain by circling the one number that tells you how much pain you have **RIGHT NOW**.

<table>
<thead>
<tr>
<th>NO PAIN</th>
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<th>WORST PAIN YOU</th>
</tr>
</thead>
</table>

5. Circle the one number that describes how during the past week, **PAIN HAS INTERFERED** with your:

   A. **General activity**

<table>
<thead>
<tr>
<th>DOES NOT INTERFERE</th>
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   B. **Mood**

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   C. **Walking ability**

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<tr>
<th>DOES NOT INTERFERE</th>
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<th>COMPLETELY INTERFERES</th>
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</table>

   D. **Normal work (includes work both outside the home and housework)**

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<thead>
<tr>
<th>DOES NOT INTERFERE</th>
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<th>COMPLETELY INTERFERES</th>
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</thead>
</table>

   E. **Relationships with other people**

<table>
<thead>
<tr>
<th>DOES NOT INTERFERE</th>
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   F. **Sleep**

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<th>DOES NOT INTERFERE</th>
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<th>COMPLETELY INTERFERES</th>
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   G. **Enjoyment of life**

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<thead>
<tr>
<th>DOES NOT INTERFERE</th>
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</tr>
</thead>
</table>
DOCTORS ARE AWARE THAT EMOTIONS PLAY AN IMPORTANT PART IN MOST ILLNESSES. IF YOUR DOCTOR KNOWS ABOUT THESE FEELINGS HE WILL BE ABLE TO HELP YOU MORE. THIS QUESTIONNAIRE IS DESIGNED TO HELP YOUR DOCTOR TO KNOW HOW YOU FEEL. READ EACH ITEM AND PLACE A FIRM TICK IN THE BOX OPPOSITE THE REPLY WHICH COMES CLOSEST TO HOW YOU HAVE BEEN FEELING IN THE PAST WEEK. DON'T TAKE TOO LONG OVER YOUR REPLIES: YOUR IMMEDIATE REACTION TO EACH ITEM WILL PROBABLY BE MORE ACCURATE THAN A LONG THOUGHT-OUT RESPONSE.

<table>
<thead>
<tr>
<th>Item</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel tense or wound up:</td>
<td>Most of the time, A lot of the time, Time to time, Not at all</td>
</tr>
<tr>
<td>I feel as if I am slowed down:</td>
<td>Nearly all the time, Very often, Sometimes, Not at all</td>
</tr>
<tr>
<td>I still enjoy the things I used to enjoy:</td>
<td>Definitely as much, Not quite as much, Only a little, Hardly at all</td>
</tr>
<tr>
<td>I get a sort of frightened feeling as if something awful is about to happen:</td>
<td>Very definitely and quite badly, Yes, but not too badly, A little, but it doesn't worry me, Not at all</td>
</tr>
<tr>
<td>I get a sort of frightened feeling if something awful is about to happen:</td>
<td>Not at all, Not quite as much, Only a little, Hardly at all</td>
</tr>
<tr>
<td>I can laugh and see the funny side of things:</td>
<td>As much as I always could, Not quite as much now, Definitely not so much, Not at all</td>
</tr>
<tr>
<td>I feel restless as if I have to be on the move:</td>
<td>Very much indeed, Quite a lot, Not much, Not at all</td>
</tr>
<tr>
<td>Worrying thoughts go through my mind:</td>
<td>A great deal of the time, A lot of the time, From time to time but not too often, Only occasionally</td>
</tr>
<tr>
<td>I look forward with enjoyment to things:</td>
<td>As much as I ever did, Rather less that I used to, Definitely less than I used to, Hardly at all</td>
</tr>
<tr>
<td>I feel cheerful:</td>
<td>Not at all, Not often, Sometimes, Most of the time</td>
</tr>
<tr>
<td>I get sudden feelings of panic:</td>
<td>Very often indeed, Quite often, Not very often at all, Not at all</td>
</tr>
<tr>
<td>I can sit at ease and feel relaxed:</td>
<td>Definitely, Usually, Not often, Not at all</td>
</tr>
<tr>
<td>I can enjoy a good book or radio or TV programme:</td>
<td>Often, Sometimes, Not often, Very seldom</td>
</tr>
</tbody>
</table>

Surname __________________________ Forenames _________________________
Date ____________________________ D Score ____________________________
CENTRAL CHESHIRE CHRONIC PAIN MANAGEMENT SERVICE
BRIEF PAIN INVENTORY - FOLLOW-UP

Name: .......................... .................................. Date: ..............................................

Please circle your response or ask for help if you are having problems.

6. How much RELIEF have pain treatments or medications FROM THIS CLINIC provided? Please circle the one percentage that shows how much.

<table>
<thead>
<tr>
<th>COMPLETE RELIEF</th>
<th>100%</th>
<th>90%</th>
<th>80%</th>
<th>70%</th>
<th>60%</th>
<th>50%</th>
<th>40%</th>
<th>30%</th>
<th>20%</th>
<th>10%</th>
<th>0%</th>
<th>NO RELIEF</th>
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</table>

7. Please rate your pain by circling the one number that best describes your pain at its WORST in the past week.

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<tr>
<th>NO PAIN</th>
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8. Please rate your pain by circling the one number that best describes your pain at its LEAST in the past week.

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9. Please rate your pain by circling the one number that best describes your pain on AVERAGE.

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</table>

11. Circle the one number that describes how during the past week, PAIN HAS INTERFERED with your:

D. General activity

<table>
<thead>
<tr>
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E. Mood

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F. Walking ability

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D. Normal work (includes work both outside the home and housework)

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E. Relationships with other people

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<tr>
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G. Sleep

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</thead>
</table>

G. Enjoyment of life

<table>
<thead>
<tr>
<th>DOES NOT INTERFERE</th>
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</table>
CENTRAL CHESHIRE CHRONIC PAIN MANAGEMENT SERVICE
DIAGNOSIS SHEET

<table>
<thead>
<tr>
<th>System</th>
<th>Location</th>
<th>Mechanism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alimentary</td>
<td>Abdomen</td>
<td>Congenital</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Anal, perineal, genital</td>
<td>Degenerative</td>
</tr>
<tr>
<td>Endocrine</td>
<td>Buttock, leg, foot</td>
<td>Infective</td>
</tr>
<tr>
<td>Haematological / Autoimmune</td>
<td>Head, face, mouth</td>
<td>Inflammatory</td>
</tr>
<tr>
<td>Multiple</td>
<td>Low back, spine</td>
<td>Ischaemia</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>Multiple sites</td>
<td>Metabolic</td>
</tr>
<tr>
<td>Nervous</td>
<td>Neck</td>
<td>Mixed</td>
</tr>
<tr>
<td>Reproductive</td>
<td>Pelvis</td>
<td>No definite cause</td>
</tr>
<tr>
<td>Respiratory</td>
<td>Shoulder, arm, hand</td>
<td>Other</td>
</tr>
<tr>
<td>Skin</td>
<td>Thorax</td>
<td>Surgery</td>
</tr>
<tr>
<td>Urogenital</td>
<td></td>
<td>Trauma</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tumour</td>
</tr>
</tbody>
</table>

**Duration of Symptoms:**
years

**Pain Type**
- Mixed
- Neuropathic
- Nociceptive
- Unknown
- Not specified

**Diagnosis:**
- Mixed
- Neuropathic
- Nociceptive
- Unknown
- Not specified

1.1 TREATMENTS: Drugs
- Anticonvulsant: CBZ, Gabapentin
- Antidepressant – other: Fluoxetine, Venlafaxine
- Antidepressant TCA: Amitriptyline
- NSAIDS: Ibuprofen, Diclofenac, Celecoxib, Rofecoxib
- Other drugs: Baclofen
- Strong opioids: Morphine, Fentanyl, Oxycodeine
- Systemic local anaesthetics: Mexiletine
- Topical agents: EMLA, Capsaicin
- Weak opioids: Dihydrocodeine, Codeine, Tramadol

Injection therapy

**Complementary**
- Acupuncture

**Psychology**
- Education
- Individual psychology
- Pain Management
- Pain Management
- Refer to PMP

1.1.1 Manual
- Graded exercise
- Massage
- OT

**Neuromodulation**
- Physio
- Reflexology

**Other**
- TENS
- SCS

**Complications:**
- Minor
- Major

**ADRs:**
- Drug
- Side effect
- Stopped taking: yes / no

**Discharge:**
Appendix 5  Patient satisfaction survey:

Central and Eastern Cheshire NHS Primary Care Trust

Central Cheshire Pain Management Service

Patient Satisfaction Survey

We are collecting this information as part of an audit to improve the healthcare service we provide to you. You are providing this information anonymously so your name should not appear on this form. Please return this in the stamped addressed envelope provided.

Q1. How many times were you seen by the Pain Management team?

1-5 times  [ ]  6 or more  [ ]

Q2. Were you satisfied with the response when you contacted the service by telephone or letter?

Yes  [ ]  No  [ ]

Q3. Was the time you waited for your appointment acceptable?

Yes  [ ]  No  [ ]

Q4. Was the location of the service convenient to you?

Yes  [ ]  No  [ ]

Q5. Were you happy with the written information you were given about the service?

Yes  [ ]  No  [ ]

Q8. Were the letters you received from the service about your treatment helpful?

Yes  [ ]  No  [ ]
Q9. Thinking about the consultations with the team, how do you rate the following? (Please tick the box that applies)

<table>
<thead>
<tr>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
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- The team understanding of your pain problems
- The team explanation of the reason why your pain had not gone away.
- The team answered my questions about the pain well.
- The team spent enough time with me

Q10. Did you experience any difficulties with your care?

Yes [ ] No [ ]

If yes, please specify: ........................................................................................................
.................................................................................................................................

Q11. Are you satisfied with your pain medication?

Yes [ ] No [ ]

If no, please specify: ........................................................................................................
.................................................................................................................................

Q12. Do you feel you have benefited from attending this service?

Yes [ ] No [ ]

Comments please: ........................................................................................................
.................................................................................................................................
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* * *

Thank you for taking the time to complete this questionnaire
Appendix 6

Independent sector provision of the Chronic Pain Management Service (CPMS) by Interface Medical Ltd (IML) to the Crewe and Winsford areas

Assurance Issues

Clinical governance

1. Evidence of an Integrated Governance structure and clinical governance systems.
   (Clinical Governance policy provided)
   
   The service is modelled closely on the current CECPCT service provided in Eastern Cheshire which itself was designed by Dr Potter (RP). RP is clinically appraised annually by CECPCT in his role as both Principal in General Practice and Lead Clinician of the ECCPMS. In the IML service all patients will be assessed personally by RP and their further care planned and, as necessary, devolved to other clinical team members who clinically and managerially report to RP.

2. Ongoing monitoring of the Clinical governance system
   (Annual CG Report to be produced and shared with PCT)
   
   The proposed level of clinical activity over the first 12 months is set out in this Service Agreement and the concordance with this will be reviewed with the PCT at 6 months with a full report at 12 months.

3. All subcontractors identified and accountability for clinical Governance structures clarified.
   (sub contractors identified and are NHS providers)
   
   All team members except one (the CBT therapist) are currently working in the CPMS in Eastern Cheshire run by the NHS PCT Provider Service and are appraised in that role. An outline of the appraisal / accreditation procedure planned specifically for the CCPMS appears in Appendix 3.

4. Clearly specified patient pathways provided, detailing the episode of care form registration to discharge and any post care arrangements.
   (patient and clinical pathways provided and checked with external clinician)
   
   The patient pathways are reflected in the spreadsheets of consulting activity for each of the clinical team members. The service specification for the ECCPMS has been reviewed by an external clinician (Dr Tim Johnson) and this has been deemed a suitable model for the CCPMS.
5. Risk analysis of all hand off points to be undertaken and identified in pathway.

All correspondence (and therefore details of treatment advised) will be copied to the patient and the general practitioner. Letters will be sent after every medical contact and the GP alerted to changes of medication and any need to provide repeat prescriptions (see Appendix 1.).

6. Clear definitions of time lines and breach alerts.
(Outlined in specification and to be included in contract)

All new patients will be offered an appointment with the pain physician at a time no later than eight weeks from receipt of the referral letter. The process of induction into the group pain management programme of suitable patients will commence within 18 weeks of referral. Breaches of these targets will be reported to the PCT commissioners with appropriate explanations.

Healthcare standards

1. External Accreditation established where appropriate.

All individual clinicians are subjected to regulation by their professional bodies and all bar one are appraised annually by the CECPCT. External accreditation is described in Appendix 3. It is intended that the service, with audit data, is appraised as a whole by an independent specialist in Chronic Pain Management with a senior PCT manager after 12 months activity and as envisaged in "Implementing Care Closer to Home – DH April 2007)."

2. Provide evidence that service meets national minimum healthcare standards.
(summary of evidence provided against each of the key areas.)

The service in East Cheshire was devised in 2004 on the precepts described in "Pain Management Services – Good Practice RCA/PS 2003” and "Adult Chronic Pain Management Services in the UK – DrFoster 2003”.

This is to include:

3. Evidence that service is in line with good clinical practice in particular relating to emergencies and complications.

This is not a crisis service – emergency problems such as (rare) severe adverse reactions to medication are referred to the GP. Less urgent enquiries can be channelled through the service landline telephone/ansamachine (Mon – Fri 9-5) with a response guaranteed by the end of the next working day.

4. Service provided in a safe environment and using safe equipment.

The service will be provided from General Practice premises already approved by CECPCT. It will be a contractual requirement between IML and the provider of accommodation that public liability or other relevant insurance is in place and
is the responsibility of the landlord. There is no equipment used by the service which could pose a risk to patients unless that equipment was used in a professionally negligent way – such an eventuality would therefore be covered by the clinician’s indemnity insurance.

5. **Care undertaken by appropriately qualified staff.**
   (A range of appropriate policies referenced and available for checking)
   (staff are NHS staff so will also be registered through the NHS)

   All clinical staff except the CBT therapist are employed by CECPCT to deliver the CPMS in Eastern Cheshire. The CBT therapist is extremely experienced and having founded, developed and run the Group Pain Management Programme at East Cheshire NHS Trust she is now in independent practice.

**Risk Management**

1. **Ensure robust risk assurance process in place.**
   (included in governance policy)
   (Risk analysis process completed and shared with PCT)

   The clinical practice and communication systems with the patients and primary care are described elsewhere. The risks within premises are assessed by CECPCT and the contract regarding premises will ensure appropriate checks and insurance continue. All clinicians are registered with their professional bodies, hold professional indemnity insurance and are CRB checked.

2. **A Risk Register is in place.**

   Adverse events whether clinical or administrative will be recorded in a register, discussed as appropriate within the team and changes made to practice if necessary.

3. **Incident reporting procedure in place and monitored.**
   (Process in place and monitoring arrangements included in contract)

   As above.

4. **Complaints process in place giving patients access to appropriate NHS systems i.e. PALS.**
   (Included in governance document and to be included in contract.)

   Verbal or written complaints will be referred to the CECPCT complaints procedure unless the problem can be solved quickly and to the patient’s satisfaction by the lead clinician or project manager.
Audit

1. **Agree an audit plan with the PCT**  
   (still to be done)

The service will be using the Pain Audit Collection System (PACS) initially in manual form. This nationally approved system provides baseline data on pain intensity, effect on life, distress, anxiety and depression prior to initial assessment and will be repeated as necessary and on discharge. Activity will also be recorded including number of appointments (including DNA’s), medical treatments given and therapies successfully deployed and represented in the discharge “pain plan”.

Patient satisfaction

1. **System in place to gain patient and referrer views.**  
   (Patient Forum is in place and evidence of patient dialogue already undertaken)  
   (Patient satisfaction indicators to be included in the contract.)

   Anonymised patient satisfaction surveying will be performed prospectively by IML (see Appendix 5.). Overall satisfaction rates of a similar service have been of the order of 70% (2006). An identical survey will be performed on a rolling basis in this service to highlight any problems early and will form part of the audit.

2. **Evidence of patients being informed of their choice and the interests of the referring GP.**  
   (to be included as a written paragraph on the consent form.)  
   (Can be included in the audit programme)

   In chronic pain management there is evidence that patient choice of style of therapy positively correlates with outcome. Involving patients in decisions over their care is a central tenet of this style of CPMS.

3. **Patient information clear and meeting appropriate standards.**

   The information leaflets on the service generally and on the PMP are as those used in the Eastern Cheshire service which have been approved by the “reading committee”.

Information and IT

1. **Information governance systems in place**  
   (Included in the governance document)  
   (Range of policies referenced and available for monitoring)

   The company is registered under the Data Protection Act.

2. **Ability to comply with NHS minimum data sets.**  
   (Now linked to NHS systems and have capability to provided data. Still to be agreed with the PCT and included in the contract.)
The records will initially be only in paper form. The PACS system (see Appendix 4.) includes a nationally accepted dataset. The electronic involvement being exclusively in the word processing of reports and clinic letters/appointments.

3. **Ability to comply with 18 week waiting time data set.**
   Still to be agreed with the PCT.

**Financial Governance**

1. **Provide evidence of the organisations financial health.**
   (Annual accounts provided for the last three years)
   (Included in the contract that these will be provided on a yearly basis.)

   *Copy accounts since 2003 are available for inspection.*

2. **Value for money is established**

   The Pain Service provided by IML is done so at 90% of new and follow-up outpatient tariff.