

5: Commissioning and planning for local pain services

NHS Trusts

5.1 At the majority of sites, the focus of discussion initially was financial pressures and the difficult financial environment for service development. At a minority of Trusts, formal consideration had been given to how the pain service should be developed. However, at most sites, there had been no recent discussions between heads of pain services and senior management; at two of the eight Trusts visited by CSAG, discussion between managers and heads of service appeared to have been stimulated by the CSAG visit itself. Two heads of services who wanted to develop their services were not conversant with the planning system in their own Trust, and did not feel able to propose cases for development. Several heads of service thought that the first barrier to overcome was the lack of support within their own directorate.

5.2 About half of Trust board members were not aware of any of the major national guidelines identified by the research team (see paragraph 4.6). The guidance most commonly mentioned by Trust board members was the report on Pain Management Programmes by the Development and Evaluation Committee in the South & West Region of the NHS (NHS Executive, 1996) and the RCA/RCS Pain After Surgery report. At each discussion group, no more than three of the guidelines listed in paragraph 4.6 had had significant impact locally,

5.3 Board members at several Trusts recognised the need for pain services to be part of a package of comprehensive care offered to the community. In contrast, at two Trusts, low priority was given to chronic pain services; in both cases, the low priority or level of funding accorded to this service by the lead purchaser was cited as the determining factor. At both Trusts, a perceived lack of evidence of benefit was thought to be a major obstacle to the service obtaining any development support.

5.4 At none of the eight Trusts visited had targets been set for maximum acceptable levels of pain, as recommended by the Audit Commission (Audit Commission, 1997).

5.5 The role of the acute pain nurse was seen as an issue for debate at board level in most Trusts. In general, two views were expressed. The first can be characterised as “specialist nurses de-skill ward staff”. The second view, which was more common, was that pain specialist nurses are essential for training, maintaining safety and standards of care, and quality improvement. This view, and the importance attached to training for all involved in the care of patients in postoperative pain, seem to be two of the critical factors determining the success of acute pain services. This difference in viewpoint appears to be based on individual values, as suggested by changes in the priority given to acute pain services with a change of nursing director at two Trusts.

5.6 A number of Trusts had Put proposals to develop chronic pain services to purchasers but the expectation of receiving funding was low. However, for three of the six acute pain services for which a need for development was perceived there had been progress recently with funding or staffing, and at three Trusts there was a stated intention to develop acute pain services further.

Commissioners of health services

5.7 At the time this study was conducted, health services were commissioned by Health Authorities and GP Fundholders. However, implementation of the White Paper entitled “The New NHS: Modern, Dependable” (Department of Health, 1997) will result in major changes to the commissioning of health services, including the development of Primary Care Groups. Despite these changes, the need for service specification and the associated support mechanisms and information requirements will remain whomsoever performs the task.

5.8 It is difficult for commissioners to choose which services should receive their attention. Many NHS services have to be dealt with simultaneously, and decisions about pain services are not taken in isolation. Other services may have been given a higher priority as a result of central initiatives or local political importance.

Table 5: Methods of contracting for pain services (11 Health Authorities)

<i>Service Purchased</i>	<i>Specified (explicitly or implicitly)</i>	<i>Health needs on paper</i>	<i>Discrete assessment</i>	<i>contract</i>
Chronic pain	11	6	2	2
Palliative care	11	9	7	8
Acute pain	10	2	1	0

5.9 Among the 12 sample and 2 pilot study sites, chronic pain services were contracted for explicitly in 6 of 11 Health Authorities that responded, although usually as part of another larger contract (e.g. anaesthetics, overall Trust contract, outpatients, or physical disability). Two sites had discrete contracts for chronic pain services. Acute pain services were less commonly specified in any contract and never contracted for separately (see Table 5).

5.10 Comments made about chronic pain services are shown in Box 2. With respect to acute pain services, comments from Health Authorities included the following: that acute pain services were “mentioned to us as purchasers but not part of the contract, seen as an on-cost, not one of our priorities”.

Box 2: Comments from discussion groups on commissioning chronic pain services

- “Chronic pain services are a bottomless pit. We are not sure of the extent of demand and the ability to benefit within the population” (Purchaser)
- “Not clear what it is we are actually purchasing” (Purchaser)
- “Don’t know what the needs of the community are” (Purchaser)
- “Uncertainty about effectiveness of treatments” (Purchaser)
- “Chronic pain not a high profile for the trust” (3 trusts)
- “Pain is an area that needs investment” (Purchaser)

5.11 The lack of specific contracts, and exclusion from meetings with commissioners, was a source of frustration to those leading acute pain services. They felt that because no explicit value was placed on the service through contracts, there was less opportunity to make Health Authorities and GPs aware of the service; they also felt that their service was only seen by Trust managers as a cost and not as a selling point.

5.12 Two groups of GP Fundholders and two groups of Health Authority staff were asked what added value (and therefore cost) they would ascribe to the provision of an acute pain service at a Trust when compared with a similar Trust at which no such service is provided. The prevailing response was that no added cost would be tolerated. The majority of GP Fundholders felt that pain control, whether provided by a formal pain control service or not, was the responsibility of the Trust and not a matter they would expect to deal with in their negotiations; however, Health Authority staff differed on this question of locus of responsibility. In two districts, GPs and the Trust saw it as essential to improve acute pain services, and together they had successfully made the case to the Health Authorities for development funding.

5.13 In three Health Authorities significant public health resources had been used to assess local pain services. Two Health Authorities had conducted health needs assessments, one for chronic pain services, and one for both chronic and acute pain services; One Authority had studied local pain services in great detail but all assessments were hampered by lack of information. It was acknowledged that detailed work to fill information gaps would be expensive and difficult.

5.14 Other local information was scarce. Five Health Authorities had instigated or been involved in the audit of some aspect of pain services; in one case this had led to a service improvement. In four Health Authorities, there had been no audit of pain services. (However, it should be borne in mind that audit of pain services was being conducted at some Trusts within their districts but not at Health Authority instigation).

5.15 Only two Health Authorities were aware of the expenditure on chronic pain services; none knew the level of expenditure on either acute or children's pain services. (Costs for treating chronic pain within palliative care were not investigated because of the impossibility of separating out the pain element of the care.)

5.16 About half of the Health Authorities did not have information on activity for chronic pain services: none had information on activity for acute pain services. There appears to be substantial variation in the values reported for activity (see Table 6) but different definitions may have been used.

Table 6: Information from Health Authorities on activity for chronic pain services

	<i>Annual events per 100,000</i>		<i>Number of Health Authorities supplying data</i>
	<i>Highest</i>	<i>Lowest</i>	
Inpatient cases (FCE)	35	6.4	6
Daycases (FCE)	155	72	6
New outpatients	158	67	5
Repeat outpatients	531	301	3
Ratio of Repeat to new outpatients	3.47	1.94	

5.17 About half of the Health Authorities were able to supply some information on tariffs in use for attaching costs to various activities within pain services (see Table 7). The prices in use appear to staff working with them to be somewhat arbitrary; this outlook undermines the function of pricing to attach an explicit value to a service to which both parties in the contract agree. In two Trusts, staff reported that over-performance against contracted levels was discouraged because the price charged for pain clinic episodes did not cover costs. We did not investigate local pricing mechanisms, nor did we match prices to casemix. Nonetheless, the variation in prices suggests the need for further work in this area.

Table 7: Tariffs charged to Health Authorities in 1996/1997

<i>Activity</i>	<i>Highest tariff (£)</i>	<i>Lowest tariff (£)</i>	<i>Number of Health Authorities supplying data</i>
First outpatient	171	54	5
Repeat outpatient	134	54	4
Elective inpatient	1,471	553	6
Day care	384	75	6

5.18 Only six of eleven Health Authorities could provide information on the waiting times that their populations experience for first available chronic pain outpatient attendance (see Table 8), of which three provided only average values. GPs in one city expressed an opinion that actual waiting times were even longer than the statistics implied. There was disappointment among clinicians working in chronic pain services and their local GPs about lengths of waiting times.

Table 8: Chronic pain clinic waiting times in weeks (6 districts)

	<i>Health Authority</i>					
	<i>1</i>	<i>2</i>	<i>5</i>	<i>7</i>	<i>8</i>	<i>10</i>
Average in district			30	26		26
Lowest in district	8	26			13	
Highest in district	52	34			25	

5.19 One Health Authority was aware of a potential problem of inequitable access to chronic pain services for ethnic minorities, but none had any data on equity of access.

5.20 Only the 3 Health Authorities that had specifically reviewed pain services had actively looked for guidelines and literature on pain services. As a result, there was only a patchy awareness of relevant national guidance among Health Authority officers. Many were unaware of important recently distributed material from the Royal Colleges and various professional associations, and the outcomes of Department of Health funded programmes, such as Health Technology Assessment (McQuay et al, 1997), in which the effectiveness of treatments in acute and chronic pain have been reviewed.

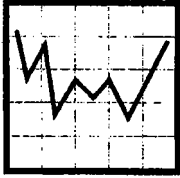
Conclusions

5.21 A low priority was accorded to chronic and acute pain services by the majority of both Health Authority and GP commissioners. This view was not shared by hospital staff and a minority of GPs and was not generally based on an assessment of patients' wishes or needs.

5.22 Few Health Authorities were able to provide information on levels of activity for the pain services they commission or accurate information on costs.

5.23 Most Health Authorities supported the provision of an acute pain service in principle but were not involved in achieving the provision of such service. Most perceived the funding of acute pain services as an overhead to surgery. Many GPs were not aware of acute pain services, did not see the need for a service, did not wish to pay any extra cost for its provision, and felt provision was the responsibility of the Trust. Neither group attached a significant added value to the provision of such a service.

5.24 Development of pain services has been difficult because explicit contracts for pain services, or anaesthesia, are rare and the relevant clinicians were not involved in the commissioning process.



6.1 The study identified 215 Trusts in the UK with a specialist chronic pain service (see Table 1). Information on these was obtained from the 12 sample sites and from responses ($n=10$) to the national postal survey of heads of service for chronic pain; all but 3 heads of service were consultant anaesthetists (the others were a physician, a psychologist and a specialist nurse). The services had been established for between 4 months and 47 years (median 15 years).

Staffing

6.2 Free comments on staffing in the survey highlighted a shortage of consultant time to deal with clinical workload, and with strategic, audit, and organisational issues. Many respondents identified a shortage of consultant sessions to deal with the increasing expectations of commissioners. Low levels of input from other health care professionals, and poor managerial and secretarial support, also seem to be problems in a number of trusts.

Consultants

6.3 Numbers of consultants and consultant sessions provided in each Trust in the sample are shown in Table 9. The Trusts gave estimates of the populations served but these were not true catchment populations. It would appear from this crude analysis that provision varies greatly: the sample mean was 1.4 consultant sessions per 100,000 population. The Association of Anaesthetists and the Pain Society recently recommended a minimum of 10 chronic pain consultant sessions per 100,000 population (Association of Anaesthetists, 1997).

6.4 The Royal College of Anaesthetists Guidance for purchasers (RCA, 1994) recommends two consultants per service to avoid cancellation of outpatient clinics and theatre sessions when a single-handed consultant takes leave. Three of the 12 services in the sample were run by lone consultants.

6.5 Consultants providing specialist chronic pain services should be contracted for a minimum of 3 sessions for that purpose (Association of Anaesthetists, 1997). Most pain consultants working at the 12 sample sites did not meet this recommended minimum and 2 had no formal sessional allowance for pain management.

6.6 Table 10 shows the distribution of pain consultant sessions per service per week, based on the national survey of heads of service; 39% of these consultants were reported to be single-handed. Many single-handed consultants were providing pain services to more than one hospital, further limiting their ability to maintain proper cover.

Table 9: The number of consultants and number of sessions in each sample site in relation to the size of the population served

<i>Sample site</i>	<i>Number of consultants</i>	<i>Number of consultant sessions</i>	<i>Estimated population served (000s)</i>	<i>Consultant sessions per 100 thousand population served</i>
1	None	None	472	0
2	3	10	340	2.9
3	3	5	1,000	0.5
4	1	2	186	1.1
5	1	4	350	1.1
6	2	3	120	2.5
7	3	7	523	1.3
8*	6	19	732	2.5
9	2	6	320	1.9
10	1	3	243	1.2
11	2	4	376	1.1
12	2	4	180	2.2

**This Trust has two hospitals with independent pain services*

Table 10: Number of consultant sessions per chronic pain service

<i>Sessions per week</i>	<i>Services (proportion)</i>
0	11 (9%)
1-2	21 (17%)
3-4	41 (34%)
5-6	23 (19%)
7-8	14 (11%)
9-10	7 (6%)
>10	5 (4%)
Total	122

6.7 For 9 of the 12 pain services at sample sites, there was a sub-consultant grade of doctor regularly present; in the national survey, only half the services responding (54%) had this resource. Thus, about half of chronic pain services provided an entirely consultant-based medical service.

Nursing

6.8 Nurses working in chronic pain services may be either general clinic nurses or specialist nurses trained in the management of chronic pain. Table 11 shows information from the national survey on numbers of sessions worked by all nurses within chronic pain services (including those by non-specialist nurses).

Table 11: Numbers of nurse sessions per chronic pain service

<i>Nurse sessions</i>	<i>Services (proportion)</i>
None or no response	40 (33%)
On demand only	9 (7%)
<3	23 (19%)
3-5	13 (11%)
6-8	8 (7%)
9-10	12 (10%)
>10	17 (14%)
Total	122

6.9 There were two specialist chronic pain nurses in post among the 12 sample sites. Nationally, specialist nurses were available in 62 of 122 services (51%), although some of the services that had a specialist nurse in Post had more than one. Application had been made for a specialist pain nurse at two of the sites, in one case this had been done annually for the past decade. The role of a clinical nurse specialist within one chronic pain service is described in Box 3.

Box 3: An example of the clinical nurse specialist role in the chronic pain service

Two part-time chronic pain nurses were employed as a job-share for 1.2 whole-time equivalents (WTEs). They estimated that 60% of their time was spent in the relief of chronic non-malignant pain, 40% of their time in the relief of postoperative pain and a negligible proportion in the relief of cancer pain. They received all the ward referrals in the hospital. They ran a nurse-led TENS clinic at which 35 patients per month were seen. Training in the use of this treatment was given (which takes 30 minutes) and the nurses reviewed the patients after a month. If the treatment was successful, the patients were then discharged. The service supplied about 250 TENS machines per year. The nurses also helped to provide pain relief for day-care procedures because there was no acute pain nurse in this Trust.

6.10 Heads of service reported a lack of interest at some Trusts in nurse training and in the development of chronic pain services. One respondent commented that an outpatient clinic for new patients had not run at full capacity for 18 months due to a lack of clinic nurses.

6.11 The requirement for specialist nursing personnel, and the independent role of the nurse specialist, have been identified in 'Provision of Pain Services' (Association of Anaesthetists and the Pain Society, 1997). Nevertheless, there was clearly a significant lack of specialised and general nursing staff working within chronic pain services.

Other disciplines

6.12 There was access to a psychologist in 80 chronic pain services (67%), however, in general, few psychology sessions were available (See Table 12). Many respondents reported problems with funding for psychologists and with the availability of suitably trained individuals. This paucity of psychological input means that psychologically-based approaches to therapy including cognitive

behaviour therapy can be offered to very few patients. Many of the services responding to the survey indicated that they would benefit from more input from psychology.

Table 12: Numbers of chronic pain services by level of access to **Psychology**, Physiotherapy or Occupational Therapy

<i>Sessions per week</i>	<i>Number of services</i>		
	<i>Psychology</i>	<i>Physiotherapy</i>	<i>Occupational Therapy</i>
None	39	21	51
On demand only	34	58	53
<3	18	18	8
3-5	15	10	5
6-10	8	5	2
>10	4	3	1
Not specified or no response	4	7	2
Total	122	122	122

6.13 **Physiotherapy** services were available in **98 (80%)** chronic pain services. However, in only **36 (30%)** were designated physiotherapist sessions provided (Table 13). Occupational therapy services were available in **69 (57%)** chronic pain services but very few services had designated sessions (Table 12).

6.14 Only **9 (7%)** services had pharmacy sessions provided (Table 13). At two of the sample sites pharmacists provided one session per week for the chronic pain service. For one of these sites the pharmacist provided regular input on the ward rounds as well as writing and providing other professionals with information regarding drugs used in chronic pain patients. The contribution of pharmacists was said to be very valuable.

Table 13: Availability of pharmacists in chronic pain services

<i>Availability</i>	<i>Services</i>
None	36
On demand only	74
Some sessions provided	9
Not specified or non-response	3
Total	122

Managerial support

6.15 Managerial support in the form of business manager time was available to **58%** of 'chronic pain services, information technology assistance in the form of specific staff to **49%**, and financial management assistance to **50%**. Those services for which management support had been available were also the ones who had made major organisational advances.

Clerical support

6.16 Among the 12 sample sites, six chronic pain services appeared to be receiving obviously inadequate levels of support: two services had no clerical or secretarial support and two had such support on demand only. In the national survey, 4% of chronic pain services had no clerical or secretarial support.

Liaison with other clinicians

6.17 In the report, "Provision of Pain services" (Association of Anaesthetists and The Pain Society, 1997) the development of interdepartmental relationships, including those with neurology, rehabilitation medicine, rheumatology, dentistry, orthopaedic surgery and neurosurgery, was recommended. Findings from the site visits indicated that there was minimal formal joint clinical working between chronic pain services and other medical specialties. The national survey also showed that only 28 services out of 122 held joint clinics with other medical specialties; these included psychiatry (n=7), rheumatology (n=8), neurosurgery (n=1), neurology (n=2), orthopaedics (n=6), oncology (n=4), and palliative care (n=6). At one of the study sites a clinic was held with an orthopaedic physician.

6.18 In the "Calman and Hine" Report on cancer services, it was stated that consultants involved in treating cancer-related illness should have close clinical and operational links with local pain clinics (Department of Health, 1995). Results from the survey show that only 49% of the chronic pain services had formal links with palliative care services; however, for some others there were good informal links. Within most chronic pain services (93%), some patients with cancer pain were treated. At one sample site cancer patients were seen only by the palliative care service.

Use of treatments for chronic pain

6.19 Among the 12 services in our sample, only one offered all the recognised treatments for chronic pain including all types of nerve blockade, psychology, physiotherapy and complementary treatments (e.g. acupuncture, aromatherapy and Shiatsu); injection therapy was available in all 12 services but for some services access to other specialist treatment was limited or non-existent. The national survey also showed considerable variation in the availability of treatments (Table 14).

6.20 Injection treatment has been the mainstay of therapy in pain clinics since they were first established and it is not surprising that virtually all clinics in the survey offered this treatment. The majority of clinics (73%) also provided continuous epidural infusions and 67% offered acupuncture as well as these two therapies. The number of more specialised clinics able to offer these services and with a full multidisciplinary team is relatively limited; only 23% of clinics offered a full range of standard anaesthetic interventions and a formal pain management programme; only 7% offered spinal cord stimulation as well.

6.21 This pattern of provision reflects the need for a relatively small number of specialised units where expertise in the less commonly given therapies can be concentrated. It is also consistent with guidance from the IASP on the need for a range of pain services providing different levels of care.

Table 14: **Treatments** used in chronic pain services

<i>Treatments available</i>	<i>Clinics (proportion)</i>
Nerve blockade	121 (99%)
TENS	120 (98%)
X-ray assisted treatments	117 (96%)
One-shot epidural	117 (96%)
Acupuncture	105 (86%)
Physiotherapy	100 (82%)
Supervised opioid therapy for non-cancer pain	91 (75%)
Continuous epidural	89 (73%)
Drug delivery systems: subcutaneous	87 (71%)
Psychology	81 (66%)
Drug delivery systems: intravenous	73 (60%)
Radiofrequency lesions	62 (51%)
Pain management programme	49 (40%)
Spinal cord stimulation	32 (26%)
Hypnotherapy	24 (20%)
Total	122

Beds

6.22 At 10 of the 12 sample sites, daycase beds were available for patients undergoing nerve-blocking procedures. In one of the hospitals with no access to daycase beds, all nerve blocks were performed on an outpatient basis; in the other hospital, patients were allotted spare beds on the wards. This led to a high cancellation rate for the procedures. Only four of the sample sites had designated inpatient beds for chronic pain. Nationally, 62% of respondents had access to inpatient beds, but these were not always designated for sole use by chronic pain services.

Premises and facilities

6.23 Pain management services tend to be provided in an outpatient or daycare setting; most patients are seen in one or both of these settings for assessment and treatment. About a third (30%) of the pain services in the national survey had self-contained premises. For the majority of services, the patient facilities were said to be acceptable in that suitable waiting areas are provided including access to refreshments. However, one-third were not able to offer nearby car parking facilities.

Office accommodation

6.24 At 7 (58%) of the sample sites there was no office accommodation for any of the professional staff; at 4 sites there was no designated office accommodation for secretarial staff. In the national survey, 41 (34%) of services had no office accommodation for professional staff and 24 (20%) had no office facilities for secretarial staff.

Patient numbers

Outpatients

6.25 Nationally, the average number of new patients per month was 35 (range 2-120) and average number of follow-up patients was 21 (range 3-799) (see Table 15). The number of new and follow-up; patients seen per month in the 12 sample services is shown in Table 16.

Table 15: Numbers of new outpatients seen in chronic pain services

New patients per month	Services
Not stated or no response	19
0-10	4
11-20	24
21-40	45
41-60	19
61-80	8
>80	3
Total	122

Table 16: Numbers of new and follow-up outpatients seen in the sample services

Site	New patients per month	Follow-up patients per month	Ratio of follow-up to new patients
1	No service		
2	33	125	3.8
3	26	35	1.3
4	15	5	0.33
5	48	103	2.1
6	Not specified		
7	50	110	2.2
8 (H)	15	61	4
8 (1)	Not specified		
9	80	136	T.7
10	17	25	1.5
11	21	150	7.1
12	33	160	4.8

6.26 At most of the sample sites there was a strategy to maintain differential waiting lists, such that patients designated urgent would be seen within three weeks

6.27 The sample services had discharged an average of only 140 patients in the previous year which is less than half the number of new patients seen. On the face of it, this suggests that the current way of working is unsustainable in the long term.

6.28 On average, a period of 32 minutes was allocated for a new outpatient consultation, 14 minutes for a follow-up; 12% of both new and follow-up patients did not attend their appointments. Confirmation of attendance was requested from new patients at only 36% of clinics, and for follow-ups at only 20%. The clinics doing this tended to have lower DNA rates.

Inpatients

6.29 Specialist pain consultants said they were often asked to see inpatients under the care of other consultants. Such patients may require several visits or interventions. One respondent estimated that at least 6 hours of work per week was being conducted on the wards. At some sites, however, inpatient referrals did not add greatly to workload. The referral of inpatients seems to vary markedly between services but the average number per year was 132 (see Table 17).

Table 17: Annual numbers of inpatient referrals to chronic pain services

Ward referrals per year	Services
0 or no response	29
<50	36
50-	19
100-	18
200-	3
300-	4
400-	6
>500	7
Total	122

Domiciliary visits

6.30 Very few domiciliary visits are done by chronic pain professionals (3.2 per service per annum on average).

Children

6.31 At 7 (58%) sample sites some children suffering from chronic pain were treated by the pain service. However, the number involved appears to be small. Nationally, children were said to be treated by 55% of services who saw, on average, less than four children each per year.

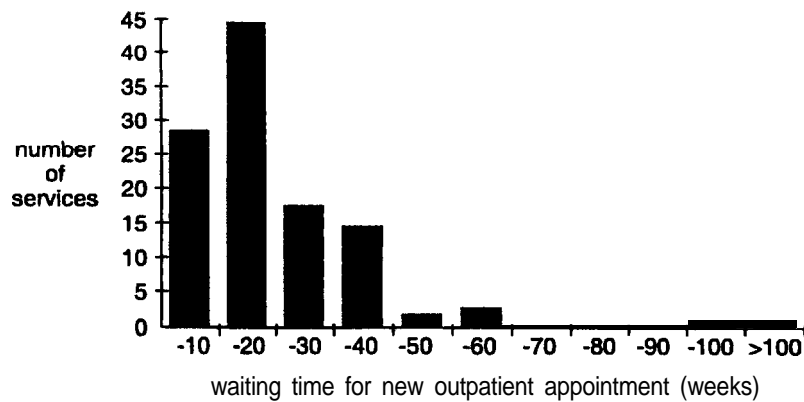
Waiting times

6.32 Numbers of patients waiting to be seen by each chronic pain service, and estimates of waiting times, varied widely among the 122 services in the national study (Table 18). Half of services had a waiting time for routine patients of 16 weeks or more. Three-quarters of services saw "urgent" patients or those who have cancer pain within 2 weeks; in the worst case, waiting times were said to be as long as 24 and 13 weeks, respectively, for such patients, which is clearly unacceptable. The Figure shows the distribution of the clinics' own estimates of routine waiting times at the time of our study.

Table 18: Patients waiting and new outpatient waiting times (weeks) in 122 chronic pain services

	Patients waiting	Waiting times		
		Routine	Urgent	Cancer
Median	90	16	2	1
Full range	10-550	4-144	0-24	0-13
Inter-quartile range	45-150	10-28	1-2	1-2

Figure: Estimated waiting times for routine new outpatient appointments in 122 chronic pain services



Audit and Research

6.33 Nationally, audit had been performed in 70% of chronic pain services, at an average rate of one audit per service per year. About 34% of respondents indicated that changes had been made to the service as a result of audit; 14% did not yet know whether changes would be made. Some respondents said they had inadequate resources to perform audit, including inadequate time.

6.34 Audit was undertaken in most of the pain management programmes studied and had produced useful results. Although these are very small services, joint audit between several Trusts had rarely been undertaken.

6.35 Research was being conducted within 36% of services.

Organisational problems identified by leaders of chronic pain services

6.36 Most heads of service (83%) felt that they were not offering optimum care to patients, which they attributed to insufficient funding, an insufficient number of consultant sessions, and a shortage of staff within the professions allied to medicine, particularly psychology. The phrase 'Cinderella service' was used several times. They believed that pain management was regarded as a low priority and that morale among staff was low.

6.37 Most respondents (81%) had tried to obtain additional resources recently: 63% had not been successful and 5% were still waiting to hear. One respondent reported that the extra money that the service had generated had not been re-invested to improve that service, and that as a result staff were de-motivated. For 11 (9%) of the services, there had been a reduction in funding and caseload had been transferred to other services.

6.38 A set of problems affecting organisational effectiveness tended to be reported in combination (see Box 4). They were identified as a more or less consistent set in approximately half of the services responding to the national survey.

Box 4: a common combination of problems faced by chronic pain services

- * The service seemed to be overstretched.
- * The value of the service was not recognised, and it felt as if it was under threat.
- * The head of the service did not have a clear budget or spending authority.
- * The service did not have sufficient business management, financial or clerical support.
- * The head of the service had not discussed the service with the Trust Chief Executive.
- * The head of the service had never been present at meetings with service commissioners.
- * The head of the service had tried to increase funding and staffing without success.
- * The head of the service was uncertain about how proposals for service development were handled formally within the Trust.

Conclusiona

6.39 Most Trusts now have specialist chronic pain services but many of these are so poorly provided with resources that they cannot possibly be meeting the local need for such a service. This is most obviously reflected in unacceptable waiting times for many patients. Particular problems are too few trained consultants with too few sessions allocated to chronic pain work. Also, only half the services had specialist chronic pain nurses working in them and only a quarter had the equivalent of a full time nurse whether specialised or not. Clerical and office support was often grossly inadequate. Some services had no access to day-case beds.

6.40 Most chronic pain services had some access to the disciplines of clinical psychology, physiotherapy, and occupational therapy, and some input from pharmacy, but there were far too few formal committed sessions from these disciplines to satisfy the potential demand. Approximately 25% of services could be described as truly multidisciplinary, however, it is acknowledged that not all patients require a multidisciplinary approach to pain relief (IASP 1990).

6.41 Only a minority of services provided the full range of treatments that might be needed by a patient with chronic pain. This, combined with the complete lack of certain disciplines in many services, emphasises the need for a dear strategy of secondary and tertiary services with accepted routes of referral for patients with particular needs. This would seem to be essential in order to preserve equity of access.

6.42 There was a surprisingly low level of liaison between chronic pain services and other services in their Trusts. There were also very variable levels of awareness and recognition of the work of the chronic pain service among local GPs. This may explain why levels of activity and referral were so variable around the country. There is a need to improve levels of knowledge throughout the NHS of the work of the service in order to ensure more consistent and appropriate referral practice. This is likely to increase referral rates and the capacity of many chronic pain services may need to be increased as a result.

6.43 In general, professionals providing chronic pain services felt poorly supported within their Trusts which partly reflected the attitudes of local Commissioners being passed on via Trust management. Heads of services reported frequent unsuccessful attempts to increase funding for their services.

Chapter 7: **Pain management programmes and other rehabilitation programmes**



Pain management programmes

7.1 Cognitive-behavioural therapy in a pain management programme is used to achieve specified objectives which depend on the nature of the patients' problems. Interventions involved can include physical m-conditioning, posture training, relaxation techniques, education, medication review and advice, psychological assessment and intervention, and graded return to the activities of daily living.

7.2 In general, pain management programmes are led by a psychologist experienced in cognitive behavioural therapy but involve a range of health care professionals working together in the programme. The ideal staffing requirement, according to a recent report of a working party of The Pain Society comprises: a medically qualified pain specialist, a clinical psychologist, a physiotherapist (trained in physical rehabilitation), an occupational therapist and a nurse. The minimum staffing is a physician, a psychologist and a physiotherapist (Pain Society, 1997).

Effectiveness of pain management programmes

7.3 Such programmes have been shown to be effective (McQuay et al, 1997). Patients in both outpatient and inpatient programmes have reported significant improvements for all the domains of chronic pain: pain experience, mood, psychological coping, physical fitness, pain communication and behaviour, social role functioning, and the use of the health care system. This was true in comparison with waiting list controls and in comparison with other therapeutic interventions (Morley et al, in press).

7.4 A recent report on pain management programmes compared the relative effectiveness and cost-effectiveness of inpatient and outpatient programmes (NHS Executive South & West R&D Directorate, 1996). It was concluded that there was an added benefit from inpatient programmes; however, there was doubt that this added benefit represented value for money. Techniques used in outpatients have also improved recently.

Availability of pain management programmes

7.5 49 (40%) of 122 Trusts had a pain management programme.

7.6 A database of pain management programmes in the UK, compiled recently at Hope Hospital Salford, contains information on 59 programmes, 53 outpatient and 6 inpatient programmes; in addition, two children's services providing multidisciplinary care, were identified (Johnson, 1997).

Format of outpatient and inpatient programmes

7.7 In outpatient programmes, patients attend on average eight sessions of 3-4 hours each week, or daily for 3-4 weeks, with at least one follow-up session. Inpatient programmes are run for approximately 15-20 days, over 3-4 weeks, with subsequent follow-up.

Primary care initiatives

7.8 We identified two pain management programmes in a primary care setting. Both had been developed as implementation studies of the CSAG guidelines for back pain (CSAG, 1994) One of them is described in Box 5.

Box 5: A primary cue-based pain management programme for back pain

The programme was situated in a local health centre with 10 GPs. Before making a referral, the GP completes a screening examination to exclude signs and symptoms that predict the need for medical intervention. Suitable patients are then seen in an assessment clinic held weekly at the health centre by the physiotherapist and psychologist from the local pain management programme team.

The philosophy of the programme is to promote in patients both an awareness of and confidence in, the care and use of their backs to minimise the risk of future episodes. This is achieved through the development and use of strategies that are either preventative or adaptive.

It is a rolling programme of six group sessions held twice weekly for 3 weeks. Patients can be admitted at any point, but are expected to attend the full series of six meetings. After completion of the programme, patients are assessed at 3, 6, and 12 months.

Rehabilitation programmes

7.9 In the CSAG Report on back pain the importance of primary care management for acute back pain was highlighted and it was recommended that secondary care for patients who have backache should be provided by a Back Pain Rehabilitation Service. At some NHS Trusts such services have been set up (see Box 6) in general, the services were physiotherapy-led, with limited psychology input. Many respondents said that these programmes seemed to them to be effective and good value.

7.10 One of the aims in the early management of acute low back pain is to avoid delay in obtaining a second opinion which can be disabling (Kendall et al, 1997). We identified one joint primary and secondary care initiative in which, this problem was being addressed (see Box 7).

7.11 In the focus group discussions, most GPs thought that the management of back pain had not attracted enough attention or enough central guidance on the professional response expected. There was support for more back pain initiatives based in the community

Box 6: A back pain rehabilitation programme in a district general hospital

A back pain rehabilitation programme was set up to reduce the two year waiting-time for an orthopaedic outpatient appointment. The programme is based on the biopsychosocial model, is headed by a physiotherapist and includes an assistant psychologist (supervised by a clinical psychologist) and a second physiotherapist. Referrals are accepted directly from GPs according to a proforma. Once a week, the physiotherapists and the consultant in pain management decide whether patients should receive physiotherapy only, enter the back pain programme, be referred to the pain clinic or be referred to a neurosurgeon. Patients referred to the back pain programme are assessed using psychometric and disability questionnaires to determine an appropriate package of treatment.

The programme has a budget of £80,000 per year but costs £90,000 per year. There are 700 new referrals per year, 6% of patients do not attend appointments and the waiting time for a new appointment is 8 weeks. A recent audit showed a reduction in medication use, disability, and distress for at least 6 months after attendance at the programme. 189 patients were removed from the orthopaedic waiting list and only 12% of these subsequently needed to see an orthopaedic surgeon. The team running the programme conclude that most patients with back pain can be managed by a back pain rehabilitation programme.

Box 7: A joint primary care and secondary care initiative in the management of low back pain

A two-year pilot study at one of the study sites, involves the physiotherapy service and a commissioning group of 37 GPs and covers a population of 69,000 in an inner city area. With the support of the local purchaser, patients with low back pain will be referred to a clinical specialist physiotherapist.

Examination and investigation take place within 3 weeks of receipt of the GP's referral supervised by an Orthopaedic Surgeon which may lead to referral on to the appropriate hospital specialist or back to the GP with advice. Other secondary or tertiary care services such as neurosurgery, rheumatology and the pain management service have agreed to accept referrals direct from the clinical specialist physiotherapist on behalf of the GP

There are strict referral criteria into the project. Patients who have clear indications of medical need should be sent directly to the appropriate hospital specialist by the GP

To date, only a small number of patients have been seen; however so far less than 10% have been referred on to a hospital specialist.

Conclusions

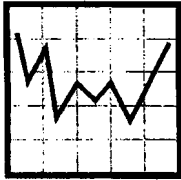
7.12 Cognitive-behavioural therapy delivered within an interdisciplinary pain management programme can lead to improvements in function, although not necessarily in levels of pain experienced. There is some evidence that this improvement may be sustained.

7.13 Examples of good practice in pain management programmes were found in relation to interdisciplinary working, and the regular use of assessment and outcome tools covering the seven domains of chronic pain.

7.14 There is controversy about the relative merits and value for money of outpatient programmes when compared with inpatient services for those patients in need of pain management programmes.

7.15 Back pain rehabilitation programmes also appear to be effective and good value for money, though some patients still need other treatments. Biopsychosocial rather than exclusively physical models seem to be most appropriate as the basis for the management of low back pain.

Chapter **8:** **Care of cancer pain in palliative care services in NHS hospitals**



Pain in cancer

8.1 Most patients who have cancer will require treatment for pain at some point in their illness. Whether a patient will experience pain can depend on the site of the tumour: 85% of patients with primary bone tumours, 52% of those with carcinoma of the breast and 5% of those with leukaemia suffer pain (Foley, 1993). Respondents working in the palliative care service estimated that 80% of their patients suffer from pain. It should be noted that this study was only designed to investigate the management of pain in palliative care services not palliative care provision in general.

8.2 The study identified a palliative care service in 162 (65%) of Trusts in the UK. Of these, 76 (47%) either returned a postal questionnaire or were visited by the research team. The majority of the 68 respondents to the postal questionnaire were consultants in palliative medicine. For 12 services, the questionnaire was completed by a specialist palliative care nurse (see Table 19). Most services had not been established as long as chronic pain services (range: 1-32 years; mean: 8 years; median: 4 years).

Table 19: Responses by professional group to the heads of service questionnaire

<i>Professional group of respondent</i>	<i>Responses</i>
Consultant palliative medicine	50
Consultant anaesthetist/chronic pain	3
Consultant physician	10
Other consultant	1
Specialist nurse	12
Total	76

Staffing

8.3 Table 20 shows numbers of services according to the provision of consultant in palliative medicine sessions per week. For 31 (41%) services another grade of doctor was regularly committed to the service, usually a clinical assistant or a specialist registrar.

8.4 A specialist palliative care nurse was in post in 70 (92%) services. The number of sessions per week that specialist nurses worked in those services are shown in Table 21. The median number of nurse sessions per service was 20 per week (i.e. most services had more than one nurse).

Table 20: Numbers of palliative care services by number of consultant sessions per week

<i>Consultant in palliative medicine sessions</i>	<i>Services</i>
unspecified	7 (9%)
0	13 (17%)
1-2	20 (26%)
3-4	9 (12%)
5-6	9 (12%)
7-8	2 (3%)
9-10	4 (5%)
>10	12 (16%)
Total	76

8.5 We interviewed 6 specialist palliative care nurses at the sample sites. At one site, specialist palliative care nurses also operated a community outreach service. Much of the specialist nurses time was spent educating other professionals within the hospital. There were close links with community teams at many of the sites; consequently, once patients were discharged, care was continued in the community. At one of the sites the community palliative care nurses were based in the hospital.

Table 21: Numbers of palliative care services by number of specialist nurse sessions per week

<i>Nurse sessions per week</i>	<i>Services</i>
not specified	16
on demand only	5
up to 5	4
6-15	13
16-25	10
26-35	6
36-45	5
46-55	6
56-65	3
66+	2
Total	70

8.6 The availability in palliative care services of other professionals is shown in Table 22. At two of the sample sites, there was regular commitment from pharmacy: at one site, the pharmacy provided one hour of input per day for the palliative care service (including hospice) and at the other site one hour per week was provided. Although a psychologist was available on a regular basis in only 18% of services, many specialist palliative care nurses were trained in counselling.

8.7 Palliative care services provided a variety of treatments for pain (Table 23). Most services provided drug therapy, counselling, and TENS.

Table 22: Availability of professions allied to medicine and complementary therapists in palliative care services

<i>Profession</i>	<i>respondents</i>	<i>number (proportion) of services with some access</i>	<i>proportion of services with dedicated input</i>	<i>average number of sessions per week</i>
Physiotherapy	67	51 (76%)	33%	6
Occupational therapy	67	50 (75%)	32%	5
Social work	67	50 (75%)	34%	7
Pharmacy	68	52 (76%)	29%	
Psychology	69	38 (55%)	18%	3
Complementary therapy	67	34 (51%)	29%	1

8.8 At one of the sample sites patients with chronic malignant pain kept a 'Pain Diary'. This diary was used to record the location, intensity and a description of the pain, and what helped to ease that pain. This technique enabled patients to participate in their pain control and enabled the professionals to assess and evaluate the pain relief obtained.

Table 23: Treatments available within palliative care services

<i>Treatment</i>	<i>Number (proportion) of services providing</i>
Drug delivery system: subcutaneous	59 (78%)
Counselling	49 (65%)
TENS	46 (61%)
Nerve blockade	28 (37%)
Drug delivery systems: intravenous	26 (34%)
Physical therapy	23 (30%)
Other psychology input	22 (29%)
One shot epidurals:	17 (22%)
Continuous epidurals	17 (22%)
reflaology	11 (15%)
X-ray screening	9 (12%)
Homeopathy	4 (5%)
Hypnotherapy	4 (5 %)

Treatments and facilities

8.9 Over half (53%) of the palliative care services had self-contained premises, with adequate patient facilities within the Trust, but 45% of the respondents had no access to designated inpatient beds. 80% per cent of respondents offered a service at more than one location. For 9% of services, there was no office accommodation for professional staff and for 21% there were no office facilities for secretarial staff.

8.10 Other services to which patients were most commonly referred by palliative care services were oncology, radiology, local hospices and community services. In the sample sites, 1-2% of patients were referred to chronic pain services for nerve blocks.

Patients

8.11 Palliative care services saw, on average, 40 new patients and 32 follow-up patients each month. There was no waiting list for a first consultation in 79% of services. On average, 42 minutes were taken for a new patient consultation and 18 minutes for a follow-up. The average non-attendance rate was 8%. Many of the patients needing treatment for pain had not been referred to the hospital palliative care service for that reason. Patients with pain other than cancer were seen in 64 (85%) palliative care services in which they contributed approximately 5% of the workload.

8.12 Children were seen in 29% of the palliative care services that responded to the national survey. Most respondents indicated that they see less than one child per year within their service.

Audit and research

8.13 Outcome measures were used in 36% of services and pain scales were routinely used in 46%. Audit had been conducted in 69% of services; average number of audits was 4. About 60% of respondents indicated that changes as a result of audit had occurred; 25% indicated that no changes had occurred; 15% did not yet know whether changes would occur. Approximately half of the services were involved in some way in research.

Organisational issues identified by heads of palliative care services

8.14 Respondents in 61 (81%) of palliative care services had recently tried to attract more resources: 22 had not been successful; 10 were waiting to hear. For 7 services, it was reported that there had been threat of a reduction in funding and four of these services had had a reduction in funding. Only 16 (21%) of respondents felt that they were delivering optimal care to their patients; most of whom felt that this was due to inadequate resources.

8.15 At the sample sites the palliative care services were generally well organised; many were part funded by charity which was seen as a source of insecurity. Many also had well-developed strategies and plans for the future, the key aims of which were:

- * to improve crisis intervention;**
- * to provide a hospice-at-home service;**
- * to develop a multidisciplinary palliative care service;**
- * to have designated beds provided for the service;**
- * to improve integration with home-care teams.**

Links with primary and community care

8.16 Many GPs in the study felt that they managed most patients with cancer well; when support was required it was available from specialist palliative care professionals. Communication between GPs and palliative care services was reported as good.

Training and education

8.17 In many of the sites surveyed, palliative care specialists were heavily involved in the training and education of others. Much of the specialist nurses' time within the hospital was spent educating professionals on the management of palliative care patients. At several sites, training courses were offered within the palliative care service, some of which were specifically on managing pain.

Conclusions

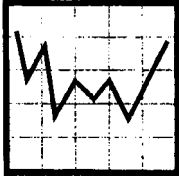
8.18 Palliative care services appeared to be better organised than chronic pain services partly because of a clearer focus and strategy for their work.

8.19 Palliative care services depended on charities for much of their funding. Some services reported a shortage of NHS funding provision.

8.20 For a minority of services, consultant sessions in palliative medicine were not available and would seem to be required.

8.21 GPs are generally more satisfied with quality of care from palliative care services than with pain management services, especially with regard to communication, response time, nurse liaison, and education.

Chapter 9: Use of complementary therapies in the relief of chronic pain



Complementary therapy is “a diagnosis, treatment and/or prevention which complements mainstream medicine by contributing to a common whole, by satisfying a demand not met by orthodoxy or by diversifying the conceptual frameworks of medicine” (Ernst et al, 1995).

9.1 Most complementary therapies are provided outside the NHS, although NHS funds can be used to pay for such treatments with certain provisos. The National Association of Health Authorities and Trusts (NAHAT) confirmed that complementary therapies are regularly paid for by Health Authorities and Trusts (NAHAT, 1993). although the amount of treatment provided is thought to be small. GPs may also use NHS funds to employ complementary therapists when providing general medical services as long as they retain clinical responsibility for the patients.

9.2 To identify complementary therapists working in the 12 sample sites, the 26 most relevant professional associations were chosen from the “Handbook of Alternative and Complementary Medicine” (Fulder, 1996) lists of members were obtained for each of the 12 sample areas. We sent questionnaires ($n=158$) to 10-15 practitioners per study site from 6 categories (acupuncturists, chiropractors, reflexologists, aromatherapists, hypnotherapists and naturopaths); 58 (36%) completed questionnaires were returned. Complementary therapists were invited to the CSAG visits, 14 attended in total.

Availability within pain services

9.3 At 10 of the 12 sample sites complementary therapy was offered within chronic pain services. At four of these sites a complementary therapist was employed to provide the care (an osteopath for 2 sessions a week, a Shiatsu practitioner for 1 session a week, an acupuncturist for one session a week and a nurse aromatherapist for 2 sessions a week). At 7 sites acupuncture was performed by the doctor(s) in pain management and at 3 by a physiotherapist. One clinical nurse specialist was planning to learn acupuncture. In one Trust, theatre recovery nurses offered homeopathy, reflexology and massage.

9.4 Nationally, 28 (25%) chronic pain services had access to a complementary therapist; for 16 of these services, sessions were regularly provided; for 8, sessions were provided on demand only; 4 respondents did not specify the number of sessions. The types of complementary therapy being provided by Trusts with a chronic pain service are shown in Table 24. Most of these services were being offered by otherwise orthodox practitioners

9.5 In the focus group discussions involving GPs, mixed views were expressed about complementary medicine: those GPs whose patients had obtained relief from pain were generally supportive; some GPs said they would not recommend or wish to discuss complementary medicine with their patients. Some GPs had developed a personal interest in individual therapies, and were enthusiastic.

There was general concern among GPs about the lack of evidence for the effectiveness of some complementary treatments. It was felt that systematic reviews of effectiveness, and guidelines relating to their proper use, would be valuable.

Table 24: Complementary therapies available in Trusts with a chronic pain service

Therapy	Trusts	within pain service	within other trust service	Not specified
Acupuncture	109	88	21	
Hypnotherapy	24	13	10	1
Reflexology	9	5	4	
Homoeopathy	6	5	1	
Aromatherapy	1	1		
Shiatsu	1	1		

9.6 Of 245 patients surveyed within Pain clinics, 34% had received complementary therapies, the most common treatments being acupuncture, osteopathy and chiropractic. In a focus group of pain clinic patients, all 5 of them had had acupuncture, three had had aromatherapy and one homeopathy. Some patients were very satisfied with the therapy received; they also stated that after suffering from chronic pain for years they were willing to try any treatment if there was a chance relief could be obtained.

9.7 Of the patients surveyed who had visited a complementary therapist: 77% had referred them&es (7% had been referred by their GP); 61% had already been seen by an NHS profession& 98% were private patients.

9.8 Of the complementary therapists surveyed, 84% did not have a waiting list for people in pain.

9.9 Recurring themes were the perceived lack of regulation and clinical standards for complementary therapies and the relative lack of evidence of effectiveness. The British Medical Association (BMA) has issued guidelines on good practice in complementary medicine (BMA, 1993); it was suggested that each body representing such a therapy should be able to demonstrate:

- * an organised structure;
- * a single register of members;
- * guidelines for relationships with medical practitioners;
- * training at accredited institutions;
- * an effective ethical code;
- * agreed levels of competence;
- * a proven commitment to research.

9.10 The Secretary of State has recently (28 May 1998) announced that the Department of Health is to provide some funds to improve the professional organisation of complementary medicine in the UK.

9.11 In a report, entitled “The Evidence Base of Complementary Medicine” (Royal London Homeopathic Hospital, 1997), the problems of conducting research in complementary medicine were discussed, and the evidence of effectiveness currently available on homeopathy, acupuncture for pain, manipulative therapy and nutritional therapy reviewed.

9.12 Ernst (1997) has also reviewed the information available on the efficacy and safety of acupuncture, homeopathy, and manipulative therapies; he concluded there was “an overt lack of conclusive evidence for or against complementary medicine”; he also highlighted those areas for which research was needed most urgently. His group have more recently carried out a meta-analysis for back pain (Ernst et al in press) and a systematic review for acute dental pain (Ernst et al 1998) both of which are positive.

9.13 The Foundation for Integrated Medicine is a charitable trust, the aim of which is “to bring a greater understanding between orthodox and complementary and alternative medicine and therapies with a view to providing improved healthcare”. The Foundation recently published a summary of the evidence base of some complementary therapies (Foundation for Integrated Medicine, 1997).

9.14 A recent announcement (Villaire, 1998) indicates that the National Institutes of Health in the USA are preparing to invest heavily in effectiveness studies of non-conventional therapies for pain, which may strengthen the evidence base in this area.

Conclusions

9.15 There is demand from patients and professionals for access to complementary therapies for pain relief.

9.16 Availability of complementary treatments within the NHS varies among pain services and also among primary care providers.

9.17 Views about the value of complementary therapies differ widely among pain service professionals.

9.18 Certain forms of complementary therapies are frequently practised by orthodox medical practitioners.

9.19 More research work is needed to evaluate the outcomes of complementary therapies in patients with chronic pain.