CSPMS

Core Standards for Pain Management Services in the UK

Second Edition

FACULTY OF PAIN MEDICINE of the Royal College of Anaesthetists

2021

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CONTENTS

PREFACE
Dr John Hughes, Dean

Pain will affect us all from time to time but will usually ease over a short period or be easily managed. For some (31–37% of the population), pain becomes persistent or chronic. In approximately half (eight million people in the UK, pain significantly interferes with their function and quality of life. The impact on quality of life is known to be as bad as that seen in patients with significant neurological illness (e.g. Parkinson's disease). A reported 41% of patients attending specialist pain management clinics state that pain prevents them from working. Severe chronic pain is associated with an increased risk of mortality, independent of sociodemographic factors. Persistent pain affects family, carers and work, and places significant demand on both health and social care resources. Managing chronic pain effectively therefore has positive effects at both personal and societal levels, benefiting all.

Pain presents in all areas of society: at home, in the community, in primary care and across all disciplines in secondary care. In many cases this pain should be and is well managed or resolved within those settings. For patients where pain remains a significant issue, management needs to be escalated, with more specialist pain services becoming involved. Referral needs to be timely as persistent pain does not go away but develops and accelerates over time through well-recognised neurophysiological processes.

Pain management is undertaken within a biopsychosocial framework requiring a multidisciplinary approach if the best patient outcomes are to be achieved. This set of standards brings together the whole team and how it interacts. Patients need to be able to see the right person at the right time in the right place and they themselves are an integral part of the process. For this to work, patients need to be able to interact across all levels of care as required (community, primary and secondary) and those levels of care need to work seamlessly together supporting the patient.

This second edition of *Core Standards for Pain Management Services in the UK* (CSPMS) builds on the first edition and takes into account feedback and changes in practice over recent years. Following engagement with the Care Quality Commission, key standards from the first edition have been incorporated in the CQC's inspection framework for all core services This edition continues to be truly multidisciplinary, with representation from patients, the Faculty of Pain Medicine, the British Pain Society, the Royal College of Nursing, the Royal Pharmaceutical Society, the Royal College of Occupational Therapists, the Chartered Society of Physiotherapy, the Royal College of General Practitioners, the British Psychological Society and palliative care medicine.

The principles behind these standards are to provide achievable benchmarks that improve the quality of care in pain management, are consistent geographically from initial presentation to escalating levels of care and across all age groups. These standards are multidisciplinary; that is to say, they apply to all clinical professions including, nursing, physiotherapy, psychology, occupational therapy, pharmacy and medicine (including general practice).

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 easily ignored as it is perceived as non-life threatening 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 issue is not new and has been recognised both nationally and internationally, with published documents promoting the timely management of persistent unresponsive pain through onward referral or joint working between primary, community, secondary and tertiary levels of care. There is an emphasis that specialists in pain medicine should be specifically trained, which in the UK is to the Faculty of Pain Medicine's curricula, assessment and examination, and they must be working within the multidisciplinary context required for pain management to be delivered to a defined standard.

This second edition of the CSPMS 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 should be routine practice and something to be worked towards where they are not currently in place. As pain management evolves so will these standards, in order that they remain a contemporary and relevant resource for the future.

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

It is intended that this work is not only for those working to deliver pain management but is also a reference and framework for those planning or negotiating pain services in the wider sense, particularly health policy planners and commissioners.

Chapter 1

Introduction

INTRODUCTION

Anna Weiss and James Taylor

Welcome to the second edition of *Core Standards for Pain Management Services in the UK* (CSPMS). We hope that this edition will build on the strong foundation established by the first edition. Having consulted you, the readers and contributors, our mission was to refine the document and improve its accessibility and practicality as a source of guidance. This has also been an opportunity to bring standards and recommendations in line with latest evidence and add new and informative content, including an update on the national framework for pain services in England, chapters that reflect an integrated approach linking tiers of care and dedicated chapters that address transitional pain management for young people and safeguarding.

The central aim of CSPMS is to coalesce best practice from across the home nations' heterogeneous pain services into a single reference document that sets benchmarks by which quality of care can be improved, from the first general practitioner (GP) consultation to intervention in a highly specialised pain service. It is hoped that these benchmarks will be used by people with pain, GPs, commissioners, regulatory bodies and pain services to improve access and continuity, champion safety and effectiveness, and direct resources to pathways and therapeutic interventions that offer the best value for money.

The identification of actual or potential hazards with the aim of reducing harm to patients is a basic tenet of clinical governance. Such hazards may be recorded on a risk register, typically divided into different domains allowing the systematic and objective recording of risk. A tool for authors of Faculty guidelines and standards has been developed to aid in identifying relevant risk domains. The intention is that authors identify key domains that would subsequently help Faculty members highlight the significance of non-compliance with Faculty guidelines and standards.

CSPMS is not a textbook or manual for the assessment and management of specific pain conditions. Instead, it is a collaborative document that highlights our multidisciplinary and patient-focused approach to managing all types of pain, in all age groups across all tiers of healthcare. To truly capture this broad and complex landscape and agree standards that will be valued by all stakeholders requires a broad group of respected expert authors and reviewers that mirror the journey of people with pain. We have therefore invited valuable contributions from people with pain, nurses, GPs, physiotherapists, occupational therapists, pharmacists, psychologists, palliative care specialists and pain doctors with broad and diverse subspecialisation. The content of each chapter is based on the best evidence available and is subject to a rigorous review process undertaken by the Professional Standards Committee and the Board of the Faculty and relevant professional bodies to provide you with authoritative guidance.

The COVID-19 pandemic has further delayed the publication of this second edition. The challenges faced by health services during the pandemic and the lessons emerging highlight once more the benefits of sound, pragmatic guidance and common standards for practice. The Faculty and all organisations which contributed to CSPMS responded to the pandemic by publishing timely and supportive guidance.

The standards and recommendations in this document should be seen as the basis for supporting people with pain, regardless of circumstances; while clinical guidelines may change in light of emerging evidence, standards and recommendations are to protect the safety and quality of care people with pain receive.

CONTENT

The second edition of CSPMS is divided into 10 chapters:

- Chapter 1: Introduction
- Chapter 2: Commissioning of services across the UK
- Chapter 3: Description of service and levels of care
- Chapter 4: Physical facilities
- Chapter 5: Pain management services team
- Chapter 6: Patient pathways
- Chapter 7: Pain interventions
- Chapter 8: Education, appraisal and revalidation for medical staff
- Chapter 9: Service improvement, clinical governance and research
- Chapter 10: Safeguarding

PRINCIPLES OF EQUALITY, DIVERSITY AND INCLUSION

Pain management services have the potential to improve the health and wellbeing of the populations they serve. To do this effectively, it is vital that services are inclusive and responsive to all those that seek help and actively search for and address barriers that may impede access and prevent a person with pain achieving maximum benefit. In addition to providing support for those that ask for help, we should

also take steps to meet the needs of those who are more difficult to reach and who engage less readily with health care.

Equality, diversity and inclusion are principles that overarch all the standards and recommendations in this document. Pain management services have a duty to consider how their policies and decisions affect people who are protected under the Equality Act 2010 (the public sector equality duty). The characteristics that are protected in relation to the public sector equality duty are:

- age
- disability
- gender
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sexual orientation.

Pain management services must also be inclusive employers and must ensure that employees and potential employees are not disadvantaged on the grounds of any of the protected characteristics. Under section 159 of the Equality Act 2010, pain management services may also take positive action to address under representation within the workforce by encouragement and enablement of persons with a protect characteristic to:

- overcome a disadvantage
- participate in activity in which their participation is disproportionately low.

PROCESS

For the second edition, we have worked with the authors in the attempt to standardise the format of chapters and quickly guide the reader to the Standards and Recommendation that stakeholders can use to enhance current services and develop new ones to better meet the needs of people with pain.

CSPMS 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, 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 includes the sections Introduction, Standards, Recommendations, Background, References (and Relevant 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 are statements that the authors consider ***should*** be routine practice in UK pain management. For services where Recommendations are not currently met, there should be a clear strategy to meet them as soon as possible.

The material presented in the Recommendations and Standards sections 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 pain they are asked to manage in any person in a particular place at a particular time. The reader should take into account these qualifying comments when applying CSPMS's Standards and Recommendations.

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

CSPMS is here to stay as a central project for the Faculty of Pain Medicine and we are grateful that we could contribute on this occasion. We are committed to making its contents as robust and as relevant as possible for this and future editions.

To help the Faculty to fulfil this goal in the future, we would like to summon your support and collaboration, be it through feedback, authorship or direct involvement with the Professional Standards Committee for the preparation of future editions.

Edited by Dr Anna Weiss ,Dr James Taylor and Dr Robert Searle

Co-ordinated by Mrs Emmy Kato-Clarke and Ms Caitlin McAnulty

Chapter 2

Commissioning of services across the UK

2.1 ENGLAND

Anna Weiss

BACKGROUND

NHS England has decided to put 'high-quality care for all' at the centre of its purpose. Quality means safe, effective care with a positive experience for people with pain. 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 the experience of people with pain, 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 Conditions, the 'House of Care' has been adapted and adopted as a model to support person-centred care.[1]

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 to decommission services that are not seen to be clinically effective. This led to continuing changes to the regulation and provision of services in the NHS, at national, regional and local level.[2]

The structure of NHS organisations much influences the flow of finance and how services are commissioned. The recent need for an emergency response to the COVID-19 pandemic has already changed on how funding is distributed and will reflect in the reshaping of services and how they are delivered.[3]

OPERATIONAL STRUCTURE FOR COMMISSIONING OF SERVICES

The Secretary of State for Health and Social Care

The Secretary of State for Health and Social Care is responsible for the work of his department, with focus on financial control, supervision of NHS delivery, performance and social care policy.[4]

The Department of Health and Social Care

The Department of Health and Social Care (DHSC) is responsible for strategic leadership and shaping, and for the delivery of health and social care policy according to governmental objectives. It no longer manages directly any NHS organisations. The DHSC accounts for delivery of its plans by 'arm's length bodies', offers guardianship of the health and social care framework and intervenes in resolution of complex issues.[5]

The overall management of the COVID-19 pandemic is a prime example of the reach and involvement of the DHSC.

NHS England and NHS Improvement (formerly established as the NHS Commissioning Board in October 2012; both organisations came together in 2019 while maintaining separate boards).

NHS England/Improvement 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, data and information
- assures that clinical commissioning groups (CCGs) are fit for purpose and improve health outcomes
- helps the development of CCGs[6]
- allocates resources to CCGs
- commissions primary care and highly specialist services. In the context of pain management, this is reflected in *Specification 170135S Adult Highly Specialist Pain Management Services* (2019).[7]

The Care Quality Commission

The Care Quality Commission (CQC) is responsible for registration of care providers and for monitoring, inspection and rating of the services they provide, with the overreaching aim of protecting service users.

Regional NHS England and NHS Improvement teams

Regional NHS England and NHS Improvement teams hold regional responsibility for quality, financial and operational performance of care in all NHS organisations in a region. They are moving to close working with sustainability and transformation partnerships (STPs) and integrated care systems (ICS).

Clinical commissioning groups

Primary care trusts (PCTs) used to commission most NHS services and controlled 80% of the NHS budget. On 1 April 2013, PCTs were abolished and replaced with CCGs. CCGs have taken on many of the functions of PCTs and some functions previously undertaken by the

Department of Health.

All GP practices now belong to a CCG. CCGs have multiprofessional membership and formal lay 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 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.

Sustainability and transformation partnerships

STPs are concerned with plans to address the long-term needs of local communities by bringing together local stakeholders (commissioners, providers, local authorities and others); they usually represent the needs of populations of one to three million.

Integrated care systems

In some areas, STPs developed into closer-knit ICS, where individual organisations take on a greater responsibility for local resources and improving the health of the local population. The NHS Long Term Plan states that by 2021 each region of England should be covered by an ICS.[2,8]

Integrated care partnerships

Integrated care partnerships (ICPs) aim at decreasing competition between providers and organisations by encouraging collaboration towards joined-up care delivery. They usually represent populations between 250,000 and 500,000 and include hospitals, community, mental health, GP services and not infrequently social care, third-sector and independent providers. These partnerships may become formalised with the publication of the 'integrated care provider contract'.

Primary care networks

Since 1 July 2019, most GP practices in England have joined up into primary care networks (PCNs) to work closely with local providers of social care, community services and the voluntary sector; this allows for better use of a broad range of professional skills and community services. PCNs usually represent populations of 30,000–50,000.

Health and wellbeing boards

Health and wellbeing boards were established under the Health and Social Care Act 2012 to act as forums for local commissioners across the NHS, social care, public health and other services. Their aims are 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

Public Health England is an executive agency of the DHSC, which provides national leadership and expert services to support public health, and works with local government and the NHS to respond to emergencies. Public Health England:

- coordinates a national public health service and deliver some elements of it
- protects the population from public health hazards
- plans for and responds to public health emergencies
- offers advice and guidance to government, local authorities and the public
- builds an evidence base to support local public health services
- supports the public to make healthier choices and works towards reduction of health inequalities
- provides leadership to the public health delivery system
- supports the development of the public health workforce.

(At the time of writing, it was announced that PHE is to be replaced by a new organisation, the National Institute for Health Protection (NHIP, possibly operational as from October 2021)

Specialist pain management services

Specialist pain management services 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 socioeconomic 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, community and secondary care pain management services are likely to be the preferred model of care in the NHS.

Pain management treatment pathways should be based around evidence-based pathways.[9]

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 commissioners.[9]

The Royal College of General Practitioners, in conjunction with the Faculty, the British Pain Society, the Chronic Pain Policy Coalition and individual professional and lay advisers, has previously published a document to help engagement and enhance discussions between healthcare professionals and commissioners when designing pain management services.[10]

Highly specialist pain management services

NHS England is directly responsible for commissioning prescribed specialised services with the aim of ensuring that services, for those individuals that require specialised care, are of a high quality and consistent across England[7]

The scope of the services considered as specialised is being reviewed on a regular basis. Specialised pain management services were defined in 2013 by *Service Specification D08*.12 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 input from people with pain and carers. This is an advisory group that reports to the Programme of Care Board and hence to NHS England.

Service Specification D08 clearly defined the groups of people with pain, the interventions and the characteristics of those services that are considered specialised and the roles of local area team commissioners to ensure that those services were commissioned.[12]

The NHS England *Service Specification 170135S, Adult Highly Specialist Pain Services* was published in 2019, replacing D08.7,12 It offers clarity on organisational responsibilities of delivery of pain management and preconditions for onwards referral (see Figure 1).

Most people with pain will be managed by local community and specialist pain management services. Only a small, but significant number will be referred to highly specialist pain management centres. The current number of highly specialist pain management centres meeting the service specification remains small.

As well as defining specialised services, the CRG-SPS was responsible for drawing up policy around complex and specialised interventions. The policies in 2015 were: intrathecal drug delivery devices for cancer pain, and occipital nerve stimulation for chronic migraine and cluster headache.

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.

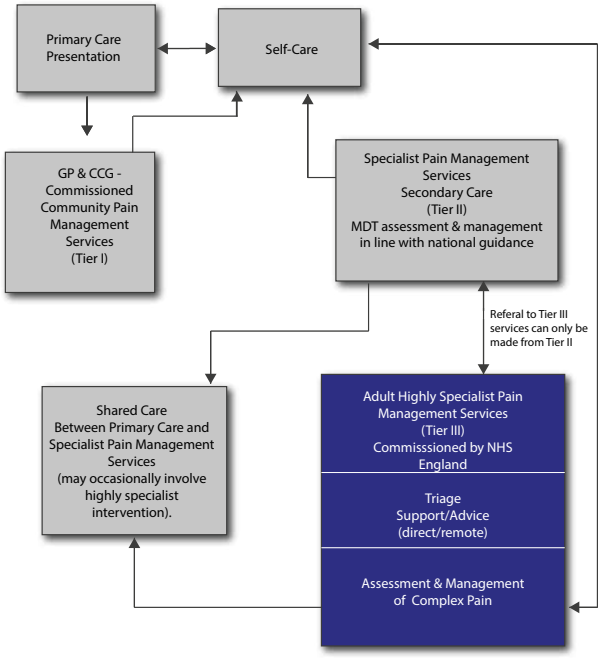

FIGURE 1: NHS England Care Pathway Illustration

Reproduced from NHS England Service Specification 170135S. Adult Highly Specialist Pain Management Services. 2019.

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2.2 WALES

Sonia Pierce

BACKGROUND

In Wales, there are seven local health boards, which are statutory bodies responsible for the planning and delivery of healthcare to their resident populations. Additionally, there are three all-Wales trusts with responsibilities for ambulance services, cancer care and public health. There are no clinical commissioning groups in Wales. Each local health board plans and provides its own services, contracting for some provision externally.

Healthcare planning In Wales

In 2018, the Welsh Government released a strategy document A Healthier Wales: Our plan for health and social care.[1] It aims to build on the philosophy of prudent healthcare and the social model of care, and on the close and effective relationships in Wales, to make an impact on health and wellbeing throughout life. There will be a greater emphasis on preventing illness, on supporting people to manage their own health and wellbeing, and on enabling people to live independently for as long as they can, supported by new technologies and by integrated health and social care services which are delivered closer to home.

Living with persistent pain in Wales

In 2008, the Welsh Government published the Designed for People with Chronic Conditions, Chronic Non-Malignant Pain directive.[2,3] This directive committed the NHS in Wales to an evidence-based multidisciplinary service provision, underpinned by national and professional standards, which were required to address the needs of the people in 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 the introduction of new approaches to health care, in 2019 the Welsh Government, clinical and academic partners and service users collaborated to produce guidance on persistent pain provisions entitled Living with Persistent Pain in Wales.[4] This guidance provides advice to health and social care professionals as well as those experiencing persistent pain and their families.

Following this, local health boards are being audited and held to account on their compliance with the directive, to help ensure improved standards of care for persistent pain management.

Operational structure for commissioning of services

All NHS organisations in Wales have developed integrated medium-term plans (IMTPs), used to outline priorities and methods of improvement.[5] These plans reflect the strategic and legislative landscape within Wales. Each plan aims to demonstrate an organisation delivers high-quality, prudent health services that meet both the priorities and ambition of the government and the needs of their populations. The National IMTP brings together the 15 organisational plans within the NHS in Wales, providing assurance on the direction for NHS Wales as a whole. The National IMTP takes stock of where NHS organisations are in delivering key ministerial priorities, acknowledging good practice seen. The National IMTP complements the NHS Planning Framework.

The NHS Planning Framework in Wales provides specific guidance for NHS bodies in the development of IMTPs, including priority areas and additional guidance from national programmes and new policy requirements. This document applies to health boards, trusts, Health Education and Improvement Wales, and supporting organisations. IMTPs must demonstrate that organisations are delivering a healthier Wales through a seamless health and social care system which is tangibly equitable. The NHS in Wales is also committed to developing an NHS executive. This new function will bring together national planning, delivery and performance management activities. This work is currently under development.

GPs in Wales are actively involved in the commissioning cycle through GP cluster-led planning, providing feedback on service design to the seven local health boards across Wales. Delivery of the primary care model for Wales, providing reform of national primary care contracts and cluster-level IMTPs offer significant opportunities to accelerate progress, introduce new approaches and influence wider system planning.[6] Health-board IMTPs must demonstrate how they have been shaped and informed by cluster-level IMTPs, setting out how services can be delivered as close to home as possible.

Specialised services in Wales are planned and commissioned by the Welsh Health Specialised Services Committee, on which the seven chief executives of the local health boards sit.[7] 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 Board. WHSCC 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 cooperation and engagement with local partners. For secondary care and primary care services this is particularly important in relation to the health, social care and wellbeing strategies, children and young people's plans and older persons' plans.

Prudent and value-based healthcare

The principles of 'prudent healthcare' were described by the Bevan Commission in 2013 and were endorsed by the Welsh government to help deliver a more sustainable and person-centred health service.[8,9] Prudent healthcare is about clinical culture and decision making in co-production with the public. It describes the distinctive way of shaping the Welsh NHS to ensure that it always adds value, contributes to improved outcomes and is sustainable.

The principles of prudent healthcare are:

1. Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production
2. Care for those with the greatest health need first, making the most effective use of all skills and resources
3. Do only what is needed, no more, no less; and do no harm.
4. Reduce inappropriate variation using evidence-based practices consistently and transparently.

The application of 'value-based healthcare' is increasingly being seen in Wales as a way of delivering the prudent healthcare principles in a measurable way.[10] It requires a healthcare system to become truly data-driven, to improve clinical outcomes and inform the allocation of resources for the greatest positive impact on individuals and the people of Wales. High value does not have to mean high cost; simple things done consistently often provide the highest value, so value-based healthcare approaches may be the simpler ways of achieving the same outcomes, built around the hopes and wishes of each person affected.

For persistent/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 used 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 local health boards, 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 people but they tend to be those with 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.
- Local health boards will have an important role in this context. The commissioning of services should take into account the NHS commissioning guidance and should seek support from WHSCC.
- Consider collaborative working with the All-Wales Medicines Strategies Group and primary and secondary care pharmacists to ensure the development and availability of appropriate prescribing guidance for a majority of chronic pain conditions 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 pathways for access to self-management.

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2.3 SCOTLAND

Blair Smith and Paul Cameron

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 eight special (non-geographical) health boards include Healthcare Improvement Scotland, Public Health Scotland and National Services Scotland, who have particularly contributed to improvement of pain management services.

Successive reports1–3 had identified the patchiness of pain management services provision and organisation across the country. The Getting to GRIPS with Chronic Pain in Scotland: Getting relevant information on pain services report4 led to the adoption of chronic pain by the Scottish government as a long-term condition in 2008, with appointment of a national lead clinician for chronic pain and the establishment of a national chronic pain steering group. This group had representation from clinical, management, service user, third sector, and policy-making bodies.

Since then, there has been considerable progress in facilitating the provision and availability of evidence-based multidisciplinary pain management, while efforts to surmount the challenges of access and resources continue.

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.

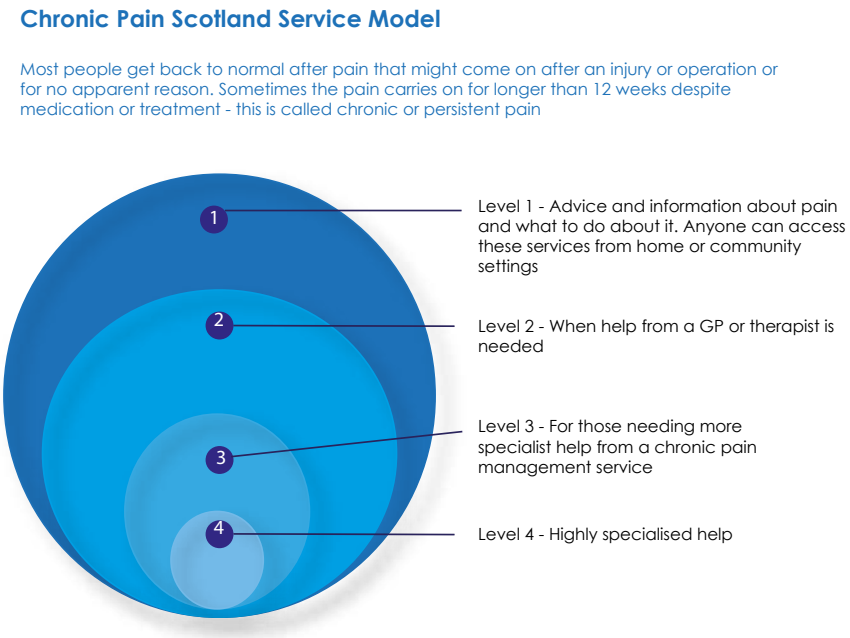

Figure 1: Scottish Service Model for Chronic Pain. Adapted from: NHS Scotland. *Future provision of specialist residential chronic pain management services in Scotland: consultation report*. 2014.

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Scottish Intercollegiate Guideline Network

The Scottish Intercollegiate Guideline Network (SIGN) guideline on the management of chronic pain was published in December 2013.[5] This guideline provides a comprehensive and systematic review of evidence relating to pain management in non-specialist settings, with clear recommendations for practice. It has been used as the basis for service provision and development across Scotland. The opioids section was updated in 2019, to reflect new evidence on use and harms associated with opioids.

Data collection exercise

An initial stocktake of pain management services had been undertaken in 2011.[6] A further data collection exercise, *Chronic Pain Services in Scotland: Where are we now?* was published in April 2014.[7] Although this report was able to collect detailed information, the majority was from secondary and tertiary services (levels 3 and 4 of the service model). A further report was commissioned in 2018 by the Scottish Public Health Network, examining the status of pain services in Scotland in levels 1–4, making specific recommendations for changes at all levels for service improvement and reduction in regional variation.[8]

Subsequent developments

- The Scottish Pain Research Community was established in 2009 as a formal network of researchers and clinicians to develop expertise in pain research for patient benefit. This structure was adopted by NHS Research Scotland.[9]
- A Scottish National Residential Chronic Pain Management Programme was opened in 2015.[10]
- The National Chronic Pain Prescribing Strategy was published in 2018, with an evolving series of supporting materials.[11]
- Chronic pain services were reviewed by the Government's Scottish Access Collaborative,[12] to guide changes required to meet the needs of patients and the service. This has led to chronic pain being adopted by the Modernising Patient Pathways Programme, and the appointment of a clinical lead for primary care and a National GP advisor for chronic pain.
- Pain medicines (opioids, gabapentinoids) are now included and monitored as national therapeutic indicators by Public Health Scotland,13 and agreed as indicators for the second edition of the Scottish Atlas of Healthcare Variation.[14]
- A validated core minimum dataset has been agreed to collect information about patients attending pain services in Scotland.[15] This will allow easy identification of baseline, comparison between services and over time, and monitoring of services improvement. It is being implemented in specialist services by Public Health Scotland, with a view to rolling out to level 2 services in due course.

Sustaining improvement

NHS boards are directly accountable to the Scottish Government for chronic pain services. A ministerial steering group was established in 2014, chaired by the minister for public health. This group evolved into the National Advisory Committee for Chronic Pain in 2017, chaired first by the deputy chief medical officer and then by the deputy national clinical director, to provide a permanent oversight group, based in the Scottish Government. This will be supported by a patient reference group, currently in formation. Recently, intensive work has focused on service provision and redesign in the context of COVID-19-related restrictions, including a framework for recovery of pain management services, championed by the cabinet secretary for health and sport.[16]

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2.4 NORTHERN IRELAND

Pamela Frances Bell and Christine McMaster

BACKGROUND

Organisational context

Health and social care services in Northern Ireland are administered together. The Department of Health has strategic responsibility for the shape of health and social care delivery, which is informed by priorities for government set by the Northern Ireland Office. It sets the commissioning direction and identifies priorities for service development and investment.

The Health and Social Care Board (HSCB)and the Public Health Agency develop an annual joint commissioning plan that reflects this strategic direction and, based on this, all health and social care trusts develop their trust delivery plans. There are six of these trusts, five of which provide health and social care services to the population, while the sixth is the Norther Ireland Ambulance Service.

Voluntary organisations and charities contribute significantly to advocacy for and delivery of improved pain management services in Northern Ireland, as well as supporting education and training of patients, carers, practitioners and researchers. Included here are Versus Arthritis, Action Mental Health, the Northern Ireland Pain Society and the Pain Alliance Northern Ireland.

Strategic background

The 20-year strategic vision for health and personal social services was initially outlined in A Healthier Future (2005).1 While long-term pain was not mentioned specifically, the document supported chronic condition management programmes. In the same year, in a report on a chronic pain workshop, the Department of Health's forerunner suggested that chronic pain should be seen as an entity in its own right.

In 2011, *Transforming Your Care*[2] set out an overarching roadmap for reshaping the provision of health and social care services to ensure safe, resilient and sustainable services. It put the individual at the centre of its model, supported population-based planning of services, emphasised the importance of prevention and tackling inequalities and promoted independence and personalisation of care.

The Patient and Client Council's 2014 report *The Painful Truth*,[3] a survey of the lived experience of people who live with chronic pain and their carers, made 10 recommendation to the minister for health for improvement. Seven were accepted and, significantly, chronic pain was recognised as a long-term condition to be added to the remit of the *Long Term Conditions Framework* (see *Living with Long Term Conditions – A Policy Framework*).[4]

In 2016, integrated care partnerships, which are collaborative networks of care providers (doctors, nurses, pharmacists, social workers, hospital specialists, other healthcare professionals and the voluntary and community sectors, as well as service users and carers) that design, coordinate and improve local health and social care services, added pain management to their list of priorities.

Health and social care commissioning, funding and delivery

Owing to its geographical size and population of less than two million, specialist services are usually organised on a Northern Ireland-wide basis but, to date, the specialist services commissioning function has not played a large role in the development of chronic pain management services, despite there being provision of some specialist interventional pain procedures (e.g. spinal cord stimulation - SCS) in some health and social care trusts. These trusts recently formed a network to quality assure the services they provide.

There are also inpatient facilities for neurosurgical procedures for pain relief at the Northern Ireland Centre for Neurosciences in Belfast. An unfunded Northern Irish child and adolescent pain service exists there also, as do limited inpatient and outreach services from tertiary child and adolescent clinical specialties such as rheumatology, but most patients, including children and young people requiring complex tertiary interventional procedures, inpatient pain management programmes or rehabilitative services, are sent abroad (usually to Great Britain) as extra contractual referrals for inpatient medical, surgical and rehabilitative treatment.

The HSCB and Public Health Agency, in response to the ***Painful Truth*** report, undertook a review of pain management services in 2014, and set up the Northern Ireland Pain Forum to inform the development of a five-year strategic development and improvement plan. This is based on a tiered step up and down long-term conditions service model and centred on supported self-management. Due to Department of Health-mandated and HSCB-led elective care reform since 2017, this plan has gone through multiple iterations and was part funded in 2018/19 and 2019/20 with transformation monies following the confidence and supply agreement between the Democratic Unionist Party and the minority conservative British government. This has temporarily addressed some gaps in health and social care trust pain management services, but inequity of access for people with pain and long waiting lists remain, and the funding remains non-recurrent.

In Northern Ireland, general practices and community pharmacies are managed by the HSCB's Directorate of Integrated Care. There are 17 GP federations coterminous with the integrated care partnerships created in 2014, and most of these actively contribute to improving pain management services in primary and community care. They are recurrently funded by the Department of Health.

Since 2017, the HSCB has made available annual non-recurrent funding for a growing number of community centre-based pain support

groups for several hundred people with pain from deprived areas. Early indications are that these have exceptionally high uptake and retention rates, as well as resulting in significantly improved wellbeing for most participants.

Voluntary agencies are also funded on an annual basis by the HSCB and health and social care trusts to offer self-management programmes to people with long-term illnesses including chronic pain.

The Public Health Authority, through the Northern Ireland Pain Forum, has improved information materials and pathways for people with pain and practitioners. Following an innovative participatory hackathon in 2017, supported by the Department of Finance Innovation Lab, there has been a social media campaign under the auspices of the Digital Transformation Services MyNI pilot in 2018 and a current Small Business Research Initiative since 2019 to develop digital solutions for improved pain management practice among people with pain, carers and professionals.

The way forward

The effectiveness of existing processes, as described above, suffered while the Northern Ireland Assembly was in abeyance, and the role and configuration of health and social care organisations is evolving under the direction of a newly re-established health ministry, albeit at a slower pace than anticipated because of the COVID-19 pandemic.

As a result of financial uncertainty, the future of pain management services in Northern Ireland remains uncertain, but Northern Ireland Pain Forum members, who include statutory and non-statutory providers and users of pain management services, continue to evolve the concept of supported pain self-management.

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Chapter 3

Description of service and level of care

*Please note the Chronic Pain Scotland service mode contains 4 with levels 1 & 2 reflecting advice and information, and community services (GP or therapist). Level 3 relates to specialist help from a chronic pain management service and level 4 highly specialised help

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

Cathy Price

INTRODUCTION

Specialist pain services aim to diagnose and manage pain disorders of varying complexity 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] Complex pain is a definition that attempts to move from describing pain in terms of chronology or causality, such as acute, chronic or cancer pain. It puts emphasis on the risk or morbidity associated with pain. However, acute, chronic and cancer pain are terms that continue to be commonly used. It is notable that individuals experiencing acute, chronic or cancer pain may find their condition manageable and may not require the support of healthcare professionals.

The Chief Medical Officer for England in 2011 suggested that chronic pain should become a 'high street disease' with rapid access to advice from specialists and generally greater understanding of chronic pain by healthcare professionals.[2] Given the prevalence of chronic pain in the population, it is important that the right people reach that specialist advice to avoid services becoming overwhelmed.

A population health needs assessment is an objective and valid method of tailoring health services.[3] Some would suggest that it should include an element of prioritisation, as need will almost always outstrip supply. This chapter reviews what is known about the health needs of those attending specialist pain clinics, placing this in context of the health needs of the general chronic pain population, and suggests standards to support meeting those needs.

STANDARDS

1. Pain services must ensure joined-up care with services in primary and secondary care.
2. Pain services must work with accident and emergency departments to ensure that there is adequate information for those who attend with chronic pain.
3. Pain services must ensure that information on waiting times is easily accessible to referrers and people with pain.

RECOMMENDATIONS

1. Pain services should form a pain network to enable people with pain to be channelled to the most appropriate advice in relation to their need.[4]
2. Pain services should ensure that there is early access to psychological care.
3. Pain services should ensure adequate access to employment advice and support.
4. Pain services should ensure that they receive the resources they require to give access to those people with pain most likely to benefit.

BACKGROUND

Epidemiological studies demonstrate that the profile of someone attending a specialist pain clinic is likely to be that of moderate to severe pain, multimorbidity, poor mental wellbeing and with significant psychosocial factors impeding recovery.

The Faculty of Pain Medicine has published the incidence of chronic pain as 31–37% of the population.[5] The Health Survey for England reported that the vast majority of the population with chronic pain (70% of men, 68% of women) report little interference with their quality of life. However, those with more severe pain also reported multimorbidity and generally poor health, including mental health.6 Just over 50% of people with more severe pain were more likely to have attended a specialist pain clinic (61% of men and 54% of women).

In Scotland, a 2014 report on pain services highlighted that people with chronic pain lacked access to basic information and allied health professionals.[7] In 2014, the Patient and Client Council in Northern Ireland identified gaps in care provision for people with chronic pain; personal stories from people with chronic pain described patchy and fragmented provision of pain management services and a desire for better recognition of chronic pain.[8]

Published in 2018, the HUNT study in Norway found that there was only an 8% chance of recovery from chronic pain if moderate to severe pain was present.[9] Pain severity, widespread pain, pain catastrophising, depression and sleep were significant predictors of future moderate to severe chronic pain, both among subjects with and without chronic pain at baseline.

The epidemiology and health needs of people attending specialist pain services in the UK remain poorly understood. Attempts to characterise those being seen are hampered by coding materials that are not helpful, difficulty in data collection and lack of prolonged follow-up.

Population needs of those attending pain clinics in England and Wales have been studied via the National Pain Audit[10] and in Scotland through the Scottish Parliament's report: *Chronic Pain Services: Where are we now?*.[7] Their findings were very similar:

- Specialist pain services are delivering care to people with a very poor quality of life: a median of 0.31 and 0.35 on the EQ-5D time trade-off adjusted score compared with a population norm of 0.8 in Scotland and 0.64 in England (different versions of the EQ-5D were used).
- 65% were women with a median age of 54–56 years.
- 8% of respondents were severely distressed and disabled. In Scotland, there was a lack of evidence that these people with pain were referred to tertiary specialised pain services.
- 20% of respondents in England reported visiting accident and emergency departments in the past six months in search of help, all of whom had seen their GP about the same problem.
- 34% had difficulty remaining in work.
- In England, many reported at the six-month stage that they had yet to receive any promised treatment.
- In Scotland, people with pain highlighted that they had had chronic pain for a long time before being referred and there was a perception of staff shortages.
- The difficulty in understanding the nature of persistent pain and accepting its very persistence is a significant problem, with about 50% of the population attending pain clinics in England still as puzzled 12 months into treatment as at the start.
- There is a lack of access to psychological care at an early stage.

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3.2 ACCESS TO PAIN MANAGEMENT SERVICES

John Hughes

INTRODUCTION

Chronic pain is commonly seen within the general population. For the majority of people with pain, effective pain management can be delivered in the community, in general practice or in secondary care by the speciality involved in managing their underlying condition.

More complex pain requires the involvement of specialist pain management services. These services are multidisciplinary and interdisciplinary. They include consultants and other grades of doctor trained in pain medicine, nurses, psychologists, physiotherapists, occupational therapists and pharmacists. Some elements of specialist pain services are also multispecialty, involving, for example, gynaecologists, palliative care, neurosurgeons, psychiatrists and gastroenterologists.

Specialist pain services see and assess a broad range of people with complex pain. They may refer people with pain on to highly specialist pain management services (see Chapter 3.5). Units providing highly specialist pain management services will commonly provide specialist pain services as well.

Specialist pain management services may be located in the community and/or secondary care hospitals and need to work seamlessly with primary and community care and highly specialist pain services to provide an integrated care pathway. Referral will normally be from the GP, hospital consultant or senior members of their healthcare professional teams.

The delivery of the care pathway for people with pain is distinct in each of the four nations of the UK. This is determined by the responsibility of each national government for the provision of healthcare and resulting differences in the organisation of service provision and commissioning. For a minority of people with pain, highly specialist pain services may be required; these are delivered within networks, often overreaching national boundaries.[1]

The International Association for the Study of Pain Task Force on Wait-Times has produced recommendations for waiting times.[2] These are as follows:

- acute painful conditions: immediately
- painful severe condition with the risk of deterioration or chronicity: most urgent – within one week
- severe undiagnosed or progressive pain with the risk of increasing functional impairment, generally of six months duration or less: urgent or semi-urgent – within one month
- all other chronic pain conditions: routine or regular – within eight weeks.

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

i. no cause will have been found, or
ii. the cause will have been identified but no specific treatment can be offered/is acceptable, or
iii. treatments have failed to relieve the pain.[3]

STANDARDS

1. National standards for access to pain management services must be met, irrespective of whether the service is situated in the community or in a hospital setting.[4]
2. Highly specialist pain management services must fulfil all the referral standards set out in the Highly Specialist Pain Management Service Specification.[1]

RECOMMENDATIONS

1. All pain management services should fulfil the pain standards set out in national guidance documents, such as those published by the National Institute for Health and Care Excellence and the Faculty of Pain Medicine.
2. People who should be referred to specialist pain services:
    i. People with chronic or recurrent pain not adequately manageddespite of primary care support.
    ii. People where referral is recommended by national guidelines.
    iii. People whose pain is causing significant distress or functional impairment.
    iv. People with analgesic misuse problems or who are taking recreational drugs/alcohol for pain relief. It is recommended that referral in this context is in collaboration with addiction services.
    v. People with pain-related psychological and psychosocial problems (e.g. pain-related fear, anxiety, reactive depression, functional impairment) that complicate their pain symptoms or rehabilitation.

vi. People requiring specific procedures as part of a pain management plan aimed at improving function and quality of life.

vii. Children and young people (under 18 years) with significant pain requiring referral to nationally recognised specialised services.

viii. People with cancer who may benefit from joint management with palliative care.

ix. 'Cancer survivors'; that is, people with cancer who have undergone treatment (e.g. surgery, chemotherapy or radiotherapy) but who have chronic pain.

x. People not responding to specialist pain service input should be considered for onward referral to a highly specialist pain management centre or network.

BACKGROUND

Pain is common within the community. Treatment and management should not be denied to people with pain or their families.[5] Chronic pain conditions comprise 5 of the 10 top-ranking conditions for years lived with disability in 2017.[6]

Many people with pain can effectively manage their pain at home or within primary care services. People with more complex pain presentation, or those not improving, often benefit from specialist pain management services. These services need to be integrated, with the person having timely access to the level of support they require (primary, specialist, highly specialist pain services) along a care pathway working across commissioning boundaries acting as a whole.

The NHS Atlas of Variation demonstrated inequality of services both nationally and locally.6 Further to this inequality, there is no consistency in waiting times for patients to access the help they need,[7] leading to significant variations in care and outcomes. A model of service specification is therefore required, linking the levels of service required across geographical areas and focusing on needs and outcomes of people with pain[7]

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3.3 PAIN MANAGEMENT SERVICES IN THE COMMUNITY (TIER 1)

Christopher Barker and Neil Collighan

INTRODUCTION

Community pain management services (tier 1) usually operate externally to secondary or tertiary care. Their scope of practice is defined by local commissioners and, as such, their function may vary widely across localities. A person's need, available clinical expertise, commissioning preferences and often geographical factors all feature in service design and delivery.

The Royal College of General Practitioners has produced guidance for clinical commissioning groups that describes 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 to allow for unhindered movement of people with pain between tiers of care when their complexity requires it. 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 of services and activities to support self-management.

STANDARDS

1. No sole practitioner acting in isolation, whatever their profession, can claim to run a pain management clinic or service.
2. Commissioners of pain management services in the community must ensure that there are appropriate clinical pathways that integrate primary, community, specialist and specialised care.
3. Pain management services in the community must have an agreed scope of practice (such as clearly defined inclusion and exclusion criteria, guidelines on the level of care and a directory of services). Individual services must be specific on their inclusion and exclusion referral criteria and have mechanisms to direct people with pain to the most appropriate care.
4. Safe delivery of all clinical services demands that they are commissioned to include medical involvement within the care pathway. The scope and place of medical involvement must be clearly defined for each pain management service, including routes of accountability.
5. Commissioners and service providers must jointly define the levels of accountability for all health professionals in the service.
6. Clear pathways of care must be in place to support safe escalation and de-escalation of complexity of care. This may include crossing care sectors from primary into specialist and highly specialist care and back.
7. All pain management services in the community must have a formal governance structure.
8. Pain management services in the community must be appropriately staffed to enable the delivery of care within their defined scope of practice.
9. Annual appraisal must be in place for all healthcare professionals, performed according to specific guidance applicable to each profession.
10. Appropriate management support must be in place to facilitate the delivery of care and quality improvement; this includes support for monitoring and auditing outcomes.

RECOMMENDATIONS

1. People with pain should be risk assessed at an early stage and referred to specialist pain management services to improve outcome.
2. Staff within the community pain management service should be appropriately trained in pain management to fulfil their role within the service.
3. Doctors in community pain management services should maintain generalist diagnostic skills and experience in the management of pain and long-term conditions.
4. All clinicians working in community-based pain management services should have a clear scope of practice.
5. Clinicians should have suitable and appropriate supervision and mentorship, in keeping with the recommendations for their particular professions.
6. Pain management services in the community should link with non-healthcare services when appropriate, including the voluntary sector. Such links should work to enhance self-management and the promotion of living well with a long-term condition.

BACKGROUND

Some community pain management services offer full multiprofessional diagnostic and treatment options, including pain management programmes and minor interventions. Others may more simply offer the delivery of rehabilitative strategies with appropriate links and

support from specialists.

Many community-based pain management services follow an outreach model from secondary care; there are also established services that originate in the community. Community pain management services can offer improved accessibility, such as pain management programmes in local gyms or team assessments and interventions delivered in GP surgeries or community hospitals. In keeping with good practice for all clinical services, pain management services in the community aim for people with pain to be seen within the appropriate care pathways by the appropriate personnel in a clinically safe, effective and cost-efficient way.

The skills necessary for safe and effective delivery of a community pain management service will be dictated by the service specification and scope of practice. Professional regulatory processes ensure that clinicians from any care sector (community, secondary or tertiary) operate within scope in an appropriately governed structure.

Pain management services delivered in the community may contribute to a wider pain management provision, as intended through the Any Qualified Provider scheme. All such services must adhere to NHS standards of care. The CSPMS provides standards and recommendations for pain management services in any setting, to secure equality of care independent of the specific characteristics of individual service design.

An individual journey of a person with pain 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 organisations.

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 assessment of people with pain, 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.

Clinical pathways should be in place to ensure safety and the appropriate level of clinical care for the individual person. This will allow escalation and de-escalation of care dependent upon need.[3]

A collaborative approach to commissioning of pain management services in the community considers views and includes input from all stakeholders, including service users, acknowledging the wider local and regional pain management service commissioning needs.

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For NHS England and NHS Scotland service diagrams refer to Chapter 2.1 England and Chapter 2.3 Scotland

3.4 SPECIALIST PAIN MANAGEMENT SERVICES (TIER 2)

Jonathan McGhie and Sonia Pierce

INTRODUCTION

Specialist pain management services (tier 2 services) involve a multidisciplinary and often multispecialty approach to managing pain.[1,2] Onward referral to this level of pain management is appropriate when tier 1 (primary care and community services) treatment options have failed, there has been an inadequate response to non-specialist strategies or there is a need for greater psychological input, drug management or interventional therapies to manage the pain.[2,6] Tier 2 services are commissioned by CCGs and can be delivered in primary care, community or secondary care settings depending on local infrastructure. Staff and facilities should generally be co-located and, for larger geographical areas, a hub-and-spoke model may be a better use of resources than several isolated, smaller centres.

Outcomes from tier 2 services include:

- discharge to tier 1 (community or primary care led) pain management services
- referral to tier 3 pain management services for highly specialist care or NHS commissioned pain treatments and interventions3
- referral to outpatient or residential pain management programmes at a local or regional level.

STANDARDS

1. Tier 2 services must be staffed by at least two consultants who have successfully completed advanced pain medicine training or hold credential equivalence, as defined by the Faculty of Pain Medicine of the Royal College of Anaesthetists.
2. Tier 2 services must include input from nursing, physiotherapy, occupational therapy, pharmacy and psychology (see Chapter 5).
3. Time for multidisciplinary meetings and discussion must be allocated within the job-plan/contract of all staff working in a tier 2 service.
4. All staff must keep their pain management skills and knowledge up-to-date and evidence this through appraisal or revalidation processes (see Chapters 8.3 and 8.4).
5. Input from other specialists (e.g. psychiatry, palliative medicine, surgical and medical specialities, gynaecology, paediatrics, neurology and rehabilitation medicine) must be available.
6. Tier 2 services must demonstrate engagement with clinical governance, audit, training and education at local and national levels in accordance with best practice.

RECOMMENDATIONS

1. Where geographical demands require practitioners to work in isolation or within a hub-and-spoke model, there should be local arrangements in place to support and maintain standards across all aspects of the tier 2 service.
2. Tier 2 services should be available and accessible in every health region for adults with complex pain problems.
3. Tier 2 services should bridge tiers 1 and 3 services to ensure that care is optimised and that discharge or onward referral occurs in a timely fashion.
4. Tier 2 services 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 tier 2 service should reflect the needs of people with pain and range of treatments used.
6. The tier 2 service should be led clinically by a healthcare professional with expertise in pain management who has achieved advanced competencies in pain medicine (such as those defined by the Faculty of Pain Medicine for doctors, or equivalent standards produced for other healthcare professionals by their respective governing bodies).
7. Tier 2 services should have access to self-management strategies for managing pain that are appropriate to their patient demographics. If the service does not run its own pain management programme, it should have referral pathways to a regional outpatient or inpatient programme.
8. Tier 2 services should offer or have referral pathways to centres that provide spinal cord stimulation, intrathecal drug delivery and paediatric pain management, as appropriate to the needs of the person with pain.
9. Tier 2 services should ensure that through efficient workforce planning they have sufficient resources to meet the needs of their patients now and in the future.[4]

BACKGROUND

While the majority of pain conditions can be satisfactorily treated at a community level or within primary care, it is recognised that more complex pain conditions require a multidisciplinary framework to be successfully managed.[3,6] Where simple medications have failed, pain is severe and impacting on physical functioning, or when there is a need for focused pain psychological therapies, people with pain should be referred to a tier 2 service.[1,2,6]

These services encompass the necessary co-located medical, nursing, psychology, physiotherapy, pharmacy and occupational therapy knowledge and skills to best address the biopsychosocial demands of a person with a painful condition. The personnel staffing the tier 2 service should have time set in their job plans for multidisciplinary communication and discussion. There should be administrative support, outpatient clinics and day-surgery theatre facilities to accommodate the volume of people with pain and breadth of interventions. It is expected that the service will have closely established links to other local medical specialities and regional tertiary services as necessary.[3,5]

In addition to managing a clinical workload, tier 2 services should be participating in local and national audit work, adhering to local governance structures and following best practice guidance. It is expected that tier 2 services would participate in and promote pain education and teaching programmes locally and regionally.

If the service is recognised for medical training by the deanery, there should be a Faculty Tutor in Pain Medicine (previously: local pain medicine educational supervisor) for the service, who reports to a regional advisor in pain medicine regionally, to ensure that the training programme adheres to standards laid down by the Faculty of Pain Medicine.

Tier 2 services should undertake workforce planning to ensure that they have sufficient resources to meet the needs of their patients now and in the future. Engagement in national pain medicine census work, national pain audits and regional planning groups is expected to identify and mitigate shortfalls in staffing or resources.[4]

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For NHS England and NHS Scotland service diagrams refer to Chapter 2.1 England and Chapter 2.3 Scotland

3.5 HIGHLY SPECIALIST PAIN MANAGEMENT SERVICES (TIER 3)

Dr Natasha Curran and Dr John Hughes

INTRODUCTION

NHS England recently published a service specification for adult highly specialist pain management services (tier 3).[1] While there are significant overlaps in relation to young people and the transition from children's services, there is a separate specification for paediatric chronic pain.[2] NHS Scotland reported on pain3 and has national clinical guidelines,[4] but, of the UK nations, only England has an adult highly specialist specification. In practice, Scotland, Wales and Northern Ireland often refer people with pain to highly specialist services in England, but could adopt NHS England's specification, with each nation acting as a network.

STANDARDS

1. Tier 3 services or networks must keep up to date with and adhere to the NHS England Service Specification 170135S or NHS England Service Specification E2b for children and those aged less than 18 years.
2. Tier 3 services or networks must keep up to date with and adhere to minimum standards as published by NHS England, the Royal College of Anaesthetists, the Faculty of Pain Medicine, the British Pain Society and the International Association for Study of Pain.[5–7]
3. Tier 3 services or networks must be in a position to see those with severe unremitting pain in a timely manner according to clinical need. Certain conditions, such as trigeminal neuralgia, cancer pain or other pain associated conditions with significant distress and disability will require an urgent referral and consultation.[7] The service must comply with national targets in relation to referral to treatment targets.
4. Tier 3 services or networks must be multidisciplinary and must include physicians, psychologists, physiotherapists, specialist nurses and occupational therapists, with access to others such as pharmacists. There must be at least two persons able to provide any specific aspect of care.[1]
5. There must be appropriate accommodation, support (e.g. information technology) and administration support for the tier 3 team.
6. Members of the team must work closely together through joint clinics and multidisciplinary team meetings to agree management plans with people with pain and GPs.[1,6]
7. Tier 3 services or networks must cover the needs of the person with pain as a whole and, as a consequence, multiple specialists should be a part of the team. Members of a multispecialty pain team should be determined by the needs of the people for whom services are designed. There should be joint clinics and patient-focused meetings. Such specialists may be neurosurgeons, neurologists, gynaecologists, urologists, rheumatologists, oncologists and other specialists.[1]
8. Tier 3 services or networks must be able to provide a whole pathway of care for the pain condition(s) in which they specialise. This would include complex interventions that may be physical and/or cognitive behavioural, as well as assessment, investigation and non-complex interventions.[1]
9. Providers of tier 3 services must establish robust protocols with referring clinicians to ensure people with pain are assessed and discharged appropriately to the referring team (responsible for providing continuing support), GP or self-care.[1,6]
10. Tier 3 services or networks must collect data in accordance with the quality standards specific to the service, as described in NHS England's Service Specification for Adult Highly Specialist Pain Management Services 170135S (or NHS England Service Specification E2b for children and those aged less than 18 years).[1,2]
11. With the knowledge and involvement of local pain management services, clear pathways must be in place for people with pain who are referred to tier 3 services from other specialties.[1]

RECOMMENDATIONS

1. Tier 3 services should be delivered as part of a networked service model.[1]
2. Referrals to adult tier 3 services for assessment and treatment should be made in line with NHS England's Service Specification for Adult Highly Specialist Pain Management Services 170135S.[1]
3. Together with patient participation in the planning of their care, MDT meetings should be conducted as a vital component of assessment, review and long-term pain management, with the expectation that people with pain will ultimately be discharged back to the referring centre.[1]
4. In the case of those people with pain requiring review in the longer term, a formal plan should be in place to ensure that people with pain are assessed every six months in relation to their requirement to remain under the care of the tier 3 service.
5. Tier 3 services should provide advice to, and liaison with, the referring specialist pain management centre (tier 2). Advice and support may be given without taking over the care of the person with pain from the referring service.

6. In accordance with relevant specialised commissioning policies relating to device implantation, tier 3 services should have immediate access to specialised neuroscience services.
7. Waiting times should be in accordance with the standards defined by the International Association for the Study of Pain.[6,7]
8. All children and young people under the age of 18 years who require support with their pain management should be referred to a specialist pain management service. NHS England Service Specification E2b defines specialised services for pain management for children and young people.[2] The specification notes that 'Chronic pain services will not be present in every children's specialist centre and therefore highly specialist chronic pain services will need to work within a network of care with arrangements for advice and referral'.[2]
9. It is expected that tier 3 services or networks will be involved in research and appropriate national and international pain management committee activities and strategy (including guidelines groups). Such services/networks 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

With the knowledge and involvement of tier 2 or specialist pain management services, clear pathways must be in place for people with pain who are referred to highly specialist pain management services from other specialities, including:

- palliative care and cancer services
- gynaecology and urogynaecology
- paediatrics
- rheumatology
- spinal injuries
- neurosciences.

Tier 3 services should be delivered as part of a networked service model by multidisciplinary teams working in tertiary settings to manage people with pain where locally commissioned pain services have not achieved adequate symptom control. This includes the tertiary level management of condition-specific presentations, as well as complex cases of a more generic nature. Interventions include pain-specific psychological interventions, inpatient care, complex medicines optimisation and rehabilitation. People with pain may be treated either within a single tertiary setting or via a networked approach with adjacent providers.

Nationally there should be an appropriate and adequate number of highly specialist pain management services/networks. The number should ensure equity and excellence for people with complex pain and pain-associated disability where ever they live in the UK. It is suggested that in England there should be at least one adult highly specialist pain management service in each region, and that Scotland, Wales and Northern Ireland each develop such a network

Tier 3 services need to work in a network arrangement with tier 2 local specialist pain management services to deliver integrated pathways of care for people with pain and services that meet the needs of local populations.[1]

Referrals to tier 3 services for assessment and treatment will be primarily for the following reasons:[1]

- a second opinion when requested by a specialist pain management consultant in secondary care (tier 2)
- specific multidisciplinary assessment and management of people with pain who have a realistic potential for improvement, but who have not responded to treatment or interventions provided by specialist pain management services in secondary care (tier 2)
- neuromodulation where specialised clinical commissioning policies govern access to treatment
- inpatient drug optimisation (including opioid management programmes)
- when a consultant pain physician discharges a child and/or adolescent patient as part of a specific transitional care arrangement
- when pain management forms part of a specialised pathway associated with another condition
- cordotomy for specific cancer pain (this is considered a highly specialist service and should only be undertaken in a minimal number of centres that have the relevant level of expertise and have a contract with NHS England Specialised Commissioning to deliver the service)
- access to specialised joint clinics (interdisciplinary and/or with other specialties) in line with the associated pain conditions being treated
- review and MDT assessment of people with pain receiving long-term treatment, which should include device implantation when part of a highly specialist pain management episode.

The standards and recommendations reflect the work done by the NHS England Clinical Reference Group for Specialised Pain 2016–2019 in updating the previous D07 original specification.1 While comprehensive, the D07 specification left many centres unable to become a highly specialist service (as they perhaps lacked provision of one element). It is hoped that the new specification will result in

clarity of commissioning for highly specialist pain services and, importantly, those specialist pain management services (tier 2) that must be locally commissioned.

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For NHS England and NHS Scotland service diagrams refer to Chapter 2.1 England and Chapter 2.3 Scotland

3.6 INPATIENT PAIN SERVICES

Mark Rockett, Chandran Jepegnanam, Sailesh Mishra

The scope of inpatient pain services (IPS) includes acute post-surgical pain management, acute pain management in medical patients and acute exacerbations of chronic pain. It is recognised, however, that some services continue to provide only postoperative pain management for surgical patients with acute pain. The scope of the IPS should reflect the roles and experience of the team and the case mix referred.

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 persistent post-surgical pain.1 The development of persistent pain following surgery is relatively common and is associated with a high prevalence of psychological illness, loss of income and increased use of healthcare services.[1,2]

People with complex pain problems require care delivered by IPS teams with their specific set of clinical skills. The aspiration of the IPS model is to coordinate interdisciplinary working to provide reliable management plans and transition to care in the community, aimed at reducing the impact of acute and chronic pain on people with pain and the services they use.[3]

Ideally, IPS will be involved in a person's care at every stage of the surgical pathway. Preoperative risk assessment for acute and persistent post-surgical pain is becoming a part of the surgical care pathway.[4] The preparation of perioperative analgesic plans for people with complex pain, guidance on analgesic techniques which minimise the use of opioids with their associated complications,[5] and education on strategies that reduce the likelihood of persistent post-surgical pain6 are examples of the contribution to pre- and perioperative care of the IPS. The IPS may be involved in follow-up and monitoring of opioid use after discharge, providing a transitional link with outpatient chronic pain services.[7]

The shift away from extended post-surgical inpatient care to daycase and enhanced recovery surgery and the management of complex pain in are the present challenges for many IPS. Provision of adequate analgesia after discharge is key in preventing people with pain re-presenting to primary, secondary and emergency care services. Prevention of inappropriate prolonged opioid use or opioid misuse disorder after discharge from hospital needs to be considered with IPS published guidance on step-down analgesia.[7,8]

The rising age of the surgical population has resulted in an increase in the number of olderpeople with pain with severe medical comorbidities presenting for major elective and emergency surgery. These high-risk patients require high levels of postoperative support, including complex, high-quality analgesia, which mandates the presence of an effective IPS with close links to critical care services.[9,10]

STANDARDS

1. Inpatient pain teams must be led by or include named consultant(s) and staff-grade, associate specialist and specialty (SAS) doctors who have the appropriate knowledge base, training and competencies, which they continue to maintain through continuing professional development, and who are appraised annually.[2,11]
2. Inpatient pain teams must be supported by an adequate number of appropriately trained inpatient pain consultants. The minimum training requirement for consultants should be Royal College of Anaesthetists higher pain training or equivalent.
3. Adequate time for inpatient pain management must be reflected in consultants' and SAS doctor's job plans.
4. An appropriately trained consultant or SAS doctor must be available for advice for every inpatient pain ward round.
5. An appropriately trained consultant must be physically present for at least one inpatient ward round per week. This requirement may be higher where inpatient pain teams have wider roles or a more complex case mix, such as major trauma centres.
6. Clinical nurse specialists must be the nursing leaders of the IPS, participating and leading audit, training, incident reporting, research and service development.
7. Adequate numbers of nurses and skill mix must be available during working hours.
8. 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 IPS 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.
9. All hospital specialties must be able to refer people with pain to the IPS for assessment.
10. People with pain under the care of an IPS must be reviewed by the service regularly, people receiving epidural analgesia or other continuous local anaesthetic infusions being seen at least once daily.
11. There must be development and maintenance of systems for the regular assessment and recording of acute and acute-on-chronic pain scores as well as relevant functional assessment.[12]
12. Pain assessment:
    - Assessment tools must be standardised and available in an appropriate range of languages for adults, children and vulnerable individuals, such as, people with dementia and people with learning difficulties.

- Functional progress must be assessed in parallel to pain. This forms the basis of a functional pain assessment where good progress with rehabilitation with adequate pain relief is the goal, rather than attempting to remove all pain.[13]

13. 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 IPS when appropriate.
14. Easily accessible protocols or guidelines must be produced to maximise the efficacy and safety of analgesic techniques. These must include guidelines for the management of common adverse effects of analgesic techniques, 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.
15. The IPS 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.
16. The IPS must be able to provide specialist pain management for complex pain problems, such as acute neuropathic pain, opioid tolerance, acute-on-chronic pain or people with problem drug use or acute cancer pain where appropriate.
17. The IPS must provide advanced methods of pain relief to facilitate the recovery of people following major surgery or trauma, appropriate to the level of care required in individual hospitals (e.g. regional analgesia for patients with blunt chest trauma requires close co-operation with emergency departments, surgical teams and critical care).
18. The IPS must have access to non-pharmacological therapies for the support of people with pain.
19. The IPS must communicate clearly and in a timely fashion with other healthcare teams responsible for the shared care of people with acute pain.
20. The IPS must prepare and disseminate information, education and resources for people with pain and ideally primary care practitioners.
21. The IPS must work in collaboration with local medical equipment management and procurement services to ensure an adequate supply of safe equipment.
22. The IPS must work in collaboration with pharmacy and medicines management groups to maintain safe and effective use of analgesia and development of new analgesic strategies as required.
23. The IPS must audit and evaluate the effectiveness of acute pain management, complications, incident reporting and staff training.[10] This should be in a setting of continuous quality improvement of acute pain management and can be delivered by either medical or nursing members of the IPS.

RECOMMENDATIONS

1. A minimum of two clinical sessions per week is recommended for IPS leads and one session for other consultants or SAS doctors delivering inpatient pain management.
2. An inpatient pain consultant should be physically present for every consultant-led ward round in a teaching and direct clinical care (DCC) role.
3. It is recommended that those appointed as leads for IPS should have completed advanced pain training.
4. Clinical nurse specialists in pain management should be able to prescribe independently.
5. The IPS should work closely with the psychology team and consider the formal involvement of pain psychologists in the direct care of people with pain supported by the IPS.
6. The IPS should work closely with the physiotherapy team.
7. 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.
8. 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.
9. Access to outpatient follow-up by appropriately trained staff should be available for people with pain:
   - discharged from hospital on high-dose opioids (> 100 mg oral morphine equivalent per day) to support dose reduction as acute pain subsides
   - whose acute pain is not improving and who may be transitioning to a persistent pain state
   - with acute pain conditions where early intervention has been shown to be beneficial (e.g. complex regional pain syndrome)
   - whose hospital admission is related to an exacerbation of a chronic pain condition.
10. All pain management services within an institution should be under a unified management and governance structure.
11. There should be provision of support for research in inpatient pain.

BACKGROUND

The IPS comprises a multidisciplinary team including nurses specialised in pain management and appropriately trained acute pain consultants. A national audit in 2014 revealed that these services are poorly resourced in the majority of NHS hospitals in the UK. The recommendations and standards in this document are to ensure the provision of an optimal inpatient pain service for all hospital inpatients, as recommended in the Chief Medical Officer's report of 2009.[14]

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 been carried out on an increasingly olderpatient population with multiple medical comorbidities.[5,10] Peoples' expectations of surgical outcome and pain relief are high, and it is a challenge to meet these expectations with limited IPS 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 programmes where the expectation is for early mobilisation and accelerated discharge from hospital. Complex enhanced recovery care bundles have led to the increasing use of advanced pain management techniques, such as continuous regional analgesia, requiring the support of an effective IPS. The most effective analgesic techniques for each surgical procedure continue to be the subject of research and innovation.[15]

In addition to the role of the IPS 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 use.[8] 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 inpatient pain service is expanding in many NHS hospitals. Preoperative prediction of those at risk of severe acute pain and/or developing persistent post-surgical pain is possible, and is becoming part of preoperative assessment.[4,16] The potential for preoperative optimisation of pain management, both in terms of analgesic drugs and pain-coping strategies, is being evaluated.[17] Psychological therapies are increasingly recognised as playing an important role in the management of inpatient pain. It is recommended that the IPS develops this aspect of their service. As further evidence becomes available, it is likely it will become a standard in the future.[18]

Some centres are now combining the IPS 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 IPS, 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 need.[19] Many inpatient pain services now provide support for these patient groups.

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3.7 OUTCOMES

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INTRODUCTION

All services are expected to measure and publish outcomes.[1] The benefits of this practice have been demonstrated in diverse areas such as cancer care, joint replacement surgery, wound healing and diabetes.[2] However, government-sponsored reviews of specialist pain services have highlighted the lack of information on the patient population, treatment offered and outcomes.[3,4] Evaluating outcomes in routine clinical practice is a worthwhile challenge for specialist pain clinics because of the complexity of interventions provided and the multidimensional presentation of people consulting for chronic pain.[5]

STANDARDS

1. All pain management services must collect information on waiting times to first appointment and treatment.
2. A pain management service must collect patient-reported outcome measures (PROMs) over a wide range of domains.[1,6,7]
3. A pain management service must report all clinical incidents for further investigations.
4. A pain management service must collect information on the patient experience. As a minimum a pain service must collect and publish Friends and Family Test data.

RECOMMENDATIONS

1. Services should ensure that all diagnoses and treatments are accurately coded to represent clearly the complexity of the people with pain they are treating.
2. PROMs data should be entered using web-based systems.
3. PROMs data should be submitted to a central repository for benchmarking (e.g. the National Neuromodulation Registry).
4. Pain management services should carry out a detailed annual survey on patient's experience of the service (e.g. Consultation and Relational Empathy Measure, CARE).
5. Pain management services should collect data related to safety including complication rates and serious incidents (such as those reported to NHS Improvement, the Serious Incident Framework (SIF) or the Patient Safety Incident Response Framework - PSIRF).

BACKGROUND

The UK government is clear that measuring and publishing information on health outcomes helps to drive improvements to the quality of care that people with pain receive.1 The Department of Health and Social Care in England has focused on introducing and collecting outcome indicators in five main domains:

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

While 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 and Social Care in England. The CQC Key Pain Management Standards, derived from the inaugural edition of CSPMS, are key quality standards against which services are assessed.[7,8]

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 to recover from episodes of ill health and ensure that people have a positive experience of care. For chronic pain services, research is clear that the health and wellbeing of people with pain deteriorate while they are waiting for treatment.[9] This has led IASP to give specific recommendations for waiting times for people with pain.[10]

In the UK, the NHS constitution confirms a person's right to begin consultant led treatment within a maximum of 18 weeks from referral.[11] 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 people with pain in a timely manner may be influenced by other performance indicators such as new patient to follow-up patient ratios. 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 care.[12] 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, accident and emergency departments and maternity services, and is an opportunity for people to provide feedback on services and care. 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 CARE measure.[13] A large, freely accessible database of CARE results allows national comparison and benchmarking.[14] In addition to this, Trentman et al have devised a patient experience of care specifically for chronic pain.[15]

Protecting people with pain from harm and treating them in a safe environment is another key outcome domain. NHS Improvement (formerly the National Patient Safety Agency),[16] the Serious Incident Framework[17] and the forthcoming Patient Safety Incident Response Framework,[18] represent reporting systems in the NHS. Additionally, some areas of practice are considered to be more risky (e.g. treating people with significant mental health disorders who may be at risk of suicide or prescribing long-term opioids for pain). Protocols need to be in place for any area of practice where safety is a concern.

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 PROMs for certain planned treatments.[1,6,7] Pain-related treatments are not included in the list of conditions requiring PROMs data but, in common with other specialties, PROMs collection is recommended and is becoming the norm.[19] There is a consensus on which PROMs should be collected in clinical practice,[7] with broad support from the clinical community.[20] The type of outcome measure used will vary according to what outcome is being evaluated, although any measure used should have been properly validated such that the strengths and weaknesses of the measure are understood. Ideally, all PROMs would be submitted to a central database, such as happens with the Electronic Persistent Pain Outcomes Collaboration in Australia,[21] to allow comparison.

The collection of comprehensive and accurate data, such as coding of diagnoses and treatments, allows for national benchmarking as well as meaningful analysis of outcomes and trends.

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Chapter 4

Physical facilities

4.1 CONSULTATION/ASSESSMENT FACILITIES

Lorraine de Gray, Andrew Nicolaou and Rishi Khanna

INTRODUCTION

Appropriate facilities for a multidisciplinary pain management service are essential for the delivery of high-quality care for people with pain.[1–9] A requirement of any initial assessment will include taking a history and, if required, a comprehensive examination.

It is widely acknowledged as best practice that a true multidisciplinary environment is offered to support people with chronic pain. Multiprofessional clinics as well as group sessions are common practice and facilities should cater for these needs.

These guidelines apply to delivery of outpatient pain management services wherever they are situated. Recent challenges to service delivery as a consequence of the COVID-19 pandemic have highlighted the conditions of an environment conducive to a good assessment of a person with pain, including resilient modes of communication, including telephone access and availability of video consultations, challenges to effective communication where translation or interpreting is required and concerns for maintaining confidentiality in remote consultations. Adequate secretarial, information technology (IT) and administrative support for this work is essential. The provision of up-to-date patient notes and records is imperative.

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

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

STANDARDS

General physical facilities

1. The entrance and reception must be well signed, accessible, comfortable and welcoming. Access to the premises and facilities within must comply with the Equality Act 2010.[7–9,10]
2. The environment must facilitate the completion of screening tools and questionnaires, with assistance available.[5,11]

Consultation/examination room

1. Access to consultation and examination facilities must be available for all patients.
2. Patients must be enabled to participate fully in their consultation and care. This must include provision for factors such as physical or learning disabilities, sight, speech or hearing problems and difficulties with reading, understanding or speaking English, including face-to-face and distant interpretation services[1,7–9]
3. Reliable means of communication (telephone access, video conferencing facilities, corresponding interpretative technology) must be available for remote consultations.
4. There must be immediate access to patient records and investigations.
5. Electronic or physical patient records must be stored and viewed securely in line with local and national information governance policies and regulations.[13,15]
6. A chaperone must be available, as per guidelines on chaperone and examination issued by the General Medical Council.[11]
7. The set-up of the clinical area must be tailored to the preservation of patient privacy, modesty and dignity, including consideration of the acoustics of the space.
8. DHSC guidance should be applied regarding room area and plans/configurations of setup for the purposes of consulting and examination. The space and layout of the room(s) must be adequate and fit for purpose for the needs of the patient, their escort and the healthcare professionals in the multidisciplinary team.[7–9]
9. The clinical area must allow full compliance with infection control policies, including access to hand washing and personal protective equipment, as well as adequate storage and waste facilities.[7–9,14]
10. Adequate workstation/desk space and communications/IT provision must be provided.
11. The necessary equipment to examine patients must be available, including examination couch (preferably electric), adequate seating and examination tools.[7–9]

RECOMMENDATIONS

General physical facilities

1. Patients should be kept informed with regards to the running of the clinic, including the personnel providing treatment and potential delays.[5,7]
2. Patient information materials and resources should be available.[5,7]

3. Reception staff should be understanding of the nature of pain medicine services and its patients.
4. Reception staff should be able to help with enquiries and outpatient bookings, as well as with the collection of any outcome data, where necessary.

Consultation/examination room

1. If required, accommodation should be of sufficient size to allow for multiprofessional clinics and group sessions.[7–9,12]
2. Good communication between pain service personnel and others is important. Communication should be mindful of patient confidentiality[15] This may be aided by the provision of telephone points and email access or by other arrangements, such as close physical proximity.[7–9,12]
3. Where children and young people are seen within a non-specialist paediatric pain clinic, consideration should be given to ensuring that the environment is suitable for their emotional and physical needs.[11,12, ,16, 17]
4. Heating and ventilation for the clinical area should be effective.[7–9]

BACKGROUND

Pain management clinics cater for a diverse group of patients with respect to age, morbidity and disability. Many patients may suffer from anxiety and depression because of their long-term pain and have negative previous experiences of the health system. 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 for each which need to be catered for. Frequently, patients are seen by more than one professional or in a group setting.[1–5]

An important aspect of the delivery of pain services is supporting people with pain to understand their situation and role in self-management to achieve the goal of living well 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 conducive to their pain management needs. The DHSC has published guidance on clinical facilities. This includes advice on matters such as accessibility for disabled patients, toilets, refreshments and car parking facilities. Measures to protect a person's privacy, modesty and dignity are a priority. The use of screens and covers/hospital gowns is an example of how this may be achieved if there is a need to dress/undress.[7–9]

The consultation and examination room may be a combined single room or separate rooms. The determinants of actual room size and set-up will be based on local needs and policy, within the context of available space and resources.[7–9]

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4.2 FACILITIES, EQUIPMENT AND MONITORING FOR DELIVERY OF THERAPIES

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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 in an inpatient and daycase setting. Safe delivery requires the appropriate facilities and equipment, in accordance with best-practice recommendations.[1]

Pain management clinicians, their managers and commissioners should ensure that people with pain are supported in the most appropriate environment.[2]

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 occurs.3
2. The management and use of medical devices and equipment must be by designated staff who have been appropriately trained.
3. Policies and equipment must be in place to protect patients and staff from cross-infection, including safe disposal of sharps and availability of necessary sterile equipment.4–9
4. Facilities for standard monitoring of physiological parameters must be provided.10
5. Full resuscitation equipment and drugs must be provided as specified by up-to-date resuscitation guidelines and hospital policy. This includes immediate access to drugs to facilitate intubation and treatment of local anaesthetic toxicity.
6. All healthcare staff must have up-to-date basic life support training.11
7. In the context of invasive interventions, at least one member of staff with at least intermediate life support training must be immediately available,12 ideally in addition to the person delivering the intervention.
8. Staff and facilities must be appropriately prepared and ready to deal with all patients and interventions booked on any one list. This includes ensuring that services are accessible.6
9. All staff must be compliant with the use of the WHO Safety Checklist.13–15 We recommend that the Faculty of Pain medicine checklist for pain procedures under local anaesthetics and sedation is used.5
10. To comply with the '5 Steps to Safer Surgery', teams must perform a pre-list team brief and a post-list debrief.13–15
11. Where general anaesthesia or sedation is required for insertion of the neuromodulation device, it must be provided by an additional trained anaesthetist and not by the operator inserting the neuromodulation device.2,16
12. Each day-surgery unit must have a fully equipped recovery area which should conform to the guidelines of the Royal College of Anaesthetists (RCoA), DHSC and Association of Anaesthetists of Great Britain and Ireland (AAGBI) for design and equipment.6 It must be staffed by recovery personnel trained to defined standards.12

    a. Patients who undergo pain intervention procedures under sedation or general anaesthesia must be transferred to an immediate recovery area until such a time when they are awake, can safely protect their airway and are haemodynamically stable. Transfer may then occur to a secondary ambulatory recovery area.

    b. Patients who undergo complex pain intervention procedures (e.g. implantation of devices, sympathetic blocks, neurolytic blocks) must be transferred to an immediate recovery area until such a time when they are haemodynamically stable. Transfer may then occur to a secondary ambulatory recovery area.

    c. Patients who undergo pain intervention procedures while fully awake may be transferred directly to a secondary ambulatory recovery area. This area must provide essential close and continued supervision of such patients, to ensure prompt management in the eventuality of an unexpected complication such as haemodynamic instability, inadvertent spread of neuraxial local anaesthetic or delayed anaphylaxis.

    d. For all patients undergoing procedures which have the potential to temporarily or permanently cause loss of sensation and/or weakness of part of the body, patients must be monitored in such a way as to prevent inadvertent harm due to pressure or weight bearing.
13. All anaesthetic and monitoring equipment must comply with standards set by the RCoA and AAGBI.10 Patients' physiological parameters must be adequately monitored throughout intervention procedures. National Early Warning Score charts or similar may be used to record periprocedure parameters.
14. The anaesthetic room and operating theatre must conform to DHSC building standards (or equivalent standards for the devolved nations),[17–19] including standards on airflow, filtration, surface finishes and ceiling height.
15. All organisations and staff using ionising radiation must conform to Ionising Radiation (Medical Exposure) Regulations (IRMER).[20]

16. 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 must be checked by the operator before use.[8]
17. All members of teams providing neuromodulation must be suitably trained and experienced in the particular part of the assessment and procedure they undertake, and must operate within their scope of practice and competency.
18. There must be access to inpatient beds in the event of perioperative complications.
19. Written discharge criteria based on nationally agreed standards and recommendations must be available.[21] Discharge may be delegated to nursing staff as part of a criteria led discharge protocol. If a patient does not satisfy the agreed discharge criteria, they must be reviewed by the pain clinician.
20. A contact telephone number for specialist advice must be supplied so that every patient knows whom to contact in case of postoperative complications.
21. Units providing additional modalities (e.g. acupuncture, TENS) must have policies in place to guide as to indications, contraindications and guidelines for their safe use (e.g. standards set by recognised bodies, such as the British Medical Acupuncture Society, the Acupuncture Association of Chartered Physiotherapists and the British Acupuncture Council).[22]
22. Physicians performing interventions should adhere to the standards recommended in Chapter 7.3: Interventional Techniques in Pain Management.
23. All pain services that use interventional techniques must have access to appropriate imaging equipment including fluoroscopy and, where appropriate, ultrasound (e.g. for peripheral nerve identification).

RECOMMENDATIONS

1. All pain services should follow best practice regarding storage and retrieval of images.

BACKGROUND

Pain intervention techniques are a commonly practised part of pain medicine in many pain services. Whenever they are part of a service, appropriate patient selection and delivery of procedures to high standards are mandatory.

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 facilities to result in a safe, welcoming and not intimidating environment. The design should cater for the requirements of the Equality Act 2010, while also adhering to manual handling regulations and all the other standards listed below.

Compliance with the Faculty of Pain Medicine safety checklist for pain procedures under local anaesthetics and sedation, 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 patients.[9]

The following ancillary anaesthetic equipment and drugs must 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.

The majority of pain interventions are carried out using fluoroscopic guidance. It is important that all staff involved in fluoroscopic interventions comply with IRMER.[20] IRMER aim to protect patients from harm when exposed to ionising radiation by:

- minimising unintended, excessive or incorrect medical exposures
- justifying each exposure to ensure the benefits outweigh the risks
- optimising diagnostic doses to keep them 'as low as reasonably practicable' for their intended use.

The National Safety Standards for Invasive Procedures and national safety programmes that follow the '5 Steps to Safer Surgery' apply to the provision of all invasive procedures.[13–15] A team brief is integral to this safe approach and will include up-to-date, clear and complete information about the patients and their planned procedure/operation, with explicit reference to site, side and the medication required. The list order is confirmed during the team brief and if any changes occur, these must be clearly communicated and documented.

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Chapter 5

Pain management services team

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

Peter Paisley and James Taylor

INTRODUCTION

Pain is a biopsychosocial experience. The International Association for the Study of Pain (IASP) emphasises that pain assessment and treatment should be multidisciplinary, involving appropriate specialists as needed, to ensure optimal management of all biomedical and psychological aspects of pain problems.[1]

A multidisciplinary team (MDT) approach to pain management ensures that all facets of the pain experience are given equal importance. It also provides superior communication and the sharing of ideas, knowledge and experience, improving continuity of care and clinical governance.

Definitions

- Multidisciplinary: defined as a service that involves several members from various health care professional backgrounds, such as medicine, nursing, physiotherapy, occupational therapy, psychology, pharmacy, play therapy.
- Interdisciplinary: defined as collaboration of team members to integrate various disciplinary perspectives and maintain a network of cooperation and communication to produce a coherent and harmonised outcome for a person with pain.[2,3]
- Multispecialty: defined as close collaboration and liaison between several medical specialities (for example, gynaecology, psychiatry, neurology, paediatrics) in assessing and managing a specific person and delivered usually in joint clinics.
- Multiprofessional: defined as working with other professionals from the same specialty.

CHRONIC PAIN

STANDARDS

1. The MDT must be multiprofessional and must include medical consultants trained in chronic pain medicine, nurses, physiotherapists, psychologists and colleagues from one or more of pharmacy, occupational therapy and general practice (GPs with a special interest).
2. No 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 their remote location must maintain formal links with colleagues/peers.
4. It may be necessary to bring a team together from primary and secondary care to provide for the components of the patient pathway, enhancing continuity of care and building cooperation.
5. The MDT must communicate on a frequent and scheduled basis about patients, procedures, policy and therapies to deliver care, which is coordinated, patient centred, evidence based and safe.
6. Resources must be available in terms of space and time for regular team meetings.
7. The multidisciplinary and multispecialty team must have adequate administrative support. Clinical governance requires continuing audit and data collection.
8. The MDT must communicate effectively with the patient's GP.
9. Members of the MDT must engage with the delivery of teaching and training for clinicians of multiple disciplines, to improve pain management locally and regionally.
10. Highly specialist pain management services (tier 3) in a tertiary centre must always have available input from multispecialty and multidisciplinary teams.

RECOMMENDATIONS

1. Specialist pain management services (tier 2) in community and secondary care should always involve an MDT; how the MDT is delivered may vary according to local factors (e.g. in remote/rural areas).
2. Pain management services should adapt the makeup of the MDT to accommodate the local requirements of all groups of people with pain, including children, adolescents, older peopleand those with complex needs.
3. The MDT should seek formal arrangements for inclusion of all members to ensure that dedicated time is available outside other service or contractual obligations.
4. All members of the multidisciplinary and multispecialty teams should participate in audit and outcome data collection and engage in continuous quality improvement.

INPATIENT SERVICES

STANDARDS

1. Inpatient pain services (IPS) must be staffed by MDTs led by appropriately trained consultant or SAS anaesthetists.
2. Close links with pharmacy services must be in place to ensure safe and appropriate prescribing of analgesics.
3. The IPS must aim to provide multidisciplinary assessment and management of pain where needed. This will involve collaborative working with pharmacists, physiotherapists, psychologists, liaison psychiatrists and addiction medicine specialists.

RECOMMENDATIONS

1. Outpatient (chronic) pain management teams should be available to provide advice to the IPS during working hours. This activity should be supported through job planning. If possible, the inpatient and outpatient (chronic) pain services should be integrated, with team members working in both environments to ensure coordinated care for people with complex pain while in hospital and also for those recently discharged to the community.
2. Clear lines of communication and close working with other services such as surgical and medical colleagues, outpatient (chronic) pain, palliative care, emergency medicine and primary care should be in place.
3. All members of the multidisciplinary and multispecialty teams should participate in audit and outcome data collection and engage in continuous quality improvement.

BACKGROUND

People with chronic pain commonly experience depression, sleep disturbance, fatigue and decreased overall physical and mental functioning. They frequently require an interdisciplinary model of care to allow care givers to address the multiple components of the person's pain experience.[4]

Chronic pain is often characterised by a background level of pain with intermittent 'flare ups' or exacerbations of pain. The MDT forms the framework for reducing symptom severity and reducing the severity and frequency of flare-ups.[5]

A multidisciplinary model has been shown to be superior to single discipline therapy in terms of not only pain levels but also mood and behavioural variables such as return to work or use of the healthcare system.[6]

The Scientific Committee of the National Pain Audit considered that a physiotherapist, psychologist and physician were key personnel. This was agreed on the basis that treatment with the strongest evidence base is, first, interdisciplinary cognitive behavioural therapy requiring confirmation of diagnosis and management of distress and disability due to chronic pain and, second, prescription of medication for the treatment of musculoskeletal pain and neuropathic pain.[7] IASP in their guidance for pain services, also recommend a physician, physical therapist and a mental health professional (psychiatrist or psychologist), with the addition of a nurse.[1] However, a significant barrier in the UK to achieving a quorate MDT is difficulty in accessing physiotherapy and psychology, with around 50% of services having no access to these disciplines.[7,8] Building a collaborative approach between primary and secondary care may allow pooling of resources. There may also be a role for the extended role practitioner bridging this gap, delivering a specific focus on rehabilitation and psychosocial support.[8]

The role of the MDT as a hub for effective communication and continuity is significant. The MDT can allow prompt recognition of treatment failure and avoidance of parallel referrals and duplication of investigations. This can reduce iatrogenic factors that potentially increase suffering such as over-investigation, overtreatment and failure to confront negative findings.[9]

Inpatient pain services that once focused on the management of acute post-surgical pain are now finding themselves with increasing involvement in complex pain management. Many referrals focus on people admitted for acute on chronic pain exacerbations or severe acute pain in the presence of opioid tolerance and dependence. Thus, the IPS will need to mirror the multidisciplinary approach of chronic pain services and draw upon the resources of these services locally if they are to manage care for people with pain effectively. There is also the potential for an IPS to evolve into a transitional pain service, with the addition of psychologists, physiotherapists and occupational therapists to identify risk factors for persistent pain, implement preventative strategies and avoid opioid dependency.[10] An estimated 4.7% of people with pain prescribed opioids develop dependence or misuse.[11] It is therefore vital that continuity between the IPS and the continuing care of people with pain in the community upon discharge is improved to prevent and mitigate the risk of iatrogenic dependence and aberrant opioid use.

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5.2.1 MEDICAL CONSULTANTS

Anna Weiss

INTRODUCTION

In UK practice, consultants in pain medicine are core members of the MDTs that constitute specialist and highly specialist pain management services. These doctors are usually anaesthetists, who have undertaken specialist training and have achieved defined competencies in all aspects of pain medicine. It is now the convention that such anaesthetist will have also obtained the fellowship of the Faculty of Pain Medicine of the Royal College of Anaesthetists (FFPMRCA) or equivalent.

Consultants in pain medicine are trained to provide integrated, coordinated management of pain and to deliver comprehensive patient-centred care. The Faculty of Pain Medicine is the only professional body in the UK that issues guidance and standards for revalidation of doctors who specialise in the management of pain.

STANDARDS

1. Consultant-only provision without access to a broader pain management MDT is not an appropriate model for pain management in any setting and must not be commissioned.
2. All specialist and highly specialist pain management services must demonstrate clearly defined input from pain medicine specialists at consultant grade. A minimum of two consultants are required within each pain management service to ensure peer support and cross cover.[1]
3. All consultants delivering pain services must comply with the professional standards set by the General Medical Council. 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]
4. All chronic pain management services must include consultants who have an appropriate knowledge base, training and competencies maintained through continuing professional development (CPD) activities and validated by an annual appraisal. The 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]
5. All inpatient pain management services must be led by or include named consultant(s), who have an appropriate knowledge base, training and competencies maintained through CPD activities and validated by an annual appraisal. The training standard for clinical involvement with an inpatient pain service is the completion of the RCoA curriculum in higher pain training for inpatient pain medicine.[4]
6. Consultants holding dual commitments in pain management and anaesthesia or intensive care medicine must participate in appropriate and proportional CPD activities.[2]
7. Consultants must have resources to develop local guidelines for the provision of safe and effective pain management and must be supported by appropriately trained specialist pain nurses.
8. Consultant job plans must make allowance for the provision of MDT working with defined time and resource allocation for multidisciplinary meetings.
9. Specific roles within a pain management service (e.g. leadership and educational role) must be represented in job planning through allocated programmed activities.
10. Consultants must provide oversight and supervision of assessment and treatment planning delegated to other members of the pain management team.[5–7]
11. Consultants must adhere to standards for the supervision of non-medical practitioners administering procedures.[7]
12. Services delivering neuromodulation, intrathecal drug delivery or specialist inpatient pain relief techniques requiring continuous support must provide sufficient consultant staffing levels to allow continuous specialist clinical supervision seven days a week, with easy access to advice and direct support for people with pain and other clinicians.
13. There must be appropriate provision, accommodation and management/administrative support for all aspects of the service, including consultant services.[1]

RECOMMENDATIONS

1. MDT working with close involvement of a consultant represents the current best practice model of care and should be applied to all pain management services across all settings.
2. Inpatient pain services should have adequate leadership and support from appropriately trained consultants, with sufficient job plan allocation to fulfil the role effectively.
3. 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 Medicine.[3,8]

4. Consultants should contribute to service design, strategic service development and negotiation with management and commissioners.
5. The Faculty of Pain Medicine has the duty to safeguard the professional principles and behaviours underpinning best care for people with pain. The following recommendations on the content and composition of consultant job plans support this duty.
   - Job plans for consultants with a substantive appointment in chronic pain should include a minimum of three whole-time equivalent (WTE) programmed activities (PAs) for DCC.
   - Job plans for lead consultants in inpatient pain should include a minimum of a two WTE PAs dedicated to inpatient pain management; job plans for other consultants with specific commitments to the inpatient pain service (e.g. ward rounds) carry a minimum of one WTE PA.
   - Job plans for consultants should adequately represent the intensity of clinical commitments with a DCC PA allocation as follows:
     i. a minimum of 1.25 PAs for a four-hour pain intervention list and associated tasks
     ii. a minimum of 1.5 PAs for a four-hour outpatient clinic and associated tasks.
   - Job plans for consultants delivering inpatient ward rounds should allow for variation in intensity of clinical commitments in their DCC by allocating 1.25–1.5 PAs for a four-hour ward round.
   - Job plans for consultants involved in service delivery within an MDT should reflect this clinical commitment through appropriate PA allocation.
   - Job plans should include a supporting professional activities (SPA) allocation in keeping with published guidance (Association of Anaesthetists, Academy of Medical Royal Colleges). This endorses a minimum allocation of 1.5 SPA for every 10 PAs job plan for the purpose of appraisal and revalidation activities. Additional SPA allocation for professional activities outside the remit of direct clinical care (e.g. external duties, college tutor and Regional Advisor activities, quality improvement activities) is affirmed through effective job planning on an annual basis.
6. Pain management services require adequate nursing, secretarial and clerical support.[6] 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 posts.[7]
7. It is recognised that working in pain medicine can be demanding, and instances of 'burnout' 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 to participate in supervision activities akin to psychology/psychiatry/general practice (e.g. Balint groups).[9]

BACKGROUND

Pain management services in the UK were borne out of pragmatism and need and have been subject to many changes over the years.[10,11] Consultant-delivered pain management services have been an integral component of UK healthcare for over 40 years.[10,11]

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 confirm specialist competency. These specialists are integral to the multidisciplinary pain team, delivering direct care to people with pain, contributing leadership, strategic planning, education, research and quality improvement.

The overall approach to care delivery for inpatient and outpatient pain management has diversified over the past decade. The current UK practice of units providing care for people with persisting pain incorporates direct patient contact for the majority of consultants. Owing to the high numbers of patients requiring review, inpatient pain management teams are usually consultant led, with care delivered by specialist nurses.

Principles of professional conduct, patient care and governance apply across all settings of pain management delivery and have been set out in the Good Pain Medicine Specialist document.[2]

In UK practice, most consultants in pain management continue to provide anaesthetic services, with professional requirements matching dual accreditation. Combined duties impact on job planning, continuous professional development activities and appraisal.

The intensity of consultant-delivered direct patient care may vary with the level and setting of care provided. Consultants delivering care with complex interventions (intrathecal drug delivery, spinal cord stimulation, 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 responsible for establishing interprofessional care pathways allowing for rapid access to imaging and neurosurgical review/intervention. These commitments must be matched by appropriate consultant staffing levels and represented in job plans.

Most people with pain referred to a pain management unit need coherent multidisciplinary care. Consultants provide a pain diagnosis, advice on complex pharmaceutical management and, where appropriate, a physical or psychosocial intervention. Consultants in pain management must work in environments which encourage teamworking 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

The annual process of job planning allows the pain clinician and the responsible manager to evaluate and adapt the present job plan following a basic set of objectives within a time-protected meeting.[12]

The basis for the NHS consultant contract is a 10-PA job plan with 7.5 PAs for DCC and 2.5 SPAs.13 A minimum of 2.5 SPAs is recommended and of particular importance for clinicians who combine duties in anaesthetics and pain management with dual requirements to CPD.

Association of Anaesthetists guidance states that 'a commonly used tariff might be for an inpatient operating list (a standard 'session' of four hours of anaesthesia and operating time) to represent a standard 1.25 DCC PAs.[14] Extending this value to other sessions such as an outpatient session or ward round should be undertaken with caution'.[13]

Sessions delivered as outpatient clinics and inpatient ward rounds are more appropriately addressed by recommendations of the Royal College of Physicians.[15] Following their guidance, delivery of outpatient clinics and ward rounds translates to a tariff of 1.5 PAs for each of these direct clinical care activities. Pain medicine consultants deliver aspects of direct clinical care that are not covered by PA allocations linked to clinics, ward rounds and the resulting administrative workload as specified above; these activities 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.

Research, audit, innovation, quality improvement and attention to patient safety are key to the delivery of high-quality pain services. This must be reflected in the preparation of consultant job plans and appropriate SPA allocation. 16,17

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5.2.2 STAFF GRADE, ASSOCIATE SPECIALIST AND SPECIALTY DOCTORS

Lucy Williams

INTRODUCTION

SAS grades encompass a group of doctors who are no longer in training but who are not consultants and have 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 specialty doctors, staff grades or associate specialists. Most SAS pain management specialists will be anaesthetists who have acquired further experience and training in pain medicine.

SAS doctors who have the appropriate experience and competencies are important members of specialist pain teams. As well as delivering direct care, they can participate in quality improvement, research, training and education. They should be encouraged to develop roles within the multidisciplinary team across both acute and chronic, inpatient and outpatient pain services.

SAS doctors may have responsibility for their own outpatient clinics, as well as for interventional procedures with indirect consultant supervision. Some SAS pain specialists may develop managerial and leadership skills and step into senior roles.

SAS 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 safe and high-quality practice and to meet requirements for revalidation as a practitioner in pain medicine.

STANDARDS

1. All SAS doctors must receive the level of supervision commensurate with their skills and experience and should not undertake work outside their capabilities.[1,2]
2. Where SAS 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 General Medical Council (GMC).[3] Deaneries may specify local trainers to be accredited as clinical or educational supervisors.
3. SAS 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 must be acknowledged within the job planning agreement. This must also include appropriate and sufficient allocation of SPA time.[4–6]
4. SAS pain specialists must have a job plan review with their clinical manager on at least an annual basis.[4–6]
5. Employers must ensure that SAS pain medicine specialists are given opportunities for career progression, development and training. Employers have a responsibility to support SAS doctors in developing their skills and experience to allow them to require less supervision and take on more responsibility as they progress through their career.[2,4,7,8]
6. SAS doctors must have appropriate levels of support to facilitate their practice, with dedicated secretarial, administrative support and office space.[5]
7. SAS doctors must participate fully in appraisal and revalidation as per GMC guidance.[4]

RECOMMENDATIONS

1. SAS pain specialists should practice in accordance with the guidelines in The Good Pain Specialist, published by the Faculty of Pain Medicine.[9]
2. SAS pain specialists should practice under the supervision of a named consultant.[1,5] Experienced SAS pain specialists may practice autonomously, with agreed responsibility for their own outpatient clinics and interventional procedures.[3–5]
3. It is recommended that all departments employing SAS doctors identify a named consultant as educational supervisor responsible for overseeing their career development. It is recommended that professional development is structured around attainment of competencies identified in the certificate of completion of training,[10] so the educational supervisor should link with the local pain medicine educational supervisor.
4. SAS doctors should have sufficient SPA time included in their job plan according to nationally agreed guidance. The Academy of Medical Royal Colleges recommends that the minimum level of SPA time should be 1.5 WTE to support revalidation.[11,12] Where SAS pain specialists have additional roles and responsibilities, SPA time should be increased appropriately.[6]
5. All SAS doctors should engage in quality improvement and audit and be supported to participate in local and national research.
6. All SAS 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 doctors.

BACKGROUND

The term 'SAS doctor' refers to a range of doctors who are neither in deanery-approved training posts nor hold a consultant appointment.[3] Doctors enter these posts for a range of personal and professional reasons. They 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 renamed associate specialist in 1981. Associate specialists are senior clinicians and, while still accountable to a consultant, they 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.

A single grade of specialty doctor was created in 2008, ending the option of new appointments to associate specialist or staff grade posts. This medical workforce reform was aimed at ensuring recognition of the valuable contribution made by specialty doctors to caring for people in pain.[12]

There are some specialists whose employment is not regulated by national terms and conditions. They are known as locally employed doctors. Their posts generally exist to address service needs and they have a number of titles. In general, these posts are not endorsed by the medical royal colleges.

It is recognised that pain management services in the UK are best delivered by multidisciplinary teams led by pain specialists, the majority of whom will be NHS consultants. For further detail see Chapter 5.1 of this document. Skilled and experienced SAS doctors are well placed to make valuable contributions to both inpatient and chronic pain services.

All SAS doctors working in pain management services should be afforded the opportunities and support to develop and contribute to the pain service according to their level of competence. [13,14]

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5.2.3 DOCTORS IN TRAINING

Kerry Elliot and Helen Laycock

INTRODUCTION

Training in pain medicine is a compulsory element of the basic and intermediate curricula for anaesthetists. Optional further training at higher (4–12 weeks) and advanced (12 months) levels are required to qualify as a consultant with a specialist interest in pain. The fellowship of the Faculty of Pain Medicine requires the trainee to pass the FFPMRCA examination and achieve the competencies of advanced pain medicine training.[1] 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. Pain medicine training must be within a school of anaesthesia.
2. Training must be within a consultant-led multidisciplinary pain management service that meets the core standards for pain management services in the UK as set out in this document.
3. The training must be well defined and meet the learning aims and objectives outline in the pain medicine training competencies.[1]
4. An educational supervisor (with an appointment and appropriate experience in pain medicine) must be assigned for the duration of training.
5. Trainees must have an introductory meeting with their educational supervisor at the start of the advanced pain training to discuss their work schedule and to ensure that it covers all areas of the curriculum, including arrangements for access to specialist services.
6. Trainees must have clear lines of clinical supervision by pain medicine consultant staff and must be able to access consultant support while providing direct care for people with pain.
7. If specialised services such as paediatrics, cancer/palliative care and complex spinal procedures are not available locally, then provision for these elements of training must be made in an alternative centre.[3]
8. The trainee must have access to a local or regional pain management programme.[2]
9. Arrangements must be made for less-than-full-time trainees to achieve their equivalent training and competencies.
10. Trainees must spend the entirety of their daytime training in pain medicine-related duties and must not participate in daytime anaesthetic on call or elective anaesthetic commitments except in extenuating circumstances, for example in the event of a major incident.[2]
11. Trainees must be included in case conferences, audits, departmental meetings and critical incident responses, and must be encouraged to improve patient safety and management skills.

RECOMMENDATIONS

1. The training centre(s) should cumulatively achieve a minimum of 300 new cases and 500 therapeutic interventions a year, with a minimum of 5 consultant half-day sessions per week devoted to pain medicine consultations and interventions. For acute postoperative pain, a minimum of 200 new patients managed by the service per year and 5 inpatient ward rounds per week.[2]
2. The regional advisor in pain medicine should have an overseeing role when the training occurs in more than one centre but may delegate this role to local faculty tutors (pain).
3. Treatment of people with pain should adhere to an evidence-based approach, with trainees critically appraising research and applying it where appropriate to the development of pain management plans.

BACKGROUND

The Faculty of Pain Medicine published guidance for the provision of higher and advanced training in pain medicine, which was updated in 2016.[2] The document outlines the organisation, workload and philosophy of pain medicine training. It is further supported by a wealth of information on the Faculty website (https://fpm.ac.uk) aimed at trainees, regional advisors and hospitals offering advanced pain training. 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 an MDT approach to care and be conducted in accordance with the General Medical Council's principles of good medical practice.[4] Experience in a wide variety of pathologies, investigation and treatment modalities is essential.

The curriculum in anaesthesia is updated at regular intervals by the FPMTAC in consultation with the Royal College of Anaesthetists, in response to the changing environment of pain medicine and results of the national pain trainee survey.[5]

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5.3 GENERAL PRACTITIONERS

Ruth Bastable, Sarah Rann and Martin Johnson

INTRODUCTION

Many people with chronic pain are managed primarily or solely in primary care by their GP and their teams. This chapter was prepared by representing members the Royal College of General Practitioners in recognition of the pivotal role of GPs in the management of people with pain.

People with chronic pain consult their GP around five times more frequently than those without chronic pain, and chronic pain is a presenting condition in around 22% of primary care consultations.[1] Most pain management will occur in general practice and its assessment should be an integral part of GP training and delivery of care. Chronic pain should be acknowledged as a complex biopsychosocial phenomenon.

STANDARDS

1. The management of pain must be an integral and important part of GP training, education and practice.
2. All GPs must be able to assess pain, triage for serious pathology, assess psychosocial factors that may maintain disability and distress, and instigate simple pain management strategies. This is a normal part of GP practice. Use of tools to support appropriate pathways and check lists must be considered.[2]
3. GPs must be aware of their responsibilities regarding prescribing; they are responsible for prescriptions signed in their name, even if the medication was started by someone else (unless there is a shared care agreement in place, responsibility for which is based on a patient's best interest); there are particular responsibilities accompanying off-label prescribing.[3,4]
4. Many drugs used in pain management are likely to be dependence-forming medications. These drugs must be treated like any other high-risk drug and appropriate strategies for patient safety must be in place.[5]
5. GPs must be able to initiate and hold conversations that involve non-medication approaches for the management of pain.
6. Controlled drug incidents must be reported to the controlled drugs accountable officer.[6,7] Reporting pathways vary across the four nations.[8–11]

RECOMMENDATIONS

1. Each GP practice should nominate a lead healthcare professional who is responsible for chronic pain management within the practice.
2. There should be appropriate training in pain management for the wider primary care team (as for other common conditions such as diabetes).[12]
3. People with chronic pain should have this condition coded within their medical record.
4. The WHO Pain Ladder should not be applied in the management of chronic pain, as it is an approach designed for the palliation of people with pain from advancing cancer.[13]
5. GPs should be aware of the risk factors for chronic pain and should collaboratively implement timely optimisation of pain medication. This should include appropriate deprescribing of pain medication.
6. GPs should be aware of the risk factors for development of complex chronic pain (defined in Chapter 3.1) and should instigate timely referral to specialist multidisciplinary pain management services in collaboration with the person with pain.
7. When assessing and treating chronic pain, GPs should be familiar with assessment tools to identify neuropathic pain and treatment options in line with NICE guidance.
8. In medicines management, patient safety is paramount. Medication without harm is the third global WHO challenge:[14]
   - People with pain who are prescribed opioids for chronic pain should be monitored regularly, including review of efficacy and adverse effect profile at least every six months when their prescription is stable and ideally every four weeks after dose changes.
   - People with pain who are prescribed high-dose opioids (greater than 120 mg oral morphine equivalents) should be managed in a multidisciplinary setting and should have a formal care plan with regular review to ensure the dose is reduced to the lowest required amount
9. People with pain who are prescribed dependence-forming medication should be monitored in line with one or more of the following:
   - Practice protocol, which reflects national guidance. This should cover risk management specifically as well as:
     - initiation
     - monitoring for effectiveness, safety, intercurrent illness, and comorbidities

- repeat prescribing
- support for drug optimisation, such as reduction/tapering
- shared care agreement, MDT approach specific to the person with pain
- specific hazards such as polypharmacy/overuse or misuse and obtaining supplies from elsewhere (e.g. online, emergency departments, out of hours services or secondary care), as well as the risk of diversion.

- Manufacturer's summary of product characteristics for the product.

10. GPs should work within their skills and competencies:
    - GPs should prescribe within evidenced informed guidance.
    - GPs should apply their existing skills, including communication and addressing a person's problem in the context of their community.
11. GPs should be knowledgeable of the specific pain management of people with pain and palliative care needs :
    - The benefits and burdens of pain management are different when someone is in the last months of life compared with someone living with, rather than dying from, a chronic disease and who has a much longer prognosis.
    - The benefits of strong opioid therapy for chronic (persistent) pain generally only outweigh the burdens and risks of such treatment when likely prognosis is measured in months and not years.
12. All GPs should be able to provide information about supported self-management for people with chronic pain (and their carers), which should include signposting information to appropriate local and national resources and agencies.

BACKGROUND

Most musculoskeletal disorders are chronic conditions; their management presents a number of challenges to GPs who have a particular role in the long-term management of chronic pain and disability.[15] People present to general practice with other chronic pain conditions, including neuropathic, visceral and widespread pain. Understanding the psychological and social dimensions of chronic pain and disability is a fundamental skill for delivery of good care for people with chronic pain conditions.

GPs have an important role to play in preventing people with pain from coming to harm from prescribing. It is important for them to maintain awareness of the problems and adverse effects of pain medications, including recent guidelines and legislation changes affecting the use of drugs such as opioids and gabapentinoids. This includes areas such as overprescribing of opioids and drug-driving legislation.

Specific strategies support GPs in safe prescribing practices by minimising exposure and potentially limiting harm. These include the monitoring for declining efficacy of dependence-forming medications (including opioids), recognising tolerance and avoiding escalation and scheduled reviews of prescribed dependence-forming medications for people with pain.

Guidance and evidence for treatment choices has changed considerably and we now recognise that, for many people with pain, medication has limited value as a long-term therapy and should be used cautiously in a selected cohort of people. Ideally, management should be of benefit, evidence informed, patient centred and should not cause harm.

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5.4 NURSES

Dee Burrows and Gillian Chumbley

INTRODUCTION

The International Association for the Study of Pain advocates a multidisciplinary approach to pain management and the inclusion of nurses in the assessment and treatment of people with pain.[1]

Nurses work with people 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 people with pain seen.[2] Nurse specialists and nurse consultants play a key role in pain management and may work in collaboration with others or as largely autonomous practitioners,[3] within their levels of competence. The Royal College of Nursing has published a pain knowledge and skills framework to guide and support pain management nurses.[4]

STANDARDS

1. All nurses must be able to assess pain and deliver evidenced, informed pain management appropriate to their level of their knowledge and skill and the setting in which they work.[4]
2. Nurses must be familiar with comprehensive and consistent pain assessment using valid and reliable assessment tools.[4–6] A good quality assessment will involve people with pain, their family members and carers.[4–6]
3. Treatment plans formulated by nurses with individuals must take account of the biopsychosocial components of the individual's pain presentation.[4–6]
4. Nurses advising multidisciplinary teams on the management of complex pain must have knowledge of non-pharmaceutical pain interventions and broader pain management approaches within their sphere of practice.[4–6]
5. Pain management nurses must have the necessary skills to effectively educate people with pain their families, members of the public, other nurses and clinical colleagues about pain and its management, within their clinical setting and according to their level of experience.[4–6]
6. All nurses working at the level of senior clinic nurse specialist and above must be qualified independent prescribers on the Nursing and Midwifery Council (NMC) register.[4]
7. Nurses in pain management must be able to critically evaluate the literature pertinent to pain management within their setting and be able to integrate the research findings into clinical delivery.[4]
8. Nurses working in pain management as a clinical nurse specialist or above (Table 1) must be able to lead the development of evidence-based protocols and guidelines for local clinical practice.[4]
9. Nurses must participate in and generate clinical audit to identify areas for change and development.[4] Senior clinical nurse specialists and consultant nurses must be able to identify risk, manage risk and innovate practice according to the outcomes of clinical audit.
10. Nurses must recognise the boundaries of their clinical competence and seek advice and collaboration as required.[1,7]
11. Nurses must be cognisant of the standards that other members of the MDT are working towards, to ensure effective collaboration.
12. All nurses must take responsibility for their professional development and partake in the annual appraisal and revalidation process. Nurses are accountable for their practice under the NMC code.[7] Employers must support this position.

RECOMMENDATIONS

1. Nurses working with inpatients should have experience in the assessment and management of both acute and chronic pain, commensurate to their level of experience.
2. Nurses should consider innovative ways to use telehealth and other approaches, such as computer applications, web-based resources and virtual reality to enhance shared decision making while promoting adherence to evidence-based practice
3. Nurses working at senior clinical nurse specialist level and above (Table 1) should contribute to and lead on the formation of regional and national guidelines and policies.[4]
4. 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.[4,6,8]
5. There should be a clearly defined career pathway for nurses working within 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 care within a pain management team.[9]

6. Senior clinical nurse specialist and consultant nurses should have the freedom and authority to act autonomously and independently where appropriate according to their clinical situation.[8]

BACKGROUND

All nurses working in the clinical environment are ideally placed to assess and treat people in pain. Nurses with specialist pain management skills work in a variety of settings and with people who have acute, persistent, cancer or complex pain. They may work in hospitals (inpatient or outpatient services), in the 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 management.[4,8] Consequently, skills range from task-driven, protocol-led roles to the service changes made by consultant nurses, which enhance patient care and outcomes.[9]

Senior clinical specialist nurses or advanced nurse practitioners will be educated to master's degree level, but there can be large variations in the provision and availability of education programmes specialising in pain.[6] The European Federation of Pain has now produced a core curriculum and a European diploma in pain nursing to expand provision for the future.

Service changes and enhanced education have led to opportunities to develop nurse-led services (e.g. acupuncture clinics, medication review clinics) and many 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 an MDT with various levels of autonomy, sharing best practice through highly specialist and advanced consultancy that facilitates person-centred care.[3,7]

Table 1: Qualifications, Experience and Training for Pain Specialist Nurses[4]

Level	Qualification	Level of education	Level of experience
Staff nurses	Registered 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		Working towards a or holding: ▸ Master's degree ▸ Independent prescriber on the NMC register	Specialist knowledge in pain management
Senior clinical nurse specialists (advanced level nursing practice)		Working towards a or holding: ▸ Master's degree (180 level 7 points/Scotland level 11) or EDPNa ▸ Independent prescriber on the NMC register	Specialist knowledge in pain management
Consultant nurses[b] (advanced level nursing practice)		Working towards a or holding: ▸ Doctorate-level degree or equivalent qualification ▸ Independent prescriber on the NMC register	Advanced clinical practice, leadership, facilitator of education and learning, evidence of research and development

a European Diploma in Pain Nursing

b England Scotland and Wales

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5.5 OCCUPATIONAL THERAPISTS

Helen Jennings, Michelle Morgan, John Tetlow, Paula Wilkinson and Hannah Williams

INTRODUCTION

Chronic pain has a significant impact on a person's ability to engage in meaningful occupations. Addressing this issue with people who experience chronic pain is important to improve their quality of life.[1,2]

Occupational therapy is founded on the premise that performance of daily activities/occupations are crucial to our physical and psychological wellbeing and health.[3] 'Occupation' as a term refers to the purposeful activities that allow people to live independently and foster a sense of preferred identity. These could include essential day-to-day tasks such as self-care, work or leisure.[4] As experts in enabling occupation, occupational therapists are primarily concerned with supporting individuals living with chronic pain to perform and engage in their chosen daily activities.[5]

STANDARDS

1. Occupational therapists must be Health and Care Professions Council (HCPC) registered.[6]
2. Occupational therapists must work within their scope of practice, depending on their qualifications, experience, knowledge and training.[7]
3. All occupational therapists must be trained in and be expected to use an occupation-focused model conceptualised within a biopsychosocial model and must be guided by other models relevant to their role and individual people with pain.[6]
4. Occupational therapists working in pain management services must be expected to demonstrate a comprehensive understanding and application of current evidence-based approaches within pain management. Advice giving alone has not been shown to be effective.[8]
5. Occupational therapists must be able to conduct a multidimensional occupation-focused assessment to establish the impact of chronic pain on all aspects of an individual's life and roles. Assessments must measure function and level of participation in the domains of self-care, work and leisure. Reliable and validated assessment methods must be used.[9]
6. Occupational therapists must work in partnership with the person with chronic pain and their carers where appropriate, agreeing individualised short- and long-term goals for their rehabilitation. Intervention techniques used must be tailored to the individual needs of the person experiencing chronic pain.[6]
7. Occupational therapists working in pain management services must demonstrate an understanding of pain mechanisms and the physiology of chronic pain to confidently support rehabilitation and encourage people with chronic pain to adopt a self-management approach.[9,10]
8. Occupational therapists must use interventions that focus on maximising occupational performance and engagement in all activity areas (i.e. self-care, leisure, work and rest).[8]
9. Occupational therapy interventions must promote people with chronic pain staying physically active through participation in occupation to reduce long term disability.[11]
10. Where groupwork is involved, occupational therapists must develop skills in group facilitation and management specific to chronic pain rehabilitation.[8]
11. Occupational therapists must have regular supervision and identify any training needs as part of their professional development.[12]

RECOMMENDATIONS

1. HCPC-registered occupational therapist(s) with specialist experience in pain management should be employed within pain management services and pain management programmes.[8]
2. Occupational therapists should have or 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 therapists. To support this development, occupational therapists should map their knowledge and skills across the four pillars of practice as detailed by the Royal College of Occupational Therapists Career Development Framework.[13,14]
3. Occupational therapists should take a personalised approach to pain management rehabilitation, agreeing short- and long-term goals based on the choices and preferences of the person with pain.
4. Occupational therapists should offer a range of self-management strategies to build greater activity, resilience and overall quality of life for people throughout their pain management rehabilitation.[15]

BACKGROUND

Effectively helping people with chronic pain requires a holistic approach encompassing the biological, psychological and social aspects of a person's life. Given that occupational therapists are one of the few health professions qualified to work with both physical and

psychosocial issues, they are ideally placed to offer such intervention. This has led to the role of occupational therapy in pain management growing significantly in recent years.

Being able to participate in one's chosen occupations is fundamentally linked with identity, self-actualisation and active participation in society. Although people with chronic pain wish to keep performing valued activities, they experience numerous challenges with engaging in them.[16] This can lead to suffering in both physical and psychological health and decline in wellbeing.[5,17] Additionally, engagement in valued activity has the potential to mediate the pain experience by altering the biopsychosocial factors which influence it, meaning that if such activity opportunities are unavailable the consequences are detrimental.[17–21]

Occupational therapists focus on restoring functional activity to improve health and wellbeing, helping the individual to break the pain cycle, supporting them to regain balance lost between occupations and, ultimately, enhancing any functional aspects of health, wellbeing and quality of life.[5]

To achieve this aim, occupational therapists begin with a detailed assessment to understand the impact of pain on ability to perform activities of daily living and function in valued roles.[1,2,7] From this assessment, a treatment plan is developed, incorporating one or more of the following approaches; acquisitional intervention (reacquiring or developing occupational skills), educational intervention (teaching techniques to enhance the performance of daily life tasks), restorative intervention (restoring/developing underlying performance components within the individual using meaningful activity) or compensatory intervention (adapting the task and the environment to compensate for an individual's decreased occupational skill).[22] Techniques such as problem solving, activity adaptation, grading of activity and pacing, goal setting and ergonomic adaptation are incorporated within these interventions to help people develop effective pain management strategies, aiming to promote occupational engagement despite pain.[5,6,7,17–20]

Chronic pain has a significant socioeconomic impact in terms of absenteeism from work, reduced levels of productivity and an increased risk of leaving the labour market, as well as a detrimental impact on the person concerned and any financial dependents.[23]

Given their remit regarding vocational occupations, productivity and knowledge of activity analysis, occupational therapists are able to assess for and provide interventions that facilitate people with chronic pain to gain, stay in or return to work.[5,24–26]

Occupational therapists are well placed to intervene early in primary care to prevent chronicity developing, as well as working in secondary and tertiary level chronic pain services with those who have developed more longstanding occupational issues.[17,19]

Occupational therapists are expected to demonstrate excellent communication skills, including empathy, validation, active listening and rapport building.[24]

Occupational therapists working in pain management are considered as specialist advanced practitioners who use their knowledge and skills, which incorporate mental and physical assessments, in a complex clinical reasoning process to identify occupational needs in people with chronic pain.

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5.6 PHARMACISTS

Greg Barton and Roger Knaggs

INTRODUCTION

Pharmacy services are an integral part of the multidisciplinary pain management team. Their roles include supply and preparation of medicines, prescribing, provision of information regarding medicines to healthcare professionals and people with pain, delivering pharmaceutical care and optimising pharmacotherapy for people with pain, 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. Clinical pharmacists working as part of the multiprofessional inpatient or outpatient pain management services must be competent to provide the service.
3. A pharmacist working as part of pain management services must be registered with the General Pharmaceutical Council (GPhC) and adhere to the standards for pharmacy professionals published by the Council.
4. A pharmacist working as part of pain management services must keep up their knowledge and skills with demonstrable CPD activity.
5. There must be sufficient pharmacy technical staff to provide support functions.
6. A pharmacist working as a 'practitioner with a special interest' in pain management must be accredited and recognised to undertake the role.[1]
7. Sterile manufacturing facilities and experienced technical staff must be available in centres that provide epidural or intrathecal drug delivery for acute and persistent pain.
8. Pain services must 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.

RECOMMENDATIONS

1. There should be access to dedicated pharmacy support for outpatient pain management services.2
2. Pharmacists should 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.
3. Pharmacists working as a member of multiprofessional pain management services should participate in an independent recognised professional programme to verify their competence level.1
4. Pharmacists working as a member of multiprofessional pain management services should consider undertaking training to become a pharmacist prescriber.
5. Pharmacists should contribute to and be actively involved in formulary management and in the development of local prescribing guidance for acute, chronic and cancer pain in both primary and secondary care.
6. A pharmacist should be consulted or invited to review information regarding medicines for people with pain.

BACKGROUND

Pharmacists routinely provide pharmaceutical care to people with pain, optimise medication use, manage medicine-related risks, use 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 provides an independent professional recognition programme for assessing pharmacist competency at three levels (launched in 2013), 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 is equivalent to excellence, and fellowship is equivalent to mastery.[5] 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 audits,[6] and ensuring the accurate and timely transfer of information about medicines between different care providers.[7]

In comparison with other professions represented in the multiprofessional 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

Physiotherapy is defined as a healthcare profession that works with people to identify and maximise their ability to move and function.[1] It aims to achieve healthy levels of activity and self-management for people with chronic pain.[2] Physiotherapists are integral members of the multidisciplinary pain management team.[3] This chapter provides guidance on the standards and recommendations to be adopted when employing physiotherapists in pain clinic and pain management settings.

STANDARDS

1. Pain management services (and programmes) must have a rehabilitative focus and must include an HCPC-registered physiotherapist within the multidisciplinary team.
2. The pain management physiotherapist must work within their scope of practice, determined by their qualification, knowledge, experience and training.
3. The pain management physiotherapist must be able to demonstrate an advanced level of knowledge and understanding of chronic pain.
4. Pain management physiotherapists have an important role in educating other health professionals and people with pain. The physiotherapist must have an advanced level of understanding of pain mechanisms and physiology, and an ability to relay this information to health professionals and to people with pain in a comprehensive and contextualised manner.
5. The pain management physiotherapist must have a strong understanding of psychological and behavioural approaches used within pain management, such as, but not limited to, cognitive behavioural therapy (CBT), acceptance and commitment therapy (ACT), motivational interviewing, graded exposure and goal setting.
6. The pain management physiotherapist must be prepared to embrace generic and integrated assessment and treatment approaches, as well as to lead on physiotherapy-specific modalities.

RECOMMENDATIONS

1. Staffing levels within a pain management service should be determined locally by clinical need and should permit an agreed level of early access to pain specialist physiotherapy to optimise rehabilitative potential.
2. An HCPC-registered physiotherapist with demonstrable specialist experience in holistic management of pain should be employed within a pain management service or clinic and/or pain management programme setting.
3. The pain management physiotherapist should have strong communication skills, including skills and attributes related to empathy, validation, active listening, group dynamics and rapport building.
4. A biopsychosocial physiotherapeutic approach informed by a psychological framework (such as ACT or CBT) should be employed during interactions with people with pain.
5. Physiotherapists working in pain management services should receive clinical supervision from a psychologist or physiotherapist experienced in cognitive behavioural approaches for pain management.
6. All patients should have individualised goals set for their rehabilitation requirements. Short- and long-term goals based on the individual's own values should be established, agreed and reviewed throughout the patient's programme of management.
7. Physiotherapists are experts in exercise therapy. Exercise and exercise therapies, regardless of their form, are recommended in the management of people with chronic pain. Improving the quality and efficacy of activity by the use of measurement relating to the frequency, intensity, time and type principles of activity is recommended.
8. Physiotherapists should use their role to improve the ability and function of people with chronic pain in the longer term. This should include helping people with pain to work towards achieving current physical activity guidelines, provided as part of a comprehensive pain management programme that includes active participation in agreed exercise or activities. Advice alone is insufficient.
9. Various approaches should be considered to improve adherence to exercise programmes, including one-to-one supervised exercise, individualised exercise in group settings, addition of supplementary material, motivational interviewing and combined group and home exercise programmes.
10. Pain specialist physiotherapists should consider becoming independent non-medical prescribers, to assist people with pain to optimise their medication use, as their pain changes throughout their rehabilitation programme, in conjunction with other members of the pain management MDT.
11. Physiotherapists have advanced knowledge in the use of electrotherapies. This knowledge should be used to provide advice to health professionals and people with pain in the appropriate use of these devices (e.g. TENS).
12. Pain specialist physiotherapists should be involved in audit, quality improvement and service evaluation.

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 people with pain to identify and maximise their ability to move and function, to enable them 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. These treatments should be applied within a biopsychosocial framework and as an integral part of the MDT intervention. When delivered in this fashion there is good evidence of their clinical and cost effectiveness.[4–6] 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 management.[7] 'Exercise', in this context, could be any approach which improves fitness, flexibility, balance and stamina as agreed with the individual person, and may be specific or through engagement with activities including, for example, walking, dance, tai chi, yoga, swimming, gym or other classes.

Physiotherapists, as diagnosticians and movement specialists, are uniquely placed to provide assistance to people 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 programmes.[8] Within this role, the physiotherapist should provide people with pain with an exercise/activity programme that incorporates components such as pacing, goal setting, graded exposure and, importantly, a reduction of fear avoidance behaviour.[8] The physiotherapist should help the person to achieve current physical activity guidelines.[9,10] The exercise programme should be delivered in a manner that is bespoke to the needs of people suffering from chronic pain and should incorporate an overarching psychologically aware approach to patient management (e.g. cognitive behavioural, acceptance-commitment therapy 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.[1]

Physiotherapists working within dedicated pain services should be considered advanced practice physiotherapists, as defined by the Chartered Society of Physiotherapists.[11] 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 competence.1 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.[8] 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 practitioner.[8] All physiotherapists working in a specialist pain management setting should be encouraged and supported to become (or to maintain their status as) advanced level practitioners.

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5.8 PSYCHOLOGISTS

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INTRODUCTION

Pain specialists have long recognised that psychological and social processes contribute to pain experience and effective treatment. Psychologists are essential to pain management teams. They bring specialist knowledge and professional expertise to the assessment, formulations and treatment of people with pain to ensure that psychosocial factors are adequately addressed and outcomes are optimised.

Psychologists play a key role in the delivery of psychologically based pain management, by contribution to interdisciplinary rehabilitation and supporting non-psychologist staff to work in a psychologically informed manner.

STANDARDS

1. All psychologists working in pain management services must be registered with the HCPC as a 'practitioner psychologist'.[1]
2. Psychologists joining a pain management service for the first time must receive appropriate training from a psychologist experienced in multidisciplinary pain management. There is, to date, no recognised training course or qualification specifically for work with people with chronic pain. A chronic pain specific induction and supervision plan must be devised locally to ensure that the psychologist is able to practise safely and to meet the psychological needs of people with pain.
3. Psychologists must receive regular professional supervision consistent with the recommendations of the British Psychological Society.[1] The supervising psychologist must have substantial experience in pain management or other medical fields requiring multiprofessional teamwork.
4. All psychologists must have appropriate training in safeguarding procedures and access to appropriate supervision and organisational safeguarding support.
5. Trainee psychologists on placement with a pain management service team must be supervised by a psychologist who is appropriately qualified and experienced in interdisciplinary pain management.
6. Psychologists working in pain management services must be competent to ensure that psychological assessments, therapies and outcome measures are evidence based. Psychologists are responsible to the HCPC for keeping their continuing professional development up to date.
7. Psychologists must have a job plan that is appropriate to their grade.[2]
8. Psychologists working in pain management teams must ensure that the treatment of children and young people is developmentally appropriate. Children and young people must be seen by a HCPC registered psychologist with suitable competencies to work with children and young people. Young adults (16 years and older) may not have access to paediatric clinical psychologists and so may need to be seen in adult pain clinics. Psychologists must ensure that these young people are supported in a developmentally appropriate way.
9. Psychologists working with children and young people must understand the models of chronic illness in childhood, as well as child development and child and adolescent mental health.
10. Psychologists working in pain management teams must be able to assess psychological risk, including anxiety, depression and risk of suicide and self-harm. The psychologist must know how to manage that risk safely within the service and with reference to other local services.
11. Psychologists must develop clear care pathways between pain management services and local Improving Access to Psychological Therapy (IAPT) or community services.
12. All psychologists working in pain management services must be able to select, administer, score and interpret appropriate self-report scales for assessment and evaluation.
13. Psychologists must have skills that enable an effective contribution to audit, quality improvement, service evaluation and research.

RECOMMENDATIONS

1. All psychologists new to pain services should shadow an experienced colleague, to develop the specialist knowledge required to communicate effectively with colleagues and to work safely with people with pain. This additional training should be included in the job description and job plan.
2. Psychologists applying to work in pain services should have previous professional experience of working in both medical and mental health contexts.
3. Psychologists working in pain management teams should have or, should work towards acquiring knowledge of pain conditions and the impact of pain on all aspects of a person's life.
4. All psychologists working in pain services should be able to provide appropriate, evidence-based psychological assessments and

therapy specific to pain management, demonstrate an up-to-date knowledge of evidence-based psychological therapies, and should ensure their delivery.

5. Psychologists working in pain management teams should be able to provide individual therapeutic interventions from an evidence-based model such as CBT, ACT and a contextual understanding of the person's lifestyle (e.g. family and healthcare).
6. Psychologists working in pain management teams should be able to provide group psychoeducational sessions, particularly covering information on common conditions such as chronic pain, anxiety, depression and stress.
7. Psychologists working in pain management teams should be able to provide group therapy including work on identification of values, readiness to change and barriers to a change process.
8. Psychologists working in pain management teams should be able to provide case discussion and formulation to other professions and support psychologically informed case management.
9. Psychologists working in pain management teams should be able to function effectively in a team context and should understand team dynamics and challenges and be able to contribute towards a healthy team environment.
10. Data (psychosocial, quality of life and functional) should be collected and analysed to ensure good clinical outcomes.
11. Service users should be involved and service satisfaction measured. Psychologists should work with service users for purposes of service development.
12. All psychologists working in pain management services should have sufficient time in their job plan to support other members of the pain team to work in a psychologically informed manner. Direct clinical contact should not exceed two-thirds of weekly sessions. The British Psychological Society guidelines recommend a 60 : 40 split for grade 8A posts and 50 : 50 for grade 8B posts.[2]

BACKGROUND

A degree in psychology does not confer a professional qualification as a psychologist. All psychologists working in health complete further postgraduate training approved by the British Psychological Society either in clinical, health or counselling psychology. 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.

Chronic pain has significant impact on physical function, on psychological wellbeing and on quality of life. It also affects the social environments of people with pain. Psychological distress, from the experience of chronic pain and other life events, contributes substantially to overall pain-associated disability. It is therefore essential that an appropriate and thorough assessment of psychosocial factors is made and that the assessment and the resulting formulation contribute to the clinical decision-making process.[3]

Professional bodies, including the Faculty of Pain Medicine, endorse the contribution of professional psychologists in specialist and higher specialist pain services.[4] Specialist pain services serve people with complex and challenging chronic pain conditions, both the people with pain and the health professionals who work with them.

Membership of the British Psychological Society is not mandatory for psychologists working in pain management services; nevertheless, membership offers professional benefits for CPD, networking and professional benchmarking.[5]

Where a psychologist is appointed as lead psychologist with management and supervisory responsibilities, they should be in a senior grade and eligible for the title of consultant (under the NHS's Agenda for Change, normally band 8C or 8D).6 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 experience.[1]

Professional registration requires that psychologists must work within their 'scope of practice'.[7] 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'.[7] Previous professional experience in medical and mental health settings is key. Pain teams often encounter people 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 to ensure that mental health services are consulted or engaged.

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 practitioner psychologists can apply.

At the time of writing, there are no formal pain-specific training courses for psychologists, but the International Association for the Study of Pain recommends a core curriculum of knowledge for psychologists working in pain services.[8]

Job plans for all psychologists working in pain services need to allow for MDT meetings, planning, supervision, report writing, CPD, audit and research.[9,11] 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.

Time for supervision and reflective practice groups to enable non-psychologists to develop their psychological skills and expertise is a component of a job plan for psychologists contributing to pain management teams.

Close liaison with other services offering psychological treatment for chronic pain at different levels of intensity is part of routine work for pain management psychologists, particularly when collaborating with IAPT staff or community services, and aiming for effective triage and clear pathways for people with pain and referrers. Where such pathways are currently in development, the psychologist working in the pain management service is well placed to offer pain expertise to ensure that that those with complex pain-related disability and distress will still have access to interdisciplinary pain management programmes.

There may be considerable overlap between mental health problems and pain-specific distress. Formal agreements between pain services and local IAPT or community services as to when pain-specific problems should only be treated by the interdisciplinary pain management team are encouraged. This requires explicit guidance on when to treat mental health in the context of pain at IAPT or in the community and when a pain service psychologist needs to treat a pain condition in the context of mental health. The level of pain management expertise required and the clinical need for input from other MDT members will contribute to this guidance.

Application of appropriate self-report scales and other standard assessment tools for formal psychological measurement is a basic competency for all pain management psychologists. Examples include the measurement of pain-related distress, quality of life and psychological wellbeing. A psychologist is well placed to advise the other members of the pain team on appropriate use of such measures and to consider the explanation given to the patient, confidentiality of data and informed interpretation of scores.

It is appropriate for the psychologist to lead on data collection for outcome and research. Psychometric tools can be used for assessment and to aid clinical decision making where evidence supports the practice.

The needs of children and adolescents with chronic pain are best served by suitably trained psychologists working within paediatric chronic pain teams. All the preceding recommendations equally apply to psychologists working in paediatric pain services. Psychologists working with children and adolescents with chronic pain need to understand how the developmental stage of the young person affects the impact of pain.

Ability 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, is the basis for pain management in this group. Awareness of education systems is important, as supporting children and young people to remain engaged in age-appropriate activity is a key treatment outcome. Knowledge of safeguarding at the appropriate level is mandatory for all engaged in clinical contacts (see also Chapter 10: Safeguarding).[10]

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5.9 MULTIDISCIPLINARY TEAMWORKING IN PAIN CLINICS

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INTRODUCTION

Chronic pain is a challenging condition in which cure or resolution is rare. Clinicians need to work with people experiencing chronic pain as a long-term condition to enable them to improve their understanding and quality of life. People with chronic pain may experience other physical and mental health problems that limit their activities and resources. Chronic pain creates difficulties in functioning in most aspects of life, affecting work, financial status, family, social life, mobility, self-care, mood, and sleep. This is a complex condition requiring a multifaceted management approach, which incorporates many or all of the following: medical, physical, psychological and activity management. To get the best possible outcomes for service users, teams should be consistent in the information they provide to people with pain, evidence based in the choice of approaches, skilled, expert, creative in their service delivery and supportive of each other. A well-functioning MDT is essential for the delivery of good care to people with chronic pain.

STANDARDS

1. Chronic pain management must be supported by an MDT.
2. The MDT must include a consultant in pain medicine, suitably trained psychologist, a chartered physiotherapist, a clinical nurse specialist and an occupational therapist. The grade of the professionals will depend on the structure of the service, the organisation and available professional support.
3. Members of the MDT must have knowledge of the roles and interventions provided by the other team members and should meet regularly.
4. The job description and grade of staff must be consistent with the relevant professional requirements.
5. The team must provide a clear and consistent intervention and follow commissioned pathways for activity and interventions delivered.
6. The MDT must have regular team meetings to discuss people with complex pain and options for management.
7. A lead clinician must take responsibility for the overall model, team cohesion, training, supervision and quality. The lead clinician can be a sufficiently senior and experienced member of the team.
8. All team members must participate in appropriate CPD.
9. There must be clear quality targets for equality of access and delivery of service, as well as outcomes that are monitored.
10. All interventions offered by the chronic pain service must be evidence based and properly commissioned. For example, a pain management programme must follow the pain management programme guidelines published by the British Pain Society.1
11. Metrics such as the Family and Friends Test, complaints and risk reporting must be reviewed as part of the service's governance processes and link into the trust governance system.[2–4]
12. The MDT must have clear processes for assessment and management of risk to include self-harm and suicidal intent, mental health problems and crises, adult and child safeguarding, drugs and alcohol misuse and must follow trust procedures for escalation and onward referral.

RECOMMENDATIONS

The MDT and a consistent model

1. The MDT should work within a biopsychosocial model with a consistent message and overall model shared by the clinical lead of the service.
2. There should be a clear standard operating policy for the service.
3. The service should evaluate outcomes and audit against national guidelines.
4. Chronic pain services should provide written information about their service model in information available to potential patients, referrers and other interested parties, for instance, on their hospital website.

Clinical activity

5. All referrals should be triaged and assessed by a consultant in pain medicine. Appropriately referred people with pain can be assessed and treated by designated members of the team.
6. Evidence-based pain guidelines should be followed with a clear rationale and processes for exceptions.
7. Joint clinics and shared case working should be provided for people with complex pain.

Supervision and training

8. Team members should have access to clinical supervision, ideally with a senior clinician with experience in chronic pain. It may be necessary for supervision to be provided externally, for example, by a neighbouring service.

9. Non-clinical staff that have regular contact with people with pain should be trained in the management of distress and conflict resolution.

Activity and quality

10. The MDT should manage patient flows through service pathways, with managers and commissioners, to ensure that long waiting lists do not develop.

Risk management

11. Shared principles put patients' welfare and safety first,[5] but should also attend to welfare and safety of all staff, including non-clinical staff such as receptionists, administrative staff and housekeepers.

BACKGROUND

This chapter aims to describe the qualities of MDT working and multidisciplinary service provision that services must meet and should aspire to. There are no clear data on outcomes for multidisciplinary services compared with unidisciplinary services, and neither are there adequate data or publications that describe the working of a multidisciplinary pain teams. The standards and recommendations in this chapter are gathered from clinicians experienced in MDT chronic pain teams and from NICE publications for MDT working; criteria for effective teamworking and healthy team culture in social care are found in Cordis Bright.[2]

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Chapter 6

Patient pathways

6.1 MANAGEMENT AHEAD OF REFERRAL TO OTHER SPECIALIST PAIN MANAGEMENT SERVICES

Cathy Price and Anna Weiss

INTRODUCTION

Effective pain management is central to most healthcare provision. The estimated prevalence of chronic pain in the UK is 43%.[1] However only 2–3% of people with chronic pain will ever attend a pain clinic. Most consultations take place outside specialist settings: 22% of GP consultations focus on pain management; and people with chronic pain consult GPs five times more frequently than those without.[2] Many people will have short lived or acute pain, others will have cancer pain. Up to 84% of people in hospital settings report pain, 55% of whom have acute medical presentations.[3] A breadth of approaches is required to ensure pain is managed well.

There are many guidelines to support non-specialists in managing pain.[4–9] As chronic pain is multidimensional in nature, multiple teams and professionals are frequently involved. Patient safety is paramount and guidance which is aimed at keeping patients safe can be missed in the process of complex pain management.[4,10] Joined-up management of people with complicated pain requires clear communication along agreed patient pathways and clinical responsibilities. People with complicated pain problems warrant specialist referral.

STANDARDS

1. All people presenting with pain must have an individualised pain management plan appropriate to their clinical condition that is effective, safe and flexible.[11]
2. Any treatable pathology that might impact pain must be clarified or excluded ahead of referral to a pain management service. Red flags (indicators of serious pathology) should be specifically sought.[12]
3. A clear diagnosis of chronic pain must be made, coded and labelled in the notes (pain longer than 12 weeks' duration).[12]
4. People with chronic pain must be active participants in decisions regarding their pain management (as detailed in Chapter 6.3: Communication and relationship building with people in pain).[13]
5. Communication between clinicians and teams must adhere to professional standards and/or locally agreed protocols (as detailed in: Chapter 6.2 First consultation, follow-up and discharge).[13]
6. A referral of a person with pain for pain management must provide as a minimum:[13]
   - details of pain assessment within the context of the current presentation (applying the biopsychosocial framework)
   - details of comorbidities, including acute, chronic and mental health conditions
   - details of treatment and response to pain management strategies offered to date, including adverse effects and complications
   - details of relevant investigations performed to date or in progress
   - for people referred for management of chronic pain conditions, information on their involvement in self-care and their expectations towards referral.

RECOMMENDATIONS

1. Assessment and management of people with pain in non-specialist settings should be according to existing national and/or local best practice guidelines:
   - emergency departments' guidance according to the Royal College of Emergency Medicine (RCEM) guidance on management of pain in adults[14] and children.[15]
   - initial assessment and management of pain[16]
   - persistent (chronic) pain management in non-specialist settings[12]
   - management of persistent pain in children and young people[17]
   - management of pain in people with pain related to palliative conditions[18,19]
   - management of chronic pain medication.[19,20]

2. For specific conditions, care for people with pain in non-specialist settings should be according to the following agreed pathways:
   - management of neuropathic pain in non-specialist settings[10]
   - low back pain and sciatica[6]
   - pelvic pain[7,8]
   - widespread pain[9]
   - complex regional pain syndrome[21]
   - headache.[22]

3. Concerning communication between clinicians and teams:
   - Healthcare professionals referring people with pain for psychological assessment should explicitly state that the aims of psychological interventions are to increase coping skills and improve quality of life.[12]
   - As multiple healthcare professionals may be involved in a person with pain's care prior to specialist referral, it is important to clarify who is providing what aspect of care to the person with pain and agree how communication will work.[13]
   - Referral should be considered when non-specialist management is failing, chronic pain is poorly controlled, there is significant distress, and/or where specific specialist intervention or assessment is considered.[12]

BACKGROUND

Pain management is recognised as a fundamental need in the care of people with pain,[13] so pain should be asked about regularly and scales should be used if frequent assessments are felt necessary.[12] Validated scales and assessment tools exist for specific clinical scenarios.[23–25]

Healthcare professionals frequently report difficulty in diagnosing chronic pain conditions and this may lead to unnecessary distress and confusion for the person with pain. Owing to the fragmented nature of healthcare, a person with pain may access and be reviewed by multiple professionals. Clear documentation of pain diagnoses is encouraged to support communication between healthcare providers and improve quality of care by providing an accurate representation of the complexity of people with pain and resources required to manage them effectively.[26]

Recent studies have emphasised the role of psychological factors in driving the pain experience and raising the risk that pain may persists.[27] A biopsychosocial approach must be maintained when managing pain.[12] Healthcare professionals referring people with pain for psychological assessment should attempt to assess and address any concerns the person may have about such a referral. It may be helpful to state explicitly that the aims of psychological interventions are to increase coping skills and improve quality of life when faced with the challenges of living with pain rather than looking for a psychological cause for pain.[12]

Effective communication is essential both within an individual team and between teams to ensure cooperation and coordination of care. The WHO describes ineffective communications as a leading cause of inadvertent patient harm.[28] They can culminate in adverse events, including an increase in preventable hospital admissions.

A multitude of evidence-based guidelines exist to support the management of pain by non-specialists. Some are generic, focusing on care processes,[4,15–19] while others are more condition specific.[5–9,21,22] National guidance on how to improve the patient experience of care[29] applies to pain management at any level of care. By ensuring that these standards are measured and used as part of an assessment of the quality of care delivered to people with pain it is more likely that the quality of pain care will improve.

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6.2 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. People with pain 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 person with pain and is followed by a mutually agreed management plan.

STANDARDS

1. Clinicians must allocate adequate time to undertake the consultation, taking into
2. consideration the complexity of the person with pain's presentation.[1] (New patient consultations require one hour for people referred with a complex pain presentation and follow up appointments typically around 20-30 minutes).[2]
3. Clinicians must communicate with the person with pain and, when appropriate, with their carers, in a way that is understandable to them.
4. Clinicians must examine the person with pain when it is clinically indicated.
5. Clinicians must be satisfied that they have consent or other valid authority before they undertake any examination or investigation.
6. Clinicians must consider a chaperone where appropriate, according to current GMC guidelines.
7. A working diagnosis must be formulated and communicated back to referrer. The diagnosis/es should be formed primarily on the basis of the pain management specialist diagnostic assessment as well as taking into account opinions of other clinicians as relevant.
8. Clinicians must formulate a shared, individualised management plan based on the best available evidence.[3]
9. Clinicians must keep clinical records that are clear, accurate, legible and up to date.
10. Clinicians must seek help from appropriately qualified colleagues when a problem arises outside their area of competence.

RECOMMENDATIONS

First consultation

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

Follow-up consultations

1. There should be full access to the person with pain'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. People with pain 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 person's pain condition should be discussed prior to discharge as part of the shared decision-making process.
2. Clinicians should ensure that the continuing care of the person with pain has been arranged when necessary, and that other healthcare workers and the person are aware of these arrangements. Signposting to third sectorsupport should also be considered.

BACKGROUND

Those presenting with pain often carry complex interrelating multiple morbidities.[4] The clinician must consider these factors and integrate them into the overall evaluation of the person's pain presentation. Consultation technique is therefore a fundamental skill.[1, 5] This interaction is pivotal to the accurate assessment, diagnosis, management and education of people with pain.

It has been shown that enablement of people with pain is correlated with longer consultations.[6] 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 assessment. [7] 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 pro forma. 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 right.[8] Informed consent is necessary, and the presence of a chaperone must be considered.[9]

From the perspective of people with pain, 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 person in their own care.[8 9] Informed consent to any chosen treatment can only take place if the diagnosis has been shared with the person with pain and the therapeutic options have been fully understood.[10]

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 while 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 people 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 care of the person with pain 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 practice. [11] 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 delayed reviews can lead to disengagement, while 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 essential.[12] This may be agreed locally with commissioners (e.g. open appointment follow-up within a specific period of time).

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6.3 COMMUNICATION AND RELATIONSHIP BUILDING WITH PEOPLE IN PAIN

Katy Simpson and Pete Moore

INTRODUCTION

People in pain 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.[1] Clear, responsive and compassionate communication between clinician and a person with pain is a strong determinant of levels of engagement and satisfaction with the service and, as a result, will typically have a strong influence on treatment outcomes. Many examples of chronic pain can be difficult to conceptualise compared with acute pain; for example, the pain of a broken bone. Medical understanding of pain is still emerging. This can make it hard for people to comprehend their own pain, can inhibit them from engaging in exercise through fear of injury, and can make it difficult for them to accept that their condition may not have a cure. Clinicians can empower people with pain in learning to live well with their pain by clearly communicating treatment options – including risks and benefits – as well as providing access to information.

STANDARDS

NICE, SIGN, the GMC, the Faculty of Pain Medicine and Health Education England provide guidance on standards and recommendations relating to communication with people with pain. The relevant documents are:

- Management of Chronic Pain (SIGN, 2013)[2]
- Patient Experience in Adult NHS Services: Improving the experience of care for people using adult NHS services (NICE, 2012)[3]
- Good Medical Practice (GMC, 2013)[4]
- Ready for Revalidation: Supporting information for appraisal and revalidation (GMC, 2012)[5]
- Conducting Quality Consultations in Pain Medicine (Faculty, 2015)[6]
- Person-Centred Approaches Framework (Health Education England, 2017)[7]
- Accessible Information Standard (NHS England 2017)[8]
- All Wales Standards for Accessible Communication and Information for People with Sensory Loss (NHS Wales, 2013)[9]

RECOMMENDATIONS

1. People in pain want to feel that healthcare professionals are listening. However, they 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 the person with pain and allows them to share the impact that the pain is having on their life.
2. Giving people the time and opportunity to tell their story can also identify other issues that may be amplifying their pain such as sleep problems, money worries, stress, relationship worries, or feeling low. Tools to aid discussion are available to people with pain and clinicians.[10,11]
3. Asking the person to share their own understanding of the pain may help guide what sort of explanation they require, in terms of depth, detail and format (for example visual or verbal). Take time to ask them what is important for them to understand.
4. Whether it is acute or chronic, people in pain typically value a clear explanation of the possible cause, the physiology, the impact on their life and the options for management of the pain. As part of shared decision-making conversations, it is important to discuss 'doing nothing' as a possible option. Healthcare professionals should use tools to check understanding, such as the teach-back method. Teach back is an easy-to-use technique to check that the healthcare professional has clearly explained information to the person with pain and that the person has understood what has been covered, had the opportunity to ask any questions and feel confident with their role moving forwards.[12]
5. Reassurance should be offered to people with pain that acute pain can heal and chronic pain can be managed. Pain can be a frightening experience and reassurance from a trusted healthcare professional and peers can help to mitigate this fear.
6. Communication includes body language, tone and words. Awareness of all three elements can make a difference to the experience for the person with pain. For example, making eye contact and sitting at the same level may seem simple, but they help to build trust and show respect.
7. The 'Hello my name is' campaign reminds healthcare professionals to introduce themselves properly as it advocates that a confident introduction is the first step to providing compassionate care.[13]

8. Clinicians should offer information in a choice of formats. Signposting people in pain 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.
9. The terminology used to describe pain can influence the experience for a person with pain: healthcare professionals should choose terms and phrases carefully; verbal and nonverbal communications should be monitored and adapted accordingly.
10. Where possible, and only with the approval of the person with pain, family and/or carers or friends should be involved in at least some discussions and consultations. This may help to protect against the damaging effects that pain can sometimes have on relationships and enable the person to self-manage within a supportive and facilitative support network.
11. People with pain should be given evidence-based and clear information on pain medication and its predicted impact on their pain. An open and frank discussion about the role of pain medication can lay important foundations for the person's self-management of their pain. Medication should be discussed with a clear explanation of the evidence for their use and potential risks of long-term therapy. It should also be clear that for the majority, medications are only a part of a wider package of tools to help manage pain.

BACKGROUND

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

Good communication between healthcare professional and the person with pain is recognised as an important factor in their satisfaction with the care they receive.[2] There is evidence that effective communication has a positive influence on 'pain control, adherence to treatment regimens and psychological functioning' in people with cancer , with the inverse being true of poor communication.[14] More research needs to be done before the same claim can be securely made for people with chronic pain, although there is some evidence that specific training in communication for healthcare professionals can reduce pain levels in these people.[2]

It is important to listen to people in pain, not only out of politeness but also as a means of improving their satisfaction with care, 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 most secure means of making or confirming a diagnosis. By listening to the person with pain, the clinician will also be able to work with them to support better treatment choices reflecting their needs, preferences, values and circumstances. Addressing the impact of pain on the individual's relationships, employment and emotional state requires time for the person to talk freely about these issues and what matters most to them.

Good communication facilitates patient understanding.[15] 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 is 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 people and may therefore impede their capacity to process large quantities of information in a single sitting.[16,17]

Recognition of specific communication barriers, linked to disease or disability, invites the application of appropriate communication aids, including visual aids or interpreting services or communication tools for people with cognitive impairment. The validity of assessment tools for people with pain and common conditions like dementia is still lacking.[18]

Clinician's or caregivers' preconceptions, and bias towards a mental health diagnosis or behavioural causes for distress in persons with communication difficulties are defined as 'diagnostic overshadowing' and may result in delayed or omitted treatment of pain or its underlying causes. 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 person with pain'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 person with pain can also help them better understand their pain and the things they need to do to manage it. This puts them in a stronger position to communicate this information to those around them, helping them get the support they need in the home, local community and workplace.

Pain relief medication prescriptions can be complicated with people taking multiple medications at different times. This can be especially complex for people with comorbidities. If the person does not feel confident or understand their medications, explore with them and collaboratively problem solve ideas to support them. Conversations should include clear and documented explanations as to when to take medication, why medications are being taken, how long it is likely to take before an effect may be seen and a discussion of possible adverse effects. This will help the person with pain to feel more prepared and confident in persevering with medications that are known sometimes to cause adverse reactions in the early stages of treatment.

As there are limited effective pharmacological options available for treating chronic pain, people with pain will benefit from the adoption of pain self-management strategies. This requires sensitive and careful guidance, particularly when discussing psychological approaches as people in pain may feel that the reality of their pain is being discounted. It is important that the person with pain 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 person with pain 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 may be helpful here.[19] Continuing support should be available to discuss the person's progress and to manage any setbacks collaboratively.

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6.4 CHRONIC (NON-CANCER) PAIN

Sonia Pierce and Gordon Stewart

INTRODUCTION

Chronic (non-cancer) pain refers to pain that exists beyond the expected time of healing, usually taken as 12 weeks or more.[1] Chronic pain affects between one-third and one-half of the population of the UK: a figure that is likely to increase further in line with an ageing population.[2] Chronic pain not only causes personal suffering to the individual but also impacts on society financially, in terms of healthcare usage, social care support and lost time at work.[3] To cope with this demand, it is essential that pain services, primary care teams and health commissioning groups work constructively to improve the provision of chronic pain services across the UK.[4]

Chronic pain must be evaluated in conjunction with the psychological and social impact that the pain has on the individual. Complex pain is defined as any pain associated with, or with the potential to cause, significant disability and/or distress.[5] Diagnosing chronic pain early and managing it well has clear benefits for both the person with pain and society.[6]

STANDARDS

1. People with chronic pain must have access to multidisciplinary pain management services as defined in Chapter 5.1.
2. Specialist (tier 2) pain services must be able to refer people with complex chronic pain conditions onwards to tertiary higher specialist (tier 3) services for assessment and management.
3. Specialist (tier 2) pain services must be able to safely discharge people with pain to primary/community (tier 1) care for comprehensive supported management according to proposed pain management plans.

RECOMMENDATIONS

1. Clinical judgement and assessment tools should be used to diagnose 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.
2. GPs and commissioners should be aware of their local pain management service structure and facilities and should ensure that these meet the recommendations and standards outlined within this document.
3. Self-management strategies should be emphasised and reinforced at all stages in the treatment of chronic pain; self-management support and advice should be available in a timely and accessible manner.
4. Evidence-based pharmacological therapies, including anti-neuropathic medications, should be offered to manage painful symptoms in accordance with national guidelines (e.g. NICE, SIGN).
5. Physical and psychological therapies should be made available to people with pain at all stages of pain management, according to their symptoms and engagement with services.
6. People with uncontrolled pain, complex conditions or severe physical or emotional distress should be referred for specialist assessment and management.
7. Practitioners should, where clinically feasible, adhere to national guidelines when prescribing anti-neuropathic medication and opioids.
8. Healthcare professionals should enable people with pain to plan the process of reducing or stopping medications that are not providing benefit or potentially causing harm.
9. Clear and consistent information should be provided when there is no effective specific medical or surgical intervention to help enable a person with chronic pain to move on and engage with activities that help them manage their own pain.

BACKGROUND

Chronic pain has been recognised as a distinct clinical problem and has been described as pain that persists past the normal time of healing. In practice, this may be less than one month or more than six months,[7] but is now most usually described as pain that continues for more than 12 weeks.[1] Pain can be perceived as a warning of potential damage but can also be present when no actual harm is being done to the body. The underlying neurophysiological changes associated with chronically painful states begin at an earlier stage than suggested by this timeframe.[8]

While chronic pain is a condition in its own right, it is also an umbrella term for severe pain occurring from a range of other clinical conditions, 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 people with chronic pain. While the precipitating diseases are varied, the symptoms of chronic pain and the impact they have on a person's life are consistent within a broad biological, psychological and social (biopsychosocial) framework.[4]

The potential for or presence of biopsychosocial issues should be detected as early as possible with a view to preventing them or minimising their impact.[5] Supported self- management is an integral part of chronic pain management and works best when the individual is able to take the lead in deciding how they want to live their life and are supported in finding ways of reducing chronic pain.[9]

The spectrum of pain ranges significantly from low risk, where an individual can deal with their own pain as a manageable condition with continued support, to higher risk individuals who require complex case-management programmes.[9] Pain management services are increasingly being commissioned in community settings, often provided by specialist multidisciplinary pain management teams. Given the number of people who suffer from chronic pain and the impact on healthcare resources and society, it is imperative that the people with pain gain access to the right care provider at the right time.[10]

The National Institute for Health and Care Excellence has produced clinical guidelines for the management of low back pain and sciatica, chronic neuropathic pain and the use of spinal cord stimulation,[11–13] 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.[14] The Scottish Government and NHS Scotland have produced a guide to promote quality improvement in the prescribing of analgesic medicines in the management of chronic pain.[15]

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 intervention.[16]

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

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6.5 ADULT ACUTE AND INPATIENT PAIN MANAGEMENT

Mark Rockett, Chandran Jepegnanam, Sailesh Mishra, Lindsey Pollard and Devjit Srivastava

INTRODUCTION

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

People's expectations of pain management may be high, and the provision of adequate analgesia is an ethical imperative, enshrined in the International Covenant on Economic, Social and Cultural Rights.[1]

Inpatient pain services (IPS) exist in almost all acute hospitals in the UK. However, these services vary in their level of staffing and support for patients out of hours and for those suffering from pain of non-surgical origin.[2] Effective pain relief is an important outcome measure for patients, and an IPS may provide improved analgesia in a cost-effective manner.[3] In addition, adverse effects of analgesic interventions are lower, and short- and long-term outcomes may be improved in subgroups of high-risk patients with advanced analgesic techniques supported by an effective IPS.[3–6]

STANDARDS

1. Inpatient pain management must be staffed by consultants, SAS doctors and specialist nurses with appropriate level of training and competencies, and with evidence of continued CPD relevant to their clinical work.
2. All people with acute pain must have an individualised analgesic plan appropriate to their clinical condition that is effective, safe and flexible with planned review.
3. All inpatients with acute pain must have regular pain and functional assessment using consistent and validated tools, with results recorded. There should be clear guidelines for communication with the IPS.
4. For people in severe pain, action must be taken immediately and an intervention must take place within 30 minutes. The effectiveness of the intervention must be reassessed after an appropriate interval.
5. People with complex pain must be referred to the IPS and must be reviewed in a timely fashion.

Hospital to community transition after surgery

6. On discharge from hospital, the discharge letter must include accurate details of all analgesia provided. The prescription of any opioid analgesia for use post-discharge must include a de-prescribing plan.

RECOMMENDATIONS

1. All hospitals should provide an IPS staffed by appropriately trained consultants, SAS doctors and nurses. Consultants should have completed higher pain training (ideally advanced pain training for lead clinicians). Senior IPS nursing staff should be independent nurse prescribers.
2. All healthcare professionals involved in the IPS must have job plans that include time dedicated to acute pain management. The job plan should offer some flexibility to acknowledge the variable demand for advanced pain management through the week.
3. Close links with the local outpatient chronic pain service is highly desirable, ideally with some IPS staff working in both acute and chronic pain. This will facilitate timely involvement of chronic pain services and transitional pain management as needed.
4. IPS should have close links with relevant health professionals, including pharmacy, physiotherapy, occupational therapy, psychology, addiction medicine and liaison psychiatry. The role of psychological strategies in complex acute and inpatient pain is being increasingly acknowledged. acute NHS trusts are encouraged to liaise with psychologists to support holistic multimodal management in complex clinical situations.
5. Specialist acute pain management advice and intervention should be available at all times to all inpatients. 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 IPS senior staff (clinical nurse specialist, consultant or other suitably qualified senior member of the MDT). Assessment of complex pain by the IPS should be timely (within 24 hours).
7. All inpatients with acute pain should have individualised treatment plans based on the principles of multimodal analgesia. This may include both pharmacological and non-pharmacological treatments. Regional analgesia interventions for acute pain should also be available where appropriate.
8. Guidelines should be in place for all modalities of pain relief in clinical use, for the alleviation of the common adverse 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. A continuing education programme should be in place for all healthcare professionals covering assessment of pain and functional

limitations, pain treatment and specific delivery techniques appropriate to their clinical duties.

10. There should be regular audit and evaluation by both nursing and medical staff of the effectiveness of acute pain management, complications and staff training. The RCoA audit recipe books serves as a useful guide.[7] The IPS should have a governance structure that allows performance to be monitored and incidents report and investigated, to maintain patient safety and continuously improve quality. Patient safety and continuous quality improvement should be core values of the IPS.

Hospital to community transition after surgery

11. On discharge, the IPS should ensure that patients are informed on how to safely self-administer medication. This should include advice on how their analgesia will be weaned and how to appropriately dispose of excess analgesic medications. They should be informed of the influence of analgesic medicines on driving, if appropriate, and other complex decision processes. A patient leaflet should be used to reinforce these messages.

BACKGROUND

Good pain management is intrinsic to high-quality healthcare. The relief of suffering is primarily a humanitarian aim, valid in its own right, regardless of its impact on other outcomes.[8] The IPS fosters a clinical environment where pain relief is everyone's responsibility – through training, education and direct clinical care. The IPS ensures standardisation of pain and functional assessment and, where appropriate, develops treatment guidelines resulting in consistent effective care.

A core role of the IPS 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 IPS. It is recognised that effective acute pain management, as part of an enhanced recovery after surgery (ERAS) programme can result in reduced lengths of stay and complications.[9] The IPS 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 people with complex pain problems. Such individuals are relatively common in today's inpatient population.[10,11] The inpatient pain service should facilitate provision of preoperative risk assessment for short- and long-term pain problems. Optimisation of pain management for people with complex pain problems prior to surgery should involve the IPS where necessary. The IPS should also lead on the development of local strategies to reduce the risk of people developing persistent post-surgical or persistent post-traumatic pain.

The planning of continuing pain management after surgery and discharge should also involve the IPS as part of a transitional pain service. The aims of the IPS should include minimising opioid use in the short term and reducing the number of patients left with long-term opioid misuse disorder. This may involve collaborative working with primary care and outpatient pain and addiction services.[12,13]

Given that persistent 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 IPS is closely linked with local outpatient chronic pain services. As an ideal, IPS 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 undertreated in medical inpatients and those in critical care settings, the IPS has a key role to play in staff and patient education, as well as providing direct clinical care for these patient groups.[14] The Faculty of Pain Medicine has recognised Essential Pain Management UK (EPMUK) as a model for delivering education in basic pain management that can be tailored to individual target groups ranging from medical and nursing students, allied health care professionals and freshly qualified foundation-year doctors and post-certification nurses. The EPMUK training tool is of use in UK practice but lacks emphasis on opioid minimisation and the use of multimodal analgesia, including regional analgesia and atypical agents.[15]

Consistency in the approach to acute pain management and provision of adequate IPS staffing throughout the UK are currently lacking.[2,16] There is a lack of provision for the management of inpatients with complex or chronic pain and those in non-surgical settings. It is hoped that these standards, building upon the previous RCoA guidelines for inpatient pain management, will prove useful for hospitals seeking to provide their patients with high-quality, safe and effective acute pain management.[17]

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6.6 CANCER-RELATED PAIN

Michael Bennett and Manohar Sharma

INTRODUCTION

Pain arising from cancer or cancer treatment is the symptom most feared by people with this disease and many report severe pain, including those living at home. Clearer management pathways for people with cancer-related pain will allow earlier integration of specialist support and lead to improved patient satisfaction and outcomes. The following standards and recommendations are adopted from the European Pain Federation standards for the management of cancer-related pain.[1]

STANDARDS

1. People with a history of cancer must be routinely screened for pain at every engagement with a healthcare professional.
2. People identified with cancer-related pain must receive a pain assessment when seen by a healthcare professional, which as a minimum classifies the cause of pain based on proposed 11th revision of the International Classification of Diseases taxonomy and establishes the intensity and impact on quality of life of any pain that they report.[2]
3. A multimodal pain management plan must be agreed with the person with cancer pain that explains the causes of their pain and its likely prognosis, the need for further investigations and the multimodal treatment options, and which includes the person's preferences and goals for treatment.
4. People with cancer pain must receive tailored, multimodal treatment, which reduces the pain and its impact on daily living. That may include a combination of medicines and nonpharmacological treatments including pain interventions oncological interventions, physical rehabilitation and psychosocial or spiritual support.
5. Support and advice for self-management must be provided.
6. The pain management plan must be reviewed regularly to assess outcomes and plan longer-term care.
7. People with cancer pain must be referred for more specialist advice and treatment if pain is not improving within a short time or if they are experiencing intolerable adverse effects of analgesia (in accordance with the Faculty of Pain Medicine's Framework for Provision of Pain Services for Adults across the UK with Cancer or Life-limiting Disease).[3] This should include access to a multidisciplinary pain team and advanced pain management techniques (intrathecal pumps and neuroablative techniques).

RECOMMENDATIONS

1. Healthcare professionals who treat people with cancer should receive continuing education and training to undertake basic pain assessment, initiate basic management and learn about correctly referring for more specialist support.
2. Regular review of service outcomes for all people with cancer pain should be in place.
3. National evidence or consensus-based guidelines should be in place for cancer-related pain.

BACKGROUND

Each year, 350,000 people in the UK are diagnosed with cancer, of whom 66% will survive for at least 5 years and 40% will be alive more than 10 years after their diagnoses.[4–6] Pain is the most common symptom of cancer at diagnosis[7] and rises in prevalence throughout and beyond cancer treatment.[8] At least 66% will experience pain before death and 55% will experience pain of moderate to severe intensity.[5,8] Between 33% and 40% of cancer survivors (persons with cancer whose curative treatment was completed) suffer from chronic pain.[9,10]

The WHO published Cancer Pain Relief (the WHO analgesic ladder) in 1986; this document advocated a stepwise approach to analgesia for cancer pain and revolutionised the use of oral opioids.11 Observational studies suggested that this approach results in pain control for 73% of people with cancer pain, with a mean reduction in pain intensity of 65%. However, despite the availability of opioids for cancer pain, a recent systematic review demonstrated that about one in three people with cancer pain is still undertreated.[12] This translates in England and Wales to 105,000 people with cancer experiencing pain every year, of whom 50,000 will be undertreated.

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 people 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 help.[13] However, pain management is not improved by assessment alone.

Peoples' levels of understanding and their fear of cancer pain and escalation of analgesia are associated with reluctance to commence opioids, reduced medication adherence, and higher pain intensity. Standardised educational interventions can improve pain outcomes and are recommended in national guidelines.[3,14]

Patient satisfaction with pain management is significantly associated with a physician stating the importance of pain management, providing instructions for managing pain at home, managing adverse effects and allaying fears about addiction.[15] Assessing pain and presenting data to physicians prior to consultation for them to use it in discussions significantly improves pain outcomes and quality of life for people with cancer pain. Use of specific prescribing guidelines for cancer pain results in significant benefits compared with control groups in both average and worst pain intensity.[16] Physician-related barriers are common and relate to both technical aspects (inadequate prescription) and the context of the interaction with people with cancer pain. In routine practice, people with cancer often receive opioid analgesia only in the last weeks of life, despite evidence suggesting that they could benefit from earlier intervention.[17] In 2012, NICE published guidelines on safe and effective use of opioids in palliative care in recognition of both undertreatment of pain and poor knowledge of opioid prescribing among non-specialists.[18]

In 2015, NHS England published *Enhanced Supportive Care*, which recommended collaboration between palliative medicine, oncology and pain medicine to improve patient journey including pain management.[19] This publication also recognised the importance of long-term management of pain related to cancer treatments (chemotherapy, radiotherapy or surgery) in the context of disease that has been cured or is in remission, and in which cases alternatives to opioids are likely to be more appropriate interventions.[20,21]

In 2019, the Faculty of Pain Medicine published a *Framework for Provision of Pain Services for Adults across the UK with Cancer or Life-limiting Disease*,[3] which is supported by the Association for Palliative Medicine, Association of Cancer Physicians and Faculty of Clinical Oncology. This framework is designed to enable services to meet the standards for cancer-related pain described in this document.

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6.7.1 MANAGING ACUTE PAIN IN CHILDREN AND YOUNG PEOPLE

Glyn Williams and Mary Rose

INTRODUCTION

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 adverse 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. This may include non-pharmacological as well as pharmacological treatments.
3. Acute pain in children must be regularly assessed with an appropriate, validated pain assessment tool. Pain assessment must be documented in the patient record.
4. Members of the acute pain service must have received child protection training and be familiar with safeguarding procedures.[1]
5. On discharge from hospital, the discharge letter must include accurate details of all analgesia provided; the prescription of any opioid analgesia for use post-discharge must include a de-prescribing plan.

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, although 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 to all inpatients. Staffing should be sufficient to provide prospective cover for all personnel.
3. Guidelines should be in place for all modalities of pain relief in clinical use for the alleviation of the common adverse 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).
4. A continuing education programme should be in place for all healthcare professionals in the areas of paediatric pain assessment, pain management and specific delivery techniques.
5. Arrangements should be in place to liaise with other specialties responsible for the shared care of children and young people with acute pain.
6. There should be regular audit and evaluation of the effectiveness of acute pain management, complications and staff training.
7. Written information should be routinely provided and disseminated to parents/children and young people with pain where appropriate.

BACKGROUND

Acute pain management teams involved in the care of children were first described in the 1990s and have become an accepted model for hospitals involved in the care of children.[2,3] The provision and the model of children's acute pain services are 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.[3,4] The competencies should include an understanding of the age-related changes in pharmacokinetic and pharmacodynamic profiles of analgesics.

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 pain.[3]

Effective acute pain relief for children uses individualised analgesic regimens based on the concept of multimodal analgesia. These regimens must be effective, flexible, to allow for interindividual variations in efficacy and requirements, and must be safe and acceptable to the child or young person with pain 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 scenarios.[4]

All children with acute pain should have regular assessment of their pain, in conjunction with clear documentation in the patient record. 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.[4,5]

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 networks.[3]

In keeping with UK-wide legislation in relation to child protection, all staff involved in healthcare provision for children and young people must receive safeguarding training to ensure they attain the competences appropriate to their role and follow the relevant professional guidance.[1]

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6.7.2 MANAGING PROCEDURAL PAIN IN CHILDREN AND YOUNG PEOPLE

Alison Bliss and Helen Neary

INTRODUCTION

Procedural pain and distress should be anticipated and managed pre-emptively. Any child about to undergo an intervention that may be potentially painful should receive appropriately timed analgesia and management of procedural distress. Management approaches should include both pharmacological and non-pharmacological strategies and psychological modalities to prepare and distract, with all members of the team working collaboratively to minimise distress. Planning for the intervention must consider appropriate inclusion of the child, family and carers.

STANDARDS

1. A child undergoing a potentially painful procedure must receive 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 to children and young people must have received child protection training and be familiar with safeguarding procedures (see Chapter 10: Safeguarding).

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 distress.[4]
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.[1,3,4,7,8]
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] This may include therapeutic or clinical holding.[8] If this is clinical holding is required, health professionals should obtain the child's assent (expressed agreement) in all but the very youngest children. For any situation that is not a real emergency, seek the parent/carer's consent or the consent of an independent advocate.[9]
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 team.[2]
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.[1,10] Some procedures, because of the length of time they require, should only be considered under sedation or general anaesthesia.
11. Recommended published guidance for the conduct of paediatric sedation should be used.[11,12] All institutions where sedation is provided should have a sedation committee.[12]

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.[2,5,10] One recent study revealed that over three-quarters of children experience at least one painful procedure within a 24-hour timeframe during their admission (with an average of six procedures), yet 22% had no analgesic intervention in the same time period, and only 28% of children received analgesia with specific relation to their painful procedure.[5]

Children and young people's experience of pain is complex, with integral components of fear and anxiety.[7,8] The undertreatment of pain and procedural distress can cause harmful and long-lasting effects,[3,13,14] 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

pharmacotherapy.[1–4] Pain should be assessed both before and after an intervention using a validated pain assessment tool appropriate for their chronological age and level of cognitive development, to determine baseline pain levels and efficacy of pain management strategies.[1,2,15]

Procedural distress may in part be effectively managed by simple measures to prepare the child for the procedure.[1,3,4,7,8] These include timely and 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 psychologists and the use of specialist psychological therapies,[2] 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 infants[7,8]), holding and non-nutritive sucking.[1,3,4,8]

Despite evidence to support their effectiveness, psychological and non-pharmacological interventions are underused, and are documented in only approximately 25% of painful procedures,[5] yet they are relatively simple, cost-effective techniques which can enhance analgesia in a timely manner.[1,4] Best practice dictates a multimodal approach combining both these modalities with analgesic agents.[1]

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 timescale for performance of the procedure.[1,4] These may include oral, intravenous, intranasal, transdermal, topical,[7] transmucosal, 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] With their consent and appropriate preparation, some children and young people may require clinical holding to be able to complete a procedure in a timely fashion with minimal distress.[9] Clinical holding, by its definition, allows children and young people to feel secure in their immobilisation, as opposed to the use of restraint which applies force to overwhelm the child, heightening their distress and anxiety.[9] 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 required.[1]

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 guidance.[16]

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6.7.3 MANAGING CHRONIC PAIN IN CHILDREN AND YOUNG PEOPLE

Paul Rolfe, Helen Neary, Peter Brook and Hannah Connell

INTRODUCTION

Epidemiological studies indicate that chronic pain in childhood and adolescence is common, with prevalence rates quoted at 15–80%.[1–5] The majority of these children can be managed effectively within primary care but, in a significant minority, chronic and recurrent pain has a major adverse effect on the child and their family at a time of major psychosocial and educational development. This latter group, with complex pain problems require specialist pain management.

STANDARDS

1. All children with chronic pain must receive a comprehensive biopsychosocial assessment by an MDT with paediatric expertise.
2. All professionals working with children must have knowledge of safeguarding, including emotional abuse, neglect and fictitious and induced illness protocols and know how to initiate a referral.
3. Treatment must be based on the best available evidence and in line with current clinical guidelines.
4. Arrangements must be in place for transition to adult services.

RECOMMENDATIONS

1. At least one hour should be available for the first appointment.
2. The MDT should include medical staff with training and expertise in paediatric pain management, specialist nurses, psychologists, physiotherapists and occupational therapists. Access to a suitably trained pharmacist should be available where necessary.
3. 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 in the form of an information sheet or assessment report.
4. The aim of treatment should be to use non-pharmacological interventions including physical and psychological interventions to manage pain where this is possible and to promote living well in the presence of pain and encourage self-management. It may be necessary to offer pharmacological therapy although evidence is limited.
5. Where possible parent or guardians should be engaged in treatment and encouraged to take an active role.
6. Children and young people presenting with complex regional pain syndrome-type symptoms should be seen urgently and diagnosed by a doctor who is aware of the diagnostic criteria and how they apply to children.
7. Follow-up appointments should be arranged at appropriate intervals with appropriate disciplines.
8. School liaison and working with other agencies such as social care should be undertaken when required.
9. Psychological intervention should be provided to support pain management. Where necessary liaison and referral to child and adolescent mental health services should be made.

BACKGROUND

Persistent pain in childhood is common. This 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.

Headache, back pain, musculoskeletal limb pain and abdominal pains are the most frequently reported.[4,5] There is a higher prevalence of chronic pain in girls, the prevalence increases with age and lower socioeconomic groups.[2]

The prevalence of chronic post-surgical pain in children after major surgery is reported as 20%. Presurgical pain intensity, child and parent psychosocial factors and pain catastrophising behaviours are predictive of chronic post-surgical pain.[6,7]

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.[8]

Following multidisciplinary assessment, the first step in management is to provide an appropriate explanation for the child and family using the biopsychosocial model of pain and the child's experience of their pain. This includes information 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.

There is good evidence for the role of psychological interventions in the management of chronic pain in children and young people.[9,10] Strategies that are currently used comprise mindfulness and resilience training, biofeedback, CBT, ACT; behavioural activation and exposure, hypnosis for procedural and recurrent pain. These interventions can be provided on a one-to-one basis or as part of a group

setting depending on the individual. Psychological interventions should assess and formulate the individual and family factors that are involved in the presentation and provide appropriate treatment. Parents and guardians should be included in the treatment.

Physical interventions include physiotherapy, TENS, desensitisation therapy and acupuncture. Physiotherapy has an established role in the management of complex regional pain syndrome and musculoskeletal pain.[11] Physiotherapy can also play a significant role as part of the multidisciplinary management of other types of chronic pain as part of an overall fitness and stamina intervention to promote living well with the pain.

There is minimal robust evidence to support the use of pharmacological agents in chronic pain in children.[12,13] When used they should be part of a multimodal 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 interventional pain procedures in children, but in certain conditions they may facilitate engagement with physical therapy and return to activity. These should be considered on an individual patient basis in specialist centres.

Rehabilitation into the usual activities of childhood, family and social life, school and hobbies is an important goal.[16,17]

All healthcare professionals involved in the management of chronic pain in children and young people must have awareness of safeguarding issues, including factitious and induced illness,[14] and know on how to initiate an 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 guidance.[15]

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6.8 TRANSITION OF CARE FROM CHILDREN AND YOUNG PEOPLE TO ADULT SERVICES

Dr Alison Bliss and Dr Devjit Srivastava

INTRODUCTION

Transition has been defined as the purposeful, planned movement of people from one health system to another.[1] For adolescents and young people, transition is the coordinated transfer of care from child-centred to .adult-orientated systems.[2] It is a process which requires forward planning and continuing support; the corner stone of such a process is good communication well in advance.

STANDARDS

1. Young people who will require continuing management of their chronic pain in adulthood must have a transition plan in place to ensure their care transfers seamlessly from paediatric to adult services.[3–7] Wherever possible, this should include a period of combined care.
2. The transition process must be planned, documented and overseen by a responsible key practitioner.[3]
3. All health care professionals involved in the care of children and young people must have received child protection training and be familiar with safeguarding procedures.

RECOMMENDATIONS

1. Planning for transition to adult services should be considered for young people in school year 9 (age 13–14 years) and onwards.[3]
2. Each young person should have a key accountable individual (nurse, youth worker, allied health professional, general practitioner or other), a 'named worker' to coordinate and support their transition.[3]
3. Young people should be involved in the transition process through peer support, mentoring, advocacy and the use of smart mobile technology.[3]
4. Young people should determine the extent that parents and carers are involved during and after the transition process.[3]
5. Young people should see the same healthcare practitioner for the first two appointments after transition to adult services.[3]
6. Young people who do not attend their first appointments should be contacted by adult services and given further opportunities to engage.

BACKGROUND

Since 2002, there has been increasing recognition by a multitude of national governing bodies that a proportion of young people who have moved from paediatric to adult services fail to engage with continuing care, missing appointments and failing to comply with recommended therapies, with detrimental consequences on their long-term physical and mental health.[8–11] Without appropriate planning, some young people and families have been found to lose confidence in healthcare and disengage. The process of transition is therefore a vital mechanism for managing expectations, supporting compliance, ensuring better care experiences and improving outcomes.[8–11] The aims, principles and process of transition are now described in detail in the NICE guideline Transition from Children's to Adults' Services for Young People Using Health or Social Services and its accompanying quality standards.[3]

Transition should begin early, from school year 9 or age 13–14 years onwards, to allow sufficient time for the young person to be involved in decision making and to understand the changes in their future care. By using a person-centred approach, young people become increasingly equal partners in the decisions regarding their care.[6]

For teenagers who present with chronic pain, transition planning should be considered from the time of presentation. For those who have been working with paediatric pain services since earlier in childhood, meeting new practitioners and moving to a new service can be a stressful and anxious time. The process requires a named professional to coordinate care overseeing the planning and regular reviewing progress. As a minimum, reviews of the transition plans should be undertaken annually.

The transition process should include an introduction to one or more of the practitioners who will take a lead role in the young person's future care. Such meetings in advance of the final handover of care can help the young person have confidence in the new team, reduce their concerns and improve their engagement with the incoming practitioners involved in their care.[9,11] Young people and families should be made aware of possible changes in management; an example may be the performance of interventional analgesia under sedation or local anaesthesia that would have been performed under general anaesthesia within paediatric services.[4]

This can lead to a smoother transition for the young person and more regular attendance at appointments in adult services, with better outcomes. Without the support of an adequately planned transition process, young people may fail to engage with the new team and this can adversely affect both their physical and mental health, their access to education or employment and their social care needs. The young person's general practitioner should be involved in the transition process from its inception.[11] Senior management in both children's and adults' services should work together to support a smooth and gradual transition for young people.[6]

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Chapter 7

Pain interventions

7.1 PAIN MANAGEMENT PROGRAMMES

Paul Wilkinson, Zoey Malpus, Gail Sowden and Ann Taylor

INTRODUCTION

Pain management promotes behaviour change and improves wellbeing in people with pain and is traditionally delivered to groups of individuals and 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 PMPs.[1–4] A number of systematic reviews have shown that PMPs significantly reduce distress and disability, enhance coping and improve various measures of physical functioning.[3–5] Where vocational training has been included in the package, return to work is also significantly enhanced.[6] 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. These standards are currently being reviewed.

The underlying principle of managing pain is that the person with pain requires the right health care for their needs, 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 and provided on an individual basis when this required.
3. A PMP must use evidence-based therapies.
4. PMPs must be properly resourced with time, personnel and facilities.
5. A person with pain's suitability for a PMP is based on the impact of pain, and there must be no discrimination on the basis of age, language spoken, literacy, litigation or judgement of motivation.
6. A PMP must be delivered by an interdisciplinary team where some competencies are shared and some are unique to particular professions.
7. PMPs may be delivered in a primary, secondary or tertiary care settings; the required resources must be available.
8. The effective delivery of standard and intensive PMPs for complex participants must be undertaken by trained staff, working as a team in adherence to the core principles.
9. Evaluation of outcomes must be standard practice. This should include assessing changes in function, psychological distress/wellbeing, healthcare use, quality of life and work/social status, participant satisfaction/experience and attainment of personal goals, where relevant.
10. There must be cooperation between primary, secondary and tertiary care to deliver effective, integrated services for people with chronic pain.
11. There must be sufficient time in job plans to attend MDT meetings to discuss clinical and service-related issues.
12. PMP staff must have adequate time and funding for training opportunities and continued professional development in the wider aspects of pain management.

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 12 half-day sessions (e.g. 12 × 3 = 36 hours), although arrangements may vary in practice.
3. A person's suitability for participation in an appropriate pain management intervention should be assessed ahead of enrolment and where appropriate, interventions to enable participation should be offered. Using a model of 'opt in' may improve engagement in pain management.[12]
4. Some very disabled and distressed people with pain will not benefit significantly from standard programmes, but may benefit from more intensive programmes (e.g. 15–20 full days). Longer, more intensive programmes give greater and more enduring benefit, but intensive programmes are not recommended as standard for all people with pain.

5. It is recommended that some of the principles of pain management should be applied early in care pathways. People with pain 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.

6. It is recommended that pain rehabilitation interventions are classified broadly into three groups:
   - early stratified care
   - standard PMPs
   - intensive PMPs.
7. Effective care requires commissioning and healthcare provision at all three levels.
8. 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.
9. Standard and intensive PMPs should be undertaken by interdisciplinary pain management teams which contain specialist healthcare professionals including doctors, psychologists, physiotherapists, nurses and occupational therapists and, in some services, access to a named pharmacist for advisory pharmacy advice.

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.[10] 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 CBT, learning and conditioning processes, skills training, physical exercise and education.[10]

PMPs should adhere to cognitive behavioural principles and typically include:[10]

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 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, particularly those relating to pain. The aim is to help guide and teach methods of managing and re-evaluating unhelpful thinking styles and beliefs or of lessening the impact of these on behaviour.
3. Graded exposure to reduce fear or to increase willingness to experience fear, 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 negative impacts of thoughts and feelings on behaviour, including cognitive restructuring or other more contextually based methods (such as mindfulness, acceptance and awareness exercises).
   - Methods for identifying, setting, planning and pursuing goals.
   - Strategies for coordinating, scheduling and managing the rate and pattern of value-based activity.
   - Skills for communication and social interaction.
   - Sleep management methods.
   - Methods for generalising and integrating new skills and behaviour change into daily life and maintaining these over the longer term.
   - Behavioural techniques for stress reduction such as diaphragmatic breathing and relaxation techniques
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 eventually to improve fitness and physical health. Mindful movement can be used to explore avoidance and habitual ways of moving and create opportunities to experiment with responding differently to avoided external and internal experiences (e.g. cognitions, emotions and sensations).
7. Education to improve knowledge, understanding and facilitate behavioural change. However, education alone does not tend to produce behaviour change or improve daily functioning and often needs to be supplemented with other methods to create an impact. Information delivered can include:

- pain re-conceptualisation
- pain psychology
- benefits, safety and risk in relation to increased activity
- how to commence, problem solve and sustain exercise and physical activity
- short- and long-term advantages and disadvantages of using aids, treatments and medication
- self-management approaches to flare-ups and setbacks
- safe, effective and appropriate use of medication
- general information and advice on issues such as diet, weight, alcohol use, smoking, recreational drug use and exercise for improving or maintaining general health.

8. Interventions to facilitate retention and return to work or desired lifestyle and hobby uptake.
9. The core staff included in recommendation 8 for Standard and Specialist PMPs are doctors, psychologists, physiotherapists, nurses, occupational therapists and in some services access to a named pharmacist. Other core staff include clinical support workers and an administrator. Required qualifications are as follows.
    - Medical practitioner: a medically qualified person (most commonly a specialist in pain medicine with FFPMRCA qualification or equivalent training).
    - Psychologist: should be eligible for chartered status with the British Psychological Society and a HCPC registered practitioner psychologist. The psychologist should have specialist expertise in managing pain or other long-term health problems. There may be a role for a British Association for Behavioural and Cognitive Psychotherapies (BABCP) -registered cognitive behavioural therapist with appropriate training and supervision, if they can evidence an advanced level of competencies for working with pain.
    - Physiotherapist: an HCPC registered physiotherapist with specialist expertise in managing people with chronic pain.
    - Occupational therapist: an HCPC-registered occupational therapist with specialist expertise in managing people with chronic pain.
    - Nurse: an NMC-registered nurse with specialist expertise in managing people living with pain.
    - Pharmacist: a GPhC-registered pharmacist, ideally with an interest in pain management. Appropriate access to medicines information is required.

PMPs have a major impact in those living with pain and their significant others. They 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.

RESEARCH REQUIRED

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

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7.2 MEDICINES

Roger Knaggs and Greg Barton

INTRODUCTION

Medicines are the most frequently used intervention in the management of acute pain, persistent pain and cancer-related pain. It is essential that medicines are prescribed, dispensed and administered correctly to ensure patient safety. All healthcare professionals must work within their professional competence when prescribing and administering medicines and when providing advice with respect to adverse effects and potential harm.

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 must be followed.[1]
3. Professional standards relating to administration and supply of medicines from regulators and professional bodies must be adhered to.[2]
4. NHS England/NHS Improvement and the former National Patient Safety Agency guidance on medicines safety must be considered and followed.
5. People who are prescribed medicines for pain relief which are subject to Driver and Vehicle Licensing Authority legislation must be informed that it is illegal to drive with legal drugs if it impairs their driving.[3,4]
6. Both medical and non-medical prescribers must ensure and maintain their competence using a nationally recognised framework.

RECOMMENDATIONS

1. Principles of evidence-based medicine and shared decision making should always be applied when considering treatment options.
2. Where relevant, medicines should be used in accordance with recommendations from national bodies and professional bodies (e.g. NICE, the Scottish Medicines Consortium, All Wales Medicines Strategy Group, Guidelines and Audit Implementation Network, Academy of Medical Royal Colleges, Faculty of Pain Medicine and the British Pain Society). Patient pathways should reflect these recommendations.
3. Where no national guidance is available, the development, approval and implementation of local prescribing guidance or shared-care agreements should be considered, particularly for medicines used less frequently.
4. People prescribed analgesic medicines should be informed to have realistic expectations and the agreed outcomes should recorded in the person's medical record.
5. People with pain should be provided with sufficient information about analgesic medicines to make informed decisions and they should be active partners in decisions about medicines.
6. Recommendations regarding initiation or changes to medicine regimens should be communicated accurately and in a timely manner between different specialties, in particular between a pain management service and general practice.
7. Prescribers should be aware that safe and effective management of acute, procedural, chronic and cancer pain in special populations, such as neonates, infants, children and young people, older people and those with renal or hepatic impairment, requires understanding of age-related changes in both pharmacokinetic and pharmacodynamics profile of analgesics. Prescribers must ensure and maintain their competence in paediatric prescribing if their practice includes the management of pain in children.[5]

BACKGROUND

The phrase 'medicines management' has been used frequently to emphasise the importance of developing robust processes for safe and cost-effective procurement, prescribing and administration for medicines.[6] Increasingly, it is being replaced by the term 'medicines optimisation', which is more about ensuring that the right person gets the right medicine at the right time, and focuses on outcomes and people rather than process and systems.[7]

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. 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.

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

In March 2015, legislation on the offence of drug driving was strengthened in England, Scotland and Wales, and this makes it illegal to drive if a drug (therapeutic/recreational) impairs mental or physical capacity.[4] 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 patients,[3] and the MHRA has provided information for patients.[4]

RESEARCH REQUIRED

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 people with pain 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 the following.

NICE guidelines

Controlled Drugs: Safe use and management. NICE Guideline NG46. Available from: https://www.nice.org.uk/guidance/ng46 (accessed 5 March 2021)

Low Back Pain and Sciatica in over 16s: Assessment and management. NICE Guideline NG59. London, 2020. Available from: https://www.nice.org.uk/guidance/ng59 (accessed 5 March 2021)

Low Back Pain in Adults: Early management. Clinical Guideline CG88. London, 2009. Available from: http://www.nice.org.uk/guidance/CG88 (accessed 5 March 2021)

Medicines Adherence: Involving patients in decisions about prescribed medicines and supporting adherence. Clinical Guideline CG76. London, 2009. Available from: http://www.nice.org.uk/Guidance/CG76 (accessed 5 March 2021)

Medicines Optimisation: The safe and effective use of medicines to enable the best possible outcomes. NICE Guideline NG5. London, 2015. Available from: https://www.nice.org.uk/guidance/ng5 (accessed 5 March 2021)

Neuropathic Pain in Adults: Pharmacological management in non-specialist settings. Clinical Guideline CG 173. London, 2020. Available from: http://www.nice.org.uk/guidance/CG173 (accessed 5 March 2021)

Osteoarthritis: Care and management in adults. Clinical Guideline CG177. London, 2020. Available from: http://www.nice.org.uk/guidance/CG177 (accessed 5 March 2021)

Rheumatoid Arthritis in Adults: Management. Clinical Guideline CG79. London, 2015. Available from: http://www.nice.org.uk/Guidance/CG79 (accessed 5 March 2021)

Care Quality Commission

Controlled drugs. Available from:https://www.cqc.org.uk/guidance-providers/controlled-drugs/controlled-drugs (accessed 5 March 2021)

NHS England and NHS Improvement Patient Safety Team (Previously National Patient Safety Agency)

National Patient Safety Alerts. Available from: https://www.england.nhs.uk/patient-safety/patient-safety-alerts (accessed 5 March 2021)

Risk of Distress and Death from Inappropriate Doses of Naloxone in Patients on Long-term Opioid/Opiate Treatment. Patient Safety Alert. NHS/PSA/W/2014/016. London, 2014. Available from: http://www.england.nhs.uk/wp-content/uploads/2014/11/psa-inappropriate-doses-naloxone.pdf (accessed 5 March 2021)

Patient safety resources (archived): Available from: https://webarchive.nationalarchives.gov.uk/20171030124143/http://www.nrls.npsa.nhs.uk/resources (accessed 5 March 2021)

Faculty of Pain Medicine

Best Practice in the Management of Epidural Analgesia in the Hospital Setting. London, 2020

Clinical guidelines. Available from: https://fpm.ac.uk/standards-publications-workforce-guidelines-publications/clinical-guidelines (accessed 5 March 2021)

Opioids Aware. Available from: https://fpm.ac.uk/opioids-aware (accessed 5 March 2021)

Patient information leaflets. Available from: https://fpm.ac.uk/about-pain-medicine-patients-relatives/patient-information-leaflets (accessed 5 March 2021)

British Pain Society

Cancer Pain Management (2010)

British Geriatrics Society; British Pain Society. Guidance on the management of pain in older people. *Age Ageing* 2013; 42 (Suppl 1): i1–57.

Intrathecal Drug Delivery for the Management of Pain and Spasticity in Adults; Recommendations for best clinical practice (2015)

Use Of Medicines Outside of their UK Marketing Authorisation in Pain Management and Palliative Medicine (2012)

Royal College of Physicians

Complex Regional Pain Syndrome in Adults: UK guidelines for diagnosis, referral and management in primary and secondary care. 2nd ed. (2018)

PATIENT PATHWAYS

At the time of writing of the second edition of CSPMS, direct access to the patient pathways (originally published through the Map of Medicine) remains unavailable. Some of the relevant content of the patient pathways can be found in other contemporary publications on the subject:

Baranowski AP, Lee J, Price C, Hughes J. Pelvic pain: a pathway for care developed for both men and women by the British Pain Society. *Br J Anaesth* 2014; 112: 452–9

Lee J, Ellis B, Price C, Baranowski AP. Chronic widespread pain, including fibromyalgia: a pathway for care developed by the British Pain Society. *Br J Anaesth* 2013; 112: 16–24

Lee J, Gupta S, Price C, Baranowski AP; British Pain Society. Low back and radicular pain: a pathway for care developed by the British Pain Society. *Br J Anaesth* 2013; 111: 112–20

Price C, Lee J, Taylor AM, Baranowski AP. Initial assessment and management of pain: a pathway for care developed by the British Pain Society. *Br J Anaesth* 2014; 112: 816–23

Smith B, Lee J, Price C, Baranowski AP. Neuropathic pain: a pathway for care developed by the British Pain Society. *Br J Anaesth* 2013; 111: 73–9

7.3 INTERVENTIONAL TECHNIQUES IN PAIN MANAGEMENT

Sanjeeva Gupta, Ganesan Baranidharan, Simon Thomson and Shyam Balasubramanian

INTRODUCTION

Interventional pain procedures can provide pain relief, aid diagnosis and enable functional restoration in certain people with persistent pain conditions. They have an established role in pain management as part of multidisciplinary approach. Ideally, pain relief following interventions should be used to aid rehabilitation.

STANDARDS

1. Informed consent must be obtained and documented adequately before every procedure, even if the same procedure is being repeated on a different occasion. Information provided must include diagnostic and therapeutic utility, risks material to the person and alternative options including the likely impact of not proceeding.
2. People with pain must be assessed before and after the intervention to determine its diagnostic/therapeutic utility.
3. Equipment and monitoring must meet the standards recommended in Chapter 4.2: Facilities, Equipment and Monitoring.
4. A WHO safety check must be performed for all invasive interventions.[1]
5. Physicians performing the procedure must be appropriately trained.
6. Physicians using fluoroscopy must know the principles of radiation safety and comply with the Ionising Radiation (Medical Exposure) Regulations.
7. Interventions must be performed with aseptic precautions with infection control measures in place.
8. Interventions must be undertaken in an area that complies with occupational health and safety standards.
9. Details of the procedure, including the technique and the medications used, must be clearly documented.
10. Centres offering interventional procedures must have clear published discharge criteria and subsequent management plans including out-of-hours emergency care.
11. The person's GP must be informed of the procedure carried out and the drugs used.
12. Anticoagulation medications must be checked and advice on stopping or continuing them as deemed suitable must be discussed and documented in clinical notes.
13. Any changes in the pain medication following the procedure, if needed, must be discussed with the person with pain and communicated to the primary care physician (GP) through a discharge letter.
14. Ready access to monitoring and resuscitation is necessary for all procedures.

RECOMMENDATIONS

1. The chosen interventional technique should be based on current best available evidence.
2. Intravenous access is recommended for certain procedures.[2]
3. Images should be stored in the hospital radiology system for documentation and future referral.
4. Physicians should possess skills in recognising and managing adverse events and in cardiopulmonary resuscitation.
5. Information concerning the management of people with spinal cord stimulation and other implantable neuromodulation devices should be readily available to clinicians not familiar with the devices and appropriate cautions and potential complications. This will include information on magnetic resonance imaging conditionality, the use of surgical diathermy, and shared care arrangements between the pain team and the out-of-hours hospital team.
6. Centres providing spinal cord stimulation, intrathecal drug delivery or peripheral nerve stimulation with implantable devices (implantable neuromodulation) should enter data on the National Neuromodulation Registry.[3]

BACKGROUND

Interventional pain procedures are used for diagnostic and therapeutic purposes. 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. Clinicians are responsible for patient selection and preparation, conduct of the procedure, outcome assessment and interpretation, and organising the subsequent management plan.[3–8]

The General Medical Council has published detailed and binding guidance on obtaining informed consent, and this must be followed.[9] Written patient information (such as that produced by the Faculty of Pain Medicine) should be used to support the decision-making process.[10]

Clinicians performing the intervention should have 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 Society.[11–16]

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-RELATED PAIN INTERVENTIONS

Manohar Sharma and Matthew Brown

INTRODUCTION

The WHO analgesic ladder was published in 1986 and remains the lynchpin for the pharmacological management of cancer pain.1 Guidelines from SIGN, the European Society for Medical Oncology and a discussion document from the British Pain Society have also been published.[2–4] Pain is common in people with cancer and despite guidelines; uncontrolled cancer pain is still recognised in 10–20% of people with cancer.[5,6]

An intervention might be a one-off injection (e.g. 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 system.[5–12]

A framework published by the Faculty of Pain Medicine recommends an MDT-based approach between pain medicine and palliative medicine in all hospitals with specialist pain services to provide assessment and offer interventions locally.[7] For those requiring complex intervention, access to a highly specialised pain service is essential. This can work in practice only with continuing effective and timely dialogue between these disciplines.[1–7,13]

For those who have undergone successful cancer treatment, a significant number suffer persistent pain and these people will benefit from access to a multidisciplinary pain service to access a variety of approaches for pain management.

STANDARDS

1. People with cancer pain must have access to pain management in line with WHO analgesic ladder recommendations and frameworks published by the Faculty of Pain Medicine and NHS England/NHS Improvement, both in the community and through local palliative care, oncology and other hospital services.[1,7,13]
2. All people experiencing cancer-related pain must have their care provided in close collaboration with their local primary care team, relevant carers and a hospital based MDT including oncology, pain medicine and palliative medicine.
3. The expectations/wishes of people with cancer pain and their family 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 and analyse outcomes, including safety and efficacy data.[7]
5. There must be more than one pain and palliative medicine physician within specialist and highly specialist pain services to support cancer related pain management and for cover of leave or there must be formal arrangements to provide cover.[7]
6. There must be written and agreed patient care pathways in place for complex cancer pain interventions, addressing care before, during and afterwards.
7. The consent process must be documented clearly. People with cancer pain must have access to written information and the opportunity to make informed decisions regarding pain intervention options based on benefits and material risks, if possible with information on patient-reported outcomes.
8. Cancer pain interventions must be planned in a timely manner through appropriate early referrals and assessment. Referrals for intervention at a very late stage must be avoided.
9. All people who experience poorly controlled cancer-related pain, despite appropriate implementation of the WHO analgesic ladder and assessment in a specialist MDT pain service, must be considered for advanced pain management options. There must be well-defined pathways, including referral criteria and indications, to offer guidance as to when a person with (or who has the likely potential to develop) uncontrolled cancer pain should be referred to highly specialist pain services for consideration of complex pain-management options.

RECOMMENDATIONS

1. Cancer related pain interventions should be offered within an MDT. There should be close collaboration with palliative medicine and between specialist and highly specialist pain services to offer best management of symptoms other than pain (e.g. frailty, breathlessness and poor appetite).
2. Within every region, formal collaboration between pain medicine, palliative medicine, oncology and relevant (anatomical site specific) surgical specialties should occur routinely (as recommended in the relevant Faculty of Pain Medicine framework).[7]
3. The MDT should offer timely assessment and pain management advice, including interventions, for people whose pain is poorly controlled despite appropriate application of the WHO analgesic ladder.
4. Clinical sessions supporting the MDT should be recognised and funded as part of an agreed job plan.

5. Within every region there should be 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.
6. Access to these interventions should be facilitated by a nominated pain consultant with responsibility for managing or coordinating cancer-related pain in every region.[14]
7. Within each region, there should be unhindered access to education and training in cancer-pain management, in line with competencies stipulated by the Faculty of Pain Medicine.[15] Teaching sessions or training resource should be recognised for this purpose and should be part of the job planning process.
8. Each region should have a cancer-pain network led by a highly specialist pain service and linked with specialist pain services in close liaison with palliative medicine and oncology services.[7] The aims of this network are to improve cancer related pain assessment and management in the region and to include second opinions for complex and difficult to control pain problems. This will direct appropriate people with cancer pain to services where more specialist procedures are available (e.g. neuroablative procedures and intrathecal drug delivery implants).

BACKGROUND

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

The management of cancer pain has changed over the years. Whereas in the 1950s and 1960s interventional pain techniques were the mainstay of cancer-pain treatment, the medical management of cancer pain developed from the 1970s onwards through the establishment of the modern hospice movement and palliative medicine as a specialty.[5] Medical management forms the cornerstone of cancer-pain management today. This approach includes chemotherapy and radiotherapy and various analgesic and adjuvant drugs.[6]

With a growing population of cancer survivors new challenges to the pain specialist arise.[17] Cancer survivors are defined as those living with and beyond cancer (i.e. who have completed initial cancer management and are living with progressive disease but not in the terminal phase or those who have had cancer in the past).[18] It is estimated that approximately 40% of cancer survivors experience pain alongside a range of other physical and psychological symptoms.[19] This relatively novel population of patients require a multifaceted approach which addresses all aspects of the biopsychosocial model of pain. The approach is essentially rehabilitative in nature, with a focus on dose de-escalation of strong opioids and adjuvant analgesics (for which interventional pain procedures may prove beneficial), graded exercise, optimisation of nutrition, psychological support and a focus on defining and achieving functional goals.[20] This approach can only be delivered through the deployment of a comprehensive MDT which engages, educates and empowers the person with pain throughout the process. More detail on MDTs can be found in Chapter 5 of these standards.

Due to advances in technology and techniques, interventional pain management has regained importance in the management of cancer pain. Individualised cancer-pain management, with a selection of conservative and invasive treatment options depending on pain presentation, should now be considered the gold standard.

A comprehensive and systematic approach including detailed history taking, examination and review of pertinent investigations is vital to manage cancer-related pain successfully. Pain should be viewed in the context of the overall presentation of the person. People with cancer, particularly advanced cases, often experience a multitude of symptoms other than pain, including fatigue, anorexia and general debility. These symptoms are likely to persist, even if effective pain control is achieved. Therefore, it is important to manage the expectations of people with cancer pain and their carers, and to set realistic treatment goals to avoid disappointment and possible disengagement from services. As people with cancer are often debilitated and the prognosis can be poor, effective pain control needs to be achieved rapidly, 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 continuing supervision and titration of analgesia is vital.

Recent evidence demonstrates that despite the WHO model being introduced many decades ago, unrelieved cancer pain and opiophobia remain prevalent,[19] and adjuvant drugs are frequently under-employed. In direct contrast to the WHO analgesic ladder approach, which recommends adjuvants as being optional, mounting evidence exists which supports the practice of routinely combining opioids with adjuvant agents due to synergistic effects and reduced overall drug-related toxicity.[21] Morphine remains the principal strong opioid for management of cancer pain. Morphine has been shown to be effective, has a simple titration regimen, is available in a variety of formulations and is cost effective.

For some pain procedures (coeliac plexus ablation and intrathecal infusions),[10–12] there is controlled-trial evidence in cancer populations. For many other interventional pain procedures, including neurolytic pain procedures (cordotomy, intrathecal and epidural neurolysis)[6,9] the

evidence from case-series (level IV, poor reference standard) is of similar quality to the WHO analgesic ladder. A pragmatic approach is therefore advocated if considering when and whether to offer such interventions. The likely benefits and risks of pain interventions should be appraised and balanced against the risks of continuing with high-dose analgesics such as opioids. Such risks and potential benefits should additionally be discussed with people with cancer pain. Interventional pain management should be considered as an adjunct to comprehensive medical management. In summary, interventions offer the potential benefit of delivering superior pain relief without the adverse effects commonly associated with opioids and adjuvant analgesics. For some people, interventional techniques represent 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

Barry Miller and Nick Plunkett

INTRODUCTION

CPD is any learning outside of formal undergraduate and postgraduate training that helps individual practitioners maintain and improve their standards of professional practice. It covers the development of knowledge, skills, attitudes and behaviours across all areas of an individual's practice. CPD includes both formal and informal learning activities. The purpose is to help improve the safety and quality of care provided for patients and the public.[1]

CPD is an integral part of good medical practice and an important component of revalidation.[2] Detailed guidance on CPD is published by the various professional and regulatory bodies and, for all anaesthetists, by the Royal College of Anaesthetists. The Faculty of Pain Medicine contributes to the College CPD committee, giving specialty-specific advice and developing pain topics for the CPD framework.

The Faculty'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: '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. 1. All pain medicine practitioners are responsible for identifying their CPD needs, planning how those needs should be addressed, and for undertaking CPD that will support their professional development and practice.[1]
2. All pain medicine practitioners must remain competent and up to date in all areas of their practice including management, research and teaching.[2] Necessary time and support must be recognised for this within the annual job-planning process.
3. Pain medicine practitioners must reflect regularly on their standards of medical practice. CPD activities should aim to maintain and improve the quality of their practice and those of any teams in which they work.[1]
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 practice.[1]
5. The Faculty of Pain Medicine and the RCoA expects every pain medicine practitioner to undertake a minimum of 50 hours of CPD (equating to 50 CPD credits/points) per year. A minimum of 20 hours must be achieved in each of the external and internal activities. In the internal category, a minimum of 10 hours must be from local clinical governance activities.[6]
6. Feedback from patients, carers and colleagues must inform the CPD needs and the personal development plan.
7. Pain medicine practitioners must keep a record of CPD activities, which must be produced at the annual appraisal. Use of the the RCoA or similar online system for documenting and cross-indexing CPD activity is recommended as evidencing CPD activity, and personal CPD reports can be generated for appraisal and revalidation purposes.

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). The plan's individual objectives should be SMART (specific, measurable, attainable, relevant, and time-bound) compliant.[7]
2. A personal development plan should 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 management 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. Specific types of CPD activities and exclusions are listed in the RCoA guidance.[3]
5. 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.[4]
6. Pain medicine practitioners should read and follow the CPD guidance documents issued by the RCoA as well as their relevant regulatory body.[6]

BACKGROUND

The principles 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, external or personal study), depending on what they are trying to learn and the 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 events.[1]

The framework of CPD skills developed by the RCoA provides a structure for planning and assessing CPD activities. This framework replaces the previous three-level CPD matrix, which was discontinued after adverse feedback from members and event providers as to its complexity and misconceptions that it was compulsory. The new framework moves away from a tiered structure and instead introduces a number of headings and skills as a simpler and more flexible way to structure and plan CPD activities. The framework has been incorporated into the Lifelong Learning Platform (LLP) as an optional resource for CPD learners in recording their CPD activities. It also provides a resource against which educational providers can map the content of courses/activities and apply for CPD approval.8

The RCoA supports the Academy of Royal Colleges' Ten Principles for College/Faculty CPD Schemes[9] and the standards and criteria for CPD activities.[11] External CPD organisers can seek RCoA approval for their events by application to the College if specific standards are met. The Faculty provides CPD assessors for reviewing pain educational meetings.[6]

The Faculty 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.[12]

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8.2 ASSESSMENT OF COMPETENCE

Barry Miller and Nick Plunkett

INTRODUCTION

It is expected that all 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 for 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.

Definitions

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

STANDARDS

1. All doctors working in pain medicine must put patient safety as their highest priority. They must abide by the duties of a doctor outlined by the GMC in *Good Medical Practice*, which states that doctors must contribute to, and comply with systems to protect patientsand respond promptly to risks to safety, whatever the cause. All doctors have a duty to raise concerns where they believe that patient safety and care is being compromised by the practice of colleagues or systems within which they work.[1,2]
2. All doctors working in pain medicine must undergo satisfactory appraisal and revalidation that reflects guidance from the GMC and the Faculty of Pain Medicine.[2,3]
3. All doctors working in pain medicine must undertake regular CPD, maintain an awareness of national standards and guidelines (such as those produced by the Royal College of Anaesthetists)[4] and must demonstrate current best practice.
4. All doctors working in pain medicine must abide by the GMC directives regarding health and probity.[2]
5. 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.
6. While the above standards focus on doctors, the same requirements are expected from all professionals practicing as part of the pain team. They must comply with their relevant regulatory and professional standards.

RECOMMENDATIONS

1. All doctors practicing pain medicine should join the Faculty of Pain Medicine to receive support and direction from the Faculty in their professional practice.[5,6]
2. All clinicians working in multidisciplinary pain medicine should demonstrate the highest standards of communication, teamworking and leadership.
3. Consultants, career-grade doctors and other practitioners in pain medicine should be aware of relevant current and evolving training and professional standards and should maintain records to evidence adherence.
4. All practitioners working in pain medicine should be supported by their employer with time allocated for appropriate SPAs. There is likely to be an additional need for doctors working in pain medicine who commonly fulfil dual clinical roles in anaesthetics and pain medicine (see Chapter 5.2.1: Medical consultants).
5. All practitioners working in pain medicine should demonstrate a commitment to lifelong learning, and should fully engage with appropriate CPD activities identified as necessary during the appraisal process.[3,7]
6. All practitioners working in pain medicine should demonstrate an ability to engage with complaints procedures as determined by their employer, including demonstration of applicable learning where relevant to themselves and/or the pain service in which they work.
7. All practitioners working in pain medicine should abide by their employers 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, developed by the Faculty. This training is 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 people with pain. In determining an individual doctor's ability to practise 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 grade.[2,9]

The Faculty has a very robust mechanism for assessment of competency in pain medicine for anaesthetic trainees at all levels pre-CCT.[10] 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 their adherence to a minimal standard of safe and effective practice.[10] 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.

The seriousness and outcome of any competence failures will determine which strategies for detection and remedial action will be employed. These 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 NHS Resolution Practitioner Performance Advice service (previously the National Clinical Assessment Service)[11] or RCoA invited reviews may provide overview or scrutiny if appropriate.[12]

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8.3 APPRAISAL

Robert Searle and Suzanne Carty

INTRODUCTION

Appraisal is a key element of the continuous process of evaluation of fitness to practise that supports the revalidation process. To maintain a licence to practise from the GMC, doctors are obliged to maintain a portfolio of supporting information that demonstrates they continue to meet the requirements set out in the *Good Medical Practice* framework for appraisal and revalidation.[1]

The GMC has set out generic requirements for appraisal.[2] These requirements are supported by guidance from both the Royal College of Anaesthetists and the Faculty of Pain Medicine,[3,4] which give specialty-specific context to this process.

STANDARDS

1. All licensed doctors working in pain medicine must have a minimum of one appraisal per year, unless there are clear mitigating circumstances that prevent this from taking place (e.g. maternity leave or long-term sickness).[1]
2. Appraisers must have suitable skills and training for the role and must meet the suitability criteria set out by the GMC and the NHS.[2,5]
3. Pain medicine doctors must respond constructively to the outcomes of appraisals.[3]
4. Any concerns identified in the previous appraisal must be documented as having been satisfactorily addressed (or satisfactory progress made) in the next appraisal.[4]
5. Supporting information must be collected, reflected on and discussed at each annual appraisal and must include:
   - up-to-date personal details and a description of the scope of work undertaken (including details of all the places worked); supporting information must cover the whole scope of practice (including clinical, non-clinical, NHS, independent sector and private work)
   - 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 patient and compliance with health and safety obligations for doctors set out in good medical practice1
   - a personal development plan
   - a description of CPD undertaken, which must cover the whole scope of practice
   - details of direct involvement in any clinical incidents or significant events which could or did lead to harm of one or more patients
   - feedback from any formal teaching undertaken
   - review of any complaints and compliments.
6. The following must be collected, reflected on 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).
7. The pain medicine doctor must be able to demonstrate to their appraiser they have reflected on their supporting information. Appraisal must include a discussion on how the doctor intends to develop or modify practice based on this reflection.[6]

RECOMMENDATIONS

1. Those appraising pain medicine doctors should be familiar with the RCoA appraisal and revalidation guidance and the FPM Good Pain Medicine Specialist guidance.[3,4]
2. Pain medicine doctors should use supporting information during their annual appraisal to demonstrate they continue to meet the principles and values set out in the Good Pain Medicine Specialist document.[3]
3. Supporting information should be relevant to pain medicine practice and should reflect the context in which the doctor works. For example, quality improvement activity would include participation in relevant national audit projects (e.g. National Audit Projects, National Pain Audit)7,8 and local pain related audit such as those suggested in the RCoA's audit 'recipe book'.[9]
4. Supporting information should be from UK practice. The use of supporting information from practice outside the UK should be discussed with the doctor's responsible officer, with reference to GMC guidance on this topic.[6]
5. It is not necessary to document all learning activities, but the doctor should document sufficient to give assurance for keeping up to date. The focus should be on quality of supporting information rather than quantity, with an emphasis on demonstrating learning and development.[4,6]

BACKGROUND

The GMC has defined the principles and values on which all doctors should base their practice.1 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 trust.[3] The process of appraisal enables doctors to discuss their practice and performance and 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 practice.[6]

As well as enabling doctors to demonstrate they are fit to practice, the process of appraisal also enables doctors to both enhance the quality of their professional work and consider their own professional needs when planning their professional development.[6]

Annual appraisal, as a mandatory component of the revalidation process for doctors contributes to a wider quality assurance in healthcare.[10]

During appraisals, pain specialists are required to use supporting information to demonstrate 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 work), while other evidence is required at least once during each revalidation cycle (such as patient and colleague feedback).[2] The Royal College of Anaesthetists has published specialty-specific guidance on what supporting evidence anaesthetists and pain specialists should include as part of their appraisal.[4] Reflection is a common theme, integral to the supporting information, and the appraisal discussion should include how this will influence current and future practice.[11]

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.[6,12–14]

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8.4 REVALIDATION

Robert Searle and Suzanne Carty

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. Licenced doctors are required to revalidate every five years, based on the results of annual appraisals.

Revalidation is an integral component of a wider quality assurance in health care. While the GMC introduced a national framework for revalidation, the 'revalidation process is owned and resourced at a local level by organisations and employers. Revalidation is therefore, part of a local clinical governance framework. It is also designed to strengthen that framework'.[1]

Detailed guidance on the standards required for individual pain medicine specialists to revalidate 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*.[2,3] These documents provide the standards for revalidation for individual pain medicine specialists. This chapter also recommends standards that a pain service should maintain 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's *Good Medical Practice* and the Faculty of Pain Medicine's *The Good Pain Medicine Specialist*.[2,3]
2. All pain medicine specialists must maintain a portfolio of supporting information that demonstrates they meet these attributes.[2,3]
3. All pain specialists must participate and engage in the annual appraisal process. This should include discussion of supporting information, what it says about their performance and practice and how they are using the document to maintain and improve standards.
4. A pain service must maintain patient confidentiality, particularly when using means of electronic communication and communicating publicly (e.g. speaking to or writing in the media).

RECOMMENDATIONS

1. A pain service should hold or participate in regular audit meetings relevant to pain medicine and support audit and research in pain medicine.
2. A pain service should support activities that maintain and develop competence and performance (e.g. seeking opportunities for learning from colleagues).
3. A pain service should cooperate with internal and external reviews and support critical incident reporting.
4. A pain service should ensure that the care of individual patients is not compromised to meet management targets.
5. A pain service should promote and encourage a culture that allows staff to raise concerns openly and safely.
6. A pain service should provide facilities that allow practitioners to follow infection control procedures and regulations.
7. A pain service should support as appropriate colleagues who have remediable problems with performance, conduct or health (e.g. by supporting their period of rehabilitation or returning to work).
8. A pain service should ensure that all staff have appropriate supervision.
9. A pain service should be open and honest with patients if things go wrong.

BACKGROUND

All licenced 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 generic standards for revalidation for all doctors have been set down by the GMC in the *Good Medical Practice* document.[3] 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*, which provides specialty-specific guidance for pain medicine doctors.[2]

The second revalidation standard outlined in this chapter states that for doctors to prove that they meet these required standards every five years, they must collect a portfolio of supporting information and evidence that demonstrates they meet the attributes required.[4] Both the GMC and Royal College of Anaesthetists provide guidance on what supporting information to collect.[4,5]

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, what this says about performance and practice, and how they are using appraisal to maintain and improve standards.[6–8]

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 CPD.[2]
2. Safety and quality: a pain service should provide a means for critical incident reporting and should cooperate with internal and external reviews. In addition, the service should ensure that 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 policies.[2]
3. Communication, partnership and teamwork: a pain service should support the appropriate supervision of staff and those with health or performance problems.[2]
4. Maintaining trust: a pain service should be open and honest with patients if things go wrong and should respect their confidentiality.[2]

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Chapter 9

Service improvement, clinical governance and research

9.1 QUALITY IMPROVEMENT

Lorraine de Gray and Michael Neil

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 people with pain. Quality improvement is a continuous process that 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 development.[1]

Quality improvement is consistent with the strategic aims of the health service to deliver high-quality care in a cost-effective way.

Quality improvement requires a thorough understanding of a clinical problem and the system in which it occurs. Clinical research can help to identify standards to be achieved with relevant and well-conducted clinical audit, providing knowledge of where, why and what needs to improve. Analysis and reflection should allow the development of necessary and contextually appropriate changes that may lead to improvement. Sometimes it is necessary to test a change before full implementation to ensure that it will lead to quality improvement. Closing the loop by repeating the audit at an appropriate time interval will then help to ascertain whether the change has been effective in leading to quality improvement.[2]

STANDARDS

1. Pain management services must establish and use regular critical incident reporting systems.[3]
2. A robust, well-supported clinical audit service must be in place to support clinicians in the process of collation and analysis of measurements and targets. The service must be capable of supporting the full audit cycle, allowing for 'closing the loop' to demonstrate that change is producing improvement.[4]
3. Clinical governance systems must 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.
4. A robust critical incident reporting system must be in place to allow a detailed, systematic, and meaningful analysis of such incidents without a blame culture.
5. 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.
6. 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-focused measures.[5]
2. Quality improvement should focus on each individual person'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 socioeconomic picture.[6]
4. 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, failure of people 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 optimise outcomes and to generate pain management guidelines.
6. Pain management services should seek out feedback from service users and stakeholders (e.g. patient satisfaction surveys). Input from patient representation on health board and trust governing bodies is key.[7]
7. There needs to be close working with commissioners and hospital management to implement necessary changes.
8. CPD for all clinicians and healthcare professionals, including doctors in training, should include quality improvement.

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 improve.[8] It is crucial to understand the successes and defects within the system and the possible constraints that may affect measurement and change. Quality improvement has not traditionally been a key component of medical education. 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.

NICE endorses the following definition of clinical audit:

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.[9]

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. In practice, barriers may be encountered at various stages of implementing change. These commonly include fear of change and reluctance to alter existing practice. Once a change has been introduced a 'closing the loop' audit will then provide the crucial feedback mechanism required to identify whether the change has been effective in leading to the quality improvement sought. It is important that the results of the quality improvement project are communicated to all relevant stakeholders to demonstrate the benefits achieved and ensure that the improvement is sustained.

It is essential to have continuing 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. Continuing education for 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 participation.[4] 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'.[10]

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9.2 NEVER EVENTS

James Taylor

INTRODUCTION

A revised 'never events' policy and framework was published by NHS Improvement in January 2018.[1] This document provides the following definitions:

Never Events are defined as Serious Incidents that are wholly preventable because 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. Strong systemic protective barriers are defined as barriers that must be successful, reliable and comprehensive safeguards or remedies – for example, a uniquely designed connector that stops a medicine being given by the wrong route.[1]

A series of eight Never Events were first defined in the UK by the National Patient Safety Agency in 2009. Under the revised policy from January 2018 there are now 15 Never Events on the list. A 16th category, undetected oesophageal intubation, has been temporarily suspended pending further clarification.[2]

Never Events are a particular type of serious incident that meet all the following criteria:[1]

1. 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.
2. 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 a specific incident occurrence for that incident to be categorised as a Never Event.
3. There is evidence that the category of Never Event has occurred in the past (e.g. through reports to the National Reporting and Learning System (NRLS) and a risk of recurrence remains.
4. Occurrence of the Never Event is easily recognised and clearly defined; this requirement helps to minimise disputes around classification and ensures focus on learning and improving patient safety.

STANDARDS

1. All invasive procedures must be carried out following completion of an appropriate WHO checklist.[3] (e.g. the Faculty of Pain Medicine checklist for pain procedures under local anaesthetics and sedation.[9]
2. The latest revision of the Never Events list must be reviewed and current practice examined to minimise the risk of a Never Event and to ensure patient safety.[2]
3. A Never Event must be investigated according to the Serious Incident Framework.[4]
4. Never Events must be reported to both the Strategic Executive Information System (StEIS) and the NRLS. Crucially, reports to both the NRLS and StEIS must clearly label the incident as a Never Event, even if this status is uncertain at the time of reporting.

RECOMMENDATIONS

1. Pain management services should be familiar with the National Safety Standards for Invasive Procedures (NatSSIPs) or relevant safety programmes for the devolved nations.[5–8]
2. Pain management services should create, adapt and adopt local standards for their procedures that are compliant with NatSSIPs or relevant national safety programmes for the devolved nations.[5–8]
3. To ensure continuous quality improvement in the delivery of safe care for people undergoing invasive procedures, pain management services should audit compliance with local standards, and should develop and refine safety standards in response to the audit.
4. Pain management services should engage with processes that attempt to design out error through removing equipment or fitting/using physical barriers to risks.
5. Pain management services should be aware of the impact of human factors on patient safety processes and support their teams to prioritise patient safety education as part of their CPD (see Chapter 8.1: Continuing Professional Development).

BACKGROUND

Invasive procedures form part of a multimodal approach to pain management. In 2015, the NHS England Patient Safety Domain published NatSSIPs,[5] which were adopted in 2016 by NHS Wales.[6] NHS Scotland follows the Scottish Patient Safety Programmes,[7] while the NHS in Northern Ireland adheres generally to NatSSIPs (personal communication). NatSSIPs and the relevant safety programmes for the devolved nations built on the WHO Surgical Safety Checklist introduced in 2009 extending its application to all invasive procedure.[2] The

aim was to standardise the safety approach to invasive procedures, to harmonise this approach across all organisations and to emphasise the importance of education in patient safety. The key message from NatSSIPs and related publications was that checklists alone cannot improve patient safety. The checklists must be conducted by teams of healthcare professionals who have trained together and who have received appropriate education in the human factors that underpin safe teamwork. The importance of this safety culture was emphasised again by the Care Quality Commission (CQC) in their 2018 report.[8] This report was a result of a request made by the Secretary of State for Health and Social Care in Autumn 2017 for the CQC, in collaboration with NHS Improvement, to examine the underlying issues in NHS trusts that contribute to the occurrence of Never Events.

The CQC points out that, despite Never Events being preventable by definition, the number of Never Events has not fallen: 'About 500 times each year we are not preventing the preventable'.[8] Acknowledging the hard work and efforts of frontline staff, the CQC report that this failing is a symptom of the underlying weakness in safety culture.

The CQC agreed with NatSSIPs that education and training for patient safety could be significantly improved and made recommendations for national bodies as well as local organisations. Some notable recommendations with future implication for pain management services include the following.[8]

1. Patient safety should form part of continuing mandatory training and should be included as part of CPD. Leaders should release their staff from their substantive duties to carry out this development.
2. Leaders with a responsibility for patient safety must have the appropriate training, expertise and support to drive safety improvement in trusts.
3. NHS England/NHS Improvement should work with professional regulators, royal colleges, frontline staff and patient groups to develop a framework for identifying clinical processes and other elements, such as equipment and governance processes, that could benefit from standardisation.
4. The National Patient Safety Alert Committee should describe in detail what good implementation of a safety alert looks like as part of good clinical governance, highlighting a system that plans and coordinates implementation in organisations and ensures continuing compliance.
5. NHS England/NHS Improvement should review the Never Events framework and work with professional regulators and royal colleges to take account of the difference in the strength of different kinds of barrier to error.

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9.3 RESEARCH AND DEVELOPMENT

Matthew Brown

INTRODUCTION

Effective pain management continues to represent an area of unmet need for a large number of patients. Securing a supportive, collaborative and productive environment for research into the underlying mechanisms and effective treatment of pain is of fundamental importance.

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 but engagement on any scale should be encouraged for all services.

STANDARDS

1. All pain management service clinicians must exhibit an awareness of new research findings and must 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. 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 advanced pain trainees should have the opportunity to participate 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).
2. Clinicians should be able to give appropriate advice to those people with pain who have become aware of new research findings from the media.
3. Pain management service staff should be aware of any pain-related research in their institution (basic or applied) and should 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 specialty lead for pain) to discuss the possibility and practicality of recruiting people with pain into clinical trials (commercial and non-commercial).[1] Support for this process may be available from the network.
5. Consultants in pain medicine should demonstrate a research component to their CPD. This could include attendance at relevant local, regional or national meetings and e-learning opportunities offered by many scientific journals, as well as personally conducting research.
6. 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, people with pain and resources.
7. Pain management services should support academic trainees in pain medicine working in their service.
8. All pain management services should have a nominated research lead to coordinate its research activities as appropriate.
9. Pain services undertaking research should have a coherent strategy to disseminate findings to the medical and research communities, as well as to the lay population.

BACKGROUND

Original research is distinct from audit. In general, audit seeks to find out whether a service or specific aspects of that service meets a desired standard.

Research involves obtaining new knowledge by undertaking studies. These may take a number of forms such as prospective or retrospective collection and analysis of data, the production of systematic reviews and the developing and testing of new treatments. Novel research commonly requires the approval of a research ethics committee, as well as other regulatory bodies depending on the type of research.[2]

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. Additionally, with advances in technology, people with pain are increasingly aware of novel pain research findings via social media, the internet and traditional media sources and welcome the opportunity to discuss them.

An example of clinical research in which trainees could engage are the National Institute for Health Research clinical trials undertaken locally (e.g. *Good Clinical Practice* in clinical research).[3] Trainees should also use existing resources and infrastructure such as the Research and Audit Federation of Trainees to aid with identifying continuing or potential research opportunities.[4]

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Chapter 10

Safeguarding

10 SAFEGUARDING PRACTICE FOR CHILDREN, YOUNG PEOPLE AND ADULTS

Kathy Wilkinson and Anna Weiss

INTRODUCTION

All health workers need to understand the principles of protecting individuals against maltreatment, neglect and exploitation. As well as immediate effects on safety, abuse of all types has been demonstrated to have a profound effect on a person's long-term mental and physical health and wellbeing.

Pain management professionals forge important relationships with their patients. These relationships can be longstanding and involve a strong psychosocial diagnostic and therapeutic approach. Pain medicine specialists are in a good position to detect, report and help manage safeguarding concerns in people of all ages.

Legislation, standards and guidance in place for child and adult safeguarding varies between the four UK countries and, while there is considerable commonality, this adds complexity to guidance.[1]

In children and young people, the range of maltreatment includes physical, emotional, sexual abuse and neglect. Specific forms of abuse such as child sexual exploitation, female genital mutilation and trafficking must also be considered. It is not uncommon for children to suffer more than one form of maltreatment. Definitions of these are outlined and expanded on in the current NHSE guidance.[2]

The range and definitions of what constitutes adult abuse, maltreatment and neglect cover the same broad categories of physical, sexual and emotional abuse and neglect. In addition, domestic, discriminatory and financial abuse, modern slavery and organisational/ institutional abuse are included.

Definitions are outlined by the NHS and the Social Care Institute for Excellence.[3,4]

STANDARDS

1. All pain management service staff in all settings must be aware of and fulfil their safeguarding duties as outlined in the relevant professional guidance (e.g. GMC, Royal College of Nursing).[5,6]
2. Legislation and guidance differ for children and young people and adults. All health professionals must undertake regular training and updates in both child and adult safeguarding to ensure knowledge, skills and attitudes for implementing local and national policy.
3. Professionals in all health care settings must have child safeguarding knowledge and competencies to deal with suspected abuse or neglect.
4. Pain management professionals delivering regular care for children and young people must have level 2 safeguarding training.
5. Health professionals with clinical responsibility for specialist pain services in children and young people must have level 3 competencies.
6. Pain management professionals must immediately seek specialist advice and notify the police in all cases of suspected or reported female genital mutilation.
7. Healthcare professionals must comply with requests for information to enable or assist the reviewing or analysis of a child's death when requested by child death review partners.
8. Training to safeguard the protection of children and adults is mandatory for all health care workers at the appropriate level of competency.

Case illustration 1
S3/S8 Even in settings where healthcare is exclusively for adults, professionals must have child safeguarding knowledge and must have the ready competencies to deal with suspected abuse and neglect. Most adults have significant contact with children and young people in their daily life and issues may arise in unexpected situations. Examples include carers whose history or behaviour raises the question about child safeguarding concerns in their professional or family life.

'A 42-year-old man undergoing assessment for a spinal cord stimulator for chronic back pain reveals to the team that when he is at home he will just be with his 12-year-old son, for whom he is the sole carer. The patient works offshore and for two in every four weeks is away from home, during which time it seems likely that his son lives alone.'

RECOMMENDATIONS

1. Pain management professionals working in any setting should have ready access and easy communication with safeguarding teams, including services for adults with special needs.
2. Pain management professionals and teams should have ready access to training and updates on local, regional and national safeguarding processes.

3. Training should be at the appropriate level, delivered in a multidisciplinary setting by expert staff and should be updated annually.
4. Pain management professionals should be informed on referral pathways, including access to early advice.
5. Pain management team members should appoint at least one person with level 3 competencies to act as child safeguarding lead.

Case illustration 2

R3 Young people aged 12–18 years make up a substantial number of cases referred to chronic pain specialists and there should be a clear plan with regard to transition of care between paediatric and adult specialists. This includes a need to consider additional vulnerabilities such as those that exist in young people who by virtue of chronic physical or mental ill health, disability or adverse social circumstances are at increased risk of abuse. The latter includes young people whose care is or has been the responsibility of the state ('looked after children' and 'care leavers').

Health professionals with clinical responsibility for chronic pain services in young people should also seek to have level 3 competencies.

'John is 17 years old and had been in care until recently when he moved into a shared flat with his girlfriend. In the past, he has had multiple admissions under a paediatric team for management of painful sickle cell crises and he had a good relationship with them. The nurses on the ward ask the pain team for help because he makes frequent requests for additional morphine. After seeing him the pain team in turn request help from the safeguarding team due to concerns about his vulnerable social status.'

BACKGROUND

Safeguarding children and young people

The lessons learnt from major reviews of very serious individual cases or groups of cases drove the development of more robust safeguarding frameworks for children and young people for Health, Social Care and Education.[1,7–10]

Severe harm and death can occur as the result of maltreatment and/or neglect. In the past five years, there have been on average 68 child deaths per year in the UK as a result of assault or from 'undetermined intent' by a third party. However, this is likely to be an underestimation of the actual number of child deaths by abuse and neglect, due to a range of issues including legal complexity of proof and misdiagnosis.[11] Less severe forms of child maltreatment and neglect occur more frequently.

Research has shown that even minor degrees of emotional and physical neglect in early life affect neural development and long-term health outcomes.[12]

Agencies including the NSPCC present annual statistics, although as noted above, these are likely to be an underestimation. According to the NSPCC 2011 report,[13] one in five children had experienced severe maltreatment. Maltreatment, sexual abuse and physical violence are strongly associated with poorer emotional wellbeing, including self-harm and suicidal thoughts.

By summer 2018, approximately 60,000 children were captured in the annual records of children subject to a child protection plan or on a child protection register.[14]

Legislation and policy

In England, the Department for Education is responsible for setting out policy, legislation and statutory guidance. Key interagency guidance is outlined in the latest version of Working Together to Safeguard Children.[2]

In Scotland, the main statutory guidance is outlined in the national guidance for child protection in Scotland[15] and 'Getting it right for every child' was launched in 2015.[16] Child Protection Committees carry out procedures locally within health boards.

In Wales, safeguarding is again organised through local safeguarding children's boards, using statutory guidance published in six parts, which covers both child and adult safeguarding practice.[17] Additional legislation is contained in the Social Services and Well-being (Wales) Act 2014.[18]

In Northern Ireland, the Safeguarding Board for Northern Ireland coordinates and ensures good practice in relation to protection of children and adults. Guidance is outlined by the Northern Ireland Department of Health.[19,20]

Female genital mutilation law

The WHO defines female genital mutilation as procedures which remove or damage the external female genital organs for no medical reason.[21] It is classified into four major types.

Female genital mutilation and assistance with mutilation procedures are illegal. It is the only form of child abuse for which mandatory reporting applies.[22] This is a personal, non-transferrable professional duty and the GMC duty of confidentiality does not apply in this case. *Violence Against Women and Girls* details Scottish law and policy on female genital mutilation.[23] The Royal College of Nursing has developed pathways that cover the travel health, sexual health and other female genital mutilation-related resources for professionals.[24]

Mandatory investigation of child deaths

Deaths due to abuse and neglect must be reviewed as part of the child death review process mandated in England and Wales.[2] Learning from serious case reviews is collated and presented by the NSPCC.[25]

Safeguarding adults

Young adult care leavers, adults of all ages with disabilities of all types and older people are particularly vulnerable. People aged 14 years or over with a learning disability should undergo an annual health check.[26]

Safe consent procedures, assessment and documentation of capacity form a major part of adult safeguarding practice in secondary care. In the UK, both the GMC and British Medical Association have published guidance and advice.[27,28]

The Winterbourne View report on maltreatment of people with learning disability and autism set recommendations on commissioning of services in all health and social care facilities.[29]

In England, national statistics demonstrate that older people are most likely to be the subject of a Section 42 safeguarding enquiry. NHS digital data from 2017/18 showed that one in every 43 adults aged 85 years and above had been the subject of an enquiry as compared with one in every 862 adults aged 18–64 years.[30]

'Neglect' and 'acts of omission' accounted for the majority of risk types that people had been exposed to. The most common location for risk enquiries to be carried out was the person's own home or a care home, with hospitals reported in 5–8% of cases.

Legislation and policy

Adult safeguarding in the UK is enshrined in the Human Rights Act 1998.[31]

In England, the Care Act 2014 does not define 'the adult at risk'.[32] It states that safeguarding duties apply to any adult who:

- has the need for care and support and
- is experiencing, or is at risk of, abuse or neglect and
- as a result of their needs is unable to protect themselves from the risk of or experiencing abuse.

In England where there is reasonable cause to suspect a safeguarding concern, be it through neglect or abuse or the risk of this occurring, the local authority has a statutory duty for to make enquiries and take appropriate action under Section 42 of the Care Act.

In Scotland the Adult Support and Protection (Scotland) Act 2007 (The Act) seeks to protect and benefit adults at risk of being harmed.[33] The Act requires councils and a range of public bodies to work together to support and protect adults who are unable to safeguard themselves, their property and their rights and provides a range of measures which they can use. Balancing intervention against autonomy is paramount.

Both Wales and Northern Ireland have combined guidance for children and adults.[17–20] Further details are in the above section on Safeguarding Children and Young People.

Adults without capacity

In England and Wales, adults deemed to be without capacity may be treated under the Mental Capacity Act 2005.[34] It aims at protecting vulnerable people who are unable to make their own decisions by clarifying who can make decisions in their stead in specific situations and allow competent patients to plan and leave instructions should they lose their capacity. The Mental Capacity Act does not apply in Scotland and patients who are deemed as lacking capacity are safeguarded and managed under the Adults with Incapacity (Scotland) Act 2000.[35] Both acts share broad principles.

TRAINING

Training to safeguard the protection of children and adults is mandatory for all healthcare workers.

The knowledge, attitudes and skills required to provide care for all patients with a possible or overt safeguarding concern are embedded in the national intercollegiate competences for both, adults and children and young people. They extend to all healthcare workers including those undertaking non-clinical and purely management roles. Training needs to be relevant to specialty and appropriate to level of responsibility for adult learners. It is recommended that training is conducted as much as practical in a multidisciplinary fashion working together with experts in safeguarding and with opportunities to discuss case scenarios which assist in everyday practice. It should be updated annually.

Training resources

E-learning for Healthcare (in partnership with UK professional bodies) programmes:

- Safeguarding Children and Young People (https://www.e-lfh.org.uk/programmes/safeguarding-children)
- Safeguarding Adults (https://www.e-lfh.org.uk/programmes/safeguarding-adults)

In Scotland, training modules are accessible through TURAS (https://turasdashboard.nes.nhs.scot), a single unified digital platform for health and social care professionals.

GUIDANCE

Professional bodies and organisations in the UK share guidance on and principles of safeguarding, References to current guidance most relevant for pain management teams and professionals are enclosed; however please note that these documents are not exclusive and may be superseded by future publications.

GMC guidance

Ethical guidance for doctors (https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors#good-medical-practice) including:

- Protecting children and young people: the responsibilities of all doctors (https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/protecting-children-and-young-people)
- Adult safeguarding (https://www.gmc-uk.org/ethical-guidance/ethical-hub/adult-safeguarding) points to the relevant paragraphs in *Good Medical Practice* which relate particularly to adult safeguarding issues
- Older adults (https://www.gmc-uk.org/ethical-guidance/ethical-hub/older-adults); the GMC also produces guidance for older adults centres around respect and dignity and involving older adults in their care and decision making
- Confidentiality: good practice in handling patient information (https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/confidentiality); relevant to both children and adults is the GMC guidance on handling patient information.

NICE guidance

- *Child Maltreatment: When to suspect maltreatment in under 18s*. Clinical Guideline CG 89 (2017).
- *Child Abuse and Neglect*. NICE Guideline NG76 (2017); includes how to respond.
- *Safeguarding Adults in Care Homes*. NICE Guideline NG189 (2021).

BMA Consent toolkit

Seeking patient consent toolkit (https://www.bma.org.uk/advice-and-support/ethics/seeking-consent/seeking-patient-consent-toolkit); advice on consent, capacity and making best interest decisions for patients is provided by both the GMC and BMA

RCoA Safeguarding plus

The RCoA web resources (Safeguarding, ethics and consent:) cover all aspects of child and adult safeguarding practice, as well as related topics on consent and other ethical issues. Guidance, learning resources and references are designed to be specific and relevant to all professionals working in perioperative care, intensive care, obstetrics and pain medicine is to be found at Safeguarding, ethics and consent (https://www.rcoa.ac.uk/safety-standards-quality/guidance-resources/safeguarding-ethics-consent).

Intercollegiate documents

Royal College of Nursing intercollegiate documents

Both documents listed here offer guidance on safeguarding procedures and training. They provide background for national differences in managing and processes of safeguarding, key definitions and glossaries of terms used in safeguarding practice.

- *Adult Safeguarding: Roles and Competencies for Health Care Staff* (2018). A guide for professionals and teams on competencies, minimum training requirements, education and training resources.
- *Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff* (2019). This intercollegiate document provides a clear framework for competencies required for all healthcare staff and people in healthcare affiliated roles.

Royal College of Anaesthetists

- *Child Protection and the Anaesthetist: Safeguarding children in the operating theatre* (2014). The RCoA in association with the RCPCH and Royal College of Nursing produced guidance on what to do in the perioperative period if abuse is suspected.

Other

- Social Care Institute for Excellence: an independent charity and improvement agency for the social care and health sectors, offering resources and references (Safeguarding: https://www.scie.org.uk/safeguarding)

- NHS England. *Safeguarding Adults Pocket Guide (2014): a guide to the Care Act 2014 and adult safeguarding practice*.
- NHS England Safeguarding app (http://www.myguideapps.com/nhs_safeguarding/default): aids navigation of all aspects of safeguarding for all ages and access to regional/local safeguarding support.

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APPENDIX 2 ABBREVIATIONS

ACT	Acceptance and commitment therapy
CARE	Consultation and Relational Empathy Measure
CBT	Cognitive behavioural therapy
CCGs	Clinical commissioning groups
CCT	Certificate of completion of training
CPD	Continuing Professional Development
CQC	Care Quality Commission
CSPMS	Core Standards for Pain Management Services in the UK
CRG-SPS	Clinical Reference Group for Specialised Pain Service – Adult
DCC	Direct Clinical Care
DFM	Dependence Forming Medication
DHSC	Department of Health and Social Care
EPMUK	Essential Pain Management UK
ERAS	Enhanced recovery after surgery
FFPMRCA	Fellow of the Faculty of Pain Medicine of the Royal College of Anaesthetists
FPMTAC	Faculty of Pain Medicine Training and Assessment Committee
GMC	General Medical Council
GP	General practitioner
GPhC	General Pharmaceutical Council
HCPC	Health and Care Professions Council
HSCB	Health and Social Care Board
IAPT	Improving Access to Psychological Therapy
IASP	International Association for the Study of Pain
ICS	integrated care system(s)
ICPs	Integrated Care Partnerships
IDD	Intrathecal Drug DeliveryIPS: inpatient pain service(s)
IRMER	Ionising Radiation (Medical Exposure) Regulations
LLP	Lifelong Learning Platform
MDT	multidisciplinary team
NatSSIP	National Safety Standards for Invasive Procedures
NHSI	NHS Improvement
NICE	National Institute for Health and Care Excellence
NMC	Nursing and Midwifery Council
NRLS	National Reporting and Learning System
PAs	Programmed activities
PCN	Primary care network
PCT	Primary care trust
PHE	Public Health England
PMP	Pain management programmes
PROMs	Patient-reported outcome measures
PSIRF	Patient Safety Incident Response Framework
RCEM	Royal College of Emergency Medicine
RCGP	Royal College of General Practitioners
RCN	Royal College of Nursing
RCoA	Royal College of Anaesthetists
SAS	Staff grade, associate specialist and specialty doctors
SCS	Spinal Cord Stimulation
SIF	Serious Incident Framework
SIGN	Scottish Intercollegiate Guidelines Network
SMC	Scottish Medicines Consortium
SPA	supporting professional activity
StEIS	Strategic Executive Information System
STP	Sustainability and transformation partnership
TENS	Transcutaneous electrical nerve stimulation
WHSCC	Welsh Health Specialised Services Committee
WTE	Whole-time equivalent

APPENDIX 3 DEFINITIONS OF TERMINOLOGY

Chronic, persistent or intractable 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 right.[1]

Complex pain:

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

Acute pain:

is pain of recent onset, of limited duration and usually related to a pathological process, disease or injury.[3]

Postoperative pain:

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

The forthcoming 11th revision of the International Classification of Diseases (ICD 11), due for publication in January 2022, offers a detailed listing of pain diagnoses (https://icd.who.int/browse11/l-m/en); search term 'Pain' and 'Synonyms')

Levels of care

Scottish Service Model for Chronic Pain

- Level 1: advice and information on self-management of pain, accessed form home or community settings.
- Level 2: GP or therapist help.
- Level 3: specialist help from a chronic pain management service.
- Level 4: highly specialist help.

Living with Persistent Pain in Wales (2017)

Levels of care

- Primary care, community care and self-management.
- Specialist care (complex pain relief; individual psychological, occupational and physical therapy).

Tiers of care

Contemporary nomenclature used in NHS England publications (e.g. Service Specification 170135 S).

Example of tiers of care for adult pain management:

- Tier I: GP- and CCG-commissioned community pain management services
- Tier II: specialist pain management services (secondary care)
- Tier III: highly specialist pain management services

GET IN TOUCH

The *Core Standards for Pain Management Services in the UK* is a living document. We strive to ensure that it remains an up-to-date and relevant resource. As such, we welcome any feedback on the content and structure of this guidance. If you do have any feedback, please email contact@fpm.ac.uk.

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