



Guidance on the provision of anaesthesia services for Chronic Pain Management

When considering the provision of anaesthesia, the Royal College of Anaesthetists recommends that the following areas should be addressed. The goal is to ensure a comprehensive, quality service dedicated to the care of patients and to the education and professional development of staff. The provision of adequate funding to provide the services described should be considered.

The prevention and management of persistent pain in adults, children and young people should be a fundamental objective of any health service. Good practice should ensure provision of a high quality, adequately resourced, multi-professional service dedicated to the care and support of patients with persistent pain and to the ongoing education and development of staff.

Summary

Persistent pain is a common and distressing condition. Chronic pain services deal with all non-cancer causes of persistent pain. Most also treat cancer related pain, often in partnership with palliative care services. Multidisciplinary management of patients with chronic pain alleviates pain and suffering, aids functional restoration and reduces the socio-economic burden of pain for the individual, health care systems and the community.¹⁻³

Effective and safe management of chronic pain requires:⁴⁻⁸

- ready access for patients to a local, first class chronic pain service;
- a seamless service between primary and secondary care;
- specialised chronic pain management services in each region for adult patients with complex pain problems;
- specialised chronic pain management services in each region for children and young people with complex pain problems with a requirement to work with children and their families;
- established links between acute and chronic pain management services within each hospital to enable patients with pain who present acutely and whose symptoms do not resolve to be managed appropriately as an outpatient;
- co-operation between chronic pain management and palliative care services within hospitals and the community;
- provision of appropriate time for direct clinical care for consultants in pain medicine, allied health professionals, managers and support staff;
- appropriate accommodation, facilities and equipment in accordance with best practice recommendations;
- formal links between hospitals on a regional basis so that a comprehensive range of treatments can be offered to all patients who need them;
- provision of pain management programmes (PMP) that promote restoration of physical and psychological function, encourage self care and decrease use of healthcare resources;
- a robust 24/7 on-call system with support from other disciplines (e.g. spinal/neurosurgery, radiology, microbiology) if neuromodulation techniques are used;
- sufficient funding to enable the service to achieve required targets and quality standards;
- continuing professional development of all staff;
- equity of access and service provision for all patients;

- regular multidisciplinary team meetings (MDT) to discuss complex patients and to agree management plans.

Consultant anaesthetists are responsible for the vast majority of chronic pain clinics in the UK. Some are full-time pain medicine consultants; many have sessions in anaesthesia or other anaesthesia-related areas. The job plans of these consultants should reflect the commitments required to run a safe and effective service.

Specific arrangements should be made for the treatment of the vulnerable (e.g. children, physical or intellectual impairment, non-English speakers, patients in prison).

There should be an active, ongoing programme of education in the nature and effective management of persistent pain for all health professionals who care for patients with chronic pain.

Activities of the pain service should be included within the institution's clinical governance, risk assessment and audit programmes.

There should be a culture that promotes an evidence-based approach to management that is supportive to research and service evaluation.

The importance of chronic pain and its management

Chronic pain is defined as pain that persists beyond the expected time of healing following injury or disease. Epidemiological studies show that up to 1 in 7 people in the UK population has chronic pain caused by a wide range of conditions.^{3,9} The 2008 Report of the Chief Medical Officer for England emphasised the importance of chronic pain services.⁹

Nociceptive and neuropathic pains are common and have a significant impact on quality of life. There has been epidemiological work on the latter to support this.¹⁰ Chronic pain becomes a more significant problem as pain prevalence increases, e.g. with ageing, more cancer survivors and trauma survivors. Unrelieved chronic pain is a major problem for individual patients and a massive socio-economic burden for the health service and the community.¹¹

Patients often have complex multidimensional problems that require multidisciplinary management. This usually involves doctors with appropriate training and competencies, and allied healthcare professionals also with specialist pain medicine knowledge and interest: nurses, clinical psychologists, pharmacists, physiotherapists and occupational therapists.

The interface between primary care and hospital chronic pain services is particularly important as many patients are referred from the community. However, many attending other hospital services will benefit from referral to the pain clinic (e.g. medical and surgical specialties, oncology, child health specialties and psychiatry). Integrated primary and secondary care pain services are increasingly seen as an optimal model of care in the evolving NHS.

There is evidence that multidisciplinary pain management is of benefit in improving the quality of life of patients.

The speciality of pain management has been at the forefront of the rigorous pursuit of evidence of effectiveness of treatments by the use of systematic reviews and well-conducted randomized controlled trials.

Complementary techniques (e.g. acupuncture) should be available when their use is supported by evidence.

The objectives of a chronic pain management service include:

- biopsychosocial assessment, investigation and management of pain;
- management of distress associated with persistent pain;
- reduction of disability and restoration of function;
- optimisation of medication that may include helping patients to discontinue long-term medication when appropriate (e.g. opioids);
- reducing inappropriate use of healthcare resources;
- attention to social, family and occupational issues;
- education and provision of information about persistent pain and its management for patients, carers and the community;
- education about pain management for non-specialist nursing, medical and allied health care professional staff, as well as managers and commissioners;
- liaison with primary and secondary care teams (e.g. primary care, palliative care, rehabilitation, addiction medicine, liaison psychiatry, oncology and radiotherapy);
- achieving national standards and targets;

- audit and evaluation of pain services and the needs/satisfaction of patients;
- promoting evidence-based healthcare;
- research into causes and management of persistent pain.

Widespread provision of basic core pain management services and the selective provision of more advanced specialist services are necessary to address the problem of persistent pain. Pain management services are required to provide both hospital and community care to patients with a wide range of different conditions.

Provision of a Chronic Pain Management Service

1 Staffing

- 1.1 The delivery of high quality, multidisciplinary pain services requires the allocation of fixed sessions for all involved healthcare personnel (rather than an ad hoc or informal approach).

The International Association for the Study of Pain has made a series of recommendations on the organisation of pain services. With regards to staffing it states:

The diagnosis and management of patients with chronic pain has become so complex that multiple skills and knowledge are required. There are many possible combinations, but such a facility must have at least one physician who assumes responsibility for obtaining a complete history and performing a screening physical examination. Old records must also be reviewed. The specialty of the physician performing this review is not particularly relevant, but clearly someone with expertise in the type of disease process responsible for the patient's chronic pain should be either the referring physician or part of the pain treatment facility's assessment team. At least two other medical specialties as well as other types of health care providers should be represented to justify the term, multidisciplinary pain clinic. There is some question as to whether any pain management facilities which are not multidisciplinary should exist in a developed nation.

Other types of health care professionals are of great value in a pain treatment facility. These include psychologists, nurses, physical therapists, occupational therapists, social workers, vocational counsellors and others. The variety and number will be determined by the types of patients seen and the number of visits per year to the facility. We should remember that the aetiologies of chronic pain are not well understood; medical treatments have already failed many of these patients and

effective evaluation and treatment may be administered by other health care professionals.¹²

- 1.2 A chronic pain management service should have:

Specialists in Pain Medicine – Every specialist chronic pain service must include consultants who have been trained and have appropriate competencies in pain medicine. The majority of services are led by doctors whose primary qualification is in anaesthesia; many will be Fellows of the Faculty of Pain Medicine, Royal College of Anaesthetists (FFPMRCA). Anaesthesia is the only specialty that incorporates advanced pain management within its training programme. Doctors play a central role in the assessment of pain and the formulation of management plans for patients. Senior doctors within the team also have responsibility for the education of student and postgraduate medical practitioners. Staff grade and associate specialist doctors with appropriate experience and competencies are well placed to provide excellent contributions to the pain service in the clinical care of patients and in education of staff.

Nurse specialists and nurse consultants play a key role in pain management. They may see outpatients independently for assessment or follow up, assess patients on wards, supervise medication, provide transcutaneous electrical nerve stimulators (TENS), deliver complementary therapies, be involved in PMPs or supervise neuromodulation.

Clinical psychologists with special training in pain management are an essential component of all chronic pain management services. They may offer individual psychological approaches and participate in PMPs.

Physiotherapists make an important contribution to the assessment and management of patients with chronic pain. They deliver physical therapies and play an important role in functional restoration programmes.

Occupational therapists can help patients regain normal function and assist in strategies for return to work.

- 1.3 The mix and number of allied health professionals in a service should reflect the case-load, types of patients and range of treatments used.
- 1.4 Medical and nursing staff should be available for the management of in-patients with persistent pain. In-patients cared for by a consultant from another specialty may receive a considerable amount of care and treatment from the pain management team. This work should be formally recorded and recognized so that appropriate funding for this

activity can be allocated. Some pain medicine consultants give support to other secondary care teams (e.g. palliative medicine, spinal surgery, rehabilitation). There should be appropriate recognition for this work within their job plan.

- 1.5** Pain management is a consultant-based service in most hospitals; individual jobs plans should reflect this as it has implications for the provision of cover and workload.
- 1.6** Any pain service that provides neuromodulation must have a robust 24/7 on call system with support from other disciplines (e.g. spinal/neurosurgery, radiology, microbiology).
- 1.7** The prevalence of comorbid mental health disorders in patients presenting to pain services is high. Defined links with psychiatric services are needed to deliver appropriate pain management and to support clinical staff.
- 1.8** Working in a chronic pain service entails a considerable amount of correspondence, dictation, preparation of reports, telephone calls, case conferences and other clinical administration. Due regard should be taken of this workload within consultant job plans. The working arrangements for pain medicine specialists should resemble those of consultant physicians in terms of job plan, support services (especially secretarial) and accommodation.
- 1.9** Special problems exist for consultant anaesthetists who divide their time between pain services and anaesthesia. Their job plans should take into account the additional demands of this combination. The individual consultant and the Clinical Director should devise an appropriate allocation of sessions between operating theatre-based anaesthesia and pain medicine to ensure maintenance of competency in all spheres of the consultant's clinical activity. Continuing professional development is required in both clinical areas and will require routine review as part of the appraisal, job planning and revalidation processes.
- 1.10** It is recommended that there should be no single-handed practitioners providing a chronic pain service. Where this is unavoidable, appropriate arrangements must be made for networking, external peer-support and review.

2 Equipment, Support Services and Facilities

2.1 Equipment

All pain services that use nerve blocks and/or neuromodulation must have access to fluoroscopy

and the ability to store and retrieve images. The management of chronic pain may also involve the use of specialist equipment (e.g. radiofrequency lesioning, percutaneous disc decompression). Centres that provide specialist services may require specialist equipment (e.g. for neuromodulation, cordotomy). There should be maintenance contracts and a rolling replacement programme for equipment.

2.2 Support services

Pharmacy. Local guidelines for prescribing and information sheets for patients about medications and their uses are helpful. Centres that provide intrathecal drug delivery need the support of the sterile preparation unit. The cost of prescribing for continuing care should have prior agreement with commissioners. Some drugs cannot be prescribed in primary care and so special arrangements are needed.

Information technology. The pain service should be provided with up-to-date electronic systems for maintaining patient bookings, medical records, outcome information and other data to support service evaluation, audit and revalidation.

2.3 Facilities

Chronic pain services are delivered in the following environments:

- Out-patient clinics in a hospital setting or in a primary care or community facilities;
- in-patient wards;
- operating theatres or other treatment facilities;
- PMPs – inpatient or outpatient;
- oncology and palliative care units within the hospital or on external sites.

Appropriate outpatient facilities include rooms for consultation, examination and treatment that are provided on a regular basis with access for wheelchairs and disabled patients.

There should be designated operating theatre sessions supported by fluoroscopy / radiographers for performance of diagnostic and therapeutic procedures.

Appropriate office accommodation should be provided for all staff in a non-clinical area that provides security for patient records and information. The service must be compliant with data protection legislation and patient confidentiality: all staff needs to be able to make confidential calls to patients and health care professionals in an appropriate environment. Appropriate facilities for trainees in pain medicine should be provided.

There should be provision of individual and group PMPs including cognitive behavioural therapy.¹³ PMPs may vary in length and intensity depending on the patient's needs. Standards for physiotherapists and occupational therapists working in PMPs are available.¹⁴ Patient accommodation is required for residential programmes.

Some patients may need overnight admission to a hospital under the care of the pain management service, for example if the patient has undergone a specialised procedure or is admitted for medication rationalization. Access to post-anaesthesia care units should be available for patients following interventions. Robust arrangements are needed for adequate medical cover on a 24/7 basis for any patients admitted to hospital under the care of the pain management team.

3 Special requirements

3.1 Pain management services for patients with cancer

The provision of pain management for patients with cancer requires close collaboration between palliative care, oncology, primary care and pain services for both in-patients and out-patients.

About 10% of adults with cancer-related pain may benefit from specialised pain management; the proportion of children who may be helped is not known. The demands on pain management services vary depending on the size and expertise of local palliative care and oncology services.

Pain medicine specialists use a range of specialist knowledge and skills for cancer pain management that may include interventions (e.g. neural blockade, neuromodulation). Modern palliative care means that pharmacotherapy and simple physical therapies have often been optimized before referral for specialist pain management.

Patients with cancer-related pain may be treated in the hospital as inpatients or outpatients, in a palliative care unit or at home.

Consultants in pain medicine who provide specialist advice and services to palliative care units require appropriate recognition of this commitment in their job plans.

3.2 Other areas of special requirements

Pain management services should make special provision for vulnerable and potentially disadvantaged groups (e.g. children, elderly, learning difficulties, physical impairment, diverse ethnic backgrounds, non-English speakers).

Particular difficulties may be encountered with those who habitually use drugs, prisoners and survivors of torture.

There is a need for specialised multidisciplinary clinics for certain conditions or patient groups (e.g. sickle cell disease, chronic pelvic pain).

There is a need for regional services for children and young people with chronic pain. These should be staffed by health care professionals with experience in managing children. There must be liaison with primary care, secondary care, schools, Children's and Adolescents Mental Health Services and other relevant services. Transitional arrangements to adult services are essential.

4 Training and Education

- 4.1 All those involved in chronic pain management should be trained adequately to ensure that they achieve the competencies needed for the delivery of a safe and effective service.
- 4.2 There should be an ongoing programme of continuing education and professional development for all staff within the pain management services. Time and funding should be provided for these activities.
- 4.3 Training in the management of pain medicine forms an integral part of the training programme for anaesthetists; this includes provision for up to 12 months of advanced training in pain medicine. Rigorous assessments of competency in pain medicine have been developed by the FPMRCA. Regional Advisers in Pain Medicine have been appointed by the FPMRCA who supervise the provision of pain medicine training and assessment. Anaesthetists who have achieved the advanced pain medicine competencies can apply for the Fellowship of the FPMRCA. These competencies are essential in all other routes to the Fellowship for specialists in pain medicine.

5 Research and Audit

- 5.1 There should be regular evaluation and audit of outcomes and complications of treatment. Whenever appropriate, audit activities should be integrated with those of related departments (e.g. anaesthesia, orthopaedics, palliative medicine).
- 5.2 The views of service users should inform service delivery and development.
- 5.3 There should be a culture that is supportive of research into persistent pain, especially the conduct of well designed clinical trials, including multicentre studies.

6 Organisation and Administration

- 6.1 Every pain management service should be clinically led by a health care professional with expertise in pain management who is responsible for coordinating the provision of a safe and effective service in consultation with colleagues.
- 6.2 Some specialist chronic pain management can be delivered in primary care or a community facility; it is important that this work is carried out by appropriately trained staff. Those working in this role in primary or community care should be under the leadership of doctors who have achieved the competences and experience in advanced pain medicine as defined by the FPMRCA.¹⁵
- 6.3 Chronic pain services should have designated management support; managers, administrative, secretarial, and clerical/IT support staff should be available to underpin inpatient and outpatient work in the same proportion that they are available for other medically-based specialties. A pain management service more closely resembles a traditional medical or mental health service rather than a surgically based model in terms of volumes and complexity of case mix.
- 6.4 The organisation of the service should encourage close co-operation with related specialties including, if appropriate, joint clinics with other doctors who have a special interest in a specific patients. Useful links may be established with occupational health specialists and employment advisors.
- 6.5 The organisation of clinics should take account of the fact that patients with complex persistent pain problems require thorough physical, mental health, social and vocational assessment. Therefore, the initial consultation may be prolonged and clinic schedules should recognise this. In this regard, comparison should be made with specialties such as psychiatry.
- 6.6 There should be agreed referral and discharge policies with established lines of communication between pain, primary care and relevant secondary care services.
- 6.7 The chronic pain service should be responsive to the needs of patients and primary care professionals. Input should be sought from patients and patient support groups.

7 Patient Information

- 7.1 The culture and practice of the service should embrace the need for patients to make informed decisions about their management, supported by verbal and written information. This should cater

for those whose native language is not English or those who have communication difficulties.

- 7.2 Patients should be made aware of sources of support (e.g. Expert Patient's programme,¹⁶ British Pain Society patient resources, condition-related self help groups).

References

1. Breivik H et al. Survey of chronic pain in Europe: prevalence, impact on daily life, and treatment. *Eur J Pain* 2006;**10**(4):287-333.
2. Morley S, Eccleston C, Williams AC. Systematic review and meta-analysis of randomized controlled trials of cognitive behavioural therapy for chronic pain in adults, excluding headache. *Pain* 1999;**80**:1-13.
3. Services for patients with pain. Clin Stand Ad Gr (CSAG). *DH*, London 2000 (www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4007468&chk=mVIBUB).
4. Pain Management Services: Good Practice. *RCoA and BPS*, London 2003 (www.rcoa.ac.uk/docs/painservices.pdf).
5. Desirable criteria for pain treatment facilities. *IASP* Seattle, USA 2006 (www.iasp-pain.org/AM/Template.cfm?Section=Home&Template=/CM/HTMLDisplay.cfm&ContentID=3011).
6. A practical guide to the provision of chronic pain services for adults in primary care. *BPS*, London 2004 (www.britishpainsociety.org/pub_professional.htm#napp).
7. Prevention and Control of Pain in Children: A Manual for Health Care Professionals. *RCPCH*, London. *BMJ Publishing Group*, London 1997.
8. Maniadakis N, Gray A. The economic burden of back pain in the UK. *Pain* 2000;**84**:95-103.
9. 150 years of the Annual Report of the Chief Medical Officer: On the state of public health. *DH*, London 2008 (www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/DH_096206).
10. Jensen MP, Chodroff MJ, Dworkin RH. The impact of neuropathic pain on health-related quality of life: review and implications. *Neurology* 2007;**68**(15):1178-1782.
11. Reyes-Gibby CC et al. Pain, depression, and fatigue in community-dwelling adults with and without a history of cancer. *J Pain Symptom Manage* 2006;**32**(2):118-128.
12. Desirable Characteristics for Pain Treatment Facilities. *IASP*, 2010 (www.iasp-pain.org).
13. Ostelo RW et al. Behavioural treatment for chronic low-back pain. *Cochrane Database Syst Rev* 2005;**25**(1):CD002014.
14. Recommended guidelines for pain management programmes for adults. *BPS*, London 2007 (www.britishpainsociety.org/pub_professional.htm#pmp).
15. Guidance and competencies for the provision of services using practitioners with special interests (PwSIs): pain management. *BPS*, London 2008 (www.britishpainsociety.org/pub_prof_pwsi.pdf).
16. Expert Patients Programme (www.expertpatients.co.uk/).