

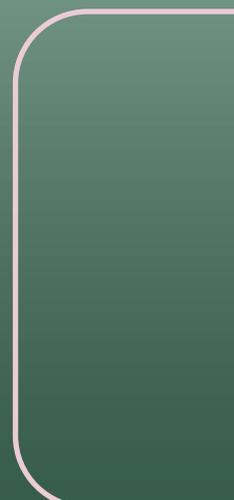
Review of the Care of People with Chronic Pain

Walsall Healthcare NHS Trust

Visit Date: 9th June 2015

Report Date: September 2015

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INTRODUCTION

This report presents the findings of the review of the care of people with chronic pain that took place on 9th June 2015. The purpose of the visit was to review compliance with the following West Midlands Quality Review Service (WMQRS) Quality Standards:

- Care of People with Chronic Pain, Version 1, August 2014

The aim of the standards and the review programme is to help providers and commissioners of services to improve clinical outcomes and service users' and carers' experiences by improving the quality of services. The report also gives external assurance of the care which can be used as part of organisations' Quality Accounts. For commissioners, the report gives assurance of the quality of services commissioned and identifies areas where developments may be needed.

The report reflects the situation at the time of the visit. The text of this report identifies the main issues raised during the course of the visit. Appendix 1 lists the visiting team that reviewed the services at Walsall Healthcare NHS Trust. Appendix 2 contains the details of compliance with each of the standards and the percentage of standards met.

This report describes services provided or commissioned by the following organisations:

- Walsall Healthcare NHS Trust
- NHS Walsall Clinical Commissioning Group

Most of the issues identified by quality reviews can be resolved by providers' and commissioners' own governance arrangements. Many can be tackled by the use of appropriate service improvement approaches; some require commissioner input. Individual organisations are responsible for taking action and monitoring this through their usual governance mechanisms. The lead commissioner for the service concerned is responsible for ensuring action plans are in place and monitoring their implementation liaising, as appropriate, with other commissioners, including commissioners of primary care. The lead commissioner in relation to this report is NHS Walsall Clinical Commissioning Group.

ABOUT WEST MIDLANDS QUALITY REVIEW SERVICE

WMQRS is a collaborative venture by NHS organisations in the West Midlands to help improve the quality of health services by developing evidence-based Quality Standards, carrying out developmental and supportive quality reviews - often through peer review visits, producing comparative information on the quality of services and providing development and learning for all involved.

Expected outcomes are better quality, safety and clinical outcomes, better patient and carer experience, organisations with better information about the quality of clinical services, and organisations with more confidence and competence in reviewing the quality of clinical services. More detail about the work of WMQRS is available on www.wmqrs.nhs.uk

ACKNOWLEDGMENTS

West Midlands Quality Review Service would like to thank the staff and service users and carers of Walsall Healthcare NHS Trust for their hard work in preparing for the review and for their kindness and helpfulness during the course of the visit. Thanks are also due to the visiting team and their employing organisations for the time and expertise they contributed to this review.

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CARE OF PEOPLE WITH CHRONIC PAIN

PRIMARY CARE

Comments about the primary care aspects of this pathway are included within the chronic pain team section of this report.

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CHRONIC PAIN TEAM

Comments and Achievements

This team provided care for adults with chronic pain. The team was motivated and keen to provide a good service and patients who met reviewers were highly appreciative of the care provided. The team worked well together. The hospital facilities and environment within which the team worked were also good.

Reviewers were impressed that the team had used the peer review visit as a mechanism for reviewing the model of care provided and identifying actions that were needed. The team was facing a difficult situation in relation to medical staffing; one consultant had retired shortly before the review, although still doing some sessions with the service, and the other consultant was planning to retire. The team had identified the need for a more integrated approach with musculo-skeletal services.

At the time of the review the team was staffed by 1.2 wte consultants, one band 7 nurse, one advanced clinical nurse specialist, one senior staff nurse, two band 5 nurses (posts occupied by bank nurses) and a medical secretary.

Out-patient reviews and therapeutic interventions were provided. The team met together weekly to discuss patients. The acute pain nurse was involved in this meeting and links with the palliative care team were also good. Telephone advice for patients was available during normal working hours. This was coordinated by the medical secretary when the clinical nurse specialist was on leave with patients' queries responded to within one working day.

The team had capacity to take 550 referrals per year but had received 880 referrals in the year before the review. Extra clinics had been run to ensure waiting time targets were achieved. The team was actively trying to reduce the number of follow up appointments provided. Reviewers commented that the patients they met had been with the service for a long time, up to 17 years, and were reluctant to be discharged from the service.

Immediate Risks: No immediate risks were identified.

Concerns

1 Prescribing of opiates and other drugs for neuropathic pain

Reviewers were given verbal evidence of high rates of prescribing of opiates and other drugs for neuropathic pain, such as Pregabalin. Guidelines for clinicians on reducing medication levels were not available and patients who met the visiting team were reluctant to reduce their medication. Reviewers were concerned about this for three reasons: a) because pharmaceutical therapies may have been being used in preference to other effective therapeutic approaches, partly because of the limited multi-disciplinary input to the team (see below), b) because of the potential for addiction and c) because of the re-sale potential.

2 Multi-disciplinary staffing

The chronic pain team did not have a physiotherapist, psychologist or occupational therapist with time allocated for work on the team. Referrals were made to community physiotherapists who did not have specific expertise in the care of people with chronic pain. Referrals could also be made to psychologists within the Trust. A full multi-disciplinary approach to the care of people with chronic pain was therefore not available. This may have contributed to the medical, prescribing-based model described above.

3 Care pathways and clinical guidelines

Pathways of care were not clearly defined. Broad referral criteria were available but these were not clear about the investigations and therapeutic interventions which should be undertaken in primary care prior to referral to the chronic pain team. Referrals were triaged by the consultant and advanced clinical nurse specialist and reviewers were told that a high proportion of referrals were inappropriate. No programme of education for primary care teams was in place to address this issue.

Guidelines for the care of patients accepted by the team were also not clear. Some patients were referred to physiotherapy or psychology services but the criteria for these referrals were not clearly defined. Clinical guidelines for care of patients with perinatal or mental health problems as well as chronic pain were not in use and reviewers were given examples of patients who had continued under the care of the chronic pain team when withdrawal of medication and referral to other services may have been more appropriate. The team did not have access to a radiofrequency machine and so could not provide medial branch blocks. Patients were having repeated facet joint injections rather than being offered facet joint denervation / Rhizolysis.

4 Care planning and goal setting

Care planning, including goal setting, was not yet in place. Achievement of goals, therefore could not be reviewed at follow up attendances.

5 Availability of self-management programmes

Structured self-management programmes were not yet available.

Further Consideration

- 1** The team had prepared a business case for a third consultant. Reviewers did not consider that this would be the best use of any resources available for the development of this service.
- 2** Reviewers suggested that the team may wish to consider the following as part of its service re-design:
 - a.** Involving a range of stakeholders in planning the re-design of the service, including patients and carers, GPs, psychology services, community physiotherapists, hospital-based musculo-skeletal services and other relevant services.
 - b.** Starting to provide self-management programmes, especially for new patients. For existing patients, self-management would need to be provided alongside programmes of medication reduction, in collaboration with patients' GPs.
 - c.** Introducing a care planning process including patient-identified goals and a time-limited review process with clearly identified 'exit' criteria and 'exit' routes from the service.
 - d.** Training community physiotherapists in the use of a simple evidence-based stratification tool, such as the STarT Back approach. If implemented at the same time as a revised referral pathway this could reduce the number, and increase the appropriateness, of referrals to the chronic pain team. This work could be undertaken in association with musculo-skeletal services, to mutual benefit.
 - e.** Starting to involve a physiotherapist and psychologist in multi-disciplinary team meetings (representatives were invited to attend the monthly team meetings), even if these staff are mainly based within other services and patients would still have to be referred to them for therapeutic

interventions. This could help with defining clinical pathways and identifying the extent of need for these therapeutic interventions.

- f. Provision of more community-based services. Most of the therapeutic interventions provided did not require an acute hospital environment. If linked with the introduction of self-management programmes this could reduce patients' dependence on the service and the perception of themselves as 'ill'.
- g. Review of the skill mix and capacity of the team when the referral pathway and clinical guidelines have been re-defined. Visiting other services may also help in providing skill mix and capacity comparators.

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COMMISSIONING

General Comments and Achievements

A draft service specification was available. This specification was ambitious in that it adopted a care pathway across primary and secondary care which was significantly different from the pathway in place at the time of the review. Reviewers were told that the draft specification had been shared with the Trust since February 2015 and the intention to redesign the pain service has been under consideration for five years.

Concerns

- 1 The concerns identified in the chronic pain team section of this report will require commissioner support and monitoring to ensure they are addressed:
 - a. Prescribing of opiates and other drugs for neuropathic pain
 - b. Multi-disciplinary staffing
 - c. Care pathways and clinical guidelines
 - d. Care planning and goal setting
 - e. Availability of self-management programmes

Further Consideration

- 1 Reviewers considered that the draft specification requires further development to achieve the commissioner's vision. In particular:
 - a. The expected patient flow between primary care, level 1,2,3 was unclear
 - b. The inclusion and exclusion criteria may benefit from further description
 - c. Care planning and self-management could have greater detail in the specification
 - d. The pain management programme was not defined
 - e. Pharmacy, low priority treatments, and a primary care training and development programme were not mentioned in the specification
- 2 After agreement of the specification, a clear implementation plan involving primary care, community and acute care would be required in order to achieve the expected patient flow; manage patient expectations and deliver effective clinical interventions. Engagement of stakeholders such as patients, public, and primary care would be essential in this process.
- 3 The CCG and the Trust were reviewing musculo-skeletal services at the time of the review. Reviewers considered that it may be an appropriate time to consider the linkages between chronic pain services, physiotherapy and musculo-skeletal care pathways and outcomes.

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Visiting Team

Jade Brooks	Mental Health and Children's Programme Manager	NHS Herefordshire CCG
Liz Cartwright	Commissioning Manager Primary and Planned Care	Telford and Wrekin CCG
Susan Jones	Pain Clinical Nurse Specialist	Heart of England NHS Foundation Trust
Dr Somasundaram Krishnamoorthy	Consultant in Pain Management & Anaesthesia	University Hospitals Coventry & Warwickshire NHS Trust
Gina Stickley	Clinical Lead Pain Service	Birmingham Community Healthcare NHS Trust
Dr Louise Warburton	GPwSI in Rheumatology and Musculoskeletal Medicine	Shropshire Community Health NHS Trust

WMQRS Team

Sarah Broomhead	Assistant Director	West Midlands Quality Review Service
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APPENDIX 2 COMPLIANCE WITH THE QUALITY STANDARDS

Analyses of percentage compliance with the Quality Standards should be viewed with caution as they give the same weight to each of the Quality Standards. Also, the number of Quality Standards applicable to each service varies depending on the nature of the service provided. Percentage compliance also takes no account of ‘working towards’ a particular Quality Standard. Reviewers often comment that it is better to have a ‘No, but’, where there is real commitment to achieving a particular standard, than a ‘Yes, but’ where a ‘box has been ticked’ but the commitment to implementation is lacking. With these caveats, table 1 summarises the percentage compliance for each of the services reviewed.

Table 1 - Percentage of Quality Standards met

Service	Number of Applicable QS	Number of QS Met	% met
Care of People with Chronic Pain			
Primary Care	2	0	0
Chronic Pain Team	27	9	33
Commissioning	2	0	0
Total	31	9	29

Pathway and Service Letters

JA-	Long-term conditions pathway	Primary Care
JS-	Long-term conditions pathway	Chronic Pain Service
JZ-	Long-term conditions pathway	Commissioning

Topic Sections

The different sections cover the following topics:

-100	Information and Support for Patients and Carers
-200	Staffing
-300	Support Services
-400	Facilities and Equipment
-500	Guidelines and Protocols
-600	Service Organisation and Liaison with Other Services
-700	Governance

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PRIMARY CARE

Ref	Quality Standard	Met? Y/N	Reviewer comments
JA-299P	<p>Primary Care Training and Development Programme – Chronic Pain</p> <p>The primary care training and development programme should include community physiotherapists and others working with people with chronic pain and should cover all aspects of QS JA-501P.</p>	N	A formalised training and development programme for services working with people with chronic pain was not in place, although the lead clinician had delivered some training to GPs.
JA-501P	<p>Primary Care Guidelines – Chronic Pain</p> <p>Guidelines on diagnosis and management of chronic pain, including low back pain, should include:</p> <ol style="list-style-type: none"> Indications for urgent referral due to suspected serious pathology ('red flags') Primary care management including: <ol style="list-style-type: none"> Self-management advice and education Physiotherapy Pain relief Cognitive behavioural techniques 'Sign-posting' to lifestyle interventions or local voluntary and community support Criteria for referral to the chronic pain team and information to be sent with each referral 	N	Broad criteria for referral to the chronic pain team were available but did not cover the detail expected. Information to be sent with each referral was not defined. Reviewers were told that GPs followed different pathways into the service and there was no GP assessment tool in place. The Trust referral form was not always used by GPs.

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CHRONIC PAIN TEAM

Ref	Quality Standard	Met? Y/N	Reviewer comments
JS-102	<p>Service Information</p> <p>Each service should offer patients and carers information covering:</p> <ol style="list-style-type: none"> Organisation of the service, such as opening hours and clinic times Staff and facilities available How to contact the service for help and advice, including out of hours (if applicable) 	Y	<p>Some of the information seen by reviewers was brief and not up to date. Hours of availability of the service was not included in the information available on the intranet.</p> <p>It was not clear what information was sent to patients with their clinic appointment, though all the patients who met with the reviewing team had received information at the time of their clinic visit.</p>

Ref	Quality Standard	Met? Y/N	Reviewer comments
JS-103	<p>Condition-Specific Information</p> <p>Discussion and written information for patients with chronic pain should also cover (when applicable):</p> <ol style="list-style-type: none"> Description of their condition and its implications Self-management training and support Pain management programmes, interventional procedures and other interventions offered Supervision of drug withdrawal Sources of support (for example, Expert Patient's Programme, patient resources from The British Pain Society, condition-related self-help groups) 	N	<p>The 'Low Back Pain' leaflet had not been updated since 2003 and would benefit from review.</p> <p>The 'Pain Series' leaflets were used but had not yet been localised.</p> <p>Information on interventional procedures did not cover all the procedures in detail, especially what to do after the procedure.</p> <p>There was no information covering the use of opioids or Lantern House (an organisation providing support for substance misuse).</p>
JS-104	<p>Care Plan</p> <p>Each patient and, where appropriate, their carer should discuss and agree their Care Plan, and should be offered a written record covering at least:</p> <ol style="list-style-type: none"> Agreed goals, including life-style goals Self-management Name of 'care coordinator' Planned pain management programmes, interventional procedures and other interventions Early warning signs of problems, including acute exacerbations, and what to do if these occur Planned review date and how to access a review more quickly, if necessary 	N	<p>Care plans were not seen covering all the aspects of the Quality Standard. Reviewers were told that some information about goals and self-management was discussed during consultations with patients. Patients who met the reviewing team did get copies of clinic letters, though some of the letters seen asked GPs to share the clinic letter information with their patients.</p>
JS-105	<p>Review of Care Plan</p> <p>A formal review of the patient's Care Plan should take place as planned and, at least, every six months. This review should involve the patient and, where appropriate, their carer, and appropriate members of the multi-disciplinary team. The outcome of the review should be communicated in writing to the patient and their GP.</p>	N	<p>Symptom management was reviewed at follow up appointments but it was not clear from the information seen whether goals and clinical outcomes were always reviewed and documented.</p>
JS-106	<p>Contact for Queries and Advice</p> <p>Each patient and, where appropriate, their carer should have a contact point within the service for queries and advice. If advice and support is not immediately available then the timescales for a response should be clear. Response times should be not more than the end of the next working day. All contacts for advice and a sample of actual response time should be documented.</p>	Y	

Ref	Quality Standard	Met? Y/N	Reviewer comments
JS-195	<p>Transition to Adult Services</p> <p>Young people transferring to the care of adult services should be offered written information covering at least:</p> <ol style="list-style-type: none"> Their involvement in the decision about transfer and, with their agreement, the involvement of their family or carer A joint meeting between children's and adult services to plan the transfer A named coordinator for the transfer of care A preparation period prior to transfer and, if appropriate, a period of shared care Arrangements for monitoring during the time immediately after transfer 	N/A	
JS-196	<p>'Letting Go' Plan</p> <p>Patients should be involved in planning their discharge from the service and should be offered a written plan covering at least:</p> <ol style="list-style-type: none"> Evaluation of achievement of agreed goals Self-care and self-management of their condition Care after discharge from the service (if any) Possible problems and what to do if these occur, including, where appropriate, arrangements for easy re-access to the service Who to contact with queries or concerns 	N	<p>Written plans covering support, care and discharge planning were not seen in the records or evidence available at the time of the visit. Some of the patients who met with the visiting team had been attending follow up appointments since 1998.</p>
JS-197	<p>General Support for Service Users and Carers</p> <p>Patients and carers should have easy access to the following services. Information about these services should be easily available:</p> <ol style="list-style-type: none"> Interpreter services, including access to British Sign Language Independent advocacy services Complaints procedures Spiritual support <i>HealthWatch</i> or equivalent organisation 	Y	
JS-199	<p>Involving Users and Carers</p> <p>The service should have:</p> <ol style="list-style-type: none"> Mechanisms for receiving feedback from patients and carers about their care and treatment Mechanisms for involving patients and carers in decisions about the organisation of the service Examples of changes made as a result of the feedback and involvement of patients and carers 	N	<p>Family and Friends tests and other mechanisms to seek user and carer views were in place across the Trust but the results were not specific to the chronic pain service. The team was not clear about any changes made as a result of feedback and involvement of patients and carers of the chronic pain service.</p>

Ref	Quality Standard	Met? Y/N	Reviewer comments
JS-201	<p>Lead Clinician</p> <p>A doctor specialising in chronic pain should have lead responsibility for staffing, training, guidelines and protocols, service organisation, governance and liaison with other services. This doctor should be a consultant specialising in chronic pain or a doctor with competences and experience in advanced pain medicine, as defined by the FPMRCA, who undergoes revalidation in pain medicine.</p>	Y	
JS-202	<p>Chronic Pain Team</p> <p>The service should have sufficient staff with appropriate competences to deliver the expected number of triage/screening of referrals (if undertaken by the service itself), assessments and procedures for the usual case mix of patients within expected timescales. Staffing levels should be based on a competence framework covering the staffing levels and competences expected, and should ensure an appropriate skill mix of staff with specialist pain management knowledge and interest including:</p> <ol style="list-style-type: none"> Consultants in pain medicine Medical staff with appropriate training and competences Nurses Clinical psychologists or staff with appropriate competences in psychological therapy Physiotherapists Occupational therapists <p>All staff should have time in their job plans allocated to their work with the chronic pain team. If the service cares for children, staff should have competences in the care of children as well as in pain management.</p>	N	<p>Staffing levels were not yet based on a competence framework. Two consultants each with 0.6 wte time covered the chronic pain service. An Advanced Clinical Nurse Specialist and a senior staff nurse were in post, but it was not clear that they had appropriate competences for their work with the team, although both had attended a half-day training master class.</p> <p>The team had no psychologist, physiotherapist or occupational therapist with time allocated to work with the team, though patients could be referred to these services.</p> <p>A business case for a physiotherapist with an interest in specialist pain management was being considered.</p>
JS-203	<p>Training Plan</p> <p>A training and continuing professional development plan should ensure that all members of the chronic pain team achieve and maintain the expected competences (QS JS-202).</p>	N	<p>A training plan was not yet in place. Some staff had attended a training session on acupuncture and a pain master class. From the records seen it was not clear if all nursing staff had completed their mandatory training as the information indicated that only 75% had been achieved.</p>

Ref	Quality Standard	Met? Y/N	Reviewer comments
JS-204	<p>Triage Team</p> <p>If triage/screening of referrals is undertaken by staff who are not part of the chronic pain team (QS JS-202), sufficient staff with competences in triage or screening of referrals should be available to ensure referrals are dealt with within agreed timescales.</p>	N/A	
JS-205	<p>Training for Other Staff</p> <p>The service should offer a programme of education in the nature and effective management of persistent pain and the triage of referrals for GPs, the triage team (if separate from the chronic pain team) and other health professionals in the local area who care for patients with chronic pain.</p>	N	Some training had been delivered to GPs but not to other professionals in the local area caring for patients with chronic pain.
JS-299	<p>Administrative, Clerical and Data Collection Support</p> <p>Administrative, clerical and data collection support should be available to support the work of the chronic pain team.</p>	Y	
JS-301	<p>Support Services</p> <p>Timely access to the following services should be available:</p> <ol style="list-style-type: none"> Spinal/neurosurgery (24/7 access is required if neuromodulation is offered) Imaging (24/7 access is required if neuromodulation is offered) Pharmacy, including a sterile preparation unit if intrathecal therapy is given Vocational counsellors/employment advisors Social workers Mental health services 	Y	Reviewers were told that the team could access all the relevant support services.

Ref	Quality Standard	Met? Y/N	Reviewer comments
JS-401	<p>Facilities and Equipment</p> <p>The service should have appropriate facilities and equipment to deliver the expected number of assessments and procedures for the usual case mix of patients within expected timescales, including:</p> <ul style="list-style-type: none"> a. Designated operating theatre sessions supported by fluoroscopy and radiographers for performance of diagnostic and therapeutic procedures b. Access to fluoroscopy c. Ultrasound (if undertaken by the service) d. Facilities for: <ul style="list-style-type: none"> i. Neuromodulation ii. Physiotherapy e. Ability to store and retrieve images f. Facilities for group work g. Office space including access to space for multi-disciplinary discussion of patients <p>Facilities and equipment should comply with all relevant Quality Standards and should ensure:</p> <ul style="list-style-type: none"> h. Appropriate privacy, dignity and security for patients i. Appropriate separation of children and adults j. Access for disabled patients k. Availability of specialist equipment when required 	N	<p>The team did not have access to radiofrequency machinery and so neuromodulation was not offered. All other aspects of the Quality Standard were met.</p>
JS-402	<p>Equipment – Tertiary Services</p> <p>Tertiary chronic pain services should have specialist equipment for:</p> <ul style="list-style-type: none"> a. Cordotomy b. Spinal cord stimulation c. In-patient pain management programmes 	N/A	
JS-403	<p>IT Systems</p> <p>IT systems for storage, retrieval and transmission of patient information should be in use for patient bookings, clinical records, outcome information and other data to support service improvement, audit and revalidation.</p>	Y	<p>A range of IT systems was in place though reviewers were told that referrals to in-house services, such as physiotherapy, were paper based.</p>

Ref	Quality Standard	Met? Y/N	Reviewer comments
JS-501	<p>Guidelines on Triage/Screening of Referrals</p> <p>Guidelines on triage/screening of referrals to the chronic pain team should be in use. These guidelines should ensure that referrals are considered for:</p> <ol style="list-style-type: none"> Self-management advice and education only Referral for further primary care management (QS JA-501P) Referral to another consultant or service for advice, investigation or intervention Acceptance of patients meeting the criteria for acceptance by the service <p>The patient and their GP should be notified of the outcome of the referral triage/screening.</p>	N	There were no guidelines covering triage and screening. In practice GPs accessed the service via 'choose and book' and all referrals were triaged by the consultant and Advanced Clinical Nurse Specialist.
JS-502	<p>Clinical Guidelines</p> <p>Clinical guidelines should be in use covering diagnosis, assessment and pain management programmes, interventional procedures and other interventions provided by the service. Clinical guidelines should cover pharmacological and non-pharmacological interventions.</p>	N	NICE (National Institute for Health and Care Excellence) guidelines had not yet been adapted for use locally.
JS-503	<p>Referral to Tertiary Chronic Pain Services</p> <p>Guidelines on referral to tertiary chronic pain services should be in use covering at least:</p> <ol style="list-style-type: none"> Criteria for referral to tertiary chronic pain services Services to which referrals should be made Information to be sent with each referral Shared care arrangements, if applicable 	N	Guidelines covering referral to Tertiary Chronic Pain Services were not yet in place. In practice informal mechanisms were in operation.
JS-597	<p>Discharge Guidelines</p> <p>Guidelines on discharge from the chronic pain service should be in use covering at least:</p> <ol style="list-style-type: none"> Criteria for discharge from the service Self-management advice and education to be given on discharge Discharge information to be given to the patient and their GP 	N	Guidelines covering discharge from the chronic pain service were not yet in place. Trust-wide discharge guidelines were available.

Ref	Quality Standard	Met? Y/N	Reviewer comments
JS-598	<p>Transition Guidelines</p> <p>Guidelines on transition of young people to adult services should be in use covering at least:</p> <ol style="list-style-type: none"> a. Involvement of the young person and, where appropriate, their family or carer in planning the transfer of care b. Involvement of the young person's GP c. Joint meeting between children's and adult services to plan the transfer d. Allocation of a named coordinator for the transfer of care e. A preparation period prior to transfer and, if appropriate, a period of shared care f. Arrangements for monitoring during the time immediately after transfer 	N/A	
JS-601	<p>Operational Policy</p> <p>An operational policy for the chronic pain service should be in use covering at least:</p> <ol style="list-style-type: none"> a. A minimum appointment time of 45 minutes for new patients b. Regular multi-disciplinary team meetings or clinics to discuss the management plans for new patients and those with more complex needs c. Allocation of a 'care coordinator' d. Arrangements for liaison with: <ol style="list-style-type: none"> i. Acute pain services ii. Triage team (if separate from the chronic pain team) iii. Support services (QS JS-301) iv. Palliative care services in hospital and in the community v. Tertiary chronic pain services (QS JZ-601P) e. Arrangements for the treatment of patients who are particularly vulnerable f. Any special arrangements for the care of children (if applicable) g. Arrangements for patients admitted to hospital for care by the chronic pain service h. Management of non-engagement with the service i. Maintenance contracts and a rolling replacement programme for equipment 	N	An operational policy for the unit was in the process of being developed and did not yet cover all the elements of the Quality Standard.
JS-699	<p>Primary Care Training and Development</p> <p>The service should contribute to the primary care training and development programme (QS JA-299P).</p>	N	A formalised training and development programme for those working with people with chronic pain was not in place, though the lead clinician had delivered some training to GPs.

Ref	Quality Standard	Met? Y/N	Reviewer comments
JS-701	<p>Data Collection</p> <p>Data should be collected routinely on:</p> <ol style="list-style-type: none"> Referrals and sources of referrals Triage or screening of referrals: number of patients referred, time to completion of triage or screening and outcome for each referral Number of patients accepted by the service Therapeutic programmes and interventions provided Outcomes of therapeutic programmes and interventions Length of time with the service and reason for discharge Key performance indicators 	N	Data were not available covering all the aspects of the Quality Standard. There was no evidence of outcomes of therapeutic programmes and interventions. Reviewers were told that 50% of patients who were discharged were referred back to the service.
JS-702	<p>Audit</p> <p>The service should have a rolling programme of audits of compliance with guidelines and protocols [Qs JS-500s] and related outcomes.</p>	N	Guidelines (Quality Standards JS - 500s) were not yet in place to enable a rolling programme of audit. Some departmental and patient satisfaction audits had been undertaken.
JS-703	<p>Research</p> <p>The chronic pain team should actively participate in research relating to the care of patients with chronic pain.</p>	N	The team did not participate in research.
JS-798	<p>Multi-Disciplinary Review and Learning</p> <p>The service should have appropriate multi-disciplinary arrangements for the review of, and the implementation of learning from:</p> <ol style="list-style-type: none"> Positive feedback, complaints, outcomes, incidents and 'near misses' Published scientific research and guidance relating to pain services 	Y	The Chronic Pain Team held regular monthly meetings and pharmacy, physiotherapy and psychology representatives were invited.
JS-799	<p>Document Control</p> <p>All policies, procedures and guidelines should comply with Trust (or equivalent) document control procedures.</p>	Y	

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COMMISSIONING

Ref	Quality Standard	Met? Y/N	Reviewer comments
JZ-601P	<p>Commissioning of Services for People with Chronic Pain</p> <p>The following services for people with chronic pain should be commissioned:</p> <ol style="list-style-type: none"> a. Primary care training and development programme (QS JA-299P) b. Triage/screening of referrals (either separately or as part of the role of the chronic pain team) c. Chronic pain team for the local area d. Tertiary chronic pain services, including for: <ol style="list-style-type: none"> i. Percutaneous disc decompression ii. Cordotomy iii. Spinal cord stimulation iv. In-patient pain management programmes <p>Criteria for referral to and discharge from each service should be specified, together with whether the service cares for children, adults or both children and adults. The range of pain management programmes, invasive procedures and other interventions offered by the chronic pain team should be agreed.</p>	N	The health economy was in the process of redesigning chronic pain services. See main report.
JZ-701	<p>Quality Monitoring</p> <p>The lead local commissioner should monitor key performance indicators and aggregate data on activity and outcomes from the chronic pain service at least annually.</p>	N	Key performance indicators were in the process of being agreed and would then be monitored through clinical quality review meetings.

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