

# Organisation of Acute and Chronic Pain Services in the UK

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# How did Pain Services begin in UK?

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- 1970s
- Keen anaesthetists performed injections for pain in their spare time
- Realisation that cutting nerves did not abolish pain
- Development of the palliative care movement
- Awareness that pain relief was inadequate in hospitals
- Movers and shakers



# John Bonica 1917-1994



- Introduced regional anaesthesia 1944
- Author of the “Management of Pain” 1953
- Founded first multidisciplinary pain clinic in Seattle 1978
- Founded IASP



# Patrick D Wall 1925-2001



- 1965: “Pain mechanisms: a new theory”
- Original thinker
- Co-editor of the Textbook of Pain
- Founding editor of the journal “Pain”
- Much loved charismatic man



# Dame Cicely Saunders 1918-2005

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- Founder of the hospice movement
- Initiator of regular administration of opiates
- Introduced idea of “total body Pain”
- Established culture of palliative care



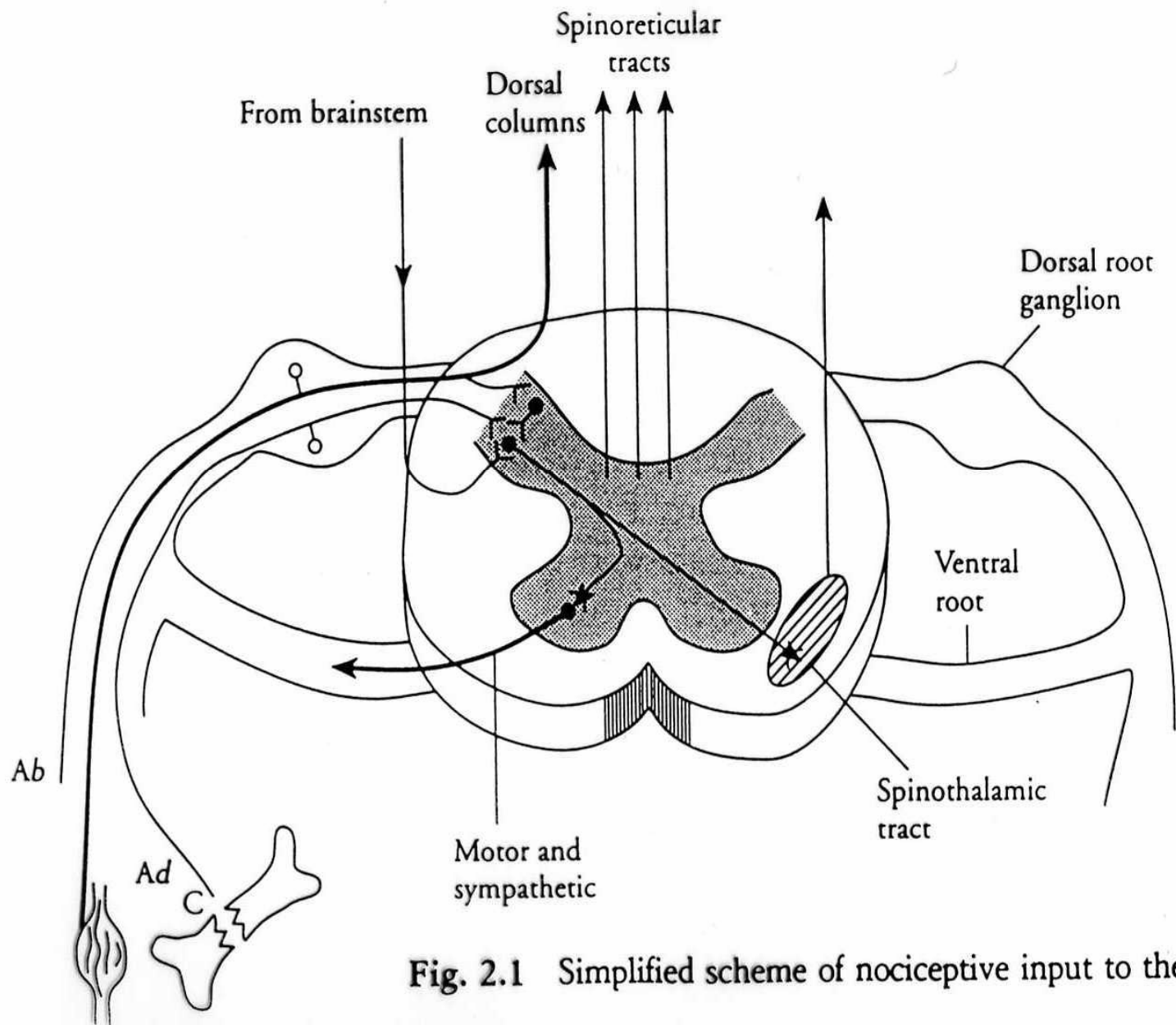
# Sam Lipton

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- Founder of the Pain Relief Foundation in Liverpool UK, Sampson Lipton died aged 72 on December 6th, 1994. Sam was a pioneer in the treatment of chronic pain, an international figure in the pain world and a teacher and mentor to many pain doctors.





**Fig. 2.1** Simplified scheme of nociceptive input to the spinal cord.

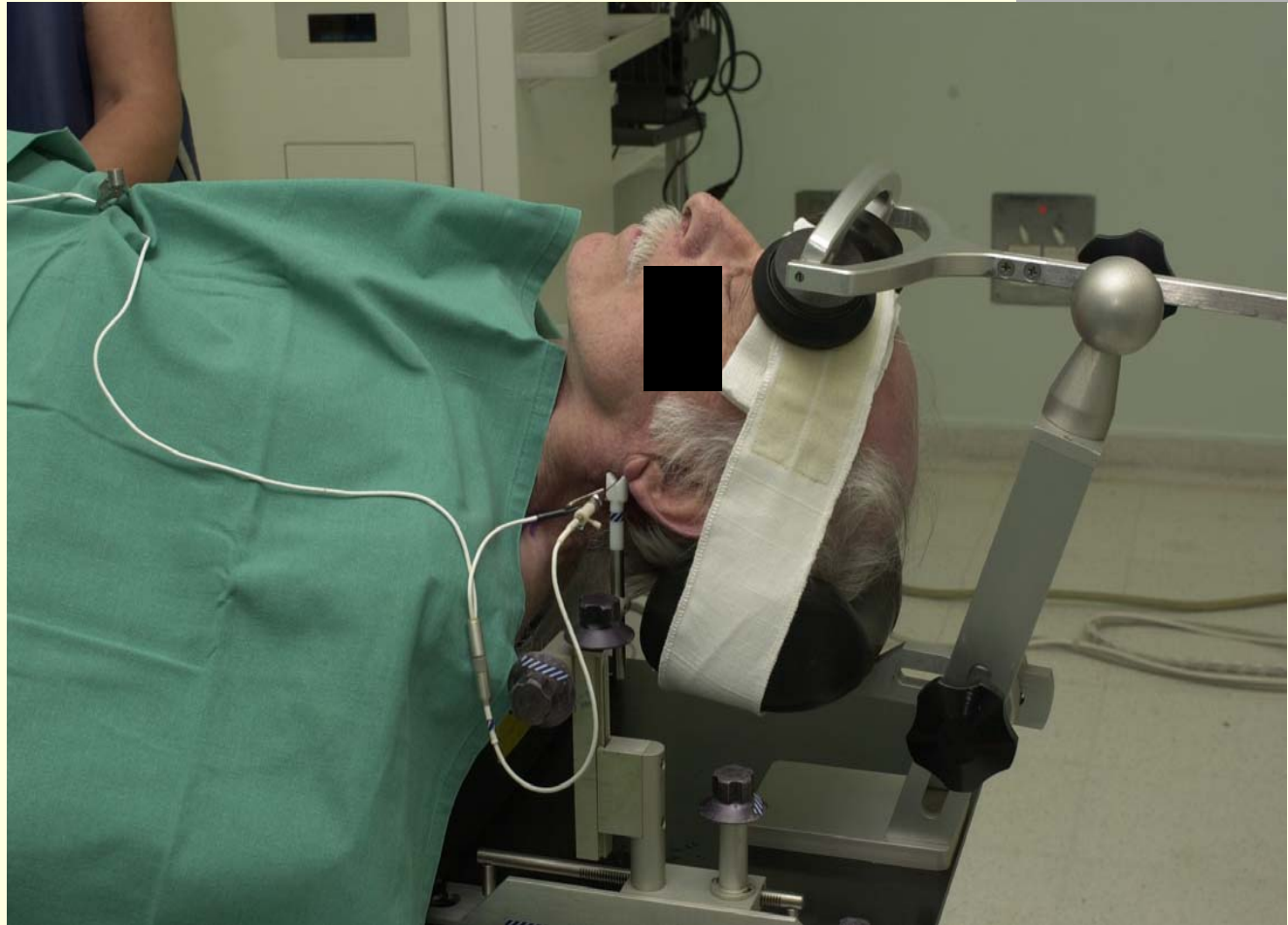






# Cordotomy (Derek Pounder, Portsmouth)

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# How are services organised now?

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- Acute pain
  - May be separate service from chronic pain
  - Present in all major hospitals in UK
  - May be an integrated service
- Chronic pain
  - Hospital based
  - Community based
  - Multidisciplinary teams
- Cancer pain
  - Largely in palliative care
  - Increasing input from chronic pain services



## 18 Week Commissioning Pathway - Spinal (including Back Pain) version 1.3, July 2007

**1.2 Self Assessment & Self Care** (Supported/Unsupported)  
(e.g. NHS Direct (Internet or Phone); Pharmacy)

**1.2.1 History**

**1.1 Patient Symptom**  
Spinal pain

**1.1.1 Description**  
New or flare in pre-existing spinal +/- nerve root pain

**1.1.2 Metric**  
Incidence & Prevalence

**1.1.3 Primary Prevention**  
Disease Prevention  
Health Protection  
Health Promotion

**2.2 Primary Assessment**  
(e.g. Primary Care)\*

**2.2.1 History\***: For spinal pain a careful history and brief examination should distinguish mechanical pain from more serious pathology, nerve root pain

**2.2.2 Examination\***: The examination should be guided by the history

**2.3 Patient Quality of Life (QoL) Measurement Start**

**2.4 Diagnostic**  
Thresholds  
2.4.1 Decision Aid\*

**2.5 Diagnostic**  
Thresholds  
2.5.1 Decision Aid\*

**2.6 Diagnostic**  
Thresholds  
2.6.1 Decision Aid\*

**2.7 Diagnostic/s (Dx)**

**2.7.1 No Diagnostic Required**

**2.7.2 Bloods\***

**2.7.3 X-ray\***  
Indications for X-ray Guidance  
MRI/CT and Right Time  
Right Place

**2.7.4 MRI\***  
Indications for MRI  
MRI/CT and Right Time  
Right Place

**2.8 Treatment**  
Thresholds  
2.8.1 Decision Aid\*

**2.9 Definitive Treatment/s (Tx)**

**2.9.1 Reassurance Information Self-Help\***  
For all spinal pain and nerve root pain with no red flags

**2.9.2 Watchful Waiting\***  
Advice to stay active, early return to work. Pain does not equal harm

**2.9.3 Physical/Psychological Tx\***  
Biopsychosocial approach. Psychosocial risk factors to be addressed

**2.9.4 Medication\***  
To enable patient to return to normal activities as soon as possible

**2.9.5 Initial Pre-op Assessment**

**2.9.6 Invasive Tx (Enhanced GMS)**

**3.2 Specialist Assessment**  
(e.g. Primary Care led interface services (e.g. ICATS) with consultant involvement or Consultant led outpatient services in Secondary Care\*)

**3.2.1 History**: Clarification and expansion of primary assessment history where needed, straight to diagnostic test or face to face assessment

**3.2.2 Examination\***: Clarification and expansion of primary assessment examination where needed, straight to diagnostic test or face to face examination

**3.3 Diagnostic**  
Thresholds  
3.3.1 Decision Aid\*

**3.4 Diagnostic**  
Thresholds  
3.4.1 Decision Aid\*

**3.5 Diagnostic**  
Thresholds  
3.5.1 Decision Aid\*

**3.6 Diagnostic/s (Dx)**

**3.6.1 No Diagnostic Required**

**3.6.2 No Red Flags\***  
Spinal pain, no clinical indicators of infection or neoplasia (MRI/CT)

**3.6.3 With Red Flags\***  
Spinal pain with potentially serious red flag features (MRI/CT)

**3.6.4 MRI\***  
Suspected Osteoporosis, Collapse (MRI/CT), spinal stenosis

**3.7 Treatment**  
Thresholds  
3.7.1 Decision Aid\*

**3.8 Definitive Treatment/s (Tx)**

**3.8.1 Reassurance Information Self-Help\***  
For all spinal pain and nerve root pain with no red flags

**3.8.2 Watchful Waiting**  
As 29.2

**3.8.3 Physical/Psychological Tx\***  
As 29.3  
Specialist uniprofessional rehab. Psychological treatment

**3.8.4 Medication**  
As 29.4

**3.8.5 Pre-op Assessment (POA)\***

**3.8.6 Invasive Tx by Surgical Provider**

**4.2 Sub or Supraspecialist Assessment**  
(e.g. Specialist Outpatient Services; Tertiary Service)\*

**4.2.1 History**: Neuropathic pain. Clarification and expansion of specialist assessment history where needed, straight to diagnostic test or face to face assessment

**4.2.2 Examination**: Clarification and expansion of specialist assessment examination where needed, straight to diagnostic test or face to face examination

**4.3 Diagnostic**  
Thresholds  
4.3.1 Decision Aid\*

**4.4 Diagnostic**  
Thresholds  
4.4.1 Decision Aid\*

**4.5 Diagnostic**  
Thresholds  
4.5.1 Decision Aid\*

**4.6 Diagnostic/s (Dx)**

**4.6.1 No Diagnostic Required**

**4.6.2 No Red Flags\***  
Chronic back pain, no clinical indicators of infection or neoplasia (MRI/CT)

**4.6.3 With Red Flags\***  
Back pain with potentially serious red flag features (MRI/CT)

**4.6.4 Specialised Imaging\***  
Specialised Imaging Investigations and Image Guided Intervention

**4.7 Treatment**  
Thresholds  
4.7.1 Decision Aid\*

**4.8 Definitive Treatment/s (Tx)**

**4.8.1 Reassurance Information Self-Help\***  
For all spinal pain and nerve root pain with no red flags

**4.8.2 Watchful Waiting**  
As 38.2

**4.8.3 Physical/Psychological Tx\***  
Intensive Multidisciplinary pain management programme

**4.8.4 Medication**  
Part of multidisciplinary care

**4.8.5 Pre-op Assessment (POA)**

**4.8.6 Invasive Tx by Surgical Provider\***  
Range of procedures for certain conditions

**2.10 Rehabilitation and Review: Quality of Life (QoL) Outcome Measurement**

**3.9 Rehabilitation and Review: Quality of Life (QoL) Outcome Measurement**

**4.9 Rehabilitation and Review: Quality of Life (QoL) Outcome Measurement**

**KEY**

**Clock Starts**

**Clock Stops**

**\* See Supplementary Information**

**Patient**



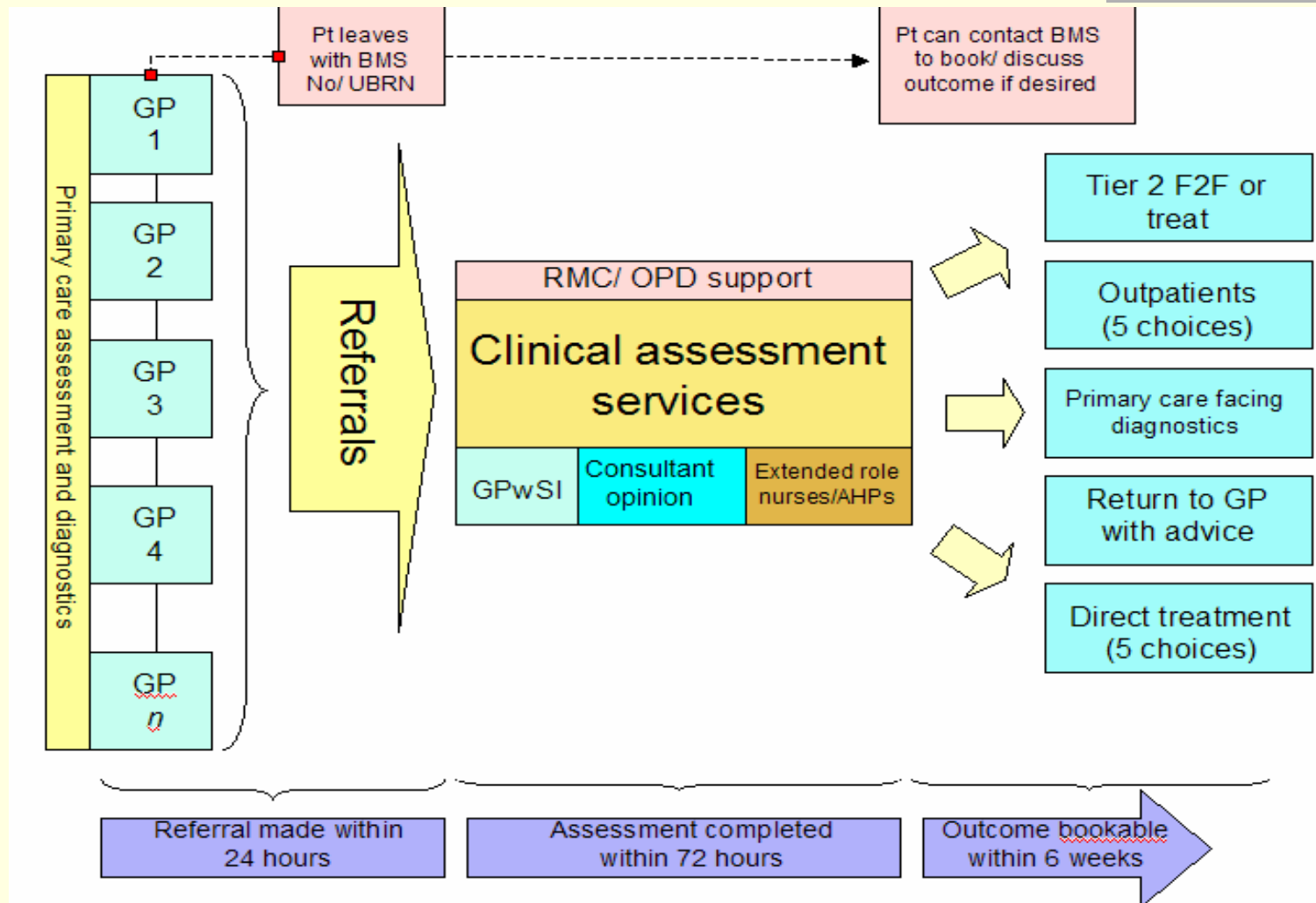
# Primary Care initiatives

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- GPs with a Special Interest in Pain Medicine
- Nurses, physiotherapists and trained in assessment and management of pain
- Triage (1727; the action of assorting according to quality OED)
- Pain Specialists working in Primary Care
- ICATS, Polyclinics



# Integrated Clinical Assessment and Treatment Services





# Secondary Care: Pain Clinics

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- Consultant(s), trainee doctors, “other” doctors, specialist nurses, physiotherapist, occupational therapist, clinical psychologist, secretaries, manager
- Out patient clinics, theatre lists with XRay facilities, ward rounds, team meetings, business meetings, audit, teaching and research.







# Range of services provided

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- Assessment
  - Holistic, includes psychological assessment
  - Often multidisciplinary
  - Simple pain management advice: pacing, goal setting etc
- TENS, acupuncture
- Drugs
  - Non opioids, opioids
  - Adjuncts eg gabapentin, amitriptyline
- Simple injections
- Cognitive Behavioural Therapy
- Education classes, pain management classes
- Day case injections/ radio frequency lesioning
- More complex interventions



# Tertiary Referrals

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- Specialist Techniques
  - Spinal Cord Stimulation
  - Intensive Patient Management Programmes
  - Intrathecal Drug Delivery
- Joint Clinics
  - Pelvic pain
  - Neurology/ headache
  - Maxillo-facial



# Pain Management services 2008

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- Scotland, Wales and Northern Ireland have their own directives
- In England (60 million people) there are about 200 hospital based pain clinics, perhaps 10 community services
- Referrals from GP or other doctor, new electronic nationwide direct booking initiative: “choose and book” has been a failure
- Patient is treated over a period of time and then discharged back to GP care.



# Instigators of Change

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- In July 2007, Secretary of State for Health Alan Johnson asked Ara Darzi, Baron Darzi of Denham, to conduct a 'once in a generation review' of the health service in England, consulting with patients and staff in order to set priorities for the next 60 years with a particular focus on questions of access, quality and safety.
- Pain management is becoming more important



# The British Pain Society



- 1,700 members
- Multidisciplinary
- Education
  - Annual Scientific meeting
  - Seminars
  - Special Interest Groups
- Publications
- Patient Liaison Committee
- Website
- Forum for exchange of ideas
- Liaises with many other organisations



April 2007

Faculty of Pain Medicine of The Royal  
College of Anaesthetists Red Lion  
Square, London





# Pain Management recognized as a Speciality in Australia

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- Milton Cohen and Roger Goucke Pain Medicine 2006 (7) 473
  - Long and complex process initiated by the Faculty of Pain Medicine of the Australian and New Zealand College of Anaesthetists
  - Criteria
    - Need for specialism had to be defined
    - Based on sound clinical and scientific principles
    - Practitioners appropriately trained and qualified
    - Must define, promote and maintain high standards
    - Development must contribute to improved health care



# In Summary....

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- Start small and let pain services evolve
- Education is the most important aspect
- Set standards in training
- Think holistically; do not just do injections
- Integrate with cancer pain management
- Recognition comes from effectiveness
- Keep up to date
- Focus on the simple things and allow the patients to speak for you.