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**Clinical Standards Advisory Group**

## **Services for Patients with Pain**

Report of a CSAG committee chaired by Professor Alastair Spence

Prepared by a research team led by Dr Gavin Thoms of the University of Manchester School of Epidemiology and Health Science, and Professor David Rowbotham of the University of Leicester Department of Anaesthesia and Leicester Royal Infirmary.



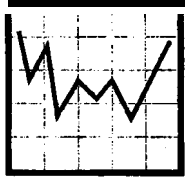
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## Preface

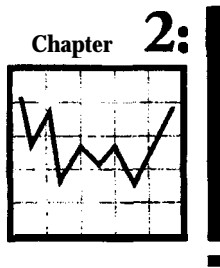
**The Clinical Standards Advisory Group (CSAG) was established in April 1991, under Section 62 of the National Health Service (NHS) and Community Care Act 1990, as an independent source of expert advice to the UK Health Ministers and to the NHS on standards of clinical care for, and access to and availability of services to, NHS patients. Remits are set by the UK Health Ministers in discussion with the Group**

**The Group's members are nominated by the medical, nursing and dental Royal Colleges and their Faculties, and the Professions Allied to Medicine, and include the Chairmen of the Standing Medical, Nursing and Midwifery, and Dental Advisory Committees. Each investigation is carried out by members and co-opted experts supported by a research unit under contract. Financial support is provided by the UK Health Departments. The Secretariat is based in the Department of Health, Wellington House, 133/155 Waterloo Road, London SE1 8UG, and a Support Team is based in the Unit of Health-Care Epidemiology at the University of Oxford.**

**The Health Act 1999 introduced a number of changes that are directly relevant to the work of CSAG. A programme of service reviews, similar to those undertaken by CSAG since 1991, will continue under the new Commission for Health Improvement. CSAG will be abolished by the end of 1999.**

**Professor Martin Harris  
Chairman, Clinical Standards Advisory Group  
1999**





# Background

2.1 Pain is one of the most common and obvious consequences of accidents and ill-health. Patients suffering from pain, particularly long-standing pain, make many demands on the NHS requiring considerable time to address. In some cases, long-standing pain results in distress and disability that can have devastating effects upon the lives of sufferers and their families, as well as serious socioeconomic consequences. Although some of these problems can remain intractable, there is a great deal that can be done to treat pain and to alleviate its effects on patients' lives.

## Definitions of pain and related terms

- 2.2 *Pain:* an unpleasant sensory and emotional experience associated with actual or Potential tissue damage, or described in terms of such damage (IASP 1986).
- Chronic pain:* pain that either persists beyond the point at which healing would be expected to be complete or that occurs in disease processes in which healing does not take place. Chronic pain may be accompanied by severe psychological and social disturbance. Chronic pain can be experienced by those who do not have evidence of tissue damage.
- Acute pain:* pain of recent onset and probable limited duration, usually having an identified temporal and causal relationship to injury or disease (Ready & Edwards, 1992). The term "acute pain" can be used to describe a range of conditions, including, for example, the severe pain associated with acute pancreatitis, and acute episodes of chronic conditions, such as low back pain.
- Pain management:* a term in common use to describe the overall specialist activity of caring for those in acute or chronic pain.
- Pain management programme:* a psychologically-based rehabilitative treatment for people with chronic pain which remains unresolved by currently available medicine and other physically-based treatments (Pain Society, 1997).

## Epidemiology

2.3 The results of recent population surveys highlight the prevalence of painful conditions in the community. It has been estimated that 7% of the population suffer chronic pain at any one time (Bowsher et al, 1991). In a recent survey of 6,000 adults in Tameside, Greater Manchester (Urwin et al, in press), 27% of females and 28% of males aged 45-64 years reported experiencing musculo skeletal pain lasting for at least one week during the previous month; pain was reported slightly more frequently (31%) in older females (aged 65-74 years). In another survey in South Manchester, 10% of adults reported some restriction of their activity during the previous month due to back pain, and

11% reported experiencing chronic widespread pain (i.e. pain lasting for more than 3 months in at least two quadrants and on opposite sides of the body) (Papageorgiou et al, 1995).

## **Management of pain**

2.4 Sufferers may take medications they have purchased over the counter, or seek remedies from pharmacists, GPs or complementary therapists. When untreated, pain can cause helplessness, depression, isolation, family breakdown and inappropriate disability. The majority of those suffering from chronic pain do not attend hospitals.

2.5 Pain is a common major symptom in diseases presenting to a range of hospital specialties, including surgery, orthopaedics, rheumatology, palliative medicine, oncology and neurology. In general, the first approach to treating pain is to diagnose and treat the underlying condition; however, despite specific treatment, some patients continue to experience severe pain.

2.6 Of these patients with unresolved pain, some will receive care from specialised services for the treatment of chronic pain. It is these services that are the main focus of this report. Expertise in treating chronic pain is scarce; typically, there is under-provision of services, and significant unexpressed demand.

## **Pain services**

2.7 The first specialist pain services in the UK were started in the late 1940s and early 1950s. They were set up by anaesthetists who offered skills in managing terminal cancer pain by nerve blockade as an alternative to analgesic regimes available at that time. Treatment was often given in the anaesthetic room during or after operating lists. Once they had established a role in providing Pain relief, anaesthetists were confronted with a changing, growing and demanding caseload. Additional resources and skills to meet this caseload were difficult to obtain.

## **The chronic pain service**

2.8 The aims in the provision of a chronic pain service are to relieve chronic pain and associated disability when Possible, and to give appropriate advice and support to those patients in pain for which no treatment is available. Chronic pain services are now provided in the majority of teaching and district general hospitals, and include outpatient sessions for the assessment of new patients, the review of current or previous patients and the administration of some treatments. Further treatments may involve daycase or inpatient admission, sometimes requiring special facilities such as X-ray.

2.9 Referrals to chronic pain services generally come from the specialties of orthopaedics, rheumatology, palliative medicine, and oncology, and, to a lesser extent, surgery and neurology. In a minority of centres there are examples of the integration of services, such as joint outpatient sessions and some joint appointments with palliative care or rheumatology. GPs can often refer patients directly to pain services, although at some hospitals referral occurs only via other hospital specialties. Patterns of referral behaviour appear to vary markedly across the UK. It is important to recognise that only a minority of patients with pain will need treatment by specialist pain services.

2.10 The International Association for the Study of Pain (IASP) has classified pain services according to the level of specialisation of the service. The IASP classification has been derived from a task force on the desirable characteristics of pain treatment facilities (IASP 1990). (See Appendix B.)

#### *The palliative care service*

2.11 Palliative care has its origins in the modern hospice movement. The aim of a palliative care service has been described as care for "patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of psychological, social and spiritual problems, is Paramount. The goal of palliative care is achievement of the best quality of life for patients and their families." (World Health Organization, 1990). Palliative care describes the care offered by a team of doctors, nurses, therapists, social workers, clergy and volunteers. Palliative medicine (which describes the work done by doctors) was recognised as a medical speciality in 1987 and defined as "the study and management of patients with active, progressive, far-advanced disease, for whom the prognosis is limited and the focus of care is quality of life" (Association of Palliative Medicine, 1992). Patients suffering with Pain from cancer may be managed by specialists in palliative medicine, by chronic pain services or by both services working together.

#### *Pain management programmes*

2.12 The aim of providing pain management programmes is to reduce the disability and distress caused by chronic pain that is resistant to treatment. Sufferers are taught physical, psychological and practical techniques intended to improve quality of life and to enable patients to be as self-reliant as possible; pain relief is not the primary goal. Such programmes may be conducted on an inpatient or outpatient basis. In general, pain management programmes are led by those working in professions allied to medicine (PAMs); most are hospital based, but some are also held in primary and community care settings. Only small numbers of patients are selected for treatment within these programmes; they are not available in every locality.

#### *Pain rehabilitation programmes*

2.13 In some areas of the UK there are physiotherapy-led rehabilitation programmes for Patients with pain; these are variously described as back schools, active rehabilitation programmes, fitness programmes or functional restoration programmes.

#### *The acute pain service*

2.14 The aim of the hospital acute pain service is the control of any intense short-lived pain although most concentrate on postoperative pain. Acute pain teams typically comprise an anaesthetist and one or more specialist nurses, who may offer hands-on pain management (particularly patient-controlled analgesia and epidural techniques), staff training, monitoring of the efficacy of treatments and their safety, and skills in guideline introduction, audit, and research. During the last decade, two factors have driven the development of acute pain teams: the recognition of previously low standards of care; and the publication, in 1990, of the report of a working party of the Royal College of Surgeons and the College (now Royal College) of Anaesthetists entitled "Pain After Surgery" (Royal College of Surgeons/College of Anaesthetists, 1990).

## Other professional roles in chronic pain

### *Primary and community care*

2.15 GPs and community staff manage the majority of patients with chronic pain. Some GPs provide complementary therapies, physiotherapy and other services within the practice setting. GPs are also involved in commissioning specialist pain services and take part in the negotiations relating to service agreements, costs and the levels of activity to be provided.

2.16 Specialist palliative care nurses can work in both hospital and community settings.

2.17 Community pharmacies have a role in enabling access to specialist and controlled medicines in the community, which is of particular importance in palliative care.

### *Complementary therapists*

2.18 Many people in the UK consult a complementary therapist, for various reasons including pain. The six therapies that account for 75% of all consultations are acupuncture, chiropractic, osteopathy, homeopathy, herbal medicine and hypnotherapy (Goldbeck-Wood, 1996). Most complementary therapy is provided outside the NHS.

## Some issues of concern relating to pain services

### *Conflicting views about effectiveness*

2.19 There is evidence that those treating patients in chronic pain have widely differing views about the values of individual treatments. The subjective nature of pain makes the evaluation of pain relief interventions particularly challenging. However, a good deal of unbiased evidence is available. Much of this material has been reviewed for the NHS Health Technology Assessment Programme (McQuay et al, 1997). There is also a Cochrane Pain, Palliative and Supportive Care Collaborative Review Group and the Cochrane Library has recently incorporated the database of the Oxford Pain Research Unit. The International Association for the Study of Pain has set up a special interest group in "systemic reviews of evidence-based medicine

2.20 The Health Technology Assessment report on systematic reviews of outpatient services for chronic pain control found evidence to support much of common practice in the management of chronic pain (McQuay et al, 1997). The authors point out that their review was not comprehensive but nonetheless they found good evidence for the use of simple analgesics, anticonvulsants, antidepressants, cognitive behavioural therapy and epidural corticosteroids. Some therapies have also been shown not to be effective; these include the use of transcutaneous electrical nerve stimulation in acute pain and in labour pain. A general conclusion is that research knowledge of effectiveness remains limited and there is considerable need for further high quality clinical trials. There is good evidence, however, that chronic pain services themselves are cost-effective. The use of pain clinics results in direct savings to the NHS equal to twice their own cost. The authors of the report also make the point that the efficacy of a service is distinct from the efficacy of a set of individual therapies. The process of care is an important intervention in itself. Firstly, because, effective therapies also need to be used appropriately and, secondly, because the process of caring for patients is in itself an important intervention.

### *Variation in provision*

2.21 The level and nature of provision varies markedly within the UK (Davies et al, 1996; Audit Commission, 1997; Scottish Office, 1994). Despite concerns about this variation, it has been difficult to investigate because of the poor availability of routine data and difficulties in documenting casemix. It is important to identify variation in terms not only of provision but also of accessibility. Pain specialists use a wider range of treatments for pain than other clinicians (Davies et al, 1993; Davies, et al, 1991). therefore, patients referred to pain clinics have access to treatments not available elsewhere (Davies et al, 1994). Some of the variation is probably explained by disagreement over the benefits of some treatments. The length of wait for treatment can also vary substantially, and there is some evidence that excessive delays hamper subsequent treatment of painful conditions (Wells, 1987).

### *Organisational strategy for pain services*

2.22 Some chronic pain services are still single-handed. Many are insecurely or inadequately funded. Many services are not governed by clear policies; staff morale may also be low. For many chronic pain services, good-quality routine information on activity, cost, demand or need are not available, and it is not possible to measure outcomes.

### *Links with managers*

2.23 Those providing pain services have often inadequately informed their sources of referral or contract income about their purpose, distinctive skills and competences, or the expected outcome of treatment. They may find it difficult to present compelling information to hospital managers and healthcare commissioners about the value for money and effectiveness of their service. In the USA, Sanders (1994) perceived that pain services had a problem of negative image. He advised leaders of pain services:

- to demonstrate wst effectiveness;
- to measure and demonstrate changes in patients health status;
- to state goals more clearly (both organisationally and at the patient level);
- to introduce greater structure;
- to use guidelines to standardise the care provided.

### *The need for multidisciplinary working*

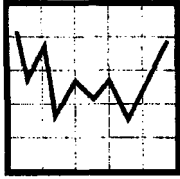
2.24 It is sometimes difficult for patients in pain to obtain access to the professions allied to medicine. The availability of such staff within pain services is extremely variable outside the limited context of pain management programmes. However, IASP consider a multidisciplinary approach to pain management to be essential for many patients (IASP 1990).

*The relationship with palliative care*

**2.25 The field of palliative care has expanded rapidly in the last decade; by comparison services for patients suffering from non-malignant chronic pain have received less attention.**

*Pain services for children*

**2.26 There has been relatively little research into, or evaluation of, the provision of Pain services for children, although some progress has been made (Zacharias & Watts, 1998). The recently published guidelines entitled "Prevention and Control of Pain in Children" (Royal College of Paediatrics and Child Health, 1997) were, in part, initiated by concern about unsatisfactory attitudes and poor practices.**



## Objectives

3.1 The objectives of the research study were as follows:

### *Chronic and acute pain services*

- To describe the organisation of pain services for NHS patients.
- To investigate access to and availability of pain services in the NHS.
- To describe the range of treatments available in the NHS for acute and chronic pain.
- To assess awareness of research evidence, and guidelines, and clinical effectiveness information regarding the management of pain, among hospital clinicians and those in general practice.
- To collate existing relevant guidelines and standards.
- To describe quality of care delivered in primary and secondary care settings, and co identify critical success factors associated with high clinical standards.

### *Chronic Pain Services*

- To investigate the perceptions of users, carers and the public regarding services provided by the NHS.
- To assess need for further training of health-care professionals.

### *Acute Pain Services*

- To assess the effects of the RCS/RCA 1990 guidance on acute pain management.
- To document and describe the needs of patients who have postoperative pain, or pain after trauma and the extent to which those needs are currently being met.

3.2 The study of acute pain services was limited to pain relief after surgery or other trauma, including clinical procedures for children. There were several exclusions from the scope of enquiry: pain relief outside NHS provision; pain relief for patients in general medical settings; pain relief for dental patients; pain relief during childbirth; and pain relief before operation for patients who have surgical problems.

## Data collection

3.4 Data were obtained from hospitals, primary care, community services, complementary therapists, and purchasers mainly via studies in a random sample of 12 “sites” (based on acute NHS Trusts), but also drawing on a national survey of heads of pain services, document reviews and professional contacts.

### *Selection of a random sample of study sites*

3.5 The definition of a study site was an NHS Trust that provides one or more pain services and the community served by that Trust, which included lead purchaser, local primary and community care services, and the local population. A sampling frame of 250 acute NHS Trusts in the UK was assembled from Binley’s Directory of NHS management (1997). 12 Trusts were randomly selected to include a representative sample of teaching and non-teaching hospitals. One of the Trusts selected in fact comprised two large hospitals which provided independent chronic pain services but neither of these had an acute pain service. One Trust had no chronic pain service. A further 2 hospitals in the sample provided only a limited acute pain service; and 3 did not provide palliative care.

### *Pilot studies*

3.6 Two “Trusts not in the sample but local to the research team agreed to be pilot study sites. They were visited by researchers and CSAG committee members. Pilot site data were not included in quantitative analyses but the findings are reflected to an extent in the commentary and discussion.

### *Data collection from 12 sample sites*

3.7 With local Ethics Committee approval, researchers visited sample sites to collect data by means of questionnaires administered to the following groups:

- staff directly involved in chronic pain services ( $n=28$ );
- nurses involved in acute pain services ( $n=9$ );
- staff involved in the care of patients with post-operative and trauma pain ( $n=106$ );
- patients attending a chronic pain clinic ( $n=245$ );

At each of the 12 sample sites, patients were approached in the clinic by a researcher and asked if they would agree to be interviewed and for their case-notes to be examined. Of 257 patients approached only 12 refused to take part. Sequential patients were approached in sequential clinics regardless of whether they were attending for a new appointment or a follow-up appointment. Recruitment continued until a predetermined number of patients had been recruited. Patients who consented to the study were then interviewed face to face for approximately 15 minutes immediately after their clinic consultation.

- carers attending the same chronic pain clinics ( $n=79$ );
- patients receiving postoperative care ( $n=214$ )



Approximately 10 patients who had had an elective abdominal procedure, in 10 of the 12 sample sites, were recruited and interviewed 2-4 days postoperatively (n=112). Patients recently discharged from daycase surgical units in 10 sites were recruited and interviewed by telephone (n=102). They had undergone operations such as laparoscopy, molar tooth extraction, hernia repair, or vasectomy.

A summary of the themes covered by questionnaires to different groups is given in Box 1.

### *CSAG Visits*

3.8 Members of the CSAG Pain Committee formally visited 6 of the 12 sample sites. These visits included discussions with staff leading and managing pain services and staff working within the services, as well as general Trust management, local commissioners and local GPs. Composition of discussion groups differed somewhat across the sites.

3.9 A total of 14 GPs and 3 practice managers took part in discussions during the CSAG visits (including two pilot visits) as did 13 community staff including community managers (3), district nurses (3), community physiotherapists (6), and a community pharmacist. The visitors also met 14 local complementary therapists (including practitioners of reflexology; Shiatsu therapy, aromatherapy; acupuncture; osteopathy; hypnotherapy, and chiropractic).

### *Focus Groups*

3.10 For practical reasons, focus groups were limited to the two pilot sites and two other sites in the random sample. Four themes were explored in eight separate focus group discussions: primary care issues (2 groups), patient satisfaction (2 groups), training and standards (1 group), and commissioning (3 groups). Questioning routes were predetermined; contemporaneous notes were taken and transcribed in detail. In 5 of the 8 focus groups, GPs were represented (n=13). A practice manager also attended one of the focus groups.

### *Interviews with GPs*

3.11 GPs were recruited for interview by random selection from lists supplied by the health authority (in 10 of the 12 sample sites) or by nomination by the local pain or palliative care service because they were known to have an interest in pain management (all sites). GPs identified by either route (n=156) were sent letters asking if they would be willing to be interviewed. Of this number, 39 GPs were not available, 60 declined to be interviewed or did not respond and 57 agreed (45 of whom had been randomly selected, 12 nominated by local pain services).

### *Questionnaires to community staff*

3.12 Questionnaires were sent to 132 community staff selected either by Trust managers or from lists of names provided by the community Trusts. 54 questionnaires were received from 11 of the 12 community services surveyed: 26 from district nursing; 15 from Macmillan nursing; 11 from physiotherapy; 1 from community pharmacy, 1 from occupational therapy.

### *Questionnaires to complementary therapists*

3.13 Names of complementary therapists practising within the sample site localities were obtained from national organisations. In all 158 questionnaires were sent out; 58 completed questionnaires were returned.

### *Questionnaires to Health Authority and Board commissioners*

3.14 Commissioning of pain services was surveyed by questionnaire to the lead authorities for the 12 sample sites and the 2 pilot sites (11 responded); and through discussions at 3 of the 8 focus groups and at all CSAG visits.

### *National survey of heads of service*

3.15 A national survey was conducted to identify all pain services in acute NHS Trusts in the UK. Chief Executives in Trusts not included in the 12 site sample (238 Trusts) were asked to indicate on a reply paid postcard which of the three services (chronic pain, acute pain, and palliative care) were provided within their Trust. If no response was received, the anaesthetic department was telephoned directly and the same information was requested. Table 1 shows the results of this exercise, including information from the 12 Trusts in our random sample.

3.16 Questionnaires were then posted to the heads of all pain services identified in the survey and given to the equivalent heads of service in the random sample. The combined response rate in terms of completed questionnaires is shown in Table 1. Many community-based palliative care services found some of the questions to be less relevant to them than the hospital-based services – this may explain the relatively low response rate from these services.

**Table 1: Services present in 250 Acute NHS Trusts**

<i>Service</i>	<i>Number (proportion) of Trusts with that service</i>	<i>Number (proportion) of Trusts returning completed questionnaires from heads of service</i>
chronic pain	215 (86%)	121(56%)
<b>Palliative care</b>	<b>162 (65%)</b>	<b>76 (47%)</b>
Acute pain	220 (88%)	153 (69%)

### *Information from relevant national organisations*

3.17 A wide variety of national organisations with an interest in pain control were approached to investigate their role and activities in this area. They comprised 19 statutory bodies, 52 professional organisations, 65 voluntary organisations and 53 other health-related organisations. The organisations that responded are listed in Appendix C. Responses included information about research in progress; standards and guidelines used in various specialties and professions; the availability of support groups for patients; and the role of the organisation in education and strategy.

*Children's pilot study*

3.18 A pilot study was undertaken to investigate the provision of services for children suffering from acute or chronic pain. Telephone contact was made with paediatric clinical nurse specialists in all specialised children's hospitals in the UK. In addition, an interview study was carried out in six hospitals: two general hospitals and two teaching hospitals from the random sample of twelve, and two specialist children's hospitals.

**Box 1: Themes covered in interviews and postal questionnaires by target pup**

***Heads of services***

- Organisation of pain services
- Treatment, investigations, and procedures
- Resources (human and financial)
- Information on referrals/waiting list/patient attendance
- Guidelines and standards
- Contractual arrangements
- Research and audit

***Local professional staff GPs, A&E and other consultants, daycase and surgical ward nurses, nurse specialists, professions allied to medicine, community staff complementary therapists***

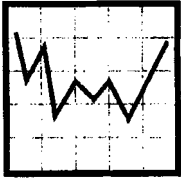
- Work structure
- Services and treatments
- Assessment of postoperative pain
- Information provided for patients
- Training and education received and provided
- Guidelines, protocols and standards
- Research and audit undertaken
- Gaps in service provision

***Patients experiencing acute postoperative, daycase, and trauma pain***

- Actual care and experience of pain management services
- Quality of care received, including patient satisfaction
- Type of care received
- Assessment of pain
- Patient satisfaction

***Patients suffering from chronic pain, and their carers***

- Lifestyle issues (e.g. ability to work)
- Experience of 'pain care' prior to referral (including treatments tried)
- Referral/waiting time
- Range of treatments received in the pain service
- Quality of care perceived
- Information provided by service
- Experience of complementary therapies
- Carers' knowledge of pain service
- Support groups for carers
- Carers' views and experience of pain service



4.1 Services for pain have grown both in terms of the number of treatments available and the number of professionals able to administer them. With this growth has come an awareness of wide variation in clinical practice, referral practice (Davies et al, 1992; Kerssens & Groenewegen, 1990), organisation of clinical care (Davies et al. 1994) and clinical opinion (Davies et al, 1993). Cherkin and colleagues (1995) reported a lack of consensus among a sample of 1200 physicians from a range of specialties treating patients with back pain. They found little association between what doctors believe and the evidence from rigorous scientific studies.

4.2 If variation in practice can be attributed to a lack of awareness of the scientific evidence, then adoption of good quality, evidence-based guidelines should be helpful.

#### *Collection of guidelines*

4.3 A substantial number of local, national and relevant international guidelines were identified at the sites visited, through the national survey, and through personal contact or correspondence (see Table 2). The main national and international guidelines, and some other guidance collected are summarised in Appendix D.

**Table 2: Numbers of items of guidance (largely guidelines) collected**

<i>Service</i>	<i>International and relevant to the UK</i>	<i>National</i>	<i>Local</i>
Chronic pain	13	6	19
Palliative care	8	5	6
Acute pain	4	6	105
General, other	4	3	

#### **National guidelines**

4.4 Very few clinicians or managers appeared to be aware of the large body of published guidance relevant to pain services. No organisation or individual had collated all existing relevant pain guidelines as in Appendix D. If awareness of national guidelines was patchy, adoption of them had also been limited. Clinicians were generally supportive of the use of guidelines, saying that they raise awareness and can improve the service.

4.5 There was enthusiasm for the back pain guidelines produced by CSAG and by the Royal College of General Practitioners (18 unprompted mentions between them). In about half of the discussions, purchasers described the Royal College of Anaesthetists Guidelines for Purchasers and the report on Pain Management Programmes by the Development and Education Committee in the South and West

Region of the NHS (NHS Executive, 1996) as valuable. Clinicians commonly mentioned the Royal Colleges' report on pain after surgery. One or two unprompted mentions were made of the WHO "Step-ladder for Pain", the IASP curriculum documents and the Royal College of Paediatrics and Child Health Manual (which was published halfway through our study).

**4.6 The most significant recent national guidclincs or guidance seem to have been the following:**

- Royal College of Surgeons/Royal College of Anaesthetists - Report of the Working Party on Pain after Surgery, 1990;
- Royal Collcgc of Anaesthetists - Guidance for Purchasers, 1994;
- CSAG - Back Pain, 1994;
- Royal College of General Pmctitioners - Clinical Guidelines for the Management of Acute Low Back Pain, 1996;
- Association of Anaesthetists of Great Britain and Ireland I -Pain Society - The Provision of Pain Services, 1997;
- Royal College of Paediatrics and Child Health Working Party on the Prevntion and Control of Pain in Children - A Manual for Health Professionals, 1997;
- Some of the international guidelines from IASP AHCP and WHO.

#### **Development of new guidelines**

**4.7 Clinicians wanted guidance on the management of difficult conditions and on the best referral pathway, wmplcx regional pain syndrome was commonly cited as an example. GPs wanted protocols or guidelines on the referral of specific types of patient, similar to the existing material on back pain. However, many were suspicious of prescriptive guidclincs, preferring a more advisory style. Clinicians also said they wanted goodquality information on what local services offer; some mentioned the value of clear, well-presented one-page guidelines, containing advice on the management of painful conditions. Factors that lead to non-adoption of guidelines were said to include a small print run, poor dissemination, apparent lack of rclvance to recipients, poor readability, uncertainty about the soundness of the scientific base, lack of clarity on implementation, and lack of a local champion.**

**4.8 Trust board members felt that more national guidelines would be useful as a basis for local guidelines. There was much support for clear guidance on what a pain service should offer, based on good clinical evidence. Purchasers expressed some support for clarification on what purchasers should be buying in a pain service. Some health authority officers warned that unless they are actively reviewing a specific service, they may not be able to react to unsolicited guidelines.**

#### **Use of Guidelines**

**4.9 Locally developed guidelines were being used by 44 (36%) chronic pain services, 50 (66%) palliative care services and almost all acute pain services. Processes of care covered by these guidelines in chronic pain and palliative care are shown in Table 3. A relatively low level of guideline USC in**

chronic pain services may reflect the smaller number of patients seen by these services allowing greater reliance on direct care by the pain specialist(s). Acute pain services rely much more on the education of others to provide better care in which case guidelines are an important component of the service.

**Table 3:** Subject of local guidelines used in chronic pain services and palliative care

<i>Subject of guideline</i>	<i>Number of services using such a guideline</i>	
	<i>Chronic pain (of 122 services)</i>	<i>Palliative care (of 76 services)</i>
Assessment of new patients	21 (17%)	28 (37%)
Follow-up of existing patients	10 (8%)	20 (26%)
Discharging patients	12 (10%)	26 (34%)
Treatment guidelines	29 (24%)	32 (42%)
Other	7 (6%)	50 (66%)*

\**mostly relating to issues other than pain control.*

4.10 Acute pain services had developed local guidelines for patient controlled analgesia (137 (95%) services), for use of epidurals (118 (82%) services) and for intramuscular analgesia (60 (42%) services). Those guidelines that were sent to us by acute pain services were assessed by two consultants working in this field. Although 23 were rated of very high quality by at least one of the consultants, many more (57) were deemed inaccurate or of very low quality by at least one of them (see Table 4).

**Table 4:** Quality of 105 local acute pain guidelines as rated by two independent consultants

<i>Rating by DGH</i>	<i>Numbers of guidelines rated</i>		
	<i>by teaching consultant</i>	<i>by both hospital consultant</i>	<i>consultants</i>
Very high quality	11	18	6
Intermediate	63	42	
Very low quality or inaccurate	31	45	19

*Use of guidelines in primary care*

4.11 Forty-eight (84%) of the GPs interviewed in the study were not aware of any guidelines for the management of chronic pain. Two (4%) mentioned the RCGP (1996) back pain guideline. Some said they would welcome the development and dissemination of guidelines that were 'credible' and 'advisory', although many did not perceive a need for any new guidelines. Some GPs reported that certain information from drug companies was helpful, particularly when presented in the form of algorithms for common conditions, such as back pain.

**Do guidelines change practice?**

4.12 CSAG's own study of Clinical Effectiveness (1997) has shown that information alone is not enough to change practice. When Davies (1996) investigated the response to the recommendations of the 1990 "Pain After Surgery" report, less than 50% of the 221 hospitals which returned data had

implemented the recommendations. The main reason cited for not doing so was lack of funding. One of these recommendations was the setting up of an acute pain team. The 1997 Audit Commission report on anaesthesia services showed that 57% of hospitals had formal acute pain teams.

## **Conclusions**

**4.13** There are many potentially useful national and international clinical guidelines relevant to acute and chronic pain services but this material is not widely known in the NHS.

**4.14** There is a need for further good quality guidelines on the management of specific conditions or situations.

**4.15** Local guidelines, particularly on the management of acute pain, were common; they were mainly intended to be educational and to achieve local consensus but were too often of inadequate quality.

**4.16** The successful adoption of guidelines and their local implementation require: that the subject of guidance is very relevant to normal clinical practice; widespread dissemination and availability;