Meeting Date		**Agenda Item**		
Report Title	Chronic Pain External Review Report Action Plan Update			
Report Author	Sally Bloomfield Head of Podiatry, Orthotics, Chronic Pain and MCAS Service			
Report Sponsor	Christine Morrell Deputy Director of Therapies and Health Science			
Presented by	Chris White Director of Therapies and Health Science			
Freedom of Information	Closed			
Purpose of the Report	To report on independent review of Chronic Pain Services commissioned by ABMU Executive Board and action plan status against recommendations which has been developed and approved by the PCCS Unit which manage this service			
Key Issues	Generally, the external review group found the ABMU chronic pain services at or above the standard of most services operating in the UK NHS in each of the performance domains they assessed. There were no significant safety risks or effectiveness concerns.			
Specific Action Required ***(please ✓one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
			✓	
Recommendations	Members are asked to: • **NOTE** the report and subsequent action plan for review			

CHRONIC PAIN EXTERNAL REVIEW REPORT ACTION PLAN UPDATE

1. INTRODUCTION

An independent review of Chronic Pain Services was commissioned by ABMU Executive Board. The Executive Board accepted the recommendations of the review, and an action plan against recommendations of the review team was developed and approved by the Primary Care Delivery Unit and is being enacted.

2. BACKGROUND

Review process: An Executive Director (Eifion Williams) of ABMU took the lead responsibility for establishing and coordinating a review of the Chronic pain Service, supported by key operational personnel.

Dr Lance M. McCracken, PhD, Professor of Behavioural Medicine at UCL was appointed as Chair of the review team and he engaged a team with the necessary range of expertise and experience. The review team was made up of the following members:

Karen Sanderson – Senior Pain Management Nurse

Professor Roger Knaggs – Pharmacist based in Nottingham

Dr. Peter Brook – Pain Consultant based in Bath

The terms of reference were established (attached Appendix 1), agreed by the Executive team and provided to the review team. It was agreed that the Board required the review team to reach conclusions and make recommendations to address the following issues:

1. The clinical safety and effectiveness of the current service model.
2. What measures are required to improve safety and effectiveness of the service.

The review invitation was initiated on the 30th of November 2016 and the review agreed on the 14 December 2016. Substantial supporting information on the chronic pain service and its performance was gathered and provided to the review team over a number of weeks and in advance of their visit. A review was undertaken of selected documents dating back to at least June 2012, including:

- a summary of service development,
- a list of service team members,
- a figure depicting the pain service pathway,
- a service specification document,
- audit data from pain services in the nine health boards in Wales,
- descriptions of waiting time data,
- recent service annual report from 2014/2015,
- a pain service report from March 2016,
- patient attendance data April to December 2016,
- waiting time data,
- a record of complaints involving the chronic pain service (1 March 2014 to 24 March 2017),
- a summary and redacted report on a recent medico-legal complaint, and correspondence related to a previous staff complaint.

A site visit by the 4 members of the review team was completed over two days, on the 26th and 27th of April 2017 where the following were undertaken:

- Interviews with current staff, an affiliated pharmacist, the Head of Service, and PCCS Unit medical director, including ten separate interviews, with at least twelve staff members.
- Visit to a clinical location where procedures are undertaken.
- Visit to a clinical location where pain clinics run.
- Briefing and debriefing of members of the Executive Team at ABMU.

The draft findings were provided to the executive lead on the 20th of May 2017. The final report was provided to the LHB on the 3rd July 2017 and reviewed by ABMU Executive Board on the 14th August 2017. The final report was released to the Unit on Wednesday 6th September 2017 (attached appendix 2).

The recommendations of the review group were as follows:

1. The service should be supported to create an additional post for a clinical psychologist, such as at Band 7.

2. Staff members should be actively encouraged to use DATIX to record, learn from, and improve practice around critical incidents.

3. Currently it seems that waiting time is the only performance indicator being tracked and analysed. We encourage the service to better utilize systems of clinical outcome assessment, and analyse the data regularly, so that it is knowns whether or how well the services are producing good clinical outcomes.

4. Operational policies should be instituted, such as in areas of consent, suicide, and managing co-morbid mental health problems.

5. Although there is local guidance on the 'Pharmacological management of Chronic Non-Malignant Pain in /Non-specialist centres' this should be updated to include most recent information in national resources, such as Opioids Aware. Consideration could be given to developing additional guidance that would provide other healthcare professionals with directions on medicines that may be prescribed or recommended from specialist services to provide transparency about use of more specialised medicines.

6. Members of staff should participate in meetings focused on clinical governance and institute a regularly minuted meeting with a focus on clinical audit, risk management, clinical effectiveness, and training.

7. Staff training and development should be built in to staff working hours on a regular basis as a standard form of support for service quality.

Those leading the service should consider whether there is a higher efficiency, perhaps lower intensity, service that could be developed as an addition to the current format of the PMP. This could increase capacit

An Action plan against the recommendation was developed by the Primary Care Unit and Actions have been taken forward as per attached updated document.

An additional report and action plan was provided to address the issues raised in medico legal complaint.

3. GOVERNANCE AND RISK ISSUES

Generally, the external review group found the ABMU chronic pain services at or above the standard of most services operating in the UK NHS in each of the performance domains they assessed. There were no significant safety risks or effectiveness concerns. At the same time they suggested a number of improvements that could be made to increase psychology resources, systematically collect and analyse critical incident and clinical outcome data, and to bolster systems to support good clinical governance, including particularly clinical audit and staff support and training.

4. FINANCIAL IMPLICATIONS

Some recommendations of the review have resulted in financial investment which has been found within the Primary Care Delivery Unit.

5. RECOMMENDATION

Members are asked to:

- **NOTE** the report and subsequent action plan for review

Governance and Assurance							
Link to corporate objectives ***(please ✓)***	Promoting and enabling healthier communities	Delivering excellent patient outcomes, experience and access	Demonstrating value and sustainability	Securing a fully engaged skilled workforce	Embedding effective governance and partnerships		
		✓					
Link to Health and Care Standards ***(please ✓)***	Staying Healthy	Safe Care	Effective Care	Dignified Care	Timely Care	Individual Care	Staff and Resources
		✓	✓				✓

Quality, Safety and Patient Experience

Ensuring that the Health Board make fully informed decisions is dependent on the quality and accuracy of the information presented and considered by those making decisions. Informed decisions are more likely to impact favourably on the quality, safety and experience of patients and staff. Implementation of the recommendations of the review will lead to service improvement and enhance quality safety and patient experience

Financial Implications

There are no financial implications contained within this report.

Legal Implications (including equality and diversity assessment)

There are no legal implications contained within this report.

Staffing Implications

There are no direct implications on workforce in this report. Staffing implications have been addressed within budget.

Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)

No specific implications

Report History	Outstanding action from Q&S Committee
Appendices	Appendix 1 : Terms of Reference Appendix 2 : Final Report Appendix 3 : Action Plan

Terms of Reference for the Review of Persistent Non-Malignant Pain Management Services in ABMU

It is proposed that a comprehensive external review of the ABMU Persistent Non-Malignant Pain Management service be undertaken to provide an external, expert opinion of the service and advise as to what measures are required to develop and improve the service. It is imperative that this is undertaken in a transparent manner and engages with the existing multi-disciplinary team, patients and relevant partners.

1. Membership

The external review team will be led by an expert in the Chronic Non-Malignant Pain field who will lead a team with the relevant skills, up to date knowledge and expertise required to undertake the review. It is suggested that the review team is multi-disciplinary and will consist as a minimum requirement of the following professionals:

- Consultant in chronic pain management
- Pharmacist specialising in pain management
- Senior nurse specialist in pain management
- Applied psychologist specialising in pain management

The chair of the review team will be required to agree the terms of reference, timescales and establish and lead the review team. Following undertaking the review, a report will be produced by the review lead, that appropriately takes into account the findings and recommendations of the whole review team.

The following professionals have agreed to be the members of the review team:

Professor Lance McCracken (Lead for the Review) – Psychologist based at UCL

Karen Sanderson – Senior Pain Management Nurse

Professor Roger Knaggs – Pharmacist based in Nottingham

Dr. Peter Brook – Pain Consultant based in Bath

The Health Board has nominated a service manager who will support the review team in terms of providing the information requirements pre, during and post visit, arranging the visit days with all staff and patients requested/identified, and day to day contact. Eifion Williams will act as the executive sponsor for the review team report. There will be a need to present the findings of the review and the resulting report to a meeting of the Health Board, following its discussion at the Executive team of the Health Board.

2. Approach

The approach to the review will be agreed with the Chair and review panel once appointed.

The panel will have access to past reports and data in advance of their visit. A visit of two days will be arranged to interview key personnel as determined by the review team. The provisional dates are the 26th and 27th of April, 2017.

Adequate time for preparation, evaluation and report drafting will also need to be recognised by the Health Board. It is envisaged that a draft report will be made available to the Chief Executive of the Health Board and an opportunity for its discussion with the executive team. Following its acceptance by the executive team, the final report will be presented to a meeting of the Health Board.

3. Terms of Reference

The Board will require the review team to reach conclusions and make recommendations to address the following issues:

1. An evaluation of the clinical safety and effectiveness of the current service model.

2. What measures are required to improve the safety and effectiveness of the service?

The review team will visit and interview staff involved in the provision of the service, patients and relevant partners. An initial meeting will be held with the executive team at the commencement of the visit and a final meeting at the end of the review visit to verbally relay initial findings.

Within a period of 1 month, a draft report will be provided by the review lead to the Chief executive of the Health Board, and arrangements made to present the findings to a meeting of the executive team. From the comments received on the draft, a final report will be made available and presented to The Health Board at the earliest opportunity.

4. Timescales

Current proposals envisage a review being undertaken on the 26th and 27th of April, 2017.

It is envisaged that a draft report will be made available to the Health Board Chief Executive before the end of May 2017.

The final report will be made available after comments have been received, and presented to the Health Board at the earliest opportunity.

The above will need to be agreed by the Chair of the Review Team.

24 February, 2017

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Independent Review of Chronic Pain Services Undertaken in April 2017

Introduction

An independent review of Chronic Pain Services provided by ABMU HB was commissioned by the Board. An executive director took the lead responsibility for establishing and coordinating the review, supported by key operational personnel. A chair for the review team was established who then gathered colleagues to establish a team with the necessary range of expertise and experience to undertake the review. The terms of reference were established, agreed by the executive team and provided to the review team. The review invitation was initiated on the 30th of November 2016 and agreed on 14 December 2016.

Substantial supporting information on the chronic pain service and its performance was gathered and provided to the review team over a number of weeks and in advance of their visit. A site visit by the 4 members of the review team was completed over two days, on the 26th and 27th of April 2017.

The draft findings were provided to the executive lead on the 20th of May, and the final report provided on the 3rd July 2017. This report sets out the approach to the review and the findings of the review team with the expectation that it supports the service continue its journey of progression.

Summary of Key Findings

Generally, we find the ABMU chronic pain services at or above the standard of most services operating in the UK NHS in each of the performance domains we assessed. We unearthed no significant safety risks or effectiveness concerns. At the same time there are a number of improvements that could be made to increase psychology resources, systematically collect and analyse critical incident and clinical outcome data, and to bolster systems to support good clinical governance, including particularly clinical audit, and staff support and training.

Terms of Reference of the Review

The terms of reference can be succinctly summarised as follows:

"The Board will require the review team to reach conclusions and make recommendations to address the following issues:

1. The clinical safety and effectiveness of the current service model.
2. What measures are required to improve safety and effectiveness of the service."

The Review Team

- Professor Lance McCracken (Chair), Professor of Behavioral Medicine, King's College London; Consultant Clinical Psychologist & Psychology Lead, INPUT Pain Service, Guy's and St Thomas' (GSTT) NHSFT

- Dr Peter Brook, Consultant in Pain Management, Bath Centre of Pain Services, Bath CRPS Service & University Hospitals Bristol (UHB)
- Professor Roger Knaggs, Associate Professor in Clinical Pharmacy Practice, School of Pharmacy, University of Nottingham
- Karen Sanderson, Advanced Nurse Practitioner, and Lead Nurse, GSTT NHSFT Pain Services

Review Methods

1. Review of selected documents dating back to at least June 2012, including a summary of service development, a list of service team members, a figure depicting the pain service pathway, a service specification document, audit data from pain services in the nine health boards in Wales, descriptions of waiting time data, recent service annual report from 2014/2015, a pain service report from March 2016, patient attendance data April to December 2016, current waiting time data, a record of complaints involving the chronic pain service (1 March 2014 to 24 March 2017), a summary and redacted report on a recent medico-legal complaint, and correspondence related to a previous staff complaint.
2. Two days of interviews with current staff, an affiliated pharmacist, the directorate manager, and medical director, including ten separate interviews, with at least twelve staff members and others.
3. Visit to a clinical location where procedures are done.
4. Visit to a clinical location where pain clinics run.
5. Briefing and debriefing of members of the Executive Team at ABMU.

Key Findings

Having reviewed the documentation and the outcomes of the discussions and interviews undertaken, the following sets out the key findings of the review team.

1. Staff, patients, and managers of the service spoke highly of the service and did not describe any significant safety risks, nor did any clearly emerge in the review of documents. In each case interviewees described services of a good standard that provide benefits for most of those who receive them. The two patients we met describe the results they achieved positively as “life changing.”

2. In general, there was a high level of staff morale, enthusiasm, and support for the service and its future. Staff report “we all get along well as a team,” “it’s a lovely team to work in,” and “by far the most enjoyable job I have ever had.” Staff consistently described a culture of mutual respect.

3. In general, staff reported having done PDRs and mandatory training.

4. As with many pain services around the UK the service is at capacity, and demand for services is high. Staff refer to the service, for example, as “stretched to capacity.” One result of this is that some staff reported a relative lack of time to reflect on practices, identify opportunities, plan service improvements, and pursue clinical development. This was described by staff as “not enough time to think.” This was a sentiment expressed by the majority of staff, but there were a couple of exceptions –just two staff we met felt they did have time to reflect and plan.

5. Staff report that their biggest challenges include keeping up with waiting times and meeting the needs of complex cases.

6. Patient waiting times were reported to have been 18 months at one point, are now reported at four and six months, in part due to staff ability to schedule additional clinics, refine treatment pathways, and reduce the length of the Pain Management Programme (PMP). The current intention is to meet a target is 14 weeks.

7. We are told that with the recent provision of a new IT system clinic letters are turned around in 24 hours.

8. The service is now considered fully staffed.

9. Some important provisions within the service are particularly under high demand, including psychology. Each discipline within the service has more than one member within the team, except for psychology, which relies on just one person. This is a risk for sustainable provision and is unsupportive for this sole provider, particularly with respect to the fundamental role of psychology within chronic pain services.

10. There are currently no resources to provide one-to-one psychology services for patients.

11. There are currently no clear data on proportion of new and follow-up visits, average numbers of visits made by those referred, re-referrals, and other data on service attendance and use.

12. We see no evidence of regular local clinical governance meetings or of a specifically active method of surveillance, including the contemporaneous recording of adverse events and risks.* This requires both a system and in training staff to be aware and report events.

13. There appears to have been few clinical audits registered and reported in the past, although we note that several audits have been recently planned.

14. There is a lack of documentation of policies or Standard Operational Procedures (SOPs), with respect to such things as interventional procedures, informed consent, screening for and management of common mental health problems, suicide risk, and so forth.

15. Services appear effective based on reports of staff and two patients. These results are unfortunately anecdotal, or reports from those who apparently have seem some data, and not evidenced with actual systematically collected data that we were able to review. *

16. While clinical outcome data appear to be collected they are not fully utilized and have not been analysed or reported.* This represents an unnecessary burden on patients if the data are not used. This also means that the effectiveness of the service cannot be reliably and validly stated, and an important mechanism for quality assurance is not being used. The recent employment of a health care support worker may help in this regard.

17. The PMP component of the chronic pain service appears to be particularly overstretched with little or no ability to absorb any increase in demand. This is an important problem as this component of service is probably the best mechanism for transitioning patients out of services overall, and for reducing long term demand. PMPs are probably the best means within the range of services provided to foster a self-management approach.

18. There is a help and advice service available for GPs, however, it appears that GPs never or almost never use this. We note that this could be a great asset for shaping more appropriate referrals, for aligning treatment pathways, perhaps supporting the delivery of more self-management within GP practices, and perhaps reducing demand.

19. The service in general is actively considering methods to increase capacity, such as telephone or Skype-type contacts. This kind of creative thinking is less evident in the PMP, most likely due to their facing heavier day-to-day demands with less time to think creatively.

20. Several local guidelines regarding use of medicines were provided for review and appear consistent with other national and international consensus guidelines. During our discussions with the clinicians interviewed it appeared that they viewed the place of medicines in a similar way.

21. It was highlighted that the Health Board was an outlier in prescribing some newer, expensive analgesics in comparison with other areas. However, no local or comparative prescribing data were provided was provided to allow us to confirm if this was initiated by the pain service or primary care.

22. Patient information leaflets for several medicines were provided. Whilst all of the key information was contained, the language could be more patient friendly. Consideration could be given to adopting leaflets from other national sources, such as the Faculty of Pain Medicine. Alternatively, the Service could consider developing or utilising the expertise of a local patient partnership or patient involvement group to redesign the leaflets so that they are as patient friendly as possible.

23. The rational and effective provision of analgesic medicines appears to be a challenge across the region, and is characterized by failures to follow guidelines, non-uniform provision, relative high cost, inadequate outcomes, failure to address potential harms, failure of integration of medication management across primary and secondary care. This of course is not solely the responsibility of the chronic pain service, and we saw no evidence that the pain service is particularly at fault in this.

24. We note that we did not have access to any feedback from referrers on the effectiveness of the service and so this is a missing piece from the information provided.

25. Finally, we met one member of staff who appeared to be in distress, apparently associated with the purpose of our review, and this person was subsequently not able to later attend an arranged interview with us due to feeling unwell.

* *Note: Each of these service limitations is unfortunately common in most pain services in the UK and essentially "standard practice."*

Interventional Procedures and Patient Safety

The review team were also asked to specifically comment on an example medical complaint case. From a visit to the facility where this case was treated we find that pain interventions are performed in appropriate and safe environments in a secondary care setting. Facilities for monitoring, airway and respiratory support and resuscitation, including defibrillation, are available at all sites where patients undergo pain intervention techniques. A WHO surgical safety checklist is performed prior to the commencement of interventions.

Interventions are performed in an outpatient setting with facilities for aseptic precautions. Whilst the procedures are not done in an operating theatre as recommended by the Core Standards for Pain Management Services (CSPMS) document produced by the Faculty of Pain Medicine, Royal College of Anesthetists, this is in line with the practice of a majority of pain specialists within the UK.

Suitable facilities to allow for privacy and confidentially are available. Equipment necessary for bariatric patients is available. All the necessary medical equipment (as recommended in the CSPMS guidelines) for the performance of procedures is available. Appropriate imaging equipment and the ability to store and retrieve images is available when needed. Fluoroscopy is available and used when indicated.

Patients are recovered in the treatment area where they receive the intervention but a fully equipped recovery area, staffed by fully trained recovery staff is available should there be any complications requiring this facility.

Oxygen supply, facemasks, suction, airways (e.g. Guedel and laryngeal mask), tracheal tubes and intubation aids, self-inflating bag, trolley/bed/operating table that can be tilted head-down rapidly are all immediately available.

There is easy access to inpatient beds in the event of perioperative complications or for patients not requiring overnight admission there is the option of monitoring in the nearby medical assessment area. There were no instances of these facilities ever having been used.

Patients were given appropriate post-procedural patient information. There are policies and facilities in place to protect patients and staff that are hypersensitive to latex containing products.

Recommendations

The recommendations of the review group are as follows:

1. The service should be supported to create an additional post for a clinical psychologist, such as at Band 7.

2. Staff members should be actively encouraged to use DATIX to record, learn from, and improve practice around critical incidents.

3. Currently it seems that waiting time is the only performance indicator being tracked and analysed. We encourage the service to better utilize systems of clinical outcome assessment, and analyse the data regularly, so that it is knowns whether or how well the services are producing good clinical outcomes.

4. Operational policies should be instituted, such as in areas of consent, suicide, and managing co-morbid mental health problems.

5. Although there is local guidance on the ‘Pharmacological management of Chronic Non-Malignant Pain in /Non-specialist centres’ this should be updated to include most recent information in national resources, such as Opioids Aware. Consideration could be given to developing additional guidance that

would provide other healthcare professionals with directions on medicines that may be prescribed or recommended from specialist services to provide transparency about use of more specialised medicines.

6. Members of staff should participate in meetings focused on clinical governance and institute a regularly minuted meeting with a focus on clinical audit, risk management, clinical effectiveness, and training.

7. Staff training and development should be built in to staff working hours on a regular basis as a standard form of support for service quality.

8. Those leading the service should consider whether there is a higher efficiency, perhaps lower intensity, service that could be developed as an addition to the current format of the PMP. This could increase capacity.

Conclusion

Generally, we find the ABMU chronic pain services at or above the standard of most services operating in the UK NHS. We unearthed no significant safety risks or effectiveness concerns. At the same time there are a number of improvements that could be made to increase psychology resources, systematically collect and analyse critical incident and clinical outcome data, and to bolster systems to support good clinical governance, including particularly clinical audit, and staff support and training.

We recognize that this review was initiated from a past event of a staff complaint or complaints. On this, with the exception of one member of staff who remains significantly affected from these past events, the staff are either new to the service or have "moved on" from focusing on the past, and a number of improvements and positive initiatives have been made. The service is generally on a good footing with the exception that additional responses to meet high demand, without compromising quality, will be needed.

Respectfully Submitted by:

Lance M McCracken, PhD
Professor of Behavioral Medicine
King's College London
& INPUT Pain Service, GSTT

On behalf of the review team:

Dr Peter Brook, Consultant in Pain Management, Bath Centre for Pain Services & UHB
Professor Roger Knaggs, Associate Professor of Clinical Pharmacy Practice, University of Nottingham
Karen Sanderson, Advanced Nurse Practitioner, GSTT, London

External Review of ABMULHB Chronic Pain Service
ACTION PLAN - September 2017

Introduction

An independent review of Chronic Pain Services provided by ABMU LHB was commissioned by the Board. An executive director took the lead responsibility for establishing and coordinating the review, supported by key operational personnel. A chair for the review team was established who then gathered colleagues to establish a team with the necessary range of expertise and experience to undertake the review. The terms of reference were established, agreed by the executive team and provided to the review team. The review invitation was initiated on the 30th of November 2016 and agreed on 14 December 2016. Substantial supporting information on the chronic pain service and its performance was gathered and provided to the review team over a number of weeks and in advance of their visit. A site visit by the 4 members of the review team was completed over two days, on the 26th and 27th of April 2017. The draft findings were provided to the executive lead on the 20th of May, and the final report provided to the Executive Board on the 3rd July 2017. The final report was received by the Primary and Community Services Unit on the 6th September 2017.

Summary of External Review Report Findings

unearthed no significant safety risks or effectiveness concerns. At the same time there are a number of improvements that could be made to increase psychology resources, systematically collect and analyse critical incident and clinical outcome data, and to bolster systems to support good clinical governance, including particularly clinical audit and staff support and training."

The objective of this action plan is to

Deliver the required actions and outcomes following the external review of the ABMU LHB Chronic Pain Service in April 2017

Item	Area	Action	Lead	Outcome/Target	Timescale	Update	Progress (RAG)
1	Those leading the service should consider whether there is a higher efficiency, perhaps lower intensity, service that could be developed as an addition to the current format of the PMP. The service should be supported to create an additional post for a clinical psychologist, such as at Band 7.	Those leading the service should consider whether there is a higher efficiency, perhaps lower intensity, service that could be developed as an addition to the current format of the PMP. This could increase capacity. Review of current PMP model & recommend changes in line with evidenced based practice including team membership & levels of PMP	NB	PMP tiered model described in line with evidence base and best practice	April 2019	AMG group developed as possible alternative PMP remodel under way to me completed for April 2019	commenced
		Identify demand for Band 7 wte Psychologist following review of above	NB/SB	Tiered PMP Capacity and demand model developed	November 2017	Consideration of benefits of 8a.	Green
		Review Chronic Pain Pathway to identify potential funding sources for extra Band 7 Psychologist	CE/HS	Streamlined pathway in place releasing capacity/funding to increase psychology capacity.	December 2017		Green
		Identify current financial resource available	SB	Amount of available funding currently identified	August 2017	Awaiting discussion with finance	Green
			IWE	Amount of available funding currently identified	July 2017	£6k available in CP pay budget	Green
		If insufficient financial resources identified following review of current service paper to Unit board/LHB for financial report	SB	Shortfall in required funding following review of services made available	January 2018	no shortfall	Green

Item	Area	Action	Lead	Outcome/Target	Timescale	Update	Progress (RAG)
2	Staff members should be actively encouraged to use DATIX to record, learn from, and improve practice around critical incidents.	Concerns report standard agenda item on Service Audit/Governance/Business Meeting	SB	Increase in reporting of incidents including near misses	This was put in place prior to the review	This was put in place prior to the review	Green
		Organise Datix learning session at team meeting	EP	Increase in reporting of incidents including near misses	January 2019	planned for team meeting in 2019	
3	Currently it seems that waiting time is the only performance indicator being tracked and analysed. We encourage the service to better utilize systems of clinical outcome assessment, and analyse the data regularly, so that it is known's whether or how well the services are producing good clinical outcomes.	Implementation of coproduction PROM	DH/CE	Levels of patient activation measured and analysed.	March 2019	ongoing constraints with Cellma to implement changes - target date changed March 2019	
		Identify meaningful outcome measures for CPAT	CE	Outcomes of CPAT measured and analysed for all service users to demonstrate value or need for change in pathway.	Jan 2018	Outcomes identified. Ongoing review of measures	Green
		Implement and measure agreed outcomes in CPAT.	EP		Feb 2018		Green
		Identify meaningful outcome measures for Injection interventions.	CE	Outcomes of Injection interventions measured and analysed for all service users to demonstrate value or need for change in pathway.	Jan 2018		Green
		Implement and measure agreed outcomes in Injection interventions	EP		Feb 2018		Green
		Identify meaningful outcome measures for PMP	NB	Outcomes of PMP measured and analysed for all service users to demonstrate value or need for change in pathway.	November 2017		Green
		Implement and measure agreed outcomes in PMP	EP		November 2017		Green
4	Operational policies should be instituted, such as in areas of consent, suicide, and managing co-morbid mental health problems.	Review and Implement Service Operational Consent policy	CE/DH	Operational policy in place.	Dec 2017		Green
				All team have been activated to understood and implement policy	Jan 2018		Green
				No consent incidents or complaints received with failings	Jan 2018		Green
		Develop and implement Threat of Suicide Operational Policy	CE	Operational policy in place.	Dec 2017		Green
				All team have been activated to understood and implement policy	Jan 2018		Green
				No threat of suicide incidents or complaints received with failings	Jan 2018		Green
		Develop and Implement Policy on the	CE	Operational policy in place.	Dec 2017		Green

		Management of Co morbid Mental Health Problems		All team have been activated to understood and implement policy	Jan 2018		Green
				No Co morbid Mental Health Problems incidents or complaints received with failings	Jan 2018		Green
		Arrange non clinical learning and develop session in the process for dealing with suicidal behaviour	CE/EP	All non clinical team have been activated to manage the process of dealing with suicidal behaviour on the telephone. Confidence scores in dealing with this improved.	Dec 2017		Green
Item	**Area**	**Action**	**Lead**	**Outcome/Target**	**Timescale**	**Update**	**Progress (RAG)**
5	Update on the 'Pharmacological management of Chronic Non-Malignant Pain in /Non-specialist centres' to include most recent information in national resources, such as Opioids Aware. Consideration could be given to developing additional guidance that would provide other healthcare professionals with directions on medicines that may be prescribed or recommended from specialist services to provide transparency about use of more specialised medicines.	Update CID534	CE	Updated Evidence based pathway available and followed by all involved in the pathway across the LHB.	March 2018	Medical Director has requested a complete review	ongoing
		Additional guidance for HCP developed and communicated and added to Chronic Pain website	CE	Pathway followed by primary care GPs and pharmacists	March 2019	website still under review	
		Pathway for high opiod users	CE/NB	Reduction in high opiod use	Dec 2017	Requires review in relation to resources	
		Ensure GP input into updated guidelines (e.g. via Primary Care Prescribing Advisory Group) with ratification at Medicines Management Board	NA/CE	Pathway agreed and followed by primary care GPs and pharmacists	March 2018	further engagement required with medicine management	
6	Members of staff should participate in meetings focused on clinical governance and institute a regularly minuted meeting with a focus on clinical audit, risk management, clinical effectiveness, and training.	Standard agenda and papers including introduced to cover all areas.	SB	Increase in teams importance and confidence scores	Commenced prior to review	Commenced prior to review	Green
		Develop areas for audit	CE	Audit program in place	Dec 2017	Audit list produced	Green
7	Staff training and development should be built in to staff working hours on a regular basis as a standard form of support for service quality.	CPD and development time built into teams job plans	EP	CPD time available for team learning, development and reflection as demonstrated by PADR paperwork/PD portfolios.			Green