A. Service Specification

Service Specification No:	1767
Service	Adult Highly Specialist Pain Management Services
Commissioner Lead	*For local completion*
Provider Lead	*For local completion*

1. Scope

1.1 **Prescribed Specialised Service**
This service specification covers the provision of adult highly specialist pain management services, but there are significant overlaps in relation to young people and the transition from children's to adult services.

1.2 **Description**
Adult highly specialist pain management services are delivered by multi-disciplinary teams working in tertiary settings to manage patients where locally commissioned pain services have not achieved adequate symptom control. They include the tertiary level management of condition-specific presentations, as well as complex cases of a more generic nature. Adult highly specialist interventions may include, pain-specific psychological interventions, inpatient care, complex medicines optimisation, follow up and rehabilitation. Patients may be treated either within the tertiary setting or via a networked approach with adjacent providers.

1.3 **How the Service is Differentiated from Services Falling within the Responsibilities of Other Commissioners**
The Core Standards for Pain Management Services published by the Faculty of Pain Medicine (FPM), along with British Pain Society (BPS) publications, set out the guidelines for delivering pain management services in England.

Broadly, there are four levels of pain management services:

1. Self-management
2. GP services and CCG-commissioned community pain management services
3. Specialist pain management services, provided in secondary care (CCG commissioned)
4. Adult Highly Specialist Pain Management services (NHS England commissioned)

NHS England will commission adult highly specialist pain management services (level 4) only.

2. Care Pathway and Clinical Dependencies

This service specification addresses the adult highly specialist pain management services to be commissioned by NHS England. It should be used to inform the commissioning of other pain management services in the community and in secondary care so that they integrate with them to provide a seamless patient flow

Access to treatment in adult highly specialist pain management services will be in line with national clinical commissioning policies published by NHS England Specialised Commissioning.

Commissioning arrangements will need to be sufficiently robust to ensure funding for the following types of activity:

- Multidisciplinary Team (MDT) meetings to coordinate the assessment, management and review of patients referred to adult highly specialist pain management services
- Joint clinics (interdisciplinary and/or with other specialties) in line with the associated pain conditions being treated

- Involvement in the ongoing care management of patients in line with the need for regular review and MDT assessment of patients receiving long term treatment. This should include device implantation when part of a highly specialist pain management episode.
- Psychological and behavioural interventions (as outpatients, inpatients or on a residential basis)
- Inpatient / day case episodes (both medical and surgical)
- The provision of advice to and liaison with the referring specialist pain management centre.

Referrals to adult highly specialist pain management services for assessment and treatment will be primarily for the following reasons:

- A second opinion when requested by a specialist pain management center (secondary care)
- Specific multidisciplinary assessment and management of patients who have a realistic potential for improvement, but who have not responded to treatment or interventions provided by specialist pain management services in secondary care
- Cordotomy for specific cancer pain
- Other neurolytic procedures where expertise is not available within specialist pain management (level 3) services
- Neurosurgical brain procedures for pain
- Inpatient drug optimisation (including opioid management programs)

2.1 **Care Pathway**

Referrals will be from specialist (secondary care) pain management services only, when a patient has been assessed as having chronic refractory pain requiring highly specialist advice and/or intervention.

Assessment will be interdisciplinary and multidisciplinary as required, leading to specific investigations, interventions, (psychological and pharmacological) resulting in the development of a pain management plan.

The core multidisciplinary team (MDT) will include the following, all of whom should be trained and experienced in the appropriate area of chronic pain management:

- specialist consultants;
- specialist nurses;
- psychologists;
- physiotherapists;

Access to occupational therapists and pharmacists should be included as appropriate.
Other members of the MDT will be governed by the area of adult highly specialist pain management on which the MDT meeting is focused (e.g. the involvement of neurology specialists for the treatment of complex headache).

Along with patient participation in the planning of their care, MDT meetings are a vital component of assessment, review and long term pain management, with the expectation that patients will ultimately be discharged back to the referring centre. The purpose of the MDT meetings will depend on the structure of the pain management unit and the position of the patient in the care pathway. The MDT meeting may be conducted in the presence of the patient, or it can be notes-based. It can also be combination of both.

Due to the nature of the service and the fact that it is intended for the more complex cases of pain management, shared care arrangements also form part of the adult highly specialist pain management care pathway.

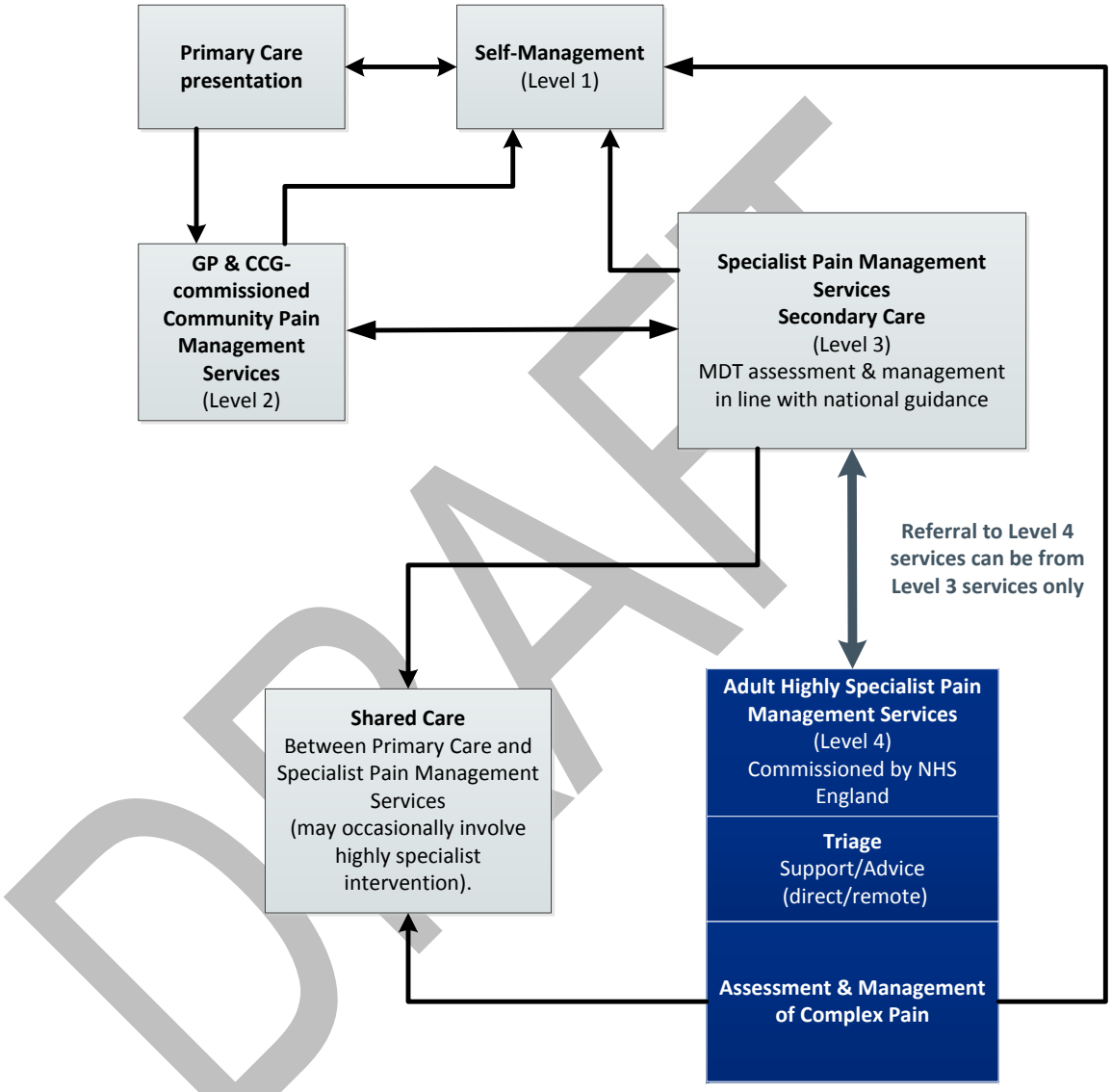
In the case of those patients requiring review in the longer term, a formal plan should be in place to ensure that patients are assessed every 6 months in relation to their requirement to remain under the care of the highly specialist pain management service. Advice and support may be given without taking over the care of the patient from the referring service. This advice may be provided remotely, with members of the MDT contributing via telephone or internet. Commissioning rules will be required to fund this activity.

Providers of Adult Highly Specialist Pain Management services will need to establish robust protocols with referring clinicians to ensure patients are discharged appropriately.

Discharge from adult highly specialist pain management services should follow one of the following routes :

- Back to the referring team (responsible for providing ongoing support), with a copy of the discharge letter/summary provided to the patient and sent to the GP
- Where specialist care is not required, then the patient can be discharged back to the GP, with a copy of the discharge letter/summary provided to the patient and sent to the referring centre
- If the patient is discharged to ongoing 'self-care' a copy of the discharge letter/summary should be provided to the GP, the patient and to the referring centre.

The care pathway can be illustrated as follows:



2.2 Interdependence with other Services

It is unlikely that any single adult highly specialist pain management service will provide all available areas of intervention. As described in section 1.2 patients may be treated within the tertiary setting or via a networked approach with adjacent providers. The number of services providing treatment and interventions will depend on demand and ease of access (for example, there will be fewer centres delivering cordotomy services and more centres delivering pelvic pain services).

Adult highly specialist pain management is a cornerstone service. Depending on the nature of the condition with which pain is associated, co-location with the following services should be considered:

- gynaecology & urogynaecology
- neurology

- neurosurgery
- palliative care & cancer services
- paediatrics
- rehabilitation (including neurorehabilitation)
- rheumatology
- spinal injuries

The corresponding specifications relating to these services should also be taken into account.

3. Population Covered and Population Needs

3.1 Population Covered By This Specification

The service outlined in this specification is for adult 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.

3.2 Population Needs

Chronic pain is recognised as a long term condition in its own right, or as a component of other long term conditions. It is estimated that around eight million people in the UK suffer with moderate to severely disabling chronic pain. 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. Most patients with chronic pain can be well-managed in community or specialist pain management (secondary care) services by appropriately trained members of an interdisciplinary pain management team. It is envisaged that only a small number of patients with more complex pain problems, such as those defined in section 2, will require treatment in adult highly specialist pain management centres.

3.3 Expected Significant Future Demographic Changes

Alongside the increased demand for pain management services as the result of an ageing population, it is anticipated that there will be an increased need for:

- cordotomy (due to an increase in cases of mesothelioma);
- cancer-related pain management (including post-surgical and chemotherapy-induced neuropathic pain) due to increased cancer survival rates.

3.4 Evidence Base

The service description and requirements are based on the Core Standards for Pain Management Services published by the Faculty of Pain Medicine (FPM) which sets out the guidelines for delivering pain management services in England; documents published by British Pain Society (BPS); and current NICE guidance.

4. Outcomes and Applicable Quality Standards

4.1 Quality Statement – Aim of Service

The aim of an Adult Highly Specialist Pain Management Service is to deliver timely, skilled multidisciplinary assessment and management for patients with chronic disabling pain by reducing the impact of pain on quality of life and improving health outcomes.

The overarching objective of an Adult Highly Specialist Pain Management service is to provide multidisciplinary and multispecialty assessment and management for patients who have not responded to treatment provided by specialist pain management services and who have a realistic potential for further benefit. This will likely include:

- supporting clinicians in managing the pain element of the conditions of patients in their care;
- delivering direct interventions to reduce, eradicate or manage pain;

- providing psychological and behavioural interventions that support patients and carers to enable them to manage their pain and improve their quality of life;
- actively promoting and delivering research, audit, teaching, and training in the area of adult highly specialist pain management with which they are involved.

Adult Highly Specialist Pain Management Services will collect appropriate key performance indicators, including those related to patient outcome measures and patient satisfaction. Each service will take part in clinical audit and national registries where they exist. Each adult highly specialised pain management service will carry out collaborative research supported by the Research and Development services within the provider network.

NHS Outcomes Framework Domains

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

4.2 Indicators Include:

Number	Indicator	Data Source	Outcome Framework Domain	CQC Key question
Clinical Outcomes				
101	Proportion of patients with neuromodulatory/ITDD devices submitted to National Neuromodulation Registry. To Include new, revisions and explantation.	Registry / SSQD	2,3	safe effective
102	Proportion of cordotomy patients entered in to the National Cordotomy Registry	Registry / SSQD	2,3	safe effective
103	Mean time from referral to treatment for non cancer patients	Provider SSQD	2,3	safe effective
104	Mean time from referral to treatment for cancer patients	Provider SSQD	2,3	safe effective
105	Proportion of patients having explantation of neuromodulation / ITDD devices due to infection within 12 months of implant	Registry / SSQD	2,3	safe effective
106	Proportion of patients	Provider SSQD	2,3	safe effective

	completing a pain management programme			
107	Proportion of neuromodulation / ITDD patients with recorded outcome measures. Using EQ5D-5L	Registry / SSQD	2,4	safe effective
108	Proportion of neuromodulation / ITDD patients with EQ5DL-5L outcome improvement on discharge.	Provider SSQD	2,3	safe effective
109	Proportion of all patients with recorded QoL outcomes in line with national guidance.	Provider SSQD	2,3	safe effective
110	Proportion of patients with QoL improvement on discharge.	Provider SSQD	2,3	safe effective
Patient Experience				
201	There is information for patients on their condition and treatment	Self declaration	4	responsive, caring
202	Patients are given a personalised care plan	Self declaration	4	responsive, caring
203	There is a mechanism in place to obtain feedback from patients and families	Self declaration	4	responsive, caring
204	Proportion of patients who were given a personalised care plan	Provider SSQD	4	responsive, caring
205	Proportion of patients or carers specifying they received helpful information about their condition and treatment	Provider SSQD	4	responsive, caring
Structure and Process				
001	There is a specialist multidisciplinary team	Self declaration	1,3,5	Effective
002	There is a multidisciplinary assessment of patients	Self declaration	1,3,5	Effective
003	There are clinical guidelines in place	Self-declaration	1,3,5	effective, safe
004	There are patient pathways in place	Self-declaration	1,3,5	effective, safe
005	The HSPS is providing advice, support and training to referring organisations	Self-declaration	1,3,5	effective, safe
006	The HSPS is actively participating in audit and research	Self-declaration	1,3,5	effective, safe
007	There is a quarterly education and governance meeting	Self declaration	1,3,6	effective, safe

Detailed definitions of indicators, setting out how they will be measured is included in appendix 1.

4.3 Commissioned providers are required to participate in annual quality assurance and collect and submit data to support the assessment of compliance with the service specification as set out in Schedule 4A-C

5. Applicable Service Standards

Minimum Standards include those defined by the:

- Faculty of Pain Medicine of the Royal College of Anaesthetists (FPM).

https://www.rcoa.ac.uk/faculty-of-pain-medicine

- British Pain Society (BPS). https://www.britishpainsociety.org/british-pain-society-publications/
- International Association for the Study of Pain (IASP). https://www.iasp-pain.org
- Service specific competencies for nursing, psychology and other staff working in the adult highly specialist pain management service.

5.1 Applicable Obligatory National Standards

- NICE (2008): Spinal cord stimulation for chronic pain of neuropathic or ischaemic origin, NICE Technology Appraisal (TA159) https://www.nice.org.uk/guidance/ta159

5.2 Applicable National Standards

- Core Standards for Pain Management Services in the UK. Faculty of Pain Medicine 2015. http://www.rcoa.ac.uk/document-store/core-standards-pain-management-services-the-uk
- Pain Management Services: planning for the future - Guiding clinicians in their engagement with commissioners. https://www.rcoa.ac.uk/node/15468
- Physiotherapy Pain Association & Chartered Society of Physiotherapy (2014) Physiotherapy Framework. Describing the values, behaviours, knowledge and skills of physiotherapists working with people in pain. CSP, London, UK http://ppa.csp.org.uk/documents/ppa-physiotherapy-framework-entry-level-graduate-expert- describing-values-behaviours
- NICE (2013) Neuropathic pain in adults: pharmacological management in non-specialist settings. Clinical Guideline (CG173) (Update Feb 17) https://www.nice.org.uk/guidance/cg173
- NICE (2016) Low back pain and sciatica in over 16s: assessment and management" (NG59). https://www.nice.org.uk/guidance/ng59
- NICE (2017) Endometriosis: diagnosis and Management (NG73). https://www.nice.org.uk/guidance/ng73
- NICE (update Dec 16) Managing Long term sickness and incapacity for work https://pathways.nice.org.uk/pathways/managing-long-term-sickness-and-incapacity-for-work
- NICE (2009) Management of long-term sickness and incapacity for work (PH19) https://www.nice.org.uk/guidance/ph19
- European Association of Urology. EAU Chronic Pelvic Pain Guidelines (2018). http://uroweb.org/guideline/chronic-pelvic-pain/
- Commission on the Provision of Surgical Services: Report of a Working Party on Pain after Surgery. Royal College of Surgeons and College of Anaesthetists (1990). http://www.rcoa.ac.uk/document-store/commission-the-provision-of-surgical-services-report-of-working-party-pain-after
- 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. 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)
- NICE (2011) Deep Brain Stimulation for refractory chronic pain syndromes (IPG382). https://www.nice.org.uk/guidance/ipg382
- NICE (2012) Headaches in over 12's: diagnosis and management (CG150). https://www.nice.org.uk/guidance/cg150/chapter/Recommendations#management-2
- *Intrathecal drug delivery for the management of pains and spasticity in adults; recommendations for best clinical practice.* British Pain Society (BPS), Dec 2015. https://www.britishpainsociety.org/static/uploads/resources/files/itdd_2015_pro_v3.pdf
- *Standards of Good Practice for Spinal Interventional Procedures in Pain Medicine.* British Pain Society and Faculty of Pain Medicine of the Royal College of Anaesthetists, April 2015. https://www.britishpainsociety.org/static/uploads/resources/files/spinal_intervention_A5_Final_April_2015_1.pdf

6. Designated Providers (if applicable)

Not Applicable

7. Abbreviation and Acronyms Explained

The following abbreviations and acronyms have been used in this document:

BPS	British Pain Society
EAU	European Association of Urology
FPM	Faculty of Pain Medicine of the Royal College of Anaesthetists
HSPS	Highly Specialist Pain Management Services
IASP	International Association for the Study of Pain
ITTD	Intrathecal Drug Delivery
QoL	Quality of Life
RCoA	Royal College of Anaesthetists

Date published: *<insert publication date>*

Appendix 1

Number	Indicator	Descriptor	Notes	Evidence documents	Data Source	O.F Domain	CQC Key question
	Clinical Outcomes - quantitative data						
101	Proportion of patients with neuromodulatatory/ITDD devices submitted to National Neuromodulation Registry. To Include new, revisions and explantation.	Numerator: Number of patients submitted to the registry Denominator: Number of patients having new implants, revisions and explantation			Registry / SSQD	2,3	safe effective
102	Proportion of cordotomy patients entered in to the National Cordotomy Registry	Numerator: Number of patients submitted to the registry Denominator: Number of patients having cordotomy			Registry / SSQD	2,3	safe effective
103	Mean time from referral to treatment for non-cancer patients				Provider SSQD	2,3	safe effective
104	Mean time from referral to treatment for cancer patients				Provider SSQD	2,3	safe effective
105	Proportion of patients having explantation of neuromodulation / ITDD devices due to infection within 12 months of implant	Numerator: Number of patients having explantation of neuromodulation / ITDD devices due to infection within 12months of implant Denominator: number of patients treated with neuromodulation / ITDD devices			Registry / SSQD	2,3	safe effective
106	Proportion of patients completing a pain management programme	Numerator: Number of patients completing a pain management programme Denominator: Number of patients entered into a pain management programme			Provider SSQD	2,3	safe effective

107	Proportion of neuromodulation / ITDD patients with recorded outcome measures. Using EQ5D-5L	Numerator: Number of patients with recorded outcomes measures Denominator: number of patients submitted to the registry	Registry / SSQD	2,4	safe effective
108	Proportion of neuromodulation / ITDD patients with EQ5DL-5L outcome improvement on discharge.	Numerator: Number of patients with improved QoL on discharge Denominator: Number of neuromodulation patients with recorded EQ5DL-5L	Provider SSQD	2,3	safe effective
109	Proportion of all patients with recorded QoL outcomes in line with national guidance.	Numerator: Number of patients with recorded QoL Denominator: number of patients treated by the highly specialist service	Provider SSQD	2,3	safe effective
110	Proportion of patients with QoL improvement on discharge.	Numerator: Number of patients with improved QoL on discharge Denominator: number of patients with recorded QoL on first assessment	Provider SSQD	2,3	safe effective
	Patient Experience				

201	There is information for patients on their condition and treatment	There must be written information for patients covering at least the following: information about the service including names and functions/roles of the MDT members - description of the patient pathway - information about patient involvement groups and patient self-help groups - information about the services offering psychological and social support - information about their condition and treatment including risks and benefits - relevant contact points.	It is recommended that the information is available in languages and formats understandable by patients including local ethnic minorities and people with disabilities. This may necessitate the provision of visual and audio material.	Operational policy	Self declaration	4	responsive, caring
202	Patients are given a personalised care plan	Patients must have a personalised care plan. The plan should specify the clinical lead for the patient and include:- management strategies - review procedures		Operational policy	Self declaration	4	responsive, caring
203	There is a mechanism in place to obtain feedback from patients and families	The service should have a mechanism in place to obtain feedback on patients' and families' experience of the services offered. The feedback should ascertain as a minimum the following - whether they have been given a personalised care plan - whether they have been given information about their condition and treatment they have found helpful		Annual report	Self declaration	4	responsive, caring
204	Proportion of patients who were given a personalised care plan	Numerator The number of patients specifying they had received a personalised care plan Denominator Number of surveys returned within the reporting period			Provider SSQD	4	responsive, caring

205	Proportion of patients or carers specifying they received helpful information about their condition and treatment	Numerator The number of patients specifying they had received helpful information Denominator Number of surveys returned with the reporting period		Provider SSQD	4	responsive, caring
	Structure and Process - infrastructure requirements, staffing, facilities etc					
001	There is a specialist multidisciplinary team	There is a multidisciplinary specialist pain team which includes : - specialist pain consultants one of whom should be the named lead clinician - specialist nurses - psychologists - physiotherapists all of the above should be trained and experienced in chronic pain management - other specialist clinicians as relevant to the focus of the MDT all should have time specified for the care of patients within the highly specialist pain management service	Operational policy	Self declaration	1,3,5	Effective
002	There is a multidisciplinary assessment of patients	Patients are assessed by the MDT prior to their treatment the assessment should include relevant specialists for the underlying condition	Operational policy	Self declaration	1,3,5	Effective

003	There are clinical guidelines in place	There are clinical guidelines in place for the referral, investigation, treatment, discharge and follow up as detailed in the service specification. These should include: - a protocol for safe practice of intrathecal opioids Where relevant these should reflect nationally and internationally agreed guidelines	Clinical guidelines cover guidelines, protocols, and 'SOPs' which describe how to manage a patient in a given clinical situation or specified point on the pathway.	Operational policy including pathways	Self-declaration	1,3,5	effective, safe
004	There are patient pathways in place	There must be agreed patient pathways for referral, assessment, investigation treatment, discharge rehabilitation and follow up, as detailed in the service specification, The pathways should be agreed with the referring services and commissioners	Pathways specify how the different hospitals and groups of professionals should interact at defined stages of the patient journey, for diagnosis, assessment, management and follow up/repatriation, as relevant. pathways should take into account nationally and internationally agreed guidance and standards.	Operational policy including guidelines	Self-declaration	1,3,5	effective, safe
005	The HSPS is providing advice, support and training to referring organisations	The HSPS should provide advice and support to clinicians within the referring specialist pain services		Operational policy Annual report with details of training	Self-declaration	1,3,5	effective, safe

006	The HSPS is actively participating in audit and research	The HSPS will undertake individual and collaborative audit and will carry out collaborative research supported by the Research and Development services within the specialised network.	Annual report	Self-declaration	1,3,5	effective, safe
007	There is a quarterly education and governance meeting	The MDT should have education and governance meetings at least quarterly. The meetings should include - audit review - risk management - quality improvement - service development	Annual report	Self declaration	1,3,6	effective, safe