Pain Management Services: Planning for the Future
Guiding clinicians in their engagement with commissioners

Royal College of General Practitioners
The following organisations have been represented in the development of the content of this document – The British Pain Society (BPS), The Faculty of Pain Medicine of the Royal College of Anaesthetists (FPM), The Royal College of General Practitioners (RCGP) and The Chronic Pain Policy Coalition (CPPC).
Compared to the history of other medical specialties, the modern development of pain management services is relatively new. However, the requirement for high quality pain services from community to complex tertiary setting has rapidly established itself to be of paramount importance within the evolution of the NHS.

In November 2011 the British Pain Society (BPS), Chronic Pain Policy Coalition (CPPC), Faculty of Pain Medicine (FPM) and the Royal College of General Practitioners (RCGP) jointly organised the first English Pain Summit, under the leadership of the CPPC. Several important recommendations emerged from Summit’s final report, *Putting Pain on the Agenda* (July 2012). The Royal College of General Practitioners (RCGP) was tasked to develop the following recommendation:

*Nationally-agreed commissioning guidance must be developed and agreed, describing best value care in chronic pain to reduce unwarranted variation.*

Following widespread consultation, including a multi professional advisory board in early 2013 (which included patient representatives), it was decided that the most pragmatic way to support the commissioning of pain services was to develop a support document. This document is designed to help enable, engage and enhance discussions between health care professionals and commissioners when designing fit for purpose pain services.

A recent (June 2013) Freedom of Information request was made by the CPPC of all 211 Clinical Commissioning Groups (CCGs) in England to establish how they were currently commissioning pain services and to also ensure that all CCGs were aware of pain management services. Responses were received from 168 CCGs. Three key findings are outlined below:

- 28% of CCGs could not supply a named clinical lead for pain management services
- 27% of CCGs could not supply a named managerial lead for pain
- 29% of CCGs did not commission a multidisciplinary pain services (defined as a minimum of a doctor, physiotherapist and a psychologist)

This inconsistent approach to the commissioning of pain services demonstrates the urgent need for this document.

The British Pain Society, Chronic Pain Policy Coalition, Faculty of Pain Medicine and Royal College of General Practitioners all commend you to read and use this support document to develop better pain services, for those that really require it, people in pain.
Executive Summary

Chronic pain carries a significant burden both to the individual living with pain, their families and carers, the NHS and Society. A number of key publications have highlighted this burden and raised the profile of pain, which traditionally has been low; the Chief Medical Officer’s Report, National Pain Audit and the Health Survey for England. The Chief Medical Officer’s report was the catalyst that led to the first English Pain Summit and a subsequent report, Putting Pain on the Agenda. One of the four key actions was to have a commissioning document, agreed by all key stakeholders, and the RCGP has taken the lead in developing this document. The key stakeholders are the British Pain Society, the Chronic Pain Policy Coalition and the Faculty of Pain Medicine.

The ultimate aim of the commissioning guidance is to ensure that people living with pain have services commissioned around their needs and those of their carers, that services provide good value for money, have clear and achievable outcomes defined and are grounded in quality. These quality services will add benefit to all whilst improving and increasing the economic sustainability of the local and national health care system.

The guidance is to support those leading pain management services to engage with local commissioners and develop or enhance pain clinicians’ skills and knowledge regarding the commissioning process. These will help support clinicians, and hopefully commissioners, in the commissioning of pain services and clinicians will need to scope out their local landscape and establish strong links with their local CCGs.

There are a variety of different service models within England and this document has not attempted to cover them all. Instead The BPS Commissioning Hub has been developed which will be a dynamic site for those involved in managing pain. Service models, commissioning issues and a variety of other resources will be available on the Hub such as Clinical Commissioning Groups (CCGs) One Page Plans, successful commissioning outcomes and Joint Strategic Needs Assessments (JSNAs). The Hub should be viewed as an extension to this document, and both document and internet resources should be seen as a basis from which to explore the commissioning of pain management services.

The NHS in England is undergoing the most far reaching and dramatic reforms since it was established in 1948 with the need to release £30 billion of efficiency savings in addition to the £20 billion QIPP savings that CCGs are already having to make. For the first time in its history the responsibility and accountability for holding the English NHS budget and commissioning of all health services will be the held by front line clinicians and managers.

The White Paper ‘Equity and Excellence: Liberating the NHS’ highlighted a commitment to increase value from resources allocated to the NHS. This requires variations to be addressed and a reduction in unwarranted variations in activity and expenditure. Currently, there is high variation nationally, often replicated locally, in access to multidisciplinary care for people living with pain, also a significant variation in waiting times and access to the key skills needed to help those with chronic pain and significant variation in patient care and outcomes. These issues need to be addressed by commissioners and providers working together.
Summary of key messages

1. Due to a variety of reasons, the NHS cannot continue in the long-term as it is currently configured; it will need to work differently, redesign services based on need, which add value and are patient centred and decommission services which are not seen to be clinically effective.

2. Value depends on outcomes; value is defined as outcomes divided by cost, not just the actual cost of providing services but also the impact of not providing them and will require a significant ‘shift’ in the way care is delivered.

3. Clinical Commissioning Groups (CCGs) have a statutory duty to improve the quality of services being commissioned by the NHS, in particular they have a duty to reduce health inequalities; pain services need to be prioritised in the same way as other long term conditions.

4. CCGs cannot prioritise everything; commissioners will be moving away from the disease/condition specific solution and LTCs will be commissioned using a multi-morbidities approach; people should be at the centre of this and there needs to be inclusive involvement of patients in both service delivery and design.

5. Because pain has historically been seen as a low priority, services have often developed in isolation and in an un-coordinated way, often with little clinical involvement; clinical, professional advice to commissioners is key to ensuring that pain management services are commissioned to deliver best value.

6. Pain management services should work within a system which is in equilibrium and there is equity of provision across socioeconomic scales; it must be both fit for purpose, and meet the needs of the local population, demonstrating that people are at the heart of the service, proposed service redesign and development.

7. Pain management is best delivered by multidisciplinary and multiprofessional teams; the composition of such teams will be driven by the local needs of the population and the professionals available with the competencies to work within pain management, however, integrated primary and secondary care pain management services are increasingly seen as an optimal model of care in the evolving NHS.

8. There is no intention to impose a ‘one size fits all’ approach to the management of pain, but rather to provide an opportunity for providers and commissioners to work together at a local level, to ensure that key services and management approaches are appropriately commissioned.

9. Pain management treatment pathways should be based around evidence based pathways such as the British Pain Society’s Map of Medicine Pain Pathways.

10. All health care practitioners that assess or treat chronic pain should be able to engage people that live with pain in supported self-management techniques.
Foreword

The NHS in England has taken the bold step to put high quality care for all, now and for future generations central to its purpose. Quality means safe, effective care with a positive patient experience. Effective care is about preventing premature mortality, enhancing the quality of life for people with long term conditions and helping people to recover from episodes of acute care or trauma. This is the derivation of the outcomes framework for the NHS in England. By focusing on outcomes and especially patient experience, issues that have often been marginalised or neglected in the past can be given the attention they deserve. This is why for Domain 2 of the outcomes framework, Enhancing the Quality of Life for People with Long Term Conditions, we have adapted and adopted the House of Care as a model to support person centred care. The foundation to the House of Care is commissioning and commissioners, I am sure that we will all welcome this practical support to not only improve the quality of care for people with pain but also, as we face difficult economic circumstances in the NHS, how to improve value. Perhaps, with intelligent commissioning, we will be able to rediscover Hippocrates maxim for people with enduring pain: “Cure sometimes, treat often, comfort always.”

Martin McShane BSc MS MRCGP MA
Domain Director, NHS England.
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Introduction

In 2008 the 150th Chief Medical Officer’s (CMO) report identified pain as a priority for England; the report contained some concerning figures:

- Each year over 5 million people in the UK develop chronic pain but only two thirds will recover.
- Patients with chronic pain are more likely to utilise NHS resources 5 times more frequently than individuals without chronic pain.

The CMO report was the catalyst that led to the first English Pain Summit. In July 2012, the report of the summit Putting Pain on the Agenda was launched at a Parliamentary reception. One of four key actions was to have a commissioning document, agreed by all stakeholders, which would support pain clinicians in their engagement with commissioners. As a consequence of the Pain Summit report, the Royal Society of General Practitioners has taken the lead in developing this document but has worked collaboratively with the Faculty of Pain Medicine (FPM), Chronic Pain Policy Coalition (CPPC) and the British Pain Society (BPS). The document has been developed through input from a number of commissioners, from people living with pain, pain management clinicians and academics.

We recognise that there are a variety of different service models and we cannot cover them all in this document. Therefore, we have established a portal on the BPS website ‘The BPS Commissioning Hub’ which will be a dynamic site for those involved in managing pain can share their service models, commissioning issues and where a variety of other resources will be available such as Clinical Commissioning Groups (CCGs) One Page Plans, successful commissioning outcomes and Joint Strategic Needs Assessments (JSNAs).

The BPS Commissioning Hub should be viewed as an extension to this document, and both document and internet resources should be seen as a basis from which to explore the commissioning of pain services.

Appendix 1 in this document defines the various boards, Appendix 2, the tools used in the commissioning process and Appendix 3 provides links to resources that may be useful in further understanding the boards and tools. Other resources will include the priorities of Heath Science Networks, Heath and Well Being Boards and Clinical Senates.

This document and resources on the hub will help to support clinicians, and commissioners, in the commissioning of pain services. Clinicians will need to scope out their local landscape and establish strong links with their local CCGs.
Understanding the changing NHS landscape in England

The NHS in England is undergoing the most far reaching and dramatic reforms since it was established in 1948 and its largest financial challenge with the need to release £15-20 billion of efficiency savings by 2014 and a further £30 billion of savings by 2020/21. We have already seen changes to commissioning and are starting to see changes to provision. Following Royal Assent of the Health and Social Care Act 2012\(^{14}\), we have seen the abolition of Primary Care Trusts and Strategic Health Authorities and the establishment of Clinical Commissioning groups (CCGs) and NHS England. For the first time in its history the responsibility and accountability of both holding the English NHS budget and commissioning of all health services will be held by front line clinicians and managers. Fig 1 outlines the commissioning process from the perspective of a commissioner. This includes the steps that are taken in considering commissioning services. Above the red dotted line, the green boxes indicate where clinicians have a substantial input into the process and below the line, the blue boxes indicate where the process is led by commissioners and managers whilst being supported by clinicians especially within the procurement and performance management process.

From the 1st April 2013 £63.4billion of the NHS budget in England (accounting for 67%) was passed to CCGs, with the remaining £32.2billion (33%) being passed to NHS England\(^{17}\). Fig 2 illustrates the organisational structure of the new NHS in England.

Fig 1. Commissioning cycle

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**Commissioning Process**

- **Planning**
  - JSNA / Priority Setting
  - Service Redesign / Specifications

- **Transaction**
  - Performance Management
  - Transactional

- **Agreeing**
  - Contracting
  - Procurement
Fig. 2. NHS organisations structure

This outlines the latest NHS structure and for more information, please see Appendices.
Due to a variety of reasons, the NHS cannot continue in the long-term as it is currently configured and like other modern healthcare systems in the Western World faces a number of challenges (Fig 3).

In order to meet these challenges and the financial efficiency saving targets, the NHS needs to work differently. The NHS will not be able to achieve these savings through using traditional practices but also it will need to improve overall efficiency made through redesigning services. The NHS will have to decommission services which are not seen to be clinically effective and to commission services based on need which add value and are patient centred.

In the past the NHS has provided services which have not always been centred around people, with many often being established as a consequence of organisational aspirations and wants. The new clinically led NHS has to be successful and has to achieve certain population-led aspirations and priorities. These have been set out in the White paper *Equity and Excellence, Liberating the NHS: ‘No Decision About Me, Without Me’*12. Improved choice and quality priorities within the 2013/14 Operating Framework *Everyone Counts, Planning for Patients*18 defines a change in the focus of NHS England’s efforts and needs to ensure that services have people at their core.

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**Fig.3. The need for change**

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**Fig.4. Definition of Value**

Slide courtesy of Sir Muir Gray – adapted from work by Professor Michael Porter of the Harvard Business School

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### Value

- Value = Outcomes / Costs

### Outcome

- Outcome = Good – Bad
- Outcome = Effectiveness (EBM + Quality) – Harm (Safety)

### Costs

- Costs = Money + Time + Carbon
  - Costs = Opportunity Lost
Services need to be commissioned around the needs of people living with pain and their carers that provide good value for money, have clearly defined, achievable outcomes and are grounded in quality. These quality services will add benefit to all whilst improving and increasing the economic sustainability of the local and national health care system. Value, within a health economy, has been defined by Professor Michael Porter in Fig 4.

Value depends on outcomes not inputs, and it is this principle that should underpin the success of the NHS in the foreseeable future. The system needs to make sure that value is achieved by ensuring that outcomes are greater than cost. Consideration should not just be taken of the actual cost of providing services but also the impact of not providing them. It is not just about making the old system merely increase capacity or go faster, but it also requires a significant ‘shift’ in the way care is delivered.

Adopting a value based approach means creating a system that efficiently matches patient need, with the necessary skills and environment to achieve best outcomes for that patient. This requires a system that is able to assess differing levels of need and offer an appropriate level of input. Best quality care is delivered when this system is able to offer safe and effective services in the most convenient environment and timescale for the patient. The authors recognise that it is not possible to describe a 'one size fits all' system, but suggest that the best quality systems will adapt to the local geography, demographics, and skill sets. However, high value systems for pain management may look quite different to the traditional outpatient based pain clinics. A community or general practitioner (GP) service may be appropriate for more straightforward cases where as secondary or tertiary care may be needed for the more complex cases. This is not about the geography of where care is delivered but about complexity of need and level of skill required to match that need.

2.1 The Commissioning Landscape

Commissioning within England involves a number of new boards with roles and responsibilities to ensure that the health and wellbeing needs of the population are addressed. The landscape is as follows and a brief breakdown of each area relevant to pain management, is provided:

- Formerly established as the NHS Commissioning Board, the NHS England will:
  - provide national leadership for improving outcomes and driving up the quality of care.
  - oversee the operation of clinical commissioning groups.
  - allocate resources to clinical commissioning groups.
  - commission primary care and specialist services.

- CCGs can commission any service provider that meet NHS standards and cost and they will commission most services including:
  - planned hospital care.
  - rehabilitative care.
  - urgent and emergency care (including out-of-hours).
  - most community health services.
  - mental health and learning disability services.
  - And are responsible to:
    - Local Health and Wellbeing Boards.
    - Regional Clinical Senates.

- Supported by:
  - Royal College of General Practitioners’ (RCGP) Centre for Commissioning.
  - Royal Colleges and Specialist Societies.

- Healthwatch
  - Responsible for patient voice, national (Healthwatch England) and local bodies.
  - Responsible to Health and Wellbeing Boards, and the public at large.

CCGs must be assured of the quality of the services they commission and both NHS England and CCGs have a duty to involve their patients, carers and the public in decisions about the services they commission.

For further description of these and other resources please see Appendices.
The case for pain as a commissioning priority

3.1 Impact of Chronic pain

Pain can have a major impact on individuals and their families; it also exerts a major burden on health care and on society as a whole. In recognition of the burden of pain to the NHS, it was announced in Parliament on 1st February 2012 that chronic pain should be viewed as a Long Term Condition (LTC). Historically pain was viewed only as a symptom of other diseases, rather than a condition in its own right, and this may have resulted in it not being a priority. People living with chronic pain can be high consumers of healthcare resources across primary, secondary and tertiary care settings. Whilst evidence clearly shows that pain can represent a huge burden, there is a robust evidence base to support a variety of approaches to its management. However, there is no standard approach to the commissioning of pain management services.

3.1.1 Impact on individuals

People with chronic pain, not only have to suffer with the physical pain itself but frequently have other co-morbidities to manage such as depression, anxiety, physical dysfunction and social isolation which can make pain management even more complex. In a recent meta-ethnography that qualitatively looked at patients’ experiences of chronic pain a number of themes were identified around these experiences.

High quality, high value pain management services can change the lives of people living with pain and pain management services need to ensure that commissioners are aware of the outcomes; services need to showcase and promote their services to the public and commissioners.

Impact on individuals

- 16% of sufferers feel their chronic pain is so bad that they sometimes want to die.\(^\text{15}\)
- 29% of patients with chronic pain experience depression.\(^\text{15}\)
- The overall quality of life for people with chronic pain is very poor; the average life score was 0.4 where 1 is perfect health.\(^\text{1}\)
- Sufferers were more likely to be anxious or depressed; 69% with severe pain reported this (Health Survey for England).

3.1.2 Burden to NHS

There is now sufficient evidence to illustrate that pain exerts a huge economic burden to the NHS (see evidence boxes).

NHS Burden

- 4,825 (some 20% of its respondents) reported visiting Emergency Departments in the previous 6 months to seek help for their pain.\(^\text{1}\)
- It also reported that some 3.469 respondents had more than 3 visits to healthcare providers.\(^\text{1}\)
- In 2004, primary care management of patients with chronic pain, was estimated to account for 4.6million appointments per year, this is equivalent to 793 whole time GPs at a cost of approx. £69 million.\(^\text{3}\)
- 37% of sufferers had used specialist pain services, rising to 57% among those with the most severe pain.\(^\text{7}\)
I am struggling to hold onto my sense of self and I do not want to give in

It's like living with this [person] who follows you around all the time . . . You're cursed with him and he gets in the way, he embarrasses me, he's unsociable and sometimes downright rude . . . I know it is me, I know there is no ‘person’ . . . but it's not me, that's not me, I'm not like that.

The old me is my real self.

I mean . . . a normal person isn't aware of their legs because they just say ‘right walk’, you know their brain tells them to walk and they walk, whereas when you're in pain you're aware of them all the time.

My body is even against me.

I have two small children, and I don't want them to say when they're older, we couldn't do this or that because my mum was sick. They're entitled to better than that.

I can't fulfil my normal role.

Today and the future are so unpredictable

One day you feel like doing something. Then, all of a sudden, bang! . The illness is so fickle, so capricious.

My days are unpredictable.

I worked all my life and now I can't enjoy my life ... it's (the pain) taken over . . . this is my future.

My future is not going to be as I thought.

I need to know what is causing my pain

No one believes me because I have nothing to show for it.

People think that you're swinging the lead as they say, because it's not a visible thing, so many people use it as an excuse, because it's an easy excuse . . . I remember at my sickness interview – you can see the disbelief in the manager's eyes.

When I had a broken arm, it was wonder-ful, they all rushed towards me to help me in the supermarket and I didn't feel a bit guilty because it was in a plaster . . . but now you . . . look perfectly alright and you do feel a bit of a fool . . . people just look at you and you just feel guilty about it all.

It doesn't make sense that there is no medical reason for it.
Commissioners need to be made aware that pain is a key priority along with other long term conditions and recognised not simply as a component of another condition. Fig 5 shows why the commissioning of pain management must be aligned to the funding and priorities given to other LTC services.

So what happens if we manage chronic pain properly?

It will reduce the:
- avoidable visits to GPs,
- avoidable steps and delays in a patient pathway,
- avoidable Emergency Department attendances,
- avoidable emergency admissions.

It will also prevent:
- multiple visits to hospital,
- high analgesic and co-analgesic drug cost,
- poor quality of life for people,
- duplication and the generation of waste within the system.

**Fig.5. Chronic pain vs other LTCs**

Chronic pain as a LTC

The Department of Health (DH) recognises chronic pain as a LTC in its own right and as a component of other LTCs:

- 15m people in England have one or more LTCs.
- Utilisation of health services is high amongst LTCs, accounting for 30% of the population but 70% of NHS spending (c. £70bn).
- If nothing changed, expenditure on LTCs would increase by 94% by 2022.²³
3.1.3 Burden to Society

Chronic pain also has a major impact on society as a whole. The Health Survey for England\textsuperscript{7} illustrated that:

- England had 14 million chronic pain sufferers (defined as pain which lasted for more than six months) and in almost one in four, pain had prevented individuals from performing usual activities (including work) on at least 14 days in the previous three months,
- Chronic pain had a major impact on employers,
- 37\% of women and 31\% of men reported chronic pain,
- Although chronic pain was more prevalent in older people, one in six 16-34 year olds were affected.

And the CMO’s report\textsuperscript{15} stated that:

- 25\% of pain sufferers lose their jobs.

3.2 Variations in pain services

The White Paper ‘Equity and Excellence: Liberating the NHS’\textsuperscript{17}, there is a commitment to increase the value from the resources allocated to the NHS. This requires variations to be addressed and a reduction in unwarranted variations in activity and expenditure. As detailed within the 2013 National Pain Audit\textsuperscript{1}, there is high variation in access to multidisciplinary care (Fig 6). There is also significant variation in waiting times and access to the key skills needed to help those with chronic pain. The National Pain Audit\textsuperscript{1} also identified significant variation in patient care and outcomes.

This national variation is often replicated at a local level, variation, both within primary care and due to inconsistent access to specialist services. There is also inconsistent provision of therapies between different specialist services e.g. limitations on prescribing and interventions that vary within and between regions. These issues need to be addressed by commissioners and providers working together.
Fig.6. National variation in pain services: PCTs with pain services as recorded in 2010

Pain service in
- Multidisciplinary service(s)
- Non-multidisciplinary service(s)
- No service

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Considerations when commissioning/delivering a high quality, high value pain service (now and for future generations)

4.1 Introduction

CCGs have a statutory duty to improve the quality of services being commissioned by the NHS. In particular they have a duty to reduce health inequalities. If CCGs are to be successful in their Quality, Innovation, Productivity and Prevention or QIPP challenge, they need to prioritise pain services in the same way as they prioritise other LTCs. Services need to be clinically effective, patient centred, responsive, integrated and multidisciplinary. Therefore, in their mandate CCGs need to:

- Commission services that will improve patient experience by delivering seamless care,
- See pain as a LTC in its own right,
- Commission integrated pain services reducing the number of steps a patient takes within an individual pathway,
- Pain Management Services should also be seamlessly integrated into other services such as rheumatology, gynaecology, etc,
- Commission pain services using a LTC model delivered by appropriately trained staff,
- Reduce clinical and available treatment variation while demonstrating improvement in service provision,
- Commission using best practice principles based on a robust evidence base,
- Support providers in increasing productivity and reducing waste; adding the value to pain provision,
- Develop integrated care pathways and service models,
- Implement the best possible outcome for the majority of its population,
- Demonstrate efficient use of resources through direct and in-direct cost analyses.

While it is correct to include chronic pain as a LTC, CCGs cannot prioritise everything. Commissioners will be moving away from the disease/condition specific solution and LTCs will be commissioned using a multi-morbidities approach (Domain 2 of the Commissioning Outcome Framework). This will be achieved through the ‘House of Care’ model\(^{21}\) with Care Planning led/supported by primary care at the centre; collaborative Care Planning will usually require a lead pain management professional and an accountable GP. The ‘House of Care’ model\(^{21}\), whilst being the accepted model in England is still evolving and pain management clinicians will need to keep abreast of future developments.

A recent report by the RCGP provides a valuable resource for LTC management: Care Planning, Improving the Lives of People with Long Term Conditions (2011), see page 15 onwards for a description of the ‘House of Care’ Model and The Year of Care Partnership information http://tiny.cc/rcgpltc.

4.2 Patient centred approach to care

People should be at the centre of every service within the NHS. You should be able to demonstrate the inclusive involvement of the patient in both service delivery and design. However, historically they have not always been involved in service development, redesign or improvement. There is now a real imperative to engage with patients through clinical commissioning and the priorities set out in a number of influential documents:
The individual living with pain is the only person who is privy to his or her entire health care journey. Health professionals see only part; in an entire year the average patient with pain is only engaging with a professional for 3 hours, the rest of time they have to manage their own condition. To ensure that services are commissioned, with patients truly at the centre, there is a need to understand the issues that patients face, the delays to their health care and their experiences, both good and bad.

As can be seen in Fig 8, where care is uncoordinated and delayed, we need to have a better understanding of the issues within the current system and need to begin to measure the total costs over entire pathways. Effective patient centred commissioning of pain services using an integrated care model, will enable the NHS to become much more value focused, and will assist in the reallocation of resources across different services, elimination of waste, improved and better use of capacity, reduction in the overall length of a patient journey and will facilitate the delivery of services in the most appropriate setting by the most appropriate provider.

### 4.3 Key success factors to developing and delivering of high value, high quality pain management

The key success factor to developing high value, high quality pain management is to ensure that people are at its centre. This will ensure that people are seen:

- By the right provider,
- In the right place,
- At the right time, first time.

It is also important to add in another couple of ‘Rs’:

- Right realistic choices and supported decision making with the patient (shared person centred management planning),
- Right management approach with patient engagement (evidence-based),
- Right health outcomes (patient-focused).

Given the burden of pain, commissioners need to ensure that the same resource allocation is made to service enhancement and/or development on par with other LTC. This may include sharing of generic LTC resources such
as self-management information, exercise on referral etc. Ideally, within pain services people should be able to move through the system seamlessly, whilst accessing appropriate services, treatment and providers when and where they need to, without delays and duplication. In summary therefore, this approach:

- Aligns care to the needs of the patient,
- Sees no boundary between health care settings,
- Sees no boundaries between disciplines,
- Allows people to become ‘partners’ in their care,
- Allows people to become providers of self-care,
- Improves communication.

High value, high quality pain management should be:

- Based on need: all management should be commissioned and provided on the basis of genuine need using the estimated prevalence of pain as a guide.
- Totally integrated at all levels: to ensure seamless transfer from one part of the system to another, and from one provider to another.
- Developed on the principles of a stepped care approach: management should provide a range from self-care to tertiary care for more complex pain management problems. The needs of people should take priority over organisational wants and aspirations.
- Evidence based: treatments being based on sound clinical judgement underpinned by NICE, accredited pathways and other guidance and guidelines.
- Truly person-centred: care should be personalised, and supported by high quality information so as to allow informed choice about treatment options. People should be actively encouraged to participate in decision making, about their own care but also the global needs of the local service, so as to ensure a sense of engagement and ownership.
- Totally inclusive and non-discriminatory: pain management should be age and disability inclusive.
- Treated as a LTC: chronic pain should have the same priorities that other LTCs have as outlined in the DH May 2012 report.

- Accessible: pain management, where possible should be proactive rather than reactive with early interventions based on robust screening and assessment. Services need to be conveniently located and easily accessible in all settings.
- Multidisciplinary and multi-speciality: people should have access to a wide range of specifically trained and experienced health care professionals and providers so as to ensure that all of their biopsychosocial needs are met. A multidisciplinary approach is the essential requirement for the provision of specialist and specialised chronic pain services.
- In balance, there should be sufficient capacity to meet the ever changing demands on the service.
- Focused on quality and clinical outcome: where outcomes are monitored robustly using an appropriate set of valid and reliable measures.
- Provided within the context of offering value, all services should ensure that outcomes are considered in the context of the cost of provision.
- Safe: potential for harm must be minimised. The report by Don Berwick and team⁴, in response to the Francis report, highlights key features that help preserve safety in services:
  - Culture change trumps rules.
  - Reassert the primacy of working with patients and carers to set goals.
  - Be wary of the risk of cost targets.

The case of opioid prescribing is a useful example of how the potential for harm must be balanced against clinical effect. Opioids can be effective in some, but not in all patients and they have the potential to cause harm. Cathy Stannard²³ eloquently illustrates how good clinical practice assesses risk and harm against efficacy.
**Fig. 8. A female patient with low back pain and sciatica: an example of non-integrated, expensive and delayed care**

1. **Patient presents for 1st time at GP surgery with lower back pain and stiffness | GP prescribes NSAIDS as analgesia.**
   - **GP Visit:** £15.00
   - **Analgesia:** £3.00

2. 4 weeks later patient represents at practice | No improvements | Initial investigations
   - **GP Visit:** £15.00 | **Analgesia:** £3.00
   - **X-Ray/Bloods:** £30.00 (block)

3. 4 weeks later patient presents at surgery with increased pain | Analgesia increased & referral made to physiotherapy
   - **GP Visit:** £15.00 | **Analgesia:** £15.00
   - **Referral to primary care physiotherapy team**

4. Patient attends first appointment with primary care MSK physiotherapy service | Treatment plan developed, patient attends a further 3 times over 8 week period | At the end of 8 weeks there is no improvement and patient is discharged, with recommendation to GP for referral to specialist back team in secondary care
   - **Physio attendances:**
     - 4 x £107 = £428

5. Patient sees GP further 3 times | Analgesia increased
   - **GP Visits:** £45 | **Analgesia:** £78

6. GP Refers to orthopaedic team for specialist opinion

7. Patient attends for first appointment with the specialist in physio | Care plan developed and patient attends twice more | On 3rd visit referral made for MRI and to Orthopaedic surgeon
   - **Initial:** £137 | 2 FU (£166 each) = £332

8. Patient attends for first appointment with Orthopaedic surgeon | Consultant sees no obvious abnormality on MRI | Diagnoses sciatica | Initiates new neuropathic analgesia | Places patient on waiting list for spinal epidural analgesia
   - **Analgesia:** £13 | **OP:** £83 | **MRI:** £308

9. Patient attends for day case epidural
   - **Day case:** £597

10. After 6 weeks, patient attends follow up outpatient appointment with Orthopaedic surgeon | Spinal block has eased the pain considerably | Patient discharged from active case load, but with facility of urgent direct access to Orthopaedic team
    - **Total cost for the care this patient received was** £2,200

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**The BPS Commissioning Hub will include case study examples of how care can be co-ordinated, integrated and cost effective.**

Patient self-medicates with OTC analgesia for pain for 6 months
Driving the pain agenda in the commissioning process

It is important that pain has a more significant profile within commissioners’ strategic plans, and that CCGs begin to embrace the importance of integrated care, on the same basis as other long term conditions.

5.1. Communicating your agenda

As the NHS embarks on a new clinically led commissioning system there is significant opportunity for clinicians and patients to engage with commissioners, public health and other health service provides especially those working within LTCs. The ability to communicate your message to commissioners is critical, and whilst commissioning is becoming more clinically-led, the decision makers are often non clinical, so your message needs to resonate in a way that all commissioners understand. It is important to be clear in what your messages are and these messages need to be based on good facts and measurable evidence; presented in such a way that is clear and has impact.

5.2. Professional advice

Each CCG has a statutory duty to improve the quality of services. In particular it has a duty to obtain appropriate professional advice on the services it commissions. Clinical Senates have been established to facilitate this professional advice. Identify who, if anyone sits on your local Senate to represent pain. Because pain has historically been seen as a low priority, services have often developed in isolation and in an un-coordinated way, often with little clinical involvement. Clinical, professional advice to commissioners is key to ensuring that pain management services are commissioned for based on best practice, clinical effectiveness and delivered in a multiprofessional team which manages a service which is suitably resourced in a seamless integrated way.

A preferred model of engagement is where we see:

- Clinicians informed by patients, talking to clinicians supported by managers.
- Managers talking to managers supported by clinicians.

An understanding of the local commissioning priorities and challenges is essential and that real achievable solutions to their QIPP challenges and capacity issues are provided.

5.3 Matching services to needs

An assessment of needs will provide justification for why a service is required based on data collected around the local population. This needs to be systematic and objective, using a framework that can be measured and open to scrutiny. Ensure that you have identified whether pain appears on the Joint Service Needs Assessment (JSNA) and/or Joint Health and Wellbeing Strategies (JHWS), and what your local commissioning priorities are. We recommend the preparation of a report in order to engage with your local Health and Wellbeing Board and Public Health about local needs making the case for pain management based on your findings.

Pain management services should work within a system which is in equilibrium and there is equity of provision across socioeconomic scales. A
review by those currently running a service must demonstrate that it is both fit for purpose, and meets the need of their local population; demonstrate that people are at the heart of the service, proposed service redesign and development. Commissioners will need to know the number of patients seen, the management approaches undertaken and what clinical outcomes you have achieved.

If you cannot count or measure activity, ensure that you quickly introduce systems to collect all of the key performance indicators required to evaluate your service. You may need to undertake service evaluations in order to provide specific and relevant information for commissioners, for instance outpatient attendances are often not coded by clinical intervention; it can be helpful if you can give more detail on what is actually delivered (e.g. acupuncture, coaching, medication management).

You should have adequate capacity to manage demand, see people in a timely manner and have the ability to adapt your capacity at times of severe pressure. Templates should exist to ensure that there is efficient and effective patient flow including referral and discharge criteria. The Expert Reference Group considers that a 4 to 8 week maximum wait for a non-urgent outpatient appointment is a good quality marker. This recommendation is consistent with the International Association for the Study of Pain waiting times guidelines\(^8\). If your review finds areas of weakness or gaps, ensure that you have a strategy in place to bridge these and develop possible solutions for commissioners.

It is important to demonstrate to commissioners how your service has changed over the past 3 to 5 years. Ensure you capture patient stories, utilise active patient groups and those who want to be involved in service redesign and improvement:

- patient activity and costs, including cost savings associated with for example new services and reduction of inappropriate unscheduled care by those using the service,
- length of wait,
- innovation in service delivery,
- patient outcomes (PROMS), including patient satisfaction survey,
- first to follow up ratios,
- number of patients transferred to other services.

Any service needs to ensure that it meets Royal College of Anaesthetists’ Faculty of Pain Medicine Standards, NICE guidelines and guidelines published by professional bodies such as BPS and adheres to recommended best practice with regards to human and physical resources. Important metrics you could use to demonstrate to your local commissioners high value and high quality include:

- NICE pain-related and/or LTC-related guidance.
- BPS/FPM Guidelines.
- BPS Map of Medicine Pathways.
- Other professional bodies’ pathways and guidelines.

The British Pain Society’s Map of Medicine pathways\(^5\) are based on the best available evidence and have been adopted by NHS England’s Clinical Reference Group for Pain. They are mandated in their service specification for specialised pain services and wherever possible should be used as main reference points by providers and commissioners of services. The 5 pathways\(^5\) are:

- Initial assessment and early management of pain.
- Spinal pain (guidance aligned with spinal task force recommendations).
- Chronic widespread pain, including fibromyalgia.
- Neuropathic Pain.
- Pelvic Pain (male and female).

Examples and templates regarding service reviews will be available on the BPS Commissioning Hub.

\(^{5}\) Examples and templates regarding service reviews will be available on the BPS Commissioning Hub.

\(^{1}\) Examples and templates regarding service reviews will be available on the BPS Commissioning Hub.
5.4 Delivery of pain management

Pain management is best delivered by multidisciplinary and multiprofessional teams (Fig 9). It is anticipated that teams will evidence how they function and co-ordinate their activities through regular team meetings. A variety of skills are required to management people with chronic pain and the composition of the multiprofessional team will be driven by the local needs of the population and the professionals available with the competencies to work within pain management. All the members of a high quality pain management team should be adequately trained and experienced. Integrated primary and secondary care pain management services are increasingly seen as an optimal model of care in the evolving NHS\textsuperscript{11}.

From a pain management perspective, it is accepted that more straightforward, simple, every day pain problems can be adequately assessed and managed by non specialists in primary and community care. Specialist pain management however, is required for people who have pain which is complex which can be defined as ‘Any pain associated with, or with the potential to cause, significant disability and/or distress’. Skilled pain management encompasses the assessment of complex cases, comprehensive understanding of physiological, pharmacological and pathological processes and the provision of highly skilled interventions. Pain management will need input, albeit remotely for primary and community pain services, from qualified specialists in Pain Medicine.

### Examples of how the above Figure can be individualised to your local needs will be available on the BPS Commissioning Hub.

5.5 Education and development

The CMO report\textsuperscript{15} identified that there were unmet needs in the pain management education...
of healthcare professionals. Education and training should underpin any high value, high quality pain management service and you should be able to demonstrate to commissioners that you meet recommendations laid down by the appropriate professional bodies. It is important to be aware of the educational standards of team members, what professional bodies require and draw up action plans to indicate how education and training will be implemented in order to maintain the expertise of the pain management team. Patient feedback (satisfaction surveys, complaints) should be used to inform education and training programmes.

5.6 Patient education, information and support

People have the right to be informed about their condition and its management, and they should be supported by appropriate and accurate information, in a format they can understand and apply to their situation. Research shows that people with low health literacy have less understanding about their health, poorer health and higher mortality than people with adequate health literacy.

Education should not only be about pain conditions and management but also about how to live with a LTC; offering encouragement to participate in education and peer support programmes to aid independent living. The recent National Pain Audit, suggests that over 50% of patients did not feel that the pain clinic adequately addressed their understanding of their condition. People should be made aware of and offered access to self-management information, patient education groups and support.

Examples of these will be provided on the BPS Commissioning Hub.

Patient information should also be available in mediums that address disability and readership issues and in forms suitable for people where English is not their first language.

5.7 Self-management principles

The rising prevalence of pain and the unpredictable chronicity that it can generate raises important challenges for service provision and for society more generally. In recent decades, it has become increasingly clear to policy makers and service leaders that the same services and approaches used to deal with more acute problems are neither appropriate for the management of LTCs, nor sustainable as LTCs will account for an ever increasing proportion of healthcare.

The Chronic Care Model advocates features of healthcare systems that are appropriate and sustainable. This model describes the system design and how it is delivered, the role of system wide communities and the kinds of support that needs to be offered for people to self-manage their condition. The principles underpinning all LTCs need to form part of any high quality, high value patient centred pain management service.

When developing integrated models for pain management, we need to develop strategies that encourage and enable people with chronic pain to become more effective self-managers through:

- Educational, training and peer-support programmes.
- Approaches to healthcare consultations in which clinicians put a strong emphasis on supporting people to manage their own conditions rather than encouraging people to rely on clinicians to manage those conditions for them.

Both strategies should be more or less integrated into larger programmes of health service redesign and should be integral parts of any high quality pain service.

Detailed information about self-management strategies that you can share with your commissioners will be available on the BPS Hub.
What does successful engagement with commissioners look like?

6.1 Making links with local CCGs

You should initially start making links with key stakeholders within your CCG such as the individual responsible for pain management services; this would typically be someone responsible for elective services. In addition making links with public health teams, who now sit in the local authority, would also be beneficial. Your local CCG may also have active service redesign groups looking at areas such as musculoskeletal services, orthopaedics and outpatient services. As pain management is often seen as being integral to other services, it may be appropriate for you to engage with these groups so as to influence the commissioning agenda locally.

A review of your local CCG business and commissioning plans would be useful to give you an understanding of what the local priorities and pressure points are, and whether there is an opportunity for your service to make a valuable contribution to the local QIPP challenges. For instance:

- Is there an opportunity to develop new care pathways or place clinical activity into a more appropriate environment?
- Is there an opportunity to better meet the needs of people in pain by expanding your MDT?
- Are there opportunities to improve care pathways for patients so that emergency department attendances are reduced/avoided?
- Are there opportunities to work with the CCG medicines optimisation and service improvement teams to redesign care pathways in order to optimise the appropriate use of analgesia?
- Are there opportunities to work more closely with front line clinicians to raise the awareness of appropriate referral management via peer review?

6.2 Development of local networks

Using the evidence in this guide and the findings of your review, you could perhaps consider establishing a local pain interest group or network. This would be an ideal opportunity for clinicians to come together to look specifically at pain management. Because pain has traditionally been seen as part of other conditions and not a LTC in its own right, it is very unlikely that there are local groups specifically looking at pain management currently. Through such a network, you can present your case to your local CCG, to both raise the importance and profile of pain.

6.3. Engagement documentation

Once you are satisfied that you are able to begin to share information about your service, consider how you present it; prepare a report on the outputs of your review, together with a short presentation.

The documentation will be different across England and therefore examples will be uploaded on the BPS Commissioning Hub. It is often worthwhile checking with your commissioning teams how much detail they require, and whether they have a standard template they wish you to use.
6.4 Joint working

As part of the dialogue with your local CCG you should be in a better position to influence the development of:

- integrated care pathways, including those that appropriately drive people away from costly secondary care services,
- referral and discharge guidelines,
- interface services,
- prescribing guidelines.

You should also be in a much better position to secure your services for the future; commissioning is a joint responsibility and for the successful commissioning of pain management those with most experience of treating people with pain need to become actively involved.

Fig.10. The role that the pain management clinician may have in influencing the commissioning of pain services
Conclusion

This commissioning guide has been developed to support the appropriate commissioning of pain management across England. Chronic pain can be a very complex condition which has far-reaching consequences for individuals, healthcare systems and the wider society.

There is no intention to impose a 'one size fits all' approach to the management of pain, but rather to provide an opportunity for providers and commissioners to work together at a local level, to ensure that key services and management approaches are appropriately commissioned.

This document is a guide to ensure that you:
- are updated with regards to the NHS changes,
- have a way of demonstrating to commissioners why pain needs to have a high priority within CCG commissioning strategies,
- are informed about what commissioners use to make decisions about high value, high quality, safe services,
- are informed and are more confident when engaging with local commissioners.

If CCGs are to commission services effectively and appropriately, we need to ensure that pain management is available to all, has a higher profile, that clinical variation is reduced or eliminated, and that patient outcomes are improved. At a time when the NHS is facing its most challenging period financially, it needs to make sure that it commissions services appropriately, and that people get access to treatments that add value, whilst improving quality of life.

This guide has been developed to illustrate the importance of appropriate commissioning of pain management and is aimed at encouraging positive and open communication between providers and commissioners to ensure that people get access to the treatment and services that they need and deserve.
References


Appendix 1: Boards

What is NHS England?

This was previously called NHS Commissioning Board and assumes overall responsibility for commissioning. CCGs will be accountable to this board. It is organised into Local Area Teams, there are 27 of these, across the country. They will directly commission the areas not covered by CCGs i.e. specialist services, primary care services, pharmacy and dental services.

What are Clinical Commissioning Groups?

They have taken over from old PCTs, They have statutory accountability for most of the NHS commissioning budget, covering hospital based services. Every GP practice is a member of a CCG, and decision making is intended to be clinician lead. CCGs are now responsible for ensuring that the health and care services provided at a local level effectively meet the needs of their population. They will prioritise health outcomes, procuring products and services, and managing service providers.

What are local area prescribing committees?

Each CCG will have a local area prescribing committee who provides the strategy to ensure consistent high quality and cost effective use of medicines. It advises on the following:

- Classification of medicines under the traffic light list.
- Assessment of clinical and cost effectiveness (including affordability) of medicines.
- Development and maintenance of joint formularies.
- Development and approval of shared care guidelines.
- Development and approval of prescribing guidelines.

These committees may be a good group to approach to work up plans for prescribing initiatives, especially relating to recent concerns about opioid prescribing.

What is the Care Quality Commission?

CQC is an independent regulator for all health and social care services in England. It will check all NHS settings to ensure that they are meeting national standards and share their findings with the public.

What is Healthwatch?

Healthwatch is a new customer champion for both health and social care. It exists in two distinct forms, Healthwatch England, at a national level and local Healthwatch, at a local level:

- Healthwatch England is a national body that enables the collective views of the people who use NHS and social care services to influence national policy, advice and guidance. It will be a statutory committee of the Care Quality Commission. There will be a requirement from the CQC to respond to the advice from Healthwatch England.
- Local Healthwatch will have a seat on the new Statutory Health and Wellbeing Boards ensuring that the views and experiences of people, carers and other service users are taken into account when local needs assessments and strategies are prepared. This will ensure that local Healthwatch will have a role in promoting public health, health improvements and in tackling health inequalities. Local Healthwatch will have a number of key roles, but in terms of the commissioning process, can help and support CCGs to make sure that services are really are designed to meet citizens’ needs.

What are Commissioning Support Units (CSUs)?

CCUs are designed to offer an efficient, locally sensitive and customer focused service to CCGs.

What are Clinical Senates?

Clinical Senates have been established to play a unique role in the commissioning system by providing strategic clinical advice and leadership across a broad geographical area to CCGs, Health and Wellbeing Boards and NHS England. They will provide a clinically led and strategically focused forum for commissioners and providers to come together and determine the most clinically appropriate means to configure services for the future. Clinical Senates will span professions and include representatives of patients, volunteers and other groups. Clinical Senates will become a trusted source of advice to commissioners in CCGs, NHS England, providers and Health and Wellbeing Boards.

What are Clinical Reference Groups for Specialised Services?

NHS England, when planning specialised services, has brought together groups of experts, along with patients and carers, to form service specific Clinical Reference Groups (CRGs). They will have strategic influence but will not hold any statutory rights. They will be coordinated through 5 National Programmes of Care. Each CRG has an identified core sets of commissioning 'products' to develop each year. CRGs covering all prescribed specialised services will draw membership from each of the geographies covered by the 12 senate areas. The CRGs will work closely together to gain consensus of agreement in the development and completion of these products. Specialised Pain sits within the CRG: Trauma Programme. Dr Andrew Baranowski is Chair of the NHS England Clinical Reference Group for Specialised Pain Services.
What are Health and Well Being Boards?

Health and Well Being Boards were established as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. They will have strategic influence over commissioning decisions across health, public health and social care. Boards will bring together CCGs and councils to develop a shared understanding of the health and wellbeing needs of the community. They will undertake the influential JSNAs and develop a joint strategy for how these needs can be best addressed.

What are the Academic Health Science Networks?

Academic Health Service Networks are Government funded schemes with a focus on combining improved health with economic improvement of populations (‘Health and Wealth’). AHSNs present a unique opportunity to pull together the adoption and spread of innovation with clinical research and trials, informatics, education and health care delivery. They will develop solutions to health care problems and get existing solutions spread more quickly.

Appendix 2: Measures and indicators

What is the NHS Outcome Framework?

The NHS Outcomes Framework sets out the indicators for measuring health outcomes in NHS services. This reflects the vision set out in the White Paper: Liberating the NHS and contains a number of indicators selected to provide a balanced coverage of NHS activity. The NHS outcome indicators are grouped around five domains, each domain has a small number of overarching indicators followed by a number of improvement areas:

- **Domain 1:** Preventing people from dying prematurely
- **Domain 2:** Enhancing quality of life for people with LTC
- **Domain 3:** Helping people to overcome 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 a safe environment and protecting them from avoidable harm.

CCGs will be held accountable to these outcomes. Pain management relates to all of the domains but has a specific relationship through Domain 2, with chronic pain being officially recognised as a long term condition (LTC) since February 2012.

What is QIPP?

The mechanism through which the NHS will achieve the required efficiency savings is via the Quality, Innovation, Productivity and Prevention or QIPP challenge. The NHS needs to be much more focused on quality and improved clinical outcomes. We need the system to become more innovative and challenge often outmoded custom and practice. The whole system needs to become more productive and less wasteful, and the prevention of illness and avoidable use of costly healthcare resources need to be positively encouraged. If the QIPP priorities are to be achieved without compromising patient care, safety or outcomes, the NHS needs to:

- Prevent unnecessary acute hospital activity.
- Develop new and improve existing non acute services.
- Reduce clinical variation.
- Reduce or eliminate waste.
- Look at entire patient pathways not just discrete parts of them.
- Look at whole population health needs.
- Test and challenge historical behaviours.
- Test out and change historical patterns of service delivery.
- Innovate.
- Develop new care pathways which are integrated and seamless.
- Invest more resources in prevention and re-enablement.

What is a Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategies?

Joint strategic needs assessments (JSNAs) are local assessments of current and future health and social care and are unique to each local area. They are not an end in themselves, but a continuous process of strategic assessment and planning. They help determine what actions local authorities, the NHS and other partners need to take to meet health and social care needs and to address the wider determinants that impact on health and wellbeing. It is important to ensure the needs of people with pain are strategically assessed as JSNAs lead to the production of joint health and wellbeing strategies (JHWSs). The NHS and upper tier local authorities have had a statutory duty to produce an annual JNSA since 2007.

Joint Health and Wellbeing Strategies (JHWSs) are the basis of commissioning plans for health and care in each local area. Based on the findings of the JSNA the members of the Health and Wellbeing board will develop a Joint Health and Wellbeing Strategy for their area. This joint strategy should support Health and Wellbeing board members to take the important step from assessing needs and available assets to planning the delivery of integrated local services based upon those needs and assets.

In this way the JSNA and JHWS combined form the basis for local decisions that drive service change such as investment and disinvestment in services according to local needs and engagement with the local community.
The JHWS will need to take account of the NHS England mandate from the Secretary of State for Health. The JHWS can also be used to influence the commissioning of local services beyond health and social care to make a real impact on the wider determinants of health. Local authorities, CCGs and the NHS England will need to have regard to local JSNAs and JHWSs as they draw up their commissioning plans so that these are fully aligned with the jointly agreed priorities.

Chronic pain is not automatically included in the JSNA analysis of the population so we urge you to discuss with your CCG and Director of Public Health.

What is the Commissioning for Quality and Innovation (CQUIN) payment framework?

The CQUIN payment framework enables commissioners to reward excellence by linking a proportion of English health care providers’ income to the achievement of local quality improvement goals.

What are Patient Reported Outcome Measures (PROMs)?

PROMs assess the quality of care delivered to NHS patients from the patient’s perspective and is coordinated by the DH.

Appendix 3: Further information

British Pain Society (BPS) Commissioning Hub
Care Quality Commission: http://www.cqc.org.uk/

Clinical Commissioning Groups:
Academic Health Science Networks:
http://www.kingsfund.org.uk/publications/clinical-commissioning-groups

Clinical Reference Groups for Specialised Services:

Clinical Senates:


Commissioning for Quality and Innovation (CQUIN) payment framework:
http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html


Commissioning Support Units:
http://www.hsj.co.uk/home/commissioning/csu-structures-and-how-they-will-operate/5055935_article?blocktitle=Resource-CentreandcontentID=8630

Health and Well Being Boards:
http://healthandcare.dh.gov.uk/hwb-guide

Healthwatch: http://www.healthwatch.co.uk

Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategies:
http://www.hscic.gov.uk/jsna
http://www.nhsconfed.org/Publications/Documents/Briefing_221_JSNAs.PDF

Local Area Teams (LATS):

NHS Outcome Framework:

Patient Reported Outcome Measures (PROMs):
http://www.hscic.gov.uk/proms

Quality, Innovation, Productivity and Prevention:
http://www.improvement.nhs.uk/qipp