ESSENCE OF CARE

A consultation on a new benchmark on PAIN
Essence of Care – A consultation on the new benchmarks for Pain

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Circulation List: PCT CEs, NHS Trust CEs, Care Trust CEs, Foundation Trust CEs, Directors of Nursing, Local Authority CEs, Directors of Adult SSs, PCT Chairs, NHS Trust Board Chairs, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads, Directors of Children's SSs, Voluntary Organisations/NDPBs, Universities UK, RCN, RCM, AHPF, SHA Lead Nurses, SHA AHP Leads, Patient Organisations

Description: Essence of Care is a versatile and structured system of benchmarks widely used in various health settings. We have taken the opportunity with the launch of the new benchmark on Pain to review all of the material to ensure the system continues to reflect best practice. The revision followed the same format as that for devising the benchmarks themselves, via focus groups whose membership comprised people receiving care, carers and staff. We are now ready to consult more widely and would welcome your comments.

Action Required: Send comments on the consultation to EOC Pain/OIS/DOH@DOH
Timing: By 2 October 2009
Contact Details: Maureen Morgan
CNO-D-E&I-PL
Room 5E58
Quarry House, Quarry Hill
Leeds LS2 7UE
0113 25 46056

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ESSENCE OF CARE

A consultation on a new benchmark on PAIN

Prepared by Department of Health – CNO Directorate
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Introduction

*The NHS Plan (2000)* reinforced the importance of ‘getting the basics right’ and of improving the patient experience. The *Essence of Care*, launched in February 2001, provides a tool to help practitioners take a patient-focused and structured approach to sharing and comparing practice. (By practitioners we mean any healthcare employee delivering direct patient care).

There is strong evidence from the NHS that Essence of Care has enabled healthcare personnel to work with patients to identify best practice and to develop action plans to improve care. The original Benchmarks covered 8 areas. These were reformatted in 2003 and a Benchmark for communication was added. Since then two new Benchmarks have been added to cover Promoting Health (2006) and Care Environment (2007).

Essence of Care Benchmarks are developed by stakeholders from focus groups that will use them. A Focus group made up of carers, patients and professionals have met to review the benchmarks and this has led to a proposed new benchmark for Pain Management. We are now ready to consult more widely on the proposed reviewed benchmarks and welcome your comments on the accompanying document. There is a need to consult on this new Benchmark, whilst the available evidence strongly suggests that this is an effective and worthwhile approach, it is good practice to consider the available evidence from time to time.

Following this consultation your comments will be incorporated into the document where appropriate and the document will be launched along side the revised Essence of Care Toolkit.
Essence of Care identifies best practice and highlights how this can be achieved. *Essence of Care* was developed in partnership with *people*¹ and *carers*² and as such reflects their views of their health and social care needs and preferences.

It is important to note at this point that *Essence of Care* is a very versatile tool that can be used in a number of ways and at different levels. For example, it can be used as:

- a quality assurance or benchmarking tool (see below);
- a reference document or checklist - *Essence of Care* includes what *people*, carers and staff³ agree is best practice and care and this can, therefore, be referred to in order to understand *people’s* and carers’ perspectives and what might need to be improved to accommodate these;
- an audit tool - as a foundation and focus for audit data collection tools used to assess practice and care (linked to above);
- a dissemination tool - to spread current good practice and care across organisations;
- a root cause analysis tool - when examining incidents and complaints or addressing risks;
- an education tool - to educate and train staff³ of all levels about *people’s* and carers needs and preferences, and to highlight the areas where specific competencies are required to provide care; and
- to provide evidence of achievement and best practice and care - for example, to the regulator or Health Service Ombudsman, for the National Cleaning Standards, when using the National Service Frameworks,

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¹ For simplicity, the term 'people requiring care’ is shorted to *people* (in italics). *People* includes children, young people under the age of 18 years and adults. This is consistent for all sets of benchmarks except those covering the Care Environment.

² The term 'carers', refers to those 'who look after family, partners or friends in need of help because they are ill, frail or have a disability. The care they provide is unpaid'. (adapted from Carers UK, 2008). Carers can include children and young people aged under 18 years.

³ The term 'staff' refers to any employee, or paid and unpaid worker (for example, a volunteer) who has an agreement to work in that setting, involved in promoting well-being.
Essence of Care – A consultation on the new benchmarks for Pain

- Standards for Better Health, or in Commissioning Assurance.

*Essence of Care* can be used by individuals, teams, directorates, and within and across organisations of all sizes. It can also be used locally or strategically, or ideally, both. It has universal application.

When using *Essence of Care* it is important to remember to:

- **make it work for people and their carers**
  - focus on areas of concern for *people* and carers;
  - use *Essence of Care flexibly* to make improvements
  - ensure involvement from *people*, carers and all staff involved in the delivery of care;

- **make it work for staff and organisations**
  - save time and effort and integrate *Essence of Care* work with other projects and initiatives, such as those required for the National Cleaning Standards, reports for regulators, Infection Control Guidance, Mixed Sex Accommodation Guidance, Dignity Champions work, Governance, Patient Environment Action Teams’ Guidance, National Institute for Health and Clinical Excellence (NICE) Guidance, Electronic Handover, Better Metrics Projects, etc
  - use within Commissioning Assurance; and

- **do not reinvent the wheel - be 'smart'**
  - share and compare best practice and care (locally, nationally, other team’s work etc)
  - where possible use evidence already in existence (for example, current audit data)
  - use valid tools that already exist and
  - use evidence gathered for one set of benchmarks, for instance those concerning, 'Respect', to provide evidence for other sets of benchmarks such as 'Communication' and 'Food and Drink'. This applies both to goals that are more specific as well as goals that cover topics such as diversity, consent and confidentiality, *people’s* involvement, leadership, education and training etc.

Much of *Essence of Care* is centred on benchmarks and benchmarking for practice and care.
QUICK START

The following is a 'Quick Start' guide to start using the Essence of Care to improve practice and care.

IDENTIFY WHAT ASPECT OF PRACTICE AND OR CARE NEEDS IMPROVEMENT

Questions to ask:
What do people requiring care and or their carers complain or raise issues about most?
Why have incidents or accidents happened?
What areas have national or local surveys highlighted as being of concern?
For example, have there been any complaints about people requiring care not being helped to eat?

LOOK AT THE BENCHMARKS, FACTORS AND INDICATORS TO SEE WHAT PEOPLE REQUIRING CARE AND CARERS SAY NEEDS TO BE IN PLACE

Things to think about:
Are there any benchmarks that link with the area of concern identified above? For example, Benchmarks for Food and Drink.
Are there any factors that link with the specific area of concern? For example, 'People receive the care and assistance they require with eating and drinking' (Assistance - Factor 5).
Review the Indicators for practical ideas of how to achieve the Factors. For example, 'a system is in place to identify that people requiring assistance to eat and drink receive it' (Indicator b).

REVIEW AND CHANGE PRACTICE AND OR CARE

Ascertain whether current practice meets the Indicators. For example, identify whether there is a system in place which identifies people requiring assistance to eat and drink. If current practice does not meet the Indicators change practice so that it does. For example, introduce a system where food is delivered on red trays for people requiring assistance.

EVALUATE PRACTICE AND OR CARE FROM PERSPECTIVE OF PEOPLE REQUIRING CARE, THEIR CARERS AND STAFF

Questions to ask:
Do people requiring care and or their carers think that care has improved? or Are they happy with the standard of care? For example, are people and or carers satisfied with the assistance given to help people eat and drink? Is there evidence that people requiring care are well nourished?

ESTABLISH IMPROVED PRACTICE AND CARE OR REVISE FURTHER

Establish improved practice and care across the team, organisation, or organisations or improve practice and care further where it does not meet the Indicators.
BEST PRACTICE – GENERAL INDICATORS

The Factors and Indicators for each set of benchmarks focus on the specific needs, wants and preferences of people and carers. However, there are a number of general issues that must be considered with every Factor these are:

**People’s experience**
- *People* feel that care is delivered at all times with compassion and empathy in a respectful and non-judgemental way
- The best interests of *people* are maintained throughout the assessment, planning, implementation, evaluation and revision of care and development of services
- A system for continuous improvement of quality of care is in place

**Diversity and individual needs**
- Ethnicity, religion, belief, culture, language, age, gender, physical, sensory, sexual orientation, developmental, mental health, social and environmental needs are taken into account when diagnosing a health or social condition, assessing, planning, implementing, evaluating and revising care and providing equality of access to services

**Effectiveness**
- The effectiveness of practice and care is continuously monitored and improved as appropriate

**Consent and confidentiality**
- Explicit or expressed valid consent is obtained and recorded prior to sharing information or providing treatment or care
- People’s best interests are maintained where they lack the capacity to make particular decisions
- Confidentiality is maintained by all staff members

**People, carer and community members’ participation**
- Everyone’s views underpin the development, planning, implementation, evaluation and revision of personalised care and services and their input is acted upon
- Strategies are used to involve *people* and carers from isolated or hard to reach communities

**Leadership**
- Effective leadership is in place throughout the organisation

**Education and training**
- Staff are competent to assess, plan, implement, evaluate and revise care according to all people’s and carers’ individual needs
- Education and training are available and accessed to develop the required competencies of all those delivering care
- *People* and carers are provided with the knowledge, skills and support to best manage care

**Documentation**
- Care records are clear, maintained according to relevant guidance and subject to appropriate scrutiny
- Evidence-based policies, procedures, protocols and guidelines for care are up to date, clear and utilised

**Service delivery**
- Co-ordinated, consistent and accessible services exist between health and social care organisations that work in partnership with other relevant agencies
- Care is integrated with clear and effective communication between organisations, agencies, staff, *people* and carers
- Resources required to deliver care are available

**Safety**
Safety and security of *people*, carers and staff is maintained at all times

---

Agreed person-focused outcome

People and carers experience individualised, timely and supportive care that recognises and manages pain and optimises function and quality of life.
BENCHMARKS FOR PAIN MANAGEMENT

Agreed person-focused outcome

*People* and carers experience individualised, timely and supportive care that recognises and manages pain and optimises function and quality of life.

DEFINITIONS

For the purpose of these benchmarks is **pain** is:

\[
\text{whatever the person experiencing pain says it is, existing whenever the person communicates or demonstrates it does (adapted from McCaffrey M 1968)\textsuperscript{5}}
\]

and

\[
\text{an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage (Merskey and Bogduk 1994)\textsuperscript{6}}
\]

The above definitions incorporate the concept of pain as a subjective and complex experience and includes acute, chronic, intermittent, palliative, temporary, long term, acute on chronic etc pain.

For the purpose of these benchmarks is **pain management** is:

\[
\text{any intervention designed to alleviate pain and or its impact, such that quality of life and ability to function are optimised}
\]

Since pain is complex managing pain requires an holistic approach. Therefore, physical (including function), social, psychological, and spiritual aspects of pain need to be considered as part of assessment, care planning, implementation, evaluation and revision of practice and care.

For simplicity, **people requiring care** is shortened to **people (in italics)** or omitted for most of the body of the text. **People** includes children, young people under the age of 18 years and adults. **Carers** (for example, members of families and friends) are included as appropriate.

\footnotesize{\textsuperscript{5} McCaffrey M (1968) Nursing Practice Theories Related to Cognition, Bodily Pain, and Man-Environment Interactions University of California at Los Angeles Students' Store:Los Angeles \\
The term **carers** refers to those 'who look after family, partners or friends in need of help because they are ill, frail or have a disability. The care they provide is unpaid'. (Carers UK, 2002). Please note, within these benchmarks it is acknowledged that the term 'carer' can include children and young people aged under 18 years.

The term **staff** refers to any employee, or paid and unpaid worker (for example, a volunteer) who has an agreement to work in that setting, involved in promoting well-being.

The **care environment** is defined as an area where care takes place. For example, this could be a building or a vehicle.

The **personal environment** is defined as the immediate area in which a person receives care. For example, this can be in a person's home, a consulting room, hospital bed space, prison, or any treatment/clinic area.
# BENCHMARKS FOR PAIN MANAGEMENT

**Agreed person-focused outcome**

*People and carers experience individualised, timely and supportive care that recognises and manages pain and optimises function and quality of life.*

<table>
<thead>
<tr>
<th>Factor</th>
<th>Best practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Access</td>
<td><em>People</em> experiencing pain, or who are likely to experience pain, and carers receive timely and appropriate management of pain</td>
</tr>
<tr>
<td>2. Patient and carer participation</td>
<td><em>People</em> (where able), carers and staff are active partners in the decisions involving pain management</td>
</tr>
<tr>
<td>3. Assessment</td>
<td><em>People</em> have an ongoing, comprehensive assessment of their pain</td>
</tr>
<tr>
<td>4. Care planning, intervention, evaluation, review and prevention</td>
<td><em>People</em>’s individualised care concerning pain is planned, implemented, continuously evaluated and revised in partnership with <em>people</em>, staff and carers</td>
</tr>
<tr>
<td>5. Knowledge and Skills</td>
<td><em>People</em>, carers and staff have the knowledge and skills to understand how best to manage pain</td>
</tr>
<tr>
<td>6. Self management</td>
<td><em>People</em> are enabled to manage their pain when they wish to, and as appropriate</td>
</tr>
<tr>
<td>7. Partnership working</td>
<td><em>People</em>, carers and appropriate agencies work collaboratively to enable <em>people</em> to meet their pain management needs</td>
</tr>
<tr>
<td>8. Service evaluation and audit</td>
<td><em>People</em>, carers and staff have the knowledge and skills to understand how best to manage pain</td>
</tr>
</tbody>
</table>
**BENCHMARKS FOR PAIN MANAGEMENT**

**Factor 1 – Access**

<table>
<thead>
<tr>
<th>Poor Practice</th>
<th>Best Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>People</em> and carers do not have access to timely and appropriate pain management</td>
<td><em>People</em> experiencing pain, or who are likely to experience pain, and carers receive timely and appropriate management of pain</td>
</tr>
</tbody>
</table>

**Indicators of best practice for factor 1**

The following indicators support best practice for managing pain:

(a) *general indicators (see page 9) are considered in relation to this factor*

(b) up to date information about pain management and services, and how to access them, is readily available in all care environments and (where applicable) given in advance. Information provided is written in plain language

(c) appropriate and timely pain management and services are accessible for *people* with pain or anticipated pain (such as pain following surgery), and their carers. This includes interventions, resources, equipment, personnel and space to provide care

(d) *people* and carers can access pain management services by referring themselves, for example, when managing further episodes of pain

(e) commissioning organisations ensure that *people* have access to a full range of pain management services

(f) a single point of access leads to appropriate pain management services that are co-ordinated

(g) information concerning access to complementary therapies and services, and their possible effects are available to *people*

(h) there is equality of access to services for all *people* with pain or anticipated pain. This includes interventions, resources, equipment, personnel and space to provide care

(i) *add your local indicators here*
BENCHMARKS FOR PAIN MANAGEMENT

Factor 2 – Patient and carer participation

Indicators of best practice for factor 2

The following indicators support best practice for managing pain:

(a) general indicators (see page 9) are considered in relation to this factor
(b) People and carers decisions about managing pain are based on informed choices and opportunities
(c) People and carers are listened to, treated with respect and can discuss their concerns openly with staff. Where appropriate, people and carers are consulted separately
(d) people’s and carers’ needs, views and preferences are sought actively (where possible) and incorporated into a plan of care
(e) People, carers and staff develop and agree a realistic, appropriate pain management plan
(f) People, carers and staff understand the pain management plan
(g) People and carers are involved in evaluation of their pain management plan
(h) add your local indicators here
BENCHMARKS FOR PAIN MANAGEMENT

Factor 3 – Assessment

Poor Practice
People have an inadequate pain assessment

Best Practice
People have an ongoing, comprehensive assessment of their pain

Indicators of best practice for factor 3

The following indicators support best practice for managing pain:

(a) general indicators (see page 9) are considered in relation to this factor
(b) any health or social services encounter includes an enquiry about pain which leads to an appropriate referral as required
(c) people's pain management needs are identified on initial contact
(d) staff are competent to recognise when a person is experiencing pain, whether or not that person is able to describe the pain and or its severity
(e) evidence-based information concerning pain assessment and management is accessible to people and carers
(f) an evidence-based tool appropriate to the needs of people and their condition(s) is used to assess pain (including severity). This includes the use of, for example, observational scales or a report from a carer where there are communication difficulties or to accommodate different cognitive levels
(g) physical, (including function), social, psychological, and spiritual aspects of people’s pain and health profile are assessed using an evidence-based tool
(h) the assessment process recognises people's and carers’ perspectives, opinions and expectations of pain and it's management
(i) people’s pain experiences and (where appropriate) previous treatment is included in the assessment, for example, whether the pain is acute, chronic, palliative, intermittent, temporary, long term etc
(j) the impact of strategies to manage pain, for example, on other treatments or existing or long terms conditions, are assessed
(k) staff are competent to assess pain and ascertain the underlying cause of pain or are able to refer onwards as appropriate
(l) assessment of pain and management strategies by people, carers and staff is ongoing and is reviewed as appropriate. For example, pain is observed regularly along with other vital physiological measurements
(m) assessment includes the use and interactions of medications, allergies, side effects etc
**BENCHMARKS FOR PAIN MANAGEMENT**

**Factor 4 – Care Planning, implementation, evaluation, and prevention**

**Poor Practice**

*People* do not have a plan of care

**Best Practice**

*People’s individualised care concerning pain is planned, implemented, continuously evaluated and revised in partnership with people, staff and carers*

**Indicators of best practice for factor 4**

The following indicators support best practice for managing pain:

(a) *general indicators (see page 9) are considered in relation to this factor*

(b) planning, implementing, evaluating and revising care involves *people* and their carers, as well as all relevant members of staff

(c) pain management plans are evidenced-based and reflect all the components of *people’s* care including recognising the individuals’ experience of pain, and the agreed level of pain relief and function to be achieved

(d) a documented rationale for the treatment plan is in place

(e) interventions, such as medication to prevent, reduce or remove pain, are provided promptly and the results evaluated

(f) access to a range of pain management interventions and services is facilitated as appropriate

(g) *people* and carers can initiate a review of pain management strategies as they require

(h) *people* hold their own records where appropriate

(i) safety issues in relation to pain management, including the use of medication, are addressed

(j) protocols, policies and pathways are evidence-based and there is proof of their use and evaluation

(k) staff are competent to plan, implement, evaluate and revise care and demonstrate a professional attitude to *people* who require their pain to be managed

(l) *add your local indicators here*
BENCHMARKS FOR PAIN MANAGEMENT

Factor 5 - Knowledge and Skills

**Poor Practice**

*People, carers and or staff have inadequate knowledge of how to manage pain effectively*

**Best Practice**

*People, carers and staff have the knowledge and skills to understand how best to manage pain*

**Indicators of best practice for factor 5**

The following indicators support best practice for managing pain:

(a) *general indicators (see page 9) are considered in relation to this factor*

(b) timely, individualised, correct and evidence-based information is provided, where appropriate, to enable *people* and or carers to participate equally in decisions about the most appropriate package to manage pain

(c) information concerning assistance available when *people* cannot care for themselves, or in an emergency, is provided to *people* and carers

(d) *people* and carers are provided with ongoing, individualised evidence-based education and training to meet their pain management needs and preferences

(e) education and training needs of *people* and carers are assessed and learning outcomes are identified and met

(f) the views and expectations of *people* and carers are used to inform *people's*, carers' and staff's education and training programmes. This includes the use of *people's* testimony's such as in the Expert Patient Programme (DH 2008)

(g) staff education includes the complexity and impact of pain on *people's* and carers' social, physical, spiritual, emotional, psychological and economic well-being

(h) staffs' attitudes to *people* in pain and pain management are assessed and education put in place to ensure understanding of *people's* perspectives

(i) commissioners have the knowledge and skills to commission a world class service for *people* with pain and their carers

(j) *add your local indicators here*
BENCHMARKS FOR PAIN MANAGEMENT

Factor 6 – Self-Management

Indicators of best practice for factor 6

The following indicators support best practice for managing pain:

(a) general indicators (see page 9) are considered in relation to this factor
(b) all means are explored to enable people to manage their pain if they wish to do so, including consideration and support of people's and carers' capacity and capability
(c) people are offered the opportunity to manage their pain to a mutually acceptable level
(d) people and carers have the opportunity to attend programmes to enable them to manage pain
(e) self-management plans are developed in partnership with people, carers and staff
(f) ongoing assessment and review of self management plans is evident
(g) the organisation identifies and removes barriers to people managing their pain
(h) people and carers are provided with up to date information about external resources, such as peer support groups and networks, Royal Colleges, the British Pain Society, people's experiences on www.healthtalkonline.org and other web based information
(i) up to date information is provided about a range of resources and how to access them: such as medication; complementary therapies; and technological, mechanical, and electronic methods of pain management is evident
(j) people and carers are enabled to use methods of pain control (where appropriate)
(k) staff support is provided when requested for people and carers to manage pain
(l) monitoring and assessment takes place for people who are administering medicines to themselves
(m) the risk of harm to people and carers who are managing pain is assessed and revised to meet individuals' needs, including the need for good medicines management
(n) add your local indicators here
BENCHMARKS FOR PAIN MANAGEMENT

Factor 7 - Partnership working

<table>
<thead>
<tr>
<th>Poor Practice</th>
<th>Best Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and social organisations do not provide an integrated service and do not liaise with other relevant agencies</td>
<td>People, carers and appropriate agencies work collaboratively to enable people to meet their pain management needs</td>
</tr>
</tbody>
</table>

Indicators of best practice for factor 7

The following indicators support best practice for managing pain:

(a) general indicators (see page 9) are considered in relation to this factor
(b) co-ordinated, continuous, consistent and accessible services exist between health and social care organisations within different environments that work in partnership with, for example, employers, voluntary organisations and schools, Royal Colleges, British Pain Society, as appropriate and as agreed. A key worker co-ordinates continuing management and care
(c) joint planning to facilitate people’s desired outcomes is evident
(d) opportunities exist for people and carers to participate in joint planning across agency boundaries, for example, as in the case of rehabilitation
(e) there is prompt and accurate information sharing between all involved in the management of care whilst meeting people’s needs and ensuring confidentiality is demonstrated
(f) an assessment and joint care review are undertaken by all relevant staff prior to people moving to another service and or environment
(g) joint documentation is utilised in the management of pain across agency boundaries
(h) add your local indicators here
BENCHMARKS FOR PAIN MANAGEMENT

Factor 8 - Service evaluation and audit

Indicators of best practice for factor 8

The following indicators support best practice for managing pain:

(a) general indicators (see page 4) are considered in relation to this factor
(b) services that support people with pain and their carers are systematically reviewed at least annually and as required. Service review should include: availability, access, quality, timeliness, and continuity of services; appropriateness of services for local health care needs; staff attitudes; and an analysis of information obtained from complaints, letters, people’s interviews, the national Patient Satisfaction Survey and Patients Advice and Liaison Services
(c) risk is assessed and reassessed within an appropriate time frame
(d) risks, incidents, complaints and concerns are recorded, monitored, analysed and the information used to improve care
(e) a written evaluation of pain services is provided annually by staff and commissioners
(f) add your local indicators here
Consultation Questionnaire

ESSENCE OF CARE BENCHMARKS FOR PAIN MANAGEMENT

Introduction

Essence of Care is a versatile and structured system of benchmarking that enables health and social care workers to review the care they provide against indicators that people have said represent their own needs and preferences.

The system was first launched in 2001, as a suite of eight benchmarks, factors and indicators, with three further sets added in 2003, 2007 and 2007, respectively. More recently, it was proposed that the management of pain be included.

The benchmarks we now seek your views on have been developed collaboratively with people using services, doctors, nurses and other health professionals, many of whom are experts in the field of pain management.

Thank-you for taking the time to consider these benchmarks for pain management. We look forward to receiving all your comments.

How to respond to the consultation

Responding on line

The revised Essence of Care documents can be viewed via the Chief Nursing Officer’s Website www.dh.gov.uk/cno. The questionnaire can be completed and submitted on line and sent to eoc.pain@dh.gsi.gov.uk.

Responding by post

Once you have read the revised document in full, print out the questionnaire and return by post to the following address:

Carole Marsden
Room 5E58
Department of Health
Quarry House
Quarry Hill
Leeds LS2 7UE

Please note that the consultation will last for three months and will close on (2nd October, 2009).

If you have any queries contact Carol Marsden at the Department of Health on Carol.marsden@dh.gsi.gov.uk who will direct you to the most appropriate person.
Freedom of Information

Information provided in response to this consultation, including personal information, may be published or disclosed in accordance with the access to information regimes. The relevant legislation in this context is the Freedom of Information Act 2000 (FOIA) and the Data Protection Act 1998 (DPA).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we received a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, or itself, be regarded as binding on the Department.

The Department will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties. However, the information you send us may need to be passed on to colleagues within the UK Health Departments and/or published in a summary of responses to this consultation.

I do not wish my response to be passed to other UK Health Departments (please mark with an ‘x’)

I do not wish my response to be published in a summary of responses

Please delete as appropriate. I am responding:

- as a member of the public
- as a health care or health protection professional or expert
- on behalf of an organisation
The Consultation Process

Criteria for consultation

This consultation follows the ‘Government Code of Practice’, in particular we aim to:

- formally consult at a stage where there is scope to influence the policy outcome;
- consult for at least 12 weeks with consideration given to longer timescales where feasible and sensible;
- be clear about the consultations process in the consultation documents, what is being proposed, the scope to influence and the expected costs and benefits of the proposals;
- ensure the consultation exercise is designed to be accessible to, and clearly targeted at, those people it is intended to reach;
- keep the burden of consultation to a minimum to ensure consultations are effective and to obtain consultees’ ‘buy-in’ to the process;
- analyse responses carefully and give clear feedback to participants following the consultation;
- ensure officials running consultations are guided in how to run an effective consultation exercise and share what they learn from the experience.

The full text of the code of practice is on the Better Regulation website at:

[Link to consultation Code of Practice](#)

Comments on the consultation process itself

If you have concerns or comments which you would like to make relating specifically to the consultation process itself please

**contact** Consultations Coordinator  
Department of Health  
3E48, Quarry House  
Leeds  
LS2 7UE

**e-mail** consultations.co-ordinator@dh.gsi.gov.uk

Please do not send consultation responses to this address.

Confidentiality of information

We manage the information you provide in response to this consultation in accordance with the Department of Health's [Information Charter](#).

Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).
If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

The Department will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

Summary of the consultation

A summary of the response to this consultation will be made available before or alongside any further action, such as laying legislation before Parliament, and will be placed on the Consultations website at http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/index.htm
Part 1 – About You

Please provide us with some information about yourself. This will help us to determine whether we have captured the views of everyone. All the information you provide will be kept completely confidential. No identifiable information about you, will be passed on to any other bodies, member of the public or press.

1. Please fill in your name and address or that of your organisation, if relevant. You may withhold this information if you wish.

Name

Address

Postcode

2. Have you replied to this consultation document?

a) On behalf of an organisation □

b) Please name your organisation in the box below

□

c) On behalf of a service or team □

d) As an individual □

3. If you are responding as an individual, what age group are you in?

<25 years □

26-35 years □

36-45 years □

46-55 years □

56+ years □
4. If you are responding as an individual how would you describe your Ethnic Origin

**White**

☐ British

Any other White background, write below

☐

**Mixed**

☐ White and Black Caribbean

☐ White and Black African

☐ White and Asian

Any other Mixed background, write below

☐

**Asian, or Asian British**

☐ Indian

☐ Pakistani

☐ Bangladeshi

Any other Asian background, write below

☐

**Black, or Black British**

☐ Caribbean

☐ African

Any other Black background, write below

☐

5. What is your religion or belief?

Christian includes Church of Wales, Church of Scotland, Catholic, Protestant and all other Christian denominations

☐ None ☐ Christian ☐ Buddhist ☐ Hindu ☐ Jewish ☐ Muslim ☐ Sikh

Any other, write below

☐
6. If you are responding as an individual, what is your sex?
   □ Male □ Female □ Transgender

7. Which of the following, best describes your sexual orientation?
   □ Heterosexual/Straight □ Lesbian/Gay Woman □ Gay Man
   □ Bisexual □ Prefer not to answer
   Any other, write below
   [Blank Space for Input]

8. If you are responding as an individual, do you have a disability as defined by the Disability discrimination Act (DDA)?
   The Disability Discrimination Act (DDA) defines a person with a disability as someone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day to day activities
   □ Yes □ No

9. If you responding as a individual, but work for the NHS, how long have you been doing so?
   <5 years □
   6-10 years □
   11-20 years □
   21+ years □
   Other □

10. If you are responding as a individual and are also a member of staff, what is your banding on The NHS Careers Framework (or equivalent)?
   1 □ 5 □
   2 □ 6 □
   3 □ 7 □
   4 □ 8 □
   Student □ 9 □
   Other □ Please Specify
11. **If you are responding as a individual who is also a member of NHS staff, In what setting do you work?**

   - Hospital □
   - Community based care □
   - GP Practice □
   - Voluntary sector □
   - Local Authority □
   - Higher/further education □
   - Other □ Please specify

   [Box for please specify]
Part 2 – About the benchmarks

1. Can you give a brief history of your involvement with Essence of Care

2. The Best Practice General Indicators

   Do the best practice general indicators cover the right things?

   Should anything else be added?
3. Benchmarks for Pain Management

Do you have general comments you would like to make about this benchmark?

To help you understand the type of comments we are looking for, can you provide your views on the following

*Are these benchmarks for pain management*

   a] relevant to current health care?

   b] relevant to current social care?

   c] applicable to all people receiving care?
d) in any setting where care is delivered?

e) useful in any situation in which care is delivered?

f) able to be used by anyone responsible for delivering care?

g) useful for all types of pain?
4. Are the factors for benchmarks inclusive of all relevant areas of best practice?

5. Are the indicators for benchmarks of pain management inclusive of all relevant activities necessary to achieve best practice?

6. Equality & Diversity

Will the benchmark on pain management contribute to improving equality and equity?

Do the indicators enable equality to be addressed appropriately?

Is there anything more this benchmark could do to promote equality and reduce inequality & discrimination?
7. Please add anything you wish to say?

Thank-you for completing this questionnaire
Bibliography


Essence of Care – A consultation on the new benchmarks for Pain


Essence of Care – A consultation on the new benchmarks for Pain


McCaffrey M (1968) Nursing Practice Theories Related to Cognition, Bodily Pain, and Man-Environment Interactions University of California at Los Angeles Students’ Store:Los Angeles


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