

Chapter 10: Acute Pain Services



Specialist acute pain services

10.1 Before 1990, organised specialist services for acute and **postoperative** pain were rare. In that year, a working party of the Royal **College** of Surgeons and the College of Anaesthetists published its report entitled "Pain After Surgery". As a result many more such services have been set up as well as educational and training initiatives to support them. The key recommendations of the report are given in Box 8.

10.2 Factors contributing to earlier poor standards of care have included fear of drug side-effects, ignorance of opioid pharmacology, low patient expectations and health-care **professionals** not fully appreciating the severity of pain after surgical procedures (RCS/RCA, 1990). In the 1970s, the **inadequacy** of care and of professional education in this area, began to be recognised. At the same time, there was a better understanding of the pharmacology of opioids and the development of more effective methods of delivering pain relief, for example patient-controlled analgesia (PCA) and epidural injections. The concept also emerged of a specialist acute pain team to manage **postoperative** pain throughout a hospital. The remit of some acute pain teams has since widened to embrace the management of pain resulting from other trauma and certain medical conditions.

Box 8: Recommendations in the report "Pain after Surgery"

- * *Responsibility for policy on management of pain relief should be given to a named member of staff.*
- * *Acute pain teams should be established in all major hospital.*
- * *Appropriate facilities should be provided for postoperative pain relief in all hospitals.*
- * *Traditional attitudes to postoperative pain relief should be challenged.*
- * *For these services, staff should be properly trained and resources made available to support them.*
- * *Education of hospital staff should be improved*
- * *Pain should be assessed systematically, involving the patient whenever possible, and the assessment recorded.*
- * *New treatment methods should be introduced and existing methods should be used more effectively with due regard for patient safety.*
- * *Audit and a continuous appraisal of activity should be performed.*

10.3 In the 12 sample sites, the recommendations of the RCS/RCA report had generally been followed. However, one Trust did not have an acute pain service and two trusts provided only limited services. Two of the hospitals in our sample appeared to represent opposite ends of the spectrum in the development of postoperative pain management; their situations are described in Box 9. Lack of

clinical leadership at Hospital B seemed to be largely responsible for the poor provision of services. This was compounded by lack of support from the hospital management.

Box 9: Contrasting acute pain services in two otherwise similar hospitals

Hospital A: In response to the RCS/RCA report, a formal acute pain team had been established comprising a consultant anaesthetist, 2 full-time specialist nurses and pharmacy support. The majority of surgical patients were seen before surgery by the pain nurses, sometimes at preoperative clinics, and all were seen daily, or more frequently) after surgery. There were comprehensive local guidelines for acute pain relief including the use of PCA and epidural analgesia. There was a clear management structure for the team. It had a comprehensive teaching remit including the education of ward nurses and trainee medical staff. The team's activity was audited and several changes in practice had been made as a result. The team had the active support of hospital clinical staff and management.

Hospital B: There was no formal pain team and no individual had taken responsibility for postoperative pain management. A pain nurse was employed but little of her time was spent on pain relief as her main responsibilities lay elsewhere. There was a dispute between senior medical and senior nursing staff about the need for a specialist pain nurse. The senior nurses thought that such an appointment would de-skill the ward nurses. This conflict seemed to have been unresolved for some time. There were no formal arrangements for the use of epidurals on the ward, and some medical staff felt that this practice was potentially unsafe and cited near-miss incidents.

10.4 Nationally, 220 (88%) Trusts said they had an acute pain service. Of these, information was collected by postal survey from 144 and from 9 by a visit (total = 70%). It seems likely that some of the Trusts had only "token" services, as in Hospital B in Box 9. In 13% of services that responded, no individual was responsible for postoperative pain management.

10.5 Table 25 shows the level of involvement of different professional groups in acute pain teams; nurses had by far the largest time commitment to the services but 19% of services had no nurse involvement which must be a cause of concern. The best services provided 24 hour nurse cover and made provision for continued cover when key staff were on leave. Many staff said they spent more time providing the service than was formally recognised.

10.6 Consultant anaesthetists were named as the head of the acute pain service in 145 (95%) cases; 7 (5%) services were led by nurses; one service had no named lead.

10.7 The national survey revealed a consistent pattern to the activities of acute pain nurses; time was divided between hands-on management of pain (approximately 40% of time), training and supervision of other staff (35%), education of patients (10%) and audit and research (11%). The duties of a typical acute pain nurse are given in Box 10.

10.8 We also interviewed the nine acute pain nurses working at the sample sites. Their practice confirmed the findings from the survey, but varied in some situations. For example, only three of them saw every patient who was receiving PCA or epidural analgesia. Moreover, the relief of acute pain was not always their sole responsibility: five of them spent up to 40% of their time treating patients with chronic pain.

Table 25: Involvement of different professional groups in providing acute pain services

<i>Professional group</i>	<i>Services with any involvement (proportion)</i> <i>n=144</i>	<i>Median hours per week (quartile values)</i>	<i>Median recognised hours per week (quartile values)</i>
Consultant anaesthetist	134 (93%)	5 (3, 8)	3 (0, 4)
Nurse	117 (81%)	38 (30, 38)	38 (23, 38)
Trainee doctor	82 (57%)	7 (4, 17)	1 (0, 5)
Clerical	37 (26%)	4 (2, 15)	1 (0, 6)
Other consultant	33 (23%)	3 (1, 5)	0 (0, 1)
Physiotherapist	23 (16%)	8 (1, 26)	0 (0, 1)
Managerial	21(15%)	6 (2, 38)	2 (0, 4)

Box 10: The duties of a “typical” acute pain nurse include:

1. for patients receiving PCA or epidurals:
 - * ensuring the provision of safe and effective pain relief;
 - * ensuring adherence to local guidelines for PCA/epidurals;
 - * facilitating the transfer to oral medication from PCA/epidurals;
 - * discussing difficult cases with medical colleagues;
 - * giving special attention to newly admitted emergency cases;
2. ensuring that pain control equipment is available for patients undergoing surgery and give assistance as necessary, in theatre recovery;
3. providing the first point of contact for problems arising on wards with pain control equipment or pain management;
4. providing training in pain relief to nursing and other staff;
5. collecting audit data and maintain an audit database.

10.9 The *importance* of the nurse’s role as educator was confirmed. They were teaching pre- and post-graduate nurses, operating department assistants, pre- and postgraduate doctors, pharmacists, physiotherapists and occupational therapists. Provision of telephone advice was also said to be highly valued.

10.10 Information about pain management was provided to patients pre-operatively by 112 (78%) services; of these 90 (80%) provided written information. Most acute pain teams (87%) were able to talk to and assess patients before surgery.

10.11 In 20 (13%) hospitals with acute pain services there was still no formal recording of patients’ descriptions of their pain on the bedside chart (pain scores); 12 (60%) of these hospitals had no acute pain nurse.

Treatments used for postoperative pain relief

10.12 Intramuscular analgesia, PCA and epidural analgesia were used at all 9 sample sites with an acute pain service. Entonox (7 sites), continuous intravenous therapy (7 sites) and TENS (6 sites) were used less frequently. Relaxation or diversion therapy was only used at one site for the treatment of postoperative pain. These findings are consistent with those from the survey (Table 26).

Table 26: Use of treatments for postoperative pain

<i>Treatment</i>	<i>Services using (proportion) n=144</i>
PCA	143 (99%)
Epidural analgesia	132 (92%)
Intramuscular	127 (88%)
Entonox	102 (71%)
Continuous intravenous therapy	95 (66%)
TENS	85 (59%)
Relaxation	20 (14%)
Diversion therapy	12 (8%)

10.13 The results of the survey confirm the increase in popularity of PCA, which appears to be the standard method of opioid administration for acute pain services after major surgery. The more complicated, but possibly more effective, epidural analgesia was also widely used.

10.14 At most hospitals, funding mechanisms for the acute pain service were unclear. Only 20% of services had an identified budget, the size of which varied from £ 1,000 to £10 1,291 per annum (median £23,000). Nursing staff costs accounted for most of this money. Although 85% of acute pain services had recently attempted to increase their resources, less than half of them had been successful. In general, current levels of funding were perceived as secure; only 6% of respondents thought their funding was under threat but one service had recently lost funding. The majority of acute pain teams (78%) felt that they were not providing optimal care, 92% of whom attributed this to inadequate funding.

10.15 Most (89%) acute pain teams were actively involved in audit which occupied approximately 10% of clinical staff time. More than half the services said that practice had changed as a result of audit. Some form of research was being undertaken in about one-third of services.

Pain relief in Accident and Emergency Departments

10.16 We interviewed the heads of 13 Accident and Emergency (A&E) departments at the sample sites. In eight departments (62%), there was some form of policy on pain management. However, most of these policies were not of an equivalent standard to those developed for postoperative pain relief. Formal assessment of pain was not widespread. Written guidelines about the management of Pain in children were available in only four departments. Seven interviewees said they were in the process of developing or implementing new policies.

10.17 There was little interaction between acute pain **teams** (in hospitals that had them) and the A&E departments; 10 of the 13 **interviewees** wanted greater collaboration, including the training of nursing and trainee **medical** staff, the use of nerve blocks for A&E patients and the development of guidelines for the management and assessment of pain in A&E.

10.18 There was an acceptance that pain management in many A&E departments could be **improved**. There are many pressures on A&E departments and it would **seem** that improving pain control **in** A&E has a relatively low priority. One **head of department** admitted that pain was managed badly, mainly **because** of time constraint. **However**, 5 said they were happy with the management of pain in their department. All heads of A&E **services** identified gaps in the provision of pain control in their departments.

Conclusions

10.19 Acute pain teams have **been established** at the majority of Trusts. However, the mere presence of an acute pain service by no means **guarantees** an adequate **level of service** – an appropriate **level** of anaesthetic and nursing input is also essential for safe and effective **care**.


10.20 The leader of the **team** is generally a consultant anaesthetist. A **dedicated** acute pain nurse is also normal, although the roles and responsibilities of nurses vary. The techniques of PCA and epidural analgesia are standard methods of pain **relief** after surgery.

10.21 At most Trusts, **useful** local guidelines on **use** of PCA and epidural analgesia have **been** written. Formal **measurement** of pain is also undertaken at most Trusts.

10.22 Funding arrangements for acute pain **teams** are **inadequate**.

10.23 The management of acute pain in A&E departments is a low priority and could be improved by applying lessons learned in managing postoperative pain.

Chapter 11



General practice, community nursing and patient perspectives on services for pain relief

General Practitioners

11.1 Information was obtained from 57 GPs through a combination of methods: **face-to-face** interviews; discussions during CSAG visits to sample sites; four focus groups.

Chronic pain

11.2 Most GPs were concerned about the way in which patients with chronic pain were managed; only 4 had no such concerns. Quality of care for patients treated by pain services was thought to be good. However, only a small proportion of those patients who could benefit were thought to receive the service. The biggest problem was said to be the number of patients requiring relief for back pain.

11.3 GPs were mostly aware of the existence of local pain clinics, but in many cases did not know what services were provided, They perceived a lack of local guidance about 'appropriate' or 'inappropriate' referrals to the pain service. At many sites, no formal information at all was provided for GPs on how to use the pain clinic. At other sites, only basic information about the pain service was provided in the Trust brochures. One group of GPs had acquired most of their knowledge about the pain service at postgraduate seminars. The quality of information from pain services about patients treated by them also varied from rudimentary to exemplary.

11.4 Patients with chronic pain frequently had problems which GPs felt needed thorough investigation before referral to pain services. They tended, therefore, to refer patients with pain initially to rheumatology, orthopaedics or neurology but were usually able to refer directly to pain services if they wished. Where this was not the case, as at one of the sample sites, local GPs felt that this policy was unacceptable. In many areas, however, direct access was technically available but effectively denied by very long waiting times. GPs thought that all patients with pain should be seen within 3 months and urgent cases much sooner.

11.5 Many of the GPs interviewed did not have access to a local multidisciplinary pain clinic. Clinics which provided only nerve-block therapy were not considered an adequate resource. Geographical convenience of pain services was thought to be an important consideration.

11.6 23 (40%) of the GPs surveyed provided services within their own practices that were relevant to the management of chronic pain, such as physiotherapy. Fourteen (25%) either administered or provided access to complementary therapies, including acupuncture, hypnotherapy, and homeopathy; a few (11%) said that they would not routinely recommend complementary therapy because of the lack of evidence for the efficacy of such treatments. This issue was also highlighted during the site visits and focus group discussions.

Cancer pain

11.7 Most GPs were involved in caring for patients suffering from cancer pain and were satisfied with standards of care. They felt that GPs could and did manage such patients well and that, in most localities, good support was provided by palliative care professionals. Telephone advice was usually readily available and hospital-based palliative care nurses often also worked in the community. This allowed easy exchange of information. A few GPs (4%) said that they managed all patients with cancer pain within primary care, with the help of specialist community nurses.

Acute pain

11.8 Fifty-two of the GPs (91%) were not aware of extant local acute pain services. However, on hearing about such a service, many had unrealistic expectations of what would be provided, for example, rapid access to an acute back pain service or urgent treatment for unusual painful conditions such as acute pancreatitis.

11.9 When questioned many GPs expressed a need for more guidance on analgesia for children in acute pain and reported that children were discharged postoperatively, or from A&E departments without adequate pain relief. One GP cited an incident in which a child had been discharged with a fracture without any pain relief. Another GP commented that:

"There seems to be a problem with pain relief postoperatively. Hospitals seem to give either nothing or Calpol; and when this is inadequate they are not prepared to give anything stronger. These children are often in a lot of pain postoperatively."

Community Staff

11.10 Information was collected from community staff at sample sites and via a postal survey: 13 community staff attended the CSAG site visits; 54 out of 132 questionnaires were returned from staff associated with the 11 sample sites (26 district nurses, 15 Macmillan/home care nurses, 11 physiotherapists, 1 pharmacist, and an 1 occupational therapist).

11.11 From comments made at the CSAG visits and the findings of the postal survey, community staff thought that patients in chronic pain needed quicker access to specialist pain services. They highlighted the need for patients to receive information about their condition and be taught coping strategies. A multidisciplinary approach to pain management was also said to be important.

11.12 Community staff thought that patients with cancer pain were well managed in the community. However, there was variation in the level of service provision for cancer patients among the sample sites: not all areas had 24-hour specialist nurse cover.

Patients with chronic pain

11.13 We interviewed 245 patients attending chronic pain clinics at the 12 sample sites and extracted information from their clinical notes. Of these, 87 (35.5%) were attending the pain service for the first time.

11.14 Median age was 51 years, 25% were under 40 years and 25% were over 61 years. Median duration of their pain was 5 years but 25% had had pain for 11 years or more. Only 26% of patients were employed, 33% were medically disabled and 25% retired. Many patients (55%) said they had stopped work because of their pain; 91% reported that pain prevented them from doing household or leisure activities. Patients variously complained that pain inhibited their ability to walk a significant distance, to sit for prolonged periods, to perform simple household tasks (e.g. cooking, cleaning and ironing), to attend social activities, to go shopping or to play sport.

11.15 All patients complained of pain at the time of the interview; pain syndromes or sites identified from casenotes are shown in Table 27; pain was said to be constant for most (72%) patients; 35% said that no doctor had told them the reason for their pain prior to attending the pain clinic.

Table 27: Pain syndromes/sites identified in patients attending chronic pain clinics

<i>Complaints identified in the notes*</i>	<i>Proportion of Patients (n=245)</i>
Back pain	34%
Neurogenic pain	16%
Lower limb pain	16%
Neck and shoulder pain	11%
Pelvic and hip pain	7%
Abdominal/groin pain	7%
Post-surgical wound pain	6%
Facial/head pain	5%
Complex regional pain syndrome	5%
Upper limb pain	5%
Chest pain	4%
Miscellaneous	7%

* Some patients experienced more than one complaint.

11.16 Chronic back pain was the most frequent complaint. Neuropathic (or neurogenic) pain was also common and was associated with conditions such as nerve root compression, trauma, viral infection, damage during surgery, diabetes, and infiltration by cancer.

11.17 Most patients had been referred either by their GP (49%) or by a hospital consultant in another specialty (44%). The majority of patients (65%) had no prior knowledge of the existence of pain clinics. However, some patients (3%) had themselves requested the referral after hearing of the pain service.

11.18 Date of referral and date of the first appointment was obtained for all but one patient. Median waiting time was 13 weeks; 25% of patients had waited 22 weeks or more; the longest wait was 90 weeks. Applying the Patients' Charter criteria, we found 58% of patients had not been seen within 13

weeks and 26% had not been seen within 26 weeks. Almost all (97%) patients had been acknowledged by reception within 10 minutes of arrival, and 81% had been seen by the doctor within 30 minutes of their appointment time.

Table 28: Prior treatments in patients attending the chronic pain clinic

<i>Therapy</i>	<i>Proportion of patients (n=245)</i>
Physiotherapy	63%
TENS	30%
Manipulation	29%
Surgery	22%
Relaxation or massage	19%
Acupuncture	18%
Osteopathy	15%
Chiropractic	10%
Occupational therapy	7%
Psychology	5%
Reflexology	5%
Psychiatry	4%
Aromatherapy	4%
Self-help/discussion groups	4%
Homeopathy	4%
Herbal medicine	1%
Hypnosis	1%

11.19 Given their long histories of pain, patients had inevitably received a wide variety of pain relief before attending the pain clinic (Table 28): 63% had received physiotherapy in some form; some had had formal manipulation, and 30% had had TENS treatment. Some forms of complementary therapy such as relaxation, acupuncture, osteopathy and chiropractic, were also relatively common. 22% of patients had undergone surgery directly related to their condition.

Satisfaction with care and assessment of outcome

11.20 Patients were asked whether they were satisfied with the care they had received from the pain service: 71% felt able to express an opinion (most of those who did not had only just started treatment) of whom 72% were satisfied; only 5% were dissatisfied; the rest (23%) were indifferent. A number of patients made additional general comments about the pain service which were mostly positive about the service provided.

11.21 Of 245 patients, 94% reported whether they had experienced a change in their symptoms: 50% of these said that they now experienced less pain than when they first started attending the pain clinic; for 11% of patients symptoms had worsened; for 37% there had been no change. Of 245 patients, 90% commented on the effect of treatment on the quality of their lives: 40% of these reported an improvement, 52% no change and 8% had experienced a deterioration.

Information provided to patients

11.22 At 6 of the 11 sample sites with a chronic pain service, patients had been given locally produced leaflets about specific drugs (e.g. **amitriptyline**, lamotrigine); specific treatments (e.g. spinal cord stimulation, chemical lumbar sympathectomy and epidural injection) or specific conditions (e.g. complex regional pain syndrome and low back pain). This information had been much **appreciated** by the patients that we interviewed and written information plus oral explanation was preferred to oral explanation alone. In some localities, patients were also sent information sheets before attending the clinic.

11.23 While in the pain clinic, some patients had also received information produced by organisations such as: Pain Concern (UK); the Welsh Pain Society; the Arthritis Rheumatism Council (ARC); the IASP; and **pharmaceutical** compaoies.

General issues

11.24 Focus group discussions and patient interviews both revealed that many patients felt, that at various stages in their illness|before referral to a pain clinic, professionals had not believed that their symptoms were genuine. One patient expressed this as follows:

“Because I can walk and move my arms, I am convinced they thought I was neurotic and not really in pain.”

11.25 Many patients also felt that they should have been seen at a pain clinic earlier, for example:

“I was not believed - from the word go. You were shoved off with a prescription, you went back two weeks later - no they wouldn't refer you to a consultant – it went on and on for nine months.”

“They (patients with pain after trauma) should be going to the pain chic then (soon after the accident), not 5 or 6 years later because it is too late then.”

11.26 Another major **complaint** was the lack of a diagnosis of their pain prior to attendance at a pain clinic. Once patients were seen by the pain service, the majority felt supported and were relieved to discover that expert advice was available.

11.27 Although only 3% of patients interviewed individually had seen a psychologist, many of those patients in the focus group sample had. Some of these patients had found it highly beneficial, for example:

“Psychologist X was a lifesaver.”

“You suddenly get tremendous confidence because you suddenly realise that psychologist X and all her knowledge and experience actually identifies you individually because suddenly you're not one of the masses.”

11.28 Many patients voiced the need for assurance about and confirmation of how best to manage their pain,. Access to an expert who could instruct them on how to do this was **seen** as highly beneficial.

In general, patients wanted advice on the best techniques to help them cope with the pain, for example:

“It was good to have it confirmed that we were doing the right things like lying in certain positions; it was good that the psychologist told us we were going right whereas before, it was; “Are we doing right or not? Are we doing damage or are we not?”

Carers’ views

11.29 We interviewed 79 carers accompanying patients to chronic pain clinics. Most were partners (64%); others were sons or daughters (10%), or parents (11%). Of these 96% gave an opinion about the care of the person with pain: 81% were satisfied and 4% were dissatisfied. An even higher proportion (93%) were satisfied with the facilities of the pain service. Most carers (80%) had not heard of pain clinics before their relative was referred to one.

11.30 Of 79 carers interviewed, 26 made additional comments which are summarised in Table 29. Comments were generally positive, for example:

“Need more services like this – makes the world of difference”.

“Having pain is terrible - having something to help my wife’s pain has been helpful.”

Table 29: Analysis of comments by carers on quality of chronic pain services

<i>Main -message of comments</i>	<i>Carers (proportion) n=79</i>
More services like the pain clinic needed	6 (8%)
Overall pleased with services being provided	5 (6%)
Would have liked the patient to be seen quicker	4 (5%)
Support groups for carers would be useful	4 (5%)
More information about pain, treatments and facilities required	4 (5%)
More support for patients required in community	3 (4%)
No comment	53 (67%)

Patients with postoperative pain

11.31 We interviewed 117 postoperative patients at 10 of the 12 sample sites. Patients had all undergone major abdominal general surgery or abdominal hysterectomy.

11.32 Of these patients only 44 (38%) had discussed the issue of postoperative pain before admission. Those who had discussed pain relief had done so at least as often with their GP (15 patients) as with a nurse (8 patients) or doctor (7 patients) at a hospital clinic. Of the patients that had received written information before admission (13%), nearly all thought it had been useful. In hospital, 67% of patients had been able to discuss postoperative pain relief before surgery and 18% had received written material.

11.33 After surgery, 50 (43%) patients experienced what they described as severe pain; 18 (15%) said that they were never asked about their pain. As treatment, 76 (65%) patients received PCA; 17 (15%) received epidurals (15%) but only 17 (15%) said they were offered choice in the method of pain relief.

11.34 Despite the large proportion of patients experiencing severe pain, patients' general level of satisfaction with the management of their pain was high. Overall 99 (85%) patients were satisfied, 13 (11%) were indifferent and only 5 (4%) were dissatisfied.

Patients in Accident & Emergency Departments with pain

11.35 We interviewed 102 patients by telephone in 10 of the 12 sample sites 2 or 3 days after discharge from A&E. They had all been treated for injuries to their upper or lower limb. The median (quartiles) age was 35 (27, 51) years.

11.36 On first attending the A&E, 26 patients had mild pain, 58 moderate pain and 18 severe pain. Only 58% of patients remembered being asked if they were in pain; 22% were offered some form of pain relief but only 11% actually received it in the department. At three sample sites, none of the patients interviewed had been given any pain relief in the department despite the fact that many were in pain. There was little evidence of the use of formal pain assessment.

11.37 Overall satisfaction with the management of pain was not as high for the A&E patients as for the postoperative group. Only one in three thought that pain management had been good or excellent; one in four described it as poor.

11.38 At the time of discharge, 91% of patients were still in pain and a similar percentage experienced pain at home. Only 37% said their pain was less severe at home compared with that experienced in the A&E department; 24% said that the pain was worse.

11.39 Oral or written information about pain relief was apparently given to only 43% of patients. Although 20% of patients had been given some pain relief medication to take home, they had similar levels of pain to those who had not.

11.40 GPs had been consulted about pain relief by 13% of patients. In general, these patients had not been satisfied with their management in the A&E; none had been given pain relief although some had experienced moderate or severe pain.

Patients after day-case surgery

11.41 We interviewed 102 patients by telephone 2 or 3 days after discharge from a daycase surgical unit. Most had undergone operations such as laparoscopy, molar tooth extraction, hernia repair, or vasectomy.

11.42 Patients experienced pain after surgery which was mild (36%), moderate (40%) or severe (17%); 61% had been offered pain relief and 59% given analgesics in the unit. Nevertheless, 82% of patients left the unit in some pain; 74% were sent home with pain relief medication. Information on their operation was given to 88% of patients but in 29% of these cases it contained no advice on pain relief.

11.43 Many patients (87%) continued to experience pain at home; 21% of whom had severe pain. Despite these levels of untreated pain, patients were surprisingly satisfied with the quality of pain management in the **daycase** units; 73% said it had been good or excellent.

11.44 Many patients (41%) obtained further pain relief on arrival at home; of these, almost half did so following the advice of staff on the **daycase** ward, a third acted on their own initiative, the rest had been given advice from their GP or pharmacist. Only 11% of all **daycase** patients consulted their GP: 5% visited a health centre; 2% received a home visit; and 4% telephoned for advice. In general, patients were remarkably satisfied with the management of their pain at home; 71% said it had been good or excellent.

Conclusions

11.45 GPs were concerned about levels of access and provision of local chronic pain services, and about management of acute pain in A&E departments. GPs and community staff wanted access to multidisciplinary chronic pain services and shorter waiting times.

11.46 GPs knew very little about local acute pain services and were satisfied with local palliative care services.

11.47 Half of patients seen by specialist chronic pain clinics were referred from primary care and half from other hospital services. Before attending the pain clinic, a third of patients were uncertain of the cause of their pain.

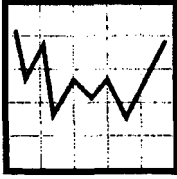
11.48 Most patients and their carers said they were satisfied with the care received in the chronic pain clinic including the information provided to them. About half reported improvements in their pain.

11.49 After inpatient abdominal surgery, patients reported considerable amounts of pain but were generally satisfied with the pain relief provided. Less than half the patients remembered discussing pain relief prior to surgery.

11.50 After attending A&E with a limb injury, less than a quarter of patients were offered pain relief in the department and only half of these received it. Many of those not given pain relief reported that they had been in moderate or severe pain. Satisfaction with pain relief in A&E was much less than that for postoperative patients.

11.51 After **daycase** surgery, most patients continued to experience pain at home which was sometimes severe. Most were, however, satisfied with their pain relief but many had to seek further medication for pain on return home. A small but significant proportion consulted their GP as a result of pain.

12: The management of pain in children



12.1 Children may experience significant acute pain as the result of trauma, medical procedures or surgery, and chronic pain as the symptom of disease or as a result of therapy (Miser et al, 1987). There is some evidence that this pain is not managed as well as it could be (Lovell et al, 1989; Schechter, 1989; Action for Sick Children, 1992; David, 1993; McKenzie et al, 1997). Important guidance in this area has recently been published (Royal College of Paediatrics and Child Health, 1997).

12.2 Information on services for pain was obtained by telephone from clinical paediatric nurse specialists in all 12 specialist children's hospitals in the UK. Only 3 of these provided specialist chronic pain services; 9 provided a specialist acute pain service. A more detailed study was also conducted in 2 of the 3 specialised hospitals that had a chronic pain service and in 4 hospitals chosen from the main 12 site sample (2 district general hospitals and 2 teaching hospitals). Ward nursing staff on paediatric medical, surgical and intensive care wards and in A&E departments were interviewed using structured questionnaires. Consultant medical staff and paediatric nurse specialists were interviewed using semi-structured questionnaires. The study did not look at the treatment of pain in children with cancer.

Pain services for children

Specialised children's hospitals

12.3 Both of the specialised children's hospitals studied provided a regular multidisciplinary chronic pain clinic in which approximately 5 children each month were being seen (2 new and 3 follow-up) mostly with neuropathic pain, musculoskeletal pain and painful arteriovenous malformations. In one hospital, acute and chronic pain services were provided jointly by 5 consultant anaesthetists and one pain specialist. In the other hospital, the chronic pain service was provided jointly by a consultant anaesthetist, two specialist nurses, a pharmacist, a paediatrician, a neurologist, a child psychologist, and a physiotherapist with a social worker also attached to the service. Both services used questionnaires specifically designed for children in their initial assessments. These two hospitals also provided 24-hour acute pain services; one of which is described in Box 11.

General hospitals

12.4 The 4 hospitals from the main sample did not have pain services specifically designed for children although the adult pain services sometimes saw children. Specialist acute pain nurses were able to teach and train on paediatric wards but could not provide direct patient care unless they were also trained in general paediatric nursing.

12.5 The national survey of chronic pain and palliative care services showed that 55% of chronic pain services and 29% of palliative care services saw some children. All but a few services saw only a handful of children each year.

12.6 One of the teaching hospitals in the pilot study which has a well-established chronic pain service was developing an outpatient chronic pain service specifically for children.

Box 11: An acute pain service in a specialist children's hospital

The acute pain service for children had been established for 3 years. Approximately 110 patients were seen per month. During the year patient-controlled analgesia machines were provided to about 500 children/year epidurals to 130 children/year, continuous intravenous therapy to 220 children/year, Entonox to about 20 children/year and bupivacaine wound perfusion to 10 children/year. A clinical nurse specialist provided 30 hours per week, her remaining time being spent in the chronic pain service. Half the clinical nurse specialist's time was spent training other staff. 24-hour cover was shared by 5 consultant anaesthetists (on call) providing a total of 12 hours of their time per week for the acute pain service. There was no specific budget for the acute pain service.

There were locally produced guidelines for the use of patient-controlled analgesia and epidurals, and an annual audit was undertaken. Research was a high priority for the service: medical staff spent 50% of their time, and the clinical nurse specialist 10% of her time, on research.

Parents' perspective

12.7 A parents' support group (for those whose child suffers from a painful chronic condition) was asked about the way in which their children's pain had been managed. These parents felt that:

- * there was a lack of awareness of the problem of chronic pain in children;
- * some professionals had a limited understanding of the pain that children can experience;
- * once a referral had been made to a specialist centre support, guidance and management for their child's pain was forthcoming;
- * the use of trained play therapists who could occupy and distract a child during painful procedures was helpful.

Survey of practice on paediatric wards

12.8 Nurses (n=20) working on each of 13 children's wards and nurses working on each of 7 neo-natal wards in the six hospitals were interviewed using a structured questionnaire. Of these, 9 paediatric nurses and 4 neonatal nurses had had some training on how to manage pain in children.

12.9 On all 13 paediatric wards, it was normal practice to use local anaesthetic prior to venepuncture and for parents to be present during painful procedures and to accompany children into the anaesthetic room. On 10 of the wards, non-pharmacological interventions, such as distraction techniques, were used to manage pain during procedures and on only 5 wards were intra-muscular injections (which are not recommended for USC in children) routinely used. All the nurses reported that parents were involved as much as possible in decisions about their children's care.

12.10 The methods used to assess pain on the wards are shown in Table 30. Although some form of pain assessment was performed in all cases, formal pain scales were used on only 8 of 13 children's wards and 2 of 7 neonatal wards.

Table 30: Assessment of pain on a sample of paediatric and neonatal wards

<i>Approach used</i>	<i>Paediatric wards (n = 13)</i>	<i>Neonatal wards (n=7)</i>
Verbal description	7	n/a
Pain scale appropriate to age group	8	2
Behaviour observation	12	7
Physiological measures	7	7
Other	2	1

12.11 On some wards, staff had devised a questionnaire to elicit information about the child's previous experience of pain, which was used in conjunction with a pain assessment and management record. These documents provided a full account of the child's pain history, and were used to record the effect of specific pain management techniques. On 5 of the 13 children's wards, and 1 of the 7 neonatal wards, it was normal practice to provide written information to parents on children's pain.

12.12 Both medical and nursing staff felt that the management of neonatal pain should be improved. One Trust had implemented a programme of improvement in this area, including teaching for junior staff and development of protocols and standards.

12.13 Audits of acute pain management had been conducted on 8 of the 13 children's wards and one of the 7 neonatal wards. For example, at one of the district general hospitals, a nurse had surveyed other nurses' knowledge of managing children's pain and shown significant gaps. At the same hospital, pain assessment on a post-surgical children's ward had been found to be poor. A tool for assessing pain had since been introduced and, as a result, the management of children's pain was said to have improved.

Survey of practice in Accident and Emergency (A&E) departments

12.14 We interviewed 10 members of staff (nursing and medical) in 6 A&E departments.

12.15 At the two specialised children's hospitals, the acute pain teams contributed to the management of children's pain in A&E. At 3 of the other hospitals, there were acute pain teams which did not provide a service in A&E (1 hospital had no acute pain service). Assessment of children's pain by the triage nurse, or other nurse caring for the child in A&E, was done using verbal descriptions and observation of behaviour. None of the departments used formal pain scales and only 2 used physiological measures to assess pain levels. Leaflets containing advice for parents and children on how to manage pain were available at only 1 of the 6 departments.

12.16 4 of the 10 A&E staff felt that the way in which children's pain was managed in their department should be improved.

Use of guidelines

12.17 Of 20 ward nurses interviewed. 13 (65%) were unaware of any national guidelines on the management and assessment of pain in children while 9 (45%) reported the use of local guidelines on the management of pain in children. In 2 A&E departments the document entitled 'Guidelines for Analgesia in Children in the Accident and Emergency Department' was being used (British Association for Accident and Emergency Medicine, 1997); other departments were using no guidelines.

12.18 When asked about the recent Royal College of Paediatrics and Child Health (1997) guidelines, medical consultant staff in 2 hospitals were unaware of them while in 3 hospitals they were aware of them but not using them.

12.19 Medical staff in the survey (n=6, mostly anaesthetists) often said that they used local guidelines on the management of acute (postoperative) pain in children.

Conclusions

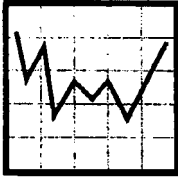
12.20 It is important to ensure that children suffering from chronic pain receive expert pain control.

12.21 Where they exist, pain services for children appear to be well organised. However, 50% of Trusts in this pilot study, did not provide an acute pain service for children.

12.22 Approximately half of staff interviewed in acute war& had no local guidelines on the management of pain in children within their own service Staff awareness and the implementation of recently produced national guidelines appeared to be poor.

12.23 One-third of nurses who routinely cared for paediatric patients in pain have no specific training in pain assessment or management.

12.24 It is essential to disseminate widely the best tools for assessing children's pain and to develop skills in pain assessment.



Chronic pain

13.1 At the 12 sample sites, we interviewed six specialist palliative care nurses, two chronic pain specialist nurses and three nurses who often work within chronic pain services. Ten of them had received training in the management of patients with pain, and 10 were involved in teaching. Most (80%) taught other nurses but many of the interviewees also had a role in the education and training of staff in other disciplines. All the nurses interviewed said they regularly updated their knowledge of pain management.

13.2 At the 12 sample sites, we also interviewed 17 healthcare professionals (mostly physiotherapists and psychologists) who specialise in the management of chronic pain or in palliative care. Most of these staff (77%) had received formal training in the management of pain, and 16 of them said they regularly updated their knowledge as part of their specialist role.

13.3 In the survey of complementary therapists ($n=58$), 78% said that more training in the management of patients in pain was needed; 58% wanted information on clinical effectiveness as part of this training and 64% wanted to take part in multidisciplinary training programmes.

13.4 The senior registrars and newly appointed consultants who attended focus group and site visit discussions felt that the training they received to become pain specialists had been highly self-directed. All of the trainees said they had had to structure their own training to gain the expertise they required. The post of research fellow in chronic pain, existing at two teaching centres in the sample, provides an opportunity for doctors to develop careers in pain management.

13.5 Education and training appear to be well developed in palliative care. Study days were available to a range of staff. Examples of good practice included training staff from a range of disciplines together and providing for the needs of professionals in both hospital and community settings. An innovative approach to education in palliative care included rotation of hospital and palliative care nurses. This concept is expected to extend to doctors in training grades (as reported at one site visit). One site had developed a palliative care educational 'roadshow' built around training in pain management.

Acute pain

13.6 Acute pain teams have a strong focus on education. Teaching is conducted in a variety of ways: by role modeling, by one-to-one teaching in the clinical area and by formal study days or sessions. Much of the teaching concerns the assessment of pain, using agreed scales, to a hospital-wide standard, and the management of patient-controlled analgesia and epidurals. Study days are funded mainly through support from pharmaceutical companies.

13.7 From the survey of acute pain nurses, we found that all were involved in some way with teaching other professionals and that around 40% of their time was spent doing so. Acute pain team members reported that they struggle to provide education, although they perceived it to be one of their main roles. On site visits, acute pain teams were concerned that staff in some clinical areas were neglected, in particular A&E. Consultants in A&E agreed that there was a need for more acute pain education in their department.

13.8 In the survey of 93 nursing staff from hospital wards, the majority (68%) of respondents had received training in the management acute pain. For half (57%) of those who had received training, the trainer was a pain nurse. However, nearly all those interviewed (91%) wanted more training in pain management, in the form of workshops and practical sessions.

13.9 At several Trusts, the **role** of the acute pain team was orientated towards training and support, rather than the provision of hands-on care. The acute pain team at one site had developed a long-term relationship with a university department, to reinforce their educational and strategic remit.

13.10 Although **education** emerged as one of the vital **roles** for acute pain teams, funding constraints and difficulty in releasing staff to take part in training were repeatedly cited as barriers in the focus group discussions. However, at one of the sample sites, the mandatory attendance of nurses at pain study days had been incorporated into job descriptions.

Primary care and community services

13.11 In the survey of 54 primary **healthcare** and community staff (mainly district nurses, specialist palliative care nurses, and physiotherapists), 83% of respondents had received some form of training in the management of pain. However, 49% felt that their knowledge was inadequate to manage the pain experienced by their patients. This is a cause for concern as the same group of respondents indicated that 21% of their consultations were associated with chronic non-malignant pain and 32% were associated with cancer pain. Almost all of the respondents (92%) wished to gain access to information on clinical effectiveness of treatments for pain. Most (85%) would like to attend **multidisciplinary** training sessions with other **health** service professionals.

13.12 From the focus group discussions, it would seem that for **GPs** most training in pain management is based in palliative care. GP trainers indicated that GP registrar training can include up to one day a week in a hospice. By contrast, the educational provision for **GPs** in the management of chronic non-cancer pain seemed negligible.

Current training programmes for different professions

13.13 The International Association for the Study of Pain (**IASP**) has proposed curricula for training in pain for medical and dental schools, basic nursing education, and students of psychology, pharmacy, physiotherapy and occupational therapy (**IASP** 1988, 1993, 1994, 1997). In the UK, the Pain Society (as the British and Irish Chapter of **IASP**) has **recently** set up a working party to **implement** these curricula, and build on these efforts already made to develop training and education programmes across the disciplines.

Doctors

13.14 The General Medical Council (1997) believes that pain education is vital, and that it should always be included in the induction of new house officers and be the subject of regular refresher courses.

13.15 In 1993, three professional bodies in the UK (AAGBI/RCA/Pain Society, 1993) collaborated to consider the IASP recommendations and to make proposals at five levels of medical training: undergraduate, postgraduate, basic specialist, higher specialist and for those taking up posts in pain management. The proposals included the following.

- * A structured programme in pain management should be provided at each medical school as part of the undergraduate curriculum.
- * Pain curricula should be integrated into other teaching programmes, for example, in palliative medicine.
- * Pain should be covered in pm-clinical, and early and late stages of clinical medical training.
- * Designated consultants should co-ordinate specialist training in pain, and all trainees should be aware of pain clinics and the activities within them.

In a recent report from the Association of Anaesthetists (AAGBI/Pain Society, 1997) these points were reiterated; in addition, the important role of education was emphasised, further developments for postgraduate education were suggested and it was recommended that continuing education in pain management should be made mandatory for those working in pain services.

13.16 In 1988, Marcer & Dighton surveyed UK medical schools. Of the 27 responding, there was no formal teaching on pain management at four; the remainder provided an average of 3.5 hours over a five year period; there was little evidence of a multidisciplinary approach to teaching.

13.17 In a more recent survey of 32 medical schools to investigate the teaching of pain management, 15 responses (47%) were received (Justins, personal communication). At six of the 15 schools, the curricula were currently being reviewed. The content and the number of hours relating to pain management varied widely. Lectures on pain were often given within pharmacology or neuroscience blocks. In the clinical years, pain was covered within the anaesthetic attachment at 9 of the 15 schools. At one school, an entire week was devoted to pain management. The subject was also being taught within palliative medicine. Extra provision was sometimes made for 4th year students with an interest in pain.

Postgraduate medical training

13.18 Specialist training in anaesthesia provides two levels of opportunity for training in pain management. First, every trainee anaesthetist receives training in pain management (for acute, chronic and cancer pain) at the senior house officer level and the specialist registrar level; details of this training are contained in the relevant training guides published by The Royal College of Anaesthetists. At some of the sample sites, attachments for trainees to the chronic pain service were available but this was not a universal practice. Second, for those anaesthetists who wish to have a major responsibility for pain management in their consultant career, it is possible to obtain 6-12 months' experience in pain management during the latter years of their specialist registrar training. The Royal College of Anaesthetists is currently considering the establishment of additional qualification and/or accreditation for these anaesthetists (AAGBI/Pain Society, 1997). The publication of the training document 'Specialist Training in Anaesthesia – Supervision and Assessment' (RCA, 1994) led to the development of training modules on the management of pain.

Nurses, midwives and health visitors

13.19 For nursing, midwifery and health visiting, the validation and monitoring of all **pre-** and post-registration programmes of training is conducted by the four National Boards (English, Northern Ireland, Wales and Scotland).

- * The English National Board informed us of five pain courses that had received approval (covering pain relief in adults, children and maternity).
- * The Northern Ireland Board sent information about all their programmes and indicated that the management of pain was comprehensively covered (pharmacology and principles of pain control).
- * The Welsh National Board informed us about pm-registration nurse education. The content devoted to pain management varied for nurses, midwives and health visitors. A range of **pain-**modules was available throughout **Wales** for registered nurses. Pain management was taught in modules on palliative care at several universities within Wales.

13.20 Opportunitia for training in pain management through continuing education are offered within several programmes accredited by the National Boards, for example, **A77-** Pain and Pain Management.

13.21 The majority of nurse **education** undergraduate programmes include pain management in the curriculum. but the average of four hours study does not give nurses adequate preparation (**Graffam**, 1990). Inadequate knowledge about pain management among healthcare **professionals** is one of the most prevalent factors in the under-treatment of pain (Gricpp. 1992, Clarke et al, 1996)

13.22 Several Masters-level university courses on pain are available in the UK. These courses are organised to provide education and training in an interdisciplinary, cross-specialty and **multi-professional** way. For some of these courses, education is provided through distance learning and attendance at residential days.

Professions allied to medicine

13.23 Some participants within the discussion groups felt that there was a shortage of places, of funding and of suitable attachments for students of psychology. **There** is an increasing recognition of the need to include pain and its management in **the** training of psychologists, particularly at doctoral level. Many modules in clinical psychology and in health psychology now include the subject of pain management. **There were** plans to attempt the **core** curriculum (**IASP** 1997) much **more** widely, but these were still at an early stage.

13.24 The Physiotherapy Pain Association (PPA) has close links with The Pain Society. The PPA Education Committee organises three study days per year, and is developing an introductory course in pain management. The PPA has also developed standards for physiotherapists. A discussion document on training for those physiotherapists working in pain management programmes has been published (PPA, 1997). The suggestions follow the curriculum framework developed by the Chartered Society of Physiotherapy and the Council for Professions Supplementary to Medicine (1996).

13.25 The College of Occupational Therapists has the main responsibility for the education of occupational therapists. The educational programmes are approved by a Joint Validation Committee which includes representatives from the Occupational Therapist's board.

13.26 Pharmacists have a key role in providing education and training in the pharmacological management of patients suffering from pain. Pharmacists from the sample sites reported that there were no specific courses for pharmacists who are interested in the management of pain. This perception was confirmed in our communication with the professional bodies that regulate the profession.

Complementary therapists

13.27 More than 100 courses in complementary medicine are available in university science and healthcare departments and in faculties of nursing. They range from university courses to higher research degrees. The amount of teaching devoted to pain ranges from a few hours to a full module as part of a BSc/DipHE; pain can be a specialist subject for a diploma or degree course.

13.28 A recent report by the Foundation for Integrated Medicine (1997) suggests that:

- * There is no simple universal system of determining the qualifications, training or experience that complementary practitioners may have.
- * Many nurses have experience of and training in certain complementary therapies, however there is insufficient information on the training received, the level of competence achieved and those circumstances in which it is appropriate for nurses to apply these skills.
- * Specialist courses in complementary medicine that medical doctors have attended vary in terms of length, thoroughness, and the level of competence required to practice.
- * A large number of complementary medicine courses provided at universities are not accredited by an independent regulatory body

Evaluation of training and education provision

13.29 For some of the pain courses, reference is made to published curriculum guidelines (IASP) but for very few courses is the impact of training evaluated. The aim of education is frequently stated as to 'increase knowledge', however, little consideration is given to how the clinician or practitioner might apply that knowledge. During this study, the only mechanism that was cited for the evaluation of education and training in pain management was an evaluation form. This lack of evaluation of pain education and training has been reported by other researchers (Clarke et al, 1996).

Conclusions

13.30 The professional organisations that can influence pre-registration curricula have been slow to incorporate the published guidelines on training for pain management. Education in pain management does not appear to be provided in a structured and coherent manner in many undergraduate courses for healthcare professionals.

13.31 Within general professional training, the multidimensional nature of pain should be emphasised and the biopsychosocial model should be promoted as appropriate particularly when treating chronic pain. Teaching on treatment strategies should include pharmacological, interventional, physical and psychological approaches.

13.32 We found great disparity not only in the training requirements of different professional groups but also the extent to which training programmes were meeting clearly identified needs.

Chapter 14: Recommendations



Recommendations to Health Authorities and Primary Care Groups (PCGs)

14.1 Health Authorities and PCGs) should review **local** provision of services for patients with pain in relation to **likely** local levels of need for those services. This process is likely to reduce the unacceptable variation that CSAG identified in levels of service around the country.

14.2 Health Authorities and PCGs) should agree with Trusts on the provision of specialist pain services of different levels of complexity and specialisation across a range of centres. Pain **centres** should be classified using a modification of the International Association for the Study of Pain (IASP) **classification**. The geographical catchment areas of centres should match the need for less commonly used procedures or facilities so that these are provided only in a limited number of specialised centres. Levels of financial support should reflect the level of specialisation of a particular service. Good communication between centres of different levels of specialisation should be encouraged perhaps through staff working in more than one centre (hub and spoke model).

14.3 Health Authorities and PCGs) should set and monitor targets for waiting times for chronic pain **clinics**. The interval between referral to a pain clinic and the **first** consultation should not exceed 3 months.

14.4 Health Authorities and PCGs) should ensure that the quality of postoperative pain relief service is specified in agreements -for surgical services, and ensure that the specified **service** is provided.

14.5 Health Authorities and PCGs) should ensure that pain control (or advice on pain control) for cancer patients can be provided when necessary by properly constituted local specialist palliative care services.

14.6 Health Authorities and PCGs) should be aware that a heterogeneous range of non-conventional or “complementary therapies is offered to patients with pain, particularly chronic pain, some of which have limited empirical support. Ultimately, public **funding** of these and other services must be justifiable in terms of effectiveness. Health Authorities should, therefore, encourage the **evaluation** of non-conventional services, which is more likely to occur when these services are provided in NHS units alongside orthodox pain services. They should also encourage the development of guidelines for standardised practice and referral criteria for any non-conventional services that might be funded by the NHS.

Recommendations to Trusts

Chronic pain

14.7 The objective of pain management services should include prevention of the development of chronicity and the disability that follows. To this end Trusts should give GPs early, possibly direct, access to appropriate investigations and to a prompt opinion from specialist secondary care services when needed. Good communication between the parts of the NHS concerned with the

management of an individual's pain is crucial. Information relevant to the care of specific patients needs to be shared promptly between agencies in secondary and primary care.

14.8 Trusts should ensure that patients with chronic pain have access to the services of a chronic pain team when necessary. Local chronic pain teams should:

- * advise local **GPs** on the range of services available, appropriate criteria for referral, appropriate **expectations from** referral, and the respective roles of **GPs** and pain teams in the long-term care of referred patients;
- * be led by a named individual whose role is clearly defined;
- * be multidisciplinary, including, for example, doctors, nurses, psychologists, pharmacists, physiotherapists, and occupational therapists;
- * have **adequate** administrative support and office space;
- * have a recognised role in **education** of professionals in the management and prevention of chronic pain;
- * devise care plans for all new patients;
- * discuss **care** plans with patients and **carers**;
- * make care plans available to other clinicians involved in the patient's care;
- * ensure that chronic pain services are **audited**.

14.9 Certain **carefully** selected patients should have access to a properly formulated pain management programme within a reasonable period of time. Pain management programmes are specific treatment packages for patients with high degrees of distress or disability as a result of chronic pain. They should not be regarded as an alternative or additional treatment suitable for most patients.

Post-operative and other acute pain

14.10 All patients undergoing potentially painful procedures should have access to the services of an acute pain team if necessary. The acute pain team should:

- * include a named doctor with designated time available for this function, and at least one specialist nurse;
- * be provided with adequate administrative support and office space;
- * work closely with pharmacists and physiotherapists with an interest in pain control;
- * have a recognised role in education of professionals throughout the Trust in **the** management of post-operative and other acute pain;

- * institute a standardised approach to the assessment of postoperative and other acute pain throughout the Trust;
- * promote the use of protocols for the management of commonly encountered situations and devise new ones when **necessary**;
- * ensure adequate arrangements for patient-controlled analgesia;
- * ensure that patients are provided with appropriate information on their risk of Postoperative pain and the strategies available to deal with it;
- * ensure that levels of postoperative pain control are audited.

Accident and Emergency (A&E) departments

14.11 There should be greater emphasis on effective pain management in patients attending **A&E** departments. This should be achieved through:

- * more extensive training of staff in pain management;
- * **use** of standardised assessments of pain;
- * use of pain management protocols in commonly encountered situations;
- * appointment of a clinical nurse specialist in pain control in larger units;
- * explicit links between the A&E department and the acute pain team.

Services for children

14.12 Pain services for children should be provided by those with training and experience in **paediatric** and **family** care as well as in the management of pain. Trusts should audit services against the pain management guidelines produced by the Royal College of Paediatrics and Child Health and the British Association of Emergency Medicine, and take account of existing models of good practice.

Training

14.13 Trusts should ensure that all **staff** responsible for the management of patients in pain are adequately trained in this area and should **support** any necessary training programmes.

Recommendations to Commissioners of Research and Development

14.14 Further research should be commissioned on the epidemiology and the social and economic impact of unrelieved pain.

14.15 New research, and systematic reviews of existing research, are needed on the effectiveness of specific **therapies** for acute and chronic pain, particularly on therapies that may prevent conditions associated with acute pain becoming chronic problems.

14.16 The value and appropriate use of pain assessment tools for children in various age groups should be reviewed.

Recommendations to Professional and Other Bodies (including NICE)

14.17 The Royal Colleges and **professional** bodies concerned with pain services should review training needs and recommended curricula in this field. Colleges and universities should ensure that **the** management of pain is adequately covered in undergraduate, postgraduate and specialist teaching and training.

14.18 Recent national and international guidelines for management of pain should be assessed for evidence base, readability, potential impact on quality of care and relevance to UK practice. The task should be done centrally on behalf of the whole NHS. The best existing national and international guidelines should be disseminated, and the best local guidelines should be shared as examples of good practice.

14.19 New evidence-based guidelines should be prepared on specific conditions such as neuropathic pain and complex regional pain syndrome, and on specific therapies such as opioids for chronic non-malignant pain, spinal cord stimulation and pain management programmes.

14.20 Good quality guidelines should be made available to **GPs** on the management and referral of patients with common pain syndromes.



References

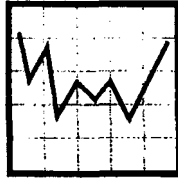
- ACC and the National Health Committee.(1997). **New Zealand Acute Low Back Pain Guide**. Accident Rehabilitation and Compensation Insurance Corporation. Wellington, New Zealand.
- Action for Sick Children. (1992). **Children in Pain**. London, National Association for the Welfare of Children in Hospital Ltd.
- Agency for Healthcare Policy and Research. (1994). **Management of Cancer Pain. Clinical Practice Guideline No.9**. AHCPR Pub. No.94-0592, Rockville MD AHCPR, USDHHS, PHS.
- Agency for Healthcare Policy and Research. Acute Pain Management Guideline Panel. (1992). **Acute Pain Management: Operative or Medical Procedures and Trauma. Clinical Practice Guideline**. AHCPR Pub. No.92-0032, Rockville MD AHCPR, USDHHS, PHS.
- Agency for Healthcare Policy and Research. Acute Pain Management **Guideline** Panel. (1992). **Acute Pain Management in Adults: Operative Procedures Quick Reference Guide for Clinicians**. AHCPR Pub. No.92-0019, Rockville MD AHCPR, USDHHS, PHS.
- Agency for Healthcare Policy and Research. Acute Pain Management Guideline Panel, (1992). **Acute Pain Management in Infants, Children and Adolescents: Operative and Medical Procedures - Quick Reference Guide for Clinicians**. AHCPR Pub. No.92-0020, Rockville MD AHCPR, USDHHS, PHS.
- American Pain Society, Quality of Care Committee. (1995). **Quality improvement guidelines for the treatment of acute and cancer Pain**. *J.A.M.A.* 274, (23): 1874-80.
- American Society of **Anesthesiologists** Task Force on Pain Management, Cancer Pain Section. (1996). **Practice guidelines for cancer pain management**. *Anesthesiology* 84:1243-57.
- American Society of **Anesthesiologists** Task Force on Pain Management. (1995). **Practice Guidelines for Acute Pain Management in the P&operative Setting**. *A.S.A.*
- American Society of Clinical Oncology; Ad Hoc Committee on Cancer Pain. (1992) **Cancer pain assessment and treatment curriculum guidelines**. *Journal Clinical Oncology* 10: (12): 1976-82.
- Association of Anaesthetists of Great Britain and Ireland and The Pain Society. (1997). **The Provision of Pain Services**. Association of Anaesthetists, London.
- Association of Anaesthetists of Great Britain and Ireland. (1994). **Day Case Surgery The Anaesthetist's Role in Promoting High Quality Care**. Association of Anaesthetists, London.
- Association of Anaesthetists of Great Britain and Ireland, the Royal College of Anaesthetists and The Pain Society. (1993). **Anaesthetists and Non-acute Pain Management**. Association of Anaesthetists, London.
- Association of **Palliative** Medicine of Great Britain and Ireland. (1992). **Palliative Medicine Curriculum**. Association of Palliative **Medicine**, Southampton.
- Audit Commission. (1997). **Anaesthesia under Examination: The efficiency and effectiveness of anaesthesia and pain relief services in England and Wales**. London.
- Bigos S., Bowyer O., **Bracn** G., et al., (1994). **Acute Low Back Problems in Adults: Assessment and Treatment, Quick Reference Guide for Clinicians**. Number 14, US Department of Health and Human Services, Agency for Health Care Policy and Research. AHCPR Pub 95-0614.
- Bowsher** D., **Rigge** M., **Sopp** L. (1991). **Prevalence of chronic pain in the British population: a telephone survey of 1037 households**. *The Pain Clinic*, 4(4): 223-23 1.

- British Association for Accident and Emergency Medicine. (1997). Guidelines for **Analgesia in Children in the Accident & Emergency Department**. BAEM.
- British Medical Association. (1993). **Complementary Medicine: New Approaches to Good Practice**. Oxford, Oxford University Press.
- Chartered Society of Physiotherapy and the Council for Professions **Supplementary to Medicine**. (1996). **The Curriculum Framework**. Chartered Society of Physiotherapy. London.
- Cherkin DC., Deyo R.A., Wheeler K., Ciol M.A., Carey T. (1995) Physician views about **treating** low back pain: The results of a national **survey**. *Spine*, 20(1):1-10.
- Clarke E.B., French B., Bilodeau M.L., Capwo VC., Edwards A., Empoliti J. (1996). Pain management knowledge, attitudes and clinical practice: the impact of nurses' characteristics and education. *Journal of Pain and Symptom Management*, 11(1): 18-3 1.
- Clinical Standards Advisory Group. (1994). **Back Pain**. London, HMSO.
- Clinical Standards Advisory Group. (1997). **Clinical Effectiveness**. London, HMSO.
- Cohen J.E., Goel V., Frank J.W, Bombardier C., Peloso P, Guillemin S. (1994). **Group interventions for people with low back pain: an overview of the literature**. *Spine* 19: 1214-22
- College of Health. (1994). **The Pain Clinic Directory**. College of Health, London.
- David T.J. (1993). **Recent Advances in Paediatrics: No.1** 1. New York, Churchill Livingstone.
- Davies H.T.O., Crombie I.K., Macrae W.A., Rogers K.M., Edmond Charlton J. (1996). **Audit in Pain Clinics: Changing the management of low-back and nerve damage pain**. *Anaesthesia* 51 (7): 641-46.
- Davies H.T.O., Cmmbie I.K., & Macrae W.A. (1994). **Waiting in pain. Delays between referral and consultation in outpatient pain clinics**. *Anaesthesia*, 49(8), 661-665.
- Davies H.T.O., Cmmbie I.K., Macrae W.A. (1994). **Why use a pain clinic? Management before and after referral**. *Journal of the Royal Society of Medicine*. 87: 382-385.
- Davies H.T.O., Cmmbie I.K., Macrae W.A. (1993). **Polarised views on treating neurogenic pain**. *Pain* 54(3): 341-346.
- Davies H.T.O., Crombie I.K., Macrae W.A., & Rogers K.M. (1992). **Pain clinic patients in Northern Britain**. *pain Clinic*, 5(3): 129-135.
- Davies H.T.O., Cmmbie I.K., Lonsdale M., Macrae W.A. (1991). **Consensus and contention in the treatment of nerve damage pain**. *Pain*, 47: 191-196.
- Davies K. (1996). **Findings of a national survey of acute pain services**. *Nursing Times*, 92: 31-33.
- Department of Health. (1995) **A policy framework for commissioning cancer services: a report by the expert advisory group on cancer to the chief medical officers of England and Wales**.
- Department of Health. (1997). **The New NHS: Modern, Dependable**, London.
- Ernst E., White A (1998). **Acupuncture for back pain: a meta analysis of randomised controlled trials**. *Archives of Internal Medicine* (in press).
- Ernst E., Pitler M.H. (1998). **The effectiveness of acupuncture in treating acute dental pain: A systematic review**. *British Dental Journal* 184 (P), p 443-7
- Ernst E. (1997). **Complementary medicine: the facts**. *Physical Therapy Review* 2:49-57.
- Ernst E., Resch K.L., Mills S. et al.(1995). **Complementary medicine - a definition**. *British Journal of General Practice*, Sept 1995:506.
- Foley K.M. (1993). **Pain assessment and cancer pain syndromes**. In Doyle D., Hanks G., MacDonald N. (eds). *Oxford Textbook of Palliative Medicine*. (1993). Oxford University Press, oxford.
- Foundation for Integrated Medicine (1997) **Integrated Healthcare: A Way Forward for the Next Five Years?** Foundation for Integrated Medicine.

- Fulder S.** (1996). *The Handbook of Alternative and Complementary Medicine. 3rd Edition.* Oxford, Oxford University Press.
- GMC** (1997) *The New Doctor.* General Medical Council. London
- Goldbeck-Wood 5.** (1996). Complementary medicine is booming worldwide. *BMJ*, **313**:131-133.
- Graffam 5.** (1990). Pain content in the curriculum – a survey. *Nurse Educator*. **15**(1):20-23
- Grieppe M.E.** (1992). Undermedication for pain: an ethical model. *Advances in Nursing Science*, **15** (1): 44-53
- International Association for the Study of Pain.** (1997). *Curriculum on Pain for Students in Psychology IASP 1997.*
- International Association for the Study of Pain, Task Force on Professional Education.** (1995). *Core Curriculum for Professional Education in Pain.* 2nd edition. **IASP Seattle.**
- International Association for the Study of Pain, Task Force on Pain in the Workplace.** (1995). *Back Pain in the Workplace.* **IASP Seattle.**
- International Association for the Study of Pain. Ad hoc Subcommittee for Occupational Therapy Physical therapy curriculum.** (1994). *Pain Curriculum for Students in Occupational Therapy or physical therapy.* **IASP newsletter, Nov/Dec, 3-8.**
- International Association for the Study of Pam.** (1993). *Pain Curriculum for Basic Nursing Education.* **IASP newsletter, Sept/Oct, 4-6.**
- International Association for the Study of Pain.** (1993). *Proposed Model of Pre-doctoral Curriculum on Pain for Dental Schools.* **IASP newsletter, May/June.**
- International Association for the Study of Pain.** (1990). *Desirable Characteristics for Pain Treatment Facilities.* **IASP Seattle.**
- International Association for the Study of Pain, Pilowsky I.** (1988) *An Outline Curriculum on Pain for Medical Schools.* **IASP Seattle.**
- International Association for the Study of Pain. Ad hoc Subcommittee on University Courses and Curricula.**(1988). *Proposed Curriculum on Pain for Pharmacy Students.* **IASP Seattle.**
- International Association for the Study of Pain.** (1986). *Pain terms. A current list with definitions and notes on usage.* *Pain*, **27.** Supplement 3: s217.
- Johnson T.W** (1997). *Database of Pain Management in the North West.* Compiled by Dr T. W Johnson, Consultant Anaesthetist, Centre for Pain Management, Hope Hospital, Salford, Manchester.
- Kendall N.A.S., Linton Sj., and Main CJ.** (1997). *Guide to Assessing Psychosocial Yellow Flags in Acute Low Back Pain: Risk Factors for long-term Disability and Work Loss.* Accident Rehabilitation & Compensation Insurance Corporation of New Zealand and the National Health Committee. Wellington, New Zealand.
- Kerssens J.J., and Groenewegen PI?** (1990). *Referrals to physiotherapy: The relation between the number of referrals, the indication for referral and the indination to refer.* *Social Science and Medicine*, **30**(7): 797-804.
- Lovell DJ., Walco G.A.** (1989) *Pain associated with juvenile rheumatoid arthritis.* *Paediatric Clinics of North America* **36:** pp.10151027.
- Marcer D. & Deighton 5.** (1988). *Intractable pain: a neglected area of medical education in the UK* *Journal of the Royal Society of Medicine*, Vol **81**:698-700.
- McKenzie I., Gaukroger P, Ragg F!, Brown T.** (1997) *Manual of Acute Pain Management in Children.* Edinburgh, Churchill Livingstone.
- McQuay HJ., Moore RA., Eccleston C., Morley S., A C de C Williams A.** (1997). *Systematic Review of Outpatient Services for Chronic Pain Control.* *Health Technology Assessment*; **1** (6).

- Miser A.W., Dothage J.A., Wesley R.A., Miser J.S. (1987). The prevalence of **pain** in a paediatric and young adult **cancer** population. *Pain* 29:73-83.
- Morley S., Eccleston C., **Williams** A. Systematic review of randomised controlled trials of **cognitive** behaviour therapy and behaviour therapy for chronic pain in adults, excluding headache. *Pain* (in press).
- National Association of Health Authorities and Trusts. (1997). **Binley's Directory of NHS Management**. Beechwood House, Essex.
- National Association of Health Authorities and **Trusts**. (1993). **Complementary Therapies in the NHS. NAHAT**, London.
- National Council for Hospice and Specialist Palliative Care Services, Working Party on Clinical Guidelines in Palliative Care. (1995) **Information for purchasers: Background to available specialist palliative care services**. NCHSPCS.
- National Council for Hospice and Specialist Palliative Care Services, Working Party on Clinical Guidelines in Palliative Care. (1995) **Outcome Measures in Palliative Care**. NCHSPCS.
- National Council for Hospice and Specialist Palliative Care Services, Working Party on Clinical Guidelines in Palliative Care. (1994) **Guidelines for Managing Cancer Pain in Adults**. NCHSPCS.
- NHS Executive South and West R&D Directorate. (1996) **DEC Report No 70. In- patient v. out-patient pain management programmes that adopt a cognitive behavioural approach**. NHS Executive.
- NHS Wales, **CRUG/VFM** (1997) **A Guide to Pain Management**. NHS Wales
- NHS Wales, **CRUG/VFM** (1997) **Acute Pain Management. A Quick Reference Guide**. NHS Wales
- Nottcutt W & Austin J. (1995). **The acute pain team or the pain management service**. *The Pain Clinic*, Vol 8(2):167-174.
- Pain Society, The British and Irish Chapter of the International Association for the Study of Pain. (1997). **Desirable Criteria for Pain Management Programmes**. London.
- Papageorgiou AC., Croft PR, Ferry S., **Jayson M.I.V, Silman A.J.** (1995). Estimating the prevalence of low back pain in the general population: evidence from the South Manchester **backpain survey**. *Spine* 20:1889-94.
- Physiotherapy Pain Association (1997) **Standards for Physiotherapists working in Pain Management Programmes**. Physiotherapy Pain Association.
- Ready L.B. and Edwards WT. (1992). **Management of Acute Pain: A Practical Guide**. **IASP Publications**.
- Royal College of Anaesthetists. (1998). **Guidelines for the use of non-steroidal anti-inflammatory drugs in the perioperative period**. RCA, London.
- Royal College of Anaesthetists. (1994). **Guidance for Purchasers**. RCA, London.
- Royal College of Anaesthetists. (1994). **Specialist Training in Anaesthesia – Supervision and Assessment**. RCA, London.
- Royal College of **General** Practitioners, Chartered Society of Physiotherapy, **Osteopathic** Association of Great Britain, British Chiropractic Association, National Back Pain Association. (1996). **Clinical Guidelines for the Management of Acute Low Back Pain**. **RCGP**, London.
- Royal College of Paediatrics and Child Health, Working Party on the Prevention and Control of Pain in Children. (1997). **A Manual for Health Professionals**. London, BMJ Publishing.
- Royal College of Physicians of London, Association for Palliative Care Unit. (1991). **Palliative Care. Guidelines for Good Practice and Audit Measures**. RCP London.
- Royal College of Surgeons of England and College of Anaesthetists' Commission on the Provision of Surgical Services. (1990). **Report of the Working Party on Pain After Surgery**. RCS, London.

- Royal London Homeopathic Hospital. (1997). **The Evidence Base of Complementary Medicine.** Research Council for Complementary Medicine, London.
- Sanders S.H. (1994). An image problem for pain centres: relevant factors and possible solutions. **APS Bulletin Jan/Feb** 17-18.
- Schechter N.L. (1989) The undertreatment of pain in children: an overview paediatric **Clinics of North America.** **36:pp** 781-794.
- Scottish Office and Health Department. Scottish Health Services Advisory Council. (1994).**The Management of Patients with Chronic Pain.**
- Scottish **Office,** Department of **Health.** (1996). The Provision of Services for Acute Postoperative Pain in Scotland. HMSO, Edinburgh.
- Sykes J., Johnson R., Hanks G.W (1997) ABC of Palliative Care: Difficult pain problems. **BMJ** **315:867-869**
- Symmons D (1997). Personal Communication. Director of ARC Epidemiology Research Unit, Manchester University, Manchester.
- Twycross A., Moriarty A., Betts T.,** (1998) Paediatric Pain Management – a multi-disciplinary approach. **Radcliffe** Medical Press Ltd. **Oxon.**
- Villaire M (1998) National Institute of Health consensus conference confirms acupuncture efficacy. **Alternative Therapies,** Jan, 4; 1. pp 21-30.
- Wells J.C.D.** (1987). The **place** of the pain clinic. **Balliere's Clinical Rheumatology** **1:123-53.**
- Welsh Health Planning Forum (1992). Protocol for Investment in Health Gain, Pain, **Discomfort** and Palliative Care. **Welsh Office** NHS Directorate.
- Williams A. C. de C.** (1993). **NNTs** used in decision-making in chronic pain management. **BMJ,** **306:1687-8.**
- Williams A. C. de C., Richardson PH., Nicholas M.K., Pither C.E., Harding VR., Ridout K.L., Ralphs JA., Richardson I.H., Justins D.M., Chamberlain J.H.** (1996). In-patient versus out-patient pain management results of a randomised controlled trial. **Pain** **66:13-22.**
- World Health Organisation,** Collaborating Centre for Palliative Cancer **Care.**(1997). Looking Forward to Cancer Pain Relief for All. **International** Consensus on the Management of **Cancer** Pain. **CBC.** Oxford.
- World Health** Organisation. (1996). **Cancer Pain Relief.** 2nd Edition, with a guide to opioid availability **WHO,** Geneva.
- World Health Organisation** Expert Committee. (1990). **Cancer Pain Relief and Palliative Care.** **WHO** Geneva. Technical Report Series 804.
- World Health Organisation.**(1989). **Palliative Cancer Care.** Policy statement based on the recommendations of a **WHO** consultation. **WHO,** Copenhagen.
- World Health Organisation.**(1986). **Cancer Pain Relief** **WHO,** Geneva.
- Zacharias M. and Watts D.** (1998). Pain relief in children: doing the simpler things better. **BMJ,** **316:1552.**
- Zech D.FJ., Grond S., Lynch J., Hertel D., Lehmann K.A.** (1995). Validation of **World Health** Organisation guidelines for **cancer** pain relief. A 10 year prospective study. **Pain,** **63: 65-76.**



Appendix A

Members of the CSAG Pain Committee, Sounding Board and Research Team

CSAG Pain Committee:

Professor Alastair Spena CBE (Chairman),* Professor of Anaesthetics, **Royal Infirmary** Edinburgh.

Professor John Alexander-Williams (Vice-Chairman),* Professor of **Gastrointestinal** Surgery, Birmingham.

Professor Iora Finlay, Medical Director, **Holme Tower** Marie Curie Centre, Cardiff

Dr Ann Goldman, Consultant in Paediatric Palliative Care, Great Ormond Street Hospital for Children, London.

Dr Douglas Justins, Consultant in Pain Management and Anaesthesia, St Thomas' Hospital, London.

Professor Chris Main, Clinical Director Behavioural Medicine, Hope Hospital, Salford.

Dr Geoffrey Morgan,* General Practitioner, Cardiff.

Dr Scott Murray, Lecturer, University Department of **General** Practice, Edinburgh.

Dr David Peters, **General** Practitioner, Centre for Community and Primary Care. London.

Dr John Scadding, Consultant Neurologist, National Hospital for Neurology and Neurosurgery, London.

Dr Kate Seers, Head of Research, RCN Institute, Oxford.

Dr Jennifer Webb, Consultant in Public Health Medicine, Lothian Health Board Edinburgh.

* CSAG members

CSAG Research Support team

Dr John Newton

Dr Elizabeth West

Ms Erica Ison

Ms Vivianne Crombie

CSAG Sounding Board

Professor Peter Croft; Professor of Epidemiology, **Keele** University; School of Postgraduate Medicine.

Dr Iain Ctombie, Reader in Epidenuology, University of Dundee.

Professor Bryn Davis, Dean of Nursing Studies, University of Wiles College of Medicine, Cardiff.

Dr Jacqueline Filshie, British Medical Acupuncture Society.

Dr A O Frank, British Society of Rehabilitation Medicine.

Professor Mike Harmer, Professor of Anaesthesia, **University Hospital** of Wales, Cardiff.

Dr Susan King, British Chiropractic Association.

Dr Henry McQuay, Clinical Reader in Pain Relief; Pain Relief Unit, oxford.

Mrs Heather Muncic, Association of Chartered Physiotherapists.

Dr T K Priestman, Royal College of Radiologists.

Dr Charles Sears, General Practitioner, Salisbury.
Professor Lorraine N Smith*, Professor of Nursing and Midwifery, Glasgow University.
Dr Elizabeth Thompson, The Faculty of Homeopathy.
Dr John Toby*, Chairman of Council, Royal College of General Practitioners, London.
Mr Phil Wiffen, Regional Pharmaceutical Advisor, Pain Research Unit, oxford.
Mr John L Williams*, Dean of the Faculty of Dental Surgery.
Dr Chris Worth, Director of Public Health, Calderdale and Kirklees Health Authority.

* CSAG Members

Commissioned Research Team

University of Manchester School of Epidemiology & Health Sciences

Dr Gavin Thorns
Professor Stuart Donnan
Ms Gretl McHugh
Dr Selwyn St Leger
Ms Lynn Smith
Ms Claire Smith
Dr Anne Fielder
Ms Emma Tavender

University of Leicester Department of Anaesthesia and Leicester Royal Infirmary

Professor David Rowbotham
Dr Beverly Collett
Ms Karla Toyc
Ms Louise Wilcox

Research Collaborators

Professor Brian Pollard, Manchester Royal Infirmary.
Dr Deborah Symmons, Arthritis and Rheumatism Council.
Dr Max Fryer, Royal Preston Hospital.

Research Subcontractors

Dr Chris Eccleston, Royal National Hospital for Rheumatic Diseases.
Professor Chris Main, University of Manchester.
MS Eloise Carr, Bournemouth University.
Professor Patricia Lyne, University of Wales.