GOVERNMENT OF WESTERN AUSTRALIA

Sustainable Health Review

Public Submission Cover Sheet

Please complete this sheet and submit with any attachments to the Sustainable Health Review Secretariat

Your Personal Details ***This information will be used only for contacting you in relation to this submission***	
Title	Mr ☐ Miss ☐ Mrs ☐ Ms ☐ Dr X☐ Other ☐
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Publication of Submissions

Please note all Public Submissions will be published unless otherwise selected below

☐ I do not want my submission published

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Submission Guidance

You are encouraged to address the following question:

In the context of the Sustainable Health Review Terms of Reference listed below, what is needed to develop a more sustainable, patient centred health system in WA?

- Leveraging existing investment in Primary, Secondary and Tertiary healthcare, as well as new initiatives to improve patient centred service delivery, pathways and transition;
- The mix of services provided across the system, including gaps in service provision, sub-acute, step-down, community and other out-of-hospital services across WA to deliver care in the most appropriate setting and to maximise health outcomes and value to the public;
- Ways to encourage and drive digital innovation, the use of new technology, research and data to support patient centred care and improved performance;
- Opportunities to drive partnerships across sectors and all levels of government to reduce duplication and to deliver integrated and coordinated care;
- Ways to drive improvements in safety and quality for patients, value and financial sustainability, including cost drivers, allocative and technical efficiencies;
- The key enablers of new efficiencies and change, including, research, productivity, teaching and training, culture, leadership development, procurement and improved performance monitoring;
- Any further opportunities concerning patient centred service delivery and the sustainability of the WA health system.

Submissions Response Field

Please type your response into the field below. Alternatively you may provide your submissions as a separate attachment (Suggested Maximum 5 pages).

SUSTAINABLE HEALTH REVIEW

PAIN MEDICINE CONSIDERATIONS

Over the last ten years there have been several reports making recommendations for a better pain management delivery model for Western Australia.

The first was the Spinal Pain Model of Care published in May 2009 for the musculoskeletal health network which made six key recommendations for Western Australia. (http://www.healthnetworks.health.wa.gov.au/modelsofcare/docs/Spinal_Pain_Model_of_Care.pdf)

1. Increased knowledge of active pain management strategies for spinal pain in the community.
2. Develop work force capacity.
3. Inter professional education for all health care providers.
4. Support initiatives which improve earlier access to positive outcome based services for spinal pain across the health continuum.
5. Promote best practice for spinal pain management including integrated care and pathways across sectors.
6. Promote consumer health management of spinal pain across the continuum of health.
7. Facilitate information and communication technology tools and support systems for management of spinal pain in Western Australia.

A second document entitled WA Framework for Persistent Pain 2016 to 2021 (http://ww2.health.wa.gov.au/~/media/Files/Corporate/general%20documents/Health%20Networks/Musculoskeletal/160907_POL_WA%20Framework%20for%20Persistent%20Pain_Final%20for%20website.pdf)

developed these ideas further outlining objectives of the framework to:

1. Increase in the awareness of the burden and the impact of persistent pain in WA.
2. Improving clinical management of persistent pain.
3. Improving navigation of and access to persistent pain services.
4. Improving the integration of care for people with persistent pain.

In parallel with these two documents the Director General of Health supported by the chief executives across WA Health, was the development of a state wide integrated tertiary service model for chronic pain. (pdf attached)

These documents clearly identify recommended efficiencies which could lead to significant improvement in patient centred care across WA Health. Unfortunately there has only been limited progress in achieving the recommendations from these three documents.

The reasons for this are legion and not necessarily related to funding. The development of the metropolitan boards and the metropolitan area health authorities has created silos which have prevented development of state wide services. It is not clear that area health services are willing to share resources between other health services.

Silos within the area health services for medical, nursing, allied health and administration prevent efficient distribution of FTE both within an area health services and between area health services.

Submissions Response Field

Please type your response into the field below. Alternatively you may provide your submissions as a separate attachment (Suggested Maximum 5 pages).

On a more positive note and at the same time WA Primary Health Authority has also been developing plans for community based pain management. This is strongly supported by the tertiary pain service and good communication pathways between WAPHA and the State Wide Pain Service are in place.

The Health Pathways project addresses best practice management of spinal pain and hopefully will allow General Practitioners to make more appropriate referrals into the integrated tertiary pain service.

The PainHealth website has proved a very useful educational tool not only for Western Australia but around the world. If properly supported it could do much more in terms of community education.

The development of multidisciplinary group based CBT style treatment programs for more complex patients is somewhat hindered by the silo effect.

Individuals injured by motor vehicle crashes or in the work place are sometimes disadvantaged by the inability of the private sector to provide group based cognitive behavioural training programs. This is something that could bring additional funding into health. It happens in other states. It seems impossible in WA.

In summary these documents give considered and practical ways for delivering best practice pain services to the WA community, however without significant central support the multitude of barriers will continue to prevent the delivery of these concepts to the WA community.

Roger Goucke

Director State Wide Pain Service

Chronic Pain Medicine

Integrated Tertiary Service Model:

Working Towards a State-wide Service

Version 1.0 - Final

Document History

Version #	Version Date	Author	Description (including summary of changes)
0.1	1 September 2015	Robyn Timms Olivia Berry	Preliminary document initiated following the first meeting with the working group on 31 August 2015.
0.2	21 October 2015	Roger Goucke Robyn Timms Olivia Berry	Incorporation of key feedback from stakeholder workshop.
0.3	14 December 2015	Joel Gurr Robyn Timms	Complete review of the document. Additional information and data requested.
0.4	11 January 2016	Joel Gurr Roger Goucke	Preparation of the document into a format for distribution and feedback.
0.5	22 February 2016	Joel Gurr	Document distributed for feedback.
0.6	24 March 2016	Joel Gurr	Stakeholder feedback incorporated prior to distribution to Executive for review.
1.0	11 April	Joel Gurr	Endorsed by CEs and Director General

Document Review

I, the undersigned confirm that this document content is true in nature and substance, and that its contents accurately reflect its purpose.

Name	Title	Signature	Date
Dr Roger Goucke	Project Clinical Lead A/Head of Service, Pain Medicine, Fiona Stanley Hospital		
Dr Stephan Schug	Head of Department, Pain Medicine, Royal Perth Hospital		
Dr Max Majedi	Head of Department, Pain Medicine, Sir Charles Gardiner Hospital		

Document Approval

I, the undersigned, have approved this document.

Position/Title	Name	Signature	Date
Dr Robyn Lawrence	A/CE SMHS and Executive Sponsor		
Mr Wayne Salvage	A/CE NMHS		
Dr David Russell-Weisz	Director General		

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Acronyms

ABF	Activity Based Funding
AEG	Area Executive Group
AH	Allied Health
AHS	Allied Health System; or Armadale Health Service
ANZCA	Australian and New Zealand College of Anaesthetists
AP	Advanced Practice
APS	Acute Pain Service
BIU	Business Intelligence Unit
CAHS	Child and Adolescent Health Service
CE	Chief Executive
CPAC	Clinical Priority Access Criteria
CRS	Central Referral Service
CSF	Clinical Services Framework
CSP	Clinical Services Plan
DoH	Department of Health
DRG	Diagnostic Related Group
EMHS	East Metropolitan Health Service
ePPOC	electronic Persistent Pain Outcomes Collaborative
FH	Fremantle Hospital
FPM	Faculty of Pain Medicine
FSH	Fiona Stanley Hospital
FTE	Full Time Equivalent
GP	General Practitioner
HOD	Head of Department
HSIU	Health System Improvement Unit
ICT	Information and Communications Technology
JHC	Joondalup Health Campus
KEMH	King Edward Memorial Hospital
KPI	Key Performance Indicator
LEAP	Life-style Education Activation Program
MDCs	Major Diagnostic Categories
MOU	Memorandum of Understanding
MPH	Midland Private Hospital
NAPAWL	Non-Admitted Patient Activity and Waitlist
NMHS	North Metropolitan Health Service
OPH	Osborne Park Hospital

PAS	Patient Administration System
PEP	Pain Education Program
PCH	Perth Children's Hospital
PHNs	Primary Health Networks
PMH	Princess Margaret Hospital
PUMP	Pain Understanding Management Program
RPG	Royal Perth Group
RPH	Royal Perth Hospital
SCGH	Sir Charles Gairdner Hospital
SE	Service Event
SHEF	State Health Executive Forum
SLA	Service Level Agreement
SMHS	South Metropolitan Health Service
SPC	Shenton Park Campus
STEPS	Self Training Educative Pain Sessions
WA	Western Australia
WACHS	WA Country Health Service
WAMS	Working Across Multiple Sites
WAPHA	WA Primary Health Alliance
WAU	Weighted Activity Unit
WSC	Wellington Street Campus

1. Background and Context to the Proposal

1.1 Overview of Chronic Pain Medicine

Chronic pain medicine is a multidisciplinary medical practice involved with the management of persistent pain problems. The specialist pain medicine physician serves both as a consultant to other physicians and often as the principal treating physician. The spectrum of care provided by a pain specialist includes prescribing medication, coordinating rehabilitative services, performing pain relieving procedures, counselling patients and families, directing a multidisciplinary team, cooperating with other healthcare professionals and liaising with public and private agencies. The chronic pain services usually comprises of medical, nursing and allied health professionals and is across the spectrum of admitted and non-admitted services.

Persistent or chronic pain is seen in every age group from paediatric to geriatric, and across all medical and surgical disciplines. Because of the complexity of persistent pain problems, multidisciplinary pain clinics have been developed throughout Australia and New Zealand. The clinics harness the inputs of a range of medical and allied health professionals to assess the biopsychosocial aspects of the patients and to formulate appropriate programs of treatment aimed at control of pain and improvement in function as well as maximising quality of life. Equally important, these multidisciplinary pain clinics also provide clinical training and clinical research in pain medicine (Faculty of Pain Medicine ANZCA, 2015).

1.2 Background

The 2014 transition of chronic pain services from Fremantle Hospital (FH) to Fiona Stanley Hospital (FSH) precipitated a discussion amongst stakeholders as to the potential benefits of a State-wide chronic pain service across the metropolitan tertiary sites. This notion had been proposed previously, however the difficultly in successfully recruiting to the FSH pain management positions was in part the catalyst for formal agreement to further investigate this option at a meeting in May 2015 attended by representatives from Anaesthesia and Chronic Pain Medicine from Sir Charles Gairdner Hospital (SCGH), Royal Perth Hospital (RPH) and FSH. This meeting was also attended by Dr David Russell-Weisz, who advised that the establishment of an integrated tertiary chronic pain service would be supported by him in principle in his impending role as the Director General (DG) of the Department of Health. The A/Chief Executive for South Metropolitan Health Service (SMHS), Dr Robyn Lawrence, agreed to support this process both as an executive sponsor and with the provision of project support. Dr Roger Goucke, FSH A/Head of Service Chronic Pain, agreed to act as the project's Clinical Lead.

Notably and concurrently, chronic pain medicine was one of the specialities recommended for system-wide action planning and implementation support in relation to the *WA Health Clinical Services Framework 2014-2024* at a workshop held on 19th June 2015. The workshop was facilitated by the Health System Improvement Unit (HSIU) and involved participants from all health services and a range of stakeholders.

1.3 Drivers for Reform

In the Western Australian context, stakeholders identified a number of drivers for reform in the speciality of chronic pain medicine. These included but were not limited to:

- Three independent services with no linked governance across WA Health, resulting in services being delivered in silos. This has resulted in:
  - inequitable waitlists between sites, with a significant waitlist at RPH;
  - different service delivery models between sites;
  - variable care pathways for patients depending on their postcode catchment and/or which site they are referred;

- duplication of some components of services; and
- patchy links to primary care services, confounding the success of post discharge follow up and long term community management.

- Increasing waitlist times, exacerbating the complexity of the medical and socioeconomic comorbidities associated with the degenerative effects of chronic pain, particularly with increasing age.
- High levels of opioid dependency worsened by extended waiting times for medication reviews.
- A small workforce with limited pain medicine physicians and specialised allied health teams.
- Limited access for leave relief across sites which exacerbates the waitlist burden.
- Insufficient specialist resources to provide education and support to primary care clinicians, including information to facilitate General Practitioners' management of medication plans and referral to community services.
- Increasing incidence and complexity of medical and socioeconomic comorbidities in the chronic pain population.
- A severe shortage of pain medicine physicians in Australia and an unsustainable medical workforce arrangement at FSH.
- Inconsistent education materials for people referred to chronic pain services, such as information to promote self-management strategies while waiting for an appointment.

1.4 Persistent Pain Framework

Further adding to the impetus to better integrate WA tertiary chronic pain services is the WA Health Networks' progression of a chronic pain management framework. The Networks' Pain Health Working Group has developed the draft *WA Framework for Persistent Pain: 2016-2021* with the aim to provide the user with an accessible, logical and practical framework for the systematic provision of management processes for persons experiencing persistent pain in WA. The priority areas for the Framework include professional and community education, clear patient pathways, access to care, enhancing outcomes, and optimisation of funding. The latter can be achieved through ensuring care is provided in the most appropriate setting by the appropriate team and reducing any duplication of services. An integrated tertiary service would potentially support this framework by ensuring consistent chronic pain management services are available across the tertiary services to integrate with general hospital sites and primary health care.

1.5 Primary Care Setting

Meanwhile in the primary care setting, a national restructure of the previous Medicare Locals has resulted in three Primary Health Networks (PHNs) in WA for the north and south metropolitan areas and the country; all with a single overarching administrative body. One key reform of the WA PHNs is the adoption of a software program, HealthPathways WA. This is a web-based portal with information on referral and management pathways helping clinicians to navigate patients through the complex primary, community and acute health care system in WA. It is designed to be used at the point of care by GPs, and chronic pain management is one of the pathways prioritised for implementation. The tool will have input from tertiary sector service providers on areas such as information to assist community clinicians' management of people with chronic pain, including detailed referral criteria for tertiary services. The goal of this is to better manage people with chronic pain in the community, minimise unnecessary tertiary referrals and aid direction to the appropriate level of care/service.

1.6 Development of the Proposal for a Tertiary Chronic Pain Service Model

Nationally and internationally, clinical services are moving towards integrated models of care to improve access to services and optimise funding and resources. For some specialties such as chronic pain management, an integrated tertiary chronic pain service is being considered to better connect public hospitals and health services to:

- enable coordinated and streamlined clinical care;
- promote equity of access;
- deliver services closer to patients' homes where possible;
- better utilise resources across the system, particularly community services; and
- facilitate appropriate clinical education and contemporary treatment.

This is highly applicable for chronic pain management services, which cross the continuum from the primary to the tertiary sectors.

The known barriers to delivering high quality, cost effective care to people with chronic pain, the identified need from multiple layers for system-wide action planning and reform, and the momentum of primary health care initiatives has precipitated the timely development of a proposal for an integrated tertiary service model for chronic pain medicine in WA.

2. Project Approach to Developing the Proposed Integrated Tertiary Chronic Pain Service Model

2.1 Project Objective and Scope

The primary objective of the project was to develop and document a proposal to integrate the governance of the three adult tertiary chronic pain medicine services as the first key step towards a State-wide model. Out of scope for the project were chronic pain medicine services at Princess Margaret Hospital (PMH), King Edward Memorial Hospital (KEMH), WA Country Health Service (WACHS), general and specialist hospital sites and community services. In addition, acute pain medicine or anaesthetic services were not in scope.

2.2 Project Outcomes

The desired outcomes for the project were two-fold:

a) obtain consensus amongst key stakeholders for a documented integrated tertiary chronic pain service model across the adult tertiary sites; and

b) achieve endorsement by the relevant Area Health Service Chief Executives and the Director General to implement the model.

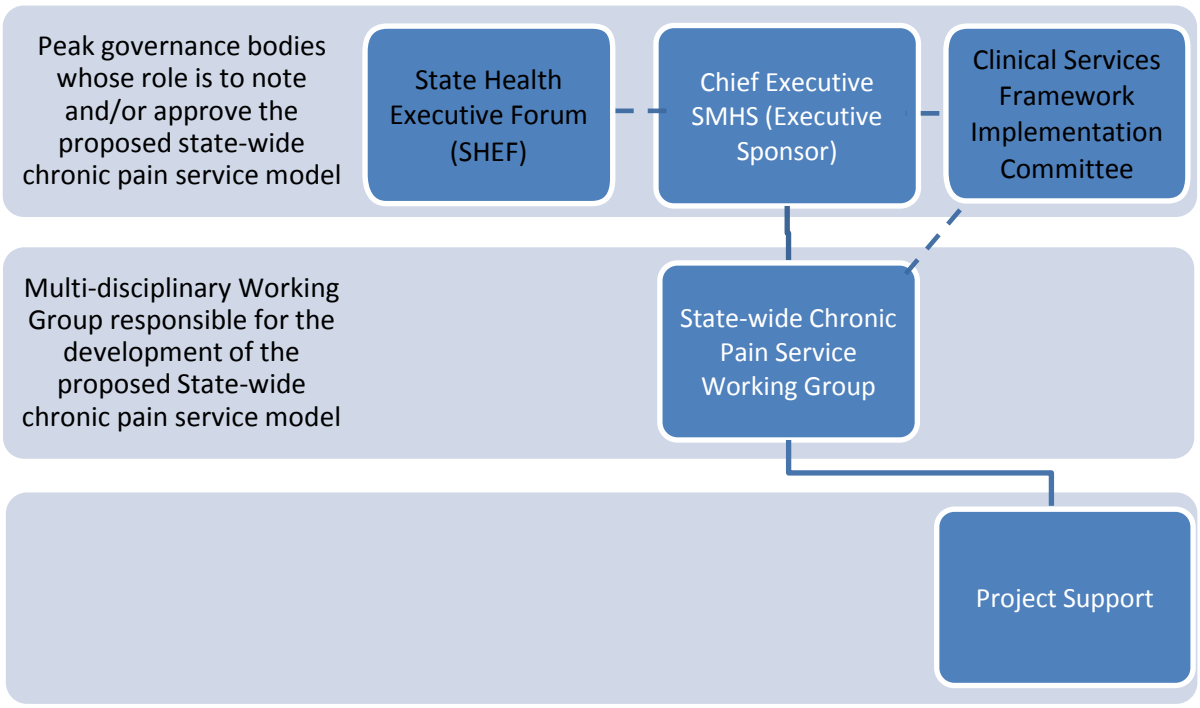
2.3 Project Assumptions and Constraints

The key requirement for any proposal developed was that it was Full Time Equivalent (FTE) neutral, with the service required to operate within its current resources allocated under an activity based funding model.

2.4 Project Governance

The overarching project governance is outlined in Figure 1. The Executive Sponsor for the project (A/Chief Executive SMHS) is responsible for progressing the proposal once complete for endorsement to the Chief Executive NMHS. Towards the end of the project the establishment of the East Metropolitan Health Service (EMHS) was announced. The EMHS is not operational until 1 July 2016 and the Chief Executive SMHS retains accountability for RPH until that time.

Figure 1: Project Governance Model



2.5 Project Resources and Role

Executive Sponsor: Dr Robyn Lawrence, A/CE SMHS

- Provides strategic direction and oversight of the service model; including advice on preferred options and caveats associated with options.
- Chairs working group meetings as required, pending availability.
- Provide executive sign off of the final, working group-endorsed, service model; and table the document at relevant executive forums including the Clinical Service Framework Steering Committee and State Health Executive Forum (SHEF).

Project Clinical Lead: Dr Roger Goucke, A/Head of Service Chronic Pain, FSH

- Provides project oversight in the context of the clinical profession, including ensuring clinical risks and considerations relevant to the profession are addressed.
- Facilitates stakeholder identification and management of clinical stakeholders; including management of stakeholder expectations.
- Provides advice on the clinical considerations pertinent to achieving the project deliverables within scope and timeframe.
- Escalates clinical risks as appropriate.

Project Manager: Robyn Timms, A/Senior Project Coordinator SMHS

- Oversees overall project management and provides project leadership and direction.
- Facilitates and manages stakeholder engagement and liaison; including participating in stakeholder identification and appropriate management strategies.
- Manages project processes and ensures deliverables are provided on time and within scope.
- Advises relevant senior stakeholders and the Executive Sponsor of project progress.

Project support: Olivia Berry, A/Senior Project Officer SMHS

- Manages project documentation and processes including timeline tracking; stakeholder and communication management; documentation.
- Participates in and facilitates stakeholder engagement, including formal documentation, and preparation of minutes.
- Documentation and follow up of project actions.
- Feeds up to Project and Clinical Leads relevant updates; escalates issues as required.

2.6 Stakeholder Consultation

As part of the planning and development of this proposal, the project team actively engaged with the broad stakeholders who deliver and manage pain services in WA, to ensure the effective scoping and development of an integrated tertiary service model for pain management across WA Health. There was strong engagement and support for reform to better align the service model across WA as well as work collaboratively. Table 1 identifies the key stakeholder consultation events. Members of the State-wide working group are listed in Appendix 7.

Table 1: Stakeholder Consultation events			
Meeting date	Location	Attendees	Purpose
Working Group meetings			
31 August 2015	FSH Board room	• Project working group members; • Heads of Department of Anaesthetics/ Pain at SCGH, RPH and FSH; • Co-Directors FSH and RPH • A/CE SMHS and A/CE NMHS (Proxy V Cheng)	• To update attendees on the impetus for an integrated chronic pain service • Gain approval for reviewing sites' services • Gather insights into major issues and risks with existing services • To obtain site/service approval for the commencement of an integrated tertiary pain service plan document.
28 October 2015	FSH Board room	As above, but with • FSH Allied Health Executive • Health Network Directorate	• Update group on progress. • Gain approval for proposed governance model.
Site consultation			
08 October 2015	FSH Anaesthetics Department	• Dr Alex Swann, HOD Anaesthetics FSH • Ms Kate Ternahan; Clinical Nurse Consultant FSH • Dr Roger Goucke, HoS Pain FSH	• Collect information for FSH chronic pain service; FTE; staff profile; clinic management, clinic codes.
14 October 2015	RPH Chronic Pain Department	• Dr Stephan Schug, HoD Pain RPH	• Gather information about RPH chronic pain service; FTE; staff profile; clinic management, clinic codes.
19 October 2015	SCGH Chronic Pain Department	• Ms Denise Fairclough, Clinical Nurse Manager SCGH • Ms Vicky Leone, Administrative Coordinator SCGH	• Gather information about SCGH chronic pain service; FTE; staff profile; clinic management, clinic codes.
23 November 2015	RPH Chronic Pain Department	• Dr Stephan Schug, HoD Pain RPH	• Confirm clinic data.
16 November 2015	Via email	• Dr Roger Goucke, HoS Pain FSH	• Confirm clinic data.
Allied Health, Nursing and Medical workshop			
20 October 2015	SCGH Chronic Pain Department	• See below (2.6.1)	• See below (2.6.1)
Clinical Network Leads and staff			
22 July 2015	SCGH Anaesthetics Department	• Dr Ce Kealley, Senior Development Officer Health Network Directorate • Dr Roger Goucke, HoD Pain FSH	
15 October 2015	FSH Board room	• Clinical Network Leads and staff	

2.7 Pain Management Workshop

On 20 October 2015, a planning workshop was held with participants from medicine, nursing and allied health from the three tertiary sites. The purpose of the workshop was to communicate and inform current service providers of the rationale, potential changes and anticipated benefits of the development of the State-wide pain service as well as identify key priorities across services. There was very positive support from all three tertiary site staff to progress towards an integrated service. Key outcomes that align with the current planning for the integrated tertiary service included support for: progression to a single service triage to promote consistency and equity, development of a system for equitable waitlist, agreement to process all external referrals through the Central Referral Service (CRS), opportunities to have one point of contact for GPs, and support to align content and naming of group programs across health services. The information from the workshop has been included in identifying priorities and next steps.

3. Overview of Current Adult Tertiary Chronic Pain Management Services in WA

3.1 Service Description and Role Delineation

Chronic pain services operate across all three adult tertiary sites. The *WA Health Clinical Services Framework 2014 -2024 (CSF 2014)* outlines the role delineation for RPH, FSH and SCGH as Level 6/VI pain medicine services. Appendix 3 provides a role delineation comparison for all pain medicine services in metropolitan WA hospitals, whilst Appendix 4 and Appendix 5 provide service definitions by level for inpatients and outpatients. These existing services have generally functioned and operated independently under the governance of each tertiary site's management structure. The chronic pain service comprises medical, nursing and allied health professionals and is across the spectrum of admitted and non-admitted services.

The chronic pain services for admitted patients comprise medical consultation and procedural services. Non-admitted services include medical and individual allied health professionals as well as multidisciplinary pain group education programs. Management of chronic pain includes psychological counselling, interventional anaesthetic techniques, cognitive behavioural therapy, exercise therapy and pharmacological management.

3.1.1 Admitted Services

The inpatient medical consultation service is a necessary tertiary service for patients where they have been admitted under another medical or surgical speciality and have pain as a complication of their presenting complaint or that develops during the admission. The case load of the consultation service is highly variable depending on the complexity and number of referrals from the various admitting specialities. The service works in partnership with the Acute Pain Service (APS) which provides input for short term pain management, often following a surgical procedure.

Chronic or persistent pain services are for more complex and ongoing pain management requirements. The time allocation for this inpatient referral service is generally a session or half a day. The medical consultants also provide a same-day admission service for procedures such as injections for musculoskeletal disorders. This service occurs in scheduled sessions for patients that have been referred from an inpatient occasion, or from outpatient services, and require a procedure.

3.1.2 Non-admitted Services

The non-admitted services are generated by referrals from General Practitioners, other specialists in outpatient clinics or from admitted services where patients are seen post discharge. Generally these patients are triaged by the Head of Department/Service and may have the first appointment with a medical consultant. Often they are referred to allied health professionals either for individual appointments such as physiotherapy, psychology or occupational therapy or group education sessions. The group education sessions comprise a short course that is generally two days as an introduction to understanding pain and a longer program over 3-5 weeks.

The longer program is for patients with more severe persistent and ongoing pain and often includes cognitive behavioural therapy by a Clinical Psychologist as well as exercise, meditation and pacing strategies provided by a Physiotherapist or Occupational Therapist. The programs across the three sites are titled differently and have slightly different program content as described in section 3.2.

3.2 Service Summary by Adult Tertiary Site

3.2.1 Sir Charles Gairdner Hospital

The WA Pain Management Centre at SCGH provides a multidisciplinary approach to all aspects of chronic pain with close liaison between medical, physiotherapy, psychology, occupational therapy and nursing personnel. The inpatient and outpatient services at SCGH also include an active palliative care service. Country patients are encouraged to consult using Telehealth. Special interests of the Centre include cancer pain, spinal cord stimulation and intrathecal drug administration systems.

There is a strong network that links pain related services within SCGH via the SCGH Pain Committee, which includes the Acute Pain Service (APS), the Chronic Pain Service (CPS) and the Palliative Care Service medical and nursing coordinators. Communication also includes a weekly face to face meeting between the APS and the CPS at which individual patients' cases are discussed and, where relevant, are handed over from one service to the other.

The SCGH staffing profile is outlined below in Table 2. Most staff are line managed by the Head of Department of Pain Medicine except nursing staff who are line managed by the Nurse Co Director Surgical Services.

Table 2: SCGH staffing profile

Profession	Allocated FTE
Medical Specialist (Pain)	2.0
Fellows/Registrars	2.0
Clinical Psychology	1.0
Physiotherapy	1.0
Occupational Therapy	0.2
Nursing	3.4

3.2.2 Royal Perth Hospital

In 2014, persistent pain services at the RPH Shenton Park Campus were relocated to the RPH Wellington Street Campus. The Chronic Pain Medicine Unit is part of the broader and comprehensive Anaesthesia and Pain Medicine Service. The service has a strong multidisciplinary delivery model similar to other sites across admitted and non-admitted services. The case-mix at RPH is influenced by the lower socioeconomic factors for the catchment area.

The Pain Medicine Service provides a short course group education program, Pain Education Program (PEP), and a longer course Life-style Education Activation Program (LEAP). The service also provides individual practitioner and multidisciplinary assessments including Telehealth.

The RPH staffing profile is outlined below in Table 3. RPH's staffing profile and reporting lines are different to that of SCGH and FSH. The Pain Medicine specialists report to the Anaesthetics Department via the Head of Department, the allied health professionals to their respective Heads of Department and nursing staff to their nursing line managers.

Table 3: RPH staffing profile	
Profession	**Allocated FTE**
Medical Specialist (Pain)	1.0
Registrar	1.0
Psychiatry	0.1
Rheumatology	0.05
Clinical Psychology	0.7[#]
Physiotherapy	1.2*
Occupational Therapy	0.2*
Nursing	3.8*

*FTE is an estimation as the service is provided by another department on an as-need basis

[#] Increased by 0.2 FTE in October 2015 as there was an identified lack of clinical psychology support for group programs and individual consultation with a potential impact on accreditation of the RPH Pain Medicine Unit as a training unit.

3.2.3 Fiona Stanley Hospital

Like RPH, chronic pain medicine at FSH is part of the broader and comprehensive Anaesthesia and Pain Medicine Service. The Pain Medicine Service transferred from Fremantle Hospital in 2014, as part of SMHS reconfiguration.

Inpatients requiring chronic pain consultations are seen by a pain medicine specialist on Tuesdays and Thursdays. Outpatient services include a range of clinics providing pain education and management programs for patients with persistent pain. Services include individual consultations in outpatient clinics and multidisciplinary assessments similar to other tertiary sites. The service provides a medical consultant, nurse and a range of other health care professionals including but not limited to an Occupational Physician, Clinical Psychology, Psychiatry, Physiotherapists and Occupational Therapists.

FSH provides education courses similar to other sites. The Self Training Educative Pain Sessions (STEPS) program is a four module program run over two days by the Pain Team (Occupational Therapist, Physiotherapist, Clinical Psychologist, Pain Specialist) providing information and skills in a broad pain management plan designed to optimise treatment outcomes. The Pain Understanding Management Program (PUMP) is a 5-week (55 hour) program with a Physiotherapist and Clinical Psychologist. Telehealth is also available and actively promoted for utilisation for country patients.

At present the pain medicine physicians at FSH are on secondment from both SCGH and RPH. Substantive appointments remain at the parent site for each of these clinicians. The FSH time is provided as part of their current contract and costed to FSH. It is important to note that interventional procedures for same day and multi-day were planned to be delivered at FSH post opening however, due to lack of specialist medical FTE, this activity has been transferred to RPH and SCGH.

The FSH staffing profile is outlined in Table 4 below. As with RPH, nursing staff report to a nursing line manager. In Allied Health all the disciplines report to the Allied Health Head of Service 1.

Table 4: FSH staffing profile	
Profession	**Allocated FTE**
Medical Specialist (Pain)	1.60 *
Registrar	1.0 #
Clinical Psychology	1.0
Physiotherapy	0.5
Occupational Therapy	0.4
Nursing	0.5

*Currently only filled at 1.25 FTE
Technically based at RPH as FSH has yet to receive college accreditation. Registrars rotate through the site

3.2.4 Other Tertiary Services

Additional pain services that operate at tertiary sites are based at King Edward Memorial Hospital (KEMH) and Princess Margaret Hospital (PMH). The KEMH service is a multidisciplinary clinic formed by a group of clinicians that have an interest in pelvic pain. The staff involved include: Psychology, Pain Medicine, Physiotherapy and Gynaecology. The PMH clinic runs 3-4 days a week and includes Anaesthetics Pain Specialist, Paediatric Rheumatology, Clinical Psychology, Physiotherapy, Occupational Therapy and a teacher. These services are out of scope for the initial phase of forming a State-wide service, however along with the general and specialist hospital sites should be considered as part of a potential phase 2.

3.3 Referrals and Activity

The process for acquiring robust historical data for chronic pain services is complex. The distinct nature of existing governance structures between the tertiary sites has engendered varying triage, referral patient administration processes and business rules which makes comparison difficult. Despite this, the data that was able to be obtained – whilst not perfect - does provide some important insights into the current services. It will be critical going forward to ensure all activity is captured consistently across all three sites to enable more robust activity comparisons and transparency. Given the increased focus on clinical service funding based on recorded activity and ongoing attention to appropriate clinical coding, data collection across WA Health will continue to improve.

An additional confounding issue for robust data analysis is the variation of activity with the significant changes for the clinical services following the reconfiguration within SMHS over the last two financial years. The pain management services at RPH Shenton Park Campus (SPC) moved to the Wellington Street Campus (WSC) in October 2014. Pain Services at Fremantle Hospital closed in December 2014 and the services were moved to FSH which opened in February 2015. These changes have significantly impacted on the data collection and activity in the 2014/2015 financial year. Due to the health service reconfiguration process it has been assumed there has been reduction in activity in 2014/2015, when services were reduced for significant periods or were being commissioned at the new site.

3.3.1 Methodology

The majority of the data presented in this section is from the Non-Admitted Patient Activity and Waitlist (NAPAWL) data collection and the inpatient data set. NAPAWL is the data source recommended for estimating Activity Based Funding (ABF) reportable non-admitted service events in WA Health and has been utilised for modelling for purchased activity funding. The data reviewed has been sourced from both NMHS and SMHS Strategy and Planning Directorates or equivalent for activity up until 28 October 2015.

Procedure codes are: 10.14 *Pain management interventions*; Medical codes are 20.03 *Pain Management*; and Allied Health codes are 40.03 *Aids and Appliances*; 40.06 *Occupational Therapy*; 40.09 *Physiotherapy*; and 40.12 *Rehabilitation*. Information on the national definitions for the outpatient clinic numbers for Tier 2 codes is provided in
Appendix 8.

From the last three financial years' data, the medical clinics (non-admitted) activity has been recorded consistently, as this is mandated and there are dedicated clerical resources to record this activity. The other key issue for the NAPAWL data is Allied Health Departments have only relatively recently been mandated State-wide to collect information in their Patient Administration Systems (PAS). Allied Health Departments were previously collecting clinical activity in the state based application Allied Health System (AHS) and some departments were also recording in PAS. As a result, it is challenging to estimate and compare across sites the activity for Allied Health allocated to pain management. Further complicating data analysis is the fact that, between sites and specialties, there is inconsistent definitions and capture of information.

During the data collection and analysis process,, the project team met with representatives at each tertiary site to further understand and validate the current data. In the process of this review, clinicians and clerical staff expressed differences in the activity level reported. Further work is required to ensure all activity is accurately captured in PAS and identified as pain activity in the future. The inconsistency of data collection is an issue that is not uncommon across WA Health.

3.3.2 Referrals

Referrals are currently from three primary sources: the CRS; internal referrals from internal hospital clinics, inpatient admissions or Emergency Departments and referrals direct to sites from GPs or Specialists.

The referral is triaged at each site once received, utilising the three clinical priority access criteria (CPAC) as outlined in Table 5 below:

Table 5: Clinical Priority Access Criteria (CPAC) for Pain Medicine

CPAC 1	Urgent	1 week		• Severe cancer pain. • New complex regional pain syndrome. • Acute Zoster.
CPAC 2	Semi-Urgent	1 month	Painful condition with intermediate duration of symptoms and progression/deterioration and risk of increasing functional impairment.	• Acute back pain becoming chronic and resulting in development of new disability/ functional impairment. • Patients with pain management conditions who concurrently have a mental health co-morbidity/ condition.

Table 5: Clinical Priority Access Criteria (CPAC) for Pain Medicine				
CPAC 3	Routine	3 months	Persistent long-term pain condition where rapid progression/deterioration is unlikely, maintenance treatment has been started or review/reassessment has become necessary.	• Postherpetic neuralgia. • Chronic back pain with established disability/functional impairment. • Persistent pain (not further specified) requiring specialist assessment and treatment. • Established long-term treatment with opioids requiring renewal of authorisation.

(Specialist Adult Clinical Priority Access Criteria, 2014)

The numbers of referrals that are able to be tracked accurately are from the CRS data. The referrals are currently distributed to the three sites by postcode; or, if a patient has been seen in the last 5 years at a service they are referred to the same site, despite their postcode. Referral to a named medical specialist overrides the postcode rule. Triaging is currently completed by the Head of Department or the nominated medical consultants at each site whether they come via the CRS or directly from the GP to the site.

The CRS provided data over the past 18 months outlining referrals to the three tertiary sites including RPH, SCGH and FSH/FH (Appendix 1). From recent data (2015) the total referrals between all sites ranges from 202 to 314 referrals per month via the CRS at an average of 247/month. The data suggests that the distribution of referrals is FSH (45%), RPH (30%) and SCGH (25%) via the CRS, noting that this is only one component of the overall referrals as sites still receive referrals directly from other health professions which are not all processed through CRS. The data also shows a trend of an increasing percentage of patients being seen in their catchment, which is likely as a result of the positive influence of the CRS.

3.3.3 Outpatient or Non-Admitted Waitlist

As noted at the beginning of section 3.3, the comparability of data is challenging due to variations in processes between sites which includes acceptance criteria of referral source; use of the CRS; documentation of referrals (including varying electronic record keeping software and practices); clerical management of referrals; quality of the information in the Patient Administration Systems and different Patient Administration Systems at tertiary sites. While definitive data is limited on waitlists, medical consultants that work across the three sites report anecdotally that the wait time is 3-6 months at SCGH and FSH compared with up to 2 years wait time for routine cases at RPH. This has resulted in significantly varied wait times for first appointments for patients depending on the site to which they are referred.

In late 2015 RPH undertook an audit of their Pain Medicine waitlist. Of 318 new referrals (up until 31 March 2015), 148 (47%) were removed from the waitlist after indicating (or not indicating via nil response) that an appointment was no longer required. What is unclear is the percentage of patients who chose not to pursue assessment and treatment due to the extended waiting time for a first appointment.

3.3.4 Admitted Activity

Table 6 below outlines inpatient separations with the discharge speciality of Pain Medicine. The activity at SCGH is reasonably consistent activity over the three years with 1071 episodes in 2012/2013, 978 in 2013/2014 and 1138 in 2014/2015. Activity at RPH was 480 in 2012/2013 and 417 in 2013/2014. The activity in 2014/2015 has significantly reduced from 400+ to 72 which appears to suggest a data recording issue and likely aligns with the transfer of the service to the Wellington Street Campus in October 2014. There is limited data available thus far for FSH given that service is in its infancy. For the two years of relatively reliable data

(12/13 and 13/14) the spilt between SCGH/RPH inpatient separations were approximately two-thirds/one third respectively.

The ward round/consultation workload is highly variable, but a necessary component for inpatient service provision. The chronic pain component is often part of complex care provision for people and often not recorded in the primary codes.

Table 6: Number of Inpatient Separations with Discharge Specialty of PAIN or PAI, 2012/13 - 2014/15 YTD

Financial year	Hospital site	Separations
2012/13	FH	54
	RPH	480
	SCGH	1071
2013/14	FH	88
	RPH	417
	SCGH	978
2014/15	FH	51
	FSH	8
	RPH	72
	SCGH	1138

Source: SMAHS Datawarehouse: tblInpatients; Date Range: 01 JUL 2012 – 30 JUNE 2015 (DischargeDateTime); Exclusions: None; Inclusions: Separations with a DISCHARGE SPECIALTY of PAIN or PAI.; Date: 29/10/2015

3.3.5 Non-Admitted Activity

The non-admitted data is comprised of medical and allied health activity in PAS. Nursing specific activity is not captured in the PAS or in any other system. Table 7 below illustrates the activity data for non-admitted pain management services across the three tertiary sites over the last three financial years and year to date (as at 28 October 2015). The data suggests that SCGH is consistently 50% of the total non-admitted activity across the State with RPH and current FSH services approximately 25% each at present.

The non-admitted trend information is reasonably consistent, especially in 2012/2013 and 2013/2014 pre-SMHS reconfiguration and for pain management medical consultations (Code 20.03). Allied Health, however, is quite variable year on year. As has been stated in this document, the allied health data is not comprehensive as data collection across all the Tier 2 allied health codes has not been recorded consistently at sites. The activity for group based education programs is not clearly evident within the data. Work is ongoing within the Department of Health to better capture, identify and consistently classify these multidisciplinary clinics, to ensure they attract the correct Activity Based Funding (ABF). A State-wide Operational Directive to record all activity on the PAS was enforced for 2014/15 to ensure Allied Health was compliant with the national definitions for recording of activity for Activity Based Funding (ABF). This should lead to consistency in the future.

Other data obtained comparing the new to follow-up appointment ratio for outpatient appointments (Code 20.03) at the tertiary sites showed an interesting trend. For SCGH the ratio of new to follow appointments was relatively low at 1:1.9 in the past 2 years. RPH by comparison was higher ranging between 1:2.5 to 1:3 and FH higher again at 1:3 to 1:35 in its last two full years of operation (NB: the limited FSH data did not allow for an accurate comparison).

Table 7: Non-admitted Tier 2 activity for Chronic Pain Medicine						
			Service events per Financial Year			
Hospital Site	Tier 2 Code	Tier 2 Description	2012/2013	2013/2014	2014/2015	2015/2016 (YTD 28/10)
Fiona Stanley Hospital	10.13	Minor Medical Procedures	N/A	N/A	1	0
	20.03	Pain Management	N/A	N/A	400	409
	40.06	Occupational Therapy	N/A	N/A	31	41
	40.09	Physiotherapy	N/A	N/A	18	73
Fiona Stanley Hospital Total			N/A	N/A	450	523
Fremantle Hospital	10.14	Pain Management Interventions	0	12	4	15
	20.03	Pain Management	1,567	1,305	564	N/A
	40.06	Occupational Therapy	0	72	29	N/A
	40.09	Physiotherapy	920	841	398	N/A
Fremantle Hospital Total			2,487	2,230	995	15
RPH - *Shenton Park Campus*	10.14	Pain Management Interventions	0	0	211	N/A
	20.03	Pain Management	1,993	2,088	1,255	N/A
	40.09	Physiotherapy	0	0	1	N/A
	40.12	Rehabilitation	82	303	202	N/A
RPH - *Wellington Street*	10.14	Pain Management Interventions	N/A	N/A	33	96
	20.03	Pain Management	N/A	N/A	103	428
	40.09	Physiotherapy	N/A	N/A		21
	40.12	Rehabilitation	N/A	N/A	10	131
Royal Perth Hospital Total			2,075	2,391	1,815	676
Sir Charles Gairdner Hospital	10.14	Pain Management Interventions	183	168	178	49
	20.03	Pain Management	5,312	4,396	4,844	1,516
	40.03	Aids and Appliances	33	11	20	8
	40.06	Occupational Therapy	106	122	12	0
	40.09	Physiotherapy	425	460	436	145
	40.12	Rehabilitation	289	280	141	56
	40.13	Wound Management	4	32	30	8
Sir Charles Gairdner Hospital Total			6,352	5,469	5,661	1,782
Grand Total			10,914	10,090	8,471	2,473

Data source: BIU 28/10/2015 - SMHS Data Warehouse: SMHS from server 810 and NMHS from server 811

- *Estimated budget based on 2015/16 price weights and the State adjusted price for tertiary sites ($5,562)*
- *2015/16 price weights see page 101 of IHPA - National Efficient Price Determination 2015-16*
- *WAU = number of Service events x cost weight*

3.3.6. Non-admitted Purchased Activity

Table 8 below outlines the purchased non-admitted activity for chronic pain medicine in 2015/16. For the three tertiary sites is it estimated to be $4.254 M in non-admitted services. As per the data in the previous table, SCGH is 50% of the total purchased non-admitted activity with RPH and FSH approximately 25% each.

Table 8: Purchased Activity Non-admitted Tier 2 activity for Chronic Pain Medicine 15/16			
Hospital Site	Service Events	WAUs	Funding
Fiona Stanley Hospital	2,520	197	$1,095,714
Royal Perth Hospital	2,280	184	$1,023,408
Sir Charles Gardiner Hospital	4,892	384	$2,135,261
Total	**9,692**	**765**	**$4,254,383**

Data source:

- SMHS V6 15/16 Outpatient Purchased Activity Profile (26082015)

- NMHS purchased activity is based on NAPAAWL data

3.3.7 Telehealth Activity

Telehealth is an important service delivery option for chronic pain services and is expected to continue to expand. Telehealth services use information and communications technologies to deliver health services by transmitting voice, data, images and information rather than moving care recipients, health professionals or educators. Video-conferencing is one of the main ways in which Telehealth is improving access to healthcare services for patients who live in rural and remote areas of WA. The cost and time savings for patients and providers is significant. For pain management services the utilisation of Telehealth at tertiary sites is building with 200 recorded service events in 2014/2015 and 300 service events expected in 2015/2016. A recent pilot study by the Allied Health Team at SCGH has shown that group programs can be successfully delivered by Telehealth.

4. Proposed Integrated Tertiary Service Model for Chronic Pain Medicine

This section outlines the proposed model for the chronic pain management service between the current adult tertiary health services in WA to form a single cohesive service. Health systems internationally have demonstrated improvements in clinical outcomes, greater service efficiencies and better processes for clinical management utilising evidence based methodologies with integrated service delivery models.

The model was developed by, and in conjunction with, the relevant stakeholders. Working towards a State-wide service was the recommended option moving forward and was supported by the working group at its meeting in October 2015. It is viewed as the initial stage of a future fully integrated chronic pain service model throughout WA. Outlined below is the proposed vision, goals and model (including governance) for the proposed integrated tertiary service model for chronic pain medicine

4.1 Vision

The vision of an integrated tertiary service model is for equitable access to pain services across WA for complex and tertiary patients, to encourage partnerships with public and private providers across the continuum, and to provide integrated evidence based care for consumers. The overarching objective is to increase consumer access to high quality services within the clinically recommended wait-times. This can be achieved through an integrated pain management service across WA Health to minimise the barriers to chronic pain services as identified in section 1 of this document; and to optimise capacity of existing resources to provide the right care to the right patient at the right time.

4.1.1 Guiding Principles

The guiding principles of the integrated tertiary service include:

- Centre of Excellence aligned with contemporary best practice and recognised models of care.
- Consultant presence to provide teaching and promote early senior decision making.
- All GP and specialist referrals managed through the CRS with scheduling to ensure wait time for first appointment is in line with CPAC guidelines.
- Evidence-guided practice which includes pre-clinic group education, solo and multidisciplinary assessments, and post-clinic group education and interventional pain procedures.

4.1.2 Goals

The vision for the integrated tertiary service will be achieved through four (4) overarching goals outlined below.

Goals for the integrated tertiary chronic pain service			
	GOAL	**OBJECTIVES**	**STRATEGIES**
Our Service	Provide equitable and open access to services for the management of complex chronic pain	• Managing the admitted and non-admitted waitlist. • Measuring the outcomes. • Defining service scope. • Accurate coding.	• Efficient and universal triage. • Utilise ePPOC questionnaire for local and national benchmarking, patient management and discharge facilitation. • Pain physicians to develop and define episodes of care. • Collaborate with existing WA Health Networks.
Our Finances	Cost effective and productive services with high value clinical outcomes	• Managing services within Activity Based Funding. • Establish Advanced Practice (AP) roles if appropriate and cost effective. • Generate income to improve care • Accurate medical coding.	• Work with ABF teams and clinical coders to ensure sustainability for the future. • Investigate funding and establish workforce models such as advanced practice roles where appropriate to improve the care pathways. • Actively monitor safety and quality indicators.
Our People	Committed, well trained individuals who work collaboratively and in partnership within and external to services	• Highly trained (evidence based). • Teamwork. • Committed. • Professional. • Build sustainability and partnerships. • Focus on learning. • Transparent and work with integrity.	• Centralise appointment of staff to promote learning across the system. • Facilitate collaboration between staff across sites. • High level recruitment and performance processes in line with service values. • Encourage learning of under and post graduate students of all professions. • Develop WA rotational training programme initially for medicine and potentially for other professional groups . • Support education and evidence based care across all professional disciplines.
Our Innovation	Maintain an exploratory path to innovation	• Ensure contemporary with international best practice. • Encourage research. • Support quality improvement and audit.	• Embed continuous improvement and research as essential within job roles at all levels. • Ensure safety and quality key outcome measures are regularly reviewed and reported at interdisciplinary meetings. • Continue support of learning opportunities including interstate and international benchmarking. • Support resourcing and partnership for research development and translation.

4.2 Proposed Model

It is proposed that from 01 July 2016, NMHS and SMHS and the recently announced EMHS tertiary sites will deliver the integrated tertiary chronic pain service formalised via an agreed Memorandum of Understanding (MOU). The integrated tertiary service would function within current resources allocated to chronic pain medicine under ABF with any efficiencies derived under the integrated model to be invested back into the service.

The stakeholder working group agreed and recommended that the first stage only include the three metropolitan tertiary sites of FSH, RPH and SCGH. In the future a potential second stage could be considered to include Child Adolescent Health Service (CAHS) and WA Country Health Service (WACHS); as well as services at King Edward Memorial Hospital (KEMH). These services, however, will continue to have access to information, communication and professional development resulting from the initial stage of the State-wide chronic pain model. Acute inpatient Pain Services (APS) are not included in this proposal and would continue in their current form. There will be ongoing cooperation between the APS, as well as palliative care services and chronic pain services for complex acute persistent pain, which currently is the clinical and operational practice.

The tangible benefits that are expected to be derived from the proposed model include the:

- promotion of active partnering and collaboration in a range of areas from clinical service delivery to teaching, training and research;
- shared operational and clinical governance that promotes consistent care at the tertiary sites;
- Implementation of a single point triage model to ensure equitable waitlists, consistency in triage and the development of a better understanding of demand for the services and type of referrals;
- ability to implement reform, reduce duplication and build capacity to meet demand;
- Flexibility to roster staff across sites and promote service continuity given the workforce shortages (primarily in medical);
- potential allocation of the total purchased activity to a single service, to allow greater malleability in its distribution to sites subject to negotiation with relevant parties;
- consolidation of roster system to facilitate registrar training across the tertiary sites; and
- capability to develop consistent resources and programs to enable early patient access and build partnerships with the primary and community care sectors.

4.2.1 Governance

The proposed governance model was discussed and agreed in principle at a meeting with key stakeholders on 28 October 2015. It is important to note that initially it is proposed that the medical staff report to a single State-wide Director. The difficulty of aligning the nursing and allied health staff under a single reporting line, given the current variable line and professional reporting lines at different sites, was acknowledged. With this in mind it was not supported in the initial stage by stakeholders but should be considered at a later stage once the service has been operational for 12 months.

Medical leadership and management under a single governance model will allow for flexible rostering of consultant medical staff across the sites to meet service demand within the available medical workforce available. The model will allow for coverage across the services to ensure there are minimal disruptions to service delivery, due to planned leave. It will also allow for sub-specialisation to be established across the sites.

The key limitation of the current model is the limited ability to lead system reform in chronic pain medicine across health services that currently provide the majority of pain services. Therefore a key element of the new model is the line management of the current Pain Medicine medical staff by the proposed State-wide Director for Chronic Pain Medicine.

4.2.2 State-wide Director

The State-wide Director will have the mandate and authority to lead agreed system wide changes across the current tertiary service providers in collaboration with health sites between NMHS, SMHS and EMHS. The proposed prime function of the role is the responsibility for providing strategic and operational leadership for the integrated tertiary service. The position will have the ability to lead changes across the system such as developing consistent and agreed triage criteria and distributing referrals across the system to manage demand. See Appendix 2 for the preliminary draft Job Description Form (JDF) for the position which outlines proposed key responsibilities and duties. These are summarised below:

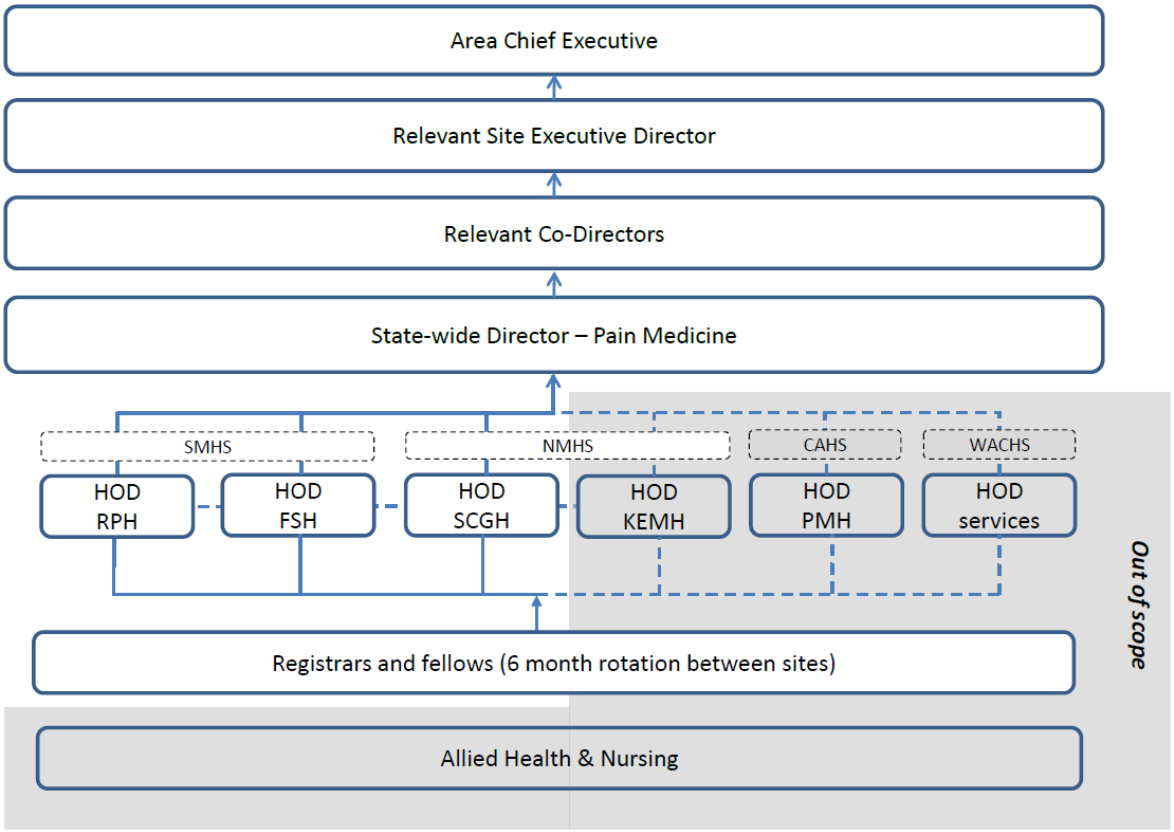
- Responsible for providing strategic and operational leadership for the integrated tertiary chronic pain service.
- Provides advice on policy and procedure development, strategic planning, workforce models, practice standards and the development of innovative approaches in service delivery.
- Ensures clinical governance mechanisms and quality improvement initiatives are in place and monitored.
- Facilitates multidisciplinary coordination of patient care and promotes education and research.
- Oversight of the relevant outpatient and inpatient rosters as well as waitlist (elective and non-admitted) for pain management over the three tertiary sites.
- Ensures efficient and flexible use of human and physical resources where delegated; noting that in the initial stage they only have accountability (financial and operational) for the medical staff.

As mentioned earlier Pain Medicine is one of the ten specialities identified as a system wide priority for improved system delivery. With this in mind, the position would be responsible for leading the State-wide Speciality Action Group to develop a Specialty Action Plan to progress system-wide strategies. The role would work in collaboration with System Policy and Planning (SPP) to support implementation of the *CSF 2014.*

The nominal FTE allocated to the State-wide Director role (estimated at 0.2FTE initially) will be found from within the current allocated medical FTE (i.e. not additional) and hence the position would be cost neutral. After 12 months, the ongoing requirement for Heads of Service/Heads of Department at the three sites would need to be assessed.

Below the proposed governance model for the tertiary services is outlined. As with other Heads of Speciality Services, the State-wide Director role will report through the relevant Co-Directors, and then through to the Executive Director and ultimately the Chief Executive of the Area Health Service (AHS). At this stage no decision has been made as to which adult tertiary site (and thus AHS) the State-wide Director would be nominally attached, however the respective Heads of Department/Speciality from all services and the Executive Sponsor are in agreement that it should be NMHS via SCGH.

Option 1: Governance structure: State wide chronic pain service model



4.2.3 Fellows and Registrars

Medical Fellows and Registrars rotate across sites as part of their post-graduate program. The Fellows and Registrars provide additional medical capacity by providing services under the supervision of the medical consultants. With the establishment of a single integrated service, the fellows and registrars would rotate across the sites as part of their program, as well as agreed placements at Child and Adolescent Health Service (CAHS) and KEMH. This would be seen as a positive benefit and make the program more attractive for registrars and fellows as well attract staff to the speciality. This has been initiated in 2016 through collaboration between the Heads of Department at the tertiary adult sites, and would be formalised under the proposed model to ensure its sustainability in the medium to long-term.

In 2016 there are four (4) registrars in fellowship programs with one additional being self-funded from overseas. These Registrars are seen as critical in the succession planning for the service as following completion of the program they will be able to potentially fill Pain Specialist vacancies in WA Health. Two positions are Advanced Trainee positions accredited by the Faculty of Pain Medicine (FPM) and funded at SCGH. Two positions at SMHS are also accredited by FPM but due for review in June/July 2016. One of these is funded by RPH; one position is funded by FSH. FSH may be in a position to apply for full accreditation with FPM late 2016 for 2017, and is dependent on filling all the current funded FTE.

4.3 Alignment with WA Health Strategy

This proposal has been developed within the context of the following documents from within WA Health, to ensure that it aligned with current WA strategies:

- WA Health Strategic Intent 2015-2020.
- WA Health Clinical Service Framework 2014 – 2024 (CSF 2014).
- WA Framework for Persistent Pain 2016-2021 (in consultation phase).
- Spinal Pain Model of Care, Musculoskeletal Health Network and Neurosciences and the Senses Health Network (2009).
- Inflammatory Arthritis Model of Care, Musculoskeletal Health Network (2009).
- Service Model for Community-Based Musculoskeletal Health in Western Australia, Musculoskeletal Health Network (2013).

As a priority, the philosophy and benefits of the integrated tertiary service model are consistent with the *WA Health Strategic Intent 2015-2020* priorities (Table 9) and utilises the workforce, accountability and partnership enablers to achieve this.

Table 9: Alignment of proposed model with *WA Health Strategic Intent 2015-2020* priorities

Prevention and Community Care Services	
	• Increased integration and communication with primary care sector. • Earlier access to evidence based education and programs by face to face delivery or written communication once referred to WA Health. • Opportunities for partnership with community and ancillary services which will provide valued community care, including Health Networks, PHNs and private care providers. The building of partnerships with the PHNs as one group to develop better systems and triage between primary and secondary services, including early management programs for comorbidities i.e. depression, drug and alcohol use etc. • Improve patients ability to have care closer to home where possible with more triage to community services.
Health Services	
Waitlist Management and Triage	• The ability to better manage the wait list with the CRS and other referral points to equitably distribute demand within capacity/utilising resources, as well as manage demand with clear consistent triage criteria. • Improved patient outcomes and reduced clinical risk via decreased time on waitlist to first appointment, with equity of access through achieving first on first off waitlist where appropriate. • Increased transparency of waitlist (including regular reporting), with better understanding of the demographics of consumers and referral patterns and potentially where to focus primary care initiatives. • Ability to manage urgent referrals and to prioritise across the State so that patients are seen within clinically recommended time frames and early access/prioritisation for assessment and medication reviews for opioids.
Service Models	• Achieve collaboration between tertiary sites; and between tertiary and community services to optimise capacity. • Ability to evaluate size and location of services to meet demand and workforce supply, including developing productivity measures. • Ability to improve information collection and regular reporting to inform on service delivery and performance by aligning systems and recording across sites. • Ability to build local expertise for specific programs e.g. Site A has expertise in interventional procedures; Site B has early intervention and education; and Site A & B both provide collaborative programs for chronic and long standing pain. • Allow the provision of more cost effective education and resource material development as one service, including updating of websites.

Standardised Pathways	• Single point of contact for entry into the tertiary health care service; allowing streamlined and efficient access to care and integration within the service and with the primary care sector and general hospital sites. • Enhanced and consistent internal processes including: referral, triage, booking and scheduling to outpatient appointments to standardise the patient pathway across the system. • Enhanced and improved communication with the patient across services. • Align extensive expertise in all pain professions in WA and have the ability to benchmark with other national and international services to improve evidence based practice and service productivity.
Workforce	• Strong clinical governance model; reduces duplication and optimises the use of a limited specialised (FTE) to meet tertiary clinical demand. • Formalises the existing strong collaborative relationship. • Improved ability to provide education, service partnership and professional network for all health service providers including the multidisciplinary team (medicine, allied health and nursing, and corporate areas) across all sites. • Leave management for consultants, registrars and fellows a whole service mechanism to minimise impact and build service capability. This could also apply to other components of the service.
Chronic Disease Services	
	• Given that a large component of the consumers referred have had persistent pain for over 3 months, the proposed tertiary service will provide a more responsive pain service to ensure ongoing chronicity is prevented where possible.
Aboriginal Health Services	
	• Ensure pain management programs and education consider the needs of cultural and linguist diverse communities' are met by the service.

5. Next Steps and Implementation

If the proposed model for integrated tertiary chronic pain service is endorsed, the following immediate steps are proposed to progress the model with the view to enable service establishment by 1 July 2016.

5.1 Immediate

1. Formalise the creation of the integrated tertiary chronic pain service between NMHS, SMHS and EMHS through the development and endorsement of a Memorandum of Understanding (MoU).
2. Chief Executives confirm where the integrated tertiary service will be based, and thus the upward reporting lines for the State-wide Director role.
3. Create the State-wide Director for Pain Management (including a Job Description Form) and appoint to the position (potentially initially through an EOI process).
4. Centralise the contracts of medical staff and develop a staged approach of contract arrangements being aligned to the new governance structure, including review of current Head of Department appointments.
5. Establish and formalise the process whereby all internal and external referrals are managed via eReferral to have a single service for receipt and triage, which includes validating the clinical criteria.
6. Determine the measures by which the success of the adoption of an integrated tertiary model will be assessed and evaluated over a defined period.

To ensure the key activities and critical milestones are achieved by the 1 July 2016, a detailed Implementation Plan should be developed. This is likely to require a project resource from the Area Health Service where the integrated tertiary service will be located to work with the State-wide Director.

As mentioned throughout the document the integrated tertiary model is considered to be the initial phase of a true State-wide chronic pain medicine model. Critical within the first 12 months of operations (i.e. by 1 July 2017) is a review of allied health and nursing resources to consider the appetite, level of consensus and risks/benefits of a future service model that aligns them under a single governance (Phase 2). Complete centralisation of all health professionals would allow the State-wide Director to have full operational and financial accountability for the service, but this will require agreement from all three Health Services.

5.2 Short – Medium Term Priorities

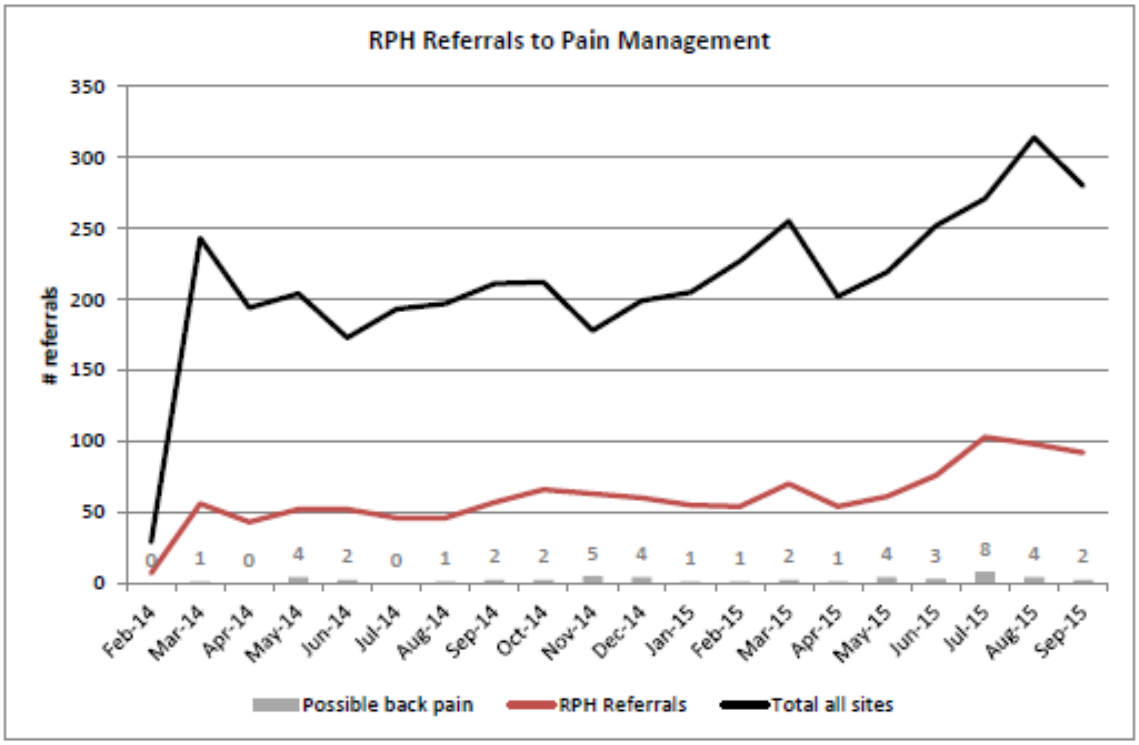
During the consultation phase a number of short to medium term priorities for the integrated tertiary service once established where proposed by various stakeholders. These were captured and are outlined below, in no particular order, for consideration by the service once fully established and which will inform its operational and strategic plan. It was considered important to capture these ideas and concepts, as although technically out-of-scope for the project, they provide an insight into the stakeholder's priorities and what they feel is possible to achieve through an integrated tertiary and future State-wide service. For some of these priorities, the integrated tertiary service would progress system-wide strategies in collaboration with System Policy and Planning (SPP) where they are relevant to support implementation of the CSF 2014:

- Develop communication/educational material for GPs and specialists for patients referred to WA Health, including information on services available in the community that they can access before their appointment (including self-management strategies).

- Develop a detailed understanding on the processing of referrals at sites (especially internal referrals), and enhance the process where appropriate whilst ensuring consistency.
- Explore opportunities to nationally benchmark the quality and effectiveness of management of persistent pain to support continuous quality improvement (e.g. electronic Persistent Pain Outcomes Collaborative (ePOCC) established by New South Wales Department of Health and The Faculty of Pain Medicine ANZCA).
- Improve data collection for admitted and non-admitted services at all sites to ensure capture, quality and consistency of information, especially to inform service planning e.g. outpatient activity reliably classified according to ABF Tier 2 non-admitted service code.
- Develop mechanisms to have accurate and consistent information of the current waitlist as well as capacity at sites to inform service design.
- Develop a process for transferring people between sites to utilise capacity especially for program access.
- Align the content and naming of short and long term education programs, with easy visibility of waiting times to allow patients to access the earliest possible program where applicable.
- Optimise the opportunities to share information across sites more easily including read only access to programs like BOSSnet at FSH for SCGH clinicians.
- Review model of current service configuration and productivity to develop detailed future options based on activity. This could include for example considering the risks and benefits of reducing the number of chronic pain medicine sites or consolidating some services as a single site (e.g. inpatient procedures).
- Partner with primary care including the Primary Health Network (PHN) to review the content and implementation of pain management pathways (including the electronic program Health Pathways).
- Further development of education and communication resources for consumers and promote online resources such as the PainHealth website. This would include working with the Health Network Directorate to regularly update PainHealth website targeted to consumers and providers.
- Explore opportunities to improve support to and collaboration with WACHS, KEMH and CAHS services, the latter including the transition from paediatric into adult services.
- Fostering of strong relationships between the hospital sites and a range of internal and external departments, as well as with private, community and non-government organisations.
- Promote cross site research enhanced by pooling resources and potential for increased research subjects given the involvement of three tertiary sites (i.e. increased capacity).
- Consider opportunities to conduct educational programs in country and metropolitan areas where there is consistent demand and need in the community.

6. Appendix 1: CRS Data - Referrals to Site Where Specialty is Pain Management or Pain Medicine

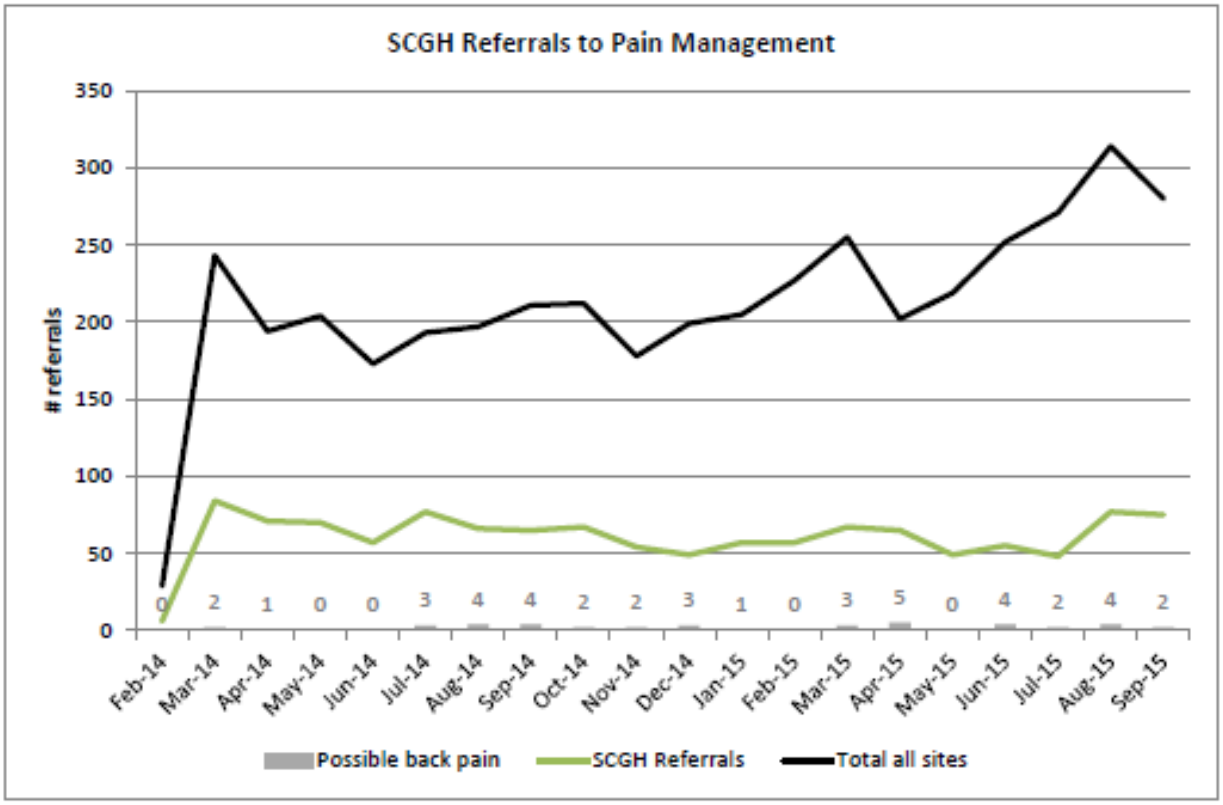
RPH referrals to Pain Management



	RPH Referrals	Possible back pain	Total all sites	% of all referrals	% in catchment	Out of catchment	
						To RPH	To Other
Feb-14	7	0	29	24.1%	42.9%	3	4
Mar-14	56	1	243	23.0%	62.5%	20	24
Apr-14	43	0	194	22.2%	67.4%	14	22
May-14	52	4	204	25.5%	48.1%	24	20
Jun-14	52	2	173	30.1%	59.6%	20	14
Jul-14	46	0	193	23.8%	58.7%	19	21
Aug-14	46	1	197	23.4%	60.9%	16	22
Sep-14	57	2	211	27.0%	61.4%	21	23
Oct-14	66	2	212	31.1%	48.5%	30	30
Nov-14	63	5	178	35.4%	63.5%	22	8
Dec-14	60	4	199	30.2%	45.0%	30	3
Jan-15	55	1	205	26.8%	69.1%	13	2
Feb-15	54	1	227	23.8%	79.6%	10	6
Mar-15	70	2	255	27.5%	65.7%	22	3
Apr-15	54	1	202	26.7%	66.7%	16	2
May-15	61	4	219	27.9%	62.3%	23	3
Jun-15	76	3	252	30.2%	72.4%	20	3
Jul-15	103	8	271	38.0%	68.0%	31	2
Aug-15	98	4	314	31.2%	65.3%	30	1
Sep-15	92	2	280	32.9%	72.8%	25	2

Inclusions: *Referrals to site where Specialty is Pain Management or Pain Medicine*
Exclusions: *Duplicate Referrals*
Note: *Possible back pain is identified by rejected by Neurosurgery or Spinal and referred to Pain*
Out of catchment To RPH is other hospitals catchment referrals that have gone to RPH
Out of catchment To Other is RPH catchment referrals that have gone to another hospital

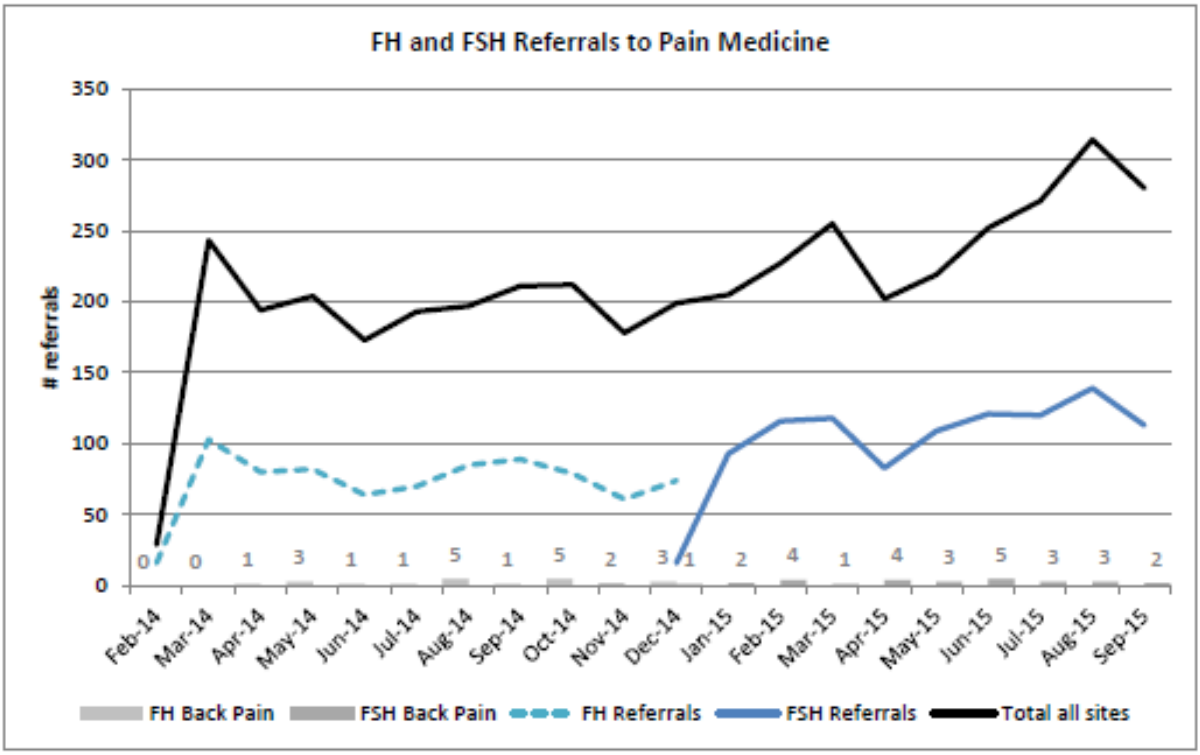
SCGH referrals to Pain Management



	SCGH Referrals	Possible back pain	Total all sites	% of all referrals	% in catchment	Out of Catchment	
						To SCGH	To Other
Feb-14	6	0	29	20.7%	0.0%	5	8
Mar-14	84	2	243	34.6%	56.0%	30	45
Apr-14	71	1	194	36.6%	56.3%	28	23
May-14	70	0	204	34.3%	52.9%	33	26
Jun-14	57	0	173	32.9%	64.9%	19	22
Jul-14	77	3	193	39.9%	66.2%	26	20
Aug-14	66	4	197	33.5%	66.7%	22	29
Sep-14	65	4	211	30.8%	58.5%	25	28
Oct-14	67	2	212	31.6%	46.3%	35	30
Nov-14	54	2	178	30.3%	70.4%	13	23
Dec-14	49	3	199	24.6%	71.4%	12	21
Jan-15	57	1	205	27.8%	73.7%	14	13
Feb-15	57	0	227	25.1%	59.6%	22	7
Mar-15	67	3	255	26.3%	74.6%	12	18
Apr-15	65	5	202	32.2%	73.8%	13	15
May-15	49	0	219	22.4%	73.5%	12	27
Jun-15	55	4	252	21.8%	74.5%	13	18
Jul-15	48	2	271	17.7%	62.5%	18	27
Aug-15	77	4	314	24.5%	63.6%	26	31
Sep-15	75	2	280	26.8%	66.7%	21	21

Inclusions: *Referrals to site where Specialty is Pain Management or Pain Medicine*
Exclusions: *Duplicate Referrals*
Note: *Possible back pain is identified by rejected by Neurosurgery or Spinal and referred to Pain*
Out of catchment To SCGH is other hospitals catchment referrals that have gone to SCGH
Out of catchment To Other is SCGH catchment referrals that have gone to another hospital

FH/FSH referrals to Pain Medicine



	FH		FSH					Out of catchment	
	Referrals	Back Pain	Referrals	Back Pain	Total all sites	% of total referrals	% in catchment	To FH/FSH	To Other hospital
Feb-14	16	0			29	55.2%	62.5%	6	2
Mar-14	103	0			243	42.4%	55.3%	40	21
Apr-14	80	1			194	41.2%	68.8%	21	18
May-14	82	3			204	40.2%	69.5%	16	27
Jun-14	64	1			173	37.0%	76.6%	14	17
Jul-14	70	1			193	36.3%	74.3%	18	22
Aug-14	85	5			197	43.1%	64.7%	30	17
Sep-14	89	1			211	42.2%	67.4%	26	21
Oct-14	79	5			212	37.3%	68.4%	22	27
Nov-14	61	2			178	34.3%	75.4%	12	16
Dec-14	74	3	16	1	199	45.2%	82.2%	10	28
Jan-15			93	2	205	45.4%	91.4%	7	19
Feb-15			116	4	227	51.1%	92.2%	4	23
Mar-15			118	1	255	46.3%	86.4%	11	24
Apr-15			83	4	202	41.1%	89.2%	6	18
May-15			109	3	219	49.8%	87.2%	11	16
Jun-15			121	5	252	48.0%	90.1%	7	19
Jul-15			120	3	271	44.3%	92.5%	7	27
Aug-15			139	3	314	44.3%	92.1%	9	33
Sep-15			113	2	280	40.4%	94.7%	5	28

Inclusions: Referrals to site where Specialty is Pain Management or Pain Medicine
Exclusions: Duplicate Referrals
Note: Possible back pain is identified by rejected by Neurosurgery or Spinal and referred to Pain
Out of catchment To FH/FSH is other hospitals catchment referrals that have gone to FH/FSH
Out of catchment To Other is FH/FSH catchment referrals that have gone to another hospital

7. Appendix 2: JDF – State-wide Director Pain Management Service

DEPARTMENT OF HEALTH

METROPOLITAN HEALTH SERVICE

JOB DESCRIPTION FORM

STATE DIRECTOR PAIN MANAGEMENT SERVICE – YEAR 1-9

PAIN MANAGEMENT

CLINICAL SERVICES DIVISION

Position No: **TBC** Effective Date: **XX** 2016

INDUSTRIAL AWARD / AGREEMENT: Department of Health Medical Practitioners (Metropolitan Health Service) AMA Industrial Agreement 2013

REPORTING RELATIONSHIPS	
Responsible to	Executive Director
Responsible to	Co-Directors

THIS POSITION

POSITIONS UNDER DIRECT SUPERVISION			OTHER POSITIONS UNDER CONTROL	
Title	Classification	FTE	Category	FTE
Medical Pain Consultants RPH FSH SCGH				
TOTAL FTEs:			TOTAL FTEs:	

PRIME FUNCTION / KEY RESPONSIBILITIES:

Responsible for providing strategic and operational leadership for the State Pain Service. Provides advice on policy and procedure development, strategic planning, workforce models, practice standards and the development of innovative approaches in service delivery. Ensures clinical governance mechanisms and quality improvement initiatives are in place and monitored. Facilitates multidisciplinary coordination of patient care and promotes education and research.Oversight of the relevant outpatient and inpatient rosters as well as waitlist for pain management over the three tertiary sites. Ensures efficient use of human and physical resources so that the state-wide service operates within the allocated budget and activity.

BRIEF STATEMENT OF DUTIES

Brief Summary of Duties

1. Specific Duties Relevant to Specialty/Sub Speciality

- Management of the state-wide pain service roster across tertiary services at NMHS and SMHS to ensure appropriate coordination of services across WA Health.
- Develop a structured framework to formalise the collaborative relationship between the respective NMHS and SMHS services to ensure the broader objectives of the State service are achieved.
- Accountable to NMHS and SMHS to meet the strategic initiatives and Key Performance Indicators as outlined in the agreed annual pain management operational plan.

2. Strategic Leadership

- Ensure high quality, best practice and outcome focussed service delivery to address the strategic needs of the state and performance requirements.
- Consult with Area and Executive Directors and the Department of Health in reference to strategic matters for the pain management services.
- Liaise with metropolitan hospital Co-Directors and Executive Directors in relation to the planning and delivery of pain management services.
- Represent WA Health on clinical matters associated with pain management services at external and inter-agency forums as appropriate.
- Establish and maintain positive working relationships between government, non-government and primary care sectors involved in the delivery of pain management services.
- Work collaboratively with General Practitioners to develop and implement strategies and initiatives regarding pain management services across the state.
- Develop and maintain strong partnerships between the components of the Metropolitan Health Services and WA County Health Service.
- Promote mechanisms to foster leadership and mentors for pain management medical staff as well as multidisciplinary teams.

3. Strategic Planning

- Develop a shared vision and clear strategic direction for State Pain Management services that meets State and National initiatives.
- In conjunction with other Health Services, provide a State-wide approach to workforce planning and development.
- Develop and implement innovative strategies and programs aimed at the highest clinical standards and clinical reform to achieve department and organisational objectives.
- Ensure appropriate pain service data is available for strategic planning and measure productivity.

4. Clinical Governance and Quality Improvement

- Inform the CEs of NMHS & SMHS as well as State Health Executive on matters related to pain management services for the state.
- Ensure the coordination of involvement of pain management services in accreditation programs.
- Assist in the development, implementation and monitoring of standard practices, policies and procedures across the State in accordance with recognised standards.
- In conjunction with all Health Services within the State, develop a framework for Clinical Governance (including peer review and service audit) that minimises risk to patients and promotes quality pain management services
- Ensures the ongoing application of continuous quality improvement principles in systematically evaluating and meeting customer needs.
- Ensure appropriate surgical transplant data is available for performance analysis.

5. Research & Training

- Monitor that all pain management meet the minimum recommended credentialing requirements specified in the pain management and accreditation guidelines to ensure service sustainability.
- Provide leadership to enhance the development of the pain management workforce in training, recruitment and retention programs.
- Encourage and organise continuing professional development activities.
- In conjunction with Health Service Leads, develop a framework that supports education and research for all staff within pain management services.
- Supervise, support and participate in the teaching and training of the pain management workforce (medical, nursing, allied health and support staff) including formal presentations and/or tutorials as required.
- Participate in the general continuing educational activities and post graduate training programs for junior medical staff, as well as teaching programs for undergraduate medical students.
- Promote, develop and participate in clinical and experimental research opportunities.
- Ensure availability and access to the pain managemetn data for research and for service outcomes.

6. Other Duties

- Perform duties in accordance with Government, WA Health, Metropolitan Health Services and Departmental / Program Specific Policies and Procedures, including the relevant Occupational Safety and Health legislation, Equal Opportunity Legislation and WA Health Code of Conduct.
- Undertake other duties as directed.

SELECTION CRITERIA

ESSENTIAL MINIMUM REQUIREMENTS

Essential Selection Criteria

1. Eligible for registration with the Medical Board of Australia.
2. Fellowship of the Faculty of Pain Medicine ANZCA or equivalent.
3. Demonstrated extensive clinical knowledge, experience and leadership in pain management services.
4. Demonstrated commitment to the delivery of safe, efficient and high quality clinical services in a multi-disciplinary environment.
5. Demonstrated experience and commitment to clinical teaching and clinical research.
6. Demonstrated high level interpersonal, negotiation and conflict resolution skills.
7. Demonstrated high level written and verbal communication skills.
8. Demonstrated knowledge of current clinical governance systems and quality improvement programs.
9. Current knowledge of legislative obligations for Equal Opportunity, Disability Services and Occupational Safety and Health, and how these impact on employment and service delivery.

DESIRABLE REQUIREMENTS

1. Leadership and senior management experience in a health service organisation.
2. Knowledge of current issues facing the health industry at the State and National level.

APPOINTMENT FACTORS:

Appointment is subject to:

- Evidence of registration by the Medical Board of Australia must be provided prior to commencement.
- Working With Children (WWC) Check, compulsory check for people who carry out child-related work in Western Australia.
- Successful Pre-Employment Integrity check
- Successful Pre-Employment Health Assessment

CERTIFICATION (Valid only if establishments registration stamp affixed to all pages.)

Exec Director / Director / Head of Division / Head of Service / Head of Department: The details contained in this document are an accurate statement of the duties, responsibilities and other requirements of the job.

Title Signature Date

Human Resource Delegate - Job Description Approved.

Title Signature Date

Occupant - I have noted the statement of duties, responsibilities and other requirements as detailed in this document

Name (in full) Signature Date

8. Appendix 3: Metropolitan Hospital Service Matrix: Pain Medicine

WA Health Clinical Services Framework 2014-2024

	SMHS						NMHS					STATEWIDE		
Site	FSH[1]	RPG	RkPG	AHS	PHC	FH	SCGH	OPH	Kalamunda	MPH	JHC	Graylands (Including Selby)	PMH/ PCH	KEMH
CSF Level 2018/19[2] (inpatients)	6	6	4	4	4	4	6[3]	3	3	4	4	4	6	4
CSF Level 2018/19 (outpatients)	VI	VI	Nil	Nil	Nil	Nil	VI	III	III	IV	III	IV	VI	IV
Service Agreements	No	No	No	No	No	No	N/A	N/A	N/A	N/A	N/A	N/A		
WAMS arrangements	No	No	No	No	No	No	N/A	N/A	N/A	N/A	N/A	N/A		
After-hours/ on call arrangements	No after-hours on-call cover.	No after-hours on-call cover	-	-	-	-	Consultant cover is provided 24 hours per day, 7 days per week.							

= Out of project scope

[1] FSH SSP Anaesthesia and Pain Medicine Version 1.0 (1 October 2014)
[2] WA Clinical Services Framework 2014-2024 (CSF)
[3] Currently Level 5 in the CSF but will be corrected in a revision to be sent to State Cabinet for endorsement

9. Appendix 4: Definition and Role Delineation – Pain Medicine (CSF 2014)

Table 8: Hospital Inpatient and Emergency Service Definitions

Level 1 Level 2	Level 3	Level 4	Level 5	Level 6
Clinical Support Services				
Pain Medicine	• Development of pain management plan via Telehealth. • GP can manage patient with short term pain issues, with advice from higher level services.	As for Level 3 plus: • Limited inpatient care with part time medical and nursing staff. • Access to physiotherapist. • Visiting pain medicine physician (or via Telehealth).	As for Level 4 plus: • Comprehensive multidisciplinary inpatient pain service. • Comprehensive array of interventional procedures. • Access to rehabilitation specialist, psychiatrist, rheumatologist and addiction specialist. • Research role with data collection.	As for Level 5 plus: • A Director or coordinator of the multidisciplinary pain clinic. • At least three medical specialties should be represented on the staff of a multidisciplinary pain clinic including rehabilitation specialist, psychiatrist/ psychologist, rheumatologist and addiction specialist. • Access to neuromodulation and intrathecal infusion devices (pumps). • Pain medicine physician on-call to support on-site senior personnel. • Leads research role and supports other centres. • Undergraduate and post-graduate teaching role with close affiliation to a major educational or research institution in the health sciences. • Provides Telehealth service.

(WA Health Clinical Services Framework 2014-2024, 2014)

10. Appendix 5: Generic Non-admitted outpatient service definitions by Level (CSF 2014)

Table 9: Generic Non-admitted outpatient service definitions by Level (CSF 2014)

Level I	Level II	Level III	Level IV	Level V	Level VI
Non-Admitted Hospital Outpatient Services					
Categories of outpatient services include: • Procedures. • Medical consultation. • Standalone diagnostic. • Allied health and/or clinical nurse specialist intervention.	• Access to generalist domiciliary nursing and/or allied health. • Pre and post acute care – may be provided through hospital or community services or via Telehealth.	As for Level 2 plus: • Access to GP or medical practitioner. • Access to limited diagnostic services. • May include teaching and training role.	As for Level 3 plus: • Access to general medical physician/ specialist and/or specialist services related to a hospital admission e.g. before or after care. • May include research role.	As for Level 4 plus: • Access to specialist medical/ nursing/allied health providing care to patients of increased complexity. • Teaching and training role. • Access to specific diagnostics relating to that specialty.	As for Level 5 plus: • Research role. • Access to any required advanced diagnostics for that specialty. • Access to any required specialist equipment for that specialty. • Services for complex conditions or complex patients for that specialty. • Services include access into a suite of sub-specialty services for that specialty.

11. Appendix 6: Outpatient Education Programs

Several group pain education programs are available between SCGH, RPH and FSH. These can be divided into two main groups: short course and long course. A brief description of each is below.
Long Course-LEAP/ PUMP/ SCAMP
Short course- STEP/ IPM/ PEP

Short courses

Table 10: Outpatient education programs- short courses

	Description	Referral criteria	Structure	Clinician input:
Self-Training Educative Pain Sessions (STEPS) and PEP	Provides information and skills in a broad pain management plan designed to optimise treatment outcomes for patients with pain. After the patient has attended STEPS, they are encouraged to phone and ask to attend individual outpatient pain medicine consultations for further advice or for services not easily available in the community such as inter-professional individual consultations, and the 5 week Pain Understanding and Management Program (PUMP). Improving the patient's network with existing community-based health professionals is aided by providing community-based physical therapy contact lists during STEPS and at pain clinic appointments. At FSH, the STEPS programme is also available via Telehealth.	A written referral is required from a health professional and some exclusion criteria apply. Some sites require patients to complete the PTQ before they attend. Inclusion criteria are: • To have an English language capacity sufficient to understand the written and spoken materials being presented; • To be able to give voluntary, informed consent for the ongoing collection of audit data; and • The patient referral is triaged as non-urgent. • Exclusion criteria for pre-clinic STEPS are: • Trigeminal neuralgia; • Concerns about the patient's suitability for a group-based education and skills program (based on known medical history and patient questionnaire) and; • Department of Corrective Services patients.	a clinical six section module broken into a 4 session program that runs over two days. Day 1: • Session 1 (Part A) (60 minutes): Completion of validated questionnaires following orientation. Lead by a clinical psychologist. • Session 2 (Part B) (60 minutes): Pacing. Lead by an occupational therapist. • Session 3 (Part C) (45 minutes): Patient Stories. Lead by a clinical psychologist. • Session 4 (75 minutes): Moving with Pain. Lead by a physiotherapist. Day 2: • Session 5 (120 minutes): Response to Pain. Lead by a clinical psychologist. • Session 6 (120 minutes): Medical Options – "Sense-making for people in pain". Lead by a pain medicine physician.	Occupational therapist, physiotherapist, clinical psychologist, pain specialist and rheumatologist.

Long Courses

Table 11: Outpatient education programs- long courses				
	Description	**Referral criteria**	**Structure**	**Clinician input:**
FSH *Pain Understanding and Management Program (PUMP)* *RPH* *Life-style Education & Activation Program (LEAP)* *SCAMP*	An evidence-based five week multidisciplinary pain management program designed to improve patient's physical function and coping capacity when dealing with ongoing pain.	A referral is required and patients are assessed for suitability.	Addresses the secondary factors that arise from living with chronic pain that amplify and perpetuate the pain, these factors include poor physical condition, inactivity and depression. The program also includes a series of educational sessions to help patients understand and manage the complex range of emotional and psychological problems that arise in chronic pain. The program is run in over a 5-week period, and includes a 1 hour exercise session followed by a 2 hour education session. After the patient has attended PUMP, patients are phoned for a 6 week follow and asked if they need to attend individual outpatient pain medicine consultations for further advice or a follow up post PUMP programme of 3 days to assess their progress (mini- PUMP-booster).	

12. Appendix 7: Pain Working Group & Stakeholders

Table 12: Pain Working Group & Stakeholders		
Name	**Health service**	**Title**
Dr Ange Halliday	FSH	Consultant - Anaesthesia & Pain Medicine Deputy Head Anaesthesia FSH
Dr Gavin Coppinger	FSH	Medical Co-Director, Clinical Services
Dr Malcolm Thompson	FSH	Consultant - Anaesthesia
Dr Max Majedi	FSH	Head of Department, Pain Medicine SCGH
Dr Sally Bradley	FSH	Director Of Clinical Services, Corporate Office
Ms Kelly Blyth	FSH	Allied Health Head of Service, Service streams 1 & 2
Ms Shae Seymour	FSH	Director Allied Health
Dr Alex Swann	FSH	Head of Department, Anaesthesia and Pain Medicine
Dr Roger Goucke	FSH (Chair and Clinical Project Lead)	A/ Head of Department, Pain Medicine (Former HOD SCGH)
Dr Ce Kealley	Health Network Directorate	Senior Development Officer, Health Network Directorate
Ms Paola Morellini	NMHS	Director Clinical Planning, Planning & Infrastructure
Dr Aresh Anwar	RPH	Executive Director Royal Perth Group, SMAHS
Dr Donald Johnson	RPH	Consultant Anaesthetist
Dr Gavin Teague	RPH	Consultant Anaesthetist/HOD, Anaesthesia & Pain Medicine
Dr Grant Waterer	RPH	Medical Co-Director, Office of the Chief Executive
Dr Stephan Schug	RPH	Consultant - Pain Medicine
Ms Dori Lombardi	RPH	Co-Director Service 4, Executive Services
Dr Jodi Graham	SCGH	A/Medical Co-Director, Surgical Division
Dr Karen Murphy	SCGH	A/Executive Director Medical Services, Corporate Medical
Dr Victor Cheng	SCGH	Executive Director SCGH/ OPH
Ms Debbie Hanlin	SMHS Area Office, Strategy Workforce	Health Services Planner
Ms Louise Hill	SMHS Area Office, Strategy Workforce	Health Services Planner
Dr Robyn Lawrence	SMHS Area Office, (Executive Sponsor)	A/ CEO
Mr Joel Gurr	SMHS Area Office, Office of the Chief Executive	A/ Director of Strategic Issues
Ms Jane Saligari	SMHS Area Office, Office of the Chief Executive	Group General Manager, Strategy Workforce
Ms Olivia Berry	SMHS Area Office, Office of the Chief Executive	A/ Senior Project Officer
Ms Robyn Timms	SMHS Area Office, Office of the Chief Executive	Senior Project Coordinator
Dr Andrew Jamieson	WACHS	Regional Director Medical Services
Dr Patrick Coleman	WACHS (Bunbury Hospital)	Consultant - Pain Medicine

13. Appendix 8: Tier 2 Non-Admitted Services Definitions

10 series – Procedure Classes

10.14 Pain management interventions	
Identifying attributes	
Number	10.14
Name	Pain management interventions
Category	Procedures
Affected body part	Multiple MDCs
Definition of service	The provision of pain management interventions for clients with moderate to severe levels of persistent pain.
Guide for use	
Activity	*Inclusions*: Interventions may include: • interventional anaesthetic techniques; • spinal cord stimulation; • joint injections: facet and sacroiliac; • radiofrequency denervation; • sympathectomy; • selective nerve root blocks; • epidural injections; • cryotherapy; and • management of intrathecal drug administration systems. *Exclusions*: • medical consultation for pain management (20.03)
Conditions	
Constraints	Non-procedural pain management interventions may be provided as part of the service in certain allied health/clinical nurse specialist clinics.

20 series – Medical Consultation

20.03 Pain management	
Identifying attributes	
Number	20.03
Name	Pain management
Category	Medical consultation
Affected body part	Multiple MDCs
Usual provider	Anaesthetist, neurologist, palliative medicine specialist, psychiatrist, accredited pain medicine physician.
Definition of service	The review of patients that suffer from chronic and persistent pain.
Guide for use	
Activity	*Inclusions*: • pain management to assist patients to cope with chronic pain without developing excessive dependence on drugs. *Exclusions*: • provision of pain management procedures in specialised clinic (10.14).
Conditions	
Constraints	Some pain management services may also be provided in specialty medical consultation and/or allied health intervention clinics.

40 series– Allied Health and/or Clinical Nurse Specialist Interventions

40.03 Aids and appliances	
Identifying attributes	
Number	40.03
Name	Aids and appliances
Category	Allied health and/or clinical nurse specialist interventions
Affected body part	Multiple MDCs
Usual provider	Allied health/clinical nurse specialist
Definition of service	Includes the fitting and maintenance of external prosthetics and aids.
Guide for use	
Activity	*Inclusions:* Fitting and maintenance of: • prosthetic legs; • external breast prostheses; • prosthetic eyes; • wigs and other such devices; • splints, crutches and wheelchairs; • orthopaedic applications; and • plaster applications. *Exclusions:* • orthotics (40.24).
Conditions	
Constraints	

40.06 Occupational therapy	
Identifying attributes	
Number	40.06
Name	Occupational therapy
Category	Allied health and/or clinical nurse specialist interventions
Affected body part	Multiple MDCs
Usual provider	Occupational therapist
Definition of service	Assessment, treatment and implementation of occupational therapy procedures and equipment for patients suffering from various mental and physical conditions.
Guide for use	
Activity	*Inclusions:* Consultations on the following services: • lymphoedema dressing; • return to home assessments; • falls management; • specialist hand, lower limb and upper limb rehabilitation, mobilisation, strengthening; • scar management; • customised manufacture of splints and implementation of home modifications such as ramps for access via wheelchairs; • burns patients for activities of daily living; • pain management; • driving rehabilitation;

	• vocational and avocational rehabilitation; • provision of equipment and assistive technology; and • education and advice on activities of daily living. *Exclusions:* • management of burns patients in dedicated allied health/clinical nurse specialist clinic (40.31).
Conditions	
Constraints	

40.09 Physiotherapy	
Identifying attributes	
Number	40.09
Name	Physiotherapy
Category	Allied health and/or clinical nurse specialist interventions
Affected body part	Multiple MDCs
Usual provider	Physiotherapist
Definition of service	Assessment and treatment of patients (with all types of medical conditions) requiring physiotherapy, such as musculoskeletal disorders, fractures and orthopaedic conditions.
Guide for use	
Activity	*Inclusions:* Consultations on the following services: • hand and neuromuscular manipulation; • paediatric orthopaedic rehabilitation; • cardiac rehabilitation; • amputee rehabilitation; • neurological rehabilitation; • pain management; • neurology; • hydrotherapy; • falls management; • mobility and gait training; • respiratory management; and • various other pre- and post-operative treatments. *Exclusions:* • hydrotherapy interventions in dedicated allied health/clinical nurse specialist clinic (40.05); • cardiac rehabilitation in dedicated allied health/clinical nurse specialist clinic (40.21); and • pulmonary rehabilitation in dedicated allied health/clinical nurse specialist pulmonary rehabilitation clinic (40.60).
Conditions	
Constraints	

40.12 Rehabilitation	
Identifying attributes	
umber	40.12
Name	Rehabilitation
Category	Allied health and/or clinical nurse specialist interventions
Affected body part	MDC 23 Factors influencing health status and other contacts with health services
Usual provider	Allied health/clinical nurse specialist
Definition of service	Care in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with impairment, activity limitation or participation restriction due to a health condition. The patient will be capable of actively participating.
Guide for use	
Activity	*Inclusions:* Consultations on the following services: • amputee rehabilitation; • brain injury rehabilitation; • care and rehabilitation of stroke patients; • counselling, prosthetics, orthotics or podiatry provided as part of a rehabilitation program; • general rehabilitation (including falls, reconditioning and pain); • orthopaedic rehabilitation; • rehabilitation for genetic conditions such as spina bifida; • rehabilitation for injuries to the spinal cord and column; • rehabilitation for neurological disorders; • rehabilitation services provided in a day hospital; • vestibular rehabilitation; and • spinal injury rehabilitation. *Exclusions:* • rehabilitation activity occurring in a spinal clinic (20.31); • rehabilitation services provided in medical consultation rehabilitation clinic (20.47); • cardiac rehabilitation provided in dedicated cardiac rehabilitation clinic (40.21); and • pulmonary rehabilitation in dedicated allied health/clinical nurse specialist pulmonary rehabilitation clinic (40.60).
Conditions	
Constraints	

(Commonwealth of Australia, 2015)