

SCHEDULE 2 PART A – THE SERVICES

Service Specification No.	04/MSKT/0001
Service	Pan Dorset Community Persistent Pain Management Service
Commissioner Lead	CCP for Musculoskeletal & Trauma
Provider Lead	
Period	1 st June 2013 to 31 st March 2016
Date of Review	April 2015

1. Population Needs

1.1 National/local context and evidence base

The population in the South West of England is just over five million which represents approximately 8% of the UK population; however the area has relatively more people over the age of 60 years of age than any other region in the UK. 13.5% of the population are aged between 65-79 and 5.8% are over the age of 80. In comparison, 11.8% of the total UK population are aged 65-79 years and 4.6% over the age of 80.

There is an estimated 660,000 people living in the South West with moderate to severe pain that has lasted for more than six months i.e. one in ten of the population and more than a third of households have someone in pain at any given time.

It is estimated that a further 400,000 people will develop chronic, persistent pain each year in this region but only two-thirds will recover. Some studies have shown that this condition is 2-3 times more common than it was 40 years ago.

Within the Bournemouth, Poole and Dorset PCT cluster population of 715,100, it is estimated that there are 90,267 people living with chronic pain.

Chronic, persistent pain affects sufferers in many ways with many reporting the experience as 'exhausting, mentally draining and frustrating' with a negative impact on family life and social interaction. Indeed 49% of people living with chronic, persistent pain experience depression with a recent survey revealing that 16% of these patients feeling that on some days their pain is so bad that they want to die.

Patients with chronic, persistent pain are estimated to book 390,000 GP appointments each year in the South West at a cost of around £14 million. 2007 UK data shows that 6.8 million analgesia and anti inflammatory prescriptions were dispensed in the South West at a cost of around £50 million.

The economic burden of pain is widespread with people losing an average 6.2 days from work over a six month period and around one fifth of people losing their jobs due to chronic, persistent pain. Extrapolation of these figures in the South West account for £460 million per year cost to the regional economy.

Figures from the Department of Work and Pensions (2009) suggest that 24% of incapacity benefit claims are due to pain-related problems. This combined with the cost of absence from work cost the South West economy over £800 million per year.

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

Evidence suggests that the most effective care for patients with chronic, persistent pain is that which enables the patient to understand and come to terms with their pain and to adopt strategies for living, which allow them to lead as fulfilling and independent lives as possible. This is to be achieved throughout the pathway beginning with the integrated provision of supported self-care and optimised medical therapy delivered in Primary Care at the onset of pain and onward referral, at an agreed time to a Community Pain Management Service which will provide enhanced pain management.

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- Department of Health (2009) 'Your Health, Your Way - A Guide to Long Term Conditions and Self Care'. Information for Healthcare Professionals.
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- McQuary et al (1997). 'Systematic Review of Outpatient Services for Chronic Pain Control'. Health Technology Assessment 1997; Vol. 1: No. 6.
- Quality, Innovation, Productivity and Prevention – QIPP.
- The National Pain Audit. Phase 1 report: 'Organisational Audit of NHS Chronic Pain Services'. November 2011.

N.B This list is not exhaustive and the Provider is contractually obligated to review evidence base on a continual basis.

2. Scope

2.1 Aims and objectives of service

The aim of this service is to enable adults living with persistent pain (of at least 3 months duration with a definitive diagnosis, including Medically Unexplained Symptoms, and/or when the patient and GP agree and accept that the pain has become chronic/persistent) to understand and come to terms with their pain and to adopt strategies for living, which allow them to lead as fulfilling and independent lives as possible. This is to be achieved throughout the pathway beginning with the provision of supported self-care and optimised medical therapy delivered in Primary Care at the onset of pain and onward referral to a Community Pain Service which will provide enhanced pain management including if clinically indicated, the provision of an interventional procedure in line with the NHS Bournemouth and Poole and NHS Dorset Interventional Procedures in the Management of Spinal Pain Policy.

The accountable provider will offer all modalities of the service i.e. GP training and the Clinical service including specialist pain management medical, nursing, clinical psychology, physiotherapy and occupational therapy provision.

The service will;

- Work with and educate GPs to safely optimise the use of analgesia and self management tools and techniques.
- Act as a Single Point of Access for patients referred with persistent pain of at least 3 months duration with an acceptance that the pain has become chronic i.e. persistent.
- Support patients in understanding their quality of life issues in the context of their persistent

pain.

- Support and signpost patients to gain a good level of information and health literacy about persistent pain and its associated manifestations.
- Encourage and support patients to become actively involved, in developing and taking forward the strategies that they will adopt in response to their persistent pain – as detailed in a jointly developed Personal Care Plan.
- Support and empower patients to gain or regain self-belief and confidence.
- Promote patients in taking as much responsibility as possible for implementing their Personal Care Plan outside of their contact with the healthcare system.
- Encourage patients to be active partners in reviewing their Personal Care Plan at agreed intervals.
- Reduce dependency and enhance quality of life for patients and families/carers.
- Promote peer support amongst patients and their families within the service and independent of the service.
- Encourage patients to play an active role in delivering the service as a mentor or as a group facilitator.
- Ensure all staff actively promote best practice, evidence-based, person-centered pain management support to service users and other professionals.
- Review and redesign the service in response to feedback from service users, key partners and evidence based best practice.
- Implement opportunities for ongoing pain management training and development of healthcare professionals.

2.2 Service description/care pathway

- The Community Pain Management Service will receive referrals from Primary Care via Choose and Book and from Secondary Care with written consent from the patient's GP.
- The service will work directly with people who live with persistent pain of more than 3 months duration with an acceptance that the pain has become chronic i.e. persistent, to mutually agree, develop and implement Personal Care Plans and set realistic goals which are regularly reviewed supporting the ethos of self-care and self-management.
- The service will hold regular multidisciplinary and inter-speciality team meetings to discuss complex patients and their needs.
- The service will provide 'outcome' targeted Wessex Deanery and Faculty of Pain Medicine accredited training and support for GPs and other frontline staff about how best to support people who live with persistent pain. Training will be delivered at a level which will be clinically effective and may take the form of a 1:1 teaching clinic, GP training Forum and by electronic means as appropriate.
- The service will facilitate health supplied group programmes e.g. intensive pain management programmes and signpost to non health supplied group programmes e.g. expert patient pain programmes as required.
- The service will provide psychological support to patients, their family and carers within a stepped model of care up to step 2 interventions and refer to Improving Access to Psychological Therapy (IAPT) / talking therapies as required.

- The service will provide interventional procedures in line with the NHS Bournemouth and Poole and NHS Dorset Interventional Procedures in the Management of Spinal Pain Policy.
- The service will distribute relevant information and signpost service users and families to robust pain management information, both written and electronic and to other appropriate services such as return to work programmes or physical activity programmes.
- The service will work closely with agencies who promote return to work or volunteering, weight loss, alcohol and substance misuse support and support for increased physical activity.

The integrated service will provide all modalities i.e. supported self-management, psychological support, medication advice, physical activity, injection therapy and signposting and will be located within community venues across Dorset, Bournemouth and Poole.

The service will be underpinned by the evidence which suggests that optimal pain management is achieved by a combination of optimal pain relief and optimal self-management with psychological and peer support playing a major role in the service provision.

The service will be provided by a multidisciplinary team of professionals including doctors who have been trained and have appropriate competencies in pain medicine as defined by the Faculty of Pain Medicine, nursing, clinical psychology, physiotherapy and occupational therapy services with specialist pain management skills. The doctor's role will be to provide medicines management and pharmaceutical advice to GPs, the prescription of medications according to the traffic light status and performing interventional therapy in line with the NHS Bournemouth and Poole and NHS Dorset Interventional Procedures in the Management of Spinal Pain Policy. All staff will be competent in motivational interviewing. Specific skills in delivering cognitive and behavioural therapies, exercise therapy and joint protection for patients with chronic, persistent pain will be encompassed within the service. The team will be managed with a strong multidisciplinary team ethos which includes the patient and their GP.

The service is available to people who are:

- Adults aged 18 years or over or in transition from paediatric services (16 – 18 years);
- Registered with a Dorset, Bournemouth or Poole GP and eligible for NHS treatment;
- Meet the referral criteria detailed in this service specification.

The service is also available to adults aged 18 years or over who are registered with non-Dorset, Bournemouth or Poole PCT GPs or foreign nationals provided the relevant cross-charging mechanisms are put in place.

The service will be underpinned by the evidence which suggests that optimal pain management is achieved by a combination of optimal pain relief and optimal self-management.

The key factors are to ensure that:

- Patients understand their condition and are able to achieve realistic expectations.
- Patients make informed and personally relevant decisions about the use of analgesia including injection therapy.
- Patients are supported to optimally self-manage their condition.
- The principles of optimal pain management become widely understood and embedded

within Primary Care and social services.

To achieve the model the service will provide the clinical service plus Wessex Deanery and Faculty of Pain Medicine accredited training for GPs. The success of the service will depend on the quality of referral and work up of patients in Primary Care.

The clinical service will;

- Triage referrals and return those who do not meet the referral criteria, referring patients on promptly where other pathologies are suspected. (returned referrals will be accompanied by guidance and further training will be offered).
- Provide a holistic assessment including explanation of the cause(s) of an individual patient's pain and its associated effects on psychological, physical and social functioning and wellbeing and the impact on the patient's quality of life.
- Provide up-to-date, relevant information about the individual patient's pain and the support and self-management options available to them.
- Work collaboratively with individual patients on personalised care planning, review and outcome monitoring according to DH best practice guidance. This will include planning for a 'flare up' of pain or acute pain on top of existing chronic, persistent pain.
- Provide motivational interviewing and counseling type interventions based on the stepped model of care including cognitive and behavioral therapies, on an individual basis.
- Refer to IAPT (Improving access to Psychological Therapies)/ talking therapies as required.
- Provide intensive Pain Management Programmes for groups of patients which include psychological, physical/exercise and social elements.
- Provide advice on safe levels of physical activity and joint protection.
- Perform medication reviews (conducting or facilitating according to 2009 NICE guidance re: concordant interviewing) within current formulary offering advice and guidance to individual patient's GP. Medication will be prescribed according to the traffic light status.
- Consider the need for specialist injection therapy where required in accordance with the NHS Bournemouth and Poole and NHS Dorset Interventional Procedures in the Management of Spinal Pain Policy and taking patient choice into consideration.
- Deliver interventional therapy in a safe environment in line with national and local guidelines (Interventional therapy should be provided in conjunction with other pain management techniques to enable the patient to live as full a life as possible following intervention).
- Arrange and coordinate access to patient led Pain Management Programmes and individual mentors.
- Provide telephone support to the patient either from a member of the service or expert patient/mentor as appropriate.
- Provide on line and web support for patients.
- Hold regular multidisciplinary team meetings to discuss and agree a management plan for complex cases. Inter specialty meetings will be called as needed and may include orthopaedic and spinal surgeons, neurologists, oncologists, rheumatologists, gynaecologists etc.
- Hold a menu of options for the provision of associated interventions such as exercise programmes, alternative therapies e.g. aromatherapy and massage, local walking groups and sports and leisure opportunities that are provided locally by other agencies.
- Signpost or refer and support patients to other services such as weight loss programmes, drug and alcohol misuse support, voluntary agencies and social services.
- Liaise with return to work, voluntary and benefits agencies enabling patients who have been medically signed off work to understand the personal and financial implications of returning

to work, either paid or voluntary.

- Assess, triage and refer patients who would benefit from a spinal surgical opinion and potential surgical intervention in line with the Pan Dorset Spinal Surgery Service specification.
- Consider and advise the patient's GP of the need to be referred to an inpatient pain management services.
- Facilitate discharge through a shared decision making format.
- Undertake clinical audit and research.
- Collect and collate service utilisation, effectiveness, safety and patient experience data.

The service will provide training and information to referring GPs on the role and aims of the Community Pain Service including referral criteria. This will ensure patient engagement and realistic expectations of the service with referral in a timely manner.

The service will provide an ongoing and rolling Wessex Deanery and Faculty of Pain Medicine accredited and nationally recognised training programme with CEPD for GPs which aims to increase the knowledge and skills in supporting patients to manage their persistent pain on a day to day basis.

The training programme will cover the following:

- Education on the causes and types of persistent pain.
- Definitions, myths and misconceptions about persistent pain.
- Service user perspectives.
- The cost of pain to individuals and the health economy.
- The importance of service user empowerment, activation and self-management.
- Effective Primary Care management including optimal analgesia within current formulary.
- The utilisation of assessment and risk stratification tools.
- The utilisation of motivational interviewing.
- The role of specialist injections.
- The role of counseling and psychological support.
- Advice and guidance on particular cases throughout the pathway.
- Clinical audit and research in Primary Care.
- Mentorship, clinical governance and clinical supervision.

The training programme may be delivered individually but will primarily be delivered within a GP forum setting.

GPs with special interest in persistent pain will be identified from within two to three localities and will deliver further education and training to locality GPs. They will also take the lead for assessing and treating more complex patients within the community.

GPs will be encouraged to attend the Community Pain Service to shadow a clinician or a patient.

On request, a Community Pain Service clinician will attend a joint GP clinic appointment for complex patient assessment, review and treatment advice.

The service will ensure that patient feedback is collected and that this is used to inform the ongoing development of GP training.

Pathway

Prior to referral to the Community Pain Service;

- The patient is optimised on medication in Primary Care, has received appropriate investigation and treatment and has been offered a self-management manual or generic support group e.g. Expert Patient Programme.
- The pain has been present for three months or more and the GP and patient agree that the pain has become chronic i.e. persistent.
- A full explanation of the aims of the Dorset Community Pain Management Service is discussed with the patient and referral is agreed whilst respecting patient choice.

When these initial steps have been undertaken and an agreement to refer has been established:

- A referral is made through Choose and Book or by Secondary Care Consultant letter to a Single Point of Access;
- The referral form is triaged. The patient and referrer are contacted and referral form returned if not within criteria with guidance and training as appropriate;
- The patient is contacted to agree a suitable time and venue for the initial assessment;
- The patient is provided with comprehensive information about the service before the initial assessment i.e. the ethos and aims of the service, what to expect at the first visit;
- A full assessment is undertaken including physical, psychological and social aspects of the patient's pain and the impact this has on their quality of life;
- A jointly agreed Personal Care Plan is produced to optimise medication and self-care strategies. A holistic assessment will identify jointly agreed and achievable physical, psychological and social goals;
- The goals set within the Personal Care Plan are implemented with support from an appropriate key worker. This may take the form of an intensive pain management class, exercise class, education, peer support group, individual psychological support using the stepped approach or interventional injection therapy or a combination of interventions. It is expected that patients will require support to engage in all three aspects; physical, psychological and social;
- The Personal Care Plan is reviewed at intervals which are agreed by the patient and the key worker;
- The patient's family/carer are involved with the patient's expressed permission;
- Information is shared with other professionals or relevant others as is required and in accordance with the patients informed consent;
- Discharge information and the discharge goals are sent to the referrer with a copy to the patient;
- With appropriate training and support, patients are encouraged to mentor others within a peer support group or as an individual mentor;
- Patients are referred to other services/agencies as required and with their agreement.

Pathway from 1st appointment in Primary Care to the Community Persistent Pain Service

1st appointment with GP

(Generally when pain is acute/sub acute)

- Self-care advice is given regarding activity levels and medications.

2nd appointment with GP

(if pain continues)

- Assess type of pain i.e. neuropathic, nociceptive or other using a validated tool;
- Review advice and medication from first visit;
- Begin appropriate medication as per the agreed pain 'ladder';
- Screen for red flags;
- Refer to appropriate services e.g. physiotherapy for MSK for assessment and treatment;
- Perform basic psychological screening with a validated tool (PHQ 2);
- Issue self-care booklet and emphasise self-management techniques.

3rd appointment with GP

(Hands on treatment, advice and medication having limited or no effect)

- Review diagnosis;
- Stratification into risk of chronicity using a validated tool (STarTBack);
- Re screen with PHQ 2 and if necessary perform a psychological assessment using validated tools GAD 7 and PHQ 9;
- Review pain relief in line with the Pain Ladder;
- Refer to generic Expert Patient Programme;
- Refer to Community Pain Service via Choose and Book if the patient has had persistent pain for more than 3 months and the GP and patient agree that the pain has become chronic/persistent.

COMMUNITY PAIN MANAGEMENT SERVICE (existing transition patients will join the pathway at this point)

- Single Point of Access;
- Triage of referral form;
- Individual assessment and screening into appropriate support/treatment;
- Personal Care Planning with goal setting and review;
- 1:1 Motivational Interviewing – face to face, telephone, computer based;
- Cognitive and behavioural therapies and psychological support;
- Group Pain Management course – Health Professional led;
- Group Pain Management course - peer led;
- Advice and guidance to GPs re: optimal pain relief

- Intervention with injection in accordance with the policy (to be supported by attendance at a group pain management course);
- Multidisciplinary and inter-specialty team reviews for complex cases;
- Return to work and occupational advice and signposting;
- Signposting to support services e.g. physical activity, voluntary services;
- Advise GP re: referral to Inpatient Pain Management Programme;
- Discharge summary to GP and patient

4th and subsequent appointments with GP

- Review goals set at Community Pain Management Service;
- Refer back to Community Pain Management Service for review.

Discharge planning will be discussed at the initial appointment and agreed goals and timeframes set accordingly within the Personal Care Plan.

Patients will receive a discharge letter which will be copied to their GP. The letter will consist of:

- The reason for referral to the service;
- A summary of the interventions received;
- Progress made to date;
- The agreed next steps including onward referral to other professionals or organisations as appropriate;
- Links to peer support;
- How to contact the service if required in future.

2.3 Population covered

Within the Bournemouth, Poole and Dorset PCT cluster population of 715,100, it is estimated that there are 90,267 people living with chronic pain. Not all of these patients require intervention or referral to a specialist service.

2.4 Acceptance and exclusion criteria

People referred to the Dorset Community Pain Management service will have:-

- Experienced high levels of pain-related distress or disability and/or with low levels of confidence to self-manage.
- Experienced daily pain of more than 3 months duration and undergone an appropriate diagnostic screen.
- Continued to suffer from pain-related distress or disability despite taking optimal analgaesics and have made an informed choice to engage with the service.

or

- Made an informed choice not to undergo specific treatment of any underlying condition (if

available)

and/ or

- Are considered likely to benefit from enhanced self-management strategies.
- Are unlikely to benefit from other medical or surgical-based management.

and/or

- Advice and guidance i.e. the GP requests advice and guidance on the day-to-day management and strategies for an individual patient.

Referral will be accepted where a patient has:

- Accepted that their pain will not be cured;
- Been optimised on medication within Primary care or the GP requests advice and guidance regarding medication issues;
- Other interventions have had no or a limited effect;
- The risk of surgical/medical intervention outweighs the benefits e.g. joint surgery with high surgical risk;
- Curable causes have been excluded.

Referral route

- From the patient's GP via Choose and Book to a Single Point of Access.
- From Secondary Care specialists e.g. Rheumatology and Orthopaedics where the patient has accepted the referral to the Community persistent pain management service. Written GP consent should be obtained before a referral from Secondary Care is made.

Exclusion Criteria

- Patients who have not been appropriately investigated or with red flags.
- Patients (and their families) who are not motivated to be referred to the service.

Response time and prioritisation

There is no definition of urgent or routine appointment within the service.

The service will be accessed within a maximum of 18 weeks but generally patients will wait an average of 6 weeks before their first appointment.

2.5 Interdependencies with other services

Whole System Relationships

The service will maintain and develop constructive working relationships with a range of relevant staff and organisations particularly:

- Acute hospital consultants and other acute hospital staff from the NHS and Independent sectors e.g. orthopaedics, rheumatology, oncology and neurology.
- Community services particularly physiotherapy, interface services including substance misuse services, occupational rehabilitation and return to work agencies and voluntary organisations.
- GPs and practice staff.

- Community pharmacies and Medicines Management Services.
- Social Services.
- Service user groups.
- Carers and family members.
- Leisure centres and exercise instructors.

Interdependencies

The successful delivery of this service is dependent on the:

- Number and quality of referrals from GPs.
- Expectations of service users and families/carers.
- Quality of care provided in Primary Care.

Relevant Clinical Networks and Screening Programmes

- Musculoskeletal Clinical Commissioning Programme.

3. Applicable Service Standards

4. Key Service Outcomes

Expected Outcomes

1. A Single Point of Access in to the service with locality provision of the service.
2. Integrated, joined up service Pan-Dorset with a reduced number of patients referred onward for complex care. A baseline will be taken after the first year of service for future reduction in year 2 and year 3
3. Enhanced knowledge and skills within Primary Care in the daily management of persistent pain with particular focus on the provision of optimal pain relief. 100% of GPs will be provided with basic education and training in an accessible format e.g. electronic, web format, 1:1, GP forums or specialist training within the first year of service. A rolling programme of education will be provided by the service. This will contribute towards a reduced number of referrals returned to GPs due to poor quality of referral.
4. Educated and supported service users with an improved quality of life whilst they continue to live with persistent pain. Improvement in confidence, self care, clinical outcomes, and quality of life outcomes will be evaluated through patient questionnaires and surveys. Including EQ-5D-5L.
5. Reduction in anxiety and depression scores and healthcare resource use. This will be measured using screening and assessment tools PHQ2, PHQ9 and GAD7.
6. Appropriate referrals to Secondary Care services e.g. spinal surgery with 5% reduction in referral to spinal surgery within the first year of service. This will be used as a baseline for further reduction over future years.
7. Reduced uptake of interventional therapies for persistent pain with a 5% reduction in uptake within the first year of service. This will be used as a baseline for further reduction over future years.
8. Shorter waiting times within Secondary Care for patients requiring interventions i.e. injection therapy or surgery for acute pain.

9. Reduced dependency on health services.
10. Increased utilisation of self-management strategies and tools. 50% of referred patients being able to self care with support by end of first year and 70% by the end of the second year
11. Increased uptake of pain management programmes with 100% of patients being offered the programme with 80% completion at end of first year.
12. Increased peer support for service users with persistent pain. 20% of previous patients to be involved as 1:1 or group peer support for future patients.
13. Provision of the service within a community setting with 100% of services being offered in a non acute setting within one year of mobilisation of the service.

5. Location of Provider Premises

Geographic coverage/boundaries

The service will be implemented in a phased approach with full implementation within the community within the first year. The service will be entirely provided in non-acute hospital settings across at least 5 main sites including: Bournemouth, Poole, West Dorset, Weymouth and Portland, North and mid Dorset. Interventional procedures will take place in a suitably equipped community hospital operating theatre. Where a community hospital venue is not available, this will be accessed within an Acute Hospital.

Location(s) of Service Delivery

The service will be delivered in a variety of locations which facilitate convenient and prompt access for patients, to minimise disruptions to their personal commitments or those of their carers and family members, and to support their recovery.

The service will be located and available at times and places which reflect the relative population demographics and anticipated needs of a particular geographical area.

The locations and times of service operation will be made as simple, straightforward and as clear as possible to patients, their families and carers.

Days/Hours of operation

The service is to be provided at times which optimise the patient's ability to attend and minimise disruption to their personal commitments or those of their carers or family members. The operating times should reflect and accommodate wherever possible patients personal circumstances and commitments and their choice of venue and time of appointment.

Group interventions will preferably be delivered in a non medical site e.g. leisure centre, community centre, village hall.

6. Individual Service User Placement