Local Commissioning of Specialist Services for Pain

Recommendations of the Faculty of Pain Medicine, Royal College of Anaesthetists

FACULTY OF PAIN MEDICINE
of the Royal College of Anaesthetists

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Background

The Faculty of Pain Medicine is the professional body responsible for the training, assessment, practice and continuing professional development of specialist medical practitioners in the management of pain in the UK. It supports a multi-disciplinary approach to pain management informed by evidence-based practice and research.

Many specialist pain clinicians and NHS managers are involved presently in discussion with local Clinical Commissioning Groups (CCG) with respect to establishment of specialist pain services in their area. This document provides recommendations that are aimed at assisting this process, especially the provision of effective and safe pain services that provide a high quality patient experience and outcome.

Pain Management Services have historically been located in secondary care, but many are now located in the community and have good links with Primary Care or other community services such as musculoskeletal services. Pain Management Services should positively relate to Primary Care to ensure that clarity exists to ensure that assessment is undertaken so that patients in pain are triaged to allow referral to services that are appropriate to their needs.

Population Needs

National/local context and evidence base

Definitions

- Chronic pain is recurrent or persistent pain that persists beyond the usual course of an acute disease or trauma, or occurs in conditions that cannot be treated. It can be considered as a condition in its own right or as a component of other long term conditions.

- Chronic pain encompasses a wide array of conditions, including musculoskeletal, neuropathic, and visceral pain. Cancer pain encompasses any pain in patients with cancer that is caused by the cancer or associated with treatment (e.g. surgery, chemotherapy, radiotherapy) or cancer related debility.

- The recent National Pain Audit identified that patients with persistent pain have a very poor quality of life, on a par with patients with Parkinson's disease or dementia. They also make frequent and multiple demands on other health and social services. Effort must be made to improve services for these people with a non-life threatening condition.

Pain services

Many people with acute, intermittent and chronic pain can be satisfactorily managed by their General Practitioner. However, some patients with persistent pain will need additional assessment and multidisciplinary management either due to the intensity of their pain, significant distress and impact on functioning and substantial co-morbidities.

Specialist or Secondary Care Pain Management Services:
Some patients with persistent pain need management by specialist, interdisciplinary, secondary care Pain Management Services based either in local hospitals or the community. These services will be commissioned by CCGs.

Specialised or Tertiary Care Pain Management Services:
For a small group of adults and children who have refractory disabling pain, specialised tertiary care services will also be required. These highly specialised services for pain management will be commissioned nationally. It is estimated that there will be 6-10 of these centres in the UK. Referral to tertiary services will be subsequent to assessment and treatment in secondary care Pain Management Services.

Incidence and Prevalence
Approximately eight million adults and children in the UK suffer with persistent/chronic pain. European studies assessing health care records of people attending primary care over a one year period have shown that approximately 30% had attended for help with pain. Half of these concerned recurring pain and two thirds were about musculoskeletal conditions. These findings align well with self-reported surveys. Historical studies of the time trends in pain prevalence have highlighted the increase in prevalence of pain. For example, two cross sectional population surveys in the North of England, undertaken 40 years apart, showed a significant rise in musculoskeletal pain. Similarly, a US investigator reported an increase in severe, chronic, disabling back pain from 4% to 10% in surveys conducted between 1992 and 2006.

With an ageing population, increasing obesity and decreasing levels of physical activity, the need for pain management is expected to rise.

Whilst the routine assessment and management of pain is a required competency of all healthcare professionals, as well as being an important component of health care planning, patients with persistent pain often have other substantial co-morbidities e.g. diabetes, arthritis, heart disease, distress, depression and disability. This makes clinical management complex and more difficult.

National policy initiatives

- The Faculty of Pain Medicine of the Royal College of Anaesthetists is the statutory body setting national standards for Pain Medicine. In 2011, the Faculty produced guidance on the provision of services for management of chronic pain. This highlights that 'Multidisciplinary management of patients with chronic pain alleviates pain and suffering, aids functional restoration and reduces the socioeconomic burden of pain for the individual, health care systems and community'. This document describes the staffing and resources required for a high quality, adequately resourced multi-professional Pain Management Service dedicated to (i) the care and support of patients with persistent pain and (ii) the ongoing education and development of staff. http://www.rcoa.ac.uk/document-store/guidance-the-provision-of-anaesthesia-services-chronic-pain-management-2013

- The British Pain Society has produced five pain patient pathway maps using best available evidence for the care of patients with pain in collaboration with Maps of Medicine. They are:
  (i).Primary assessment and management (focused on community care).
  (ii).Spinal pain: low back pain and radicular pain (community and secondary care leading

to specialised care).
(iii). Musculoskeletal, non-inflammatory pain (community and secondary care, leading into specialized care).
(iv). Neuropathic pain (community and secondary care, leading into specialized care).
(v). Pelvic pain in the male and female (community and secondary care, leading into specialised care).
http://www.britishpainsociety.org/members_articles_ppp.htm

- The Pain Summit held in 2011 sets out the key objectives for specialized pain services and pain services nationally. (Chronic Pain Policy Coalition - A report of the Pain Summit 2011. http://www.painsummit.org.uk

Other national policy documents

- General Provision of Anaesthetic Services: Good Practice in Chronic Pain Management. http://www.rcoa.ac.uk/document-store/guidance-the-provision-of-anaesthesia-services-acute-pain-management-2013
- British Pain Society: Acute Pain Management: Scientific Evidence (3rd Edition). http://sydney.edu.au/medicine/pmri/pdf/Acute-pain-management-scientific-evidence-third-edition.pdf
- Faculty of Pain Medicine (2010): Best practice in the management of epidural analgesia in the hospital setting. http://www.rcoa.ac.uk/document-store/best-practice-the-management-of-epidural-analgesia-the-hospital-setting
- British Pain Society (2010): Opioids for persistent pain: Good practice. http://www.britishpainsociety.org/book_opioid_main.pdf
- British Pain Society (2010): Cancer pain management. http://www.britishpainsociety.org/book_cancer_pain.pdf
- British Pain Society (2009): Spinal cord stimulation for the management of pain. http://www.britishpainsociety.org/book_scs_main.pdf
- British Pain Society (2008): Intrathecal drug delivery for the management of pain and Spasticity in adults; recommendations for best clinical practice. http://www.britishpainsociety.org/book_ittd_main.pdf
- British Pain Society (2007) Recommended guidelines for pain management programmes for adults. http://www.britishpainsociety.org/book_pmp_main.pdf
- British Pain Society, Royal College of Psychiatrists, Royal College of GeneralPractitioners and Advisory Council on the Misuse of Drugs (2007) joint guidance: Pain and substance misuse: improving the patient experience. http://www.britishpainsociety.org/book_drug_misuse_main.pdf
- The Assessment of Pain in Older People (2007): Guidance from the British Pain Society. http://britishpainsociety.org/book_pain_older_people.pdf
- British Pain Society: The use of drugs beyond licence in palliative care and pain management. http://www.britishpainsociety.org/book_usingdrugs_main.pdf

Scope

Aims and objectives of service

The aim of the Pain Management Service is to provide patients with persistent disabling pain a timely service that delivers skilled multidisciplinary interventions to reduce or remove the cause(s) of pain and/or to enable patients to manage their pain with psychological and behavioural support that aids functional rehabilitation.

Service objectives:

- Provide a multi-professional patient specific assessment of the patient's pain and put in place an individual management plan.
- Provide appropriate pharmacological management for pain.
- Provide treatment interventions to reduce, eradicate or manage the pain.
- Provide psychological and behavioural interventions that support patients and their carers in managing the pain, enabling patients to lead more normal lives with reduced disability.
- Provide out-patient and in-patient care particularly around the management of pain problems of high medical and psychological complexity, and around the use of controlled drugs.
- Increase social and physical functioning.
- Promote independence and wellbeing for patients through the provision of structured self-management support, with concomitant benefits of fewer inappropriate medical appointments and readmissions.

Service description/care pathway

Pain Management Services are integrated multidisciplinary teams that include specialist doctors, nurses, psychologists, physiotherapists, occupational therapists and pharmacists operating in the community, in local hospitals or in both.

Pain Management Services always involve a Consultant in Pain Medicine. 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 usually obtained the Fellowship of the Faculty of Pain Medicine of the Royal College of Anaesthetists (FFPMRCA). They offer integrated coordinated 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 management. For more information on the specialist pain doctor see http://www.rcoa.ac.uk/document-store/what-pain-medicine-doctor

Pain Medicine specialists work closely with a range of other health care professionals who all possess a high level of expertise in different aspects of management of patients with complex pain. Members of the team work closely together through joint working and clinics and interdisciplinary multidisciplinary team meetings and agree management plans with patients and General Practitioners. This multidisciplinary working is a fundamental requirement for effective patient care.

There should be appropriate provision, accommodation and management/administrative support for all aspects of the service.

Assessment of referrals

- Out-patient or in-patient assessment (where patient is already in hospital) to confirm or make a diagnosis of chronic pain and to agree a management plan with the patient and members of the multidisciplinary team. This may involve patient education and self-management strategies, pharmacological treatments, physical therapies, individual or group psychological techniques and interventional techniques (e.g. neural blockade, coeliac plexus blocks, neuromodulation techniques including spinal cord or peripheral nerve stimulation, spinal infusion pumps).

- Multidisciplinary team meetings.
- Follow-up appointments with therapists.
- Follow-up out-patient appointments to monitor progress.
- Day Case or in-patient interventional procedures.
- Advice and educational resource for patients and their carers.
- Management and rehabilitation by appropriately trained pain specialists for complex pain and pain-associated disability e.g. Pain Management Programmes.
- Advice and educational resource for primary and secondary care health care professionals outside of the team.

There should be resources to support teaching, training, audit, clinical governance and research within the team.

Referral
Patients will be referred by their General Practitioners or by hospital Consultants. Patients referred to the service may include:

- Any patient with persistent or recurrent pain not managed satisfactorily by their General Practitioner.
- Patients with significant distress and functional impairment caused by their persistent pain.
- Patients with analgesic misuse problems or those who take recreational drugs to alleviate pain.
- Patients with pain-related psychological and psychosocial problems (e.g. pain-related fear/ anxiety, reactive depression, inability to function appropriately) that significantly complicate pain symptoms and rehabilitation, impair successful treatment and contribute to a pattern of excessive disability. They cannot be managed without a specific interdisciplinary, cognitive behavioural therapy pain management approach delivered by a comprehensive, interdisciplinary team working in a specialised pain management service.
- Patients who require specific procedures to reduce or eliminate pain symptoms and increase functioning.
- Young people (under 18 years of age) who have significant pain, if the local service accepts children/ adolescents with pain problems. If not, referral to national specialised pain services is needed.
- Patients with cancer who cannot be managed by palliative care without the input of pain medicine specialists.
- 'Cancer survivors' i.e. those patients who have undergone treatment for cancer (e.g. surgery, radiotherapy or chemotherapy) but who now have persistent pain.

If patients do not respond to strategies provided by Secondary Care Pain Services, onward referral to tertiary care Pain Management Services could be considered. If patients are referred onwards to tertiary Pain Management Services, there should be a formal agreement for the provision of ongoing care and follow-up.

Timely access
Currently, there is a national specification for access to general pain services in primary and secondary care of 18 weeks. Commissioning arrangements should ensure that these are met. The International Association for the Study of Pain (IASP) has investigated waiting times for treatment of persistent pain and formulated recommendations . More rapid access is required for those with severe unremitting pain e.g. trigeminal neuralgia, cancer pain, any pain associated with significant distress and disability.

Location
Pain Management Services can be located either in the community, in the secondary care hospital or both. If partially located in the community, there must be clear liaison and interaction between staff working in the community and those working in secondary care to provide the opportunity for multidisciplinary patient discussion, team education, audit/clinical governance, supervision and support.

Pain Management Clinical Staffing
Staffing should include input from:

- Specialised Consultants in Pain Medicine (minimum of 2 because of the need for peer support and cross cover).
- Consultants from other specialties e.g. gynaecology, psychiatry, paediatrics, palliative care as appropriate.
- Specialist pain management nurses.
- Specialist pain management clinical psychologists providing cognitive and behavioural therapy and other psychological interventions, individually or in a group setting.
- Specialist physiotherapy.
- Specialist occupational therapy.
- Access to dedicated pharmacy.
- Specialist paediatric pain management input from appropriate range of health care professionals as needed.

Minimum standards

- These are defined by the Faculty of Pain Medicine, Royal College of Anaesthetists, the International Association for the Study of Pain (IASP) and the British Pain Society.
- Medcial staff must have proven experience and competency in the management of patients with problematic, persistent or recurrent pain. They should be revalidated and appraised with respect to this specialist knowledge and competence.
- Service specific competencies for nursing, psychology and other staff working in the Pain Management Services should be defined and followed as per the recommendations.

Data collection
Activity for pain management is usually recorded under treatment function code 191. This should apply to in-patients, out-patients and pain management programmes and should be used in both secondary and community care settings. There is recent evidence that coding of out-patient as well as in-patient activity is poor in all locations. Urgent attempts should be made to improve this.

Acceptance and exclusion criteria

Acceptance
Patients should be referred to pain management services when their pain has been investigated and either no cause can be found or the cause has been identified and no specific treatment can be offered or accepted, or when specific treatment has failed to relieve the patient of their pain.
Exclusion
Pain Management Services are not always successful in relieving the patient's pain. This may be for a variety of reasons. Whilst it may be helpful to review a previous patient after a period of

time to ensure that no new treatments have been developed, multiple repeated referrals are not necessarily in the patients best interest. In these difficult and complex pain problems, discussion between the GP and the Consultant in Pain Medicine will be helpful. Consideration can then be given for referral to a tertiary care service if appropriate.

Interdependencies with other services

The strategic vision is for chronic pain services to work within a clinical network across primary, community and secondary care.

As this is a service for people with chronic long term conditions, shared care arrangements are a vital part of the care pathway. Services will need to link with other specialists within secondary care e.g. neuro/spinal surgery, rehabilitation, neurology, elderly care, gynaecology, surgery, radiology, gastroenterology, oncology, palliative care, psychiatry. Some services will need to link with paediatrics. There should also be links with other sectors including social services, employment advisors and 'back to work' schemes.

Providers should establish robust protocols with referring clinicians ensuring that the service is able to discharge patients appropriately. It is not envisaged that patients will remain in the secondary service indefinitely - they will move back to Primary Care.

Applicable Service Standards

NICE guidance

- NICE (October 2008): Spinal cord stimulation for chronic pain of neuropathic or Ischaemic origin, NICE Technology Appraisal TA159. http://www.nice.org.uk/guidance/TA159
- NICE (2009): Low back pain: Early management of persistent non-specific low back pain. Clinical guideline 88. http://www.nice.org.uk/cg88
- NICE (2009): Management of long-term sickness and incapacity for work. Public Health Guidance 19. http://guidance.nice.org.uk/PH19
- NICE (2010): Neuropathic pain: The pharmacological management of neuropathic pain in adults in non-specialist settings. Clinical guideline 96. http://www.nice.org.uk/cg96

Department of Health guidance

- Department of Health (2006): The musculoskeletal services framework http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4138412.pdf
- Programme budgeting categories – available at: http://www.dh.gov.uk/health/2012/08/programme-budgeting-data/

Guidance from professional bodies

- Royal College of Anaesthetists (November 2010): Best practice in the management of epidural analgesia in the hospital setting. http://www.rcoa.ac.uk/document-store/best-practice-the-management-of-epidural-analgesia-the-hospital-setting

- Royal College of Anaesthetists (Revised 2011): Guideline for the provision of anaesthetic services. Guidance on chronic pain management, chapter 7. http://www.rcoa.ac.uk/system/files/CSQ-GPAS7-ChronicPain.pdf
- Royal College of Anaesthetists (2012) Raising the standard: a compendium of audit recipes: chronic pain services http://www.rcoa.ac.uk/system/files/CSQ-ARB-2012.pdf
- Royal College of Obstetricians and Gynaecologists: Royal College of Obstetricians and Gynaecologists (2012): Initial management of chronic pelvic pain. Green top guideline No.41. http://www.rcog.org.uk/files/rcog-corp/CPP_GTG2ndEdition230512.pdf
- European Association of Urology (EAU). EAU Chronic Pelvic Pain Guidelines (2012) http://www.uroweb.org/fileadmin/guidelines/2012_Guidelines_large_text_print_total_file.pdf
- International Association for the Study of Pain (2009) 'Desirable characteristics for pain treatment facilities'. http://www.iasp-pain.org/AM/Template.cfm?Section=General_Resource_Links&Template=/CM/HTMLDisplay.cfm&ContentID=3011
- IASP Task Force recommendations on waiting times: www.dgss.org/fileadmin/pdf/Task_Force_on_Wait-Times.pdf
- Royal College of Paediatrics and Child Health:Commissioning Tertiary and Specialised Services for Children and Young People (2004) http://www.longtermventilation.nhs.uk/_Rainbow/Documents/RCPCH_Tertiary%20commissioning.pdf

Key Service Outcomes

Pain Management Services should be routinely collecting data on patient outcomes. Some suggested outcomes are listed below.

Adult clinical outcomes (baseline and 6 months post treatment)

- Brief pain inventory (short form).
- SF-12– Quality of Life measures pain related functional health and wellbeing.
- PHQ-9 – well used measure of depression.
- Employment, educational or training status.
- Patient Global Impression of Change.
- Percentage of patients assessed within 3 months of referral.
- Percentage of patients entering multidisciplinary treatment pathways within 12 weeks following assessment.
- Percentage of patients discharged to primary care (adults) or paediatrician within 12 months of referral.

Clinical Outcome Children/adolescents (baseline and 6 months post treatment)

- PedQL – paediatric quality of life measure.
- Bath Adolescent Pain Questionnaire– change in physical measures and pain related anxiety (ages 11-18).
- School attendance- Baseline % term attendance and 1 year post-treatment % term attendance.
- Parent SF-12.

Patient experience

- NHS Outpatients questionnaire

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