Improving the Lives of People with Complex Chronic Pain:

How to Commission Effective Pain Management Services in England

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Contents

Key messages for those commissioning healthcare services

The Faculty of Pain Medicine (FPM) has worked with the Royal College of General Practitioners (RCGP) and other stakeholders to produce guidance for clinical commissioning groups that emphasises self-management strategies and clinical input tailored to the individual complexity of pain, as outlined in *Core Standards for Pain Management Services in the UK* (CSPMS UK) [5]. Implementation of frameworks of care based on this commissioning guide and attention to the following key messages will help deliver the best standards of cost-effective care.

The management of chronic pain

- Chronic pain is a very common disease (ICD -11 classification) and can be largely managed in primary and community care.
- Many people adapt well and manage it successfully.
- Treatment should be stratified according to need.
- People with chronic pain often need support to self-manage their condition.
- If people are unable to self-manage well, they are at significant risk of worsening disability, depression, dependency on strong analgesic medication and adverse social consequences, including unemployment.
- Early targeted biopsychosocial intervention in lower risk groups is associated with better outcomes.

Patients with complex pain conditions

- Some patients with complex pain are at risk of poor outcomes. This high-risk group should be identified at an early stage.
- An integrated multidisciplinary approach must be provided for complex patients with chronic pain
- Generic symptom management programmes are neither suitable nor evidence based for patients with complex pain.
- Specialist mental health support is required for the more severely affected patients.

Specialist pain management services

- Specialist pain management services may be located in the community, but are usually within specialist care hospitals (secondary care). These services must work seamlessly with other pain management services in order to provide an integrated management plan with the patient.
- Referral will normally be from the General Practitioner 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 no cause will have been found, or that the cause will have been identified but no specific treatment can be offered/is acceptable, or treatments have failed to relieve the pain.
- Where pain is a primary reason for referral to secondary care, direct onward referral to specialist pain services must be permitted.

Introduction

The aim of this document is to provide guidance to support collaborative commissioning for patients' persistent or chronic pain conditions that is simple, practical, affordable, and effective.

There is a societal and humanitarian need for pain management to support those in pain and distress. Sufferers and patients' advocates often refer to chronic pain as the 'invisible disability', a term which emphasises under-recognition, its impact on individuals and underinvestment in provision of appropriate, supportive, timely services.

These are unprecedented times for the commissioning of pain services. The healthcare landscape is rapidly changing and becoming more complex with increased integration of community and secondary care, reduced funding and the risk of fragmentation of services by shorter term commissioning policies. Current commissioning practices are highly variable across the United Kingdom and in some areas quality pain management services are at risk. This has caused general concern about the consequences of current commissioning strategies and the ability to meet the needs of its most important stakeholders: our patients.

What is Chronic Pain?

Chronic pain is defined as pain that lasts or recurs for more than three months [1]. Chronic pain is a disease rather than a symptom. It carries its own disease definition and is characterised by continuity and/or recurrence and personal, social and societal consequences. Neurobiological changes coupled with physiological and psychological responses to this form the complex condition known as chronic pain.

Reappraisal of the phenomenological characteristics of chronic pain and basic science research has contributed to the ICD -11 classification of chronic pain.

This includes the entity of chronic primary pain and clear diagnostic coding criteria for other chronic pain conditions [1].

People with chronic pain related to different areas in the body often share common life factors predisposing to risk for continuing pain, pain related medical descriptions, psychological consequences, mediators of disability and factors linked to their social and family context [2]. Condition specific management alone, offered in 'pursuit of cure', often fails people with chronic pain, leading to unresolved pain and rising distress.

What does good pain management care look like?

Due to highly variable commissioning practices, it has become increasingly common to see methods of care (i.e. single interventions or limited groups of treatments) spread over various providers.

Patients with chronic pain frequently present with a complex mixture of medical, psychological and social factors. This requires a coordinated biopsychosocial approach to support patients effectively. Small incremental positive change is made possible through access to a range of enabling treatments including some specialist treatments. This process is difficult to manage in primary care alone. Initial assessments require time, interprofessional integration and specialist rehabilitation. For patients with complex pain, they need specialists with the training and expertise to manage their care holistically. Patients with complex pain benefit from comprehensive care delivered by appropriately trained and experienced specialists.

What are the implications of fragmentation of care?

Delivering treatment of complex health conditions in silos with a reliance on reductionist and single modality approaches often renders treatment ineffective, wasting considerable resource [3]. This in turn results in delays in accessing the right care by the right professionals at the right time and is likely to contribute to dependency on addictive pain medications and the declining potential for functional rehabilitation [26]. A current consequence of this is the well-publicised 'opioid crisis', with a consequent rise in prescription addiction.

If there is not a full recognition of these risks of fragmenting care, then an attempt to cut costs will likely have the reverse impact. Costs will rise further as quality of life for this group diminishes with the well-recognised consequence of increased heath care consumption (more appearances at both the GP surgery and overstretched Emergency Departments) as well as high social costs [16] [19].

What is the role of the Faculty of Pain Medicine?

The Faculty of Pain Medicine (FPM) has a pivotal role in the safety and quality of care delivered for patients with pain, be it acute, persistent or related to incurable disease. The FPM takes a leadership role in fulfilling legislative responsibilities in pain training and medical standards of care and works with other stakeholder bodies to set wider standards for care of pain as a whole. The FPM acknowledges the financial challenges faced by the NHS and supports prudent and best-targeted use of its resources.

CSPMS UK [5] recommends that care is designed around the following principles:

- Effective triage
- Appropriate evidence based pathways
- Effective patient and professional education
- Identification and provision of the right care for patients with complex pain
- Measurement of meaningful health and social care outcomes.

1 Understanding the needs of people living with pain

1.1 Living with Pain (the patient's perspective)

People with long-term pain find themselves in an increasingly complex health service, where they can struggle to find both the pathways of care and the specialists who can manage their pain.

The evidence based review, *Including Qualitative Research in Pain,* provides a qualitative evidence synthesis of narratives of people with pain [4]. The evidence-based review provides a thematic analysis to enable a deep understanding of what it is like to live with pain. Key problems include the personal struggles associated with day-to-day living, feeling let down by healthcare systems, poor access to specialist services which help, and the importance of being listened to and validated.

While there is understandable focus on societal studies to quantify the impact of pain, the patient voice must not be forgotten. The referenced book is crucial reading for all involved in the care of this patient group, including commissioners and practitioners, as it provides a rich insight into current difficulties through patient's own words.

TABLE 1

(From: Toye, F et al (2018) "Appendix 2: Living with Chronic Pain", *Including Qualitative Research in Pain Education*, IASP, pp59-79 [2])

COMPLEXITY OF CONDITION

"I am in constant severe pain like someone is pulling me part. There are good and bad days. Pain threatens very aspect of my life. I can't sleep. I can't move. I can't look after myself; I cannot fulfil my role. I can't do the things I have always been able to do. My life is impoverished and confined." (p 65)

SIMPLISTIC CARE DELIVERY

"I am frustrated with my doctor and health care system…The doctor downplays my problems. They focus on the physical symptoms…" (p 79)

PROFESSIONALS LACKING KNOWLEDGE

"My GP does not have the knowledge to treat my pain. I need someone who knows what to do. Medication is not going to make me better" (p 59)

NEED FOR CARE IN PARTNERSHIP

"I need clear and accurate information. I need the clinician to speak clearly and take time to explain things in language that I can understand. Take time to get to know me and encourage me to discuss things" (p 59)

"I need to be involved in the decisions about my care and my goals. I want the clinician to consider my preferences and plan my care around me as a unique individual with individual needs. I want us to make decisions about me in partnership" (p 61)

1.2 The Burden of Pain

Pain is a common symptom of many conditions. For a proportion of patients, it may be the only or predominant symptom and therefore chronic pain is recognised as a condition in its own right [6] [7].

Severe unremitting pain impacts on social functioning, workplace roles and drains mental performance to such an extent that patients often feel depressed and isolated [8] [9] [10].

Patients can become suicidal from the burden of their symptoms [11] [12].

Severe chronic pain shortens life expectancy [13]. It is estimated that 14 million people live with chronic pain in England alone. A quarter of these people (3.5 million) stated that their pain had kept them from their usual activities, including missing more than 2 weeks of work in the last 3 months [14]. **Pain is the major component in 5 out of the top 10 conditions with the higher Global Disease Burden [15].**

With increasing life expectancy of the UK population, it is anticipated that chronic pain will become a greater problem for patients, their families and society [17]. However, chronic pain is not a disease of old age alone. Half of people with chronic pain are of working age will have time off work because of their symptoms and 25% will lose their employment. Pain is the second most common reason given by claimants of welfare benefit [16].

In his 2009 publication, the Chief Medical Officer summarised the economic burden of chronic pain: '*It is estimated that back pain alone costs the economy £12.3 billion per year. The cost of pain from all causes is far higher'* [11].

TABLE 2

Facts demonstrating the impact of chronic pain
➢ £584 million is spent on prescriptions for painkillers in the UK [11]
➢ The economic cost of pain is estimated to be up to 10% of GDP [11] ○ £12 billion spent on back pain
➢ 41% of patients reported that their pain prevented them from working [15]
➢ Patients with chronic pain make significant demands on healthcare resources [16]: ○ They consult their GPs up to five times more frequently than other patients do. This translates to 4.6 million GP appointments per year. ○ They are hospitalised nearly three times as often as the general population!
➢ In the UK the prevalence of moderate to severe chronic pain is calculated as 10.4% to 14.3% [17]

Data from the First National Pain Audit (2011) confirm poor quality of life in patients eventually assessed by pain services at a level comparable to those with advanced senility [16]. It is suggested that there may be a relationship between chronic pain and mortality, particularly cancer mortality demonstrated in a systematic review [18].

1.3 Identifying people with complex pain

Though chronic pain is very common, [17] the majority of people with chronic pain will self-manage, often with support from primary or community care. This is similar to any other long term condition. However, some patients have complex pain conditions and their pain management will require specialist support. This group are at higher risk of long-term disability and distress, high levels of co-morbidity, high levels of health care consumption, unemployment, and high social costs. They do not respond to simple interventions in primary care and will eventually exhaust available options [19].

TABLE 3

Factors that influence complexity in chronic pain (the 'Complexity Model') [20]	
Medical comorbidities	Psychiatric comorbidities
Multiple chronic pain problems/triggers	Physical conditioning
Number of past surgeries	Risk for medication abuse and diversion
Polypharmacy	Sleep disorders
Body mass index	Goal setting
Tobacco smoking	Coping and social support
History of head trauma	Educational level and employment status

Pivotal to care pathways is the identification of this group of complex patients and the provision of necessary specialist care. Patients with pain need to be screened for at an early stage or their condition risks worsening significantly leading to long-term disabling pain [21] [22].

More complex triage approaches may involve the inclusion of other factors or the use of screening tools. These may include risk factors such as belief structures, coping mechanisms and other health factors. While most of the evidence of risk refers to musculoskeletal problems [23] [24], where available, evidence shows that similar risk factors are applicable to other chronic pain conditions [25].

As people experience pain for longer, the prognosis for recovery deteriorates. This is associated with high costs for the individual and society. Both the International Association for the Study of Pain and the Chief Medical Officer for England recommended rapid access to specialist advice in this context [26] [11].

Effective triage allows treatment to be stratified to risk, with those suitable for specialist pain care identified rapidly and referred to appropriate services. Crucially, this avoids over-treatment of low risks groups with intensive and costly rehabilitative or interventional strategies and patients being caught in a merry-go-round of referrals especially given current funding constraints.

CASE STUDY

As an illustrative example of the value of triage and wastage of resources without is the example of chronic back-pain management.

The former NICE back pain guidance [27] recommended of CPP (combined psychological and physiotherapy interventions) of 100 hours within the care pathway for back pain based on failure to respond to some preliminary evidence-based treatments rather than stratified triage [28].

Analysis of the care pathway indicates that the flux of patients through the pathway to this intensive treatment is very high based on failure to respond to other treatment alone and without reliance on newer evidence on the value of stratification to risk.

Strong evidence supports that even the most high risk, complex patients can usually be treated effectively by experts with more modest programmes of care of around 30-40 hours that is less than the larger less complex group to which 100 hours of treatment would be applied). Without triage, these 100 hours of treatment would be given to people who would get better in any case based on experience and simple applied epidemiological evidence [29].

While the FPM is aware of poor uptake nationally of this recommendation, this approach would have led to wasteful application of scant resources in low risk patients with a good prognosis.

Therefore, a key function of this document is to provide definitive expert guidance to enable cost-effective commissioning to be achieved. Formal evidence of treatments clearly is the recognised building block as in the case above. However, if individual treatments are not organised in care pathways carefully and the flow of patients through pathways considered, a system of care may be constructed that is not only ineffective but may increase costs very rapidly. Expert consultation and advice with organisations like the FPM is crucial.

2. Value of Pain Management Services

2.1 How patient management services improve patient outcomes

Clear, responsive and compassionate communication is a strong determinant of levels of patient engagement and satisfaction and will typically have a significant influence on treatment outcomes. People in chronic pain may not initially understand their condition well, which can inhibit them from engaging in exercise or activity through fear of injury, or make it difficult for them to accept that their condition may not have a cure [5].

Well commissioned pain management services provide for the following key elements of patient care to improve outcomes:

- **Assessment and diagnosis**: Well commissioned pain management services offer assessment and pain condition diagnosis and then adopt a narrative-based, integrated biopsychosocial approach. Time allocated for the initial assessment is appropriate, to meet the complexity of the patient's presentation and should offer a platform for introducing positive change. The same principle applies for follow up appointments if these are deemed necessary when managing complex patients. New patient consultations require **one hour** for people referred with a complex pain presentation and follow up appointments typically **around 20-30 minutes** based on the time necessary to do the key tasks of the consultation required to meet core standards.
- **Review:** Pain management services offer '*an opportunity for a fresh, comprehensive review of a patient when persisting* (chronic) *pain is thought to be contributing to slower than expected progress'* [30].
- **Explanation:** Services offer an explanation of conditions and their management using communication methods tailored to patients' needs [31].
- **Rationalisation:** Services aid rationalisation of treatments including medicine optimisation, investigations and referral, to offer patients the most effective pathway and to ensure cost effective use of resources [32].
- **Specialist multimodal treatments:** Services offer expertise in complex medication management, including advice on management of opioid de-escalation, supported by the education of patients and non-specialist health care providers. Most patients reported to the 2011 National Pain Audit [16] that they required more than one type of treatment to improve.
- **Complex case management:** Services offer support to complex/high frequency health care users, developing care plans with front line services to positively impact on readmission rates [33] [34].
- **Collaborative working:** Services provide collaborative working through:
    - liaison with primary care including management plans and providing support near home
    - outreach to primary care and others involved in the management of patients Pain MDT
    - input to other specialist MDTs
    - specialist support for palliative care
    - professional education
    - networking.
- **Specialist interventions:** Specialist pain services should offer complex multimodal interventions in keeping with the current evidence base and national guidelines, including:
    - spinal cord stimulation [35]
    - intrathecal drug delivery devices [36]

  This is either by local provision based on available expertise of clinicians or by referral to other specialist and highly specialist (Tier 3) pain management services.
- **Education:** Patient education supplements self-management and medication management [37]. Pain management services are well placed and very experienced in providing evidence based education and educational resources [38].
- **Shared decision making:** In well commissioned multidisciplinary pain services, the patient will be at the centre of their care [31].

2.2 Impact of lack of services

Chronic pain should not be left untreated. The following are unacceptable consequences of inadequate provision for patients with pain:

- “Pin-ball care”: where those with chronic pain are passed between healthcare professionals without clear direction or a patient pathway
- Wasted healthcare costs through unnecessary investigation and intervention
- Ineffective and inappropriate treatments
- High social care costs
- Avoidable hospital admissions and GP visits, including unproductive visits to Emergency Departments
    - In the 2011 National Pain Audit 20% of respondents reported visiting Emergency Departments in the 6 months prior to a pain clinic appointment in search of help. All had seen their GP about the same problem [16].
- Poor safety from missed diagnoses and the lack of screening for issues such as suicide risk
- Missed opportunities for patients whose overall quality of life would otherwise have improved six months after specialist pain management treatment.

Over time, poor commissioning will deplete existing services through:

- Worsening variation in access to the required multidisciplinary care
- Ineffective clinics not specified to fulfil the minimum requirement for staffing and competencies
- Failure to secure statutory healthcare outcomes within the domains of the NHS Outcomes Framework for patients with long term conditions [39].

Integrated multidisciplinary teams best deliver pain management; 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 [39].

Every specialist pain service should be multidisciplinary and include, at a minimum, psychologist, physiotherapist or other rehabilitation professional, and a pain physician. Nursing staff also play a key role [11] [40].

Professions that deliver added benefit to patient progress include occupational therapists and pharmacists working within or in support of multidisciplinary teams. Established patient representation informs service design and delivery and enables working in partnership [5].

As early as 2012, on recommendation of England’s Chief Medical Officer, a Pathway for Care was published by the British Pain Society [37]. This was a consensus document based upon best available evidence.

3. Standards of Care and Effective Commissioning

3.1 Ethical and effective commissioning

Commissioning is a process that should provide good value for money and subscribes to an ethical framework, based on the "Seven Principles of Public Life" which should apply to all in public services as published through the Committee on Standards in Public Life [41]. Commissioning practice varies across the four nations of the UK and across regions within England. The principle of patient/client centredness is paramount and experience from commissioning Adult Social Care highlights the necessity for working in partnerships, with the engagement of patients/clients and providers [41].

The effective commissioning of pain management services should ensure that all five domains in the Department of Health's Long Term Conditions Framework [39] are also met:

- 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

3.2 Understanding Pain Management Core Standards of Care

Well-functioning multidisciplinary pain services deliver care in keeping with the NICE quality standards [43] and multidisciplinary professional standards [5]. The FPM recognises the difficulties and uncertainties linked to the commissioning of pain management services and has published definitive guidance on the required standards of pain services in every setting applicable to UK practice.

CSPMS UK [5] was written to provide a comprehensive framework for safe, responsive and professional delivery of services for patients with pain. It addresses all areas of delivery, including persistent pain management in all age groups, cancer pain, acute/in-hospital pain, and community care. It establishes safe standards for service delivery, including recommendations on staffing and composition of teams, accommodation and equipment. These standards are based on available evidence and multidisciplinary professional consensus.

CSPMS UK is the basis for standards adopted by the Care Quality Commission (CQC) with the Key Core Standards agreed informing any CQC inspection across NHS England [44].

3.3 Using Evidence for supporting high value care

Evidence should be used to support high value care. Evidence may be in the form of randomised care, registries and/or cohort studies. High value care is determined by overall quality of care, patient experience and cost. Not all treatments can be tested through randomised trials and this is especially the case when assessing multidisciplinary care.

CASE STUDY: RADICULAR PAIN

(Costs are indicative and the case is illustrative of complexities in considering treatments in isolation of whole treatment pathways)

In region Z, a decision was made based on value of care models to limit the number of nerve root injections used primarily for nerve root pain to a maximum frequency of two per year. The cost of a single nerve root injection is approximately £500 [47], and there is a relative absence of evidence for the benefit of repeat injections using traditional randomised controlled trials [48]. However, if the treatment is effective, patients usually report that the benefit lasts for only 3-4 months, and therefore two injections would likely only provide benefit for maximum 8 months in a year. According to the value of care model in question, the outcome for these individuals may be declared a failure.

CASE STUDY: RADICULAR PAIN continued

The next medical step in a care pathway for radicular pain would be a more interventional treatment, such as the NICE-approved spinal cord stimulator (SCS) implantation [35] [45]. This is often a valuable treatment but possible life-time costs if effective may be very high e.g. £50,000-100,000 [46] [47].

In an individual case, one additional nerve root injection per year in the intermediate term may facilitate rehabilitation, which may prevent the patient from requiring more interventional treatment. The cost saving of one less injection per year would only be £500 per treatment.

There are many other factors which could be put into the model increasing complexity and impact on decision-making but the principle is that the cost effectiveness of individual pain treatments is highly contextual and linked to the care pathways in which they exist, flux of patients through pathways and patient-specific outcomes. This document does not dictate which treatment is correct in this scenario.

Case studies such as above indicate that there are very significant difficulties with the application and the use of and approach to isolated areas of evidence in pain medicine in complex situations. The positivist or experimental method is methodologically unsound in this context and sociological approaches should be considered. Lack of evidence from one methodological approach (e.g. randomised double blind trials) is not evidence of lack of effect. The FPM has concerns over removing treatments that are beneficial to individuals given the complexity of interpreting evidence whatever view is taken about future use of a treatment or procedure across the population of patients. Best pain practice requires a level of pragmatic support by experts in complex patients. Analysis of the cost-effectiveness of a specific treatment on an individual treatment basis could prove costly to the NHS if pathways are not considered as a whole.

Management of these issues requires an atmosphere of trust between pain specialists and those commissioning care, with careful impact modelling on rebound costs from decision making around limiting treatments and new frameworks to determine the reliability of experiential, pragmatic evidence.

3.4 Measuring Quality of Care

Quality of care is measured by clinical effectiveness, safety and patient experience. The measurement of clinical effectiveness is difficult if it is to be fully captured. A reasonable consensus on domains to measure has been achieved internationally [49] with broad support from the clinical community [50]. Core domains include pain intensity, pain frequency, physical activity, emotional wellbeing, satisfaction with social roles and activities, productivity (paid and unpaid, at home and at work, inclusive presentism and absenteeism), health-related quality of life, and patient's perception of treatment goal achievement. However, the response rates in any exercise to capture and compare outcomes from pain clinics are low with no greater than 20% of patients captured at follow up [51] [16]. Currently research is progressing as to how to balance the dataset required against questionnaire burden, patient and clinical engagement in the process.

A practical approach would be to agree a Key Performance Indicator (KPI) such as confidence to manage pain [52]. Waiting times are extremely important to patients and rapid access to advice within two weeks was recommended in the CMO report of 2008 [11]. IASP has produced guidance on waiting times recommending no more than 8 weeks wait, Norway recommended a maximum of 16 weeks based upon a consensus amongst patients, policy makers and healthcare professionals for most non urgent pain conditions [53]. Patient domains of experience of care are equally as important to measure such as involvement in decision making and feeling understood. A full economic evaluation of the impact of a pain service is beyond the scope of routine measurement of outcome. However, the impact of a service on emergency attendances, other outpatients or a reduction in the use of prescription drugs of potential dependency would provide some evidence of the economic impact of a service. These need to be tailored to the service. These have been measured previously in UK Pain Clinics either through direct measurement or linkage to Local Hospital Episode Statistics data [16] [54] [56].

4. Creating Seamless Care Pathways

Design, commissioning and delivery of care must ensure that there are appropriate end-to-end clinical pathways that co-ordinate primary, community and specialist care seamlessly. Early recognition of those likely to have a poor outcome from non-specialist pain services has to be embedded in this process. Pain management services should be commissioned in a way that secures unhindered movement of patients between tiers of care, within defined pathways of care. Access to individual tiers of care should be defined by the needs of the patient.

Pain management treatment pathways should be based around evidence-based pathways, such as the British Pain Society's Pain Pathways [37]. The safety of all patients and especially those at risk of poor outcome must be identified during triage.

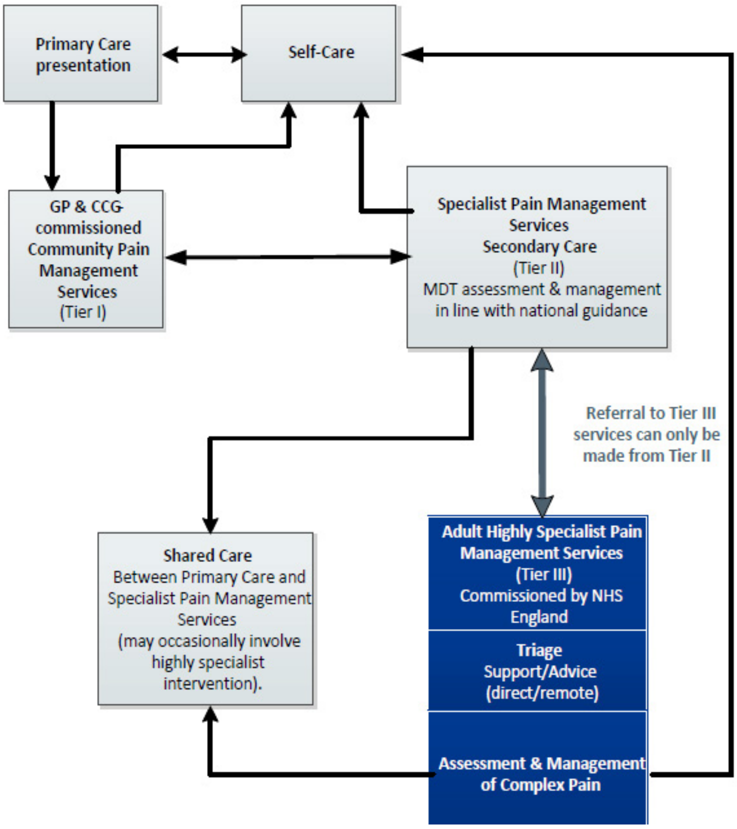
The NHS England Specification for Adult Highly Specialist Pain Management Services clarifies flow and interdependence between tiers of care [56]:

Tier I: GP and primary care services and CCG-commissioned community pain management services

Tier II: Specialist pain management services provided in secondary care (commissioned by CCGs)

Tier III: Adult highly specialist pain management (tertiary) services (commissioned by NHS England)

Diagram 1: (From: Adult Highly Specialist Pain Management Services, NHS England August 2019 [56])



4.1 Stepped, stratified and personalised care models.

A whole systems approach enables the right patients to reach specialist pain services. However, often the vital part each of these elements play in ensuring the right patients gets to specialist care services is often not fully appreciated.

In *stepped models*, pain rehabilitation interventions are used to promote behavioural change and improve wellbeing in people living with pain.

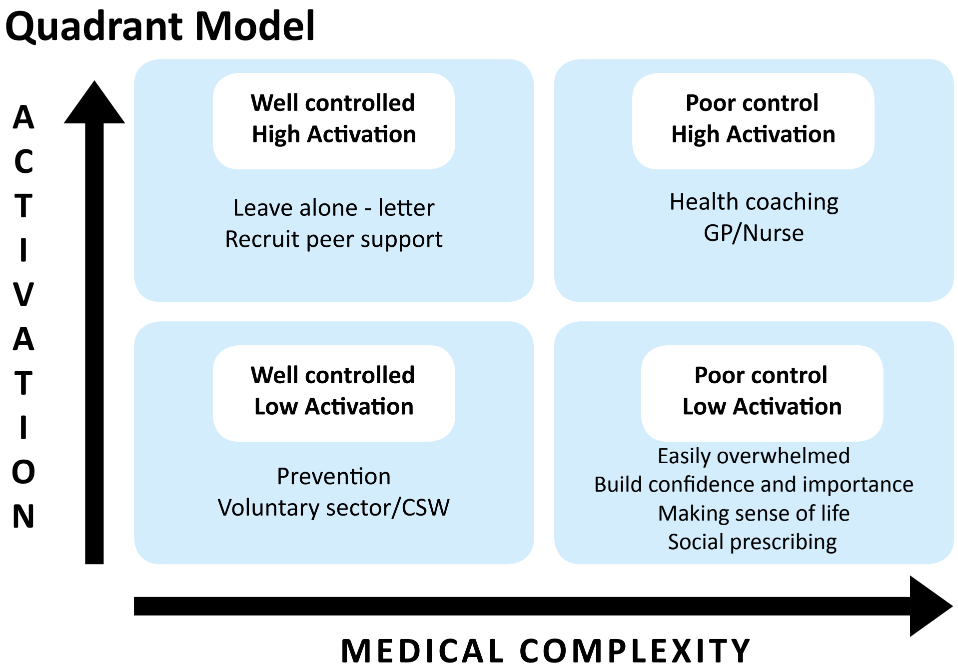
Stratification of patient management according to their level of complexity can support decision making on how much support to self-management should be allocated. It is recommended that interventions should be classified broadly into the following groups:

- Use of the Patient Activation Measure within a quadrant model so that social prescribing or health coaches can be successfully deployed [57]
- Early stratified care initially (including proportionate combined psychological and physiotherapy)
- Standard PMPs and Intensive PMPs (for complex patients see Section 4.2.5)

Central to evidence-based, cost effective treatment of people with pain is the need to triage all patients with pain early, based on the risk of long-term disability. Stratification of intervention to risk allows for stepped care models of care (typically based on low, moderate and high-risk (complex) groups) to be applied and allows for the early detection of complex patients.

Diagram 2

(Derived from: A New Model to Encourage Person-centred Approaches to Long-term Condition Management In Primary Care [57])



The concept of personalised care means that people have choice and control over the way their care is planned and delivered. It is based on 'what matters' to them and their individual strengths and needs [57] [58]. This concept is endorsed through its implementation in the NHS Long Term Plan, which aims at offering personalised care to 2.5 million people within the next 5 years [60].

4.2 Specialist Pain Management Services

Specialist pain management services form part of the network of support, making that network accessible to patients through joined up and co-ordinated care. Services may be configured differently from centre to centre. An important principle is that the services maintain critical relationships between hospital services (as a cornerstone service), musculoskeletal services, and mental health services, as well as supporting primary and community care services. Collaborative pathways should be developed with various mental health teams, including liaison psychiatry, substance misuse teams, old age psychiatry and community mental health teams.

The basic essence of specialist provision is that specialist pain management services need to be commissioned to provide support to non-specialists through education and facilitation as well as guidance on medicine treatments and interventions.

All services must comply with the standards for best practice in the provision of pain management services (CSPMS UK) [5].

4.2.1 Specialist support of self-management for low risk patients

Specialist pain management services can provide advice and support on early usually community-based self-managements interventions in **low risk** patients, which may usefully adopt various alternative formats.

In evaluating outcomes from innovative models of early self-care, caution is required not to confuse treatment benefit with improvement through natural history alone given the better prognosis for lower risk groups.

Pain management services in the community should link with non-healthcare services when appropriate, including the third/voluntary sector. Such links should work to enhance self-management and the promotion of living well with a long-term condition.

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. This should not be confused with Pain Management Programmes (see **Section 4.2.5**) which are lengthy and aimed at those with needs that are more complex.

4.2.2 Types of condition and addiction support

For musculoskeletal conditions, experienced musculoskeletal practitioners are well placed to recognise those who require specialist pain services.

However, clear arrangements must be in place for the 20-30% of patients with pain that is not musculoskeletal [10] [17].

The commissioning process should include specification and local provision for a pain and addiction service. There are currently significant public health issues related to patients on high dose opioids.

4.2.3 Inpatient pain services

An inpatient pain service needs to be commissioned for the diagnosis and management of complex pain disorders. The aim of this service is to ensure an appropriate length of stay for patients with pain disorders and to reduce the risk of inappropriate admissions from the Emergency Department. Inpatient pain services were traditionally established and commissioned to support the management of acute post-surgical and non-surgical pain. The profile of most inpatient services has changed over the recent years, determined by changing clinical demand. Inpatient services continue to provide care, governance and education to deliver high quality post-surgical care. The increasing demand arises from two distinct groups of patient: surgical patients with pre-existing opioid use and patients with chronic pain admitted for management of other health conditions or with exacerbation of their chronic pain conditions. Many have significant associated anxiety and depression as well as substance misuse that's often approached in a multidisciplinary way through inpatient service incorporating useful inputs from psychology, liaison psychiatry and substance misuse service as needed.

4.2.4 Interventional Pain Therapies

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.

Interventional procedures are an adjunct and not usually an endpoint in treatment. The selection processes for injection treatment should involve expert assessment on a biopsychosocial basis. This includes:

- medical assessment (multiple sites of pain means meaningful improvement may be unlikely in a single site injection),
- a psychological assessment to identify factors that may have an adverse impact on outcome, and
- a physical assessment to consider if pain relief will likely lead to increased function.

Neglecting these principles leads to unintended negative outcomes with excessively high numbers of patients having procedures, resulting in reliance on medical treatments alone, excess cost and a failure to address the central goals of pain management and treatment, namely self-management. Though interventions to simply provide pain relief are not the desired endpoint pragmatically, some patients that cannot be fully managed in any other way may be successfully treated by repeat injections. Treatment in this context may be viewed as classed of limited value across whole cohorts of patient but may be of considerable value to an individual. The FPM is cautious about policy-driven, barring of injections treatments in distressed or vulnerable individuals who find them helpful.

4.2.5 Pain management for medium to high-risk patients

Evidence-based self-management interventions for complex, high-risk individuals are mainly delivered by expert pain practitioners (e.g. medical, psychologist or physiotherapist) face to face. Multidisciplinary teams of trained, skilled, experienced specialist psychologists, physiotherapists and pain medicine specialists must be supported to manage complex high-risk patients.

Standard and Intensive Pain Management Programmes (PMPs)

In complex patients, there is high-level evidence for the efficacy of both outpatient and residential PMPs. A number of systematic reviews have shown that PMPs significantly reduce distress and disability, significantly enhance coping, and improve various measures of physical functioning. Where vocational training has been included in the package, return to work is also significantly enhanced [29]. There is evidence for decreased use of healthcare resources in terms of numbers of consultations and reduction of medication. Cost-effectiveness analysis has demonstrated positive effects in other healthcare systems.

These are undertaken by interdisciplinary pain management teams which contain specialist healthcare professionals including at least doctors, psychologists, and physiotherapists. Individual specialist pain rehabilitation psychology and/or physiotherapy treatment may be required before, during or after PMPs to enable self-management and progression to PMPs. 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.

A detailed account of the requirements and practice of PMPs and the underlying evidence base is outlined in the BPS document *Guidelines for Pain Management Programmes for Adults* [29].

4.3 Highly Specialist Pain Services

Highly Specialist services cater for complex cases (see **Diagram 1**). Regionally based services should be organised by collaborative arrangements with the full support and involvement of the relevant service providers and health professionals.

NHS England is directly responsible for commissioning Prescribed Specialised Services with the aim of ensuring that services, for those individuals that require adult highly specialist pain management service care, are of a high quality and consistent across England. Adult highly specialist pain management services are defined by the Service Specification 17013 5S [56].

The Service Specification clearly defines the groups of patients, the patient pathway, the interventions and the characteristics of those services that are **highly specialist.** It is the role of the Regional Area Team commissioners to ensure that those services are commissioned and that the standards are maintained.

Commissioning of Specialised Services in Scotland, Wales and Northern Ireland is subject to individual national guidance. In practice, these services are delivered collaboratively by referral to a limited number of centres providing specialised and highly specialised interventions [56].

4.4 Clinical coding

In percentage terms, 0.25% of the population is estimated to be seen annually in pain clinics in the UK [59]. A clinic can estimate this figure at a CCG level by using known population data.

Clinical coding needs to be simplified and we recommend that the NHS introduce new codes for diagnosis and treatment.

Key principles on the approach to coding in pain medicine are:

- Services should be identified using the treatment specialty code of 191
- Chronic pain patients seen as inpatients should be coded as an outpatient attendance
- Inpatients should be coded using ICD 10, and in the future ICD 11 (which has some generic codes for pain). Often pain should be coded as a co-morbidity, as it is the complications of having chronic pain that bring people into hospital (e.g. medication side effects, high distress)
- General practice activity should also be coded using a single term of chronic pain
- Outpatient coding is treatment driven (OPCS codes) and should be identified as occurring within a multidisciplinary environment or not.

5. Conclusions

This document provides an overview to support collaborative commissioning for patients' persistent or chronic pain conditions that is simple, practical and affordable. Chronic pain leads to disability, depression and has adverse social consequences including unemployment. Some patients with complex pain are at risk of poor outcomes. This high-risk group should be identified at an early stage through effective triage and an integrated multidisciplinary approach. This will avoid wasted healthcare costs through unnecessary investigation and ineffective and inappropriate treatments and missed opportunities to improve quality of life.

This guidance is underpinned by the principles outlined in CSPMS UK [5] and is intended to ensure commissioning is optimised for the best patient and service outcomes. Implementation of frameworks of care based on this commissioning guide will help deliver the best standards of cost-effective care.

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