National Pain Audit

Phase 1 Report: Organisational Audit of NHS Chronic Pain Services

November 2011

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HQIP
Healthcare Quality Improvement Partnership

Executive Summary:

Background

Pain is a complex biopsychosocial experience. Pain that persists longer than expected can be difficult to treat. There is very little known as to how services are matched to needs. Three reports in recent years have highlighted the need for better information on these services – The Audit Commission in 1997, The Clinical Standards Advisory Group in 2002, the Chief Medical Officer in England's report in 2009.

The National Pain Audit sets out to improve information on such services. It is a collaboration between the British Pain Society and Dr Foster Intelligence. The audit aims to cover all specialist pain services in England and Wales.

The National Pain Audit has reported organisational data for the years 2010 - 2011 against a wide range of standards set by the Faculty of Pain Medicine, British Pain Society and International Association for the Study of Pain.

Findings:

- Two hundred and fourteen services have been identified in the two countries. Most PCT/LHBs provided between one and three services for their population. Some PCTs had multiple providers within the same locality.Twenty eight PCT/LHBs did not appear to have services available for their patients. Data returns were poorest in the Midlands and South East.
- Most services appeared to meet government waiting time targets. It is not known whether this fully meets the needs of patients as international research indicates that more rapid access is often needed.
- 64% of English services and 80% of Welsh services assess themselves as multidisciplinary. However, using stricter criteria to define multidisciplinary status, requiring the presence of key personnel, only 40% of English services and 60% of those in Wales appear to meet this higher standard. There is wide geographical variation; in some areas patients need to travel great distances to receive multidisciplinary care. Key personnel are often patchily available. Some localities have multiple clinics, others have none leading to confusion for referrers and patients.
- Services claiming to offer specialist treatments and interventions were often lacking appropriate specialist staff (or failed to confirm their presence). Given that these are specialist services and patients will, by definition, have failed generalist care, the lack of appropriately trained senior staff to supervise and support treatment is concerning.
- Many services do not have good access to technological support to provide good information about patients.
- Few services are able to train staff which may impact on the sustainability of the service.

Recommendations:

- A code needs to be applied to all specialist pain services regardless of setting to identify them.
- Patient waiting times need to be audited in line with International Association for the Study of Pain's (IASP) recommendations The impact of such waits needs to be better understood.
- If a service cannot provide multidisciplinary care then it must be able to signpost to services which can. Such services need to be appropriately accessible to patients.
- An agreed definition of multidisciplinary care is needed.
- An agreed standard of necessary personnel to deliver psychologically based treatments in a pain service is needed.
- Standards for training for physiotherapists and psychologists are needed.
- A robust treatment classification is needed.
- There needs to be a widespread agreement on standards of care with these supported by governmental bodies.
- If key personnel are not available then the case mix should be adjusted to take this into consideration. Phase 2 of the audit will establish the case mix at individual services and provide clearer information in this area.
- Mergers of some of the services where there is multiple provision may improve standards of care.
- Services require greater support in access to information about patients than is currently available.
- Clarification is required as to how patients receive guidance and self help – phase 2 of the audit will help establish this.

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November 2011

Background

Pain is a complex biopsychosocial experience. Pain that persists longer than expected can be difficult to treat. Whilst many people are able to manage their pain successfully, some require referral to specialist pain services. The definition of a specialist pain service for the purpose of coding in the UK is described as “for the diagnosis and management of complex pain disorders, requiring a multidisciplinary approach”. Provision of these services is inconsistent, and chronic pain is not given the priority it requires in view of the extent of its burden on individuals and society[1].

The prevalence of chronic pain with a high expressed level of need is estimated at 6.4% of the population, depending on the definition[2]. Severe pain is estimated at 11% for adults and 8% for children[3]. Older age, female sex, poor housing and type of employment (for example heavy manual work) are significant predictors of chronic pain in the community. The average annual incidence is 8.3% and average annual recovery rate 5.4%[4]. Severe chronic pain is known to have adverse effects on employment status, daily activities, relationships, mood, sleep and all aspects of general health. Daily back pain is known to be associated with greater coronary events.

Pain is not consistently managed across the whole health/social care system at present. Specialist services in secondary and tertiary care are tasked with managing complex pain, often too late and with few resources. In recent years more services have been set up in primary care, with or without specialist input. However, little is known of the population served, the services offered and outcomes. It is hoped that by improving the management of people with difficult chronic pain that the consequences will be ameliorated, with obvious benefits both to the patient and to society. Patients should also be afforded better knowledge of the services that are provided and how they compare with others.

The Department of Health's Clinical Services Advisory Group (CSAG) in 2000 found a wide variation in quality of care offered by providers[5]. Half the patients attending a pain management clinic had been referred by their GP and half by their hospital consultant. The majority of patients (65%) had no prior knowledge of the existence of pain management clinics. A quarter of patients had waited more than 22 weeks for an outpatient appointment in the pain management clinic. The longest wait was 90 weeks. Shortages of specialist psychologists, physiotherapists, occupational therapists and pharmacists hindered a multi-disciplinary approach. There was little attempt to assess provision of pain services in relation to what local people actually needed. Most of the pain management services felt that pain relief was not adequately recognised. Eighty-one per cent had recently tried to obtain additional funding but sixty-three per cent had been unsuccessful. Many patients were positive about their experiences from attending the pain management clinic. They said their pain had improved. They felt supported and relieved to discover that expert advice is available. Many felt that they should have been seen at a pain clinic earlier. However, services discharged far fewer patients than they took on each year making them unsustainable in the long term. Little appears to have changed since then.

One of the key challenges has been the lack of supported standards of quality of care. NICE guidance does not support clear standards for the management of people with chronic pain; instead guidance on chronic pain is found in a number of areas known to be

associated with chronic pain eg. osteoarthritis, low back pain and neuropathic pain. It is therefore often regarded as “hidden”. This can lead to considerable challenges when establishing standards of care.

NICE, through its Health Technology Assessment programme and guidelines panels, has however reviewed several areas of Pain management. It recommends registries for epidural steroids and spinal cord stimulation, changes in practice to the management of chronic low back pain and greater input of vocational rehabilitation workers. At present there is no way to assess the impact of these wide ranging changes.

Standards have been published by the Faculty of Pain Medicine on provision of services[6]. The Royal College of Anaesthetists has a chapter on pain management in its Audit Recipe book. The International Association for the Study of Pain has also published standards on waiting times[7]. The British Pain Society also provides individual guidance on treatment. There is also no recognised classification for treatments. The diversity of recommendations and standards makes it challenging to agree key standards for a National Audit.

The Welsh Government published its ‘Service Development and Commissioning Directive for Chronic Non-malignant Pain’ in 2008[8] which sets out its approach to tackling improvements in service provision and care for people living with persistent pain. This highlighted the patchy provision of services in Wales and the need to provide services closer to home for the vast majority of patients. Following this, Local Health Boards have been audited upon their compliance with the Directive to help ensure improved standards of care.

A recent Scottish benchmarking audit for chronic pain[9] demonstrated signification variation in patient care and led to the Scottish government recognising chronic pain as a long-term condition in its own right. This has also lead to a direct intervention from the Health Secretary and has already had a positive impact on patient care.

The Chief Medical Officer in England acknowledged the difficulties. With this in mind the National Pain Audit was established. It does not currently cover Scotland as an audit had so recently been carried out. The National Pain Audit aims to try to better describe what is happening with English and Welsh pain services.

In common with many chronic conditions there is very little known as to how services are matched to needs. Current NHS information systems do not collect data in relation to disability (as opposed to disease) and are incapable of collecting data across groups of disease[10].

From 1998 to 2003 the British Pain Society ran a clinical audit where members submitted data on services voluntarily on an annual basis. Whilst nowhere near comprehensive in its data coverage the audit did highlight methodological issues that needed consideration and developed a useful basis for the current audit[11].

The National Pain Audit has been initiated to collect detailed data on pain services. The three year study aims to improve NHS services for people affected by chronic pain and will establish a national data collection system which will enable services to monitor

performance, share data, and to gather feedback and consensus of interested parties. Areas of data collection include, patient case mix, demographics, diagnosis, treatments, assessment of condition severity and patient outcomes.

The audit is funded by the Health Improvement Partnership (HQIP) and is being carried out by a partnership of the British Pain Society and Dr Foster Intelligence.

Aims of the National Pain Audit:

- To improve the quality and effectiveness of care by measuring services against established national standards.
- To improve access to specialist pain services for patients and services users.
- To improve awareness of specialist pain services within the NHS amongst patients, commissioners and clinicians.
- To help close the gap in the variation of care.
- To accelerate the rate of improvement and development in both the organisation and delivery of care for people with chronic pain.
- To establish the new standards relating to the delivery of a high quality pain service.

To deliver this over a three year cycle the audit is divided into three phases:

- **Phase 1:** Pain service registration and completion of a service questionnaire by the registrant based upon key standards. Organisations are benchmarked against national and internationally agreed standards where they could be ascertained. Standards were refined by the scientific committee.
- **Phase 2:** Gathering of case mix information from both the provider clinicians and patients. Also collecting information from patients about their journey to a pain service.
- **Phase 3:** Assessing outcomes of care from a patient perspective using validated standard questionnaires and questions developed specifically for the audit by both clinicians and patients.

The audit has been lead by the British Pain Society which is multi-professional in its remit and has significant patient involvement in its activities.

This report covers phase 1 of the audit (i.e. organisational data.)

Methodology:

Recruitment to the Audit:

All services in England and Wales that came under the HES treatment definition of a specialist pain management regardless of setting were eligible to participate. A list of participating centres is given in Appendix 1.

Centres were located over January 2010 to July 2011 using the following methods:

1. Emailing contacts within Primary Care Trusts, Local Health Boards, Hospital Audit Leads, PCT audit leads, British Pain Society members.

2. Letters sent to all Chief Executives from Sir Liam Donaldson, at the time Chief Medical Officer, requesting participation.

3. Articles placed in the Chief executives bulletin from Sir Liam Donaldson, the British Pain Society Newsletter and Faculty of Pain Medicine section of the Royal College of Anaesthetists Bulletin.

4. Hospital services using treatment definition code 191 located and contacted by telephone.

Once located, services were emailed a questionnaire to complete that described their services using the fields described in Appendix 2. The questionnaire was based upon the Faculty of Pain Medicine standards for General provision of Pain services (Appendix 3) the International Association for the Study of Pain's (IASP) classification of pain services (Appendix 4) and IASP recommendations on waiting times. Feedback was also specifically invited from the Patient Liaison Group of the British Pain Society and the Chronic Pain Policy Coalition, which has many patient organisations within the coalition.

Data Validation Checks:

Data were validated using the following methods:

1. Initial scan of return for obvious errors (e.g. duplication, fields mismatched, numerical errors) by project team that included clinicians.

2. Telephone call to clinical lead identified in the questionnaire to confirm data

3. Cross referencing of information collected with that contained in Hospital Episode Statistics (HES) for England and PEDW for Wales.

4. Establishing a website "Find a Clinic" that was public facing with the data contained within it and inviting comment on accuracy.

5. Presentation of preliminary findings at specialist society annual scientific meeting and inviting feedback from British Pain Society council and Faculty of Pain Medicine clinicians as to validity.

6. Cross referencing of items within the questionnaire (e.g. verifying that the staffing and resources stated matched the clinic type classification.) Discrepancies were noted and reported on.

Data Analysis:

Data was reported by organisation. Thus a service may be spread over several organisations but each were reported individually; several services were reported in one organisation but these were amalgamated together for the purpose of the audit.

Services were reported by alphanumeric data for population served, average waiting times, PCT/LHB served and location of service.

Services were classified by self assessment according to the IASP definitions:

A: Modality Orientated Clinic – clinic carrying out one treatment only

B: Pain Clinic – clinic carrying out more than one treatment but service has single profession

C: Multidisciplinary Pain Clinic – service carrying out more than one treatment, more than one type of health care professional

D: Multidisciplinary Pain Centre – as per multidisciplinary pain clinic but also carrying out research

A service was classified as meeting agreed standards across a range of domains (Appendix 2) which were described as 'Met' or 'Not Met'.

Reporting was by individual provider, PCT and SHA and per 100K population.

Standards were then grouped by:

- Data completeness
- Type of Clinic
- Key standard on waiting times (see below)
- Key standard on multidisciplinary care (see below)
- Clinical Staffing
- IT support
- Wheelchair Access
- Administrative Support
- Pharmacy Support
- Able to carry out audit
- Able to carry out research
- Other

Key Audit Standards:

One feature of this audit was to define two key standards that services should meet. Key standards were defined as:

- Meeting waiting times for elective access to treatment (as defined by the current NHS England target of 18 weeks wait for elective care treatment)
- Access to multidisciplinary care

Key standard on Waiting Times

Patients state that the time they waited to be seen is critical to a good experience. Research has established that patients with chronic pain deteriorate while waiting for treatment. The deterioration includes escalating pain and depression and decreased health-related quality of life. In addition, an international survey of IASP Presidents and other key informants identified that problems with wait-times for appropriate services or with lack of access to services occur in many countries

IASP has therefore defined minimum standards on waiting times as:

• **Acute painful conditions should be treated immediately** (e.g. sickle cell, painful crises and pain related to trauma or surgery.)

• **Most urgent (treatment within 1 week):** A painful severe condition with the risk of deterioration or chronicity, such as the acute phase of complex regional pain syndrome (CRPS), pain in children or pain related to cancer or terminal or end-stage illness.

• **Urgent or semi-urgent (treatment within 1 month):** Severe undiagnosed or progressive pain with the risk of increasing functional impairment, generally of 6 months' duration or less (e.g. back pain that is not resolving or persistent post surgical or post-traumatic pain.)

• **Routine or regular (treatment within 8 weeks):** Persistent long-term pain without significant progression.

The UK government has an elective wait time of 18 weeks. This was therefore chosen as the key standard. Times were reported by provider, PCT and SHA per 100K population.

Key Standard on Multidisciplinary Care

The minimum standard for multidisciplinary care was defined by the availability of medical, rehabilitation and psychological expertise. This was agreed by the scientific committee on the basis that treatment with the strongest evidence base is firstly interdisciplinary cognitive behavioural therapy[12] requiring confirmation of diagnosis and management of distress and disability due to chronic pain and secondly prescription of medication for the treatment of musculoskeletal pain and neuropathic pain[13 14]. These were reported in NHS Atlas format which gives a pictorial guide to variation in care by primary care trust and Strategic Health Authority[15]. Services were reported in two ways at primary care trust level: by their location within a primary care trust and by the number of primary care trusts that they serviced. This then gave an indication of which primary care trusts were meeting these key standards both by easy access to care in terms of time patients needed to wait for care and also by how far patients had to travel to receive care. These were elements considered important by both professional and patient groups. Thus, for example, a patient could have access to multidisciplinary care but have to travel many miles to receive it, or they could wait a very long time but the service could be local to their needs. It was not ascertained at this stage how patients made these choices.

Results:

Data Returns

Two hundred and fourteen clinics returned information on their service covering 151 Primary Care Trusts (PCTs) in England and 10 clinics in 7 Health Boards in Wales. One hundred and thirty-six clinics in England were based in acute trusts and 31 in community trusts; their setting was not clear in 37 cases. The majority of PCTs and LHBs had 1-2 services located within them. However, this was subject to considerable variation. Some providers stated that they had multiple pain clinics, and five clinics based in a single PCT (Hertfordshire) returned data. But for 28 PCTs there appeared to be no service or insufficient information was returned. For example, several services based in the Midlands did not participate in the Audit, with one clinic claiming that it would paint their service in a bad light. Also in some cases we received a 'summary' of data for all clinics within the PCT/hospital trust. In two cases only this summary information, rather than data for all services, was provided, hence services were merged into a single clinic. This happened with Doncaster and Bassetlaw Hospitals NHS Foundation Trust, where the clinic count was reduced from 4 to 1, and Gloucestershire Hospitals NHS Foundation Trust, where the count was reduced from 8 to 1.

Number Clinics located in PCT/LHB	N
1	68
2	43
3	17
4	1
5	1
Not Available	28

There was great difficulty in locating clinics that were based outside of hospitals and no way of cross-referencing these with HES data. If care outside hospital becomes more common then information systems will need to adapt to this. Otherwise there is no easy way to identify these services.

Differences in service provision may occur due to the desire of some PCTs/LHBs to ensure that services are located conveniently to patients rather than being centralised or to encourage competition. There is a balance between the sustainability of a multidisciplinary team and a number of small but conveniently located clinics. However, it may then be very confusing for both patients and referrers to understand which clinic to refer to incurring considerable delay.

Audit Standard: Data Completeness

Respondents in England completed 63% of questionnaire fields; this figure was very similar at 62% for Wales. The least well responded to items were those on staffing.

England:

blank cells	all cells	% blank	% complete
11256	30192	37%	63%

Wales:

blank cells	all cells	% blank	% complete
564	1480	38%	62%

Clinics located by SHA

The number of clinics that returned data varied widely in each region. There appear to be the lowest number of clinics per head of population in the East Midlands and the highest in the North East.

sha code		clinic count	Per 100K population
Q30	North East SHA	13	0.50
Q31	North West SHA	31	0.45
Q32	Yorks & The Humber SHA	19	0.36
Q33	East Midlands SHA	12	0.27
Q34	West Midlands SHA	22	0.41
Q35	East of England SHA	23	0.40
Q36	London SHA	32	0.42
Q37	South East Coast SHA	17	0.39
Q38	South Central SHA	15	0.37
Q39	South West SHA	20	0.38
	Wales	10	0.33

Commentary:
Whilst the Midlands and the South East Coast had the poorest responses there does appear to be significant under-provision of service in these regions.

Audit Key Standard: Waiting times

For the 18 weeks key standard, 80% of clinics in England reported meeting the standard, 2.5% explicitly did not meet the standard whilst the remainder did not answer the question. The question on waiting times has one of the highest completion rates, which is unsurprising given waiting times are a key government target. In Wales where targets are somewhat different 50% of clinics achieved 18 weeks for elective waits with a lower completion rate of 70%. This variation may demonstrate how targets could affect structure and function of a clinic.

Again there was significant variation in wait times in England as shown by table Eighteen-week wait target by SHA in England.

Where waiting times were over 18 weeks the median wait was 20 weeks in England and 33 weeks in Wales.

Eighteen-week wait target by SHA in England

shacode		Yes	No	Insufficient Information	% meeting standard
Q30	North East SHA	13	0	0	100%
Q31	North West SHA	24	0	7	77%
Q32	Yorks & The Humber SHA	15	1	3	79%
Q33	East Midlands SHA	6	0	6	50%
Q34	West Midlands SHA	17	0	5	77%
Q35	East of England SHA	22	0	1	96%
Q36	London SHA	22	3	7	69%
Q37	South East Coast SHA	12	0	5	71%
Q38	South Central SHA	14	0	1	93%
Q39	South West SHA	18	1	1	90%
	England	**163**	**5**	**36**	**80%**

Commentary:

Whilst coverage was not 100% it is unlikely that one region will have tended to return less data than another. Therefore there is significant variation between regions in terms of pain clinic coverage for the population.

Audit Key Standard: Multidisciplinary care

The questionnaire asked clinics to identify their type of service using the IASP classification:

A: Modality Orientated Clinic – clinic carrying out one treatment only

B: Pain Clinic – clinic carrying out more than one treatment but service has single profession

C: Multidisciplinary Pain Clinic – service carrying out more than one treatment, more than one type of health care professional

D: Multidisciplinary Pain Centre – as per multidisciplinary pain clinic but also carrying out research

Using these criteria, services reported their type of provision as shown in the table 'Self-report: Multidisciplinary clinic provision by SHA in England and in Wales':

Self-report: Multidisciplinary clinic provision by SHA in England and in Wales

	clinic count	Modality Oriented (%)	Pain Clinic (%)	Multidisciplinary Pain Clinic (%)	Multidisciplinary Pain Centre (%)	blank	% complete
North East SHA	13	0 (0)	0 (0)	10 (77)	3 (23)	0	100%
North West SHA	31	5 (16)	7 (23)	12 (39)	3 (10)	4	87%
Yorks & The Humber SHA	19	1 (5)	5 (25)	6 (32)	6 (32)	1	95%
East Midlands SHA	12	0 (0)	5 (42)	4 (33)	3 (25)	0	100%
West Midlands SHA	22	1 (5)	8 (36)	8 (36)	3 (14)	2	91%
East of England SHA	23	3 (13)	5 (22)	11 (48)	4 (17)	0	100%
London SHA	32	3 (9)	7 (22)	10 (31)	11 (34)	1	97%
South East Coast SHA	17	0 (0)	3 (18)	9 (53)	4 (24)	1	94%
South Central SHA	15	1 (7)	3 (20)	7 (47)	3 (20)	1	93%
South West SHA	20	0 (0)	6 (30)	8 (40)	5 (25)	1	95%
England	**204**	**14 (7)**	**49 (24)**	**85 (42)**	**45 (22)**	**11**	**95%**
Wales	**10**	**0 (0)**	**2 (20)**	**7 (70)**	**1 (10)**	**0**	**100%**

However, multidisciplinarity is such an important issue that the scientific advisory committee felt it would be best demonstrated by the presence of key personnel as outlined above. Therefore, data on key personnel were used to provide a stricter basis on which to assess multidisciplinary status.

The findings from this stricter approach were that 81 out of 204 English clinics could be defined as multidisciplinary by the presence of a psychologist, physiotherapist and physician. From this analysis 40% achieved the key standard of being a multidisciplinary pain clinic; 15% did not. The respective figures for Wales are 60% and 30%. However, despite several attempts at validating the data in the remaining 45% of English clinics and one Welsh clinic, the fields were either left blank or contained invalid data so their status could not be ascertained. Data are shown below in the table 'Multidisciplinary clinic provision by SHA in England and in Wales':

Multidisciplinary clinic provision by SHA in England and in Wales

shacode		Yes	No	Insufficient Information	% meeting standard
Q30	North East SHA	9	1	3	69%
Q31	North West SHA	10	3	18	32%
Q32	Yorks & The Humber SHA	6	5	8	32%
Q33	East Midlands SHA	3	2	7	25%
Q34	West Midlands SHA	6	4	12	27%
Q35	East of England SHA	9	5	9	39%
Q36	London SHA	12	2	18	38%
Q37	South East Coast SHA	6	5	6	35%
Q38	South Central SHA	6	1	8	40%
Q39	South West SHA	14	2	4	70%
	England	**81**	**30**	**93**	**40%**
	Wales	**6**	**3**	**1**	**60%**

Commentary:

Both the Midlands and SE Coast seem relatively poorly served by multidisciplinary services using the stricter approach to multidisciplinarity. If data is analysed by the presence of key professionals who are necessary to provide multidisciplinary pain care then the number of multidisciplinary clinics was substantially lower than the number self-rating themselves as multidisciplinary.

Audit Standard: Research

Fifty-six clinics in England (27%) reported that they regularly carry out clinical research. Of the English clinics defining themselves as multidisciplinary clinics or centres, 47 (36% of those self-defined as multidisciplinary) reported that they carry out research. Two of the self-reported multidisciplinary pain clinics in Wales carried out research.

Audit Standard: Clinical Staffing

For those services reporting that they provided psychologically based rehabilitation 48% in England and 60% in Wales reported the presence of a clinical psychologist.

For English services reporting specialist medication management (92%) the presence of a consultant was confirmed in 71%, suggesting that up to 29% of clinics may not offer senior support. Given that General practitioners have struggled to manage medication in this group, and that prescription may involve strong opioids on a long term basis and medicines with significant side effects, these figures are concerning**.** In contrast 90% of clinics in Wales had access to consultant support for medication management.

Given that medicines management is so challenging in this group the Faculty of Pain Medicine also recommends that a service has access to a clinical pharmacist. Seventy eight per cent of responders in England reported access to an onsite pharmacy but only 30% in Wales. Senior medical staff are also needed for the provision of interventional pain management. This is an area that requires careful management as the evidence base is unclear and patients often need to be considered on individual merit. Eighty-one percent of English clinics carried out interventional pain management, with 72% able to offer a consultant-led interventional pain service. In Wales 70% of clinics reported carrying out interventional pain management with all of these having access to a consultant.

Physiotherapy posts

Only 52% of services in England reported having access to a physiotherapist (60% for Wales). Given that pain may severely limit physical activity they should be regarded as key personnel in any pain service, and the skills required to work effectively with chronic pain are not the same as routine outpatient physiotherapy care. We were only able to locate standards from the 1990's for physiotherapy.

Commentary:

To ensure that treatment is carried out to the appropriate standard key skills, knowledge and an appropriate level of seniority is necessary. Under half of services in England had access to clinical psychologists to support provision of psychological rehabilitation. Around three-quarters had a consultant physician to support medication management and interventional pain medicine. This suggests that around a quarter of services may not have consultant support despite offering complex interventions and treatments. Given the complexity of case mix and risk of significant harm if complex treatments do not have senior input this is worrying. Around half of services had no specialist physiotherapy available - a serious gap in provision.

People with chronic pain who require specialist care, have, by definition, been struggling under the care of their General Practitioner. A significant number will have severe pain, not amenable to pain relief a GP is familiar with and a significant number are likely to be both severely physically and mentally disabled by their pain. If relevant specialist staff are not available then the case mix must be reduced accordingly to exclude those with significant

emotional distress, taking complex mixtures of medicines or requiring interventional pain management. Standards for physiotherapists working in pain management date from 1996, were due for revision in 1999 but this appears not to have happened. Training courses for physiotherapists are occasionally given for pain management but none are designed to test competence and none are based on any accepted guidelines. Psychologists have no specific standards.

It is highly probable that the usefulness of a service may be severely compromised as a result. These issues require further exploration and research.

Audit Standard : IT support

Information Technology support is essential to management of a patient in a specialist service. Information needs to be clearly communicated to others in a timely fashion, appointments need to be scheduled efficiently and team members often need to liaise with other health and social care personnel.

This standard was well completed attaining 92% completion rates for England and 90% for Wales. However, in England only 57% of services reported that they had good access to patient information systems. In Wales 80% reported good access to patient information systems.

Commentary:

People in pain who attend specialist facilities have usually seen a variety of specialists, have tried a variety of treatments and have significant co-morbidity. It is important to have good access to this information in planning care. Without this care is significantly compromised.

Audit Standard: Wheelchair Access

As the population attending pain services is frequently highly disabled good wheelchair access is essential. Ninety three percent of respondents completed this section with all of these stating that they had wheelchair access. Similarly, of the 80% of services in Wales who responded, all reported good access for those with disabled facilities.

Audit standard: Supporting Professional Activities

These activities ensure continuity of service and maintenance of high standards. Without training, new staff services would face significant challenges to sustainability. Clinical audit ensures that services are able to maintain a high standard of care[16].

The Faculty of Pain Medicine states “services should 'Carry out regular supporting professional activities'”. Services were asked to report on their ability to perform audit and teach various professions.

In general there was a high completion rate (around 90%) for this section of the audit . Seventy four per cent of English services reported that they were able to carry out clinical audit. Fifty three per cent of services reported being able to teach medical students and

physiotherapists. Sixty six percent reported being able to teach nursing staff. Ninety per cent of services in Wales carry out regular audit, 50% teach medical students, 70% teach physiotherapists and 80% teach nursing staff.

Commentary*:*

Audit appears to be a core activity of many pain services which should drive quality. However, only around half of services are able to train medical students, with numbers somewhat better for other staff. This threatens the viability of services in the longer term.

Audit Standard: Service has access to administrative staff to support the smooth operation of the service

This section also had a high completion rate (94% for England and 90% for Wales); 84% of English services and 80% of those in Wales reported having dedicated administrative staff.

Without administrative support services cannot function. This figure needs to be 100%.

Other findings:

- 24 hour availability to cover inpatients specifically for neurostimulation and intrathecal pumps: England 51%, Wales 40%.
- Patients with chronic pain may have significant psychiatric co-morbidity. Nine services in England reported defined links to psychiatric services as recommended by the Faculty of Pain Medicine. In Wales none reported such links. The importance or otherwise of this needs to be understood.

Recommendations:

- A code needs to be applied to all specialist pain services regardless of setting to identify them. Currently the treatment function in HES only applies to acute settings. This should be extended to non-acute settings.
- Patient waiting times need to be reviewed specifically for pain services and the impact of such waits better understood.
- If a service cannot provide multidisciplinary care then it must be able to signpost to services which can. Such services need to be appropriately accessible to patients.
- An agreed definition of multidisciplinary care is needed.
- Standards for training for physiotherapists and psychologists are needed.
- An agreed definition of necessary personnel to deliver psychologically based treatments in a pain service is needed.
- A robust treatment classification is needed.
- There needs to be a widespread agreement on standards of care with these supported by governmental bodies .
- A consensus as to standards of multidisciplinary care is needed.
- If key personnel are not available then the case mix should be adjusted to take this into consideration. Phase 2 of the audit will establish case mix in individual clinics.
- Mergers of some of the services where there is multiple provision may improve standards of care.
- Services require greater support in access to information about patients than is current.

- Clarification is needed as to who is providing education/self-help and what is meant by this.

Appendix 1: Participating Centres returning information

England:

TRUSTS		
code	**name**	**clinic count**
total clinics		**174**
RA2	Royal Surrey County Hospital NHS Trust	1
RA4	Yeovil District Hospital NHS Foundation Trust	1
RA7	University Hospitals Bristol NHS Foundation Trust	1
RA9	South Devon Healthcare NHS Foundation Trust	1
RAE	Bradford Teaching Hospitals NHS Foundation Trust	1
RAJ	Southend University Hospital NHS Foundation Trust	1
RAL	Royal Free Hampstead NHS Trust	1
RAN	Royal National Orthopaedic Hospital NHS Trust	1
RAP	North Middlesex University Hospital NHS Trust	1
RAS	The Hillingdon Hospital NHS Trust	1
RAX	Kingston Hospital NHS Trust	1
RBA	Taunton and Somerset NHS Foundation Trust	1
RBB	Royal National Hospital for Rheumatic Diseases NHS Foundation Trust	1
RBD	Dorset County Hospital NHS Foundation Trust	1
RBK	Walsall Hospitals NHS Trust	1
RBL	Wirral University Teaching Hospital NHS Foundation Trust	1
RBN	St Helens and Knowsley Hospitals NHS Trust	1
RBS	Alder Hey Children's NHS Foundation Trust	1
RBZ	Northern Devon Healthcare NHS Trust	1
RC3	Ealing Hospital NHS Trust	1
RC9	Luton and Dunstable Hospital NHS Foundation Trust	1
RCB	York Hospitals NHS Foundation Trust	1
RCC	Scarborough and North East Yorkshire Health Care NHS Trust	1
RCU	Sheffield Children's NHS Foundation Trust	1
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	1
RD1	Royal United Hospital Bath NHS Trust	1
RD3	Poole Hospital NHS Foundation Trust	1
RD7	Heatherwood and Wexham Park Hospitals NHS Foundation Trust	1
RDD	Basildon and Thurrock University Hospitals NHS Foundation Trust	1
RDE	Colchester Hospital University NHS Foundation Trust	3
RDU	Frimley Park Hospital NHS Foundation Trust	1
RDZ	The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	1
REF	Royal Cornwall Hospitals NHS Trust	1
REN	Clatterbridge Centre for Oncology NHS Foundation Trust	1
REP	Liverpool Womens NHS Foundation Trust	1
RET	The Walton Centre NHS Foundation Trust	1
RF4	Barking, Havering and Redbridge Hospitals NHS Trust	2

RFS	Chesterfield Royal Hospital NHS Foundation Trust	1
RGC	Whipps Cross University Hospital NHS Trust	1
RGM	Papworth Hospital NHS Foundation Trust	1
RGN	Peterborough and Stamford Hospitals NHS Foundation Trust	1
RGP	James Paget University Hospitals NHS Foundation Trust	1
RGQ	Ipswich Hospital NHS Trust	1
RGR	West Suffolk Hospitals NHS Trust	1
RGT	Cambridge University Hospitals NHS Foundation Trust	1
RH8	Royal Devon and Exeter NHS Foundation Trust	1
RHM	Southampton University Hospitals NHS Trust	1
RHQ	Sheffield Teaching Hospitals NHS Foundation Trust	1
RHU	Portsmouth Hospitals NHS Trust	1
RHW	Royal Berkshire NHS Foundation Trust	2
RJ1	Guy's and St Thomas' NHS Foundation Trust	1
RJ2	The Lewisham Hospital NHS Trust	1
RJ7	St George's Healthcare NHS Trust	1
RJC	South Warwickshire General Hospitals NHS Trust	1
RJD	Mid Staffordshire NHS Foundation Trust	2
RJE	University Hospital of North Staffordshire NHS Trust	2
RJL	Northern Lincolnshire and Goole Hospitals NHS Foundation Trust	1
RJR	Countess of Chester Hospital NHS Foundation Trust	1
RJZ	King's College Hospital NHS Foundation Trust	1
RK5	Sherwood Forest Hospitals NHS Foundation Trust	1
RK9	Plymouth Hospitals NHS Trust	1
RKB	University Hospitals Coventry and Warwickshire NHS Trust	1
RKE	Whittington Hospital NHS Trust	1
RL1	Robert Jones and Agnes Hunt Orthopaedic and District Hospital NHS Trust	1
RL4	The Royal Wolverhampton Hospitals NHS Trust	1
RLN	City Hospitals Sunderland NHS Foundation Trust	1
RLT	George Eliot Hospital NHS Trust	1
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	1
RM2	University Hospital of South Manchester NHS Foundation Trust	1
RM4	Trafford Healthcare NHS Trust	1
RMC	Royal Bolton Hospital NHS Foundation Trust	1
RMP	Tameside Hospital NHS Foundation Trust	1
RN1	Winchester and Eastleigh Healthcare NHS Trust	1
RN3	Great Western Hospitals NHS Foundation Trust	1
RN5	Basingstoke and North Hampshire NHS Foundation Trust	1
RN7	Dartford and Gravesham NHS Trust	1
RNA	The Dudley Group of Hospitals NHS Foundation Trust	1
RNH	Newham University Hospital NHS Trust	1
RNJ	Barts and The London NHS Trust	1
RNL	North Cumbria University Hospitals NHS Trust	2
RNQ	Kettering General Hospital NHS Foundation Trust	1
RNS	Northampton General Hospital NHS Trust	1
RNZ	Salisbury NHS Foundation Trust	1
RP5	Doncaster and Bassetlaw Hospitals NHS Foundation Trust	1
RPA	Medway NHS Foundation Trust	1
RPY	The Royal Marsden NHS Foundation Trust	1
RQ6	Royal Liverpool and Broadgreen University Hospitals NHS Trust	1

RQM	Chelsea and Westminster Hospital NHS Foundation Trust	1
RQW	The Princess Alexandra Hospital NHS Trust	2
RQX	Homerton University Hospital NHS Foundation Trust	1
RR1	Heart of England NHS Foundation Trust	1
RR7	Gateshead Health NHS Foundation Trust	1
RR8	Leeds Teaching Hospitals NHS Trust	2
RRF	Wrightington, Wigan and Leigh NHS Foundation Trust	1
RRJ	The Royal Orthopaedic Hospital NHS Foundation Trust	1
RRK	University Hospital Birmingham NHS Foundation Trust	1
RRV	University College London Hospitals NHS Foundation Trust	1
RT3	Royal Brompton & Harefield NHS Foundation Trust	2
RTD	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	1
RTE	Gloucestershire Hospitals NHS Foundation Trust	1
RTF	Northumbria Healthcare NHS Foundation Trust	4
RTH	Oxford Radcliffe Hospitals NHS Trust	1
RTK	Ashford and St Peter's Hospitals NHS Trust	1
RTP	Surrey and Sussex Healthcare NHS Trust	1
RTR	South Tees Hospitals NHS Foundation Trust	3
RTX	University Hospitals of Morecambe Bay NHS Trust	1
RV8	North West London Hospitals NHS Trust	2
RVJ	North Bristol NHS Trust	1
RVR	Epsom and St Helier University Hospitals NHS Trust	1
RVV	East Kent Hospitals University NHS Foundation Trust	2
RVW	North Tees and Hartlepool NHS Foundation Trust	2
RVY	Southport and Ormskirk Hospital NHS Trust	1
RW6	Pennine Acute Hospitals NHS Trust	4
RWA	Hull and East Yorkshire Hospitals NHS Trust	1
RWD	United Lincolnshire Hospitals NHS Trust	3
RWE	University Hospitals of Leicester NHS Trust	1
RWF	Maidstone and Tunbridge Wells NHS Trust	1
RWG	West Hertfordshire Hospitals NHS Trust	5
RWH	East and North Hertfordshire NHS Trust	2
RWJ	Stockport NHS Foundation Trust	1
RWP	Worcestershire Acute Hospitals NHS Trust	1
RWY	Calderdale and Huddersfield NHS Foundation Trust	2
RX1	Nottingham University Hospitals NHS Trust	1
RXC	East Sussex Hospitals NHS Trust	2
RXF	Mid Yorkshire Hospitals NHS Trust	2
RXH	Brighton and Sussex University Hospitals NHS Trust	2
RXK	Sandwell and West Birmingham Hospitals NHS Trust	1
RXL	Blackpool Fylde and Wyre Hospitals NHS Foundation Trust	1
RXN	Lancashire Teaching Hospitals NHS Foundation Trust	1
RXP	County Durham and Darlington NHS Foundation Trust	2
RXQ	Buckinghamshire Hospitals NHS Trust	2
RXR	East Lancashire Hospitals NHS Trust	1
RXW	The Shrewsbury and Telford Hospital NHS Trust	1
RY6	Leeds Community Healthcare NHS Trust	1
RYJ	Imperial College Healthcare NHS Trust	2
RYQ	South London Healthcare NHS Trust	3
RYR	Western Sussex Hospitals NHS Trust	1
HCHC	Hampshire Community Health Care	1

5PX	Mid Essex PCT	2
5F5	Salford PCT	2
5P6	West Sussex PCT	2
5QL	Somerset PCT	2
5NK	Wirral PCT	1
5QT	Isle of Wight NHS Primary Care Trust	1
5M2	Shropshire County PCT	1
5QA	Eastern And Coastal Kent PCT	1
5HQ	Bolton PCT	2
5NY	Bradford and Airedale Teaching PCT	1
5L1	Southampton City PCT	2
5C3	City And Hackney Teaching PCT	1
5F1	Plymouth Teaching PCT	1
5FE	Portsmouth City Teaching PCT	1
5PG	Birmingham East And North PCT	1
5NX	Hull Teaching PCT	1
5NJ	Sefton PCT	1
5EM	Nottingham City PCT	1
5PA	Leicestershire County And Rutland PCT	2
5PF	Sandwell PCT	1
5C4	Tower Hamlets PCT	1
TAN	North East Lincolnshire Care Trust Plus	1

Wales:

381	Aneurin Bevan Health Board	1
382	Pain clinic Ysbyty Gwynedd	1
384	Pain Clinic, Glan Clwyd Hospital	1
388	Chronic Pain Management Service, Velindre NHS Trust	1
357	Royal Glamorgan Hospital	1
385	West Wales General Hospital	1
389	Pain Clinic, Withybush General Hospital	1
403	Ysbyty Maelor Hospital , Wrexham	1
	Abertawe and BroMorgannwg (limited data at present)	1
	Bronllys Pain Management Programme, Brecon	1

Appendix 2:Data fields

STRUCTURAL DATA:

- HOSPITAL \ CLINIC NAME
- ODS SITE CODE
- PARENT PROVIDER ODS CODE
- ADDRESS LINE 1
- ADDRESS LINE 2
- ADDRESS LINE 3
- TOWN
- POSTCODE
- TELEPHONE NUMBER
- EMAIL ADDRESS

GENERAL INFORMATION:

- FACILITY SETTING
- DESCRIPTION OF SERVICE
- PCT(S) SERVED BY THE FACILITY
- POPULATION SIZE SERVED BY THE FACILITY
- AVERAGE WAITING TIME FROM REFERRAL TO FIRST APPOINTMENT

STAFFING:

- NUMBER OF CONSULTANT POSTS BY SPECIALTY
- AVERAGE WTE OF CONSULTANT(S)
- NUMBER OF LOCUM CONSULTANT POSTS BY SPECIALTY
- AVERAGE WTE OF LOCUM CONSULTANT(S)
- NUMBER OF NON CONSULTANT CAREER GRADE DOCTORS
- AVERAGE WTE OF NON CONSULTANT CAREER GRADE DOCTORS
- NUMBER OF TRAINEE DOCTORS BY TYPE
- AVERAGE WTE OF TRAINEE DOCTORS
- NUMBER OF HEALTH PROFESSIONALS WORKING AT THE FACILITY BY TYPE
- AVERAGE WTE OF HEALTH PROFESSIONALS BY TYPE
- NUMBER OF ADMINISTRATIVE AND SUPPORT POSTS AT THE FACILITY BY TYPE
- AVERAGE WTE OF ADMINISTRATIVE AND SUPPORT STAFF
- NUMBER AND TYPE OF STAFF TRAINING SESSIONS AVAILABLE

FACILITIES:

- ACCESS TO FACILITIES SUITABLE FOR INTERVENTIONAL PAIN PROCEDURES
- AVAILABILITY OF FACILITIES AND SPECIALIST EQUIPMENT
- ACCESS FOR WHEELCHAIRS AND DISABLED PATIENTS
- AVAILABILITY OF INPATIENT BEDS AND 24 HR MEDICAL COVER
- SUPPORT SERVICES AVAILABLE FOR PATIENTS
- ACCESS TO INFORMATION TECHNOLOGY
- OUTPATIENT FACILITIES
- AVERAGE DURATION OF FIRST OUTPATIENT APPOINTMENT
- AVERAGE DURATION OF FOLLOW-UP APPOINTMENT

- NUMBER OF NEW PATIENTS SEEN DURING THE LAST FINANCIAL YEAR [2008/2009]
- NUMBER OF FOLLOW-UP PATIENTS SEEN DURING THE LAST FINANCIAL YEAR [2008/2009]
- NUMBER OF TELEPHONE CONSULTATIONS DURING THE LAST FINANCIAL YEAR [2008/2009]
- MULTIDISCIPLNARY TEAM WORKING ARRANGEMENTS
- TREATMENTS PROVIDED AT THE PAIN FACILITY
- AUDIT ACTIVITY
- CLINICAL RESEARCH ACTIVITY
- CLINICAL TRAINING & TEACHING AVAILABLE AT THE FACILITY

Appendix 3: Standards Applied to Audit

Item	Audit standard	Demonstrated by
Data completeness	100 % fields completed	% of questionnaire fully completed
Data correctness	100% completed correctly- for location & treatments as inpatients reported	Cross tab with known data from HES , routine statistics under 191 code
Type of Clinic (IASP standard)	Centre correctly describes type of clinic	Cross check with items Multidisciplinary (min staffing) Only one treatment provided Research capability
Staffing – clinical	Meets minimum requirement of RCOA GPAS CH 7 1.2	Physician Psychologist Physiotherapist
Staffing– clinical	Staffing appropriate for treatments provided RCOA GPAS CH 7 1.3	Psychological treatment has psychologist Pain management programme has at minimum psychologist /physiotherapist /medic working together medicines management has a medic injections have a medic Where multidisciplinary service there is a multidisciplinary team meeting to discuss patient care
Staffing inpatients with persistent pain – hospital based services only	100% acute hospitals have specialist nurse and doctor RCOA GPAS CH 7 1.4	Inpatients matched to staff for ward visits
For Neuro-modulation (spinal cord stimulation) services	24/7 availability of staff	Item on service questionnaire
Mental health support	Established risk assessment protocol for acting on potential suicidal risk	Item on questionnaire
Wrong diagnosis	Established risk assessment protocol for acting on misdiagnosis	Item on questionnaire
Administrative Support	Item 2.1 GPAS minimum standard	Item on questionnaire
Access to Pharmacy	100% have access 2.1	Item on questionnaire

Support for Medicine Advice	GPAS	
Information Technology support	Service has computerised access to notes and for audit purposes	Item on questionnaire
Wheelchair access	100%	Specific item on questionnaire
Timely access to Care	< 18 weeks for routine elective care IASP standard on waiting times	Item on wait time Calculate from waiting times question on questionnaire
Timely access to Care	< 1 month for urgent care IASP standard on waiting times	Can offer rapid assessment Calculate from waiting times question on questionnaire
Timely access to Care	< 1 week for emergency cases as per IASP	Calculate as above
Offer access to specialised support	At least one clinic per region can offer a service for: Cancer Survivors of Torture Children & adolescents Sickle cell Substance mis-users GPAS CH 3.0	Item on questionnaire
Carry out regular supporting professional activities	Teaching students Audit Research – for those listed as multidisciplinary pain centre by region	Items on questionnaire

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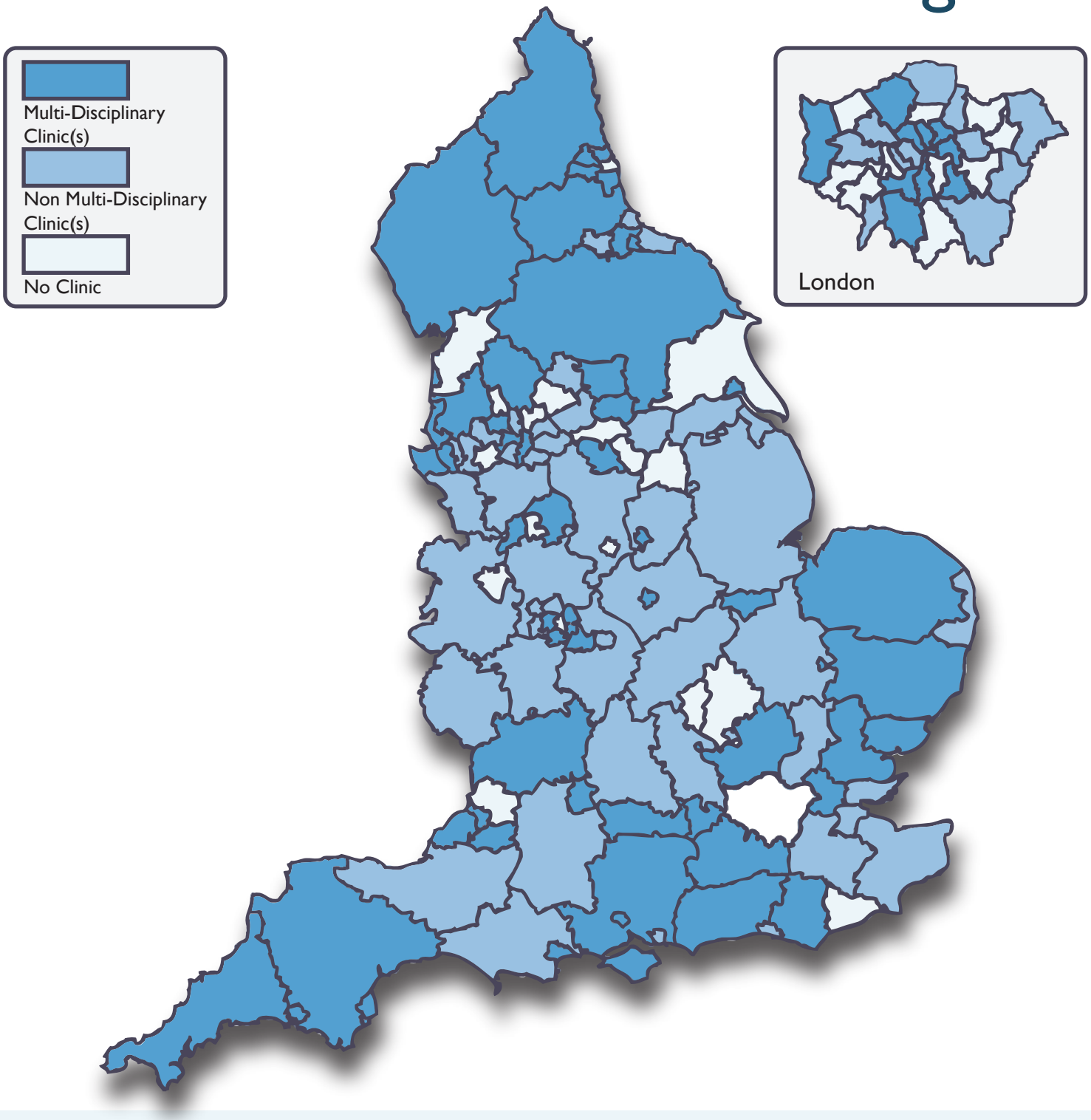
Pain Clinic Distribution in England



The National Pain Audit has developed a minimum standard for multidisciplinary care, consisting of the presence of a medical consultant, specialist psychologist and a physiotherapist. Measured against this standard, 40% of services in England and 60% of those in Wales provide data that confirms they meet the Audit standard for multidisciplinary care. There is wide geographical variation in access to multidisciplinary care; in some areas patients need to travel great distances as key personnel are often patchily available. Shortages of specialist psychologists, physiotherapists, occupational therapists and pharmacists hinder a multi-disciplinary approach.

The National Pain Audit

The British Pain Society

HQIP Healthcare Quality Improvement Partnership

dr foster