

CSPMS

Core Standards for Pain Management Services in the UK

 FACULTY OF
PAIN MEDICINE
of the Royal College of Anaesthetists

October 2015

Endorsed by
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Preface

Dr Kate Grady, Dean

Pain affects all of us on occasion, but thankfully can be controlled or abates over a short period of time. For some, pain is ongoing to the degree of becoming persistent and for many is it significant. An estimated 14 million people in the UK live with chronic pain. The effects can be far reaching; quality of life is known to be as bad as that with a significant neurological illness such as Parkinson's disease. A reported 41% of people who attend pain management clinics state that their pain has prevented them from working. Startlingly, severe chronic pain is associated with an increased risk of mortality, independent of socio-demographic factors. Persistent pain also affects family and carers.

Pain therefore is a frequently presenting complaint across a wide range of health care settings. It presents to primary and community care and specialist (secondary) and specialised (tertiary). For most, their pain is treated, managed or resolved within the primary care and community setting. The pain management of those for whom this does not happen must be scaled up, which means referral to more specialised care. This referral should be timely; persistent pain does not go away but develops and accelerates over time through well recognised neurophysiological processes.

The Faculty of Pain Medicine has previously contributed to the Royal College of Anaesthetists Guidelines for the Provision of Anaesthetic Services (GPAS) and detailed best practice for Anaesthetists involved in Pain Management Services. It is important for the whole of the multidisciplinary team to have guidelines and standards, and that is the reason for the collaborative Core Standards for Pain Management Services in the UK (CSPMS UK).

Representatives of the Faculty of Pain Medicine, the British Pain Society, the Royal College of Nurses, the Royal Pharmaceutical Society, the College of Occupational Therapists, the Chartered Society of Physiotherapy, the Royal College of General Practitioners, the British Psychological Society and patient representatives have jointly been the authors of this document.

The principle driving these standards is to have an acceptable level of care in pain management which is consistent, both geographically and from initial to escalating levels of care. These standards are multidisciplinary, that is to say they apply to all clinical professions to include nursing, physiotherapy, clinical psychology, occupational therapy and medicine. It is intended however that this work is not only a clinical guideline for those working to deliver pain management but that it is a reference and framework for those planning or negotiating pain services in the wider sense, particularly commissioners.

Pain management is without a doubt threatened in the current climate. Standards become all the more important at such times. Pain can be all too easy to ignore as it is seen as a non-life threatening condition and the clinical consequences of untreated pain are not immediate or ever highlighted. Frequently therefore pain is under addressed, under managed and under treated. Onward referral for those patients with unresolved pain is often neglected. This is an issue which has been recognised and tackled by the Faculty of Pain Medicine's 'Right Patient Right Professionals Right Time' (RPRPRT) initiative. The RPRPRT documents promote the timely management of persistent unresponsive pain through its onward referral from primary or community care to secondary and tertiary care. They emphasise that specialists in pain medicine are trained to the Faculty of Pain

Medicine's curricula, assessment and examination must be well within the reach and accessible for all those living with persistent pain and they must be working within the multidisciplinary context required for pain management to be delivered to a defined standard.

The CSPMS UK document presents high but realistic standards which are drawn from the evidence base. It is written in sections comprising standards which are a 'must' and recommendations which are not simply aspirational but something to be worked towards where they are not currently in place. As pain management evolves so too will these standards such that they become a contemporary and relevant resource for the future.

Alongside its multidisciplinary authorship the document has been out to extensive stakeholder consultation. Implicit in this is an acceptance of these standards such that these standards become the cornerstone of the delivery of pain management across the United Kingdom.

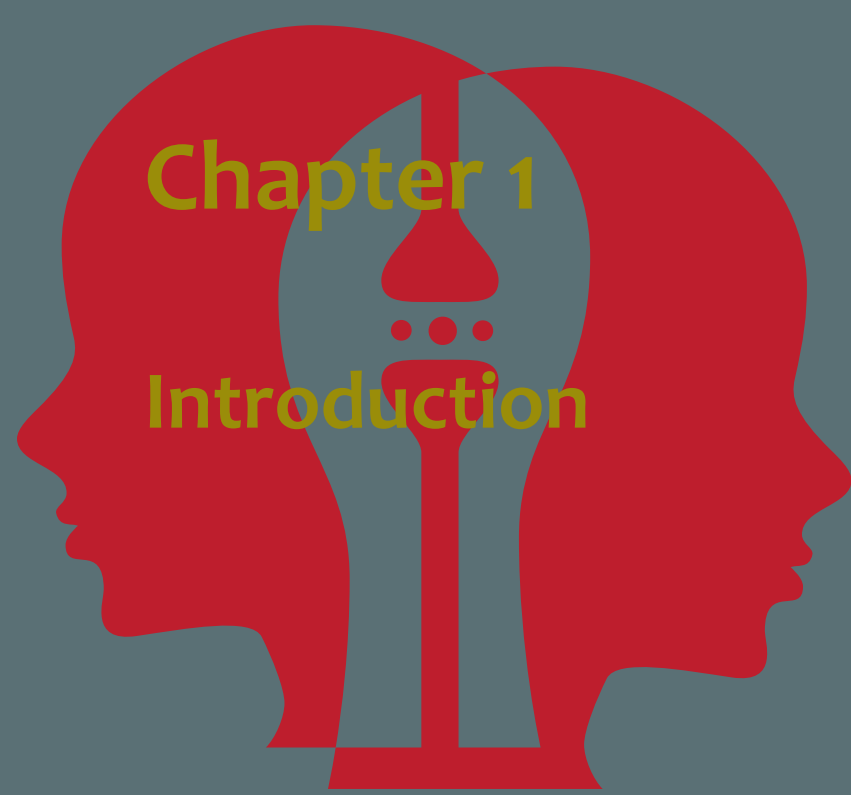
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Chapter 1

Introduction



Chapter 1 Introduction

Beverly Collett and Anna Weiss

Aims

This document is a collaborative multidisciplinary publication providing a robust reference source for the planning and delivery of Pain Management Services in the United Kingdom. It is designed to provide a framework for standard setting in the provision of Pain Management Services for healthcare professionals, commissioners and other stakeholders to optimise the care of our patients. It is a document that will evolve, and cannot be viewed as definitive at this stage, but it will provide a firm foundation for the future.

Background

Pain clinics were initially developed in the late 1940s as services to help patients with cancer pain when there was widespread professional reluctance to prescribe opioids. These were largely run by anaesthetists who excelled in the blockade of nerves with local anaesthetic or their destruction with neurolytic solutions. It soon became apparent, however, that there was a societal need for health care professionals to improve their management of people with persistent non-cancer pain, as well as those with cancer pain. Over time, there was a realisation that methods used to treat cancer pain were less effective in non-cancer pain, and so the focus of services began to change. Clinics became multi-professional, with physiotherapists, nurses, clinical psychologists and others becoming key members of the team. Pain Relief Clinics became Pain Management Clinics, as the focus of care also incorporated management strategies for patients whose persistent pain was not seen as curable. In 1975, the multidisciplinary International Association for the Study of Pain (IASP) was created as an organisation devoted to the study of pain mechanisms and management of acute, chronic and cancer pain. The Intractable Pain Society of Great Britain and Ireland was founded in 1967 by consultant anaesthetists for patients suffering pain. With advancing recognition of the multidisciplinary nature of pain management, it became a multi-professional organisation and was renamed The Pain Society in 1988, while also becoming a Chapter of IASP. From these beginnings, The British Pain Society emerged in 2004¹, when the Irish Pain Society formed its own Chapter of IASP. In 2007, the Faculty of Pain Medicine was established within the Royal College of Anaesthetists (RCOA). Fellowship of the Faculty was initially gained by undertaking an Advanced Pain Training year. In 2011, the Fellowship examination was introduced to ensure that anaesthetists who wished to practice pain medicine completed a specified training and attained an agreed training standard. Consultants in pain medicine in the United Kingdom are expected to demonstrate completion of training as determined by, or equivalent to, the Faculty of Pain Medicine (FPM) Advanced Pain Training criteria².

This evolution in the professionalisation of pain medicine and pain management over recent decades has been accompanied by ongoing changes to the NHS across the four nations of the United Kingdom. The recognition of pain as a frequently under-treated condition of epidemic proportions has gradually worked its way into the consciousness of politicians and policy makers. As early as 2009, the then Chief Medical Officer, Sir Liam Donaldson, recognised chronic pain as a public health issue and recommended that 'agencies involved in the management of patients with chronic pain should form local pain networks to work together to improve the quality of local services'³. Major developments and initiatives followed, including The English Pain Summit (2011), the National Pain Audit (2010-2012), development of The British Pain Society's *Map of Medicine* Chronic Pain pathways (2013) and, on the part of the RCoA, the Chapters on acute and chronic pain in the *Guidelines for the Provision of Anaesthetic Services 2014* (GPAS) document.

NHS England is working towards a 'House of Care' model in the management of patients with persistent pain, including healthcare efforts "at steps towards ensuring self-management". This includes 'developing practical tools and commissioning guidance to support the delivery of the Mandate commitment for everyone with a long term condition being offered a personalised care plan by April 2015'⁴. The recognition of the need for pain management services to provide a valuable contribution to the health and wellbeing of patients is occurring

against the backdrop of devolution of healthcare across the four nations, and a universal concern about rising costs of healthcare.

The changing face of the NHS and rising patient expectations is driving a need for change in the way that pain management services are organised and commissioned². Services are expected to be centred around people. Traditional roles and practices may not produce the savings required, and efficiencies may have to be made through service redesign. This offers opportunities for different ways of working for patients' benefit. Integrated primary and secondary pain management services are seen as optimal in the emerging NHS landscape⁵. The national differences in providing such integration are acknowledged.

Agreement of professionals and users of pain management services towards a shared and common set of professional standards and associated recommendations has never seemed more urgent. This document will be of particular relevance to all relevant stakeholders, including healthcare professionals, hospital managers, commissioners involved in management, and in the design of pain management services in primary care, the community, and specialist and specialised services within the hospital setting.

The publication of this first edition of *Core Standards for Pain Management Services* is a key part of an evolutionary journey to build a comprehensive index of recommendations and standards for pain management services in the United Kingdom. The Core Standards will be updated as the evidence base develops further. We acknowledge that in a number of areas, particularly those dealing with service configuration, the current evidence base is incomplete. The Faculty of Pain Medicine and the British Pain Society are addressing this 'evidence gap', and the National Institute for Health and Care Excellence (NICE) have agreed that pain management is on the list of Quality Standards, and there is ongoing work on this to strengthen the authority of our recommendations.

Content

The CSPMS UK document is divided into nine chapters, covering the following areas:

- Chapter One: Introduction
- Chapter Two: Commissioning of services across the UK
- Chapter Three: Description of services
- Chapter Four: Physical facilities for the delivery of pain management services
- Chapter Five: Pain management service team
- Chapter Six: Patient pathways
- Chapter Seven: Pain interventions
- Chapter Eight: Education, appraisal and revalidation
- Chapter Nine: Service improvement , clinical governance and research

The safeguarding chapter will be included in the document at a later date, in the meantime please refer to relevant country legislation and statutory guidance.

Process

The CSPMS UK document has been designed so that its constituent chapters and sections have been written by respected UK professionals and lay representatives. The document has been subject to review by the Professional Standards Committee and the Board of the Faculty of Pain Medicine, and then sent out for wide stakeholder consultation. In the preparation of this document we have consulted with and sought representation from UK organisations and professional bodies linked to pain management.

Each guidance chapter will have the agreed format of Introduction, Standards, Recommendations, Background, References and Relevant Ongoing Research (where appropriate).

Standards must be followed. Standards aim to represent current best practice in pain management as published in relevant literature and/or agreed by a body of experts.

Recommendations will be statements that the authors feel **should** be routine practice in UK pain management. For services where Recommendations are not currently met there should be a clear strategy to meet these as soon as possible.

Guidance documents of this type should be seen as work in progress. With regard to the clinical Recommendations and Standards, the material presented does not in any sense obviate the need for experienced clinical judgement exercised by individual practitioners acting in the best interest of their patients. Moreover, the guidance should not in any way inhibit the freedom of clinical staff to determine the most appropriate treatment for any patient they are asked to manage in a particular place at a particular time. The reader should take into account these qualifying comments when applying CSPMS UK's Recommendations and Standards.

For many pain management services across the UK (especially in geographically more remote settings) some of the Recommendations and Standards (particularly those describing staffing) may require a major reorganisation of healthcare delivery, and will require time for implementation because of practical constraints such as workforce shortages. When such constraints exist, it is important that these services work closely with local commissioners to agree an appropriate action plan.

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Chapter 2

Commissioning of Services in the UK

- 2.1 England
- 2.2 Wales
- 2.3 Scotland
- 2.4 Northern Ireland

2.1 ENGLAND

Beverly Collett and Andrew Baranowski

Background

NHS England has decided to put 'high-quality care for all' central to its purpose. Quality means safe, effective care with a positive patient experience. Effective care is about preventing premature mortality, enhancing the quality of life for people with long-term conditions and helping people to recover from episodes of acute care or trauma.

This is the derivation of the Outcomes Framework for the NHS in England. By focusing on outcomes and especially patient experience, issues that have often been marginalised or neglected in the past can be given the attention they deserve. This is why for Domain 2 of the Outcomes Framework, Enhancing the Quality of Life for People with Long Term Conditions¹, the 'House of Care' has been adapted and adopted as a model to support person-centred care.

The NHS in England is also facing significant financial challenges. To improve overall efficiency, it is planned to redesign services based on need, which add value and are patient centred, and, decommission services which are not seen to be clinically effective.

Operational Structure for Commissioning of Services²

The Secretary of State for Health

The Secretary of State for Health has ultimate responsibility for the provision of a comprehensive health service in England, and ensuring that the whole system works together to respond to the priorities of communities and meet the needs of patients.

The Department of Health

The Department of Health (DH) is now responsible for strategic leadership of both the health and social care systems, but is no longer the headquarters of the NHS, nor will it directly manage any NHS organisations.

NHS England (Formerly established as the NHS Commissioning Board in October 2012).

NHS England is an independent body, at arm's length to the government. Its main role is to improve health outcomes for people in England. It:

- Provides national leadership for improving outcomes and driving up the quality of care.
- Oversees the operation of CCGs.
- Allocates resources to CCGs.
- Commissions primary care and specialised services.

Clinical Commissioning Groups (CCGs)

Primary Care Trusts (PCTs) used to commission most NHS services, and controlled 80% of the NHS budget. On 1st April 2013, PCTs were abolished and replaced with clinical commissioning groups (CCGs). CCGs have taken on many of the functions of PCTs, and in addition some functions previously undertaken by the DH. All GP practices now belong to a CCG. CCGs have multi-professional membership and formal patient representation.

CCGs commission most services, including:

- Planned hospital care.
- Rehabilitative care.

- Urgent and emergency care (including out-of-hours).
- Most community health services.
- Mental health and learning disability services.

CCGs can commission any service provider that meets NHS standards and costs. These can be NHS hospitals, social enterprises, charities, or private sector providers. However, they must be assured of the quality of services they commission, taking into account both National Institute for Health and Care Excellence (NICE) guidelines and the Care Quality Commission's (CQC) data about service providers.

Both NHS England and CCGs have a duty to involve their patients, carers and the public in decisions about the services they commission.

Health and Wellbeing Boards

Every "upper tier" local authority is establishing a Health and Wellbeing Board to act as a forum for local commissioners across the NHS, social care, public health and other services. The boards are intended to:

- Increase democratic input into strategic decisions about health and wellbeing services.
- Strengthen working relationships between health and social care.
- Encourage integrated commissioning of health and social care services.

Public Health England

A new organisation has been created, Public Health England (PHE), which provides national leadership and expert services to support public health, and also works with local government and the NHS to respond to emergencies.

Public Health England:

- Co-ordinates a national public health service and deliver some elements of this.
- Builds an evidence base to support local public health services.
- Supports the public to make healthier choices.
- Provides leadership to the public health delivery system.
- Supports the development of the public health workforce.

Specialist Pain Management Services

These are commissioned by the CCGs. CCGs have a statutory duty to improve the quality of services being commissioned by the NHS, in particular they have a duty to reduce health inequalities; pain services need to be prioritised in the same way as other long term conditions, given its recognition decreed as such in 2012.

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

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

Pain management treatment pathways should be based around evidence-based pathways, such as the British Pain Society's *Map of Medicine Pain Pathways*³.

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

The Faculty of Pain Medicine has published recommendations for staffing and resources for specialist pain management services to aid clinicians in their discussions with commissioners⁴.

The Royal College of General Practitioners, in conjunction with the Faculty of Pain Medicine, the British Pain Society, the Chronic Pain Policy Coalition and individual professional and lay advisers has published a document to help engagement and enhance discussions between healthcare professionals and commissioners when designing pain management services⁵.

Specialised Pain Management Services

NHS England is directly responsible for commissioning Prescribed Specialised Services⁶ with the aim of ensuring that services, for those individuals that require specialised care, are of a high quality and consistent across England.

The scope of the services considered as specialised is being reviewed on a regular basis. Specialised pain management services are defined by the Service Specification D08⁷. This document was written by the Clinical Reference Group for Specialised Pain Service – Adult (CRG-SPS).

The CRG-SPS is chaired by a leading Pain Medicine clinician, and has representation from regional Senate pain medicine specialists, The Faculty of Pain Medicine, The British Pain Society and other specialist societies and includes patient and carer input. This is an advisory group that reports to the Programme of Care Board and hence NHS England.

Service Specification D08, clearly defines the groups of pain patients, the interventions and the characteristics of those services that are considered Specialised. It is the role of the Local Area Team commissioners to ensure that those services are commissioned and that the standards are maintained.

Most pain patients will be managed by local community and specialty pain management services. Only a small, but significant number will be referred to specialised pain management centres. Currently the number of specialised centres meeting the Service Specification is small and in the long term, restructuring and financial investment may be required.

As well as defining Specialised Services, the CRG-SPS is responsible for drawing up policy around complex and specialised interventions. The first policies for 2015 are: Intrathecal Drug Delivery Devices for cancer pain, and Occipital Nerve Stimulation for chronic migraine and cluster headache. Whereas the CRG-SPS leads on the development of these policies and provides the clinical evidence and perspective, there are also teams from Public Health England that evaluate the evidence and teams that draw up the financial data. The draft policies are assessed for congruence with policies drawn up by other CRGs by the Program of Care Boards, and the final recommendations to the NHSE Board are made by the Clinical Priorities Advisory Group (CPAG).

The CRG-SPS also has a role in supporting the decision making and delivery of the future direction of NHS England policy, and a role in providing clinical information for government.

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2.2 WALES

Sharmila Khot and Sharon Hopkins

Background

In Wales, the NHS has recently been through a massive restructuring exercise. Initially, in 2003, the five hospital Health Authorities were dissolved leaving only the 22 small, Local Health Boards (LHBs), which were in charge of commissioning, whilst the hospitals remained as NHS Trusts. However, from 2009, the 22 LHBs were combined to form 7 Local Health Boards - statutory bodies responsible for the planning and delivery of healthcare to their resident populations. Additionally, three all-Wales Trusts were formed with responsibilities for ambulance services, cancer care and public health. There are no Clinical Commissioning Groups in Wales. Each LHB plans and provides its own services, contracting for some provision externally.

Healthcare planning in Wales

The NHS put forward a strategy document published in 2009 entitled '*Setting the Direction*'. This set out clear plans to refocus the NHS in Wales so that services are shifted from the secondary care setting back into the community. The Welsh Government published its '*Service Development and Commissioning Directive for Chronic Non-malignant Pain*' in 2008, which set out its approach to tackling improvements in service provision and care for people living with persistent pain. This document 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, LHBs have been audited on their compliance with the directive, to help ensure improved standards of care for chronic non-malignant pain management.

Operational Structure for Commissioning of Services

Currently in Wales, the commissioning (planning, contracting, delivery and monitoring) of services is led by a partnership made up of the executives of the new LHBs, the clinical directors working in those Health Boards, and a number of 'Locality Leadership Teams'. These are comprised of a range of health and other professionals, drawn from a distinct geographical area, each with roughly the same population. The GPs in Wales are actively involved in the commissioning cycle through GP-led Neighbourhood Care Networks providing feedback on service design to the seven Local Health Boards across Wales. Currently 60 GP-led Neighbourhood Care Networks feed views on service design back to their Local Health Boards. GPs look at improving care in areas such as care pathways, prescribing and referrals and suggest improvements. In Wales, Neighbourhood Care Networks have given GPs the opportunity to have their opinions heard and contribute to improved care. The Network lead is always a practising GP who is appointed and paid by the LHB.

From the 1st April 2010, specialised services in Wales have been planned and commissioned by the Welsh Health Specialised Services Committee (WHSSC), on which the seven chief executives of the LHBs sit. This committee is responsible for deciding which services are commissioned (planned and paid for) at national level, and which services must be commissioned individually by each LHB. WHSSC also works to ensure a link between specialised and secondary care services to enable seamless pathways for patients. The current Referral-to-Treatment Target for patients in Wales is 26 weeks.

The purchaser/provider split no longer exists in Wales, and there is greater emphasis on primary and secondary care working, both collaboratively and independently, towards the planning of a commissioning cycle for any service and in developing a jointly agreed solution based on local population's health needs. This model will ensure the emphasis remains on co-operation and engagement with local partners. For secondary care and primary care services this is particularly important in relation to the Health, Social Care and Well-being Strategies, Children and Young People's Plans and Older Persons' plans.

Prudent Healthcare:

The Bevan Commission, in a recent report, supported the ambition of world-class health and social services for Wales. It defined these as 'services best suited to Wales, but comparable with the best anywhere'. The Welsh Government and National Assembly for Wales accepted the report and its recommendations, which are in line with the actions set out in the programme for the government.

The key commissioning principles include:

1. Services to be based around prudent principles as proposed by the Bevan Commission and the Welsh Minister for Health and Social Services.
2. Utilisation of an outcomes focused methodology to map and design the whole pathway for service users in order to achieve the best possible clinical outcomes for the individual patient. Therefore service commissioning should be based around effective delivery of outcomes.

Prudent Healthcare refers to healthcare conceived, managed and delivered in a cautious and wise way within the context of resources; characterised by forethought, vigilance and careful budgeting in order to achieve tangible benefits and quality outcomes for patients. A key principle of Prudent Healthcare is coproduction; the focus of which is on achieving the outcomes that matter to individuals, rather than on the process of delivering services. The role of the professional is to facilitate that journey. Prudent Healthcare is based on the framework of prevention, efficiency and substitution.

The principles of Prudent Healthcare are:

- Do no harm.
- Carry out the minimum appropriate intervention.
- Only do what only you can do.
- Promote equity on the basis of clinical need.
- Remodel the relationship between user and provider on the basis of co-production.

For chronic pain management services, the recommendations for commissioning processes would therefore include:

- Establishment of early biopsychosocial assessment within the community setting, and ensuring that principles of self-management are available early to the majority of service users with chronic pain conditions.
- Integrating with public health services in prevention and early intervention at community level of care to reduce or prevent chronic pain related disability.
- Use of care pathways developed and utilised by multidisciplinary teams and informed by user groups to support the provision of effective pain management within local communities as far as possible.
- Seamless, non-fragmented care provided by integrated multiprofessional teams working across primary, secondary and social care to ensure early and effective pain assessment and management.
- Governance of such teams will be a vitally important element, and such multidisciplinary services should be governed by consultants specialised in pain medicine with the necessary qualifications and expertise.
- Commissioning arrangements to consider service developments between LHBs, support from national public health services and regional service arrangements, including support for development of tertiary pain services and specialised interventions, by WHSCC.

- The use of novel and tested data collection tools, pathways mapping, service development tools, and service user involvement in the modernising of service delivery will require training and development of new roles in a cost effective manner.
- Optimising existing roles, the development and expansion of skills and competencies, and working across or breaking down traditional organisational and professional boundaries will all require support from individual health boards and partnership between health boards and the Welsh Deanery to take this forward within the context of *Designed to Work: A workforce strategy to deliver Designed for Life*.
- Specialist services may only cater for small numbers of patients but these tend to be the extremely complex cases. Regionally based services should be organised by collaborative arrangements with the full support and involvement of the relevant service providers and health professionals.
- LHBs will have an important role in this context. The commissioning of services should take into account the NHS commissioning guidance published in 2007 and seek support from WHSCC.
- Consider collaborative working with the All Wales Medicines Strategies Group and primary and secondary care pharmacists to ensure development and availability of appropriate prescribing guidance for a majority of chronic pain conditions, in order to facilitate early and appropriate treatment in primary and secondary care and regular review of medications.
- Develop collaborative pathways with various mental health teams, including liaison psychiatry, substance misuse teams, old age psychiatry and community mental health teams.
- Development of several pathways for access to self-management including the Expert Patient Programme, Back in Action programme, Pain Management Programme, Mindfulness based pain and stress management and Acceptance and Commitment therapy.

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2.3 SCOTLAND

Steve Gilbert, Lesley Holdsworth and Blair Smith

Background

NHS Scotland covers a population of around 5.3 million people, and is divided into 14 geographical NHS Boards, which have a wide variation in population and geography. These range from Orkney, with a remote and rural population of less than 20,000 spread over 20 islands, to Greater Glasgow and Clyde in the central belt with 1.2 million people. The seven special (non geographical) Health Boards include Healthcare Improvement Scotland and National Services Scotland, who have particularly contributed to improvement of pain management services.

In Scotland, successive reports^{1,2,3} had identified the patchiness of pain management services provision and organisation across the country. The GRIPS⁴ *Getting Relevant Information on Pain Services* Report led to the appointment of a National Lead Clinician for Chronic Pain, and, the establishment of a National Chronic Pain Steering Group, with representation from clinical, management, service user, third sector, and policy-making bodies.

Progress since 2009

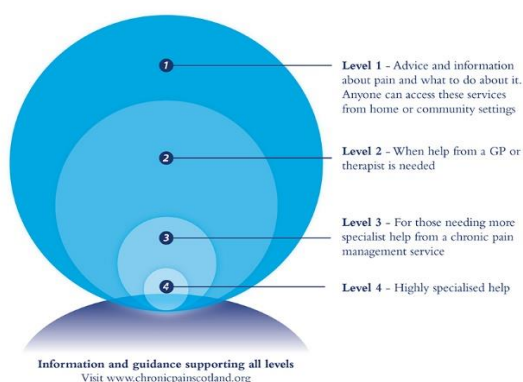
Over the last six years, there has been considerable progress in providing multidisciplinary pain management, but there remain five out of the fourteen NHS Boards where there is no local access to pain management programmes.

The Steering Group developed the Scottish Service Model for Chronic Pain, which sought to emphasise the fact that the majority of people with chronic pain receive care in the community or in primary care, rather than in specialist centres.

Figure 1; Scottish Service Model for Chronic Pain, 2013

Scottish Service Model for Chronic Pain

Most people get back to normal after pain that might come on after an injury or operation or for no apparent reason. Sometimes the pain carries on for longer than 12 weeks despite medication or treatment – this is called chronic or persistent pain.



Scottish Intercollegiate Guideline Network (SIGN)

A guideline development group was established to review the evidence for pain management in non-specialist settings. SIGN Guideline 136, *Management of Chronic Pain*, was published in December 2013⁵.

Website development

A new website was commissioned (www.chronicpainscotland.org).

Data Collection Exercise

An initial stocktake of pain management services had been undertaken in 2011⁶. A further data collection exercise, *Chronic Pain Services in Scotland: Where are we now?* – was published in April 2014.⁷ Although this was able to collect detailed information, the majority was from secondary and tertiary services (Levels 3 and 4 of the Service Model).

Sustaining Improvement

A significant advance has been that, for the first time, NHS Boards will be held directly accountable to the Scottish Government for chronic pain services, with the requirement to include chronic pain in their Local Delivery Plans⁸.

A new team consisting of the National Lead Clinician, National Coordinator, Chair and secretariat was introduced to support the work of the National Chronic Pain Improvement Group and its working sub groups.

Establishing a Scottish Residential Pain Management Programme

A Scottish National Residential Chronic Pain Management Programme was established in Glasgow and was operational from early 2015.

What has been achieved?

- The Scottish Service Model has been accepted across NHS Scotland.
- A well organised and representative National Chronic Pain Improvement Group directs and oversees service improvements.
- The Sub groups of the National Chronic Pain Improvement Group are:
 - Learning & Development.
 - Primary Care Management.
 - Children & Young People's Services (as well as transition).
 - Self-management resources.
 - Coordination and Collaboration on Research and Data Collection.
- An interactive website for patients, carers and professionals, to support the aims above. (www.chronicpainscotland.org)
- A strong patient voice, at national and local levels, contributes to the planning and design of services.
- A mechanism to monitor improvement has been established.
- The Scottish Pain Research Community was established by the research subgroup in 2010.
- A Scottish National Residential Chronic Pain Management Programme has been opened in 2015.

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2.4 NORTHERN IRELAND

Pamela Frances Bell and Christine McMaster

Background

Health and social care in Northern Ireland are provided as an integrated service.

The *Review of Public Administration*¹ (RPA) in Northern Ireland saw significant changes in the structure of organisations delivering health and social care (HSC). There have been two major phases for implementation of the RPA. The first involved the establishment of the five new integrated HSC Trusts, and the retention of the Northern Ireland Ambulance Trust with effect from 1 April 2007. The second (2009) established new organisational arrangements to replace the four Health and Social Services Boards with a single HSC Board (HSCB), the four Health and Social Services Councils with The Patient and Client Council (PCC), and it also established a regional Public Health Agency (PHA) with responsibility for health improvement, and a Business Services Organisation, which provides a range of support functions. Responsibility for commissioning health and social care services rests primarily with the HSCB with the PHA providing professional advice and support.

Operational Structure for Commissioning of services

The Department of Health, Social Services and Public Safety (DHSSPS) has strategic responsibility for the shape of health and social care delivery, informed by Priorities for Government set by the Northern Ireland Office. It sets the commissioning direction, identifying priorities for service development and investment. In response, each year the HSCB and the PHA develop the joint Commissioning Plan and, based on it, Local Commissioning Groups, which are geographically identical with the five Health and Social Care Trusts, publish their Local Commissioning Plans for their geographical areas. Respective Health and Social Care Trusts respond by setting out how they will deliver the Local Commissioning Plans in their Trust Delivery Plans.

Some specialist services are organised on a Northern Ireland wide basis, but to date the specialist (regional) commissioning function has not played a large role in the development of chronic pain management services. Historically there is provision of some specialist interventional pain procedures in some HSCTs but not others; there are no inpatient facilities, other than on an ad hoc basis, such as for trigeminal neuralgia management. A regional, but unfunded, child and adolescent service exists within Northern Ireland, as do outreach services from tertiary child and adolescent clinical specialities like rheumatology. Therefore most patients requiring complex tertiary interventional procedures and those, including children and young people, needing inpatient pain management programmes are sent abroad (usually to England) as extra contractual referrals. Until recently, primary care services including general practices and community pharmacies were managed regionally by the HSCB's Directorate of Integrated Care through local offices co-terminous with Local Commissioning Groups and HSCTs, but without formal working relationships.

Healthcare planning in Northern Ireland

In 2005, the Department of Health, Social Services and Public Safety (DHSSPS) in Northern Ireland published its 20-year regional strategic vision for health and personal social services in *A Healthier Future*². Whilst long term pain is not mentioned specifically, the document does support chronic condition management programmes. In the same year, in a report on a chronic pain workshop, the DHSSPS suggested that chronic pain should be seen as an entity in its own right.

In 2011, *Transforming Your Care*³ (TYC) set out an overarching road map for change in the provision of health and social care services in Northern Ireland. It focused on reshaping how services are structured and delivered in order to optimise available resources and ensure safe, resilient and sustainable services. It puts the individual at

the centre of the model, supports population-based planning of services, focuses on prevention and tackling inequalities, and promotes independence and personalisation of care.

Integrated Care Partnerships are a key element of TYC. They are collaborative networks of care providers, bringing together doctors, nurses, pharmacists, social workers, hospital specialists, other healthcare professionals and the voluntary and community sectors, as well as service users and carers, to design and co-ordinate local health and social care services. The Minister for Health Social Services and Public Safety considers that they will have a further role in designing chronic pain management services, although this is not one of their current clinical priorities.

The PCC, as the voice of patients and clients in health and social care, carried out a survey (*The Painful Truth*⁴) of over 2,500 people living with chronic pain. Published in February 2014, it set out their experiences of living with long-term pain and of the services provided across primary and secondary care. This identified dissatisfaction with many aspects of the understanding of the burden of chronic pain and the paucity of services for sufferers (only 19% being referred to pain clinics). It made ten recommendations for improvement to the Minister of Health, Social Services and Public Safety, seven of which were accepted wholly or in part. Significantly, chronic pain was recognised as a long-term condition, and training for General Practitioners and frontline healthcare staff will be taken forward, as will support for self-management. There will be no specific strategy (either within health and social care or across government) for chronic pain; it will sit within the Long Term Conditions Framework (see *Living with Long Term Conditions – A Policy Framework*⁵).

Living with Long Term Conditions - A Policy Framework

In 2012 DHSSPS published *Living with Long Term Conditions – A Policy Framework (LLTC)*, which has implications for the commissioning of chronic pain services, especially since the Health Minister announced in mid-2014 that chronic pain was to be regarded as a long term condition in its own right and that it would be part of the implementation of the policy framework. LLTC emphasises the need to work in partnership with people who have long-term conditions and their carers to communicate effectively and put individual care plans in place to facilitate multidisciplinary and integrated service delivery.

Working in partnership - In recognition of the multi-faceted nature of chronic health conditions, LLTC urges collaboration across organisational, sectoral and departmental boundaries to improve delivery of integrated services.

Supporting self-management/ Management of medicines - It places the onus on statutory health and social care commissioning agencies to ensure the development and delivery of quality assured self-management training, education and rehabilitation programmes in collaboration with independent, community and voluntary providers and in response to identified need. It promotes the use of technology also to facilitate out-of-hours access to services, including medicines management.

Information and support for Service Users and Carers - LLTC emphasises the importance of making available good and regularly reviewed information to people with long term conditions and their carers, including staff, through a range of accessible formats, media and technologies across the whole spectrum of service providers, including a central HSC information portal and the use of information prescriptions. It also recognises the importance of support for people and their carers in managing their often complex medicines regimes through better integration of community pharmacy services amongst others.

LLTC recommends tools for carers' needs assessment (NISAT Regional Carer's Support and Needs Assessment Tool for adults⁶, and UNOCINI⁷ for young carers), and calls for support plans to help carers in their role as respected partners in planning, improving quality and enhancing the delivery of care.

A single point of contact should be identified to co-ordinate services and provide information and support, including knowing where to get help, e.g. for dealing with money/benefits.

GP registers - In order to improve care and service, GP practice-based registers should be used to ensure the pro-active and early identification of people with long-term conditions through holistic needs assessment.

Reshaping existing services - Where appropriate, existing services should be re-shaped to be more accessible, appropriate and effective, in line with an assessment of population needs; direct payments should be maximised to enable people to make their own decisions about how their social care is delivered and how this support is shaped, and there should be appropriate use of assistive and other new technologies and equipment to support people at home.

The Way Ahead

In response to *Painful Truth* report, the HSCB and PHA, working closely with the Long Term Conditions Strategic Framework Implementation Group, have undertaken a scoping exercise on current chronic pain services in Northern Ireland. Provision of chronic pain services has been assessed and the gaps identified. A key recommendation was the establishment of a Chronic Pain Forum in 2015 for primary and secondary care healthcare professionals, patients, commissioners and third sector organisations to co-create service transformation. At the request of the NI Assembly Health Committee, a five-year service development plan has been prepared, to be presented to the DHSSPS. The Chronic Pain Forum is also working with Integrated Care Partnerships to develop a chronic pain service specification to inform chronic pain service developments by Local Commissioning Groups in 2016 and beyond.

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Chapter 3

Description of Service

- 3.1 Population Needs of People in Pain attending Specialist Pain Services in the UK
- 3.2 Access to Pain Management Services
- 3.3 Pain Management Services in the Community
- 3.4 Pain Management in the Secondary Care Setting including Specialist Services
- 3.5 Pain Management in the Specialised Services
- 3.6 Acute Pain Services
- 3.7 Outcomes

3.1 POPULATION NEEDS OF PEOPLE IN PAIN ATTENDING SPECIALIST PAIN SERVICES IN THE UK

Cathy Price

Background

Specialist pain services aim to diagnose and manage complex pain disorders through a multidisciplinary approach. Complex pain is defined as: 'any pain associated with, or with the potential to cause, significant disability and/or distress'¹. Identification, assessment and initial management of problematic pain have been recognised in Key Recommendation A of the *First English Pain Summit*².

The epidemiology and health needs of people attending specialist pain services remain poorly understood. Attempts to characterise those being seen are hampered by coding materials that are not helpful, a lack of consensus on outcome measures, and lack of clarity as to the optimal items for any large survey. As a result information is often old, highly variable and falls quickly out of date. The British Pain Society is in the process of addressing these issues.

The only large-scale surveys of population needs based on those attending pain clinics in the United Kingdom were as part of the National Pain Audit that ran from 2009-2013^{3,4}. This covered England and Wales only. This included 10,000 patient questionnaires covering patients' health state and experiences of pain services. The '*Getting to GRIPS with chronic pain in Scotland*' 2008 document reported on 54 patients attending 11 focus groups⁵. It was felt that this was not an entirely representative sample, as it was small, but it did highlight patchy and fragmented provision of pain management services and patients' desire for better recognition of chronic pain. A pain summit in 2012 in Northern Ireland highlighted that this was the population with the greatest need resulting from social deprivation factors. Since then, the 2014 Patient and Client Council report of 2500 patient stories highlighted many of the gaps in care provision; however no detailed survey has been undertaken of Northern Ireland's pain clinic population needs⁶⁻⁷. Therefore data from the National Pain Audit has been extrapolated to Scotland and Northern Ireland.

The key findings of the National Pain Audit population surveys are:

- Specialist pain services are delivering care to a group of people who report a very poor quality of life: 0.4 on the EQ5D-3L adjusted score (where a score of 1.0 represents perfect health); this score is on a par with people suffering with advanced senility.
- 8% of respondents are severely distressed and disabled.
- 20% of respondents reported visiting A&E in the past 6 months in search of help, all of whom had seen their GP about the same problem.
- The respondents often have mainly musculoskeletal pain and many are of working age.
- The greatest impact is upon ability to work.
- There is high variation in access to multidisciplinary care, with less than half of clinics fulfilling the minimum requirement for staffing and competencies.
- About half of respondents have improved their overall quality of life six months into treatment.
- About half of respondents feel better supported to manage their pain.
- Many reported at the six-month stage that they had yet to receive any treatment promised.
- Many services lack clear safety protocols to manage risks associated with medication errors, diagnoses and distress levels.

However, pain services appear to focus mainly on spinal pain or other musculoskeletal pain problems, despite there being a clearly documented need in the elderly and also in patients with other diagnoses such as pelvic pain or neuropathic pain.

The difficulty in understanding the nature of persistent pain and accepting its very persistence is a significant problem, with about half of the population attending pain clinics still as puzzled 12 months into treatment as at the start.

These very real challenges highlight where pain services should focus energies, namely:

- Working to reduce the need for patients to seek help via A&E for their pain.
- Development of core standards for staff and facilities for both inpatients and outpatients.
- Building effective relationships with other care givers to ensure that the needs of specified populations such as the elderly and those struggling to maintain employment are met.
- Researching the most effective ways to help people understand and accept persistent pain.
- Ensuring they meet the core requirements of multidisciplinary team membership and competencies.
- There are clear waiting times standards that ensure multidisciplinary care and that access to it is delivered in a timely manner.
- Safety protocols need to be reviewed in many services to ensure that mental health risk assessment and a full case-review of missed diagnoses are included; and that training is given to identify and manage those at risk.
- Defining relevant outcome measures (See Chapter 3.7).

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3.2 ACCESS TO PAIN MANAGEMENT SERVICES

John Hughes

Introduction

Chronic pain is commonly seen within the general population. All patients have a right to good quality care. Much of this can be effectively managed within the community and by the patient's General Practitioner.

More complex pain requires involvement of specialist or specialised pain management services and multidisciplinary, interdisciplinary, and multi-speciality teams. These include consultants in pain medicine, specialist clinical psychologists, physiotherapists, and occupational therapists, nurses and other consultants (e.g. gynaecologists, neurosurgeons, psychiatrists, gastroenterologists, orthopaedic surgeons etc.).

Pain management services may be located in the community, specialist care hospitals or in specialised pain management units, and need to work seamlessly as if in a single unit in order to provide an integrated management plan with the patient. Referral will normally be from the GP or Hospital Consultant or senior members of their healthcare professional teams.

It is anticipated that on referral, the patients' pain will have been investigated and that either:

- i. no cause will have been found, or
- ii. that the cause will have been identified but no specific treatment can be offered/is acceptable, or
- iii. treatments have failed to relieve the pain¹.

Standards

1. Fulfil the standards set out in the service specification for specialised pain services⁸.
2. National standards for access to specialist pain management services must be met irrespective of whether the service is situated in the community or hospital setting⁹.

Recommendations

People who should be referred:

1. Patients with persistent or recurrent pain not adequately managed in primary care.
2. Patients where referral is recommended by national guidelines such as the British Pain Society/*Map of Medicine* patient pathways²⁻⁶.
3. Patients whose pain is causing significant distress or functional impairment.
4. Patients with analgesic misuse problems or who are taking recreational drugs/alcohol for pain relief - possibly in collaboration with addiction services.
5. Patients with pain-related psychological and psychosocial problems (e.g. pain related fear, anxiety, reactive depression, functional impairment) that complicate their pain symptoms or rehabilitation. These patients require an interdisciplinary pain management approach delivered by a specialist or specialised pain management service.

6. Patients requiring specific procedures as part of a pain management plan aimed at improving function and quality of life.
7. Young people (under 18yrs) with significant pain require referral to nationally recognised specialised services.
8. Patients with cancer who may benefit from joint management with palliative care.
9. 'Cancer survivors' i.e. patients with cancer who have undergone treatment (e.g. surgery, chemotherapy or radiotherapy) but who have persistent pain.
10. Patients not responding to specialist pain service input should be considered for onward referral to a specialised pain management centre.

Specific recommendations for access to services

The International Association for the Study of Pain (IASP) Task Force on Wait Times has produced recommendations for waiting times⁷. These are as follows:

- Acute painful condition - immediately.
- Most urgent - within a week (severe condition with the risk of deterioration or chronicity).
- Urgent or semi-urgent - within 1 month. Severe undiagnosed or progressive pain with the risk of increasing functional impairment, generally of six months duration or less.
- Routine or regular - within eight weeks.

Background

Pain is common within the community, and treatment and management should not be denied to patients or their families¹⁰. Many patients can be effectively managed at home or within primary care services. More complex cases, or those not responding, often benefit from specialist or specialised pain services. These services need to be integrated, with the patient having timely access to the level of support they require (primary, specialist, specialised) along a treatment or care pathway as if they were acting as a whole.

There has not been equality of services either nationally or locally as demonstrated by the *NHS Atlas of Variation*¹¹. Further to this, there is no consistency in waiting times for patients to access the skills required to help them with their chronic pain¹². There are also large differences in access to the key skills required for patients in chronic pain, leading to significant variations in patient care and outcomes¹³.

Management of complex pain typically requires multidisciplinary teams of healthcare professionals having high levels of expertise to deal with the inter-related aspects of their patients' needs. This is a fundamental element of effective patient care¹. These services should be equitable across geographical areas at national and local level. Such services need to have the multidisciplinary teams available to deliver the management required in a timely and efficient manner. A model of service specification is therefore required linking the levels of service required across geographical areas and focused on patient needs and outcomes¹².

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3.3 PAIN MANAGEMENT SERVICES IN THE COMMUNITY

Christopher Barker and Neil Collighan

Introduction

Pain management services in the community are becoming more common in the UK. Community care is changing rapidly; within the specialty of pain management, there is considerable variation in what is offered to patients, ranging from uni-professional practitioners or small dual-disciplinary teams, to large multi-professional teams. In line with the current commissioning preferences and the political drive to move the management of long-term conditions back into the community, more secondary care specialist pain management services are providing a broad range of services in the community with input from all members of the multidisciplinary team.

The Royal College of General Practitioners (RCGP) has produced guidance for clinical commissioning groups that moves away from the IASP structure towards a description of multidisciplinary care at all stages in the management of pain, with an emphasis on self-management strategies and clinical input tailored to the individual complexity of pain^{1,2}.

Pain management services should be commissioned in such a way as to allow unhindered movement of patients between these tiers of care, with defined pathways of care; this should be defined by the needs of the patient. In addition to long-term management, pain management services in the community can play an important role in screening, diagnosis, treatment, referral, education, prevention and signposting.

Standards

1. Commissioning of pain management services in the community must ensure that there are appropriate clinical pathways that integrate primary, community, specialist and specialised care.
2. Pain management services in the community must have an agreed scope of practice and clearly defined guidelines on its level of care and directory of services.
3. All pain management services in the community must have a formal governance structure.
4. Pain management services in the community must be appropriately staffed to enable the delivery of care within their defined scope of practice.
5. Annual appraisal must be in place for all healthcare professionals, performed according to specific guidance applicable to each profession.
6. Appropriate management support must be in place to facilitate the delivery of care and quality improvement; this includes the support for monitoring and auditing outcomes.
7. No sole practitioner acting in isolation, whatever their profession, can claim to run a pain management clinic or service.

Recommendations

1. Staff within the community pain management service should be appropriately trained in pain management to fulfil their role within the service.
2. Doctors in community pain management services should maintain generalist diagnostic skills and experience in the management of pain and long-term conditions.
3. All clinicians working in community based pain management services should have a clear scope of practice.
4. Clinicians should have suitable and appropriate supervision and mentorship, in keeping with the recommendations for their particular professions.
5. Clear pathways of care should be in place to support safety and escalation and de-escalation of complexity of care. This may include crossing care sectors from primary into specialist and specialised care and back. Triaging is important to ensure an appropriate level of referral to minimise the length of a patient's care.
6. Pain management services in the community should link with non-healthcare services when appropriate, including third-sector and voluntary sector. Such links should work to enhance self-management and the promotion of living well with a long-term condition.

Background

There is currently a lack of definition as to what constitutes a community pain management service. In keeping with aspirations for all clinical services, pain management services in the community must strive for patients to be seen within the appropriate care pathways by the appropriate personnel in a clinically safe, effective and cost-efficient way.

Many specialist pain management services formerly based in hospitals are now operating in community hospitals or treatment centres, and may offer services with improved accessibility, such as pain management programmes in local gyms, or team assessments and interventions delivered in GP surgeries or in community hospitals.

Variability of service design is well recognised. Many of the community-based pain management services follow an outreach model from secondary care; there are also firmly established services that originate in the community. Much local and regional variation exists on how such services were established and how they are developing. Patient needs, available clinical expertise, commissioning preferences and often geographical factors are all factors in service delivery.

Pain management services delivered in the community may contribute to a wider pool of pain management provision, as intended through the AQP (Any Qualified Provider) scheme. All AQP services must adhere to NHS standards of care. These CSPMS Core Standards aim at affirming recommendations and standards for pain management services in any setting, to ultimately secure equal standards of care independently of the specific characteristics of individual service design.

Pain management services in the community normally focus on the ongoing management of pain as a long-term condition. An individual patient's journey seen in a community setting may include the escalation and de-escalation of care between healthcare sectors (e.g. for complex interventional techniques), or social care networks, third sector or voluntary organisations.

Pain management services in the community pride themselves on good links with other community services; closer community links enable services to keep an up-to-date knowledge of third sector, voluntary sector or alternative community based services, potentially aiding liaison and support for self-management. Pain management services in the community are thus generally well placed to deliver quality standards within the National Service Framework for Long Term Conditions.

The range of pain management services provided by individual units/providers is mostly determined by local need and clinician and commissioner engagement. Pain management services in the community provide patient assessment, patient interventions and rehabilitation. They tend to work closely with other community based services, which promotes signposting to other services or GP neighbourhoods within the locality. On rare occasions, they may even work in acute Hospital/Trusts to reduce admissions to wards and enable rapid discharge of people with chronic pain.

Pain Management services in the community do not necessarily require medical leadership, but should involve medical input at some specified point for governance reasons. Safe delivery of all clinical services demands that they are commissioned to include medical involvement within the patient care pathway. The scope and place of medical involvement must be clearly defined for each pain management service, including routes of accountability. A collaborative approach to commissioning of pain management services in the community does ideally consider views and include input from all stakeholders, including service users, and acknowledges the wider local and regional pain management service commissioning needs. Community services can offer 'ring-fenced' care where the scope is clearly identified; patients outside this scope are not suitable for such a service and must be referred elsewhere.

Commissioners and service providers must jointly define the levels of accountability for all health professionals in the service. Individual services must be specific on their inclusion and exclusion criteria and rules/mechanisms for onwards referral. To manage referrals from many community sources, it is essential that specialist community services offer a full range of diagnostic skills, and specialist management from a multi-professional team³. Robust clinical pathways should be in place to ensure safety and the appropriate level of clinical care for the individual patient. This will allow smooth escalation and de-escalation of care dependent upon need. The existing pathways of care and national guidelines (British Pain Society Pain Patient Pathways on *Maps of Medicine*⁴, Faculty of Pain Medicine publications)⁵ form the evidence base from which all pain management services should be designed and delivered.

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3.4 PAIN MANAGEMENT IN THE SECONDARY CARE SETTING INCLUDING SPECIALIST SERVICES

Jonathan McGhie

Introduction

Pain Management can be delivered in primary care, in the community, in secondary (specialist) care or in tertiary specialised services. The national strategy for the delivery of pain services, endorsed by the Royal College of General Practitioners and the Faculty of Pain Medicine, is to give patients access to the right provider in the right place at the right time¹.

At all levels of pain management provision, multidisciplinary care that is well integrated with supporting specialties should be offered to patients, with a focus on self-management strategies.

The Faculty of Pain Medicine has issued recommendations on the provision of specialist pain services².

Standards

1. A specialist pain management service will have at least two consultants who have achieved competencies and experience in advanced pain medicine, as defined by the Faculty of Pain Medicine of the Royal College of Anaesthetists, and undergo successful annual appraisal.
2. No sole practitioner acting in isolation, whatever their profession, can claim to run a pain management clinic or service.
3. Any practitioner working single-handedly because of remote location must maintain formal links with colleagues/peers.
4. Specialist pain management services will involve nursing, physiotherapy, occupational therapy and clinical psychology staff. These specialists will have dedicated sessional time in the pain management service and attend multidisciplinary team (MDTs) meetings.
5. Specialist pain management services must have access to dedicated pharmacy input (See Chapter 5.6).
6. Input from other local specialists, e.g. psychiatry, palliative medicine, surgical and medical specialties, gynaecology, paediatrics, neurology and rehabilitation medicine must be available as needed to manage the patient case mix.
7. The pain management service must demonstrate engagement with clinical governance, audit, training and education at a local and national level in accordance with best practice.

Recommendations

1. There should be no single-handed practitioners providing pain management services.
2. Specialised pain management services should be available and accessible in every health region for adults with complex pain problems.

3. Specialist pain management services should bridge community pain services and regional specialised centres to ensure patient care is optimised.
4. The pain management service should be staffed to a level that is sufficient to undertake a comprehensive biopsychosocial assessment, including a full needs evaluation of physical and mental health and social circumstances.
5. The mix and number of allied health professionals in the service should reflect the types of patients and range of treatments used.
6. The pain management service should be led clinically by a healthcare professional with expertise in pain management, who has achieved competencies in pain medicine as defined by the FPMRCA and who undergoes annual appraisal.
7. Specialist pain management services should offer, or have referral pathways to, centres that can offer spinal cord stimulation, intrathecal drug delivery, paediatric pain management, and dedicated pain management programs as appropriate to the needs of the patient.

Background

Historically, pain service development in the UK was driven by the enthusiasm and vision of individual clinicians, informed by progressive guidance from IASP (The International Association for the Study of Pain) and the British Pain Society. Service quality varied greatly according to the number, training and specialisation of staff and number of procedures offered.

IASP stratifies centres according to staff mix and interventions provided³: from single modality clinics (e.g. biofeedback) to a pain clinic staffed by a single profession (usually anaesthetics), to a pain clinic that has representation from more than one professional group that has frequent MDT meetings, to a pain 'centre' which additionally includes a research or academic interest.

With NHS reconfiguration and a political drive to move the management of long-term conditions back into community services, the RCGP has produced guidance for Clinical Commissioning Groups that moves away from the IASP structure towards a description of multidisciplinary care at all stages of pain management, with an emphasis on self-management strategies and clinical input tailored to the complexity of the pain¹.

Pain transcends specialty, so it is of relevance to every health care professional. It is important for pain to be managed well at all stages of the patient's pathway, and for the symptoms not to be ignored until the patient can attend a secondary or tertiary pain centre. A significant proportion of pain patients can be treated locally in primary care, however, to successfully manage the burden of symptoms and distress that occurs in complex pain states, a cohesive and well-resourced multidisciplinary pain clinic is required.

Therefore, it is of concern that The National Pain Audit in 2011⁴ found that only 40% of pain centres in England and 60% of pain centres in Wales were multidisciplinary. While the incomplete data-return may have led to an under-estimate in the range of facilities, it highlighted a huge variation in service provision and regional spread of centres that impairs equity of access to pain management services in England and Wales.

The future goal of pain service development is to better integrate community, specialist and specialised care services so that patients can access services appropriate to their need.

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3.5 PAIN MANAGEMENT IN THE SPECIALISED SERVICES

Andrew P Baranowski

Introduction:

Since the adoption of the White Paper 'Equity and excellence: liberating the NHS' published by the Department of Health in July 2010, England has seen services divided into speciality services commissioned by Clinical Commissioning Groups and specialised services commissioned directly by NHS England through Local Area Teams. These arrangements ensure national standards based on specifications and policies written by Clinical Reference Groups.

Currently there are very few Specialised Pain Management Centres in England. The aim is that they will increase in number to ensure that equity and excellence is achieved in the provision of specialised pain services.

Standards

1. All Specialised Pain Management Centres must adhere to the NHS England Service Specification D08¹ (or NHS England Service Specification E2b for children and those aged less than 18 years) and to the relevant policies as published by NHS England from time to time. It is the responsibility of the Specialised Centre to ensure it keeps up-to-date with such documents.
2. Specialised Pain Management Centres must adhere to minimum standards as published by NHS England, The Royal College of Anaesthetists, Faculty of Pain Medicine, The British Pain Society and the International Association for Study of Pain^{2,3,4}. It is the responsibility of the Specialised Centre to ensure it keeps up-to-date with such standards.
3. Specialised Pain Management Centres must be in a position to see those with severe unremitting pain in a timely manner according to clinical need. Certain situations, such as trigeminal neuralgia, cancer pain or other pain-associated conditions with significant distress and disability will require an urgent referral and consultation. The service must comply with national targets in relation to referral to treatment targets.
4. Specialised Pain Management Centres must be interdisciplinary. An interdisciplinary team is an integrated working group where each individual has a high level of expertise in different aspects of management of patients with complex pain. The team should include: physicians, psychologists, physiotherapists and specialist nurses, with access to others such as pharmacists and occupational therapists. Cross cover should be available indicating that there must be at least two persons able to provide any specific aspect of care¹.
5. There must be appropriate accommodation, support (e.g. IT), and administration support for this team. Members of the team should work closely together through joint clinics and multidisciplinary team (MDT) meetings to agree management plans with patients and General Practitioners, and facilities to enable that must exist^{1,2,3}.
6. Specialised Pain Management Centres must cover the needs of the patient as a whole, and, as a consequence, multiple specialists should be a part of the team. Members of a multi-specialty pain team should be determined by the needs of the patients for whom services are designed. There should be joint clinics and patient-focused meetings. Such specialists may be neurosurgeons, neurologists, gynaecologists, urologists, rheumatologists, oncologists, etc¹.

7. Specialised Pain Management Centres must be able to provide a whole pathway of care for their patients for the areas that they specialise in. This would include complex interventions that may be physical or cognitive behavioural, as well as assessment, investigation and non-complex interventions. Specific pain management programs for the areas of specialisation should exist¹.
8. Specialised Pain Management Centres must collect data in accordance with the quality standards specific to the service, as described in NHS England's Service Specification for Specialised Pain Services D08 (or NHS England Service Specification E2b for children and those aged less than 18years)^{1,5}.

Recommendations

1. Nationally there should be an appropriate and adequate number of Specialised Pain Management Centres. The number should ensure equity and excellence for patients with complex pain and pain-associated disability where ever they live in England. It is suggested that in England there should be at least one specialised pain Service in each Senate Region.
2. Specialised Pain Management Centres should work in a co-ordinated manner with other such centres across England (and where appropriate with other countries within the UK). Such collaboration should ensure that the needs of the whole population are met, even if the condition is rare, complex and specialised.
3. Specialised Pain Management Centres should work as a network with other local providers, using a model of shared care with local networks being encouraged. Services should be as local as possible, and formal networks should ensure minimum standards are met.
4. Referral to Specialised Pain Management Centres should be from secondary care and above, and those procedures that can be safely undertaken locally and that do not need specialised centres are the commissioning responsibility of CCGs as per the Clinical Advisory Group document for the recommendation of prescribed services.
5. Waiting times should be in accordance with the standards defined by the International Association for Study of Pain⁶.
6. Specialised Pain Management Centres should have the complete multidisciplinary team to provide 3-4 specialised areas of care for the whole patient journey. Examples of areas might be complex facial pain and headache, complex abdominal and pelvic pain, complex pain associated with neurological disease, complex neuromodulation or Intrathecal Drug Delivery (ITDD).
7. Complex patients appropriate for referral to a Specialised Pain Management Centre should be considered as those that a secondary care specialist or team feels that they cannot support or manage in a secondary care environment. Examples of these patients could be those with: multiple system disorders, complex drug abuse and dependency issues, psychological and psychosocial problems that significantly complicate pain symptoms and rehabilitation, difficult to treat cancer related pain, requirement for specialised interventions such as ITDD Devices, and others as listed in the specialised pain service policies.
8. Patients should be referred to tertiary services from secondary level care pain management consultants or from other clinicians. The expectation is that the patient must have completed a pain management programme, but this may not always be appropriate if it is clear that tertiary care is what is required. The referral pathway may be agreed more locally to reflect existing services configuration. Details of this local agreement should be appended to service specifications.

9. All children and young people less than 18 years old should be under a Specialised Pain Management Centre if a pain management service is indicated. Specialised services for Pain Management for Children and Young People are separately defined in NHS England Service Specification E2b¹. The specification advocates a strategic vision for chronic pain services to work within a clinical network and that the footprints and strategic plan for this will be developed.
10. It is expected that Specialised Pain Management Centres will usually be in Teaching Hospitals, and that members of the team will be involved in research and appropriate national and international pain management committee activities and strategy, (including guidelines groups). Such centres will be involved in teaching, education and contribute to local and national audits as appropriate. They will also have close association with community and local pain management services.

Background

One aim behind the restructuring of the NHS (White Paper: 'Equity and excellence: liberating the NHS' published by the Department of Health in July 2010) was to ensure that specialised services provide equity of access and high quality of care, with uniform standards across England for those persons with rare and complex medical conditions.

The routine assessment and management of pain is a required competency of all healthcare professionals, as well as being an important component of healthcare planning^{2,7}. Most patients with chronic pain can be well managed in the community or local hospitals by appropriately trained members of interdisciplinary pain management services; these services are commissioned by CCGs. However, some patients with more complex chronic pain problems require management in centres that offer specialised pain management services.

There are currently only approximately 6-10 Specialised Pain Management Centres in the UK that provide tertiary services. The number of tertiary patients seen varies by centre according to local pathways, specialism provided and service capacity available. Centres see between 400 and 2,000 new patients a year.

Specialised Pain Management Centres (PMC)¹ should be geographically distributed, dedicated centres, designed for national delivery of services, and resourced to provide highly specialist treatments. Generally, they are placed within a teaching hospital environment, but working in close association with community and local pain management services, as well as networking with other specialised services across England (both pain and non-pain specialised services). A Specialised Pain Management Centre is usually run by one provider. A comprehensive service should be delivered which may be within a defined network among a small number of providers if no one Hospital has the full range of provision in an area. This may be through a prime provider contract to ensure standards and coordinated services. Networking between Specialised Pain Management Centres across England and local networks are key to providing a high quality service.

A Specialised Pain Management Centre (PMC)¹ consists of key professionals (clinical and academic, pain and non-pain specialised) who have a remit to lead and deliver the highest standard of patient care, research, audit output, teaching, and training in the area of complex pain and pain-associated disability, within a dedicated environment. The team must be available to support the patient throughout the whole patient journey (assessment, investigation and treatment of underlying and associated conditions, as well as pain as a primary condition), and should be able to provide complex interventions that include dedicated pain management programs for the specific conditions managed. It is often not the complexity of the treatment alone that requires a specialised service, but the fact that the treatment also requires a multi-specialty approach, or some of the time a fully integrated or "interdisciplinary" team approach. Often this is a shared care situation with primary and secondary care that requires a dedicated specialised pain management service.

Interventions may include¹:

1. Complex manipulation of medication under consistent supervision in an inpatient setting. This can include opioids. Patients requiring intensively supervised medication management can have excessive lengths of stay and multiple re-admissions if not managed appropriately, and they usually have pain related psychological and psychosocial problems.
2. Complex procedures for patients with complex pain and pain-associated disability that require extra skills, such as the use of computerised tomography (CT) scanning or other specialised imaging, supported by multi-specialty and interdisciplinary input, that cannot be undertaken using simpler approaches. Examples would be deep brain stimulation/neuromodulation and other neurosurgical procedures for pain.
3. Neuromodulation in complex situations where a specialised team is appropriate, e.g. pelvic pain.
4. The management of complex pain by intrathecal drug delivery.
5. Intensive outpatient, residential or inpatient Interdisciplinary Cognitive Behavioural Therapy pain management programs delivered by an interdisciplinary team for patients with persistent pain and pain-associated disability. These services are highly structured and require a high level of competency in delivery. Highly specialised centres may provide dedicated pain management programs for sickle cell disease, facial pain, urogenital pain, hypermobility, persistent/refractory angina and other conditions, as well as programs for children and young people.

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Pathways are:

- Primary Assessment and Management (focused on community care)
- Spinal pain – low back pain and radicular (community and secondary care, leading into specialised care)
- Musculoskeletal non-inflammatory (community and secondary care, leading into specialised care)
- Neuropathic Pain (community and secondary care, leading into specialised care)
- Pelvic pain in both the male and female. (community and secondary care, leading into specialised care)

3.6 ACUTE PAIN SERVICES

Mark Rockett, Brigitta Brandner, Fiona Duncan and Jane Quinlan

Introduction

Acute pain is, by definition, pain of recent onset, of limited duration and usually related to a pathological process, disease, or injury¹. The experience of acute pain is universal, but hospital inpatients frequently suffer severe pain as a result of surgery, trauma or medical illness. Acute pain is also a major component of the pain related to cancer. In hospital, two thirds of patients experience pain during their admission. Pain is often poorly relieved, with up to 20% of all inpatients suffering moderate to severe pain at any given time². Even within the surgical population, where the noxious stimulus is well defined and systems are in place to manage acute pain, almost 60% of patients experience severe pain in the postoperative period, with a marked negative impact on health-related quality of life^{3,4}.

Inadequate relief of acute pain may impact significantly on the rehabilitation of patients after surgery, and is a significant risk factor for the transition from acute to chronic pain⁵. The development of chronic pain following surgery is relatively common, and is associated with a high prevalence of psychological illness, loss of income and increased healthcare use^{6,7}.

The shift away from inpatient to day-case surgery has also provided a challenge to acute pain teams, with the majority of operations being carried out with the expectation of the patient returning home within 24 hours⁸. The provision of adequate analgesia after discharge remains a challenge, but is essential to prevent increased pressure on primary care or emergency departments resulting from readmission to hospital.

The rising age of the surgical population has resulted in an increase in the number of elderly patients with severe medical co-morbidities presenting for major surgery, often in an emergency setting. These high-risk patients require high levels of postoperative support, including complex, high quality analgesia, which mandates the presence of effective acute pain services (APSs) with close links to critical care services.

The scope of the APSs has expanded over the past few years to include acute pain management in medical patients and those with more complex background chronic pain or drug misuse.

Patients with complex pain problems require a specific set of clinical skills, and the APSs are pivotal in co-ordinating interdisciplinary working to provide robust and reliable management plans, supporting ongoing care in the community and reducing the impact on secondary care services.

The role of the APS is therefore grounded in the compassionate aim of reducing suffering and pain, whilst it contributes to recovery and rehabilitation, as well as to prevention of the progression from acute to chronic pain.

Standards

Acute pain services must reach the following standards:

1. Acute pain teams must be led by or include named consultant(s), who have appropriate knowledge base, training and competencies, which they continue to maintain through CPD activities, and who are appraised annually. It is recommended that those appointed as Leads for Acute Pain Services should have completed advanced pain training^{2,4}

2. Acute pain teams must be supported by an adequate number of appropriately trained acute pain consultants. The minimum training requirement for consultants should be RCoA higher pain training or equivalent.
3. Adequate time for acute pain management should be reflected in consultant job plans. An appropriately trained consultant must be available for advice for every acute pain ward round. An appropriately trained consultant must be physically present for at least one inpatient ward round per week.
4. Adequate nursing numbers and skill mix must be available during working hours.
5. Adequate staff and systems must be in place to provide timely pain management to all inpatients. Out of usual working hours, this may be in the form of APS nursing staff or appropriately trained anaesthetic staff (intermediate pain training as a minimum standard). A clear point of contact for expert advice must be available at all times.
6. Patients under the care of an APS must be reviewed by the APS regularly, with patients receiving epidural analgesia or other continuous local anaesthetic infusions being seen at least once daily.
7. There must be development and maintenance of systems for the regular assessment and recording of acute and acute-on-chronic pain.
8. Pain assessment:
 - Pain is recognised as the fifth vital sign. Assessment tools must be standardised and available in an appropriate range of languages for adults, children and vulnerable individuals, such as the elderly with dementia and patients with learning difficulties.
 - Functional progress should be assessed in parallel to pain on movement.
9. Based on the pain assessment, there must be clear protocols for the management of acute pain by ward-staff and guidance for discussion with, or review by the APS when appropriate.
10. Easily accessible protocols or guidelines must be produced to maximise the efficacy and safety of analgesic techniques. These should include guidelines for the management of common side effects such as nausea and vomiting, and screening tools to recognise rare but important complications, such as neurological injury, spinal haematoma or abscess after neuraxial blockade.
11. The APS must ensure the provision of mandatory education, appropriate to their clinical areas of work for nurses, medical staff and other healthcare professionals in the assessment and management of acute pain to allow them to manage pain safely and effectively.
12. The APS must be able to provide specialist pain management for complex pain problems, such as: acute neuropathic pain, opioid tolerance, acute-on-chronic pain, or patients with problem drug use or acute cancer pain.
13. The APS must provide advanced methods of pain relief to facilitate the recovery of patients following major surgery or trauma, appropriate to the level of care required in individual hospitals (e.g. paravertebral or epidural analgesia for patients with severe chest trauma requires close co-operation with emergency departments, surgical teams and critical care).
14. Close liaison with other healthcare teams responsible for the shared care of patients with acute pain.
15. The preparation and dissemination of information, education and resources for patients.

16. Provision and maintenance of equipment. This requires close co-operation with local medical equipment management and procurement services.
17. Collaboration with pharmacy and medicines management groups, particularly in the development of new analgesic strategies.
18. Audit and evaluation of the effectiveness of acute pain management, complications and staff training¹⁶. This should be in a setting of continuous quality improvement of acute pain management.

Recommendations

1. Adequate time must be provided for acute pain management. Two clinical sessions per week are recommended for lead consultants and one session for other consultants.
2. An acute pain consultant should be physically present for every inpatient ward round in a teaching and direct clinical care role.
3. Clinical nurse specialists in pain management should be able to prescribe independently.
4. All hospital specialties should be able to refer patients to the APS for assessment.
5. The APS should be involved in hospital-wide education.
6. Research and continuous quality improvement in pain management should be core functions of the APS. In particular, regular audit of efficacy/effectiveness of the service, including side-effects and safety of advanced pain management techniques.
7. Access to non-pharmacological therapies, and close links with physiotherapy and clinical psychology departments is desirable.
8. The production and implementation of screening tools for patients likely to suffer severe post-surgical pain, and management guidelines to improve their care is recommended.
9. The production of local guidelines, or adoption of national guidelines where available for the management of acute medical pain problems, in collaboration with local acute medicine physicians is recommended.
10. Access to outpatient follow up by appropriately trained staff is desirable:
 - for patients discharged from hospital on high-dose opioids, to support dose reduction as acute pain subsides;
 - for patients whose acute pain is not decreasing, and who may be transitioning to a chronic pain state;
 - for patients with acute pain conditions where early intervention has been shown to be beneficial (such as back pain or complex regional pain syndrome);
 - for patients whose hospital admission is related to an exacerbation of a chronic pain condition.
11. All pain management services within an institution should be under a unified management and governance structure.
12. There should be provision of support for research in acute pain.

Background

The inpatient pain service comprises a multidisciplinary team including nurses specialised in pain management, as well as appropriately trained acute pain consultants. National audit in 2014 has revealed that these services are poorly resourced in the majority of NHS Hospitals in the UK. The recommendations and standards in this document are intended to ensure the provision of an optimal inpatient pain service for all hospital inpatients, as recommended by the Chief Medical Officer in his report of 2009¹⁰.

The relief of acute pain is primarily a humanitarian matter, but effective pain management may result in improved clinical outcomes and reduced complication rates, particularly in high-risk patients undergoing major surgery. Ever more complex surgery is now being carried out on an increasingly elderly patient population with multiple medical co-morbidities. Patients' expectations of surgical outcome and pain relief are high, and it is a challenge to meet these expectations with limited APS resources.

Advances in minimally invasive surgery have resulted in a significant reduction in post-surgical pain in some cases. However, new techniques present challenges of their own, particularly when combined with enhanced recovery (ERAS) programmes where the expectation is for early mobilisation and accelerated discharge from hospital. Complex ERAS care bundles have led to the increasing use of advanced pain management techniques, such as continuous regional analgesia, requiring the support of an effective APS. The most effective analgesic techniques for each surgical procedure continues to be the subject of ongoing research and innovation¹¹.

In addition to the role of the APS for hospital inpatients, it is becoming increasingly important to develop pathways for effective pain management after discharge, with systems to monitor and reduce inappropriate prolonged opioid use¹². These aims may be achieved by postoperative telephone follow-up, or even rapid access outpatient clinics.

In addition to the challenge of pain relief after surgery, the remit of the acute pain service is expanding in many NHS Hospitals. Preoperative prediction of those who are likely to suffer severe acute pain and those at risk of developing chronic pain is now possible, and is becoming part of pre-assessment^{13,14}. The potential for preoperative optimisation of pain management, both in terms of analgesic drugs and pain-coping strategies, is being evaluated and provides an exciting prospect for the future.

Some centres are now combining the APS with other clinical teams, including critical care outreach, hospital at night, resuscitation and vascular access. Although this may be seen as a threat to the traditional model of the APS, it also provides opportunities for expanding the role of the service into other areas of perioperative medicine.

Pain relief in medical patients has lagged behind that in surgery, partly due to a lack of accurate information as to the extent of the problem. It is now clear that acute pain in medical inpatients is as problematic as in surgical patients, and this represents a significant area of unmet clinical need¹⁵. Many acute pain services now provide support for these patient groups.

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3.7 OUTCOMES

Cathy Price and Robert Searle

Introduction

Assessing activity and effectiveness should be a key component of pain service standards. NHS England is clear that measuring and publishing information on health outcomes helps to drive improvements to the quality of care people receive¹. To do this, a pain service will need to use appropriate outcome indicators. This chapter aims to describe appropriate outcomes a pain service may use to help inform interested parties about the process of delivering a pain service and patient outcomes.

Standards

1. An outpatient based pain service must record performance outcomes related to caseload (number of new and follow-up patients seen), new to follow-up outpatient ratios, and waiting times from referral to treatment.
2. An inpatient based Pain Service must record performance outcomes related to the total number of patients managed, and waiting times from referral to assessment.
3. Pain services must collect outcomes related to patient experience, where possible using approved or validated measures that allow benchmarking or comparison with similar services, e.g. the Friends and Family Test or Consultation and Relational Empathy (CARE) measure. Whatever measure is used, it should be sufficiently detailed and meaningful to influence staff, managers and executives.

Recommendations

1. Pain services should keep a record of complaints and compliments.
2. Pain services should encourage members of staff to complete the national NHS staff survey.
3. Pain services should collect outcomes related to patient safety, including adverse patient-safety events (including those reported to the NPSA) and Serious Incidents as part of the Serious Incident Framework. It should also collect outcomes related to complications from treatment.
4. Pain services should collect outcomes related to the clinical effectiveness of pain management therapies offered by their service. This should form a part of regular audit processes. Outcome measures used should be validated and relevant to the intervention being audited.

Background

The government is clear that measuring and publishing information on health outcomes helps to drive improvements to the quality of care that patients receive¹. The Department of Health has focused on introducing and collecting outcome indicators in five main domains:

- Preventing people from dying prematurely.
- Enhancing quality of life for people with long term conditions.
- Helping people recover from episodes of ill health.
- Ensuring that people have a positive experience of care.
- Treating and caring for people in a safe environment and protecting them from harm.

Whilst chronic pain is not specifically mentioned in the NHS outcomes framework, the outcome standards recommended in this document broadly reflect the domains considered important by the Department of Health.

Collecting outcomes that relate to pain service structure and processes is important, and relates to a number of outcome domains. For example, timely pain service interventions can help people recover from episodes of ill health and ensure people have a positive experience of care. For chronic pain services, research is clear that patients deteriorate while waiting for treatment². This has led IASP to give specific recommendations for waiting times for patients in pain³. In the UK, the NHS Constitution confirms a patient's right to consultant-led treatment within a maximum of 18 weeks from referral. A key performance outcome for a pain service should therefore be waiting times from referral to treatment. The ability of a pain service to see patients in a timely manner may be influenced by other performance indicators, such as new patient to follow-up patient ratios. This data is collected at a national level by organisations such as Dr Foster, which allows comparison between similar services and national benchmarking. New patient to follow-up patient ratios are cited as a marker of efficiency in outpatient specialties, and high rates of follow-up appointments can be a marker of problems in primary and secondary care⁴. Some commissioning bodies may enforce certain targets related to new to follow-up ratios, and pain services should collect this data.

Ensuring that people have a positive experience of care is an important outcome domain. The NHS Friends and Family test was introduced in 2013 for hospital wards, A&E and maternity services, and is an opportunity for patients to provide feedback on services and care. In 2015 it will be introduced across all outpatient specialties. Other validated measures of patient's feedback exist, and could be considered as part of outcome assessment for this domain. One example would be the Consultation and Relational Empathy (CARE) measure⁵. This is a large freely accessible database of CARE results that allows national comparison and benchmarking. Similarly, pain services should record compliments which can be used to reflect on service provision.

Protecting patients from harm and treating them in a safe environment is another key outcome domain. Pain services should collect data related to patient safety, including complication rates, patient safety incidents reported to the NPSA, and serious incidents (in accordance with the Serious Incident Framework)⁶. Reflecting on these outcomes will help reduce the risk of patient harm. An audit of complications is included in the 2014 Royal College of Anaesthetists' Guidance on *the provision of anaesthesia services for chronic pain management*⁷.

As part of the domain relating to helping people recover from episodes of ill health or following injury, the NHS outcomes framework mandates the collection of patient reported outcome measures (PROMS) for certain planned treatments. Pain related treatments are not included in the list of conditions requiring PROMS data. Risk adjustment algorithms have been found not fit for purpose when applied to people with persistent pain (perhaps due to the complexity of presentation). However, the 2014 Guidance for *the provision of anaesthesia services for chronic pain management* suggest there should be regular evaluations and audit of outcomes of treatment⁷. The type of outcome measure used will vary according to what outcome is being evaluated, although any measure used should have been properly validated so that the strengths and weaknesses of the measure are understood. For example, general quality of life measures tend to have 'floor effects', and there may be difficulties defining meaningful change when using measures.

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Chapter 4

Physical Facilities

- 4.1 Consultation/Assessment Facilities
- 4.2 Equipment & Monitoring (incl. equipment safety and training)

4.1 CONSULTATION/ASSESSMENT FACILITIES

Lorraine de Gray and Andrew Nicolaou

Introduction

Appropriate facilities for a multidisciplinary pain management service are essential for the delivery of high quality care to patients¹⁻⁹.

Taking a thorough history and assessment is of fundamental importance and very often the foundation of this care. It may well include a comprehensive physical examination.

It is widely acknowledged as best practice that a true multidisciplinary environment, with access to a range of specialities and resources, should be available for the treatment of pain. This is especially so in complex cases and the treatment of certain groups. Functional disability and psychological distress are commonly encountered in this patient population. Moreover, multi-professional clinics as well as group sessions are common practice and facilities should cater for these needs.

Pain medicine services are primarily delivered in an outpatient setting in secondary care. However, it is recognised that the provision of pain services is evolving and that they may increasingly be seen in primary and community settings.

More specialised pain services may be provided in tertiary centres; however, elements of these services may possibly be accessed in other settings.

Adequate secretarial, IT and administrative support for this work is essential. The provision of up-to-date patient notes/records is imperative – whether hard paper copy or by electronic provision.

The configuration of existing services may well be variable and a reflection of differing local needs, support and infrastructure as well as variation in practice.

Recommendations

General Physical Facilities

The delivery of multidisciplinary pain management services requires adequate, 'fit for purpose' accommodation.

1. The entrance and reception should be well signed, accessible, comfortable and welcoming, with the reception staff understanding of the nature of pain medicine services and its patients. They should be able to help with enquiries and outpatient bookings, as well as with the collection of any outcome data where needed. Access to the premises and facilities within must comply with the Equality Act 2010^{7-9,14}.
2. Facilities should allow for the completion of any screening tools and questionnaires or other specific local materials and help with this should be identified and available for those who have difficulties in completing this material⁵.
3. Information on the running of the clinic, such as waiting times, should be given alongside patient information leaflets where relevant^{5,7}.
4. Ideally the outpatient area should have, or be close to, other resources such as public WCs, baby care facilities and provision of refreshments. The nearest drop-off and pick-up point to the clinic, and car-parking

for patients with disabilities should be clearly signposted. Access should be available for wheelchair users and, where not based on the ground floor, clinic facilities should be available for those patients who will not travel in an elevator⁷⁻⁹

Consultation / Examination Room

5. Virtually all patients will require access to a consulting/examination room.
6. The space and layout of the room(s) should be adequate and fit for purpose for the needs of the range of healthcare professionals in the pain team and the patients seen⁷⁻⁹.
7. The consulting and examination room may be a combined single room (a more flexible arrangement) or separate rooms (there may be a need for this in specific clinics). The determinants of actual room size and set-up should be based on local needs and policy, within the context of available space and resources. Department of Health guidance exists⁷⁻⁹ regarding room area and plans/configurations of setup for the purposes of consulting and examination. General healthcare experience and ergonomic analysis suggests a 16m² room size is considered suitable for this purpose, although there are other options.
8. Accommodation should be of sufficient size to allow also for multi-professional clinics as well as for group sessions. This very often requires larger space provision. Likewise, certain specialised pain services may have specific needs requiring different and larger specialist clinical spaces⁷⁻⁹.
9. The necessary equipment to examine patients must be available, including examination couch (preferably electric), adequate seating, examination tools and clinical hand washing facilities⁷⁻⁹.
10. Adequate workstation/desk space and communications/IT provision should be provided. This is particularly important when accessing patient records and any results, imaging and investigations. There is also the need to contemporaneously document the assessment and examination in patient records. Good communication between pain service personnel and others is important. This should be mindful of patient confidentiality, and may be made easier by the provision of telephone points and email access or by other arrangements such as close physical proximity⁷⁻⁹. When using electronic communication, it is important to keep in mind the pitfalls of email correspondence, in particular breach of patient confidentiality and the Data Protection Act 1998¹⁵.
11. The setup of the clinical area should be tailored to the preservation of patient privacy, modesty and dignity: this includes consideration of the acoustics of the space. The use of screens and covers/hospital gowns is an example of how this may be achieved if there is a need to dress/undress⁷⁻⁹.
12. There should be adequate space for patients, escorts and equipment plus storage and waste facilities. Heating and ventilation for the clinical area should be effective⁷⁻⁹.
13. A chaperone should be available when needed, as per guidelines on chaperone and examination issued by the General Medical Council¹⁰.
14. An audio induction loop and interpreter/language line should be available when required⁷⁻⁹.
15. Where paediatric patients are seen within a non-specialist paediatric pain clinic, consideration should be given to ensuring that the environment is suitable for the emotional and physical needs of the child. This may require arranging for paediatric patients to be seen within the setting of a paediatric outpatient department rather than in the pain clinic. Equally, the clinical environment should be adapted for the specific needs of adolescents, where these are different from those of children and adults¹¹⁻¹³.

Background

Pain management clinics cater for a very diverse group of patients, who may range from the young to the very old in age. As compared to other hospital outpatient services, a significant number of patients attending a pain clinic may have high levels of functional disability and negative previous experiences of the health system. Many patients may suffer from anxiety and depression because of their long-term pain. Various health professionals, including doctors, nurses, psychologists, physiotherapists and occupational therapists, form an integral part of the pain service and although they have many needs in common in terms of facilities, there are specialist requirements which need to be catered for. Frequently, patients are seen by more than one professional or in a group setting¹⁻⁵.

An important aspect of the delivery of pain services is educating patients and taking them through a journey of understanding, accepting, learning to take ownership, and empowering them to manage and live with their pain. The environment in which pain services are delivered needs to foster this journey. Patients should be allowed access to the necessary educational material, and be provided with the opportunity to engage with their health professionals in an environment that is well away from the hubbub of a busy general outpatients department. Welcoming and easily accessible facilities which cater compassionately for the needs of patients with chronic pain and disability will undoubtedly provide a conducive environment for the delivery of an excellent pain service.

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4.2 EQUIPMENT & MONITORING (INCL. EQUIPMENT SAFETY AND TRAINING)

Lorraine de Gray

Introduction

Pain Management Services offer a broad spectrum of therapies ranging from acupuncture, transcutaneous electrical nerve stimulation (TENS), physiotherapy and hydrotherapy in an outpatient setting, to more invasive intervention techniques including spinal injections and nerve blocks, to significantly more complex procedures including neurolytic blocks and neuromodulation. Safe delivery requires the appropriate facilities and equipment to cater for the needs of patients with chronic persistent pain in accordance with best-practice recommendations¹.

Pain Management clinicians, their managers and commissioners should jointly strive to ensure that patients are always cared for in the most appropriate environment providing 'gold standard' equipment and services².

Standards

1. Medical devices and clinical equipment must be purchased, managed, maintained and used in accordance with legislation and manufacturers' guidance. Accountability for the management of such devices must be transparent and clearly defined. Policies must be in place to ensure that this occurs³.
2. The management and use of medical devices and equipment must be by designated staff who have been appropriately trained and certified.
3. Facilities for monitoring, airway and respiratory support and resuscitation, including defibrillation, must be available at all sites where patients undergo pain intervention techniques. All staff must regularly attend for mandatory resuscitation training.
4. The anaesthetic room and operating theatre must be appropriately prepared and ready to deal with all patients and interventions booked on any one list⁴. All staff in theatre must be compliant with and engage in the use of a WHO surgical safety checklist. Regular team briefings aid the smooth and safe running of a procedure list.
5. Each day-surgery unit⁶ must have a fully equipped recovery area, staffed by recovery personnel trained to defined standards. Transfer from the immediate recovery area to a second stage (ambulatory) recovery area may take place when the patient is awake, in control of their airway, oriented and haemodynamically stable.
6. Full resuscitation equipment and drugs must be provided as specified by up-to-date resuscitation guidelines and hospital policy. Staff should be trained to ALS standards.
7. Up-to-date, clear and complete information about operating lists must be available. Any changes must be agreed by all relevant parties, to ensure that the correct operation is performed on the correct side (if relevant) of the correct patient.
8. The following ancillary anaesthetic equipment must also be available at all sites where patients are undergoing any pain intervention procedure, even if no sedation or anaesthesia is being administered: Oxygen supply, facemasks, suction, airways (e.g. Guedel and laryngeal mask), tracheal tubes and intubation aids, self-inflating bag, trolley/bed/operating table that can be tilted head-down rapidly.

9. All anaesthetic and monitoring equipment must comply with standards set by the RCoA and AAGBI. Patients' physiological parameters must be adequately monitored throughout intervention procedures.
10. The anaesthetic room and operating theatre must conform to Department of Health building standards⁷, including standards on airflow, filtration⁸, surface finishes and ceiling height.
11. Policies and equipment must be in place to protect patients and staff from cross-infection, including safe disposal of sharps.
12. The operating and anaesthetic rooms must conform to radiological protection specifications where designated. All X-Ray equipment must be used and conform to IRMER⁹. External door signs should indicate when X-Ray/fluoroscopy is in use.
13. Staff must have access to lead aprons of the appropriate thickness, with thyroid shields being worn by members of staff who have to remain in close vicinity to the patient when the fluoroscopy machine is in use. X-ray dosimeter badges and rings must be worn by members of staff who are constantly in close vicinity to fluoroscopy equipment, such as the operating clinician.
14. All anaesthetic and monitoring equipment, fluoroscopy or ultrasound equipment and radiofrequency lesion generators must be fully serviced at regular intervals designated by the manufacturer, and a service record must be maintained. All equipment should be checked by the operator before use.
15. For teams providing neuromodulation, the clinician implanting the device must be suitably trained and experienced in the particular part of the assessment and procedure they undertake, and operate within their scope of practice and competency.
16. After complex pain intervention procedures, patients must recover in a specially designated area, which should conform to the guidelines of the RCoA, Department of Health (DH) and Association of Anaesthetists of Great Britain and Ireland (AAGBI) for design and equipment. The secondary recovery area must provide essential close and continued supervision of all patients, who should be visible to the nursing staff.
17. There must be easy access to inpatient beds in the event of perioperative complications. If a patient requires overnight admission, an inpatient bed must be found. Some units have additional short-stay overnight capacity which can sometimes be used for this purpose.
18. Written discharge criteria based on nationally agreed standards and recommendations must be available¹⁰. Discharge is usually delegated to senior nursing staff according to protocols. If a patient does not satisfy the agreed discharge criteria they must be reviewed by the pain clinician. Patients may be discharged home with residual sensory or motor effects after nerve blocks or regional anaesthesia. The duration of the effects must be explained, and the patient must receive written instructions as to what is safe activity until normal sensation returns.
19. A contact telephone number for specialist advice must be supplied so that every patient knows whom to contact in case of post-operative complications.
20. A policy regarding the provision of acupuncture for patients with acute and/or chronic pain must be in place and updated regularly.
21. A policy regarding the provision of TENS in patients with acute or chronic pain must be in place. Healthcare Professionals are responsible for maintaining patients' safety whilst administering TENS as a treatment. Appropriate advice and information must be given to enable patients to maintain their own safety when administering TENS unsupervised. Appropriate references should be made to the TENS manufacturers' guidelines. A policy should be in place to guide as to indications, contraindications and guidelines for use of TENS.

Recommendations

1. Pain management clinics may be based in a primary, secondary or tertiary care setting. Whereas certain interventions such as acupuncture, TENS and intra-articular or trigger point injections lend themselves to being delivered in all three settings, all other invasive procedures of medium (e.g. spinal injections) or high complexity (e.g. neuromodulation) should only be delivered in a secondary or tertiary environment.
2. Acupuncture is delivered using single-use sterile needles after appropriate informed consent is obtained. All staff providing acupuncture need to be trained and comply with standards set by recognised bodies, such as the British Medical Acupuncture Society, the Acupuncture Association of Chartered Physiotherapists and the British Acupuncture Council. Access to full resuscitation facilities and equipment is mandatory.
3. TENS is a modality of non-drug mediated pain relief. It is common practice for TENS clinics to offer instruction and or loan of a TENS machine. Any TENS machines that are on a recurring loan system should be subject to the appropriate electrical and mechanical engineering (EME) testing, and a record should be kept that will allow multiple users of any one TENS machine to be traced.
4. Simple trigger-point or intra-articular injections may be delivered in an outpatient clinic setting. Facilities for strict aseptic precautions to be applied and access to the correct skin preparation, needles and injectables should be guaranteed. Access to full resuscitation equipment and facilities must be in place for the immediate management of major procedural complications such as anaphylaxis or inadvertent intravascular injection of local anaesthetic drugs.
5. All other pain intervention techniques require, as a minimum, access to a dedicated operating session in a properly equipped operating theatre within either a purpose-built, self-contained day surgery pain unit with its own ward, recovery areas and dedicated operating theatre(s), or as part of a general day-surgery unit.
6. Facilities are needed to allow for privacy and confidentiality during the pre-procedure discussion and examination. There should be separate male and female changing facilities, ideally in cubicles that allow patients to dress and undress in privacy, and to wait and recover before and after their procedure. Patients should have access to secure storage for their personal belongings whilst undergoing their procedure.
7. Patients with limited mobility may require transferring from wheelchair onto a trolley and vice versa. Facilities for the storage of trolleys and wheelchairs are required. A sufficient number of experienced staff with appropriate manual-handling skills and access to patient hoists and transfer equipment is required to safely manage and treat these patients.
8. Specialist seating, operating tables, monitoring and manual handling aids should be available for bariatric patients.
9. There should be provision of day-to-day working stock of linen and theatre clothing with access to storage of such linen.
10. There should be space for the temporary holding of materials for disposal and reprocessing, for example soiled linen for the laundry and any items for central cleaning.
11. Pain clinicians need to have access to the necessary sterile equipment¹¹, including sterile gowns, masks, gloves, skin preparation lotions, drapes, spinal/epidural/peripheral nerve block and hypodermic needles, different sized syringes, and the necessary injectables including local anaesthetic drugs, particulate and non-particulate steroids, radio opaque dye, phenol and glycerol. Basic pre-packed kits may be provided which contain the essentials to which additional equipment may then be added. Sharps disposal units should be available¹². Equipment for nerve identification has to be available when performing peripheral nerve blocks (nerve stimulator, ultrasound or both).

12. All pain services that use interventional techniques need to have access to appropriate imaging equipment and the ability to store and retrieve images. Imaging activity is supported by trained radiographers as per IRMER regulations.
13. The operating table should be of a type that allows for easy use of fluoroscopy. As a minimum, it must allow for a head-down tilt. Tables that allow for a traversing top with offset column break can in addition be useful to allow the patient to be positioned appropriately when access is challenging.
14. Where radiofrequency lesioning is provided, clinicians need to have access to the necessary lesion generator and appropriate needles and leads. Theatre staff need to be trained in the operation of the generator. The generator must be EME tested and have a clear and up-to-date service record.
15. Where neuromodulation is provided, clinicians need to have access to the required equipment to insert, maintain and programme such devices. Programming devices require EME certification and must be kept serviced regularly. Where general anaesthesia is required for insertion of the neuromodulation device, this must be provided by an additional trained anaesthetist and not by the anaesthetist inserting the neuromodulation device.
16. There should be policies and facilities in place to protect patients and staff that are hypersensitive to latex-containing products¹³.
17. A parking bay is required for storage of mobile fluoroscopy and ultrasound equipment with provision for the electrical charging of the machines overnight.

Background

Pain intervention techniques are an integral part of the practice of pain medicine and, when performed in the appropriately selected patient and practised to high standards, can make a significant impact to the overall management of chronic pain, leading to a significant improvement in functional and psychological wellbeing.

It is worth remembering that, for many patients, this aspect of pain management can be quite frightening. The technological nature of the operating department has the potential to cause significant fear and distress in patients, the great majority of whom will be awake or only lightly sedated when undergoing such procedures. This should be taken into account when designing such facilities so as to produce an environment that is safe, welcoming and not intimidating. The design should cater for the requirements of the Equality Act, whilst also adhering to manual handling regulations and all the other standards listed below.

Compliance with the WHO surgical check list, and monitoring patients to the required standards, in combination with highly-trained clinicians and staff, will further ensure that the patient experience and outcomes are likely to be of the high standard that we would wish to provide to all our patients¹⁴.

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Chapter 5

Pain Management Services Team

- 5.1 Definition, Membership and Interaction of the Multidisciplinary and Multispecialty Team
- 5.2.1 Medical Consultants
- 5.2.2 Staff and Associate Specialist Grades and Specialty Doctors
- 5.2.3 Medical Trainees
- 5.3 General Practitioners
- 5.4 Nurses
- 5.5 Occupational Therapists
- 5.6 Pharmacists
- 5.7 Physiotherapists
- 5.8 Psychologists

5.1 DEFINITION, MEMBERSHIP AND INTERACTION OF THE MULTIDISCIPLINARY AND MULTISPECIALTY TEAM

Beverly Collett and Mark Rockett

Introduction

Pain is a biopsychosocial experience. The International Association for the Study of Pain has emphasised the importance of the multidisciplinary team (MDT) in the management of both acute and especially persistent pain to ensure that all facets of the pain experience are given equal importance in assessment and management of this condition.

Definitions:

Multidisciplinary: this indicates a service that involves several members from various health care professional backgrounds, such as medicine, nursing, physiotherapy, occupational therapy, psychology, play therapy.

Multispecialty: this indicates a service with close collaboration and liaison between several medical specialities (for example, gynaecology, psychiatry, neurology, paediatrics) in assessing and managing a specific patient and usually joint clinics.

PERSISTENT (CHRONIC) PAIN

Chronic, or persistent, pain: refers to pain that exists beyond the expected time of healing, usually taken as 3 months or more. Chronic pain has been recognised as a long-term condition in its own right¹.

Complex pain is defined as: 'any pain associated with, or with the potential to cause, significant disability and/or distress'²

Standards

1. The multidisciplinary team must include medical consultants trained in chronic or acute pain medicine as appropriate, nurses, physiotherapists, psychologists, pharmacists and often occupational therapists, and, where available, suitably trained GPs with a special interest (GPwSI) and SAS doctors.
2. The multidisciplinary team must communicate regularly and effectively with the patient's general practitioner.
3. Resources must be available in terms of space and time for regular team meetings.
4. The multidisciplinary and multispecialty team must have adequate administrative support. Clinical governance requires ongoing audit and data collection.
5. No sole practitioner acting in isolation, whatever their profession, can claim to run a pain management clinic or service.
6. Any practitioner working single-handedly because of remote location must maintain formal links with colleagues/peers.

Recommendations

1. Specialist Pain Management Services in community and secondary care should always involve a multidisciplinary team; how the MDT is delivered may vary according to local factors, e.g. in remote/rural areas.
2. Specialised Pain Management Services in a tertiary centre should always involve a multi-specialty and multidisciplinary team.
3. Pain management services should be staffed and operate to accommodate the local requirements of all patient groups, including children, adolescents, the elderly and those with complex needs.
4. The multidisciplinary team should seek formal arrangements for inclusion of all clinicians involved in the provision of pain management services. This should include specialty doctors, general practitioners and locum staff.
5. All members of the multidisciplinary and multi-specialty teams should participate in audit and outcome data collection.

ACUTE PAIN/POST-OPERATIVE PAIN

Acute pain is pain of recent onset, of limited duration and usually related to a pathological process, disease, or injury³.

Post-operative pain is one type of acute pain. However, acute pain can occur with trauma or with episodes of acute illness.

Standards

1. Acute pain teams must include adequate numbers of appropriately trained doctors and nurses.
2. Where not available within the core acute pain service, there must be access to expertise in regional anaesthesia.
3. Close links with pharmacy services must be in place to ensure safe and appropriate prescribing of analgesics.
4. Pain Management services should have a unified governance and management structure to ensure that acute and chronic services work together in comfort.

Recommendations

1. Formal MDT meetings are desirable when managing complex pain cases. These meetings should involve representatives from the patient's medical team, chronic pain specialists, physiotherapists or psychologists.
2. Close links with other teams involved in pain management, such as palliative care and oncology, can result in improved patient outcomes.

Background

Pain is a biopsychosocial experience. The physical pain experience and the psychological factors associated with that experience all play a role in how a person reacts to it and the distress, which can arise.

Acute pain should be assessed, investigated and a diagnosis for the cause of the pain made. Often, as the condition is treated or the injury heals, the pain will resolve. However, when the cause of the pain cannot be treated successfully (e.g. diabetes or some cases of cancer) when there is permanent damage to the nervous system (e.g., post-surgical scar pain, post-stroke pain) or where the cause of the pain is not known (e.g. irritable bowel syndrome, painful bladder syndrome, back pain, fibromyalgia) then the multidisciplinary team becomes more important in assisting the patient to manage the pain. Multidisciplinary work with the patient's clinical team, as well as with allied health professionals such as physiotherapists, is critical to good acute pain management.

Medication not normally licensed for pain can be helpful in some cases. Injections can sometimes be of benefit in some pain conditions. Impairment of physical function and deconditioning can make pain worse and so treatment is not always aimed at the pain itself, but also at its consequences. Pain can result in low mood, anxiety and loss of confidence, and psychological strategies can help to empower the patient.

Thus, access to a multidisciplinary team is important for the optimal management of persistent pain. For complex pain conditions, multi-specialty teams may offer the most effective and efficient approach to assessment and planning of long-term management. For example, patients with complex pelvic pain, pain concurrent with substance misuse, or chronic paediatric or adolescent pain are very likely to benefit from a coherent multispecialty team approach (this is not an exhaustive list).

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5.2.1 MEDICAL CONSULTANTS

Anna Weiss and Mark Rockett

Introduction

In UK practice, Consultants in Pain Medicine are at the core of delivery of the integrated multidisciplinary teams that constitute pain management services in the community, in local hospitals or in tertiary centres or in all three settings. These doctors are usually anaesthetists, who have undertaken specific specialist training and achieved the defined competencies in all aspects of pain medicine, and who have normally obtained the Fellowship of the Faculty of Pain Medicine of the Royal College of Anaesthetists (FFPMRCA). They offer integrated, co-ordinated, holistic management of pain using unique knowledge and skills within the context of the multidisciplinary team to deliver comprehensive patient-centred care. They are the only specialists that are revalidated specifically with respect to complex pain management¹.

Standards

1. All pain management services must demonstrate clearly defined input from pain medicine specialists at consultant grade. A minimum of two consultants is required because of the need for peer support and cross cover¹.
2. All consultants delivering pain services must comply with the professional standards set by the GMC. For specialists in pain medicine, the achievable and desirable standards of professional conduct are published in the 2014 Faculty of Pain Medicine publication *The Good Pain Medicine Specialist*² which complements this publication.
3. Every chronic pain specialist unit must include consultants who have an appropriate knowledge base, training and competencies which they continue to maintain through CPD activities, and who are appraised annually. The basic standard of training is represented by successful completion of the RCoA curriculum for Advanced Pain Training (or equivalent) and endorsed by the FFPMRCA (or equivalent)^{3,4}.
4. Every acute pain team must be led by or include named consultant(s), who have an appropriate knowledge base, training and competencies which they continue to maintain through CPD activities, and who are appraised annually. The minimum training standard for clinical involvement with an acute pain service is the RCoA curriculum in Higher Pain Training. It is recommended that those appointed as Lead for Acute Pain Services should have completed Advanced Pain Training^{3,5}.
5. Consultants with job plans that include dual commitments in pain management and anaesthesia or intensive care medicine must participate in appropriate and proportional CPD activities².
6. Consultant job plans must make allowance for the provision of multidisciplinary team working with defined time and resource allocation for multidisciplinary meetings.
7. Specific roles within a pain management service (such as service lead, clinical governance lead, research or education lead) must be acknowledged in job planning and represented through programmed activities allocation.

8. Consultant delivered services, such as neuromodulation, provision of intrathecal drug delivery (ITDD), or specialist inpatient pain relief techniques requiring continuous support, must provide sufficient consultant staffing levels to allow for easy access to information, review and support by patients and other clinicians, to guarantee safe service provision 7 days a week.
9. There must be appropriate provision, accommodation and management / administrative support for all aspects of the service, including consultant services¹.

Recommendations

1. Consultant-only pain service provision is no longer an appropriate model for pain management in any setting. Multidisciplinary team working with close involvement of a consultant represents the current best-practice model of patient care and should be applied to all pain management services across all settings.
2. Acute pain services should have adequate leadership and support from appropriately trained consultants, with sufficient job plan allocation to fulfil the role effectively.
3. Consultants have a central role in assessment of patients and formulation of treatment plans; equally they must provide oversight and supervision for assessment and treatment planning delivered by other members of the pain management team^{4,5}.
4. Consultants should contribute to service design and strategic service development, and engage in negotiation with management and commissioners.
5. The Faculty of Pain Medicine has the duty to safeguard the professional principles and behaviours underpinning best patient care. For that reason, it wishes to make the following recommendations on the content and composition of consultant job plans:
 - It is recommended that job plans for consultants with a substantive appointment in chronic pain include a minimum of 3 WTE (Whole Time Equivalent) PAs (Programmed Activities) for DCC (Direct Clinical Care).
 - It is recommended that job plans of lead consultants in acute pain include a minimum of a 2 PAs WTE dedicated to acute pain management; job plans of other consultants with specific commitments to the acute pain service (such as inpatient ward rounds) carry a minimum of 1 PA WTE.
 - It is recommended that job plans for consultants with a chronic pain medicine commitment acknowledge the differing intensity of clinical commitments in their DCC PA allocation as follows:
 - i. A minimum of 1.25 PAs for a 4-hour pain intervention list, to account for the delivery and organisation of the list, including preparation and checks of equipment and medications, team briefing, patient review before and after procedure, consent and resulting administrative tasks.
 - ii. A minimum of 1.5 PAs for a 4-hour outpatient clinic to account for administrative tasks relating to referral letter triage, patient biopsychosocial assessment and planning of care, including the requesting and review of investigations, dictation of letters, liaison with other agencies involved in the patient's care, preparation for MDT meetings and case conferences (this is not an exhaustive list).
 - It is recommended that job plans for consultants delivering inpatient ward rounds allow for variation in intensity of clinical commitments in their DCC by allocating 1.25-1.5 PAs for a 4-hour ward round.

- It is recommended that job plans of consultants involved in service delivery within an MDT should reflect this clinical commitment through appropriate PA allocation.
 - Job plans should include an SPA (Supporting Professional Activities) allocation in keeping with the joint guidance of the AAGBI and endorsed by the RCoA/AoMRC. This endorses as a minimum an allocation of 1.5 SPA for every 10 PA job plan for the purpose of appraisal and revalidation activities. Additional SPA allocation for further professional activities outside the remit of DCC (e.g. external duties, college tutor and RA activities, Quality Improvement activities etc.) should be affirmed through effective job planning.
 - The details of individual job plans must be affirmed through the annual job planning process. Diary evidence should inform the allocation for DCC PAs and SPAs.
6. Pain management services cannot fulfil their role effectively without adequate nursing, secretarial and clerical support⁶. There are no published up-to-date recommendations on levels of support staff in pain management services. Historical guidance on levels of support should be considered when appointing to new consultant posts⁷.
 7. It is recognised that working in Pain Medicine, whilst rewarding, can be demanding, and instances of ‘burn out’ have been reported. Employers are invited to develop mentoring schemes, especially for newly appointed consultants. Consultants are encouraged to consider joining peer support networks and/or participation in supervision activities akin to psychology/psychiatry/general practice (e.g. Balint groups)⁸.
 8. Consultants working in paediatric pain medicine services and those leading transition of adolescents to adult pain services should possess or acquire the advanced level pain medicine and/or paediatric pain medicine competencies recommended by the Faculty of Pain Medicine⁹.

Background

Pain management services in the UK were borne out of pragmatism and need, and have been subject to many changes over the last 40 years^{7,10}. Consultant-delivered acute and chronic pain management services have been an integral component of UK health care for over 30 years^{7,10}.

Over time, changes to NHS healthcare delivery, service funding and commissioning have influenced pain services in community, specialist and specialised settings¹. Alongside these changes, there has been increasing awareness of the needs of the wider pain patient population, most recently demonstrated through data published in national pain audits^{6,11} and reinforced through publications such as those of SIGN¹² and GPAS^{4,5}.

Contemporary practice of pain management in the UK relies on the expertise and availability of pain specialists, the majority of whom work at consultant level. Currently, only medical specialists in pain medicine have statutory training requirements, levels of competency and an examination to assess competency to practice⁶. These specialists are integral contributors to the multidisciplinary pain team, delivering direct patient care and contributing leadership, strategic planning and education. Consultants participate in, and often lead on, audit and clinical governance activities. In units with active research programmes, consultants develop and oversee research projects and provide research governance.

The overall approach to care delivery for acute and chronic pain has diversified over the last decade. Current UK practice of units providing care for patients with persisting pain incorporates direct patient contact for the majority of consultants. Due to the high numbers of patients requiring review, acute pain management teams are usually consultant-led, with routine care delivered by specialist nurses. Direct pain medicine consultant contact is often reserved for the more complex cases. Consultants working in acute pain must have appropriate resources

to develop local guidelines for the provision of safe and effective pain management, and must be supported by appropriately trained specialist pain nurses. Strong links are recommended between the acute inpatient and outpatient services to allow immediate access to advice and support when necessary.

Common principles of professional conduct, patient care and governance apply equally across all settings of pain management delivery and have been set out in the *'The Good Pain Medicine Specialist'* document².

In UK practice the majority of consultants in pain management continue to provide anaesthetic services. In practice, the professional requirements match those of dual accreditation. Combined duties will naturally impact on job planning, continuous professional development activities and appraisal. The limitations to study-leave time and budgets may impact on ease of achieving individual CPD goals, and consultants are encouraged to include planning of these in their annual appraisal and job planning process.

The intensity of consultant-delivered direct patient care may vary with the level and setting of care provided (community, specialist, specialised care). Specifically, consultants delivering specialised care with complex interventions (IDD, SCS, cordotomy, complex in-hospital pain management) need to consider provision of safe and workable rotas to cover for demands of continuing care. Consultants providing complex interventions are also responsible for establishing inter-professional care pathways allowing for rapid access to imaging and neurosurgical review/intervention. These clinical commitments have to be matched by appropriate consultant staffing levels and represented in job plans.

Most patients referred to a pain management unit are in need of a coherent multidisciplinary approach to their pain problems. Consultants are tasked with providing a pain diagnosis, advice on complex pharmaceutical management and, where appropriate, physical or psychosocial intervention, whilst ensuring patient safety, dignity and confidentiality. These elements of care should not be delivered in isolation. Consultants in pain management must work in environments which encourage team working and effective communication. Equipment and accommodation must be safe and appropriate. Planning for team interventions and feedback, scheduled MDT meetings, departmental business and governance meetings are some of the basic requirements necessary to support the multidisciplinary team.

Job planning

Job planning is an annual process that should allow the pain clinician and the responsible manager to evaluate and adapt the present job plan following a basic set of objectives (e.g. SMART) within a time-protected meeting.

The basis for all consultant job plans in the NHS is the 10 PA contract with a division of PAs as 7.5 PAs DCC and 2.5 SPAs.

AAGBI guidance¹³ states that 'a commonly used tariff might be for an inpatient operating list (a standard 'session' of 4 hours anaesthesia and operating time) to represent a standard 1.25 DCC PAs, including preoperative and postoperative visits, machine and equipment checks, and drawing up drugs. Extending this value to other sessions such as... an outpatient session such as chronic pain...should be undertaken with caution.'

It is therefore recognised that it may be difficult to extrapolate this tariff to a pain management outpatient consultation setting which includes triage of referral letters; the consultation itself; dictating of complex letters; reviewing and acting on results; and telephoning GPs, patients or other agencies. Furthermore, consultants delivering inpatient pain ward-rounds are meeting with increased demands on time because of rising referral numbers of increasingly complex patients, which may lead to ad hoc interventions, investigations, and liaison with other teams (see chapter 3.6). Therefore, the recommendations of the Royal College of Physicians (RCP)¹⁴, may be more appropriate to outpatient department (OPD) clinics and inpatient ward-rounds. Following the RCP guidance when planning pain management posts and job plan reviews, participation in OPD clinics and ward-rounds translates to a tariff of 1.5 PAs for each of these DCCs.

Pain medicine consultants deliver other aspects of DCC that are not entirely covered by PA allocations linked to clinics, ward rounds and the immediately linked administrative work load as specified above. They are frequently

involved in ad hoc patient reviews on wards (outside agreed ward rounds), MDT with various clinical teams, preparation of MDT treatment plans and preparation of reports for the Department of Work and Pensions, Driver and Vehicle Licensing Agency and for various other purposes. These clinical duties do require separate acknowledgement within job plans.

It is recommended that a diary of activities is kept to demonstrate the range, duration and timing of all work that an individual consultant undertakes.

A minimum of 2.5 SPAs, as per the NHS Consultant Contract^{15,16}, is recommended and of particular importance where clinicians work combining duties in anaesthetics and pain management with dual requirements in their CPD.

Research, audit, innovation, quality improvement and attention to patient safety are all key to the delivery of high-quality pain services. This must be reflected in the preparation of consultant job plans and appropriate SPA allocation.

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5.2.2 STAFF AND ASSOCIATE SPECIALIST GRADES AND SPECIALTY DOCTORS

Roger Laishley

Introduction

The Staff and Associate Specialists (SAS) grade encompasses a group of doctors who are no longer in training but are not consultants, with a wide range of training, experience and competencies. Such attributes will influence the extent of their individual practice in pain medicine. The majority of these pain medicine clinicians will be working as Associate Specialists, Staff grades or Specialty Doctors. Most SAS pain management specialists will be anaesthetists who have acquired further experience and training in pain medicine.

SAS and Specialty Doctors who have the appropriate experience and competencies are well placed to provide excellent contributions to specialist pain teams. As well as the clinical setting, such commitment may include audit, research, training and education of others. They should be encouraged to develop roles within multidisciplinary pain medicine teams including both acute and chronic pain medicine services.

Whilst the provision of a good pain service is led by Consultants, Associate Specialist and Senior Specialty doctors will have acquired a high level of specialist knowledge and expertise, and they may have the capacity to work independently within agreed lines of responsibility. This could include responsibility for their own outpatient clinics and patients, as well as interventional procedures. Some SAS and Specialty Doctor pain specialists may develop managerial and leadership roles.

SAS and Specialty Doctors will usually work in multidisciplinary teams alongside their Consultant colleagues and will require the same levels of support and recognition. They are expected to maintain their skills and competencies to support a high level of practice, as well as meeting requirements for revalidation as a practitioner in pain medicine.

Standards

1. SAS and Specialty Doctor pain specialists must ensure that they maintain their skills and competencies in accordance with the guidelines for safe practice as published by appropriate bodies recognised by the Faculty of Pain Medicine. Whilst there is no published minimum competence level for SAS doctors working in pain medicine, where an individual SAS doctor has trained initially as an anaesthetist they should have as a minimum the basic-level training certificate¹.
2. SAS and Specialty Doctor pain specialists must practice in accordance with professional standards set by the GMC. They must undergo annual appraisal and comply with requirements set for revalidation^{2,3}.
3. All SAS and Specialty Doctors must receive the level of supervision commensurate with their skills and experience, and should not undertake work outside their capabilities^{2,4-6}.
4. Where SAS and Specialty Doctors undertake roles in supervision and training of trainees, they must ensure that they adhere to standards for the supervision of trainees as outlined by the GMC^{7,8}.
5. SAS and Specialty Doctors must have an agreed job plan that reflects their seniority and level of service provision. Any specific roles undertaken within a pain management service should be acknowledged within the job planning agreement. This must also include appropriate and sufficient allocation of SPA time^{1,2,5,6}.

6. SAS pain specialists and Specialty Doctors must have a job plan review with their clinical manager on, as a minimum, an annual basis^{1,2,5,6}

Recommendations

1. SAS and specialty doctor pain specialists should practice in accordance with the guidelines in *'The Good Pain Specialist'*, published by the Faculty of Pain Medicine⁹⁻¹¹.
2. Normally, SAS pain specialists should practice under the supervision of a named consultant^{2,6}. More experienced SAS and Specialty Doctor pain specialists should be given the opportunity to practice with a greater degree of autonomy, with agreed responsibility for their own outpatient clinics and interventional procedures^{1,2,5,6}.
3. Employers must ensure that SAS and Specialty Doctor pain medicine specialists are given the opportunity for career progression, development and training. Employers have a responsibility to support SAS specialists in developing their skills and experience to allow them to require less supervision and take on more responsibility as they progress through their career^{1,5,6,12}.
4. It is recommended that all departments employing SAS and Specialty Doctors identify a named consultant as Educational Supervisor responsible for overseeing their career development. As it is recommended that such career development be based on the attainment of competencies identified in the CCT document¹³, the Educational Supervisor should link with the Local Pain Medicine Educational Supervisor¹.
5. SAS and Specialty Doctors should have sufficient SPA time included in their job plan. The Academy of Medical Royal Colleges recommends that the minimum level of SPA time should be 1.5 WTE to support revalidation^{14,15}. Where SAS pain specialists have additional roles and responsibilities, SPA time should be increased appropriately^{2,6}. It is recommended that for Associate Specialists and Senior Specialty doctors who are over threshold 2 of the Specialty Doctor contract the minimum should be 2 (WTE) SPA's^{6,16,17}.
6. SAS and Specialty Doctors should have appropriate levels of support to facilitate their practice. This should include dedicated secretarial, administrative support and office space^{6,9,10}.
7. All SAS and specialty doctors should regularly audit and reflect upon their practice. National as well as local research should be supported^{6,11}.
8. All SAS and Specialty Doctors working in pain management should be encouraged to become members and/or Fellows of the Faculty of Pain Medicine. If needed to support such affiliations, appropriate access to any specialist examinations organised by the Faculty of Pain Medicine should be made available to SAS and Specialty Doctors.

Background

The term 'Staff and Associate Specialist' is a collective term that refers to a range of doctors who are neither in Deanery-approved training posts nor hold a consultant appointment⁵. Doctors enter these posts for a range of personal and professional reasons and are usually skilled and knowledgeable in their specialty but their individual experience varies.

The Associate Specialist grade was introduced as a permanent career grade in 1964, initially entitled Medical Assistant grade and re-named Associate Specialist in 1981. They are senior clinicians and, whilst still accountable to a consultant, work with a degree of autonomy.

The Staff Grade was introduced in 1988 as one of the many measures implemented to help resolve the problems of the hospital medical staff career structure. This grade generally had less experience than Associate Specialists on appointment, and largely helped with meeting service requirements.

In 2008, NHS employers reformed the medical workforce so that there would be no new appointments to the Associate Specialist and Staff Grade posts. Instead a new single grade of Specialty Doctor, was created. The stated aim was to ensure that the valuable contribution Specialty Doctors made to patient care was properly recognised and valued.

In addition, there are some specialists whose employment is not regulated by national terms and conditions. Their posts generally exist to address service needs and have a number of titles. In general, these posts are not endorsed by the Medical Royal Colleges.

It is recognised that the practice of pain medicine in the UK is best delivered by multidisciplinary teams led by pain specialists, the majority of whom will be NHS consultants. Skilled and experienced SAS doctors are well placed to make valuable contributions to both acute and chronic pain medicine services.

All SAS and Specialty Doctors with interest and enthusiasm for the specialty of pain medicine should be afforded the opportunities and wherewithal to develop and contribute to the pain service commensurate with their level of competence. They must be encouraged and supported by employers and colleagues to develop their skills and experience. In addition to their clinical service roles, SAS and Specialty Doctors in pain management should be involved in teaching, training, research and development of services. Where appropriate this may include managerial and leadership activities.

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5.2.3 MEDICAL TRAINEES

Lucy Miller

Introduction

Training in pain medicine is a compulsory part of the basic and intermediate curriculum for anaesthetists. Further training at higher (4–12 weeks) and advanced level (12 months) is optional but is required to qualify as a consultant with a specialist interest in pain. In addition to the compulsory assessments and case studies required to complete advanced pain training, Fellowship of the Faculty of Pain Medicine requires the trainee to pass the FFPMRCA examination. The Board of the Faculty of Pain Medicine is responsible for appointing Regional Advisors in Pain Medicine to supervise the provision of specialist training.

Standards

1. The training must be within a School of Anaesthesia.
2. Training must be within a multi-disciplinary pain management service.
3. The training must be well defined and state the learning aims and objectives as required to meet the 2010 Pain Medicine Training competencies.
4. An Educational Supervisor (with an appointment and appropriate experience in Pain Medicine) must be assigned for the duration of training.
5. If specialised services such as paediatrics, oncology/palliative care and complex spinal procedures are not available locally, then provision for these elements of training must be made in an alternative centre.
6. The trainee must have access to a pain management programme.
7. Arrangements must be made for less-than-full-time trainees to achieve their equivalent training and competencies.
8. Trainees must have clear lines of supervision by pain medicine consultant staff, and be able to access consultant support throughout their training.

Recommendations

1. The training centre should have a minimum of 300 new cases a year, with a minimum of 5 consultant sessions and 5 inpatient ward rounds per week. Therapeutic interventions should be at least 500 per year.
2. The Regional Advisor should have an overseeing role when the training occurs in more than one centre, but may delegate this role to Local Pain Medicine Educational Supervisors.
3. Trainees should spend the whole of their daytime working hours in pain medicine related duties.

Background

In 2010 the Faculty of Pain Medicine published guidance for advanced training in pain medicine for anaesthetists¹. This four page document outlines the organisation, workload and philosophy of pain medicine training. It is further supported by a wealth of information on the Faculty website. This is aimed at trainees, regional advisors and hospitals offering advanced pain training². Training centres wishing to be recognised for training are invited to complete a review form to enable assessment by the Faculty of Pain Medicine Training and Assessment Committee (FPMTAC)³.

Training centres must include a multi-disciplinary team approach to care and be conducted in accordance with the General Medical Council's principles of good medical practice. Experience in a wide variety of pathologies, investigation and treatment modalities is essential. Trainees must be included in case conferences, audits, departmental meetings and critical incidence responses, and encouraged to improve patient safety and management skills.

Treatment of patients should adhere to an evidence-based approach, with trainees critically appraising research and applying it where appropriate to the development of pain management plans.

The 2010 curriculum in anaesthesia is updated at regular intervals by the FPM Training and Assessment Committee in response to the changing environment of pain medicine and results of the national pain trainee survey.

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5.3 GENERAL PRACTITIONERS

Martin Johnson

This Chapter has been prepared by a representative of the Royal College of General Practitioners (RCGP) following discussions with the Faculty of Pain Medicine, as the Faculty is aware that many patients in Primary Care are managed primarily by a General Practitioner.

Introduction

With 14 million chronic pain sufferers in England alone¹ General Practitioners (GPs) are at the forefront of the monumental battle to cope with the massive number of patients with this long term condition (LTC). The management of chronic pain patients in primary care within the UK accounts for 4.6 million appointments per year, equivalent to 793 full-time general practitioners². Despite these dramatic statistics, chronic pain has so far not been elevated to the status that many other LTCs hold, with the net result that the management of chronic pain within primary care has never been co-ordinated and quality of care has suffered. Many people with chronic pain manage better when they have access to specialist pain management.

In 2013, the RCGP wrote guidelines to advise Clinical Commissioning Groups (CCGs) on the commissioning of pain management services³.

Standards

To reflect the current practice of pain management provision in primary care, this first edition of the document does not include any standards. These should evolve with consideration of the recommendations listed below, and will be published accordingly in future editions.

Recommendations

1. The management of acute, chronic and cancer pain should be an integral and important part of GP training, education and practice.
2. All GPs should be able to assess pain, triage for serious pathology, assess psychosocial factors that may maintain disability and distress, and instigate simple pain management strategies, evaluate such strategies and triage to specialist pain management services if the patient is not responding or improving within eight weeks.
3. All GPs should assess pain using a structured biopsychosocial approach, and ideally using validated assessment tools.⁴
4. When assessing and treating chronic pain, GPs should consider assessment for neuropathic pain.
5. In patients with acute or sub-acute pain, GPs should be aware of the possibility of chronicity developing, and should screen for this and consider early referral to specialist multidisciplinary pain management services for pain that is not resolving.

6. All GPs should be able to provide information about supported self management⁵ to their chronic pain patients (and carers), which should include signposting information to appropriate local and national resources and agencies.
7. GPs should regularly review patients on analgesics or adjuvant therapies.
8. All patients that are receiving WHO level 2 or above analgesic/adjuvant therapy should be reviewed at least annually, and a further assessment of their pain problem and treatment made.
9. GP practices should consider keeping a register of all patients with chronic pain.
10. Each GP practice should consider nominating a lead healthcare professional (HCP) that is accountable for the development of a chronic pain service within the practice, and consider appropriate training in pain management for other members of the primary care team.
11. GP Training schemes should include formal training in pain management within their curriculum. As a minimum, training should cover acute, persistent, cancer and complex pain assessment and their first-line management.

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5.4 NURSES

Dee Burrows and Gillian Chumbley

Introduction

The International Association for the Study of Pain (IASP) advocates a multidisciplinary approach to pain management and the inclusion of nurses in the assessment and treatment of patients with pain¹.

Nurses work with patients of all age groups experiencing acute and chronic pain, in primary and community care, outpatient and inpatient settings. The number of nurses in a particular service will be determined by the types and numbers of patients seen². Nurse Specialists and Nurse Consultants play a key role in pain management and may work in collaboration with others or as autonomous practitioners³, within their levels of competence. The Royal College of Nursing has published a pain knowledge and skills framework to guide and support pain management nurses⁴. Standards and recommendation applicable to all pain management professionals working in Multidisciplinary and Multispecialty Teams are detailed in Chapter 5.1 of this document.

Standards

Qualifications, Experience and Training for Pain Specialist Nurses. Table 1:

<u>Level</u>	<u>Qualification</u>	<u>Desirable Level of Education</u>	<u>Desirable Level of Experience⁵</u>
Staff Nurses	Registered General Nurse	Bachelor's Degree Introductory module in pain management	Broad general experience in nursing. Experience as pain link nurse. Evidence of an interest in pain management.
Clinical Nurse Specialists		Hold or be working towards a Master's degree	Specialist knowledge in pain management.
Senior Clinical Nurse Specialists		Master's degree	Highly specialist knowledge in pain management.
Consultant Nurses		Master's degree. Working to Doctorate Level or equivalent	Advance theoretical and practical knowledge.

1. Pain is viewed as a biopsychosocial phenomenon that includes sensory, emotional, cognitive, developmental, behavioral, spiritual and cultural components⁶. All nurses must be able to assess pain and deliver evidenced, informed pain management appropriate to their level and the setting in which they work. All nurses must have an understanding of the complexities of pain, commensurate with their level of practice.

2. Pain must be assessed in a comprehensive and consistent manner using valid and reliable assessment tools. Patients have a right to the best possible pain assessment, which is an integral aspect of nursing care and should involve patients and their family members⁶.
3. Treatment plans formulated by nurses with patients will take account of the biopsychosocial components of the individual's pain presentation.
4. Nurses advising multidisciplinary teams on the management of complex pain must have specialist knowledge of medication and non-pharmaceutical pain interventions.
5. Nurses must recognise the boundaries of their clinical competence, and seek appropriate support and advice when necessary⁷.
6. Nurses must be able to critically evaluate the literature pertinent to pain management within their setting and be able to integrate the findings into clinical delivery.
7. Nurses must participate in and generate clinical audit to identify areas for change and development.
8. Nurses must have the necessary skills to effectively educate patients and their families as well as members of the public, and to teach other nurses and clinical colleagues about pain and its management, within their clinical setting and according to their level of experience.
9. All nurses must partake in the annual appraisal and revalidation processes.

Recommendations

1. Nurses working in pain management at Staff Nurse level and above (see Table 1) should be able to develop and produce evidence-based protocols and guidelines for local clinical practice.
2. Nurses working at Senior Clinical Nurse Specialist level and above (see Table 1) should contribute to and lead on the formation of regional and national guidelines and policies.
3. Nurses working in pain management should move from a role of administering and giving advice about pain medications, to prescribing, within their sphere of competence. All nurses working at Clinical Nurse Specialist level and above should be qualified independent prescribers.
4. Nurses working with inpatients should have experience in the assessment and management of both acute and chronic pain, commensurate to their level of experience.
5. Nurses should consider innovative ways to use technology, such as computer applications (Apps) and other web based resources, to enhance shared decision making while promoting adherence to evidence-based practice.
6. Senior Clinical Nurse Specialists and Consultant Nurses should be able to facilitate the development of researchable questions, and to collaborate and/or lead clinical research. This would also include the ability to write grant-proposals and business plans.
7. There should be a clearly defined career pathway for nurses working within the specialism of pain management. The pathway should evidence a continuum of learning and practice, from a protocol driven focus with concentration on specific tasks, to the autonomous practitioner who has their own case load and is providing first contact care⁸ within a pain management team.

Background

All nurses working in the clinical environment are ideally placed to assess and treat patients in pain. Nurses with specialist pain management skills work in a variety of settings and with patients who have acute, persistent, cancer or complex pain. They may work in hospitals (wards or outpatients), community or in primary care. Their experience will range from the newly appointed clinical nurse specialist to the highly educated consultant nurse, with advanced practical and theoretical knowledge in pain management⁵. Consequently, skills range from task driven, protocol led roles, to the service changes made by consultant nurses, which serve the enhancement of patient care and outcomes⁸.

These service changes and enhanced education have led to opportunities to develop nurse-led services, e.g. acupuncture clinics, and medication review clinics, and some senior nurses take on their own caseload. Nurses can be found working across the interface between primary and secondary care, providing specific services for selected client groups with persistent pain. They mostly work as part of a multidisciplinary team- though with various levels of autonomy, sharing best practice through highly specialist and advanced consultancy that facilitates person-centred care⁹.

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5.5 OCCUPATIONAL THERAPISTS

Michelle Morgan and Rosemary Rutledge

Introduction

The World Federation of Occupational Therapists defines occupational therapy as ‘a client centred health profession concerned with promoting health and wellbeing through occupation’¹. The term ‘occupation’ refers to the broad range of purposeful tasks and activities (self-care, work and leisure) that individuals perform daily. Occupational therapy is founded on the belief that performance of these daily activities is crucial to our physical and psychological wellbeing and health. Occupational therapists are experts at enabling people to perform everyday activities².

As chronic pain has a major impact on peoples’ ability to engage in the activities they want to do, need to do and are expected to do, occupational therapists are ideally placed to work in this field, with the aim of minimising the impact pain has on an individual’s performance of daily activities. Occupational therapists help people to change aspects of themselves, the activity, the environment, or all of these, to enable performance and participation. ‘Through their overarching focus on occupational engagement, occupational therapists make a unique contribution to pain prevention and management programmes’³. Indeed, it is ‘strongly recommended’ that occupational therapists form part of the interdisciplinary/multidisciplinary team in pain management programme settings⁴.

The following provides a number of recommendations and standards for utilising occupational therapists in such settings (where chronic pain is of non-cancer origin).

Standards

1. The occupational therapist must work within their scope of practice, depending on their qualifications, experience, knowledge and training⁵.
2. They must demonstrate empathy and utilise active listening skills.
3. The occupational therapist must employ a biopsychosocial model. All occupational therapists are trained and expected to use this model in any setting. They should also be guided by other models relevant to their role and to the individual patient⁶.
4. The occupational therapist must be able to conduct a comprehensive and multidimensional assessment to establish the impact of chronic pain on all aspects of an individual’s life and roles, and also to be able to measure function in areas of self-care, work and leisure using a variety of reliable and validated assessment methods³.
5. Following assessment, each patient must agree individualised short and long term goals for their rehabilitation with their occupational therapist. Intervention techniques used should be relevant to each individual⁹.
6. The occupational therapist must gain and demonstrate a good understanding and use of the psychological and behavioural approaches evidenced to be effective in the area of pain management (currently recommended as cognitive-behavioural therapy, motivational interviewing, acceptance and commitment therapy). Advice giving alone has not been shown to be effective⁴.

7. The occupational therapist must use interventions that focus on maximising occupational performance and engagement in all activity areas, i.e. self-care, leisure, work and rest².
8. The occupational therapist must promote the development of self-efficacy and self-management skills^{2,3}.
9. Practice must promote patients staying active to reduce long term disability.
10. Pain management is a specialist area for occupational therapists, and therefore it is essential that they receive appropriate training and support to work in this area.

Recommendations

1. There should be an HCPC-registered occupational therapist with specialist experience in pain management employed within a pain management service.
2. The occupational therapist should have/develop the appropriate areas of knowledge and skills as set out in the International Association for the Study of Pain's core curriculum for occupational therapists¹⁰.
3. The occupational therapist should develop excellent communication skills, quickly and easily developing a rapport with patients.
4. Occupational therapists should facilitate individuals to establish a healthy balance of daily activity in the areas of self-care, work, leisure and rest².
5. Where group-work is involved, the occupational therapist should have/develop skills in group facilitation and management specific to chronic pain rehabilitation.
6. The occupational therapist should gain additional training, experience and skills in the application of cognitive-behavioural principles in the management of chronic pain⁴.

Background

Occupational therapists are experts in enabling individuals to restore functional activity. Their philosophy focuses on the link between what people do and their health and wellbeing. Everything a person does helps to define their identity and, therefore, if a person is unable to do what is important to them because of chronic pain, their physical and psychological health and wellbeing suffer³.

The consequences of chronic pain on activity performance are wide ranging. It impacts on self-care, work (paid or unpaid), family and social role fulfilment, community participation, physical activity, habits and routines, leisure and sexual relationships. Occupational therapists will assess the impact of pain on all of these areas.

Relinquishment of various daily living activities results in an imbalance in the individual's life. This compounds the initial pain problem and leads to the individual being caught up in a maladaptive pain cycle, with non-performance of particular activities undermining self-confidence, personal autonomy and life roles, and decreasing physical ability. The overall goal of an occupational therapist is to help the individual break the pain cycle, regaining the balance lost between the personally relevant occupational tasks and, ultimately, improving physical and psychological health, wellbeing and quality of life. Engagement in meaningful activity has the potential to mediate the pain experience by altering biological, psychological and social factors which influence the experience of pain^{3,8,9,11,12}.

The interventions/techniques that occupational therapists use include: activities of daily living preparation (for example activity analysis, skill development, activity adaptation, problem solving); prioritising, planning and pacing of activities to resolve an imbalance of under/over activity; occupational engagement and establishment of a meaningful daily routine; ergonomics; communication skills training; coping skills training; relaxation training; stress management; environmental modification; development of skills to set and achieve goals through graded activity; restoration of the balance between work, rest, self-care and leisure activities; provision of equipment if required; and facilitation of return to work. Pain management strategies aim to promote occupational engagement despite pain^{3,8,9,11-13}. These interventions are best provided by an occupational therapist as an integral part of an interdisciplinary/multidisciplinary team, but can also be applied to individual interventions.

With a focus on functional activity enablement, occupational therapists are well placed to intervene early to prevent chronicity developing, particularly in primary care^{3,9}.

It is recommended that a set of detailed practice standards are developed for occupational therapists working in pain management and pain management programmes, to ensure best practice, profile the important role occupational therapists have to play in the field of pain, support the development of pain champions, and to assist with identification of future training needs, research and development.

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5.6 PHARMACISTS

Roger Knaggs

Introduction

Pharmacy services are an integral part of the multi-professional pain management team, and their roles include supply and preparation of medicines, provision of information regarding medicines to healthcare professionals and patients, delivering pharmaceutical care and optimising pharmacotherapy for patients, and overseeing processes to ensure the safe and effective use of medicines.

Standards

1. All inpatient pain management services must have dedicated pharmacy resources.
2. There must be access to dedicated pharmacy support for outpatient pain management services¹.
3. Clinical pharmacists working as part of the multidisciplinary inpatient or outpatient pain management services must be competent to provide the service.
4. There must be sufficient pharmacy technical staff to provide support functions.
5. A pharmacist working as a 'Practitioner with a Special Interest' in pain management must be accredited and recognised to undertake the role².
6. Sterile manufacturing facilities and experienced technical staff must be available in centres that provide epidural or intrathecal drug delivery for acute and persistent pain.

Recommendations

1. Pharmacists may support other members of multidisciplinary pain management services by undertaking regular medication review to assess the safety, effectiveness and tolerability of medicines prescribed for pain relief.
2. Pharmacists working as a member of multidisciplinary pain management services should participate in an independent recognised professional recognition programme to verify competence level.
3. Pharmacists working as a member of multidisciplinary pain management services would benefit from undertaking training to become a pharmacist prescriber.
4. Pharmacists should contribute to and be actively involved in formulary management and in the development of local prescribing guidance for acute and persistent pain in both primary and secondary care.
5. Pain services should have access to a medicines information service to provide expert advice on the use of analgesic medicines in special circumstances (e.g. pregnancy and breastfeeding, renal impairment, hepatic impairment) and potential interactions with other medication.
6. A pharmacist should be consulted or invited to review information regarding medicines for patients.

Background

Pharmacists routinely provide pharmaceutical care to patients, optimise medication use, manage medicine-related risks, utilise evidence-informed decision-making and encourage professional collaboration. Their expertise improves prescribing quality and patient outcomes. Pharmacists have a pivotal role in implementing medicines optimisation and promotion of a patient-focused approach to getting the best from investment in and use of medicines.³

The Royal Pharmaceutical Society Faculty (launched in 2013) provides an independent professional recognition programme for assessing pharmacist competency at three levels, reflecting the earlier knowledge and skills framework from the Department of Health (England)⁴. Advanced Stage I is equivalent to previous Foundation level, with Advanced Stage II equivalent to Excellence, and Fellowship equivalent to Mastery⁵. As yet, few pharmacists have gone through this process and for now, it remains the responsibility of Chief Pharmacists (or equivalent) to ensure that pharmacists are competent for their role.

External drivers such as legislation and policy statements have resulted in developments including medicines reconciliation, requirements for medicines storage and controlled drugs audits⁶ and ensuring the accurate and timely transfer of information about medicines between different care providers⁷.

In comparison to other professions represented in the multidisciplinary pain management team, the pharmacy team will be very small. In many cases the contribution will be from just one practitioner, who will often carry other responsibilities to make the post viable. It is essential that robust arrangements are in place to ensure continuity of service for annual leave, sickness and study leave.

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5.7 PHYSIOTHERAPISTS

Paul Cameron and Cormac Ryan

Introduction

Physiotherapy is defined as a healthcare profession that works with people to identify and maximise their ability to move and function¹. It aims to achieve healthy levels of activity and self-management for people with chronic pain². Physiotherapists are an integral part of the multidisciplinary pain management team³. The following provides some guidance as to the recommendations and standards to be adopted when utilising physiotherapists in pain clinic and pain management settings.

Standards

1. Pain Management Services (and programmes) must have a rehabilitative focus and must include a Health and Care Professionals Council (HCPC) -registered Physiotherapist within the multidisciplinary team. Staffing levels should be determined locally by clinical need, and facilitate an agreed level of early access to pain specialist physiotherapy, to optimise rehabilitative potential.
2. The pain management physiotherapist must have additional training in the cognitive-behavioural principles of pain management.
3. The pain management physiotherapist must work within their scope of practice, determined by their qualification, knowledge, experience and training.
4. The pain management physiotherapist must be able to demonstrate an advanced level knowledge and understanding of chronic pain.
5. Pain management physiotherapists have an important role in educating other health professionals and patients. The physiotherapist must have an advanced level of understanding of pain mechanisms and physiology, and an ability to be able to relay this information to health professionals and to patients in a comprehensive and contextualised manner.
6. The pain management physiotherapist must have a strong understanding of psychological and behavioural approaches used with pain management, such as cognitive behavioural therapy (CBT), acceptance and commitment therapy (ACT), motivational interviewing, graded exposure and goal setting.
7. The pain management physiotherapist must be prepared to embrace generic and integrated assessment and treatment approaches, as well as to lead on professional-specific modalities.

Recommendations

1. An HCPC-registered Physiotherapist with specialist experience in holistic management of pain should be employed within a pain management service or clinic and/or pain management programme setting.
2. The pain management physiotherapist should have strong communication skills, including skills and attributes such as empathy, validation, active listening, and rapport building.

3. A biopsychosocial physiotherapeutic approach informed by a psychological framework should be employed during interactions with patients, e.g. ACT, CBT and motivational interviewing.
4. All patients should have individualised goals set for their rehabilitation requirements. Short-term and long-term goals based on the individual's own values should be established, agreed and reviewed throughout the patient's treatment.
5. Physiotherapists are experts in exercise therapy. Exercise and exercise therapies, regardless of their form, are recommended in the management of patients with chronic pain. Improving the quality and efficacy of activity by the use of measurement relating to the number of repetitions or duration of activity is recommended.
6. Physiotherapists should use their role to provide chronic pain patients with advice and encouragement to consider their own activity levels in order to improve ability and function in the longer term. This could be provided as part of a comprehensive pain management programme which includes active participation in agreed exercise or activities. Advice alone is insufficient.
7. Various approaches should be used to improve adherence to exercise programmes including one-to-one supervised exercise, individualised exercise in group settings, addition of supplementary material and combined group and home exercise programmes.
8. Aiming to change behavioural patterns around painful physical sensations should be integral to a rehabilitative approach by a physiotherapist. This will promote lasting behavioural changes.
9. Pain specialist physiotherapists should consider becoming independent non-medical prescribers in order to assist patients to optimise their medication use, as the patient's pain changes throughout their rehabilitation programme, in conjunction with other members of the pain management MDT.
10. Physiotherapists have advanced knowledge in the use of electro-therapies. This knowledge should be used to provide advice to health professionals and patients in the appropriate use of these devices, e.g. TENS (Transcutaneous Electrical Nerve Stimulation).

Background

The role of physiotherapists in pain management has grown significantly in recent years and physiotherapists are now seen as an integral part of the multidisciplinary pain management team.

Physiotherapists work with patients to identify and maximise their ability to move and function, to enable patients to improve their health and wellbeing^{1,3}. Within a pain management programme, physiotherapists contribute to a range of interventions and monitoring activities, including patient education, electrotherapy, exercise therapy, graded exposure to functional activity, as well as to research and evaluation. All of these should be applied within a biopsychosocial framework and as an integral part of the multidisciplinary team. When delivered in this fashion there is good evidence of their clinical and cost effectiveness^{4,5}. This same range of interventions can be applied within a pain service providing individual appointments as well as in group settings.

Exercise is a key component of pain management⁶. 'Exercise', in this context, could be anything which improves fitness, flexibility, balance and stamina as agreed with the individual patient, and may be specific or through engagement with activities including, e.g. walking, dance, tai chi, yoga, swimming, gym or other classes. Physiotherapists, as diagnosticians and movement specialists, are uniquely placed to provide assistance to

patients with pain, particularly to promote improved physical outcomes, and the Physiotherapy Pain Association recommends that physiotherapists play a leading role in the exercise component of pain management programmes⁷. Within this role the physiotherapist should provide patients with an exercise/activity programme that incorporates components such as pacing, goal setting, graded exposure and importantly, a reduction of fear avoidance behaviour⁷. This should be delivered in a manner that is bespoke to the needs of patients suffering from chronic pain and that incorporates an overarching psychologically aware approach to patient management e.g. cognitive behavioural approaches, acceptance-commitment therapy approaches and motivational-behaviour-change approaches.

There are no specific guidelines in relation to staffing levels for physiotherapists or other health professionals in a pain service or pain management programme. This is likely to be a reflection of the lack of a standardised pain service, thereby making staffing levels difficult to ascertain. However there is clearer guidance in relation to the knowledge and skill sets required of physiotherapists working in a pain management setting.

Currently, physiotherapists working within a pain management service frequently go beyond what might be considered their traditional role⁵. For this reason, it is essential that physiotherapists working in this setting receive appropriate training and support to ensure that they are practising within their professional and personal competence¹. The Physiotherapy Pain Association, with the support and endorsement of the Chartered Society of Physiotherapy, has developed a competency framework which can be used to guide the continued professional development of physiotherapists working within pain management. It describes the domains in which they should be skilled (such as knowledge and understanding of chronic pain) and the level of expertise in each domain that would be expected of an entry-level graduate, an experienced graduate, an advanced practitioner and an expert practitioner⁵. All physiotherapists working in a specialist pain management setting should be encouraged and supported to become advanced level practitioners.

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5.8 PSYCHOLOGISTS

Zoey Malpus, Hannah Connell and Neil Berry

Introduction

Pain is a complex biopsychosocial phenomenon, and chronic pain affects people of all ages from early childhood to old age. Pain specialists have long recognised that psychological and social processes contribute significantly to pain and its management, and psychologists have been at the heart of pain management teams since their inception. They have become increasingly involved in chronic pain services more generally, bringing specialist knowledge and professional expertise to help ensure that psychosocial factors are properly considered and addressed.

Standards

1. All psychologists working in pain services must be registered with the Health and Care Professions Council (HCPC) as a 'practitioner psychologist'¹.
2. All psychologists joining a pain service for the first time must receive appropriate training with a psychologist experienced in interdisciplinary pain management.
3. Psychologists must receive regular professional supervision consistent with the prevailing recommendations of the British Psychological Society². The supervising psychologist must have substantial experience in pain management or other medical fields requiring multi-professional teamwork.
4. Trainee psychologists on placement with a pain service team must be supervised by a psychologist who is appropriately qualified and experienced in interdisciplinary pain management.
5. Psychologists working in pain services must be competent to ensure that psychological assessments, therapies and outcome measures are evidence based.
6. Psychologists must have a job plan that is appropriate to their grade³.
7. Psychologists working in pain teams must ensure that the treatment of children and young people is developmentally appropriate, and ideally delivered by paediatric clinical psychologists with specialist knowledge of chronic pain in childhood.

Recommendations

Psychologists play a key role in the delivery of psychologically-based pain management, either directly, by its contribution to multi and interdisciplinary rehabilitation, or indirectly by supporting non-psychologists to work in a psychologically-informed manner.

There are significant clinical governance implications for psychologists working in pain services and, to be able to deliver a quality service, they must adhere to a range of professional standards:

1. **Appropriate qualifications/Registration:**

All psychologists working in pain services must be registered with the HCPC as a “practitioner psychologist”¹ and, unless only recently qualified, should be eligible for Chartered Psychologist status with the British Psychological Society⁴. They are not required to be members of the British Psychological Society, but membership of the Society can be considered advisable to help ensure that they are aware of developments in theory, research and practice. Where a psychologist is appointed to be lead psychologist with management and supervisory responsibilities for junior psychologists or other team members, s/he should normally be in a senior grade and eligible for the title “consultant”⁵ (under the NHS’s *Agenda for Change*, this normally means Band 8C or 8D). Psychologists in training may have placements in pain service teams but they must be supervised by a practitioner psychologist who has the appropriate qualifications, training and experience².

2. **Appropriate training (core and specific):**

Professional registration requires that psychologists must work within their ‘scope of practice’⁶. The HCPC Standards of Proficiency define this as ‘...the area or areas of your profession in which you have the knowledge, skills and experience to practise lawfully, safely and effectively’⁶. To meet this requirement, where possible, psychologists applying to work in pain services should have previous professional experience of working in both medical and mental health contexts. Many of the psychosocial issues associated with pain conditions and their management do not require psychiatric or mental-illness-based models. Not infrequently, however, pain teams treat patients with complex and serious mental health problems. It often falls to the psychologist to carry out appropriate assessments (e.g. where there may be a suicide risk) and ensure that mental health services are consulted or engaged.

While most psychologists working in pain service teams have been trained as clinical psychologists, the ‘scope of practice’ of some health and counselling psychologists means that they too can work appropriately in adult pain service teams. It is important that job descriptions and person specifications for advertised posts specify the particular experience, qualifications, skills and competencies that are required, so that appropriate candidates apply whether they are clinical, health or counselling psychologists.

It is important that psychologists working in chronic pain have the skills to deliver evidence-based psychological therapy, and provide high-level assessment, formulation and therapy supervision to the teams they are part of. These skills may derive from professional training or from appropriate clinical core experience. All appropriately trained psychologists new to pain services should receive clinical supervision² and a relevant CPD programme, including shadowing experienced colleagues, to develop the specialist knowledge required to communicate effectively with professional colleagues and to work safely with patients. This pain-specific additional training should be included in the job description and job plan.

At the time of writing, there are no formal pain-specific training courses but the International Association for the Study of Pain recommends a core curriculum of knowledge for psychologists working in pain services⁷.

3. **Appropriate supervision**

All psychologists working in pain services should receive appropriate supervision from a senior psychologist with substantial experience in pain management. If this is not possible, the supervising psychologist should have extensive experience of other medical fields which require multi-professional teamwork. The British Psychological Society recommends a minimum of 1.5 hours per month and this should be appropriate to the psychologist’s grade^{2,3}. Psychologists who lead pain services or pain teams should have access to peer supervision or be given time in their job plan to develop professional networks.

4. **Provide evidence-based psychological assessment and therapy**

All psychologists working in pain services should be able to provide appropriate, evidence-based psychological assessments and therapy specific to pain management. Psychologists should show an up-to-date knowledge of evidence-based psychological therapies⁸, for example by reading Cochrane Reviews⁹ and other peer-reviewed literature, and ensuring that they are able to deliver them. This may be in a group or individual format according to individual psychological formulation and the service context.

5. Caseload / Job plan

All psychologists working in pain services should have sufficient time in their job plan to allow for MDT meetings, planning, supervision, report writing, CPD, audit and research¹⁰. The balance of group and individual direct clinical work will be negotiated with the service lead to meet personal development needs and those of the pain service. Total caseload for clinical work will be appropriate to grade, and direct clinical contact will not normally exceed two-thirds of weekly sessions. Non-direct clinical activity includes supporting other members of the pain team to work in a psychologically informed manner, report writing and case working.

The British Psychological Society provides guidelines for the activity of clinical psychologists, including job plans for different grades³. This varies across services according to the complexity of presenting problems and the need for team working and liaison. Factors include the number of clinical contacts, caseload and balance of direct clinical to non-direct clinical activity. The guidelines recommend a 60:40 split for grade 8A posts and 50:50 for grade 8B posts.

6. Supporting others to work in a psychologically informed manner

Within a stepped model of psychological care for pain services, the psychologist should offer training and supervision to staff not formally trained in psychological methods.

7. Clinical Outcomes/ Audit / Research

All psychologists working in pain services should use validated psychometric tools where formal psychological measurement is required. Examples include the measurement of pain-related distress, quality of life and psychological wellbeing. The psychologist should also advise the other members of the pain team on the appropriate use of such measures. It is often appropriate for the psychologist to lead on the data collection for outcome and research. Psychometric tools can be used for assessment and to aid clinical decision making. Data (psychosocial, quality of life and functional) should be collected and analysed to ensure good clinical outcomes. Service users should be involved and service satisfaction measured. Psychologists can also work with service users for purposes of service development. Psychologists should routinely contribute to the required audit cycles.

8. Children with chronic pain

The needs of children and adolescents with chronic pain are best served by paediatric clinical psychologists working within paediatric chronic pain teams. All the preceding recommendations apply to psychologists working in paediatric pain services equally. Psychologists working with children and adolescents with chronic pain need to understand how the developmental stage of the young person affects the impact that pain has. It is essential that psychologists working with children understand the models of chronic illness in childhood, as well as child development and child and adolescent mental health. Psychologists should be able to assess and provide psychological interventions to children and their families, including working directly with children and working with parents to reduce the impact of pain. Awareness of education systems is important, as supporting children to remain engaged in age-appropriate activity is a key treatment outcome. Knowledge of child-safeguarding and access to appropriate supervision and organisational safeguarding support is essential¹¹.

Background

Psychology is one of the few professions where a degree does not automatically lead to a professional qualification. All psychologists working in health have to complete further postgraduate training (a doctorate) either in clinical, health or counselling psychology. Currently only clinical psychology is an NHS-funded training route, and most psychologists working in pain services are clinical psychologists.

The importance of psychosocial processes in pain has long been recognised. That pain can have significant psychosocial consequences is indisputable, but it is also clear that psychosocial factors make an important contribution to the experience of pain. Indeed, as pain is essentially a perceptual phenomenon, it may be said that it is not possible to have pain without the involvement of psychosocial factors.

Chronic pain has a significant impact on physical function, on psychological wellbeing, and on quality of life. It also impacts on the social contexts in which patients live. Psychological distress, from the experience of chronic pain and other life events (from which people with chronic pain are not exempt), contribute very highly to the overall pain-associated disability and the readiness for pain rehabilitation interventions. It is therefore essential that an appropriate and thorough assessment of psychosocial factors is made, and that that formulation contributes to the clinical decision-making process¹².

Professional bodies specialising in pain, including the Faculty of Pain Medicine, promote biopsychosocial models of pain and of pain management which value the contribution of professional psychologists in specialist and specialised pain services. The management of pain in clinical settings normally takes place without the involvement of professional psychologists¹³. However, specialist pain services often serve patients with complex and challenging chronic pain conditions: challenging both for the patients themselves and for the health professionals who work with them.

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Chapter 6

Patient Pathways

- 6.1 First Consultation, Follow-Up and Discharge
- 6.2 Communication with Patients
- 6.3 Chronic (Non-Cancer) Pain
- 6.4 Adult Acute Pain Management
- 6.5 Cancer Pain
 - 6.6.1 Managing Acute Pain in Children and Young People
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6.1 FIRST CONSULTATION, FOLLOW-UP AND DISCHARGE

Anthony Davies and Christopher Barker

Introduction:

The patient-clinician consultation is a key interaction in delivering effective pain management. Patients referred to the specialist pain management service are typically complex with multiple factors impacting on their presentation. A biopsychosocial framework is recommended to promote an in-depth, robust assessment. This facilitates the confirmation of the diagnosis and the explanation to the patient and is followed by a mutually agreed management plan.

Standards

1. You must allocate adequate time to undertake the consultation, taking into consideration the complexity of the patient's presentation (discussion indicates that an average of 45 minutes is the current norm for new patients).
2. You must communicate with the patient, and when appropriate with their carers, in a way that is understandable to them.
3. You must examine the patient when it is clinically indicated.
4. You must be satisfied that you have consent or other valid authority before you undertake any examination or investigation.
5. You must consider a chaperone where appropriate, according to current GMC guidelines.
6. You must formulate a shared, individualised management plan based on the best available evidence.
7. You must keep clinical records that are clear, accurate, legible and up-to-date.
8. You must seek help from appropriately qualified colleagues when a problem arises outside your area of competence.

Recommendations

First consultation:

1. Referral letters should have a minimum data-set agreed between primary and secondary care providers.
2. The referral documentation should make explicit whether the patient has a physical disability or specific communication needs, so that appropriate support (e.g. access, aids, interpreter, etc.) can be organised in advance.
3. The pain management specialist should have full access to the patient's clinical notes (either written or electronic) and to previous relevant investigations.
4. A working diagnosis should be constructed.
5. There should be clear correspondence of the assessment and agreed management plan to the referrer in a timely manner.

6. A copy of the assessment and management plan should be forwarded to the patient.

Follow-up consultations

1. There should be full access to the patient's clinical notes.
2. Review appointments should take place in a timely manner.
3. Follow-up arrangements should allow adequate provision to meet clinically necessary demands.
4. Patients should be encouraged to take an interest in their health and take action to improve and maintain it.

Discharge/further referral

1. A strategy for the longer-term management of the patient's pain condition should be discussed prior to discharge.
2. You should ensure that the continuing care of the patient has been arranged when necessary, and that other healthcare workers and the patient are aware of these arrangements.

Background

Those presenting with pain often carry complex inter-relating multi-morbidities¹. The clinician must consider these factors and integrate them into the overall evaluation of the patient's pain presentation. Consultation technique is therefore a fundamental skill^{2,3}. This interaction is pivotal to the accurate assessment, diagnosis, management and education of patients with pain.

It has been shown that enablement of patients is correlated with longer consultations⁴. As chronic pain is typically a long-term condition, much of the work of a pain management specialist lies in enabling those with pain to live and function as well as possible alongside their condition. Thus it is essential that the pain medicine specialist is able to provide all aspects of a comprehensive biopsychosocial assessment⁵. This will include understanding the biological (diagnostic and aetiological perspectives), psychological (distress and/or unhelpful cognitions) and social (functional disability) processes implicated in pain.

Minimum information will be agreed between referrer and provider. This is sometimes facilitated by an agreed proforma. Access to additional information, including investigations, is essential to help inform the management plan. Clinical examination should be undertaken when appropriate. The value of the examination may be greater than the simple gathering of clinical information, and can have a therapeutic benefit in its own right⁶. Informed consent is necessary, and the presence of a chaperone must be considered⁷.

From the patient perspective, the management plan is often the key aspect of the consultation. Shared decision making in shaping this plan is essential. This will only be realised by fully involving the patient in their own care⁸. Informed consent to any chosen treatment can only take place if the diagnosis has been shared with the patient, and the therapeutic options have been fully understood⁹.

The agreed management plan often involves other members of the interdisciplinary team. Good, clear communication with colleagues is essential. It is important to recognise that whilst the pain medicine specialist may lead the interdisciplinary team, other members of the MDT provide comprehensive specialist care which is crucial to the successful management of patients with complex pain needs. It may be necessary to involve professionals external to the pain management team. Timely referral is important.

Communication of the assessment and agreed management plan to others involved in the patient's care is essential. This is usually in the form of a written report and is especially important where shared care with other

clinicians is in place. Increasingly, such reports are copied to patients as best practice¹⁰. Formulation of detailed letters and reports takes time and there must be adequate provision for this.

Follow-up arrangements should support the therapeutic process, and the time to follow-up should be appropriate. Unduly protracted reviews can lead to disengagement, whilst overly frequent input can produce dependence. As chronic pain is a long-term condition, the facility to access pain management services at short notice for advice regarding flare-up management is essential¹¹. This may be agreed locally with commissioners, e.g. open appointment follow-up within a specific period of time.

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6.2 COMMUNICATION WITH PATIENTS

Neil Betteridge, Katy Simpson and Tom Green

Introduction

Patients arriving at pain services have complex care needs that can be challenging to meet in primary care settings, and they will often have experienced feelings of disappointment or frustration with healthcare services prior to their referral. Clear, responsive and compassionate communication between clinician and patient is a strong determinant of levels of patient engagement and satisfaction with the service and, as a result, will typically have a strong influence on treatment outcomes. People in pain may not initially understand their condition well, which can inhibit them from engaging in exercise through fear of injury, or make it difficult for them to accept that their condition may not have a cure. Clinicians can empower patients in learning to manage their own pain by clearly communicating treatment options – including risks and benefits – as well as providing access to information.

Standards

NICE, SIGN, the GMC and the RCoA provide guidance on standards and recommendations relating to communication with patients. The relevant documents are:

1. SIGN Guidance 136: *Management of Chronic Pain* (2013)¹
2. NICE Clinical Guideline 138: *Patient experience in adult NHS services - Improving the experience of care for people using adult NHS services*. (2012)²
3. GMC: *Good Medical Practice - The duties of a doctor registered with the GMC* (2013)³
4. GMC: *Colleague and patient feedback in revalidation* (2013)⁴
5. Royal College of Anaesthetists: *Conducting Quality Consultations in Pain Medicine* (2015)⁵

Recommendations

1. Patients want to feel that healthcare professionals are listening. People in pain often feel this is not the case, as they are likely to have previously encountered a lack of awareness, or even suspicion and disbelief, at the wider societal level. Taking the time to listen enhances the relationship between professional and patient, and allows them to share the impact that the pain is having on the patient's life.
2. An explanation of the pain should be given to patients. Whether it is acute or chronic pain, patients typically value a clear explanation of the possible cause, the physiology, the impact on their life and the options for management of the pain.

3. Reassurance should be offered to patients that acute pain can heal and chronic pain can be managed. Pain can be a frightening experience and reassurance from a trusted healthcare professional can help mitigate this.
4. Communication includes body language, tone and words. Awareness of all three elements can make a big difference to the patient experience. For example, making eye contact and sitting at the same level may seem simple, but they help to build trust and show respect.
5. Information should be offered to patients in a choice of formats. Signposting patients to such resources can allow them time to digest the information and can facilitate shared decision making in future consultations. This should be done regularly and not just at the initial appointment.
6. The terminology used to describe pain can influence the patient experience. Terms and phrases should be carefully chosen, and patients' reactions monitored to enable healthcare professionals to adapt their language accordingly.
7. Where possible, and only with the patient's approval, family and/or carers or friends should be involved in at least some discussions and consultations. This may help protect against the damaging effects pain can sometimes have on relationships.
8. The extent to which pain medication can reasonably be expected to ease the pain should be made clear to patients. An open and frank discussion about the role of pain-relief medication can lay important foundations for the patient's self-management of their pain. Medication should be discussed in the context of being part of a wider package of tools to help manage pain, with particular care being taken to avoid misunderstandings about psychological therapies.
9. Patients may lack a clear understanding of what they themselves can do to manage their pain, or even of the meaning of 'self-management'. Where appropriate, strategies should be discussed with them, realistic goals and targets for work/activity/exercise set, and resources provided, including information about community-based support groups.
10. Pain relief medication prescriptions can be complicated with multiple medications needing to be taken at different times. This can be especially complex for patients with co-morbidities. Clear and documented explanations as to when medication needs to be taken should be given to increase the patient's confidence and understanding. A discussion of possible side effects will also help the patient feel more prepared and confident in persevering with medications that are known sometimes to cause adverse reactions in the early stages of treatment.

Background

The management of pain is challenging for everyone involved, whether healthcare professional, patient or carer. Effective pain management for most patients will require a collaborative approach where the patient is informed, listened to and actively involved, to the extent that they wish, in decision making.

Good communication between healthcare professional and patient is recognised as an important factor in the patient's satisfaction with their care¹. There is evidence that effective communication has a positive influence on 'pain control, adherence to treatment regimens and psychological functioning' in cancer patients, with the inverse being true of poor communication⁶. More research needs to be done before the same claim can be securely made for patients with chronic pain, although there is some evidence that specific training in communication for healthcare professionals can reduce pain levels in these patients¹.

It is important to listen to patients, not only out of politeness, but as a means to improving patient satisfaction, experience and treatment outcomes. As many chronic pain conditions are difficult to diagnose and do not appear on tests, taking a detailed case history will often be the surest means of making or confirming a diagnosis. By listening to the patient, the clinician will also be able to work with the patient to support better treatment choices reflecting the needs, preferences, values and circumstances of the individual. Addressing the impact of pain on the individual's relationships, employment and emotional state requires giving space to the patient to talk about these issues.

Good communication facilitates patient understanding⁷. People in pain will often not have had a satisfactory explanation of their pain. This lack of understanding can lead to fear, avoidance of physical activity and unwillingness to engage with self-management strategies. If it is not well understood that chronic pain will most probably be incurable, this can give rise to disappointment and a loss of trust in the healthcare services when a cure is not forthcoming. In addition to addressing patient understanding in clinical settings, there are a wide range of resources in different media which seek to explain pain in a manner accessible to all. It should be noted that chronic pain can reduce cognitive and memory function in some patients and may therefore impede their capacity to process large quantities of information in a single sitting.

The effects of pain reach beyond the individual and can often have a destructive impact on their wider social world. Relationship breakdown and social isolation are common experiences among people in pain. Wherever possible, and only with the patient's permission, family members and/or others in caring roles should be invited to attend sessions on understanding pain and its emotional effects. Effective communication with the patient can also help them better to understand their pain and the things they need to do to manage it and to communicate this information in turn with those around them, thus helping them to be better supported in the home, local community and workplace.

As there are limited effective pharmacological options available for treating chronic pain, many patients will benefit from the adoption of pain self-management strategies. This requires sensitive and careful guidance, particularly when discussing psychological approaches as patients may feel that the reality of their pain is being discounted. It is important that the patient is supported in engaging in this process and does not feel that they have been abandoned to manage alone. A collaborative approach can help the patient to come up with a realistic plan to manage their pain and focus on reengaging with the activities they define as most important to them. A personalised approach using Patient Activation Measures can be helpful here⁸. Ongoing support should be available to discuss the patient's progress.

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6.3 CHRONIC (NON-CANCER) PAIN

Jonathan McGhie

Introduction

Chronic, or persistent, pain refers to pain that exists beyond the expected time of healing, usually taken as three months or more. Chronic pain has been recognised as a long-term condition in its own right¹. In 2008 the Chief Medical Officer emphasised the impact of chronic pain. It is prevalent, affecting more than 7 million people in England and Wales, and is a burden both to the patient and to the state from increased healthcare usage and lost time at work². 'Chronic pain' can encompass pain arising from nerve origin (neuropathic), musculoskeletal, or visceral sources (nociceptive). Frequently the pain picture is mixed and the pain arises from several sources. Whilst the biological symptoms of pain often predominate, they must be evaluated in conjunction with the psychological and social impact that the pain has on the individual. Problematic/ complex pain is defined as: 'Any pain associated with, or with the potential to cause, significant disability and/or distress'³. Diagnosing chronic pain early and managing it well has clear benefits for both the patient and society⁴.

Standards

1. Patients with chronicity must have access to clinical psychology and specialist pain management physiotherapy early in their treatment pathway.
2. Specialist (secondary care) centres must be able to refer complex chronic pain conditions onwards to tertiary specialised centres for assessment and management.

Recommendations

1. Once essential diagnostic investigations have occurred and been actioned, chronic pain should be diagnosed and managed as early as possible in the patient pathway.
2. Clinical judgement and assessment tools should be used to clarify the type of pain and to qualify physical and emotional functioning according to a biopsychosocial framework. This should occur at baseline and in response to treatment.
3. General Practitioners should be aware of their local pain management service structure and facilities, and ensure that these meet the recommendations and standards outlined in this document.
4. The patient with problematic chronic pain should be directed to pain management services within the primary care, the community or specialist (secondary) care setting for biopsychosocial assessment and management .
5. Self-management strategies should be emphasised and reinforced at all stages in the treatment of chronic pain, and the patient should be offered access to written and electronic literature about managing pain.
6. Evidence-based pharmacological therapies, including anti-neuropathic and opioid medications, should be offered to manage painful symptoms in accordance with national guidelines (e.g. NICE, SIGN).

7. Physical and psychological therapies should be made available to patients at all stages of pain management, according to their symptoms and engagement with services.
8. Patients with uncontrolled pain, complex conditions, or severe physical or emotional distress should be referred for specialist or specialised assessment and management
9. Practitioners should ideally adhere to national guidelines when prescribing anti-neuropathic medication and opioids.

Background

Chronic pain can exist as a condition in its own right or as part of another long-term condition, such as diabetes or arthritis. This variation in clinical presentation coupled with the subjective nature of pain makes it impossible to create a single pathway to describe best practice for managing patients with chronic pain.

The British Pain Society Pain Patient Pathways, hosted on *Maps of Medicine*, are the most comprehensive publication in support of an integrated approach to patient care to date. These pathways look in detail at the initial assessment of chronic pain and the management of some common presentations, including chronic pelvic pain, fibromyalgia, low back pain and neuropathic pain⁵.

Pain management services are increasingly being commissioned in community settings, often provided by specialist multidisciplinary pain management teams. Given the number of patients who suffer from chronic pain and the impact on healthcare resources and society, it is imperative that the patients gain access to the right care provider at the right time⁶.

The National Institute for Health and Care Excellence (NICE) has produced clinical guidelines for the management of low back pain, chronic neuropathic pain and the use of spinal cord stimulation⁷⁻⁹ which are useful references for the clinician when prescribing or accessing specialist services for complex chronic pain states. There are similar recommendations on chronic pain management from the Scottish Intercollegiate Guideline Network (SIGN)¹⁰.

Complex and specific chronic pain states, for example pelvic pain or complex regional pain syndrome, may warrant onward referral to a regional tertiary pain management centre for specialised intervention¹¹.

Chronic pain pathways may also involve pain management programmes, which may be inpatient or outpatient based, and serve to reinforce non-pharmacological techniques and self-management strategies.

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6.4 ADULT ACUTE PAIN MANAGEMENT

Mark Rockett

Introduction

Acute pain presents in all inpatient settings. It may be associated with trauma, surgery or acute medical illness. Patients suffering from cancer pain or chronic pain also commonly experience acute exacerbations or may develop an unrelated acute pain problem.

Patients' expectations of pain management are high, and the provision of adequate analgesia is an ethical imperative, enshrined in The International Covenant on Economic, Social and Cultural Rights¹. Good quality acute pain management can be provided for the majority of hospital in-patients, provided there is adequate investment in staff and equipment.

Acute pain services (APS) exist to some extent in almost all acute Hospital/Trusts in the UK. However, these services vary in the level of staffing and support for patients out of hours, and those suffering pain not of surgical origin². Effective pain relief is an important outcome measure for patients, and an APS may provide improved analgesia in a cost-effective manner³. In addition, side effects of analgesic interventions are lower, and short-term and long-term outcomes may be improved in subgroups of high-risk patients with advanced analgesic techniques supported by an effective APS³⁻⁵.

Standards

1. Acute pain management must be supervised by consultants and specialist nurses with appropriate training and competencies.
2. All patients with acute pain must have an individualised analgesic plan appropriate to their clinical condition that is effective, safe and flexible.
3. All in-patients with acute pain must have regular pain assessment using consistent and validated tools, with results recorded with other vital signs. There should be clear guidelines for communication with the APS.
4. Patients in significant pain must be treated within 30 minutes and reassessed after an appropriate interval.
5. Patients with complex pain must be referred to the APS and reviewed in a timely fashion.

Recommendations

1. All hospitals should provide an APS staffed by appropriately trained consultants and nurses. Consultants should have completed higher pain training (ideally advanced pain training for lead clinicians). Senior APS nursing staff should be nurse prescribers.
2. All healthcare professionals involved in the APS should have job plans that include time dedicated to acute pain management.
3. Close links with chronic pain services are desirable, ideally with APS staff working in both acute and chronic pain.

4. APS should have close links with relevant allied health professionals, including pharmacy, physiotherapy, occupational therapy, clinical psychology and liaison psychiatry.
5. Specialist acute pain management advice and intervention should be available at all times to all in-patients, and staffing should be sufficient to provide prospective cover for all personnel.
6. Pain that is identified as complex or problematic should be referred to the APS. Assessment of complex pain by the APS should be timely (within 24 hours).
7. All in-patients with acute pain should have individualised treatment plans based on the principles of multimodal analgesia. This may include both pharmacological and non-pharmacological treatments.
8. Guidelines should be in place for all modalities of pain relief in clinical use, for the alleviation of the common side effects associated with pain relief (for example, nausea and vomiting), and for the early detection of severe adverse effects (for example, excessive sedation, respiratory depression and neuraxial damage).
9. An ongoing education program should be in place for all healthcare professionals covering pain assessment, pain treatment and specific delivery techniques appropriate to their clinical duties.
10. Arrangements should be in place to liaise with other specialties responsible for the shared care of patients with acute pain.
11. There should be regular audit and evaluation of the effectiveness of acute pain management, complications and staff training.
12. Patient safety and continuous quality improvement should be core values of the APS.

Background

Good pain management is intrinsic to high-quality healthcare, and the relief of suffering is primarily a humanitarian aim, valid in its own right regardless of its impact on other outcomes⁶. The APS fosters a clinical environment where pain relief is everyone's responsibility – through training, education and direct clinical care. The APS ensures standardisation of pain assessment and, where appropriate, develops treatment algorithms resulting in consistent effective care.

A core role of the APS is supporting the management of pain in the setting of rapidly evolving surgical techniques. This requires advanced and adaptable pain management skills, best delivered by an experienced, multidisciplinary APS. It is recognized that effective acute pain management, as part of an enhanced recovery after surgery (ERAS) programme can result in reduced lengths of stay and complications⁷. The APS is a vital part of the ERAS team, developing safe, effective and cost-effective solutions based on a wealth of clinical experience and a deep knowledge of pain medicine.

Postoperative pain management continues to challenge healthcare teams, particularly when faced with patients with complex pain problems. Such individuals are relatively common in today's inpatient population^{8,9}. An APS is essential to ensure that these patients receive adequate treatment. The APS should be involved in patient care before, during and after planned surgery. They may develop preoperative assessment tools to highlight patients and procedures with a higher risk of severe acute or chronic pain. Careful planning, and appropriate standardisation of postoperative pain management is essential for all patients, to minimise the impact of acute pain before and after hospital discharge, and to reduce the risk of ongoing inappropriate opioid use or transition to chronic post-surgical pain^{10,11}.

Given that chronic pain is commonly the consequence of surgical intervention, and that a high proportion of inpatients suffer an exacerbation of chronic pain, it is essential that the APS is closely linked with local chronic pain services. As an ideal, APS staff should work in both environments, but where this is not possible, clear lines of communication for timely advice must be in place.

It is clear that acute pain often goes unrecognised and under-treated in medical inpatients, and the APS has a key role to play in staff and patient education, as well as providing direct clinical care for this patient group¹².

Consistency in the approach to acute pain management, and provision of adequate APS staffing throughout the UK, is currently lacking². It is hoped that these standards, building upon the previous RCoA guidelines, will prove useful for Hospitals seeking to provide their patients with high quality, safe and effective acute pain management¹³.

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6.5 CANCER-RELATED PAIN

Michael Bennett and Manohar Sharma

Introduction

Pain arising from cancer or cancer treatment is the symptom most feared by patients with this disease, and many report severe pain, particularly those living at home. Clearer management pathways for patients with cancer-related pain will allow earlier integration of specialist support and lead to improved patient outcomes.

Standards

1. Patients with cancer-related pain must receive a pain assessment when seen by a healthcare professional, which at a minimum establishes aetiology, intensity and the impact of any pain that they report.
2. Access to analgesia must be available within 24 hours following a pain assessment which directs the need for analgesia. This must include access to a prescriber as well as access to a dispensed prescription.
3. Patients and carers must receive adequate information on the use of analgesics, especially strong opioids (in accordance with NICE guidance on *Opioids in Palliative Care*). This must cover how to take analgesia, the likely effectiveness of this, how to monitor side effects, plans for further follow-up, and how to get help - especially out of hours.
4. Patients and carers must be referred for specialist support if pain is not well controlled despite initial management. Specialist support must be available in each region in the form of palliative care services, oncology services (including radiotherapy), and specialist pain services

Recommendations

1. Patients with cancer should be screened for pain when attending any routine outpatient appointments in primary care or hospital clinics.
2. Patients with cancer-related pain should receive a detailed assessment of pain including a history and examination to determine aetiology, intensity and impact.
3. Addressing concerns about pain and strong opioids through provision of educational materials should be routine.
4. Guideline-based prescribing, using NICE guidance on *Opioids for Palliative Care* and/or other local or regionally agreed protocols should be in place.
5. There should be easy access to pain assessment and monitoring via phone or face-to-face contact.
6. Contact information for out-of-hours support should be easily accessible.
7. Established referral pathways should exist between oncology, palliative care and pain services to co-ordinate care while taking into account patient and family expectations.

8. Access to oncological (radiotherapy) and surgical management options to control pain should be available regionally, e.g. spinal stabilisation, surgical fixation of pathological fractures, vertebroplasty or palliative debulking of tumour.
9. Access to specialist services for pain which is difficult to control with usual care should be available regionally. This should include access to advanced pain management techniques (intrathecal pumps and neuroablative techniques).
10. Regular audit and sharing of outcome measures for all patients with cancer pain should be in place including safety and efficacy data on various methods of pain control.

Background

Each year in England and Wales, 140,000 people die from cancer¹. In the last 6 months of life, patients spend 65-80% of their time at home. Many are admitted as inpatients nearer to death, though not necessarily because of pain. Analysis of 950 cancer patients calling NHS primary care 'out-of-hours' providers in 2010-2011 revealed that the commonest reason was uncontrolled pain (30% of calls)². Admission to hospital is frequently precipitated by uncontrolled symptoms, including pain.

The World Health Organisation (WHO) published *Cancer Pain Relief* (WHO analgesic ladder) in 1986; this advocated a stepwise approach to analgesia for cancer pain and revolutionised the use of oral opioids. Observational studies suggested that this approach results in pain control for 73% of patients, with a mean reduction in pain intensity of 65%. Despite the efficacy of this intervention, a European survey published in 2009³ found that, of 5,000 cancer patients (including 617 community based NHS patients in the UK), 72% experienced pain (77% in UK) which was of moderate to severe intensity in 90% of this group. This is consistent with a recent systematic review that demonstrated cancer-pain prevalence of up to 75% in advanced disease, and that almost one in two patients are under-treated⁴. This translates in England and Wales to 105,000 cancer patients experiencing pain every year, of whom 50,000 will be under-treated. This evidence suggests that a number of barriers exist to the implementation of the analgesic ladder in clinical practice, which in turn highlights failings to implement a better system of care within the NHS for patients with advanced cancer pain.

Early and systematic assessment of cancer pain is recommended in national and international guidelines, and this can identify potentially complex management requiring specialist help⁵. However, pain management is not improved by assessment alone without directing this data to a professional.

Poor knowledge and fearful attitudes within patients towards cancer pain and analgesia are associated with reluctance to commence opioids, reduced medication adherence, and higher pain intensity. Standardised educational interventions can improve pain outcomes⁶, and are recommended in national guidelines. However, identifying which patients benefit most, or which patients require more intervention has not been achieved.

Patient satisfaction with pain management is significantly associated with a physician stating the importance of pain management, receiving instructions for managing pain at home, managing side effects and allaying fears about addiction⁷. Assessing pain, and presenting this data to physicians prior to consultation, for them to use it in discussions, significantly improves pain outcomes and quality of life for patients. Use of specific prescribing guidelines for cancer pain results in significant benefits compared to control groups in both average and worst pain intensity⁸. However, physician-related barriers are common, and relate to both technical aspects (inadequate prescription) as well as the context of the interaction with patients. In routine practice, patients often receive opioid analgesia only in the last weeks of life despite evidence suggesting they could benefit from earlier intervention⁹. In 2012, NICE published guidelines on safe and effective use of opioids in palliative care in recognition of both under-treatment of pain and poor knowledge of opioid prescribing amongst non-specialists¹⁰.

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6.6.1 MANAGING ACUTE PAIN IN CHILDREN AND YOUNG PEOPLE

Glyn Williams and Mary Rose

Introduction

Acute pain in children can be present in a number of clinical situations: trauma, surgery and concurrent medical illness. It may also be an important component of the pain associated with cancer or present on a background of a chronic pain condition.

Multidisciplinary acute pain management led by an acute pain service is now common in hospitals specialising in the treatment of children. A well-run service can potentially provide better pain relief, lower the incidence of side-effects, reduce complications and promote early discharge.

Standards

1. Children's pain management must be supervised by consultants and specialist nurses with training and competencies in acute paediatric pain management.
2. All children with acute pain must have an individualised analgesic plan, appropriate to their developmental age and clinical condition, that is effective, safe and flexible.
3. Acute pain in children must be regularly assessed with an appropriate, validated pain assessment tool.
4. Members of the acute pain service must have received child protection training and be familiar with safeguarding procedures¹.

Recommendations

1. A multidisciplinary acute pain service should be in place in all hospitals involved in the treatment of children. This should include medical and nursing involvement as a minimum, though ideally there would be access to psychological, therapeutic (physiotherapy or occupational therapy) and pharmacy services. All healthcare professionals involved should have job plans that include time dedicated to acute pain management.
2. Specialist acute pain management advice and intervention should be available at all times, and staffing should be sufficient to provide cover at all times.
3. All children with acute pain should have individualised treatment plans based on the principles of multi-modal analgesia. This should include both pharmacological and non-pharmacological treatments.
4. All children with acute pain should have regular pain assessment that is validated for their developmental age and the clinical setting.
5. Guidelines should be in place for all modalities of pain relief in clinical use, for the alleviation of the common side effects associated with pain relief (for example nausea and vomiting), and for the early detection of severe adverse effects (for example, excessive sedation, respiratory depression and neuraxial damage).

6. An ongoing education program should be in place for all healthcare professionals in the areas of paediatric pain assessment, pain management and specific delivery techniques.
7. Arrangements should be in place to liaise with other specialties responsible for the shared care of patients with acute pain.
8. There should be regular audit and evaluation of the effectiveness of acute pain management, complications and staff training.
9. Written information should be routinely provided and disseminated to parents/patients where appropriate.

Background

Good acute pain relief is regarded as central to the provision of good quality clinical care^{2,3}. The relief of suffering associated with acute pain is fundamentally a humanitarian issue; however, effective acute pain management is also likely to improve the quality of clinical care by preventing some complications, reducing hospital stay and promoting recovery and rehabilitation⁴. It can also enable more efficient use of acute hospital facilities.

Multidisciplinary acute pain management was developed in the 1990s and now has an established evidence base⁵. The recommendation for MDTs was endorsed in 2009 by the Chief Medical Officers of England, Wales, Scotland and Northern Ireland³.

Acute pain management teams involved in the care of children were also first described in the 1990s, and have become an accepted model for hospitals involved in the care of children^{6,7}. The provision and the model of children's acute pain services is not consistent across the country, but the underlying principle is that it should be supervised by consultants and specialist nurses with training and competencies in acute paediatric pain management^{7,8}.

Multidisciplinary pain services are essential to ensure quality and consistency of care. They facilitate the introduction of best practice, allow the use of complex pain management interventions and deliver staff education. This promotes efficacy and safety in pain management, which may improve outcome, decrease the incidence of persistent pain, increase the scope of medical and surgical interventions, and reduce the need for interventions within primary care and the risk of return to hospital because of unrelieved pain⁷.

Inadequately managed acute pain can have psychological, physiological and socioeconomic consequences. It can worsen patient suffering, adversely affect clinical outcomes and increase the financial costs of healthcare.

Effective acute pain relief for children uses individualised analgesic regimens based on the concept of multi-modal analgesia. These regimens must be effective, flexible – to allow for inter-individual variations in efficacy and requirements, and safe and acceptable to the patient and their families. The analgesia used must be appropriate to the developmental age of the child, the clinical setting and the medical condition or procedure. Current evidence would support this approach, and provides demonstration of its efficacy in a wide variety of clinical scenarios⁸.

All children with acute pain should have regular assessment of their pain, in conjunction with clear documentation. This underpins successful pain management, and can also contribute to the prevention and/or early recognition of pain. In children pain is assessed in three fundamental ways: self-reporting, behavioural/observational measures, and physiological measures. These form the basis for the wide variety of pain tools available.

The tool chosen for each individual child must be validated and be appropriate to their developmental age and the clinical setting. The training of healthcare staff in the use of these tools is essential for effective use and for understanding the clinical implications of the results^{8,9}.

In some clinical scenarios, e.g. acute-on-chronic pain, it is not uncommon for difficulties in pain management to occur. Access to specialist paediatric pain medicine advice should be available, either within the hospital or via local and regional networks⁷.

In keeping with UK wide legislation in relation to child protection, all staff involved in healthcare provision for children and young people must receive training to ensure they attain the competences appropriate to their role and follow the relevant professional guidance¹.

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6.6.2 MANAGING PROCEDURAL PAIN IN CHILDREN AND YOUNG PEOPLE

Alison Bliss and John Goddard

Introduction

Procedural pain and distress should be anticipated and managed pre-emptively. Any child about to undergo an intervention which may be potentially painful should receive appropriately timed analgesia and management of procedural distress. The intervention may be diagnostic or therapeutic, medical or surgical. Management options should include both pharmacological and non-pharmacological strategies, and psychological modalities to prepare and distract, which should be utilised by all members of the healthcare team. Planning for the intervention must consider appropriate inclusion of the child, family and carers.

Standards

1. No child should undergo a potentially painful procedure without receiving appropriate prophylactic analgesia and management of procedural distress. This should encompass the use of pharmacological, non-pharmacological and psychological modalities.
2. All health care professionals involved in the provision of pain relief procedures to children and young people must have received child protection training and be familiar with safeguarding procedures.

Recommendations

1. All professionals involved in undertaking procedures and interventions in children should be trained to anticipate, assess and treat procedural pain^{1,2}.
2. Children of all ages, including infants and premature neonates, are capable of perceiving pain and therefore all should receive appropriate analgesia prior to potentially painful procedures^{1,3}.
3. All children and their families/carers should receive appropriate explanation and further psychological support to prepare them for the procedure and minimise procedural distress⁴.
4. All children undergoing an intervention should have their pain and distress assessed using a validated pain assessment tool appropriate for their chronological age and level of cognitive development^{1,2,5,6}.
5. Analgesia should be multimodal and commensurate with the levels of anticipated pain^{1,3,4,7}.
6. Sufficient time should be allowed for the analgesic agent(s) to achieve maximum effectiveness in relation to their route of administration before the procedure is commenced^{1,3,4}.
7. Procedures should be undertaken after appropriate preparation, in a calm and quiet setting, adequately resourced with equipment and personnel, including age-appropriate distraction tools and techniques^{1,3,4}.
8. Analgesia should be sufficient to cover any continuing pain that may occur following the procedure^{1,3,4}.

9. Guidance and training in the management of procedural pain and distress should be available for all members of the healthcare team².
10. It should be recognised that some procedures or interventions may cause significant levels of pain and distress and should therefore only be performed under sedation or general anaesthesia^{1,8}. Some procedures, because of the length of time they require, should only be considered under sedation or general anaesthesia.

Background

Procedural pain has been described by children and families as the most feared and distressing component of medical care^{1,4}, and yet studies from over two decades continue to report significant numbers of children experiencing moderate to severe pain as a consequence of medical interventions^{2,5,8}. One recent study revealed that over three-quarters of children experience at least one painful procedure within a 24 hour time-frame during their admission (with an average of 6 procedures) and yet 22% had no analgesic intervention in the same time period, and that only 28% of children received analgesia with specific relation to their painful procedure⁵.

Children and young people's experience of pain is complex, with integral components of fear and anxiety⁷. The under-treatment of pain and procedural distress can cause harmful and long-lasting effects^{3,9}, which may negatively affect future attitudes and behaviours^{3,4}. Untreated pain in the young may also generate long-term adverse consequences for the developing nervous system^{3,4,6}.

The management of procedural pain requires adequate preparation and distraction, in conjunction with timely analgesic and sedative pharmacotherapy¹⁻⁴. Pain should be assessed both before and after an intervention using a validated age-, development-appropriate tool, to determine both the baseline condition and the effectiveness of pain management strategies^{1,2,10}.

Procedural distress may in part be effectively managed by simple measures to prepare the child for the procedure^{1,3,4}. These include timely realistic explanations, involving parents and carers, suitable child-friendly clinical settings and use of distraction techniques appropriate to age and ability. Play therapists may guide the child's active participation in interaction with tactile, auditory or visual stimulation tools and encourage parent/carer participation^{3,4}. Those children whose levels of distress and apprehension are more extreme may require the involvement of clinical psychologists and the use of specialist psychological therapies², including guided imagery, hypnosis and cognitive-behavioural approaches^{3,4}.

Relief of pain and distress may be aided by the use of physical, non-pharmacological agents such as heat/cold, massage, counter-irritation, sucrose (in the youngest infants⁷), holding and non-nutritive sucking^{1,3,4}.

Despite evidence to support their effectiveness, psychological and non-pharmacological interventions are underutilised, and documented in only approximately 25% of painful procedures⁵; yet they are relatively simple, cost-effective techniques which can enhance analgesia in a timely manner^{1,4}. Best practice dictates a multi-modal approach combining both these modalities with analgesic agents¹.

Evidence is available to support the effectiveness of a wide range of analgesic agents through a variety of routes, allowing the clinician to choose an agent which best fits with the clinical need and time-scale for performance of the procedure^{1,4}. These may include oral, intravenous, intranasal, transdermal, topical⁷, trans-mucosal, rectal and inhalational routes^{1,4}. The key is allowing sufficient time for the chosen agent to reach its peak effect before commencing the procedure.

Disruptive behaviour generated as a consequence of unmanaged anxiety, pain and distress may prolong the time required to complete the intervention or ultimately lead to failure to complete^{1,4}. Clinicians must be aware that

for some children and their families, the levels of procedural distress will preclude the safe completion of the procedure, and appropriate sedation or general anaesthesia will be required¹.

In keeping with UK wide legislation in relation to child protection, all staff involved in healthcare provision for children and young people must receive training to ensure they attain the competences appropriate to their role and follow the relevant professional guidance¹¹.

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6.6.3 MANAGING CHRONIC PAIN IN CHILDREN AND YOUNG PEOPLE

John Goddard and Mary Rose

Introduction

Epidemiological studies identify a point prevalence for chronic and recurrent pain in children and young people of at least 15%¹⁻³. The majority of these children will be managed effectively within primary care but, in a significant minority, chronic & recurrent pain has a major adverse effect on the child and their family at a time of major psycho-social and educational development. This latter group, with a complex pain problem, requires specialist pain management.

Standard

1. All children with a complex pain problem should receive multidisciplinary pain assessment and management which addresses the biological, psychological and social components of their pain.
2. Arrangements must be in place for transition to adult services.
3. All health care professionals involved in the provision of chronic pain management to children and young people must have received child protection training and be familiar with safeguarding procedures.

Recommendations

1. Multidisciplinary assessment should be undertaken for all children and young people with complex chronic pain. Personnel required for multidisciplinary assessment are medical staff with training and expertise in paediatric pain management, and allied health care professionals including specialist nurses, clinical psychologists, physiotherapists and occupational therapists.
2. Assessment should be performed in a timely manner, depending on the urgency of the referral.
3. At least one hour should be available for the first appointment.
4. Children and their families should be given a developmentally appropriate explanation for the child's pain, based on the biopsychosocial model of pain. This should be supported with written information.
5. The aim of treatment should be to use pharmacological, physical and psychological interventions to manage pain, restore function and encourage self-management.
6. Follow-up appointments should be arranged at appropriate intervals with appropriate disciplines.
7. School liaison should be undertaken when required.
8. Because of the distress associated with persistent pain, there should be close liaison between the pain service and Child and Adolescent Mental Health Services.

9. There should be established working relationships with other medical specialties, e.g. paediatric rheumatologists, gastroenterologists, neurologists, orthopaedic surgeons as well as liaison with primary care.
10. Members of the multidisciplinary team should meet on a regular basis (at least monthly) to discuss the management of cases.
11. The service should have mechanisms in place for measuring the efficacy of interventions.
12. There should be healthcare professional education, audit and clinical governance programmes in place.
13. Members of the multidisciplinary team should have received child protection training and be familiar with safeguarding procedures.

Background

Chronic pain is defined as any continuous or recurrent pain lasting more than 12 weeks, or pain that persists beyond the normal expected time for tissue healing. Chronic pain may occur as a consequence of a disease, as a result of the treatment for a disease, following an injury, or as a condition in its own right (idiopathic).

Chronic pain may have nociceptive and/or neuropathic components.

Common problems are headaches, recurrent abdominal pain and musculoskeletal pain³. Incidence of these is higher in girls and increases with age.

Chronic pain affects a child's psychosocial and educational development. Children and young people with chronic pain experience anxiety, sleep disturbance, school absence and social withdrawal.

Following multidisciplinary assessment, the first step in management is to provide an explanation for the child and family which pulls together the biopsychosocial model of pain and the child's experience of their pain. This includes explanation about the cause of the pain, the impact of the pain on psychosocial factors and the role of biological, psychological and social factors as maintaining factors for the pain.

Effective management of chronic pain requires the addressing of all three components (biological, psychological and social).

There is good evidence for the role of psychological interventions in the management of chronic pain in children and young people⁴. Strategies that are currently used comprise relaxation, hypnosis, biofeedback, cognitive behavioural techniques and acceptance and commitment therapy.

Physical interventions include physiotherapy, transcutaneous electrical nerve stimulation (TENS), massage therapy, desensitisation therapy and acupuncture. Physiotherapy has an established role in the management of complex regional pain syndrome and musculo-skeletal pain⁵. Physiotherapy can also play a significant role as part of the multidisciplinary management of other types of chronic pain.

There is minimal robust evidence to support the use of pharmacological agents in chronic pain in children⁶. When used they should be part of a multi-modal approach and may have a role in facilitating participation in physical therapy programmes and graded return to activity.

Similarly there is little evidence to support the use of nerve blocks, but in certain conditions they can facilitate engagement with physical therapy and return to activity.

Rehabilitation into the usual activities of childhood, family and social life, school and hobbies is an important goal.

All health care professionals involved in the management of chronic pain in children and young people must have awareness of safeguarding issues and know on how to initiate appropriate referral . In keeping with UK wide legislation in relation to child protection , all staff involved in healthcare provision for children and young people should receive training to ensure they attain the competences appropriate to their role and follow the relevant professional guidance⁷.

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Chapter 7

Pain Interventions

- 7.1 Pain Management Programmes and Pain Rehabilitation
- 7.2 Medicines
- 7.3 Interventional Techniques in Pain Management
- 7.4 Cancer Pain Interventions

7.1 PAIN MANAGEMENT PROGRAMMES AND PAIN REHABILITATION

Paul Wilkinson, Zoey Malpus and Gail Sowden

Introduction

Pain rehabilitation consists of methods to promote behaviour change and improve wellbeing in people with pain and is traditionally organised in programmes of care referred to as Pain Management Programmes (PMPs).

There is high-level evidence for the efficacy of both outpatient and residential PMPs¹⁻⁴. A number of systematic reviews have shown that PMPs significantly reduce distress and disability, significantly enhance coping, and improve various measures of physical functioning³⁻⁵. Where vocational training has been included in the package, return to work is also significantly enhanced⁶. There is evidence for decreased use of healthcare resources in terms of numbers of consultations and reduction of medication^{1,3,7,8}. Cost-effectiveness analysis has demonstrated positive effects in other healthcare systems^{9,10}.

A detailed account of the requirements and practice of PMPs and the underlying evidence base is outlined in the document *Guidelines for Pain Management Programmes for Adults*¹¹. The standards of care defined here are largely adopted from that document, with permission.

The underlying principle of managing pain is that the right person with pain, requires the right health care professionals at the right time. PMPs are used for individuals with persistent pain which adversely affects their quality of life, and where there is significant impact on physical, psychological and social function.

Standards

1. There must be timely access to all forms of pain rehabilitation.
2. Standard and Intensive PMPs must be available in a group format, but in some circumstances may be best provided on an individual basis. Consent must be obtained.
3. PMPs must be properly resourced with time, personnel and facilities.
4. Suitability for a PMP is based on the impact of pain, and there must be no discrimination on the basis of age, literacy, litigation or judgement of motivation.
5. A PMP must be delivered by an interdisciplinary team where some competencies are shared and some are unique to particular professions.
6. PMPs may be delivered in a primary, secondary or tertiary care settings; the required resources must be equally available in both settings.
7. The effective delivery of standard and intensive PMPs for complex participants must be undertaken by highly-skilled staff, working as a team in adherence to the core principles.
8. Evaluation of outcomes must be standard practice. This should include assessing changes in function, psychological wellbeing, healthcare use, quality of life and work status where relevant.

9. Interventions to facilitate return to work should be viewed as an essential component of the work of PMP teams, and be integrated with other treatment offered.
10. There must be co-operation between primary care, secondary care and Local Authorities to deliver effective, integrated services for people with chronic pain. This will include pain management and other treatments such as medicines and injections.
11. PMPs must aim for high-quality leadership and effective team working.
12. PMP staff must have adequate time for training opportunities and continued professional development in the wider aspects of pain treatment.

Recommendations

1. PMPs should be considered as the treatment of choice for people with persistent pain which adversely affects their quality of life and where there is significant impact on physical, psychological and social function.
2. For commissioning purposes, it is recommended that a standard PMP should be a minimum of twelve half-day sessions (e.g. 12x3 = 36 hours), though arrangements may vary in practice.
3. Some very disabled and distressed patients will not benefit significantly from standard programmes, but may benefit from more intensive programmes, e.g. 15-20 full days. PMP clinical staff should assess participants comprehensively. Longer, more intensive programmes give greater and more enduring benefit, but intensive programmes are not recommended as standard for all patients.
4. It is recommended that some of the principles of pain management should be applied early in care pathways. Patients should be allocated to subgroups according to their risk of persistent disabling pain, and receive appropriate matched treatment (stratified care). Non-specialist staff can be trained to deliver low-intensity or brief psychologically-informed pain management interventions, focused primarily on improving physical functioning and self-management skills.
5. It is recommended that pain rehabilitation interventions are classified broadly into three groups:
 - Early stratified care.
 - Standard PMPs.
 - Intensive PMPs.Effective care requires commissioning and health care provision at all three levels.
6. Individual pain rehabilitation psychology and/or physiotherapy treatment may be required before, during or after PMPs. Specialist PMP teams should have the financial and operational flexibility to deliver these elements of care.
7. Standard and intensive PMPs should be undertaken by interdisciplinary pain management teams which contain specialist healthcare professionals including doctors, psychologists, physiotherapists and, ideally, nurses and occupational therapists.

Background

The general aim of PMPs is to improve participation in daily activities, reduce distress, and enhance quality of life for those with persistent pain and disability. This may include focus on increasing mobility, self-care, work, leisure and social activities, and reducing reliance on medication or healthcare use. Specific goals should be identified by the individual participants, although these are likely to be more effective when they are shaped and clarified with the help of healthcare providers.

PMPs should consist of a variety of methods for directly and indirectly producing behaviour change, including methods based on cognitive and behavioural therapy, learning and conditioning processes, skills training, physical exercise and education.

PMPs should adhere to cognitive behavioural principles and typically include:-

1. **Graded activation** guided by participant goals. This consists of a process of goal-setting, identification and management of barriers to activity, and the practice of specific practical and psychological skills in order to produce integrated and sustainable patterns of healthy activity.
2. **Cognitive therapy methods** to identify, examine, and change the impact of distressing, misleading, or restricting thoughts and beliefs.
3. **Graded exposure** to reduce fear or to increase willingness to experience fear, in order to reduce avoidance and increase activity.
4. **Methods to enhance acceptance, mindfulness and psychological flexibility** through a process called “psychological flexibility”.
5. **Skills training and activity management** to provide an opportunity for direct practice in the use of skills for changing behaviour, pursuing goals and dealing with barriers to the achievement of these goals.
Typical skills taught in PMPs include the following:
 - Methods for altering the adverse impacts of thoughts and feelings on healthy behaviour.
 - Methods for identifying, setting, planning and pursuing goals.
 - Strategies for co-ordinating, scheduling and managing the rate and pattern of goal-directed activity.
 - Skills for communication and social interaction.
 - Sleep management methods.
 - Explicit methods for generalising and integrating new skills and behaviour change into daily life and maintaining these over the longer term.
6. **Physical exercise** to change behaviour patterns around physical sensations - including pain, to increase willingness to engage the body in movements and to expand patterns of activity. Exercise also aims to increase movement, to enable increased goal-directed activity, and to eventually improve fitness and physical health.
7. **Education** to improve knowledge and understanding. This is a weak way to produce behaviour change or improve daily functioning and therefore often needs to be supplemented with methods to create an impact.

Information delivered can include:

- Pain anatomy, physiology and mechanisms.
- Pain psychology.
- Safety and risk in relation to increased activity.
- Advantages and disadvantages of using aids, treatments and medication.
- Self-management approaches to flare-ups and setbacks.

8. **Lifestyle and lifestyle change issues** for improving or maintaining general health.
9. **Interventions to facilitate return to work.**

The Core Staff recommended for Standard and Specialist PMPs are a psychologist, a physiotherapist and a medical practitioner. Occupational therapists and nurses may also play an important role in PMPs. Clinical support workers and an administrator is also required. Access to pharmacists is very useful. Required qualifications are as follows:

Medical Practitioner - a medically qualified person (most commonly a specialist in pain medicine with FFPMRCA qualification).

Psychologist - a chartered clinical psychologist, Health and Care Professions Council (HCPC)-registered practitioner psychologist or a British Association for Behavioural & Cognitive Psychotherapies (BABCP1)-registered cognitive behavioural therapist with appropriate training and supervision. The psychologist should have specialist expertise in managing pain or other physical health problems.

Physiotherapist - a HCPC-registered physiotherapist with specialist expertise in managing people with chronic pain.

Occupational Therapist - a HCPC-registered occupational therapist with specialist expertise in managing people with chronic pain.

Nurse - a NMC-registered nurse with specialist expertise in managing people with chronic pain.

PMPs are cost-effective, reduce healthcare consumption and enable more appropriate use of healthcare resources. Importantly, PMPs reduce presentation with pain-related issues to primary care and accident and emergency departments, reduce onward referrals to specialist services, and reduce the need for medication. PMPs are established as a core part of pain treatment, and existing gaps in service provision should be addressed.

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Research in progress to inform practice

1. More research is required to establish the optimum composition of PMPs.
2. More research is required to improve receptivity to PMPs.

7.2 MEDICINES

Roger Knaggs

Introduction

Medicines are the most frequently used intervention in the management of acute pain, persistent pain, cancer pain and palliative care. It is essential that medicines are prescribed, dispensed and administered correctly to ensure patient safety. All healthcare professionals must work within the bounds of their professional competence when providing information and advice to patients regarding medicines.

Standards

1. All medicines must be prescribed in accordance with legal requirements, such as the Medicines Act 1968, the Misuse of Drugs Act 1971 and the associated Misuse of Drugs Regulations 2001, and their amendments.
2. The principles outlined in the General Medical Council's *Good Practice in Prescribing and Managing Medicines and Devices* 2013 must be followed¹.
3. Professional standards relating to medicines from professional bodies, such as the Nursing and Midwifery Council, General Pharmaceutical Council and Health and Care Professionals Council must be adhered to.

Recommendations

1. NHS England and former National Patient Safety Agency guidance on medication safety should be considered and applied to analgesic medicines as appropriate.
2. Principles of evidence-based medicine should always be applied when considering treatment options.
3. Where relevant, medicines should be used in accordance with recommendations from national bodies (e.g. National Institute for Health and Care Excellence (NICE), Scottish Medicines Consortium (SMC), All Wales Medicines Strategy Group (AWMSG), Guidelines and Audit Implementation Network (GAIN), and patient pathways should reflect these recommendations.
4. Alternatively, medicines should be prescribed in accordance with recommendations from national professional bodies, such as the Medical Royal Colleges, Faculty of Pain Medicine and the British Pain Society.
5. Where no national guidance is available, consider the development, approval and implementation of local prescribing guidance or shared-care agreements, particularly for medicines used less frequently.
6. All prescribed medicines should be reviewed regularly for safety, effectiveness and tolerability.
7. Patients should be provided with sufficient information about analgesic medicines to make informed decisions and they should be active partners in decisions about medicines.

8. Recommendations regarding initiation or changes to medicine regimens should be communicated accurately and in a timely manner between a pain management service and general practice.
9. Both medical and non-medical prescribers should ensure and maintain their competence using a nationally recognised framework².
10. Prescribers should be aware that safe and effective management of acute, procedural, chronic and cancer pain in neonates, infants, children and young people requires understanding of age-related changes in both pharmacokinetic and pharmacodynamics profile of analgesics. Prescribers have to ensure and maintain their competence in paediatric prescribing if their practice includes the management of children³.

Background

The phrase 'medicines management' has been used frequently over the last decade and has ensured processes of safe and cost-effective procurement, prescribing and administration for medicines⁴. Increasingly, this is being replaced by 'medicines optimisation', which is more about ensuring that the right patient gets the right medicine, at the right time, and focuses on outcomes and patients rather than process and systems⁵.

Acute pain is the body's normal response to tissue damage, and many types of cancer pain are also related to tissue damage or compression. Both acute pain following injury or trauma and some types of cancer pain respond well to analgesic medicines such as paracetamol, nonsteroidal anti-inflammatory drugs and opioids. Persistent non-cancer pain serves no physiological purpose, and has important psychological and social components, as well as underlying pathophysiological mechanisms. Medicines are generally less effective for persistent pain than for other types of pain, and should be used in combination with other treatment approaches to support improved physical, psychological and social functioning. Patients should be provided with sufficient information about medicines in a format that is easily understandable to them.

Initial prescribing of analgesic medicines should always be considered a trial, and appropriate outcomes agreed with the patient. If the agreed outcomes have not been achieved, or little progress has been made towards them, then the prescriber and the patient need to consider together whether to continue. Side effects with analgesic medicines are relatively common, and these need to be balanced with their effectiveness. A vicious cycle may develop when patients experience inadequate analgesia, and this may lead to repeated dose escalation without considering the benefit being provided.

In March 2015, legislation on the offence of drug-driving was strengthened, and this makes it illegal to drive following taking a range of drugs, some of which may be used/misused for either therapeutic or recreational purposes. At present, blood-levels for 15 drugs have been included. A 'zero tolerance' approach has been adopted for drugs mostly used for recreational purposes, including cannabis, cocaine, MDMA and LSD, but also ketamine and heroin (diamorphine), and a low blood concentration has been set. The second group of drugs are those used for therapeutic purposes, including some benzodiazepines (clonazepam, diazepam, lorazepam, nitrazepam, oxazepam and temazepam), methadone and morphine, where a 'risk-based' approach has been used to set a higher blood-concentration. There is a medical defence for people who have been prescribed medicines and are taking them in accordance with the advice of a prescriber. Although only a few benzodiazepines and opioids have been included in the legislation, all benzodiazepines and opioids can impair driving ability. The risk of driving impairment is increased if the medicine is taken with alcohol. The Department for Transport has published guidance to help healthcare professionals explain the implications of the new law to patients⁶, and the MHRA has provided information for patients⁷.

As drugs that interact with novel targets are developed, clinical studies using appropriate outcome measures will be required to assess safety, efficacy and tolerability. There is also a need for more research to understand the role of analgesic medicines, particularly for persistent pain, within multidisciplinary routine clinical care. Clinical outcomes and tolerability for analgesic medicines for individual patients may be improved with increasing emphasis on personalised or stratified medicine, however, much more research is required.

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Resources

Some suggested sources of guidance relating to use of medicines in pain management include:-

1. NICE Clinical Guidelines
 - Clinical Guideline 177. Osteoarthritis: Care and management in adults. 2014. <http://www.nice.org.uk/guidance/CG177>
 - Clinical Guideline 173. Neuropathic pain – pharmacological management: The pharmacological management of neuropathic pain in adults in non-specialist settings. 2013. <http://www.nice.org.uk/guidance/CG173>
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Patient Pathways

Available at <http://bps.mapofmedicine.com> (BPS members) or (<http://www.mapofmedicine.com/>).

- Initial assessment and early management of pain
- Spinal pain
- Pelvic pain
- Chronic widespread pain, including fibromyalgia
- Neuropathic pain.

7.3 INTERVENTIONAL TECHNIQUES IN PAIN MANAGEMENT

Sanjeeva Gupta and Shyam Balasubramanian

Introduction

Interventional pain procedures can provide pain relief, aid diagnosis and enable functional restoration in patients with persistent pain conditions. They have an established role in pain management as part of multidisciplinary approach. The window of opportunity obtained with the pain relief following interventions should be optimally utilised to rehabilitate the patients.

Standards

1. Informed consent must be obtained before every procedure, even if the same procedure is being repeated on a different occasion.
2. Patients must be assessed before the intervention and assessed again after the procedures to determine the diagnostic/therapeutic utility.
3. Physicians performing the procedure must be appropriately trained.
4. Physicians using fluoroscopy must know the principles of radiation safety.
5. Interventions must be performed with aseptic precautions, and infection control measures should be in place.
6. Details of the procedure, including the technique and the medications used, must be clearly documented.
7. Centres offering interventional procedures must have clear discharge criteria and subsequent management plans.
8. The patient's GP must be informed of the procedure carried out and the drugs used.

Recommendations

1. The diagnostic and therapeutic utility of every intervention should be considered and discussed with the patient.
2. The chosen interventional technique should be based on current best available evidence.
3. Interventions should be undertaken in an area that complies with occupational health and safety standards.
4. Intravenous access is necessary for procedures such as epidural. Ready access to monitoring and resuscitation is necessary for all the procedures.
5. Images should be stored in the hospital radiology system for documentation and future referral.

6. Physicians should possess skills in recognising and managing adverse events and in cardiopulmonary resuscitation.

Background

Interventional pain procedures are used for diagnostic and therapeutic purposes. The objective of these techniques is to target and modulate anatomical structures that are essential in either the generation or the transmission of pain signals. Interventional pain management techniques range from muscle trigger point injections to advanced spinal neuromodulation. Clinicians should perform a comprehensive multidimensional assessment prior to embarking on invasive procedures. They are responsible for patient selection and preparation, conduct of the procedure, outcome assessment and interpretation, and organising the subsequent management plan¹⁻⁶.

When obtaining consent, information about the benefits, limitations and complications of the blocks (including those due to the medications used) should be discussed. Wherever appropriate, if alternative management strategies are available, this should also be discussed with the patient to enable them make an informed choice.

Clinicians performing the intervention should have sound knowledge, skills, attitudes and experience relevant to the interventional pain procedure. They should have appropriate supervised experience in the conduct of the interventional procedure before undertaking independent practice. They should be aware of the evidence base for the procedures and be aware of the indications and contraindications. Some injection techniques are undertaken based on anatomical landmarks; others require radiological guidance such as fluoroscopy and ultrasound. Clinicians should be able to demonstrate their knowledge on the applied anatomy relevant to the interventional procedures and should be able to recognise radiographic anatomy. Those working with fluoroscopy should know the principles of radiation safety. Clinicians should have thorough knowledge of the pharmacology and adverse effects of the medications used in the injectate.

Depending on the complexity and invasiveness of the procedures, the interventions should be performed in clean rooms in an office-based set-up or in the operating theatre in a sterile environment. The recommendations and standards for different interventions are set out in the documents published by the Faculty of Pain Medicine and the British Pain Society⁷⁻¹¹.

Recent advances in the understanding of the pain pathway, applied anatomy and imaging technology have allowed greater precision and wider application of interventional pain procedures in long-term pain sufferers. These procedures are complementary to multimodal management modalities, and are continually evolving. Careful selection of patients, skilful technique and good care pathways are essential for optimal outcome following pain interventional procedures.

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7.4 CANCER PAIN INTERVENTIONS

Manohar Sharma and Louise Lynch

Introduction

The WHO Analgesic Ladder was published in 1986¹. It was intended to improve the management of cancer pain and remove barriers to opioid use, by providing a structured framework for the use of analgesics. It remains the lynchpin for the medical management of cancer pain. Using this concept, 80-90% of cancer pain can be successfully managed. Guidelines from SIGN and a discussion document from the British Pain Society have also been published^{2,3}. Unfortunately, despite these, uncontrolled cancer pain is still recognised in 10-20% of patients^{4,5}.

Interventional pain control is an alternative means of either augmenting or replacing pain relief. It can be effective for both patients whose pain is uncontrolled by the WHO Ladder and for those whose pain is controlled, but whose quality of life is limited, by drug-related side effects. Interventions involve performing an injection or otherwise invasive procedure. This might be a one-off injection, for example, a spinal neurolytic block or percutaneous cordotomy, or it might involve a longer-term infusion, such as that from an epidural or intrathecal drug delivery system⁴⁻⁹. The potential benefits of using interventions include not only superior pain relief, but also a significant reduction in the inevitable side effects of opioids and adjuvant analgesics. For some patients it is the only effective means of controlling their pain. Interventional pain management should be considered routinely, together with oncology treatments and surgical procedures, as a pain relieving tool.

Standards

1. Patients must have access to pain management in line with WHO Ladder recommendations, both in the community and through local palliative care, oncology and other hospital services.
2. All patients suffering with cancer-related pain must have their care provided in close collaboration with their local primary care team, close relatives and a secondary-care-based multidisciplinary team including oncology, pain medicine and palliative medicine.
3. Patients' and families' expectations/wishes must be taken into account when deciding on the most appropriate intervention or option to control pain and related symptoms.
4. Pain management units offering complex cancer pain interventions, including spinal neurolysis, cordotomy, spinal infusions and intrathecal implants, must have adequate resources in place to collect outcomes, including safety and efficacy data.
5. There must be more than one pain and palliative medicine physician within each tertiary pain management service to support cancer pain management and for holiday cover, OR there should be formal arrangements to provide cover for absences.
6. There must be written and agreed patient care pathways in place for complex cancer pain interventions, to optimise patient care before, during and afterwards. Cancer pain interventions need to be planned in a timely manner through appropriate, early referrals. Referrals at a very late stage should be avoided.
7. All patients who experience poorly controlled cancer-related pain, despite appropriate use of the WHO Ladder, must be considered for advanced pain management options. This must be irrespective of

geographical and logistical issues which may otherwise deny these patients effective pain relieving treatment options. Relevant logistical arrangements must be supported to allow equitable access for all patients to these pain relieving treatments.

Recommendations

1. All patients should have pain management in line with the World Health Organisation (WHO) Analgesic Ladder, along with the consideration of oncology interventions, such as radiotherapy, and surgical treatments if applicable, as a routine.
2. Patients should have access to written information, and opportunity to make informed decisions regarding pain intervention options based on benefits and risks and, if possible, with information on patient reported outcomes.
3. Within each region there should be good collaboration between pain medicine, palliative medicine, oncology and relevant (anatomical-site-specific) surgical specialities. This multidisciplinary team should be able to offer timely assessment and pain management advice, including interventions, as part of a package of care for patients whose pain is poorly controlled despite appropriate application of the WHO Ladder. These clinical sessions should be recognised and supported as part of an agreed job plan.
4. Cancer pain interventions should be offered within a multidisciplinary team, and, in particular, there should be close collaboration with palliative medicine, so as to offer best management of other co-morbidities not related to pain, for example, frailty, breathlessness and poor appetite.
5. Other services should be easily accessible to aid in the diagnosis and treatment of cancer-related pain. A management plan for an individual patient may involve one or more of radio- or chemotherapy, surgical procedures and “pain interventions”. The formulation of these individual patient management plans will require effective communication between the relevant clinicians.
6. Cancer-related spinal instability or imminent neurological compromise requires urgent review in conjunction with a spinal surgical team, to determine whether spinal fixation or decompression has a role. Uncontrolled pain may be a presenting feature in these cases.
7. Within every region there should be availability of, and easy access to a range of core cancer-pain interventional options including;
 - Epidural and/or spinal infusions, including intrathecal drug delivery systems.
 - Neuroablative procedures including spinal neurolysis.
 - Sympathetic neurolytic blocks.
 - Percutaneous cordotomy and open surgical cordotomy.

These should be facilitated by a nominated pain consultant with responsibility for managing or coordinating cancer-related pain in every region.

8. There should be easy access, within each region, to education and training in cancer-pain management, in line with competencies as stipulated by Faculty of Pain Medicine, for those who are interested in, or have regular contact with, patients suffering from cancer pain. These teaching sessions or training resource should be recognised for this purpose, and be part of the job planning process.
9. Each region should have a cancer-pain network lead by a tertiary pain management centre and linked with specialist pain clinics (District General Hospital Pain Services) in close liaison with palliative medicine and oncology services. The aims of this network are to improve cancer-pain assessment and management in the region, and to include second opinions for complex and difficult to control pain problems. This will direct

appropriate patients to services where more specialist procedures are available, e.g. neuroablative procedures and intrathecal drug delivery implants.

10. There should be well-defined pathways, including referral criteria and indications, to offer guidance as to when a patient with (or who has the likely potential to develop) uncontrolled cancer pain should be referred to tertiary pain services for consideration of complex pain-management options.

Background

60% to 70% of patients with cancer are likely to experience pain at some stage of their disease. Cancer-pain management in children, adolescents and cancer survivors is outside the scope of this chapter, but represents a growing area with a requirement for additional training and service development. Cancer pain is often multifactorial. It can be caused not only by the cancer itself, but also by treatments such as chemotherapy, radiotherapy and surgery. One third of cancer patients do not experience any pain at all.

The management of cancer pain has changed in recent times. Whereas in the 1950s and 60s interventional pain techniques were the mainstay of cancer-pain treatment, the medical management of cancer pain was developed from the 1970s onwards by the establishment of the modern hospice movement and palliative medicine as a speciality⁴. Medical management forms the cornerstone of cancer-pain management today. This includes chemotherapy and radiotherapy, and various analgesics and adjuvants (tricyclic antidepressants, anti-convulsants, bisphosphonates, steroids, etc.)⁵.

A wider range of surgical and orthopaedic interventions are available than previously. More recently, interventional pain management has regained importance. Individualised cancer-pain management, with a selection of conservative and invasive treatment options depending on pain presentation, should now be considered the gold standard.

Good history taking and assessment and diagnosis of cause of the pain are vital in managing cancer pain. The pain has to be seen in the context of the overall presentation of the patient. Cancer patients, particularly in the advanced stages, often experience a multitude of symptoms other than pain, such as fatigue, anorexia and general debility. These symptoms are likely to persist, even if effective pain control is achieved. It is therefore important to manage patients' and their families' expectations, and set realistic treatment goals in order to avoid disappointment and possible disengagement from services. As patients are often debilitated and prognosis is poor, effective pain control needs to be achieved quickly, and the lengthy titration protocols that are sometimes used in chronic pain management are often inappropriate. In contrast to chronic pain, cancer pain is usually not static, and on-going supervision and titration of analgesia is vital.

The mainstay for medical management of cancer pain is the three-stepped WHO Analgesic Ladder. Using this concept, 80-90% of cancer pain can be successfully managed¹. Several recent pain surveys and critical reviews have shown that in spite of decades of the WHO model, unrelieved cancer pain and opiophobia are still as prevalent, and, the adjuvant drugs are frequently under-employed. Instead of the WHO Ladder approach that recommends adjuvants as optional, there is mounting evidence supporting the benefits of routinely combining opioids with other pharmacological adjuvant agents due to synergistic effects, and reduced toxicity. The principal strong opioid for management of cancer pain remains morphine. Morphine has been shown to be effective, has no ceiling dose, has a simple titration regime, is available in oral, injectable and rectal formulations, and is cheap. For some pain procedures (coeliac plexus ablation¹⁰ and intrathecal infusions⁹), there is controlled-trial evidence in cancer populations. For many other interventional pain procedures, including neurolytic pain procedures (cordotomy⁷, intrathecal and epidural neurolysis), the evidence from case-series (low quality), is of similar quality to the WHO Analgesic Ladder.

A pragmatic approach is therefore desired in deciding when and whether to offer such techniques. The likely benefits and risks of pain interventions need to be considered and balanced against the risks of continuing with

high-dose opioids, and need to be discussed with patients. Interventional pain management should be considered adjunct to comprehensive medical management. In summary, interventions give the potential benefit of providing superior pain relief without side effects of opioids and adjuvant analgesics and for some patients it is the only effective means of controlling their pain.

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Chapter 8

Education, Appraisal and Revalidation for Medical Staff

- 8.1 Continuing Professional Development
- 8.2 Assessment of Competence
- 8.3 Appraisal
- 8.4 Revalidation

8.1 CONTINUING PROFESSIONAL DEVELOPMENT

Mark Taylor

Introduction

Continuing Professional Development (CPD) is any learning outside of formal undergraduate and postgraduate training that helps individual doctors maintain and improve their standards of medical practice. It covers the development of knowledge, skills, attitudes and behaviours across all areas of an individual doctor's practice. The purpose is to help improve the safety and quality of care provided for patients and the public¹.

CPD is an integral part of *Good Medical Practice* and an important component of revalidation². Detailed guidance on CPD is published by the General Medical Council and, for all anaesthetists, by the Royal College of Anaesthetists. The Faculty of Pain Medicine (FPM) contributes to the College CPD committee, giving specialty-specific advice, and has developed pain medicine topics for level 3 of the CPD matrix.

The FPM's *Good Pain Medicine Specialist: Standards of Revalidation for Specialists in Pain Medicine*³, which is based on the GMC's *Good Medical Practice*, emphasises the importance of CPD in developing, maintaining and applying knowledge, skills and performance to practice, as well as providing essential supporting information needed for revalidation.

CPD is a priority 1 standard for Anaesthesia Clinical Services Accreditation (ASCA): 'Continuing professional development and revalidation are mandatory requirements for all anaesthetists, including non-consultant and non-training grades. Employers, hospitals or otherwise, should ensure that adequate funding and time are available for this purpose'⁴.

Standards

1. All pain medicine practitioners are responsible for identifying their CPD needs, planning how those needs should be addressed, and undertaking CPD that will support their professional development and practice¹.
2. All pain medicine practitioners must remain competent and up-to-date in all areas of their practice including management, research and teaching².
3. Pain medicine practitioners must reflect regularly on their standards of medical practice, and CPD activities should aim to maintain and improve the standards of their practice and also those of any teams in which they work¹.
4. Pain medicine practitioners must reflect on what they have learnt through their CPD and record any impact (or expected future impact) on their performance and practice¹.
5. The FPM and RCoA expects every pain medicine practitioner to undertake a minimum of 50 hours CPD (equating to 50 CPD credits/points) per year. A minimum of 20 hours should be achieved in each of the external and internal activities. In the internal category a minimum of 10 hours should be from local clinical governance activities⁵.
6. Pain medicine practitioners must keep a record and evidence of CPD activities undertaken⁵.

7. A pain medicine practitioner's CPD must also support the needs of others, e.g. patients, teams and organisations in which they work. Feedback from patients, carers and colleagues can inform the CPD needs and the Personal Development Plan (PDP).
8. Keeping a record of CPD activities is essential, and this must be produced at the annual appraisal. Registered users of the RCoA online CPD system can automatically generate this summary report.

Recommendations

1. The breadth of 'whole of practice' CPD for a pain medicine specialist is extensive. This requires careful planning in discussion with their appraiser, and should be an integral part of formulating the annual appraisal personal development plan (PDP). The PDP individual objectives should be 'SMART'-compliant.
2. A CPD PDP may need to be reviewed throughout the year to ensure it remains relevant, e.g. taking account of new developments or change in medical practice or changes in the law or medical regulations.
3. Regular Pain Medicine MDT meetings, Clinical governance meetings (including clinical incidents and morbidity and mortality reporting), and CPD meetings are an essential part of practice and should be planned with employers.
4. Clinicians who practice anaesthesia and pain medicine need to fulfil their CPD requirements for both areas of professional activity. Necessary time and support needs to be recognised for this within the annual job-planning process.
5. CPD is planned for the individual, but this may be informed by the topics within the RCoA CPD matrix.
6. Specific types of CPD activities and exclusions are listed in the RCoA guidance³.
7. Reflections on clinical governance and CPD activities are an important part of practice. These should be recorded and produced as supporting information at annual appraisal.
8. Pain medicine practitioners should read and follow the CPD guidance documents issued by the RCoA⁴.

Background

The principals of CPD for a pain medicine practitioner are the same as for all other medical practitioners. There is no single correct way to do CPD, and a practitioner may choose their own preferred ways of learning, e.g. internal CPD, external CPD or personal study, depending on what they are trying to learn and available opportunities. There is evidence that undertaking a range of different CPD activities to address a particular need is likely to be more effective than one-off events¹.

The CPD matrix developed by the RCoA provides a taxonomy and structure for planning CPD activities. The three-level matrix can be used as a resource to identify CPD requirements depending on an individual's professional practice. Educational providers can map the content of courses and activities against the knowledge and skill areas covered by the CPD matrix. The matrix's structure is currently under review by the RCoA CPD committee.

The RCoA supports the Academy of Royal Colleges' *ten principles for College/Faculty CPD schemes*⁶⁻⁷, and the *Standards and Criteria for CPD activities*⁸.

External CPD organisers can seek RCoA approval for their events by application to the College if specific standards are met. The FPM provides CPD assessors for reviewing pain educational meetings⁵.

The FPM organises a comprehensive educational programme of meetings and study days each year. In addition, it publishes a biannual newsletter, *Transmitter*, and a wide range of guidance on clinical and organisational matters is available on the faculty website.

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8.2 ASSESSMENT OF COMPETENCE

Barry Miller and Nick Plunkett

Introduction

Definitions

- Competence - ability to perform a task, or role
- Competency - defined behaviour with respect to knowledge, skills and performance in an area of competence.

It is expected that all career grade doctors practising any aspect of pain medicine (acute, chronic or cancer; adult or paediatric) in the public or private sectors will maintain their knowledge and skills appropriately. Standards have been established by the Faculty of Pain Medicine (FPM) with regard to training, retraining and CPD. Evidence of adherence to standards would include audit cycles, outcome measures, patient satisfaction and colleague multi-source feedback reviews, CPD records and logbooks of activity.

Standards

1. All doctors working in pain medicine must put patient safety as their highest priority. They must abide by the spirit of *Good Medical practice*, which states that 'the safety of patients must come first at all times...You must (also) protect patients from risk of harm by another colleague's conduct, performance or health by taking appropriate steps immediately so that the concerns are investigated and patients protected where necessary'¹.
2. All doctors working in pain medicine must undergo satisfactory appraisal annually, including periodic 360 appraisal (See Chapter 8.3).
3. All doctors working in pain medicine must undergo revalidation every five years (see Chapter 8.4).
4. All doctors working in pain medicine must undertake regular CPD, and demonstrate incorporation of current best practice into their own practice.
5. All doctors working in pain medicine must abide by the GMC directives regarding health and probity².
6. All doctors working in pain medicine must avoid practising outside their area of expertise/training, arrange specific referral where indicated in an individual case, and specific training where appropriate to close any gaps in competence.

Recommendations

1. Consultants and other Career Grade doctors practising pain medicine (acute, chronic or cancer) should be aware of current and evolving training and professional standards, and must maintain records to evidence adherence. Doctors practising pain medicine who are not Fellows/Members of the FPM should consider attaining Fellowship/Membership by whatever means is appropriate, and avail themselves of the support and direction that the Faculty can offer them in their professional practice^{3,4}.

2. All doctors working in multidisciplinary pain medicine should demonstrate the highest standards of communication, team working and leadership.
3. All doctors working in pain medicine should be supported by their hospital directorates with time allocated for appropriate Supporting Professional Activities (SPA), recognising the additional need for support in the most common situation of a mixed Anaesthetics/pain medicine post, with access to internal and external CPD opportunities, and ability to work within an agreed job plan.
4. All doctors working in pain medicine should be aware of and, where appropriate, act on professional standards as laid down by the Faculty or its professional committees, e.g. Faculty of Pain Medicine Professional Standards Committee, and other Faculty recommendations as may be issued from time to time⁵.
5. All doctors working in pain medicine should demonstrate current best practice in their relevant area of pain medicine.
6. All doctors working in pain medicine should demonstrate a commitment to life-long learning, and fully engage with appropriate CPD activities involving all three levels of the RCoA CPD matrix^{6,7}.
7. All doctors working in pain medicine should demonstrate an ability to engage with complaints procedures as determined by their employing Hospital, including demonstration of applicable learning where relevant to themselves and/or the pain service in which they work.
8. All doctors working in pain medicine should abide by their employing Hospitals' agreed work patterns/roles designed to improve the safety and quality of their work, e.g. in relation to observing suitable rest periods after on-call commitments.

Background

The Faculty of Pain Medicine is responsible for training and standards in pain medicine. All recently appointed consultants in anaesthesia and pain medicine who have trained in the UK will have comprehensive, standardised training pre-CCT, that was developed by the Faculty and delivered and administered locally through Pain Training Advisory Groups chaired by the local Regional Advisor in Pain Medicine. The Faculty allows for further directed pain training for consultants and other Career Grade doctors under supervised conditions as appropriate.

The importance of assessment of competence is core to the profession's commitment to deliver safe and effective care for patients. In determining an individual doctor's ability to practice safely and effectively, there is a body of regulatory and advisory guidance as laid down by GMC, RCoA and AAGBI. Central to this is the prevention of incompetence, its early detection, and its rectification.

Pain medicine in the UK is primarily practised by specially trained anaesthetists. A definition of a poorly performing anaesthetist, and by extension of a pain medicine doctor, has been suggested: 'A poorly performing anaesthetist is one whose performance is outside the accepted limits of practice. Within these limits an anaesthetist may adopt practices which are different from those of other departmental colleagues, provided that there is a reasonable body of anaesthetists who would practise in a similar way. It is widely accepted that the practice of individual anaesthetists may vary where evidence supports a range of different techniques'⁸.

While the range of practice in the field of Pain Medicine is broad with significant areas of specialisation, it is expected that a doctor working in Pain Medicine will adhere to GMC *Good Medical Practice* principles generally, and specifically by a knowledge of and adherence to, as a minimum, all levels of the curriculum relevant to pain medicine training appropriate to their career grade⁹.

The Faculty has a very robust mechanism for assessment of competency in Pain Medicine for anaesthetic trainees at all levels pre-CCT¹⁰. For pain medicine doctors post-CCT, it is expected that the doctor will undergo annual appraisal and five yearly revalidation. Inherent to this process is that the doctor demonstrates his/her adherence to a minimal standard of safe and effective practice¹⁰. Appraisal provides a means for detecting potential shortcomings in a doctor's competence to practice, and can be an effective tool for prevention of incompetence.

Post-CCT individuals wishing to take up pain medicine will be expected to undergo training consistent with pre-CCT guidance in centres with experience of such training.

When identifying areas of incompetent practice, it is likely that a doctor who falls short of accepted standards will have, within today's sentient and monitored health care system, raised concerns that trigger mechanisms that will result in investigation and action appropriate to the concerns raised.

Strategies to confirm incompetence and suggest remedial action depend on the seriousness and outcome of any competence failures, and may result in local responses (mediated by individuals with designated extra responsibilities, such as the clinical director and/or medical director) with local agreed initiatives (e.g. extra training/alteration of roles) or responses by national bodies such as the GMC. The National Clinical Advisory Service or RCoA Anaesthesia Review Team may provide overview or scrutiny if appropriate.

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8.3 APPRAISAL

Robert Searle

Introduction

Appraisal is a key element of the continuous process of evaluation of fitness to practise that supports the revalidation process. In order to maintain a license to practise from the GMC, doctors are obliged to maintain a portfolio of supporting information that demonstrates that they continue to meet the requirements set out in the *Good Medical Practice Framework for appraisal and revalidation*.

The GMC has set out generic requirements for appraisal. These requirements are supported by guidance from both the Royal College of Anaesthetists and The Faculty of Pain Medicine, which give specialty specific context to this process.

Standards

1. All pain medicine specialists must have a minimum of one appraisal per year¹.
2. Appraisers must have suitable skills and training for the role².
3. Pain medicine specialists must respond constructively to the outcomes of appraisals³.
4. Any concerns identified in the previous appraisal must be documented as having been satisfactorily addressed (or satisfactory progress made), in the next appraisal⁴.
5. Supporting information for each annual appraisal must include:
 - Up to date personal details and a description of the scope of work undertaken.
 - A signed self-declaration confirming the absence of any probity issues.
 - A signed declaration confirming the absence of any medical condition that could pose a risk to patients and confirmation of compliance with health and safety obligations for doctors set out in *Good Medical Practice*¹.
 - A personal development plan.
 - A description of CPD undertaken.
 - Details of direct involvement in any clinical incidents, Significant Untoward Incidents or other similar events.
 - Feedback from any formal teaching undertaken.
 - Review of any complaints and compliments.
6. The following must be included and discussed at appraisal at least once during each five-year revalidation cycle:
 - Evidence of quality improvement activity.
 - Evidence of colleague feedback and patient feedback (if direct contact with patients occurs).
 - Evidence of professional performance as a clinical supervisor and/or trainer (if such a role is undertaken).

Recommendations

1. Where possible, appraisals should be conducted by an appraiser from within the same specialty at least once during the revalidation cycle.
2. Those appraising pain consultants should be familiar with RCoA's *Supporting Information for Appraisal and Revalidation: Guidance for Doctors in Anaesthesia, Intensive Care and Pain Medicine* (2014) and the *Good Pain Medicine Specialist* (2014)^{3,4}.
3. Pain specialists should use supporting information during their annual appraisal to demonstrate that they continue to meet the principles and values set out in *The Good Pain Medicine Specialist* (2014)³.
4. Supporting information should be relevant to pain medicine practice and reflect the context in which the doctor works. For example, quality improvement activity would include participation in relevant national audit projects (e.g. NAP, National Pain Audit) and local pain-related audit such as those suggested in *Raising the standard: a compendium of audit recipes for continuous quality improvement in anaesthesia* (RCoA 2012)⁵.
5. The pain doctor should be able to demonstrate to their appraiser that they have reflected on their supporting information. Appraisal should include a discussion on how the pain doctor intends to develop or modify their practice based on this reflection⁶.

Background

The GMC has defined the principles and values on which all doctors should base their practice¹. Using this as a framework, the Faculty of Pain Medicine has developed specialty-specific standards for pain medicine doctors across the four main domains identified by the GMC; Knowledge, skills and performance; safety and quality; communications, partnership and teamwork; and maintaining trust³. The process of appraisal enables doctors to discuss their practice and performance in order to demonstrate that they meet the principles and values set out in these documents. Annual appraisals inform the revalidation process by which Responsible Officers inform the GMC that a doctor remains up-to-date and fit to practice⁷.

As well as enabling doctors to demonstrate that they are fit to practice, the process of appraisal also enables doctors both to enhance the quality of their professional work, and to consider their own professional needs when planning their professional development⁷.

During appraisals, pain specialists are required to use supporting information to demonstrate that they meet the GMC principles and values needed for revalidation. Some supporting information is required at every annual appraisal (such as general information about the scope of your work), whilst other evidence is only required once during each revalidation cycle (such as patient and colleague feedback)⁶. The Royal College of Anaesthetists has published specialty-specific guidance on what supporting evidence anaesthetists and pain specialists should include as part of their appraisal⁴. "Reflection" is a common theme integral to the supporting information, and appraisal discussion should include how this will influence current and future practice⁸.

Although the supporting information required is the same across the UK, the process of appraisal differs according to location in England, Scotland, Wales or Northern Ireland.

Although the GMC do not stipulate that an appraiser should be from the same specialty as the appraisee, the RCoA recommend that for anaesthetists with few anaesthetic sessions (defined as one day or less per week) whose appraiser is not an anaesthetist, the views of the clinical director in anaesthesia (or appropriate deputy)

are sought and considered at the appraisal⁴. This is to ensure that the doctor has maintained the key skills necessary to fulfil his or her clinical commitments (a judgement that may be difficult to make for appraisers from other specialties). As pain specialists often work less than full time in pain practice, it would seem sensible to recommend that, where possible, appraisals should be conducted by an appraiser from within the same specialty at least once during the revalidation cycle.

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8.4 REVALIDATION

Robert Searle

Introduction

Revalidation is the process by which doctors are required to demonstrate on a regular basis that they are up-to-date and fit to practice. Licensed doctors are required to revalidate every five years, based on the results of annual appraisals.

Detailed guidance on the standards required for the revalidation of individual pain medicine specialists is available in the Faculty of Pain Medicine publication *The Good Pain Medicine Specialist: Standards for Revalidation of Specialists in Pain Medicine* and the GMC document *Good Medical Practice*.^{1,2} These provide the standards for revalidation for individual pain medicine specialists. This chapter will also recommend standards a pain service should maintain in order to facilitate revalidation of pain medicine doctors working within it.

Standards

1. All pain medicine specialists must aim to meet the principles and values set out in the GMC document *Good Medical Practice* (2013) and the Faculty of Pain Medicine document *The Good Pain Medicine Specialist* (2014)^{1,2}.
2. All pain medicine specialists must maintain a portfolio of supporting information that demonstrates they meet the attributes set out in *Good Medical Practice* (2013) and *The Good Pain Medicine specialist* (2014).
3. All pain specialists must participate and engage in the annual appraisal process. This should include discussion of supporting information, what this says about their performance and practice, and how they are using this to maintain and improve standards.

Recommendations

1. A pain service should hold or participate in regular audit meetings relevant to pain medicine.
2. A pain service should support activities that maintain and develop competence and performance.
3. A pain service should co-operate with internal and external reviews.
4. A pain service should support critical incident reporting.
5. A pain service should support audit and research in pain medicine.
6. A pain service should ensure that the care of individual patients is not compromised in order to meet management targets.
7. A pain service should promote and encourages a culture that allows staff to raise concerns openly and safely.

8. A pain service should provide facilities that allow practitioners to follow infection control procedures and regulations.
9. A pain service should support, when appropriate, colleagues who have remediable problems with performance conduct or health.
10. A pain service should ensure staff have appropriate supervision.
11. A pain service should be open and honest with patients if things go wrong.
12. A pain service should maintain patient confidentiality, particularly when using means of electronic communication.

Background

All licensed doctors are required to demonstrate every five years that they are up-to-date and fit to practice medicine. This process is called revalidation. The standards by which doctors are judged in order for them to revalidate have been published by the GMC in their document *Good Medical Practice* (2013).² These are generic standards for all doctors, and in order to provide specialty specific relevance, individual Colleges and Faculties have also provided specialty-specific guidance based on the core values set out in the original GMC document. The Faculty of Pain Medicine has published the document *The Good Pain Medicine Specialist* (2014), providing specialty specific guidance for pain medicine doctors¹.

In order for doctors to prove that they meet these required standards every five years, they should collect a portfolio of supporting information and evidence that demonstrates that they meet the attributes required.³ Both the GMC and Royal College of Anaesthetists provides guidance on what supporting information to collect^{3,4}.

The third revalidation standard required for all doctors is that they participate in the annual appraisal process. This should include discussion of and reflection on supporting information, and what this says about performance and practice, and how they are using this to maintain and improve standards⁵.

In addition to these three main revalidation standards, a pain medicine service may help and facilitate the revalidation of doctors working within it by promoting a working environment that helps to meet the values and attributes needed for good medical practice. This chapter therefore makes recommendations for a pain service to provide facilities or support under the four broad domains that cover the spectrum of medical practice:

1. **Knowledge skills and performance** - a pain service should facilitate activities that promote governance, audit and CPD¹.
2. **Safety and quality** - a pain service should provide a means for critical incident reporting, and co-operate with internal and external reviews. In addition it should ensure management targets do not compromise the care of individual patients. It should allow staff to raise concerns, and provide an environment where clinical procedures can be performed safely and in accordance with infection control policies¹.
3. **Communication, partnership and teamwork** - a pain service should support the appropriate supervision of staff and those with health or performance problems¹.
4. **Maintaining trust** - a pain service should be open and honest with patients if things go wrong, and respect their confidentiality¹.

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Chapter 9

Service Improvement and Clinical Governance

- 9.1 Quality Improvement
- 9.2 Safety: Never Events
- 9.3 Research & Development

9.1 QUALITY IMPROVEMENT

Lorraine de Gray

Introduction

The purpose of Quality Improvement is to provide reliable, safe, effective, efficient and timely delivery of the best evidence-based management of pain for all our patients. This requires constant monitoring, measurement and evaluation which will in turn lead to the necessary changes to ensure better patient outcomes, better system performance and better professional development¹.

Relevant and well-conducted clinical audit provides us with the knowledge of where, why and what we need to improve. Analysis and reflection should allow us to develop the necessary changes that may lead to improvement. Sometimes it is necessary to test a change before full implementation in order to ensure that it will lead to quality improvement. Closing the loop by repeating the audit at an appropriate time interval will then allow us to ascertain whether the change has been effective in leading to quality improvement².

Standards

1. Pain management services must establish and utilise regular critical incident reporting systems³.
2. To know that change is producing improvement, it is essential to have a robust audit system in place with the ability to “close the loop” and repeat the audit where necessary.
3. A robust, well-supported clinical audit service must be in place to support clinicians in the process of collation and analysis of these measurements and targets. The service must be capable of supporting the full audit cycle, allowing for "closing the loop" and repeating of the audit where necessary⁴.
4. Clinicians must have sufficient time in their daily job plans to allow them to engage effectively and in a meaningful way in quality improvement processes.
5. Pain services must have the support of good leadership that promotes connections between the aims of changes and the design and testing of those changes. Attention to the policies and practices of reward and accountability is mandatory.

Recommendations

1. Validated national key screening tools and outcome measures are required. These should measure various components of the multidisciplinary aspects of pain management. There should be clear, transparent, robust reporting, looking both at process- and patient-focussed measures⁵.
2. Quality improvement should focus on each individual patient’s journey through the pain service. We recommend patient focused screening tools and outcome measures that should encompass the biopsychosocial model of pain management – thus looking at the physical, psychological and social aspects.

3. Quality improvement should also focus on the wider provision of the pain management service, including effective use of resources, training and impact on the wider socio-economic picture⁶.
4. In order to identify service delivery system problems or barriers, we suggest that data should be collated to look at appropriateness of referrals, waiting times to access different points of service, patient failure to attend for appointments, efficiency of communicating clinic letter, and patient satisfaction.
5. Screening tools and outcome data should be used to direct treatment decisions to maximize success and to generate pain management guidelines.
6. Clinical Governance systems should be in place to allow appropriate reflection and discussion on the outcome data, in particular to highlight areas of concern and/or areas that require change or improvement.
7. Critical incident reporting – a robust system should be in place to allow a detailed, systematic, and meaningful analysis of such incidents without a blame culture.
8. Once deficits within the system are identified and changes instituted, it is essential to measure the effects of the quality improvement collaborative intervention on care processes or outcomes of care. In order to be able to understand the impact of a change, data needs to be collated over a sufficient period of time to allow a meaningful change.
9. Pain management services should seek out feedback from service users and stakeholders (e.g. patient satisfaction surveys). Input from patient representation on Health Boards and Trusts' Governing Bodies is key⁷.
10. There needs to be close working with CCG and Hospital management to implement necessary changes.
11. Continuing Professional Development of all clinicians and healthcare professionals, including doctors in training, is required to help understand and develop further skills in audit and quality improvement.
12. Emphasis should be on the need to develop greater awareness of the need to look at the various domains of quality as part of each health professional's annual appraisal process.

Background

Quality improvement is the science of analysis of performance and the use of systematic efforts to improve it. Improvement requires application of knowledge and a thorough understanding of the system one is trying to improve. This requires insight and understanding of what is required and why it is required to improve⁸. It is crucial to understand the successes and defects within the system and the possible constraints that may affect measurement and change. Doctors have not traditionally been taught how to achieve change; techniques widely used in industry, based on the work of Deming from which the *Model for Improvement* and most other improvement techniques derive, have only been introduced into healthcare in the past decade.

Knowledge of what is required to improve will only be acquired by having validated screening and measurement tools and benchmarks in place. Moreover, a robust audit system needs to be in place to collate and analyse these measurements and targets.

A definition of clinical audit endorsed by the National Institute for Clinical Excellence (NICE)⁹ is: 'Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure,

process and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated changes are implemented at an individual, team or service level and further monitoring is used to confirm improvement in healthcare delivery.’

Once the need for change or improvement is apparent, the next step is to develop a change that will lead to improvement. This will in turn require testing before implementation, and in some instances it becomes apparent that further cycles of change are required. At this point ‘closing the loop’ audit will then provide the crucial feedback mechanism required to identify if the change has been effective in leading to the quality improvement sought.

It is essential to have continued development of healthcare accreditation standards, aimed at driving awareness of the need and importance of measurement of the quality of pain management for improvement purposes. Ongoing education of all clinicians practising pain medicine is required to draw them actively into the process of continually testing change and to allow them to develop a basic understanding of the standards of their work, as well as the skills they need to test changes in that work. This also requires leadership that enables connections between the aims of changes and the design and testing of those changes. There needs to be a clear trail of accountability without a blame culture. Good leadership supports a culture in which all professionals involved in service delivery and commissioning are enabled to be proactive and positive towards improving the quality of care and to work within agreed standards of clinical governance. Services that are successful in their pursuit of quality improvement tend to have good leadership, staff engagement (especially clinicians) and patient participation⁴. As Davidoff¹⁰ very aptly stated, the whole ethos of quality improvement is an “unshakeable belief in the idea that everyone in healthcare really has two jobs when they come to work every day: to do their work and to improve it”.

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9.2 SAFETY: NEVER EVENTS

Beverly Collett

Introduction

A revised *Never Events Policy and Framework* was published by NHS England on 27 March 2015. This includes changes to the definition of what a Never Event is, and adjustments to the types of incident that are included on the Never Events list, reducing the list from 25 to 14 incident types¹.

'Never Events' are a particular type of serious incident that meet all the following criteria²⁻³:

- They are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of the specific incident occurrence for that incident to be categorised as a Never Event.
- There is evidence that the category of Never Event has occurred in the past, for example from reports to the National Reporting and Learning system (NRLS), and a risk of recurrence remains.
- Occurrence of the Never Event is easily recognised and clearly defined this helps minimise disputes around classification and ensures focus on learning and improving patient safety.

It is anticipated the Never Event list will be reviewed annually by NHS England.

The 2015/16 changes published through NHS England apply to NHS practice in all four UK nations.

The Never Events list relevant to Pain Medicine for 2015/16¹:

The following Never Events list is the list of incidents that apply to Pain Medicine and is applicable for all incidents that occur on or after 1 April 2015.

SURGICAL
<p>1. Wrong site surgery</p> <p>A surgical intervention performed on the wrong patient or wrong site (for example wrong knee, wrong eye, wrong limb, wrong tooth or wrong organ); the incident is detected at any time after the start of the procedure.</p> <ul style="list-style-type: none"> • Includes wrong level spinal surgery and interventions that are considered surgical but may be done outside of a surgical environment e.g. wrong site block (unless being undertaken as a pain control procedure for a long term pain condition), biopsy, interventional radiology procedures, cardiology procedures, drain insertion and line insertion e.g. PICC/ Hickman lines. • Excludes interventions where the wrong site is selected because of unknown/unexpected abnormalities in the patient's anatomy. This should be documented in the patient's notes. • Excludes incidents where the wrong site surgery is due to incorrect laboratory reports/ results or incorrect referral letters • The WHO Surgical Safety Checklist [3] may be used in theatres or locations e.g. radiology suites or clean rooms, where pain interventions are performed. The Professional Standards Committee is currently designing a specific template for pain interventions based on the WHO Surgical Safety Checklist. <p>Guidance:</p> <ul style="list-style-type: none"> • Safer Practice Notice – Standardising Wristbands improves patient safety, 2007, available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=59824 • Patient Safety Alert – WHO Surgical Safety Checklist, 2009, available at

<http://www.nrls.npsa.nhs.uk/resources/clinical-specialty/surgery/>

- How to Guide to the five steps to safer surgery', 2010, available at <http://www.nrls.npsa.nhs.uk/resources/?EntryId45=92901>
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- Standards for providing a 24 hour interventional radiology service, 2008, The Royal College of Radiologists. Available at http://www.rcr.ac.uk/docs/radiology/pdf/Stand_24hr_IR_provision.pdf

2. Wrong implant/prosthesis

Surgical placement of the wrong implant or prosthesis where the implant/prosthesis placed in the patient is other than that specified in the surgical plan either prior to or during the procedure and the incident is detected at any time after the implant/prosthesis is placed in the patient.

- Excludes where the implant/prosthesis placed in the patient is intentionally different from the surgical plan, where this is based on clinical judgement at the time of the procedure
- Excludes where the implant/prosthesis placed in the patient is intentionally planned and placed but later found to be suboptimal.

Guidance:

- Safer Practice Notice – Standardising Wristbands improves patient safety, 2007, available at <http://www.nrls.npsa.nhs.uk/resources/?entryid45=59824>
- -Patient Safety Alert – WHO Surgical Safety Checklist, 2009, available at <http://www.nrls.npsa.nhs.uk/resources/clinical-specialty/surgery/>
- How to Guide to the five steps to safer surgery', 2010, available at <http://www.nrls.npsa.nhs.uk/resources/?EntryId45=92901>
- NB. This relates to implantable devices such as Spinal Cord Stimulators and intrathecal pumps.

3. Retained foreign object post-procedure

Retention of a foreign object in a patient after a surgical/invasive procedure.

'Surgical/invasive procedure' includes interventional radiology, cardiology, interventions related to vaginal birth and interventions performed outside of the surgical environment e.g. central line placement in ward areas.

'Foreign object' includes any items that should be subject to a formal counting /checking process at the commencement of the procedure and a counting /checking process before the procedure is completed (such as swabs, needles, instruments and guide wires) except where:

- Items are inserted any time before the procedure that are not subject to the formal counting/checking process, with the intention of removing them during the procedure and they are not removed
- Items are inserted during the procedure that are subject to the counting/ checking process, but are intentionally retained after completion of the procedure, with removal planned for a later time or date and clearly recorded in the patients notes
- Items are known to be missing prior to the completion of the procedure and may be within the patient (e.g. screw fragments, drill bits) but where further action to locate and/or retrieve would be impossible or be more damaging than retention

Guidance:

- Standards and recommendations for safe perioperative practice, 2007, available at <http://www.afpp.org.uk/news/safe-practice-highlighted-in-new-afpp-publication>
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- Tracking subsequent removal of intentionally retained swabs, 2011, available at <http://www.nrls.npsa.nhs.uk/resources/?entryid45=132834&p=2>

5. Wrong route administration of medication

The patient receives one of the following:

- Intravenous chemotherapy administered via the intrathecal route
- Oral/enteral medication or feed/flush administered by any parenteral route
- Intravenous administration of a medicine intended to be administered via the epidural route

Guidance:

- HSC2008/001: Updated national guidance on the safe administration of intrathecal chemotherapy, 2008, available at http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthservicecirculars/DH_086870
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- Patient Safety Alert NPSA/2007/19 - Promoting safer measurement and administration of liquid medicines via oral and other enteral routes, 2007, available at <http://www.nrls.npsa.nhs.uk/resources/?entryid45=59808>
- Patient Safety Alert NPSA/2007/21, Safer practice with epidural injections and infusions, 2007, available at <http://www.nrls.npsa.nhs.uk/resources/?entryid45=59807>

8. Mis – selection of high strength midazolam during conscious sedation

Mis - selection refers to

- When a patient receives an overdose due to the selection of a high strength midazolam preparation (5mg/ml or 2mg/ml) rather than the 1mg/ml preparation, in a clinical area performing conscious sedation.
- Excludes clinical areas where the use of high strength midazolam is appropriate. These are generally only in general anaesthesia, intensive care, palliative care, or where its use has been formally risk assessed within an organisation.

Guidance:

- Rapid Response Report - Reducing risk of overdose with midazolam injection in adults, 2008, available at <http://www.nrls.npsa.nhs.uk/resources/patient-safety-topics/medication-safety/?entryid45=59896&p=2>
- Safe sedation, analgesia and anaesthesia with the radiology department, 2003, available at <http://www.rcr.ac.uk/publications.aspx?PageID=310&PublicationID=186>
- Over sedation for emergency procedures in isolated locations, 2011, available at <http://www.nrls.npsa.nhs.uk/resources/type/signals/?entryid45=94848>

Standards

1. The Never Events update must be reviewed by the Pain Management Services team and current practice examined to minimise the risk of a Never Event and ensure patient safety.

Recommendations

1. Pain Management Services and their teams should review the Never Events updates and their current practice, and implement any additional safety measures as deemed necessary.

Background

Learning lessons from incidents requires timely reporting. Failure to report a Never Event is unacceptable, and a potential sign of cultural and safety failings in an organisation.

There should be early, meaningful and sensitive engagement with affected patients and/or their families/carers. There should be an appropriate investigation, following a systems-based methodology to ensure contributory factors, root causes and focused actions and learning are identified.

Staff involved in the Never Event should be supported and treated fairly with reference to the NPSA Incident Decision Tree⁴. The primary focus of the investigation should be on identifying underlying factors that contributed to the Never Event occurring, including understanding why the relevant barriers were not properly in place to prevent the Never Event.

The NHS England Never Events Taskforce has recently reported and the main recommendations of the report cover three themes⁵:

- **Standardise** – The development of high-level national standards of operating department practice that will support all providers of NHS-funded care to develop and maintain their own more detailed standardised local procedures. The report also recommends the establishment of an Independent Surgical Investigation Panel to externally review selected serious incidents.
- **Educate** – Consistency in training and education of all staff in the operating theatres, development of a range of multimedia tools to support implementation of standards and support for surgical safety training, including human factors.
- **Harmonise** – Consistency in reporting and publishing of data on serious incidents, dissemination of learning from serious incidents and concordance with local and national standards taken into account through regulation.

In order to respond appropriately to the report's recommendations, NHS England will engage and collaborate with a range of organisations to ensure the initiatives developed are accessible, achievable and manageable; and also ensure that the right kind of standard practice is developed across NHS perioperative care, education, training and regulation.

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9.3 RESEARCH & DEVELOPMENT

David Rowbotham

Introduction

In the context of a clinical service, research activity may include developing basic and clinical research programmes, participating in delivery of clinical research, awareness of important new research findings and translating research into clinical practice. The extent of a pain management service's involvement in research will depend on its size and configuration.

Standards

1. All pain management service clinicians must exhibit an awareness of new research findings and strive to translate these into clinical practice.
2. All Advanced Pain trainees must have the opportunity to take part in aspects of research, i.e. developing basic and clinical research programmes, participating in delivery of clinical research, awareness of important new research findings and translating research into clinical practice.
3. All services accommodating academic pain trainees must be aware of and plan for the additional challenges associated with the training scheme and the balance of academic and clinical training.

Recommendations

1. All pain management services clinicians should exhibit an awareness of new research findings, and strive to critically appraise, evaluate and translate these into clinical practice where appropriate. This could be via regular regional, local or departmental research meetings (e.g. journal club format or included in audit meetings).
2. Clinicians should be able to give appropriate advice to those patients who have become aware of new research findings from the media.
3. Pain clinic staff should be aware of any pain-related research ongoing in their institution (basic or applied) and seek to collaborate with the investigators if appropriate.
4. Services should liaise with their regional National Institute for Health Research Clinical Research Network (including the regional network speciality lead for pain) to discuss the possibility and practicality of recruiting patients into clinical trials (commercial and non-commercial). Support for this may be available from the network¹.
5. All trainees, especially those undertaking advanced pain training, should have the opportunity to take part in research as described above. The nature/extent of this will depend on the opportunities available. Advanced Pain trainees should be considered for training to become involved in any NIHR clinical trials undertaken locally (e.g. Good Clinical Practice in clinical research²).

6. Consultants in Pain Medicine should demonstrate a research element in their continuous professional development. This could include attendance at local, regional or national meetings and e-learning opportunities offered by many scientific journals, as well as personal research.
7. All pain management services should strive to co-operate with credible pain researchers who seek their collaboration.
8. Clinical research is challenging and complex; consideration should be given to the establishment of networks of research-active services to create a critical mass of staff, patients and resources.
9. Pain management services should have a constructive and understanding attitude to the needs of academic trainees in pain medicine working in their service.
10. Consideration should be given to the appointment of a research lead in every service.
11. All pain management services should have a nominated research lead to co-ordinate its research activities as appropriate.

Background

Original research is distinct from audit; research involves obtaining new knowledge by developing and testing new treatments, and often requires the approval of a research ethical committee, as well as other regulatory bodies depending on the type of research³. In general, audit seeks to find out if a service, or specific aspects of that service, meets a desired standard.

Research and/or research awareness is an essential element of any clinical service. It fosters an innovative culture, improves clinical care and outcomes, and promotes staff retention and recruitment. Also, the widespread use of the internet and other media means that many patients become aware of new developments and expect informed discussion of these during their consultation.

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Author List



Author list

Dr Shyam Balasubramanian	Consultant in Pain Medicine, Coventry
Dr Andrew Paul Baranowski	Consultant in Pain Medicine, London
Dr Christopher Barker	General Practitioner with specialist interest in pain, Liverpool
Dr Pamela Frances Bell	Consultant in Pain Medicine, Belfast Trust (retired) Chair, Pain Alliance of Northern Ireland
Professor Mike Bennett	St Gemma's Professor of Palliative Medicine, Leeds
Dr Neil Berry	Consultant Clinical Psychologist, Southampton
Dr Neil Betteridge	Co-Chair of the CPPC
Dr Alison Bliss	Consultant in Paediatric Anaesthesia & Pain Medicine, Leeds
Dr Brigitta Brandner	Consultant Anaesthetist, London
Dr Dee Burrows	Clinical Nurse Specialist, Torbay and South Devon
Dr Paul Cameron	PhD (Medicine) Researcher / National Chronic Pain Coordinator / Lead Physiotherapist, Dundee
Dr Gillian Chumbley	Consultant Nurse, Imperial College Healthcare NHS Trust, London
Dr Beverly Collett OBE	Consultant in Pain Medicine, Leicester Royal Infirmary
Dr Neil Collighan	Lead Clinician for Pain Services in East Kent Hospitals
Dr Hannah Connell	Consultant Clinical Psychologist, Chronic Pain Service Lead, Bath
Dr Anthony Davies	Consultant in Pain Management & Anaesthesia, Plymouth
Dr Lorraine de Gray	Consultant in Pain Medicine, Queen Elizabeth Hospital NHS Foundation Trust, Norfolk. Chair, Regional Advisors of Pain Medicine
Dr Fiona Duncan	Nurse Specialist in the Acute Pain Service, Blackpool.
Dr John Goddard	Consultant in Paediatric Anaesthesia and Pain Medicine, Sheffield
Dr Kate Grady	Consultant in Pain Medicine and Anaesthesia, Manchester. Faculty of Pain Medicine Dean.
Dr Tom Green	Pain Concern
Dr Sanjeeva Gupta	Consultant in Pain Medicine, Bradford
Dr Sharon Hopkins	Director of Public Health at Cardiff and Vale University Health Board, Cardiff
Dr John Hughes	Consultant in Pain Medicine, James Cook University Hospital, Middlesbrough
Dr Martin Johnson	Co-Chair of the CPPC. RCGP's Clinical Champion for Pain
Dr Sharmila Khot	Consultant in Intensive Care and Pain Medicine, University Hospital Wales, Cardiff. Hon Senior Lecturer, CUBRIC, School of Psychology, Cardiff University
Dr Roger Knaggs	Associate Professor in Clinical Pharmacy Practice, Nottingham
Dr Roger Laishley	Associate Specialist in Anaesthesia and Pain Medicine, Bournemouth
Dr Andrew Lim	Associate Specialist in Anaesthesia, Bath
Dr Louise Lynch	Consultant in Pain Medicine, Leeds
Dr Zoey Malpus	Consultant Clinical Psychologist, Central Manchester Foundation NHS Trust
Dr Jonathan McGhie	Consultant in Pain Medicine, South Glasgow University Hospital
Dr Christine McMaster	Consultant in Public Health Medicine, Public Health Agency, Northern Ireland
Dr Barry Miller	Consultant in Pain Medicine, Royal Bolton Hospital. Chair, Training and Assessment Committee
Dr Lucy Miller	Consultant in Pain Medicine, North Devon Healthcare NHS Trust Trainee Representative, Faculty of Pain Medicine
Michelle Morgan	Senior Occupational therapist, Pain Management Programmes, University Hospitals Leicester

Dr Andrew Nicolaou	Consultant anaesthetist and Lead for chronic pain service at St George's University Hospitals NHS Foundation Trust
Dr Cathy Price	Consultant in Pain Medicine, Southampton
Dr Jane Quinlan	Consultant in Acute Pain, Oxford
Dr Nick Plunkett	Consultant in Anaesthesia & Pain Medicine, Sheffield
Dr Mark Rockett	Consultant in Pain Medicine, Plymouth Chair of Acute Pain Working Party
Dr Mary Rose	Clinical Director and Consultant in Paediatric Anaesthesia and Pain Management, Lothian, Scotland
Professor David Rowbotham	Professor of Anaesthesia and Pain Management, Leicester Clinical Director of the National Institute for Health Research Clinical Research Network for the East Midlands
Rosemary Rutledge	Advanced Practitioner Occupational Therapist, Condition Management Programme , Belfast
Dr Cormac Ryan	Senior Lecturer in Physiotherapy, Teesside University
Dr Robert Searle	Consultant in Anaesthesia and Pain Medicine, Cornwall
Dr Manohar Sharma	Consultant in Pain Medicine and service lead at the Walton Centre for Neurology and Neurosurgery NHS Foundation Trust, Liverpool.
Dr Katy Simpson	Pain Concern
Dr Gail Sowden	Consultant Physiotherapist, Staffordshire and Stoke-on-Trent NHS Partnership Trust and the Research Institute for Primary Care and Health Sciences, Keele University
Dr Mark Taylor	Consultant Anaesthetist, Plymouth. Vice-Dean of The Faculty of Pain Medicine
Dr Anna Weiss	Consultant in Pain Medicine, Royal Cornwall Hospital
Dr Paul Wilkinson	Consultant in Pain Management, Newcastle
Dr Glyn Williams	Consultant in Paediatric Anaesthesia and Pain Management, Great Ormond Street Hospital
Dr Steve Gilbert	Consultant in Anaesthesia and Pain Management, NHS Fife. National Lead Clinician for Chronic Pain 2011-14
Lesley Holdsworth	Special Programmes Lead, HIS Chronic Pain Programme Lead
Professor Blair Smith	Professor of Population Studies, University of Dundee and National Lead Clinician for Chronic Pain May 2014 to date