FACULTY OF
PAIN MEDICINE
of the Royal College of Anaesthetists

Gap Analysis of UK Pain Services 2025

Contents

Plain English summary

Pain which lasts longer than three months is called chronic pain. It is a disabling and distressing condition affecting many people and is complex and difficult to treat.

Within the UK, the NHS provides a specialised service for people who are experiencing chronic pain. Most of this care takes place in hospitals, with care led by a consultant who specialises in treating pain, and can also involve nurses, physiotherapists, psychologist, and GPs who have an interest in treating people with chronic pain. The Faculty of Pain Medicine (FPM) is the professional body responsible for the training, assessment, practice and continuing professional development of specialist medical practitioners involved in the management of pain in the UK.

During the covid pandemic, pain services were put under great strain. After the pandemic, the FPM commissioned a working group to evaluate the state of pain services across the UK. The scope of the work was to compare the service currently being delivered against the level of care which should be achieved, the 'gold standard' of care defined by the FPM in its document *Core Standards for Pain Management Services in the UK second edition.*

The working group formulated a survey covering 21 key areas, or standards, and sent this to all members of the FPM. Responses were received from 97 different clinical units across the UK, including primary, secondary and tertiary care. Respondents could state if a standard was 'met', 'partially met' or 'unmet'.

No single standard was met by all sites, with four key areas having less than 25% of respondents stating that their clinical unit met the standard. These were for the areas of research and development, the management of outcome data (examining the outcomes of treatments), pain services for children, and provision of cancer pain services. Other areas which were found to need national attention include providing the support of psychologists within the service, providing training for doctors and pain specialists, improving access to specialist treatments which act directly on the nerves to alleviate pain (neuromodulation), and providing online information and consultation facilities for patients.

Executive summary

Pain is a useful defensive sensation designed to protect us. However, when pain becomes chronic, it outlives its utility and becomes a disabling and distressing condition. Chronic pain is now categorised as a disease in the latest World Health Organisation's ICD 11 (International Classification of Disease).[1] Pain is one of humanity's oldest medical problems and yet remains one of the most complex and difficult conditions to treat or manage and represents a major public health issue.[2, 3]

In the United Kingdom (UK), multi-disciplinary services for patients experiencing chronic pain are currently commissioned by the NHS as specialised services. Pain management care is delivered by a multiprofessional team including medical consultants who specialise in pain medicine, specialist nurses, specialist physiotherapists, specialist psychologists, and GPs who have an interest in treating people with chronic pain. Most secondary and tertiary care specialist pain services include a medically qualified consultant who has undertaken training in pain medicine. The Faculty of Pain Medicine is the professional body responsible for the training, assessment, practice

and continuing professional development of specialist medical practitioners involved in the management of pain in the UK.[4]

Pain services across the UK were put under great strain during the covid pandemic. The 'Gap Analysis working group' (GAP group) was commissioned by the Board of the Faculty of Pain Medicine (FPM) post covid in November 2021 to evaluate the state of pain services across the UK. The GAP group's remit was to establish the gap in pain services (structure, process, outcomes) between the services delivered on the ground as measured against the 'gold standard' that was laid out in the published FPM document *Core Standards for Pain Management Services in the UK second edition* (CSPMS UK).[5] The working group consisted of six medically qualified specialists in pain medicine, a doctor training in pain medicine, two researchers and an administrator. A multidisciplinary cross speciality clinical reference group was formed to provide inputs to this project. A GAP survey questionnaire covering 21 domains extracted from the CSPMS was developed. The respondents to the survey were medically qualified specialists in pain medicine (members of the FPM) and allied health professionals working in pain services across the UK.

This report is a 'Gap Analysis' (GAP) survey of the gap that exists between the 'gold standard' and the current state of delivery of pain management services (Structure, Process, Outcomes). The secondary objective of this GAP report was to evaluate the survey results and develop quality performance metrics.

There were 164 respondents to this GAP analysis from 97 individual clinical sites delivering pain services in the UK. The majority of respondents worked in secondary care (74.23%), followed by tertiary care (22.68%) and finally primary care (3.09%).

The respondents identified themselves as primary (community based), secondary (hospital based) and tertiary (with higher pain services such as paediatrics, neuromodulation etc).

The survey included questions pertaining to 21 standards. Overall, of all responses from the 97 respondents to the 21 standards, 58.22% of all pooled responses stated these standards were fully met, 19.65% were partially met, 15.08% were unmet with the rest being classed as 'don't know/didn't answer' (see Figure 1).

Four aspects of chronic pain services need urgent redress. These are the standards where more than 25% of the respondents indicated that these were unmet in their services: provision of paediatric pain services (38.1% unmet/ 23.7% partially met), provision of cancer pain services (27.8% unmet/36.1% partially met), research and development (42.3% unmet/ 19.6% partially met), and outcome data management support (33% unmet/ 21.6% partially met) (see Figure 2).

Other key aspects of pain services delivery where attention should be focussed nationally include the provision of psychological support services within chronic pain (unmet 16%/ 20.6% partially met), pain training (unmet 17.2%/ 11.3% partially met), provision of neuromodulation services (unmet 13.4%/18.6% partially met) and information website/remote consultation facilities (unmet 13.9%/ 26.8% partially met). A summary of the standards and findings can be found in Table 1.

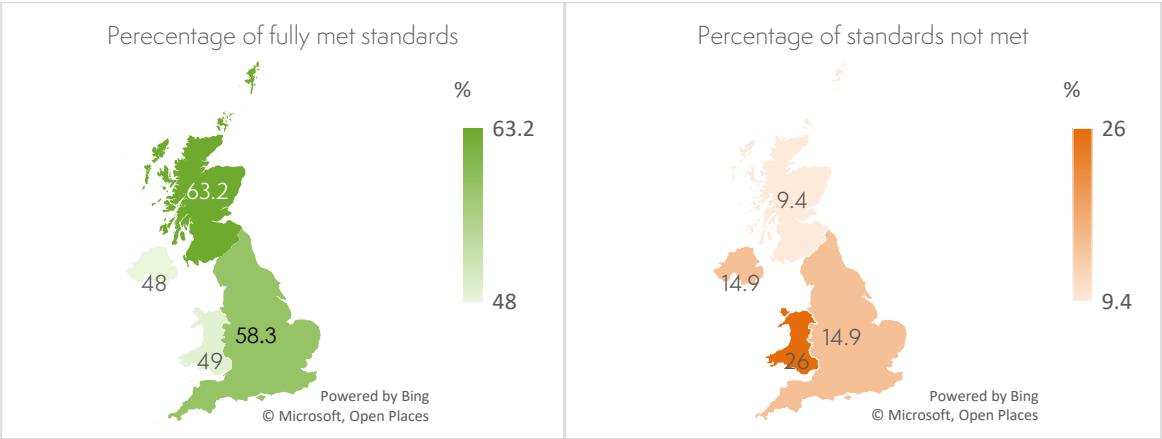


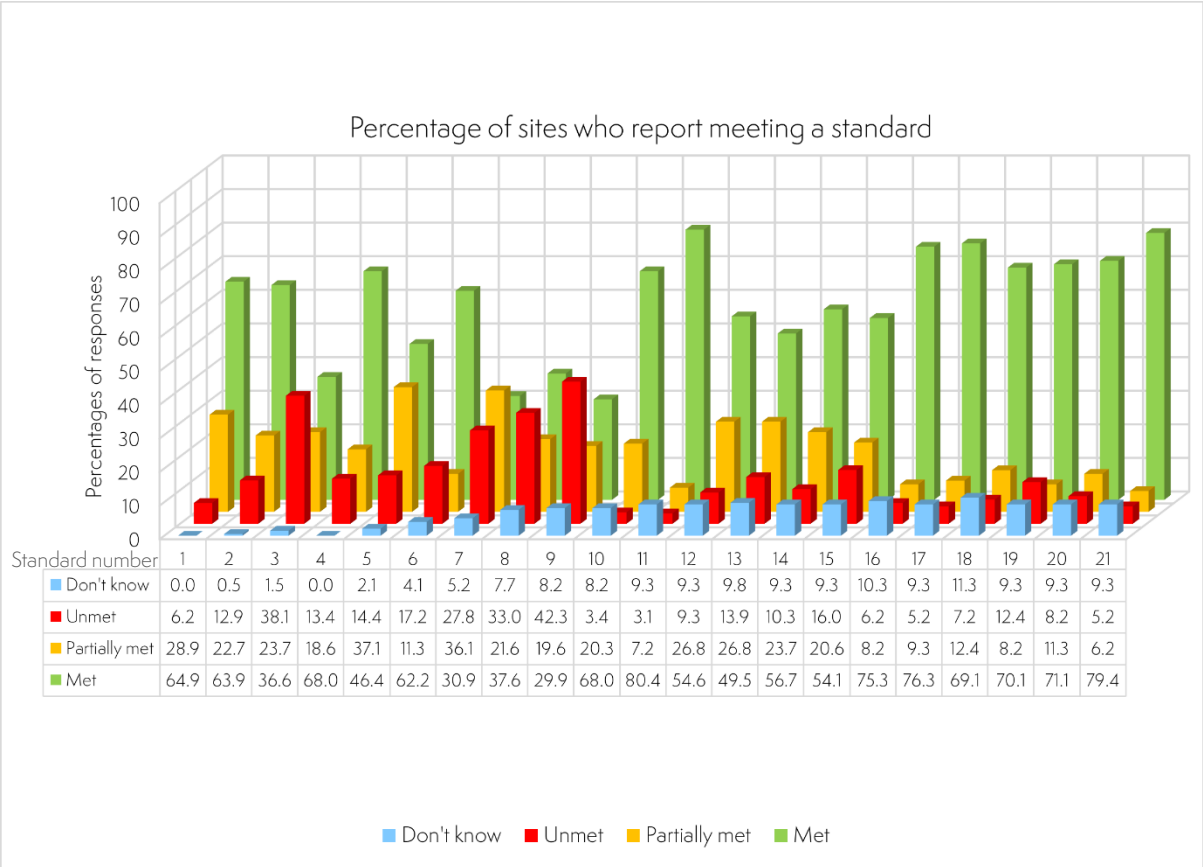
Figure 1: *Heat maps showing the percentage of pooled responses to standards questions answered as fully met or completely unmet across the UK*

Standard		% met	% partially met	% unmet	% Don't know/ didn't answer/ NA
1	Medical involvement	64.9	28.9	6.2	0.0
2	Waiting list times	63.9	22.7	12.9	0.5
3	Paediatric pain service	36.6	23.7	38.1	1.5
4	Neuromodulation service	68.0	18.6	13.4	0.0
5	Pathways for chronic pain	46.4	37.1	14.4	2.1
6	Pain training	62.2	11.3	17.2	9.3
7	Cancer pain service	30.9	36.1	27.8	5.2
8	Outcome data management support	37.6	21.6	33.0	7.7
9	Research and development	29.9	19.6	42.3	8.2
10	Consultation facilities	68.0	20.3	3.4	8.2
11	Safeguarding	80.4	7.2	3.1	9.3
12	Access to specialised pain management services	54.6	26.8	9.3	9.3
13	Information website and remote consults	49.5	26.8	13.9	9.8

14	MSK (musculoskeletal) services	56.7	23.7	10.3	9.3
15	Mental health support	54.1	20.6	16.0	9.3
16	Medical consultants – education, appraisal and revalidation	75.3	8.2	6.2	10.3
17	MDT working	76.3	9.3	5.2	9.3
18	In-hospital complex pain service	69.1	12.4	7.2	11.3
19	Physiotherapy	70.1	8.2	12.4	9.3
20	Pain management programme (PMP)	71.1	11.3	8.2	9.3
21	Interventional pain procedures	79.4	6.2	5.2	9.3

Table 1: *Summary of standards and findings*

This is the first comprehensive report of the state of the UK pain services since 2012/2013 when the National Pain Audit (NPA) was performed. There are areas of concern nationally in the delivery of pain services (highlighted above) that need to be evaluated by the FPM Board and a roadmap for improvement developed.



Standard number	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
Don't know	0.0	0.5	1.5	0.0	2.1	4.1	5.2	7.7	8.2	8.2	9.3	9.3	9.8	9.3	9.3	10.3	9.3	11.3	9.3	9.3	9.3
Unmet	6.2	12.9	38.1	13.4	14.4	17.2	27.8	33.0	42.3	3.4	3.1	9.3	13.9	10.3	16.0	6.2	5.2	7.2	12.4	8.2	5.2
Partially met	28.9	22.7	23.7	18.6	37.1	11.3	36.1	21.6	19.6	20.3	7.2	26.8	26.8	23.7	20.6	8.2	9.3	12.4	8.2	11.3	6.2
Met	64.9	63.9	36.6	68.0	46.4	62.2	30.9	37.6	29.9	68.0	80.4	54.6	49.5	56.7	54.1	75.3	76.3	69.1	70.1	71.1	79.4

Figure 2: *Percentage of all sites response to meeting a standard*

We wish to thank the respondents from across the UK for giving us their valuable time for this GAP survey, the working party including the administrators for keeping us on track over the last 2.5 years on this project and the FPM Board for commissioning and supporting this project.

Signed

Dr Dev Srivastava

On behalf of the GAP working group.

Key messages:

1. There is a need to establish a directory of Tier 1, 2 and 3 services within the UK
2. No standard was fully met by all pain services, with large regional and national variation
3. The following areas need urgent attention across the United Kingdom:
    a) Provision of paediatric pain services
    b) Provision of cancer pain services
    c) Provision of outcome data (PROMS) support to pain services
    d) Provision of support for research and innovation to pain services
    e) Increased support of psychological services and PMP access

Membership of the working party

The GAP Analysis working group consisted of the following members:

Dr Dev Srivastava – Chair of the GAP working group. Consultant in Anaesthesia and Pain Medicine, Raigmore Hospital, Inverness.

Dr Suzanne Carty, Consultant in Anaesthesia and Pain Medicine, Somerset.

Dr Matthew Brown, Consultant in Pain Medicine, The Royal Marsden Hospital, London. Honorary Associate Faculty, The Institute of Cancer Research, London.

Prof Sailesh Mishra, Consultant in Anaesthesia and Pain Medicine, Newcastle Upon Tyne

Dr Alice Rose Hodges, Anaesthetic Trainee ST5 with an interest in Pain Medicine, Somerset.

Dr Beatrice Bretherton – Researcher, Faculty Pain Medicine, London.

Ms Sue Copley – Researcher, Faculty Pain Medicine, London.

Mrs Emmy Kato-Clarke – Standards Manager, Faculty Pain Medicine, London.

Ms Lucy Southee, Patient Voice, Faculty Pain Medicine, London.

Dr Ganesan Baranidharan, Vice Dean Faculty of Pain Medicine, Consultant in Pain Medicine, University Hospital, Leeds.

Special thanks are due to Dr Lorraine de Gray, Dean of Faculty of Pain Medicine and Mr James Goodwin, Associate Director of Faculties, Royal College of Anaesthetists, London, for their invaluable support for this project.

Table of figures

Report

Introduction

Chronic pain is an important public health issue with an estimated 7.9 million people in the United Kingdom experiencing moderate to severe pain.[6] Chronic pain is a complex, multidimensional condition that is associated with high economic costs and a significant burden on healthcare and social support systems.[7] Due to the resulting disability, chronic pain can cause job loss, financial challenges, mood and cognitive disorders and social isolation.

The COVID-19 pandemic exacerbated the existing issues in pain management service delivery, making the delivery of effective pain management more challenging.[8] In turn, this was further compounded by the challenges faced by the NHS regarding its capacity and ability to deliver safe and effective elective care during the pandemic and recovery. This situation impacted on all clinical services in the UK, including pain medicine.

In a survey conducted in May 2020 by the Faculty of Pain Medicine (FPM) 25% of clinicians reported their services had been fully suspended and there was a significant shift towards telemedicine. Furthermore, 90% of units had stopped all procedure lists and pain staff were re-deployed to support other services.[9] In a survey conducted in August 2020, only 20% of respondents indicated their pain services had returned to full activity.[10] Only half reported that all pain team members were back in their normal roles and just under 10% indicated they were not at work due to the psychological consequences of COVID-19, physical illness or the need to self-isolate.[10] The survey further highlighted that in-hospital pain services (IHPS) were heavily impacted by the COVID-19 pandemic with only 50% of respondents reporting that after March 2020 IHPS units across the UK were providing 'minimal care'.

The continuing development of the specialty of pain medicine has also been impacted by the pandemic. A survey of pain medicine trainees in early January 2021 revealed that 35% of chronic pain services in the UK had stopped completely and 30% of higher and advanced pain trainees had been redeployed.[9] This therefore significantly impacted pain training. Free text comments from respondents suggested there was very limited training in areas where services were still running, most interventions were on hold and there were few face-to-face consultations.[9] The survey also highlighted that patients and pain specialists had to adapt to more remote consultations, there were limitations on multidisciplinary group sessions and there was a marked reduction in the provision of pain interventions.

The challenges associated with the COVID-19 pandemic are ongoing and continue to impact the provision of pain medicine services in the UK, particularly when re-establishing activities. Indeed, the FPM published guidance on the resumption of pain services following disruption by the pandemic and highlighted five key considerations to help achieve a reset locally.[11] These included:

- Prioritisation, triage and stratification
- Assessment
- Treatment
- Social distancing and PPE
- Supportive professional activities and education

As the UK and NHS reverse the reduction in clinical services in a safe and timely manner and learn to live with COVID-19, this represents a prime moment to assess the current state of pain services in the UK. Such an

assessment will also help to address the future, providing the data required to develop national and local plans to achieve universal provision of high-quality pain services.

Gap analysis (GA) is a reporting process used in business for service improvement. GA involves the comparison of actual performance with desired performance and the subsequent development of an action plan. The FPM Board in November 2021 commissioned a working party to perform a GA of pain services across the UK. The working party was tasked to first develop a survey questionnaire to compare actual performance of the delivery of pain medicine services with the 'gold standard' (the *Core Standards for Pain Management Services in the UK second edition* (CSPMS UK)) developed by the FPM.[5] The CSPMS is a document that lays down the 'gold standards' for pain service structure, processes and outcomes for the UK.

The GA project had two aims:

1. To map the current performance of pain service delivery (Structure, Process, Outcomes) with respect to the 'gold standard' (CSPMS).
2. To develop quality performance metrics for assessing the performance of pain services nationally in the longer term.

Methods

This project was conducted by a working group established by the FPM who worked with relevant stakeholders including local pain champions throughout the duration of the project. The project working party consisted of Dr Dev Srivastava, Dr Suzanne Carty, Dr Matthew Brown, Prof Sailesh Mishra (all consultants in pain medicine), Dr Alice Hodges (specialist registrar anaesthetics), Dr Beatrice Bretherton, Ms Sue Copley (researchers) and Mrs Emmy Kato-Clarke (FPM manager). The corresponding members included Dr Ganesan Baranidharan and Dr Paul Wilkinson. At specific points over the duration of the project, pain patients and/or patient organisations and other relevant stakeholders were involved to ensure the project met the needs and preferences of beneficiaries. A multi-disciplinary, cross-speciality clinical reference group including other statutory organisations was formed, to provide inputs on this project to the working party.

The Survey

The survey adopted the GA method which is a process whereby actual performance is compared with desired performance. This method helps to identify which areas can be improved which would enable the development of an action plan on two fronts:

1. Strategic: focus on the overall organisation of Pain Services in the UK and the planning and execution at that level.
2. Operational: focus on the day-to-day work of a team or department.

A GA can help make the case to balance the allotment and integration of resources from their current allocation level closer to the desired standard. These resources can be time, money, material or human resources. It was intended that by using this method in a survey it would generate an FPM-related prompt for structured local reflection by each pain service with identification of local gaps and action plans for improvement. Furthermore, it would provide a snapshot of issues that impact pain services nationally, allowing the FPM to make a case to commissioners on national priorities in improving pain management services.

The first step in this project was the development of the GA survey questionnaire by the working group. To do this, the domains for which the current and desired state of pain services would be assessed were voted for in two Delphi rounds (where iterative rounds of anonymised responses to the initial ideas are obtained in order to reduce the range of responses and achieve an expert consensus[13, 14]) by the FPM's Professional Standards Committee. To assess the operational domains of the state of pain services in the UK, the second edition of the FPM's CSPMS[5] was used. This was considered the 'gold standard' (desirable state) in each domain. For in-hospital pain services, the Royal College of Anaesthetists' (RCoA) Guidelines for the Provision of Anaesthetic Services (GPAS) document formed the basis of assessment domains.[12] Additional domains pertaining to adapting to the COVID-19 pandemic were also incorporated.[11] The final survey comprised the questions in Appendix A. The questions covered a total of twenty-one domains. The questions which related to the CSPMS standards were rated as met, partially met or unmet and included a free-text comments box. In questions where relevant, a not applicable option was also offered.

Respondents

The GA questionnaire was sent to all FPM members whose contact details were held by the FPM. FPM members work in the speciality of pain medicine; recipients of the questionnaire were asked to disseminate the survey to members of their teams when appropriate. This method was thought to be most suitable in terms of the practicality of obtaining responses and also addressing the needs of FPM members who often are leads or work in the pain services.

The working party prepared a list of local champions and incorporated the support of Regional Advisors in Pain Medicine to encourage members to respond to the questionnaire. The GA questionnaire development process is highlighted in Figure 3 below.

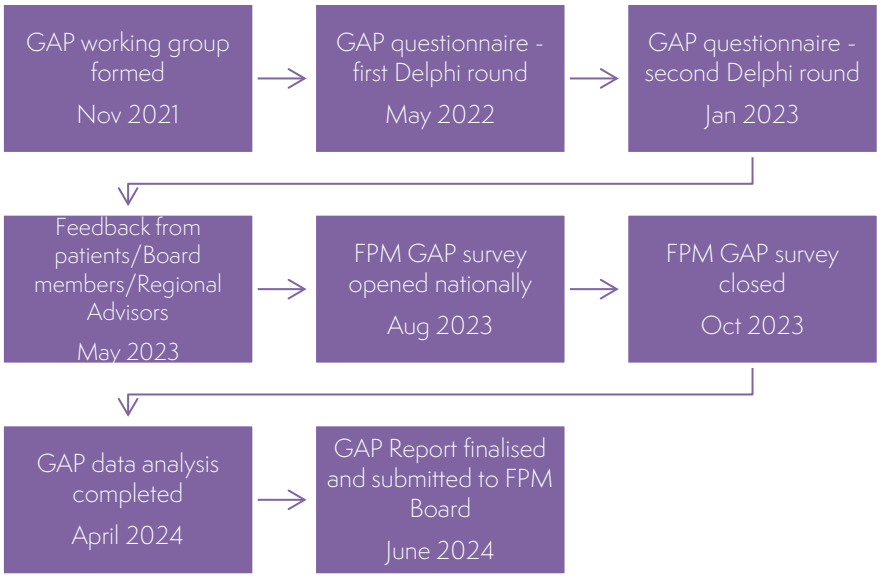


Figure 3: *The GAP analysis process with key dates/ timelines*

Data collection

The final survey was disseminated using Survey Monkey. Nine months prior to the survey, the GA project was presented to the Regional Advisor's meeting at FPM, London. All FPM educational events through 2022/2023 highlighted/advertised the project. The Dean of the FPM encouraged the members to participate via her

communications and an article on the GA project was published in the FPM newsletter *(Transmitter*). Six to eight weeks prior to the survey, FPM members and services across the UK were contacted by email and asked to set aside time in their diaries in the next six-eight weeks along with their teams/managers to complete the survey.

The GA survey was sent out to the FPM members on 01 August 2023 and the survey closed on 26 October 2023. Additionally, the survey was available for members to complete on the FPM website (https://fpm.ac.uk/standards-guidelines/gap-analysis). Local champions were encouraged to request their colleagues to participate in the GA survey. Two reminders by email/telephone were made to prompt the pain champion to complete the survey.

Data analysis

Quantitative data

Quantitative data were initially cleaned to screen for incomplete responses and multiple responses from a single site. All data were scrutinised and discussed by Dr Srivastava, Dr Carty and Ms Bretherton, and a decision made about inclusion in the study. This resulted in the development and use of the following discrimination algorithm:

1. Tiers in each location were scrutinised and the correct tier of the pain service was counted. For example, there could be two pain services in a region, one could be a Tier 2 service in a district general hospital and the other a Tier 3 service in a tertiary hospital. Respondents from Scotland, Northern Ireland and Wales have a slightly different nomenclature of services. For the purposes of this survey, we allocated the responses to one of the three NHS England tiers for uniformity.
    a. Tier 1 – Community service
    b. Tier 2 - Secondary care service
    c. Tier 3- Tertiary service
2. If there was more than one response from a location but from different tiers, these responses were counted separately.
3. If there was more than one response from the same location, tier and occupation, and one or more responses were partially filled, the most complete was taken and the partially completed response(s) excluded.
4. If there was more than one response from the same location and tier and the responses were comparably completed, the consultant clinical lead response was counted.

Following data cleaning, counts and frequencies were generated in Excel pivot tables.

Free text responses

Free text responses from all respondents (regardless of location, tier and occupation) were analysed. Each free text response underwent thematic analysis, where the key themes for each free text response were characterised. This thematic analysis was performed on each standard's key themes and were then inputted into a word cloud (https://www.jasondavies.com/wordcloud/) with the following settings: Archimedean spiral, n scale, 5 orientations from –90° to 90°, 250 words, to create a single word cloud, which was then downloaded as a .SVG file and converted to a .PNG file.

Results

Responses to the questionnaire were returned by 164 respondents from 102 different sites across the UK. Twenty-three returned questionnaires were devoid of answers beyond role and site information and the first three responses only, these were deleted from the analysis. Where sites had multiple respondents, a single respondent from each site was used to provide the information; where possible this was the consultant clinical lead, or the most senior clinician by role with the most complete responses. This resulted in responses from 97 sites; 76 responses from England (including one from the Isle of Man and one from private practice), 14 from Scotland, 4 from Wales and 2 from Northern Ireland. One response was coded as "UK based", as it reflected care provided by the Ministry of Defence (MoD). While this site is included in the 'All of UK Sites' data, it is not represented as a single site in the charts below (see Figure 4). The regions within the UK were not uniformly represented, ranging from 24 locations within the South of England commissioning region, to 8 locations from the Midlands and East of England commissioning region (hereafter referred to as Midlands only, to avoid confusion with the East of England commissioning region), and no commissioning body from Scotland, Wales or Northern Ireland having more than 3 locations identified. Most responses were from consultant in pain medicine and/or anaesthesia, with 11 responses from specialist allied healthcare professionals, psychologists, specialist trainees or GPs with special interest.

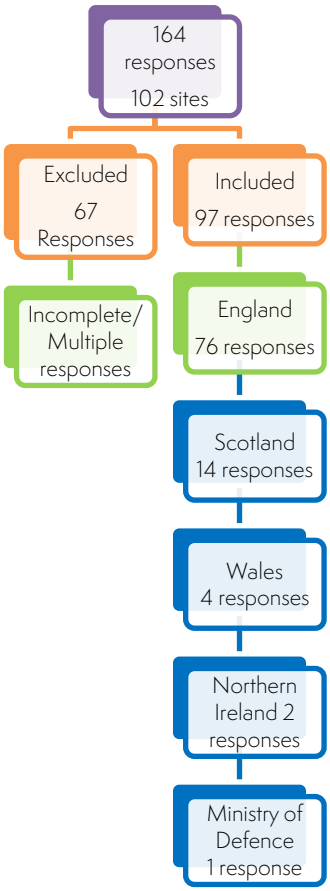


Figure 4: *Inclusion and exclusion process (responses) for the Gap Analysis*

Most responses (72/97) were from sites who said they provided Specialist Pain Management Service (Tier 2), with 22/97 responses from highly specialist pain management services (Tier 3) and the remaining 3 responses from pain management service in the community (Tier 1) (See Figure 5). All free text comments from all respondents were included in the qualitative thematic analysis.

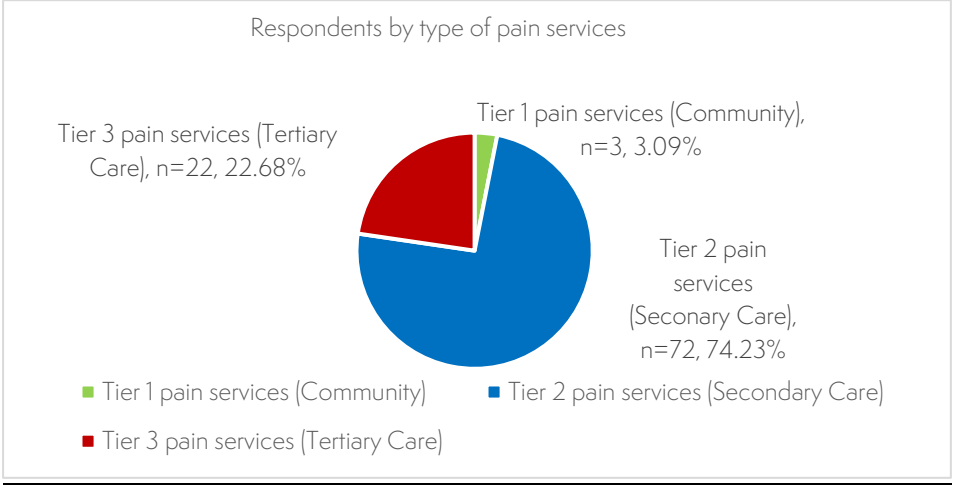


Figure 5: *Respondents by the Tier of pain service (those included)*

Overall compliance with standards

For all standards, pooled responses denoted an overall compliance rate of 58.22%, with 19.65% partial compliance and 15.08% of responses stating the standard in question was unmet (see Figure 6).

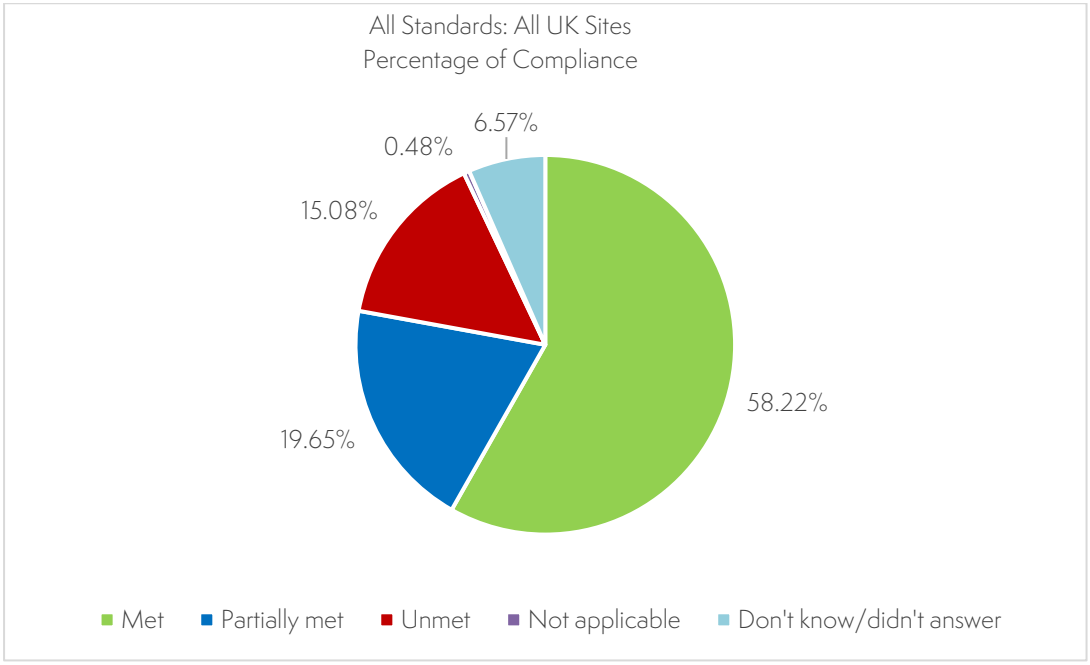


Figure 6: *Percentage compliance with standards*

The compliance rates of individual countries can be seen below, in Figure 7. See also Appendix B for further graphical representation.

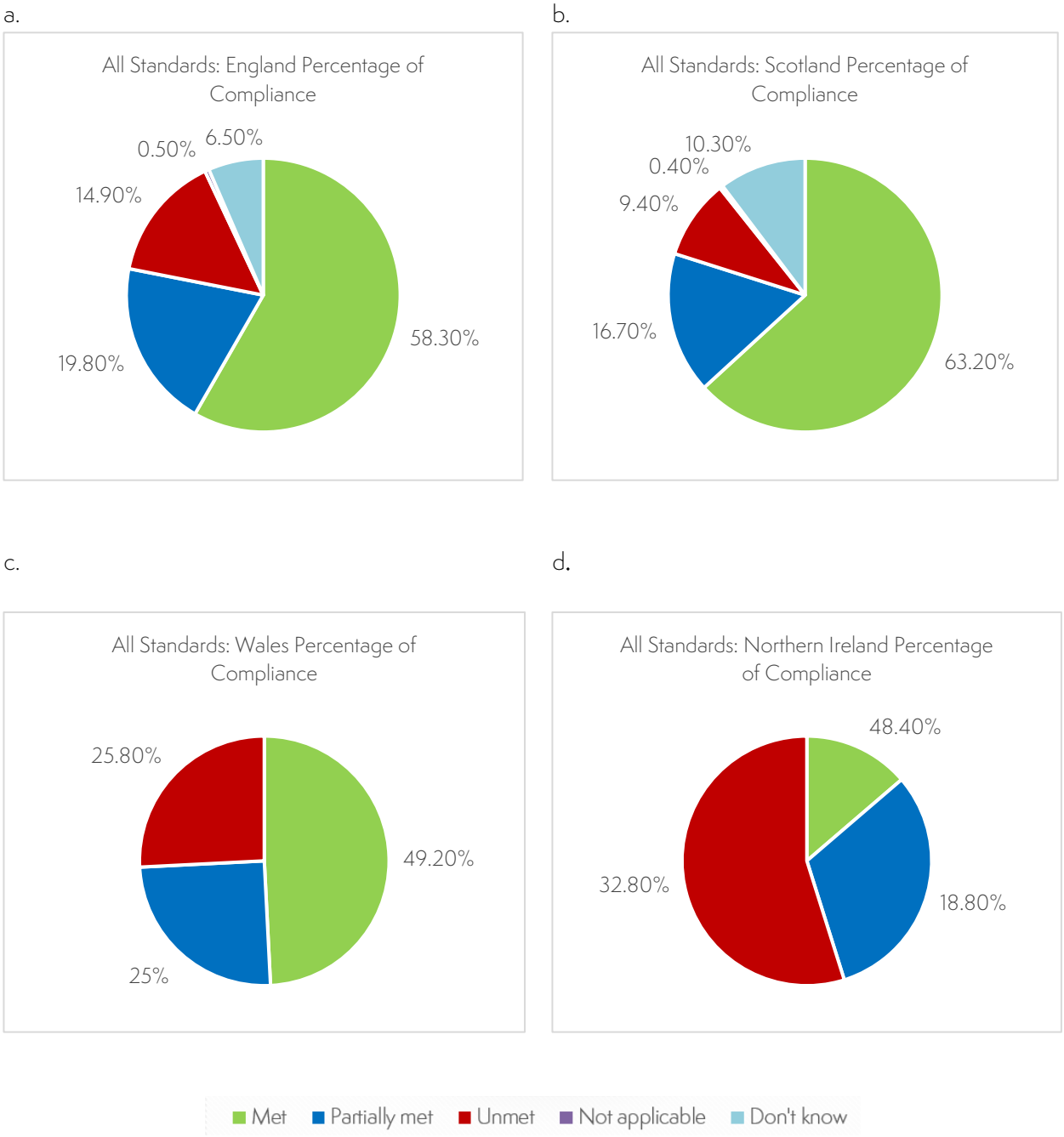


Figure 7: *Percentage compliance with standards in England (a), Scotland (b), Wales (c) and Northern Ireland (d)*

Compliance with all standards was also reduced to the regional level where there were sufficient sites in a commissioning region to give an overall picture – only England had more than five sites per commissioning body (see Figure 8).

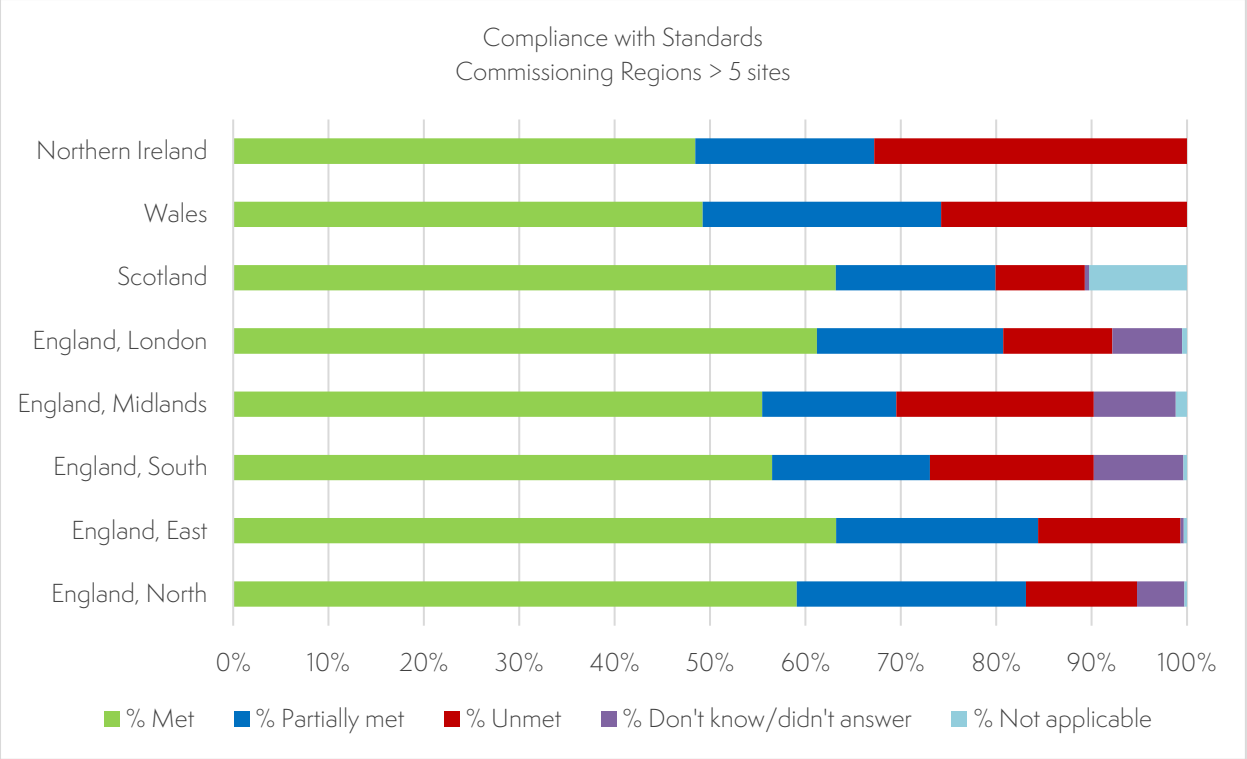


Figure 8: *Percentage compliance with standards according to commissioning region*

Each standard was then assessed separately.

Standard 1: Medical Involvement, Chapter 3.3

Standard 1 was addressed in question 3:

Q3: Safe delivery of all clinical services demands that they are commissioned to include medical involvement within the care pathway. The scope and place of medical involvement is clearly defined for each pain management service, including routes of accountability.

The standard was deemed as met throughout the UK by 63/97 respondents (64.95%), with 28/97 respondents indicating that it was partially met (28.87%) and 6/97 stating unmet (6.19%), five of which were in England and one in Scotland. By country, 67.11% reported met in England (51/79), 64.29% in Scotland (9/14), 50% in Wales (2/4) and 50% in Northern Ireland (1/2, see Figure 9).

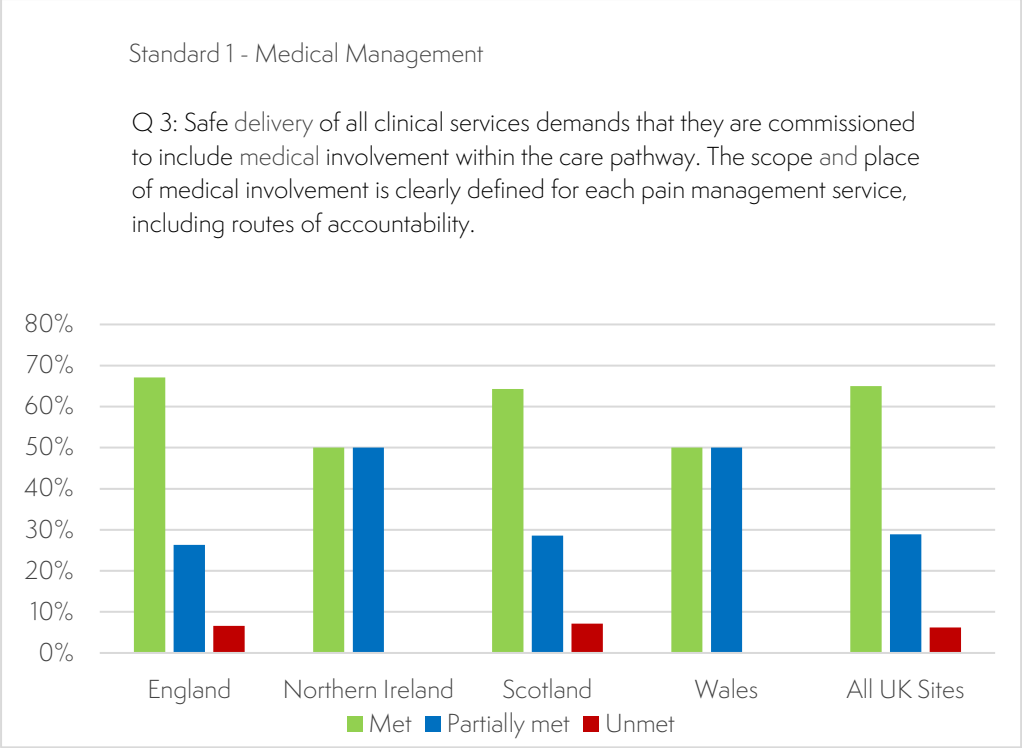


Figure 9: *Percentage compliance with standard 1 (medical involvement)*

Within England, the East of England commissioning region had the highest level of services reporting that the standard was met (88.89%) with the North of England commissioning region the lowest, having 59.09% of sites stating the standard was met. All sites reporting the standard was unmet were based in the South of England commissioning region. Other countries had too few sites per region to make any meaningful comparisons. More detailed data about individual regions can be found in Appendix C.

Within the whole of the UK, the standard was met by 66.67% of Tier 2 services (48/72), with Tier 3 services meeting the standard in 63.64% of sites (14/22), and Tier 1 services reporting it was met in 33.33% of sites (1/3).

A key theme from the free text responses for this standard was consultant input, whether in the form of consultant-led pain clinics, MDT meetings, triaging or ward rounds with clearly defined medical involvement and responsibility. However, other respondents acknowledged there was an inconsistent and limited medical provision in some cases. For instance, non-medically qualified staff were required to request scans, prescribe drugs and make decisions under a named consultant who was not expected to be available for the clinics. Long waiting times (e.g. two years with no assessment) were also noted by respondents together with an interventionist approach prior to the exploration of conservative management options.

Standard 2: Waiting list times, Chapters 3.1 and 3.2

Waiting list times were addressed in questions 4 and 5.

Q4: The service collects information on waiting times to both first appointment and treatment.

82.54% of all UK sites reported that information on waiting times to first appointment and treatment was collected, with a further 9.28% reporting the standard was partially met. 5.15% of sites reported the standard was unmet, and

the remaining 1.03% (a single site) did not offer a response. 82.89% of sites in England reported they fully met the standard (63/76). For Scotland, this figure was 92.86% (13/14), for Wales it was 100% (4/4) and 50% in Northern Ireland (1/2). The standard was unmet by 5.26% of English reporting sites (4/76) and 50% in Northern Ireland (1/2, see Figure 10).

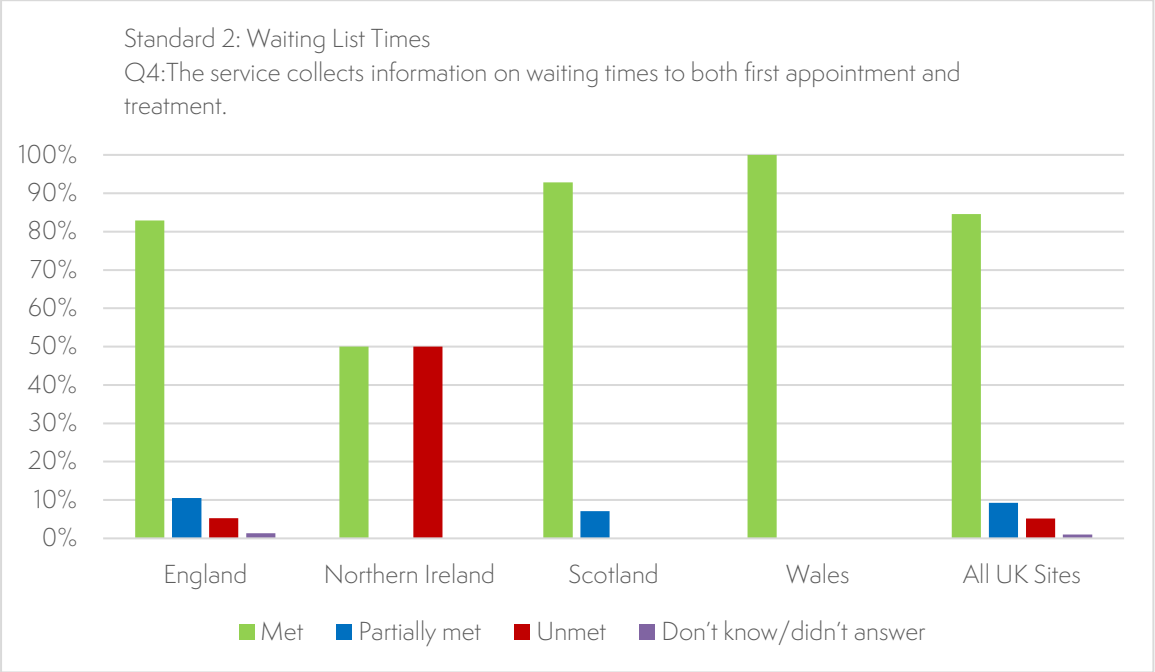


Figure 10: *Percentage compliance with standard 2 for the collection of information on waiting times to both first appointment and treatment*

Every site within East of England commissioning region reported that information on waiting times was collected (9/9), with London reporting the standard was met by 66.67% of sites. Midlands had the highest English level of sites reporting unmet (12.5%, 1/8). Within Scotland, only NHS Highlands reported partially met, other sites all reported information on waiting times for first appointment and treatment was collected. Tier 3 reported 90.91% of sites met the standard, 81.94% of Tier 2 sites, and all Tier 1 sites within the UK.

Q5: The service manages patient flow through service pathways, with managers and commissioners, to ensure that long waiting lists do not develop.

Only 43.3% of all sites reported this was met (42/97), with 36.08% reporting their sites partially met the standard. 20.26% of sites reported their sites did not manage patient flow to ensure long waiting lists did not develop (20/97). The highest rates of sites reporting met was in Wales (75%, 3/4), whereas both sites in Northern Ireland reported it was unmet. Only 39.47% of sites in England reported it was met (30/76), with 23.68% reporting it was unmet (18/76, see Figure 11).

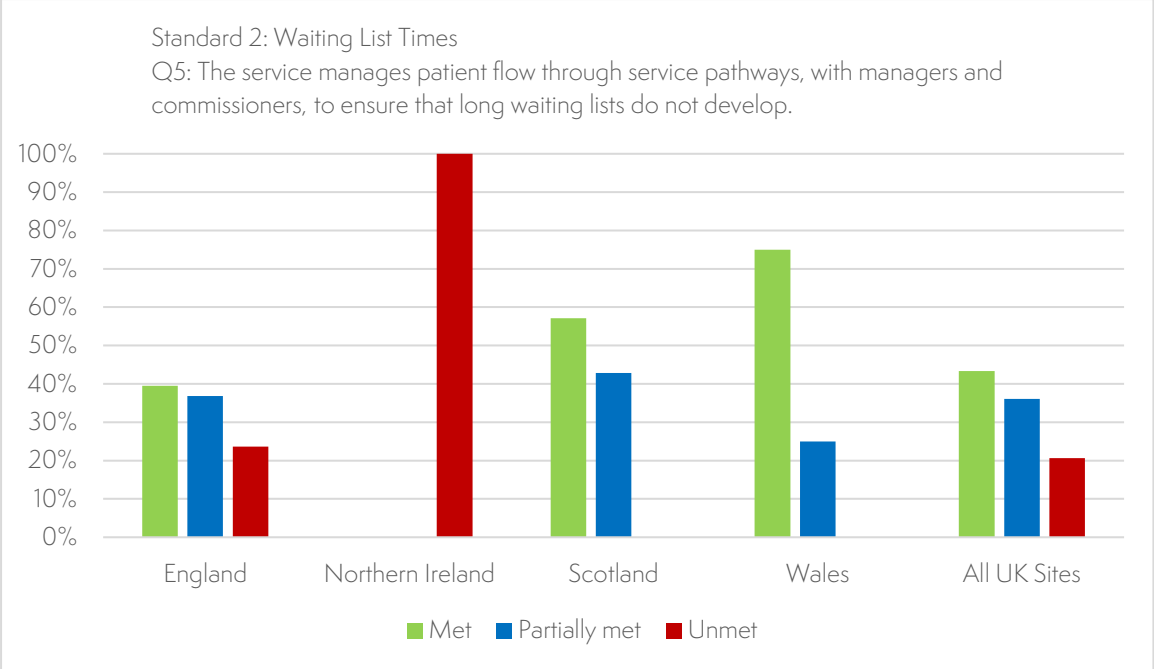


Figure 11: *Percentage compliance with standard 2 for the management of patient flow through service pathways, with manager and commissioners to ensure long waiting lists do not develop*

East of England had the highest level of met responses within England, at 55.56% (5/9) and the South of England had the lowest at 29.17% (7/24).

All three Tier 1 sites reported the standard was met, with only 38.89% of Tier 2 sites reporting met (28/72) and 25% reporting unmet. Tier 3 had 50% of sites reporting it was met (11/22), and 9.09% unmet.

The most emphasised key theme for this standard was long waiting lists, which have been impacted by the COVID-19 pandemic, strikes and staffing/resource issues. Although most free text responses noted that waiting times were collected, some stated this was primarily for the time to first appointment, with less oversight for time for further care following the first appointment. There were some observations about limited clarity regarding what is classed as 'treatment' and that although these waiting time data were collected, they were not necessarily presented to the consultant body in a timely manner. Additionally, there was no strategy for managing existing backlogs and future demand. Despite comments suggesting that some teams were ignored by managers and prevented from engaging directly with commissioners, there were reports of collaborative working (e.g. between inpatient and chronic hospital pain services and community services), waiting lists being actively managed on a weekly basis, extra clinics and lists and effective pathways.

Standard 3: Availability of paediatric pain services referral pathway, Chapters 6.7.1, 6.7.2 and 6.7.3

Paediatric pain services were addressed in questions 6 and 7.

Q6: The service manages paediatric patients with pain. If not, the service has a referral pathway to a centre which offers paediatric services.

Within the whole of the UK, 42.11% of sites reported this was met, with 25.77% stating it was partially met, and 31.96% reporting it was unmet. One site did not answer the question. No site in Wales or Northern Ireland reported that the standard was met. The private practice did not provide a paediatric service (see Figure 12).

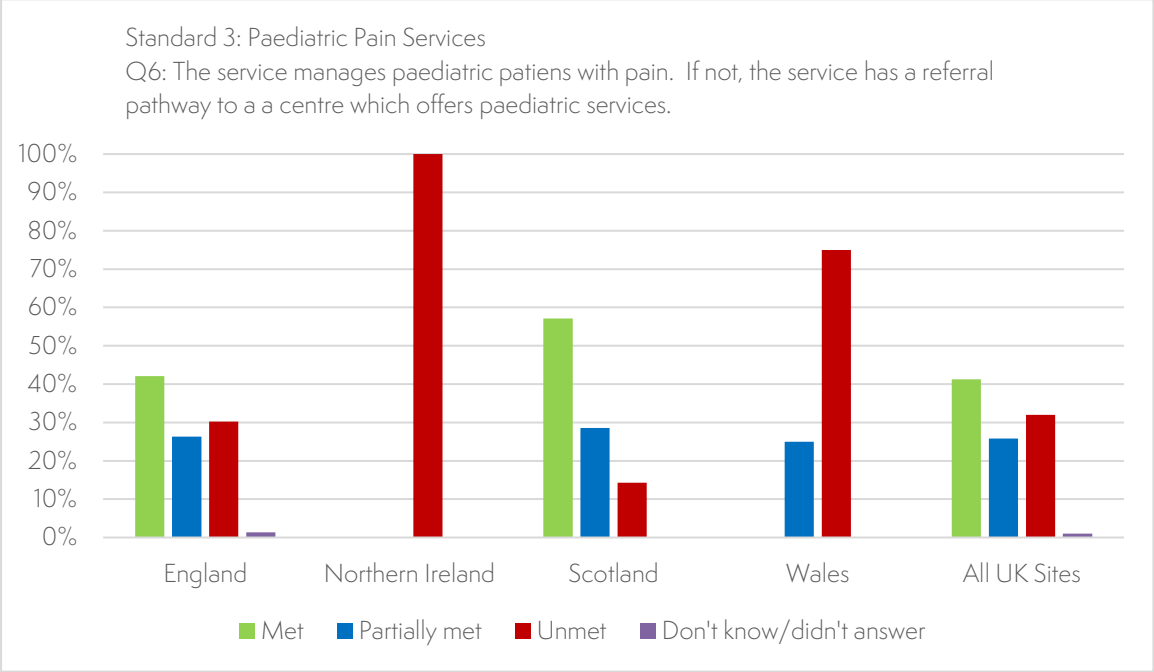


Figure 12: *Percentage compliance with standard 3 for the management of paediatric patients with pain*

Within the English regions, North of England had the highest rate of sites reporting the availability or referral pathway for paediatric patients, at 59.09% (13/22), and the South of England and London both reported the lowest levels at 33.33% (8/24 and 4/12 respectively); the South also had the largest number of sites in England reporting it was unmet (41.67%, 10/24).

No services within Tier 1 reported paediatric services, with all 3 reporting it was unmet. Tier 2 level services had 40.28% reporting met, 25% partially met, and 33.33% unmet. Tier 3 had the highest level of sites reporting the standard was met, at 50% met, 31.82% partially met and 18.1% unmet.

Q7: The service provides visible referral criteria to referrers and patients for paediatric pain patients.

Most sites within the UK reported this was unmet (44.33%, 43/97). Only 31.96% of sites reported their site provided a visible referral criteria for paediatric pain patients (31/97). Northern Ireland had no sites reporting it was either met or partially met. Wales had 1 site reporting met, with the other 3 reporting unmet. England had only 30.26% met, with 47.37% of sites reporting unmet. Scotland had the highest level of services reporting this was met, at 50% (7/14), and only 1 site reporting it was unmet (7.14%, see Figure 13).

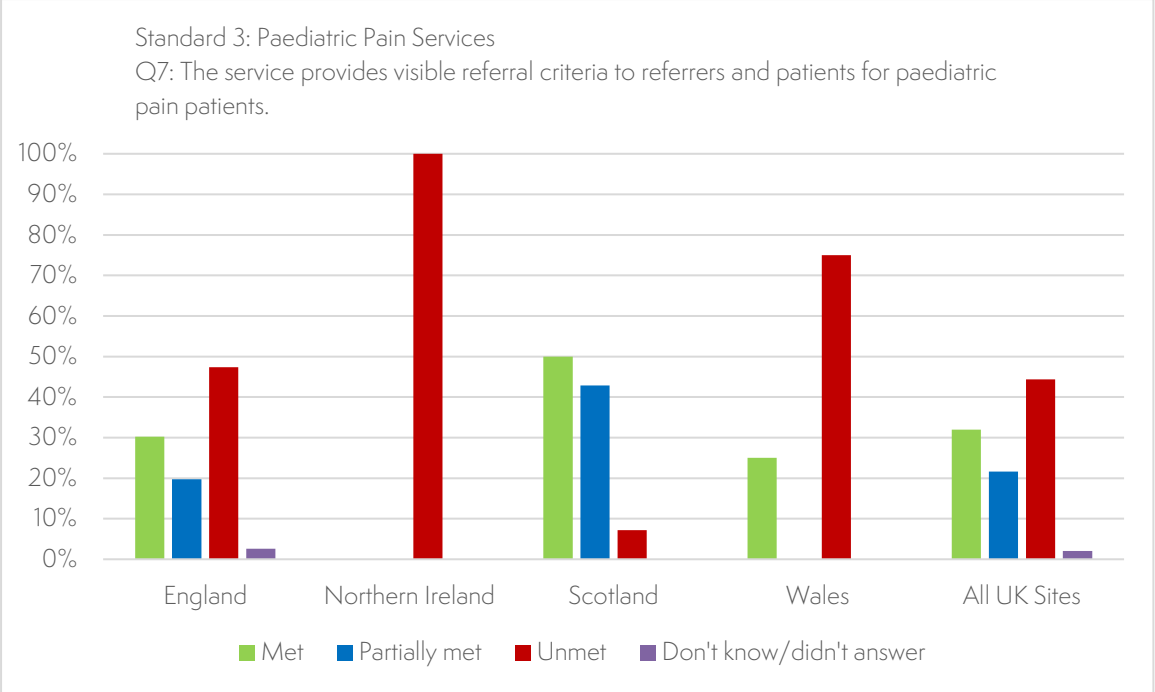


Figure 13: *Percentage compliance with standard 3 for the provision of visible referral criteria to referrers and patients for paediatric patients*

North of England had the highest English regional level of services reporting met for this question, at 54.55% (12/22), and East of England the lowest, at 11.11% (1/9). Midlands had the highest percentage of sites reporting unmet, at 75% (6/8), with the North of England reporting 27.27% of sites did not meet the standard.

No Tier 1 site met this standard, with all 3 sites reporting it as unmet. Tier 2 level services reported 30.56% for sites which met this standard, though 47.22% (34/72) stated it was unmet. A larger percentage of Tier 3 services reporting meeting the standard at 40.91% (9/22), though 27.27% (6/22) reported it was unmet.

The key theme from the free text responses was that the service of the respondents was not commissioned for under 18s. However, there was evidence of signposting to other centres which included a mix of formal and informal referral pathways. Some teams arranged bespoke appointments with older teenagers to facilitate the transition from paediatric to adult services. Also, for those who work with paediatric services, they noted that the paediatric teams stive to provide an outstanding service.

Standard 4: Availability of neuromodulation services, Chapter 7.3

Q8: The service provides neuromodulation services. If not, the service has functioning links with a centre offering neuromodulation.

68.04% of sites reported this standard was met. This ranged from 100% of sites in Wales, 71.43% in Scotland, 68.42% in England, but no sites in Northern Ireland reported this was met (50% partially met, 50% unmet, see Figure 14). A neuromodulation service was not provided within private practice.

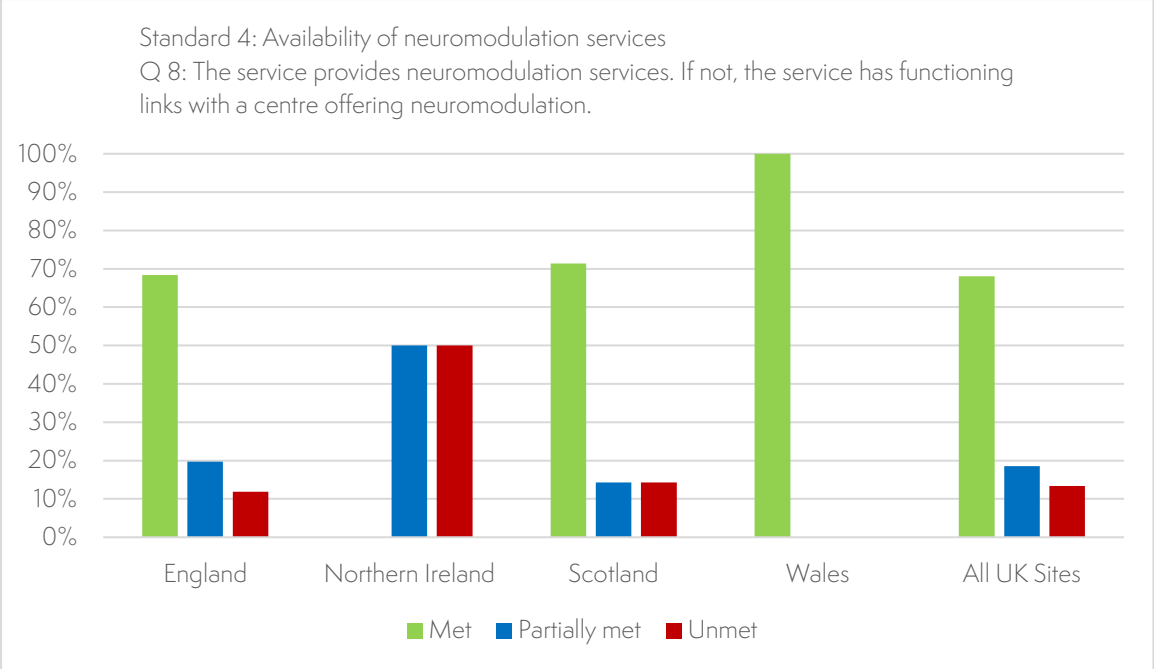


Figure 14: *Percentage compliance with standard 4 for the provision of neuromodulation services.*

East of England had the highest level of sites within the English regions reporting they have neuromodulation services, or links to a centre offering this service (88.89%). Midlands had the lowest level, at 50%, and 25% of sites in this region reported the standard was unmet.

Tier 3 services had the largest proportion of sites meeting the standard, at 77.27% (17/22).66.67% (48/72) of Tier 2 services reported the standard was met, and only 1 of the 3 Tier 1 services reported the standard was fully met, with the remaining 2 reporting it was partially met.

In the free text responses, most respondents noted they had links with a neuromodulation centre if they did not provide a neuromodulation service. There was a comment on uncertainty regarding whether they should be referring due to poor evidence for neuromodulation. For those who indicated they provide a neuromodulation service, this included a centre who offered approximately 20 spinal cord stimulators per year including battery replacements with 5-10 per year from out of area referrals. Another respondent stated they provide spinal cord stimulation, peripheral nerve stimulation and dorsal root ganglion stimulation with 10-20 new patients per year, 10-20 returning and 20 external referrals per year. There were mixed comments regarding data being fed into the National Neuromodulation Registry for those services who undertake neuromodulation.

Standard 5: Pathways for chronic pain, Chapter 6.4

Pathways for chronic pain was addressed by questions 9 and 10.

Q9: The service's pain management pathways for chronic pain in adults meet the current evidence-based standards as outlined in Core Standards for Pain Management Services in the UK (CSPMS UK).

63.92% of sites reported their service met the current evidence-based standards outlined in CSPMS UK for pain management pathways (see Figure 15). A further 28.87% reported it was partially met, with only 5.15% (5/97) reporting it was unmet. Two respondents did not answer the question. By country, Scotland had the highest rate of

services reporting the standard was met, at 71.43% (10/14); both Northern Ireland and Wales each reported 50% compliance, with this rising to 63.16% of sites in England.

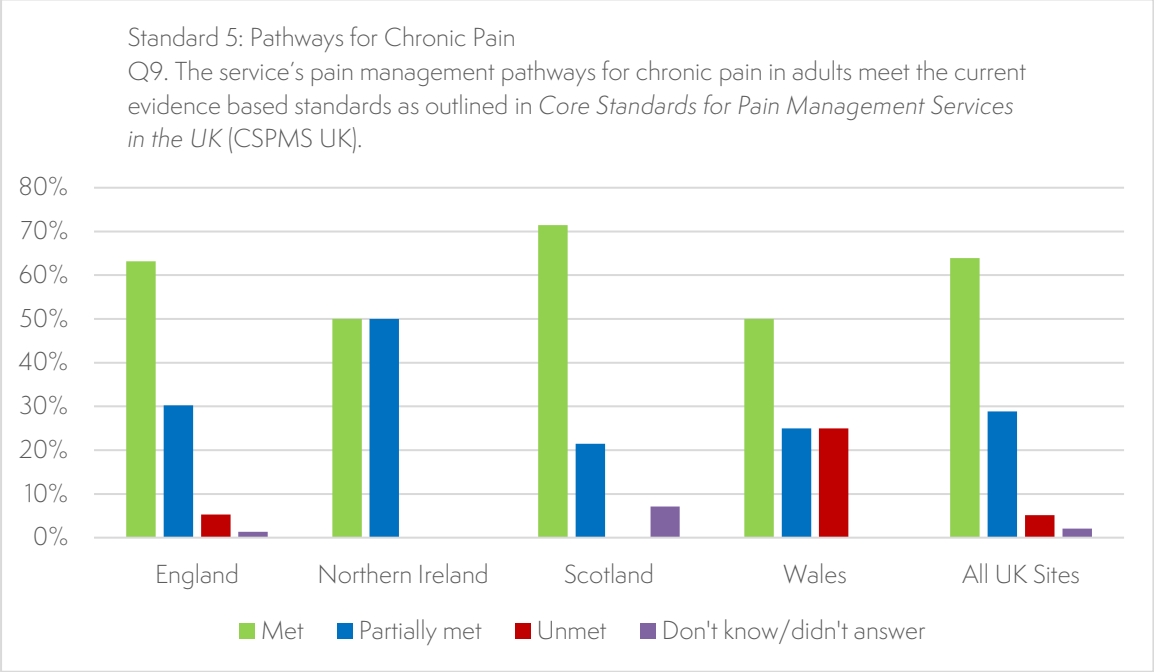


Figure 15: *Percentage compliance with standard 5 for meeting the current evidence-based standards for the service's pain management pathways for chronic pain*

Within the English regions, the percentage reporting the standard was met ranged from 75% in the London commissioning region, to 58.33% within the South of England commissioning region. South of England also had the highest number of sites (2/24) reporting this was unmet, with Midlands, and the Northern region also reporting one site did not meet this standard. No regions in Scotland reported the standard was unmet, which was also the case in Northern Ireland.

13 out of 22 (59.09%) Tier 3 level services reported the chronic pain pathways met the current standards, with 48/72 (66.67%) of Tier 2 level services. Of the Tier 1 services each reported either met, partially met or unmet.

Q10: The service collects Patient Reported Outcome Measures (PROMs) data.

Only 28.87% (28/97) of all UK sites reported that PROMS data was collected as per the standard (see Figure 16). 45.36% (44/97) of sites reported that this standard was partially met, and 23/97 (23.71%) reported this standard was not met. Scotland had the highest rate of sites meeting the standard, at 35.71%, with 14.29% reporting it was unmet. In England, the number of sites reporting met was almost matched by those reporting it was unmet, at 28.95% and 25% respectively. Wales had 1 site reporting it was not met, with 1 met and 2 partially met, while Northern Ireland reported 1 partially met and 1 unmet.

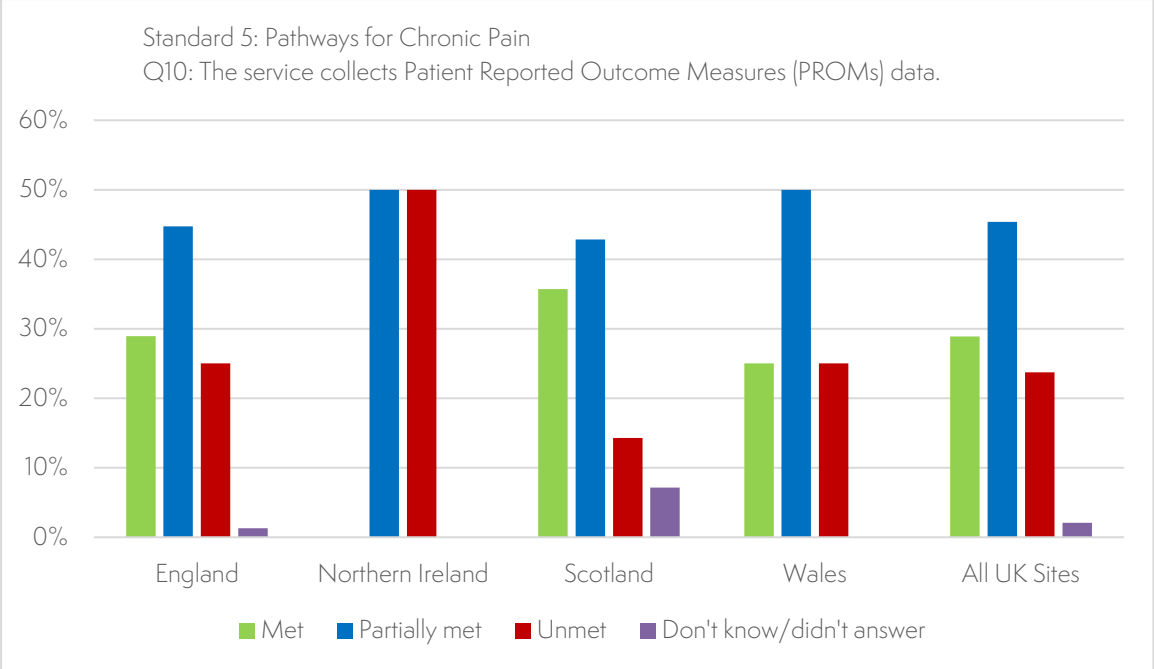


Figure 16: *Percentage compliance with standard 5 for collecting PROMS data*

Midlands reported the highest percentage of sites meeting the standard for collecting PROMS, with 37.5% (3/8) reporting it was met – the same number also reported it was unmet. North of England had the lowest percentage of sites reporting the standard was met, at 22.73% (5/22), and again the same number also reported not meeting the standard.

All Tier 1 sites reported they met the standard for collecting PROMS. This was not reflected by Tier 2 (22.22%) or Tier 3 (40.91%) services. Almost half of Tier 2 services said it was partially met (48.61%) and 26.39% stated it was unmet. Tier 3 reported 40.91% and 18.18% for partially and unmet respectively.

The two most prominent key themes from the free text responses included mixed reporting of collecting patient reported outcome measures and limitations around meeting the current evidence-based standard. Indeed, some respondents noted outcome measures were collected (e.g. the EQ5D, PROMIS-29, pain scores, global impression of change, psychology assessment, PHQ9, GAD7 and PCS) either on paper or electronically (e.g. in the National Neuromodulation Registry), reviewed and analysed. However, others reported that outcome measures were not consistently collected, recorded in clinical correspondence, collected in MDT, limited when outside of the neuromodulation service, collected for psychology or physiotherapy, and were impacted by staff resources. It was apparent this was a key area of improvement for some respondents, as evidenced by the ongoing development of new systems in their service.

Standard 6: Pain trainees, Chapter 5.2.3

This standard was addressed in questions 11, 12 and 13.

Q11: The service is able to provide supervision for Stage 1 and 2 pain training as per the RCoA curriculum.

Over two thirds (70.10%) of all sites reported that supervision was provided as per the RCoA curriculum. This varied between 69.74% in England, to 100% of sites in Northern Ireland. No sites in Northern Ireland, Scotland or Wales said this was unmet, although 17.11% (13/79) of sites in England reported it was not met (see Figure 17).

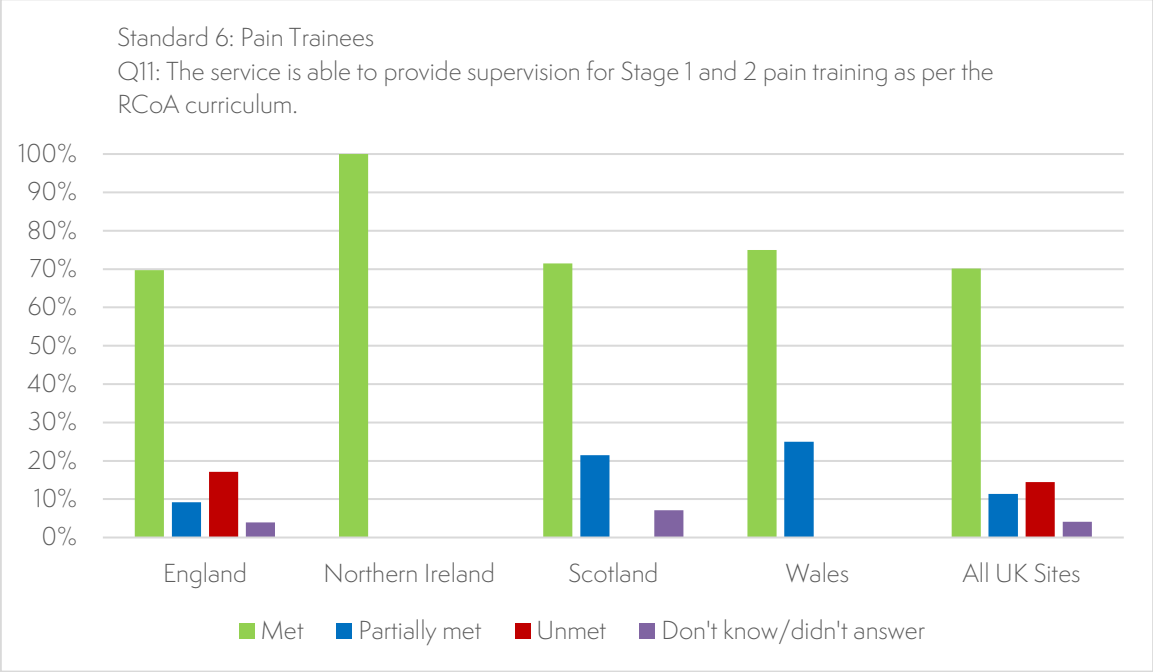


Figure 17: *Percentage compliance with standard 6 for the provision of supervision for stage 1 and 2 pain training*

East of England region was the only area within England not to have sites reporting this standard was unmet. Sites reporting it was unmet varied from 37.5% of sites in Midlands, to 8.33% in London and 9.09% in the North of England.

All Tier 1 sites reported this standard was unmet, while 68.06% and 86.36% of Tier 2 and Tier 3 respectively reported it was met.

Q12: Your centre is able to provide supervision for Stage 3 and Specialist Interest Area (SIA) pain training as per the RCoA curriculum.

Almost half of sites across the UK who said that they were able to provide supervision for Stage 3 and SIA training (49.48%), although for this question, the option of 'not applicable' was offered, and was used by 15.46% of sites. Less than half of sites in England met this standard (47.37%), with 57.14% of sites in Scotland and 50% in Wales saying this was met (see Figure 18). Both sites in Northern Ireland said they met the standard. 25%, 14,47% and 14.29% of sites in Wales, England and Scotland respectively said they did not meet the standard.

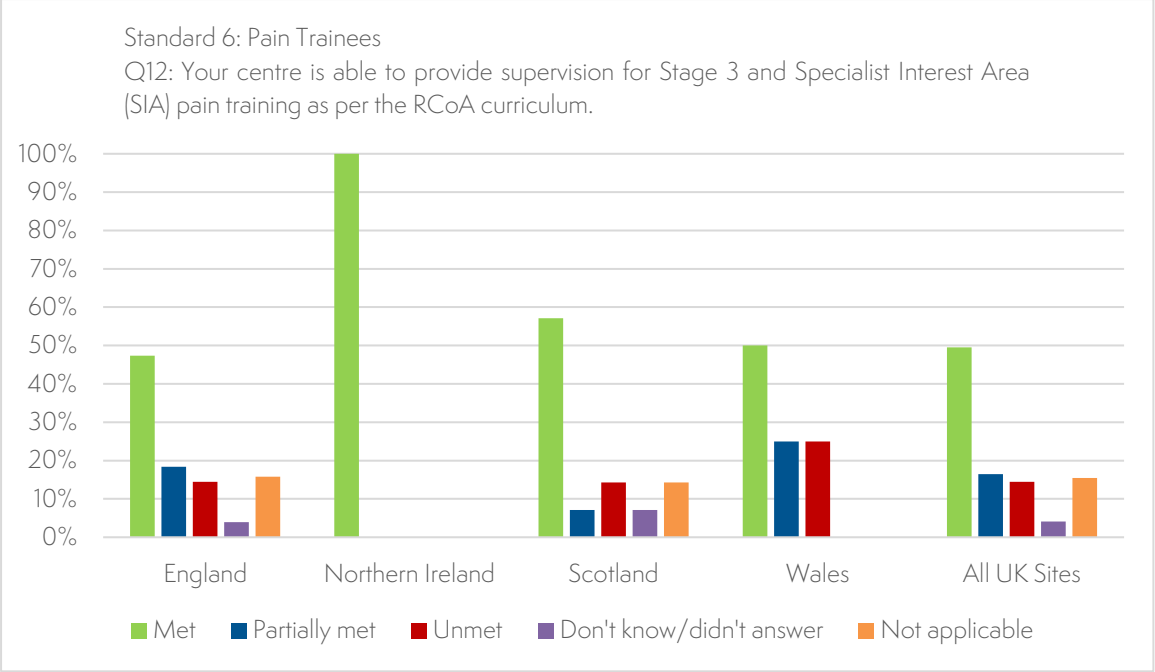


Figure 18: *Percentage compliance with standard 6 for the provision of supervision for Stage 3 and SIA pain training*

London and the Midlands had the highest percentage of sites reporting they were able to provide Stage 3 and SIA pain training (66.67% and 62.5% respectively), and both regions had no sites reporting it was unmet.

There was a large variation in responses between the tiers of service, with 81.82% of Tier 3 sites saying the standard was met, and only 41.67% of Tier 2 sites meeting the standard.

Q13: The service has a member of staff who acts as Faculty Tutor for pain training.

67.01% of sites reported they had a member of staff acting as Faculty Tutor (see Figure 19). This ranged from 50% of sites in Wales to 100% in Northern Ireland, with 78.57% of sites in Scotland and 65.79% of sites in England. 23.68% of sites in England reported this standard was unmet (18/76), with one site in Scotland and 2 sites in Wales also not having a Faculty Tutor.

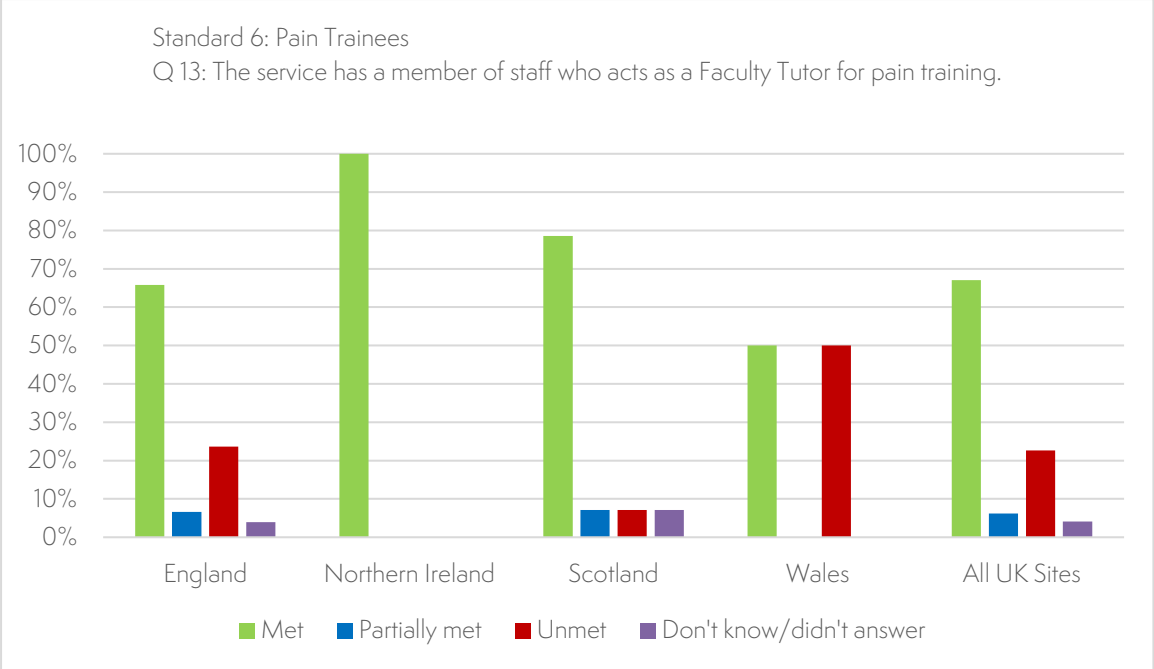


Figure 19: *Percentage compliance with standard 6 for a member of staff in the service who acts as Faculty Tutor for pain training*

London had the highest percentage of sites reporting they had a Faculty Tutor (83.33%, 10/12), with North of England next highest at 72.73% (16/22), then South of England (62.50%, 15/24), East of England (55.56%, 5/9), and Midlands the lowest at 50% (4/8).

As with questions 11 and 12, no site offering a Tier 1 service said this standard was met. 65.28% of Tier 2 and 81.82% of Tier 3 services said they had a member of staff who acts as Faculty Tutor for pain training.

Free text responses indicated mixed reports of services providing supervision for stage 1, 2, 3 and SIA pain training. Regarding stages 1 and 2, some respondents noted they are able provide this training, whilst some are unable to provide stage 2. Reasons included no formal supervision or insufficient supervision, no regular training commitment and limited workforce capacity. However, some services acknowledged they have full members of the Faculty of Pain Medicine who are Tutors, a pain training committee, Regional Advisor and a recognised supervisor. A respondent stated that pain trainees had little overall time allocation due to other modules. Despite this, the respondent's service had sufficient resources to provide support for basic assessment and management of acute and chronic pain in adults. They also highlighted they introduced trainees to the concept of biopsychosocial multi-disciplinary pain management, the principles of the assessment, diagnosis and treatment, as well as the limitations of various factors in the management of patient expectations. Respondents noted there were options including the provision of this training in their team, supporting advanced trainees to gain additional procedure experience at their centre when unavailable elsewhere and working collaboratively with other centres to provide the training for stage 3 and SIA pain training. Additionally, some respondents acknowledged that due to resources, they were unable to provide stage 3 and SIA pain training, and although their service did not provide training for RCoA trainees, they did provide training for GP trainees and non-medical colleagues.

Standard 7: Availability of cancer pain services, Chapter 6.6

Q14: The service is able to provide cancer pain services.

65 of the 97 sites reported they met or partially met the standard. Only 30.93% of sites said they were fully able to provide cancer pain services, with 36.08% saying they partially met this standard (see Figure 20). 27.84% of sites said they did not meet the standard. In England, more sites said they did not meet the standard (30.26%) than said that it was met (27.63%). In Northern Ireland, both sites said they offered cancer pain services. 50% of sites in Wales said they met the standard (2/4) with one site saying they partially met the standard and one saying it was unmet. In Scotland, the greatest number said they partially met the standard (42.86%) with 35.75% meeting it, and 14.29% saying it was unmet.

Tier 3 services reported the highest level of sites providing cancer pain services, at 50% saying it was met, 40.91% saying partially met and 9.09% saying unmet.

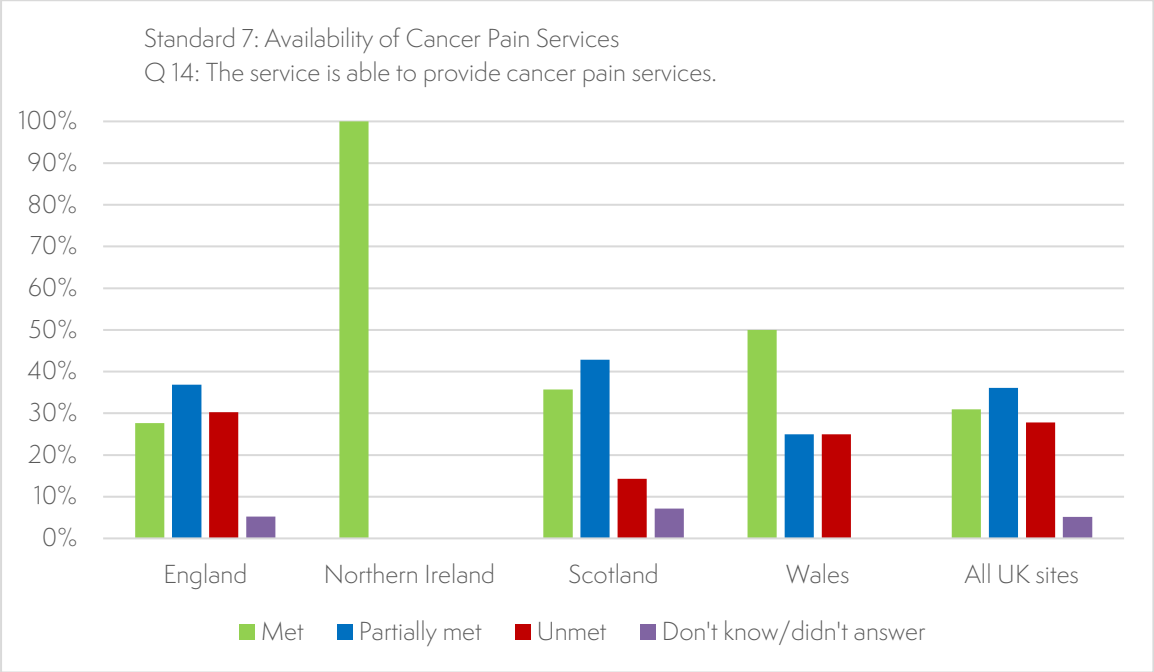


Figure 20: *Percentage compliance with standard 7 for the provision of cancer pain services*

3 out of the 5 England commissioning regions reported more sites who did not meet the standard than sites who did. East of England had only 11.11% of sites reporting they provided cancer pain services, and 44.44% saying they did not meet the standard. The Midlands had only 12.5% of sites meeting the standard with 50% reporting it was not met, and the South of England had 16.67% met and 33% not met. London saw the greatest number of sites providing this care (41.67%) although a third of the services in London reported the standard was not met. A cancer pain service was not provided in private practice.

Q14a: If your centre offers cancer pain services what level of care do you provide?

Of the 65 sites who reported providing some level of cancer pain services in Question 14, 49 sites reported which level of care was provided. Available responses were Level 1 to Level 4, with 5 sites reporting Level 1, 15 sites reporting Level 2, 19 sites reporting Level 3 and 10 sites reporting Level 4 (see Figure 21).

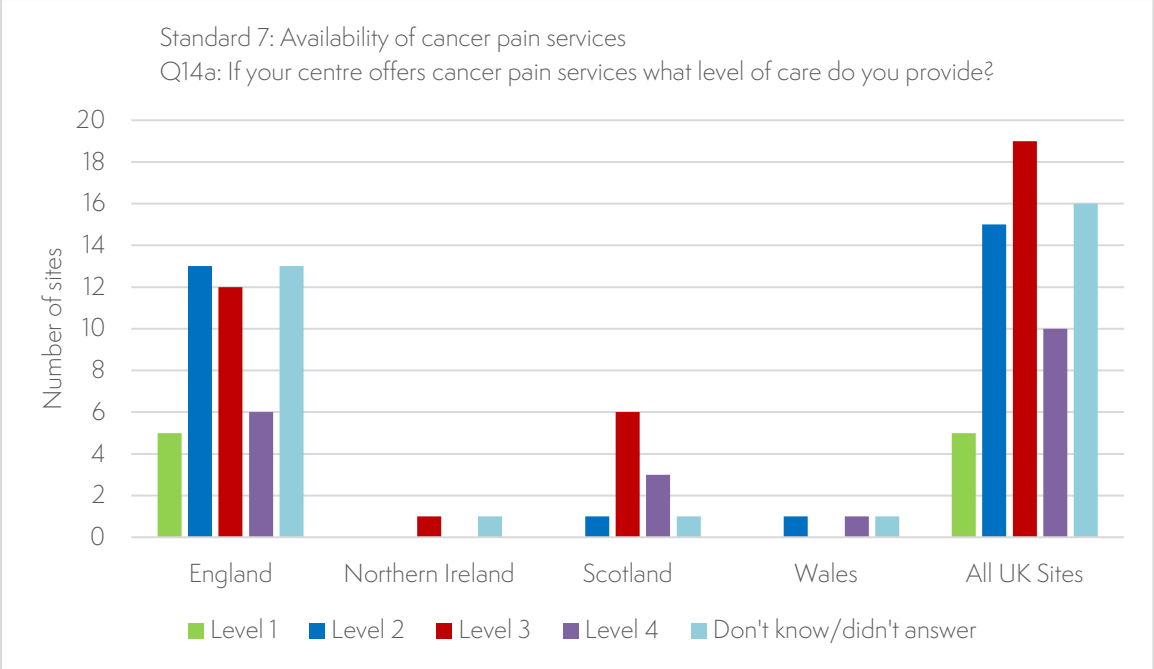


Figure 21: *Number of sites providing Level 1, 2, 3 and 4 care*

The distribution of the levels of care within England can be seen in the chart below, with the Midlands only reporting care provision by 1 out of 9 sites, with the Northern Region reporting most sites offering some level of care (see Figure 22).

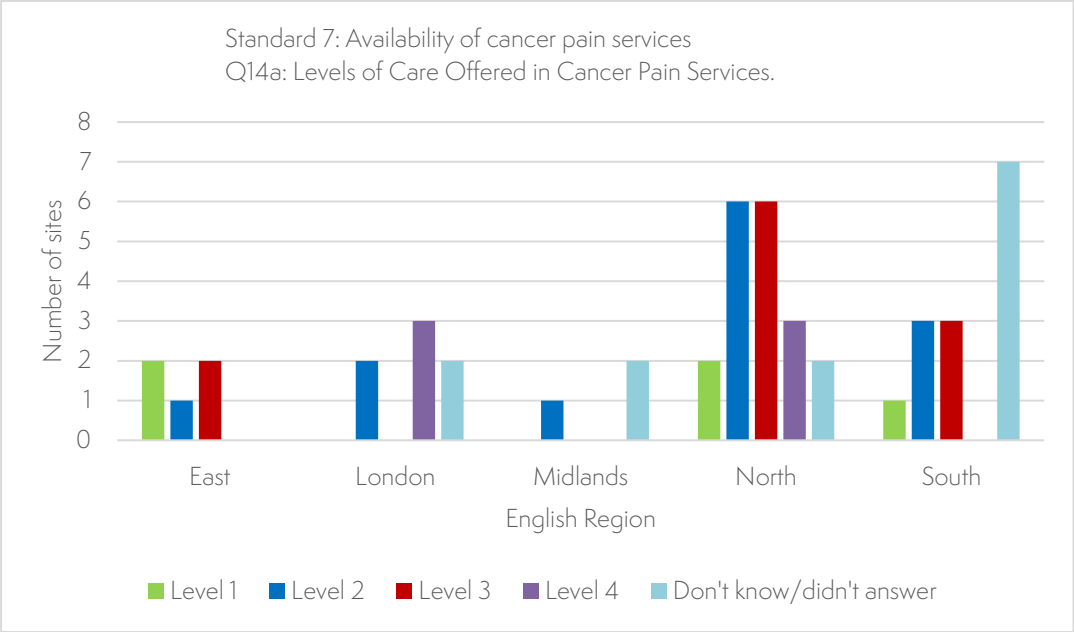


Figure 22: *Number of sites providing Level 1, 2, 3 and 4 care in cancer pain services in English commissioning regions*

The predominant theme from the free text responses was that cancer services were provided by the palliative care team. Despite this, there were comments of collaborative working with palliative care and oncology teams. This was characterised by reviewing patients, having weekly input along with the palliative care physicians, providing services at local hospices and in some cases, delivering specialised care. For those who offer cancer pain services,

procedures included spinal cord stimulation, intrathecal pumps, coeliac plexus blocks, cordotomy, neurolytic blocks, intrathecal phenol, denervation, epidural catheters and domicile epidurals. It was acknowledged there was some service pressure due to less than optimum nursing, psychology and rehabilitation input for cancer related pain service and limitations with theatre space. Another respondent also noted their service mainly focussed on cancer survivors and opioid problems.

Standard 8: Effective data management support available, Chapters 3.7.5 and 5.1

Effective data management was addressed in questions 15 and 16.

Q15: Clinical governance systems are in place to allow appropriate reflection and discussion on the outcome data, in particular to highlight areas of concern and/or areas that require change or improvement.

Just over half (56.58%) of all sites indicated they had clinical governance systems in place to allow for analysis of outcomes and to indicate where areas requiring improvement may exist (see Figure 23). 24.74% of sites stated the standard was partially met, with 11.34% stating it was unmet. All countries reported ≥50% compliance with this standard.

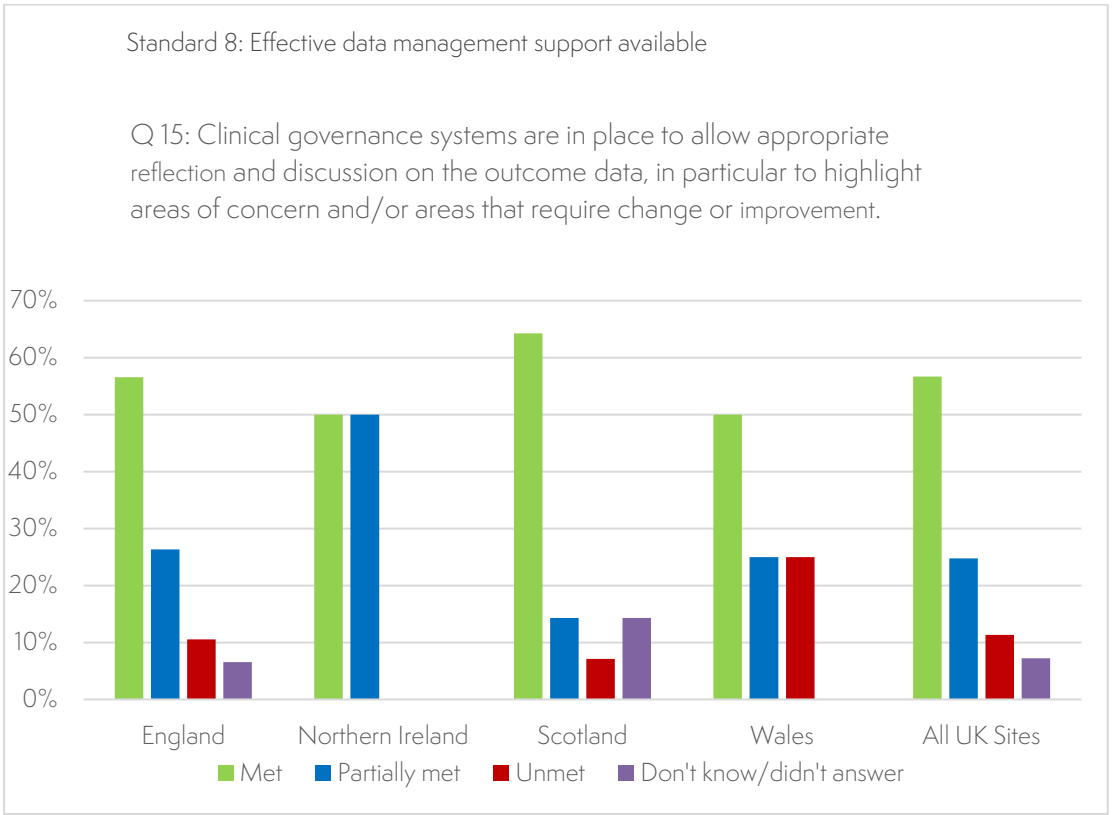


Figure 23: *Percentage compliance with standard 8 for outcome data management support*

Of the five English regions, sites within the East of England commissioning region had the highest rate of reporting this standard was met. Compared to their reported 77.78% met, North of England reported only 40.91% of sites had sufficient clinical governance systems in place to permit reflection and allow for improvement.

All Tier 1 services reported sufficient clinical governance systems were in place, with 56.94% of Tier 2 and 50% of Tier 3 services reporting this was met, though 23.61% and 31.82% of Tier 2 and 3 services stated they partially met

the standard. Approximately 1 in 8 of both Tier 2 and 3 services reported they did not meet the standard (11.11% and 13.64% respectively).

Q16: The service has a pain database for research and it has either Research Ethics committee [REC] or Caldicott Guardian approval.

50% of sites stated they did not meet this requirement (53/97, see Figure *24*). Only 18.56% of sites stated they met the standard, and again 18.56% stated they partially met the standard. Neither Wales nor Northern Ireland had sites who reported meeting the standard, with both England and Scotland reporting approximately 1 in 5 sites having both a pain database for research and either a REC or Caldicott Guardian (19.74% and 21.43% respectively).

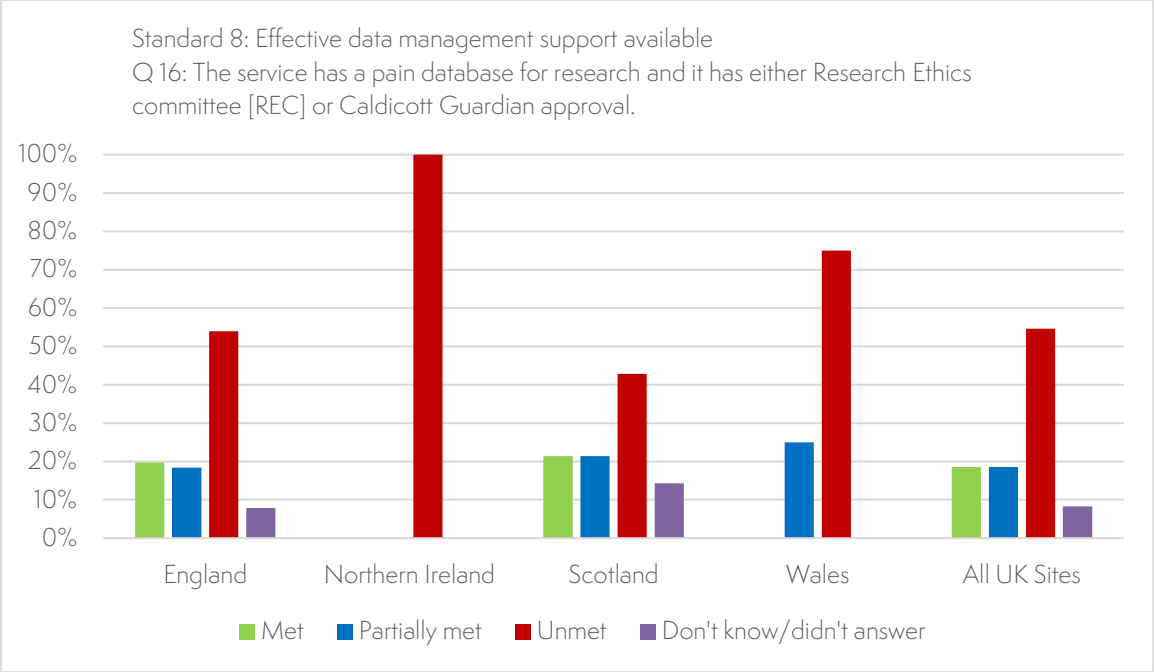


Figure 24: *Percentage compliance with standard 8 for having a pain database for research and either REC and Caldicott Guardian approval*

The highest reporting region meeting the standard was London commission region, with 33.33% of sites stating they met the standard and the fewest sites reporting it was unmet, at 41.67%. Northern England was the lowest, with only 13.64% of sites reporting compliance, although 31.82% stated it was partially met. East of England had the largest percentage of sites who reported the standard was unmet, at 66.67% (6/9 sites).

Only 16.67% of Tier 2 services reported they had a pain database and either REC or Caldicott Guardian, rising to 22.73% of Tier 1 services. One of the three Tier 1 services reported they met the standard, the remaining two sites stating it was unmet.

Free text responses indicated that clinical governance meetings occur on a regular basis, primarily in MDTs, though some services reported having audit meetings to reflect on the work done by the service, MD leadership meetings on a monthly basis and clinical governance meetings on a bi-monthly basis. Despite these positive responses, some respondents acknowledged that clinical governance systems were not in place, with the systems being inflexible and that clinical governance systems were an important area of improvement. This was because the systems were

cumbersome and difficult to interpret, and there were gaps between clinical provisions and the management of the services due to staffing issues.

Regarding research-related databases, there were mixed responses; some services had databases (whether for research or quality improvement projects), some were in the process of being set up and some did not have a database. Nevertheless, services that were actively involved in research did have REC approval whether that be from NHS/HSC or University RECs. Some comments demonstrated the challenges associated with services taking part in research. For instance, one respondent acknowledged they are not currently supported to do research, had unsuccessful previous attempts and had little time to get involved.

Standard 9: Research and development, Chapter 9.3

Q17: The department has protected time to discuss relevant research and newer developments.

42.27% of sites indicated they did not meet this standard, with only 29.9% stating they had protected time to discuss research and development (see Figure 25). Scotland had the highest percentage of sites reporting they met the standard (42.86%, 6/14), England reported 30.26% compliance, and no sites in Wales or Northern Ireland reported meeting the standard.

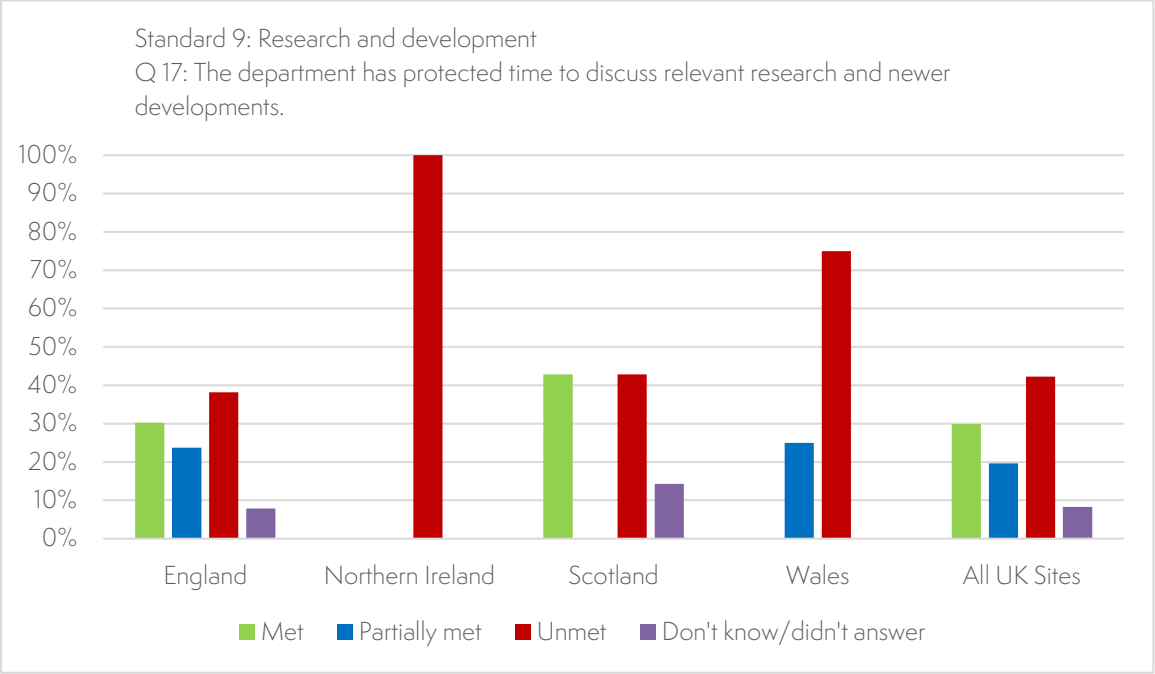


Figure 25: *Percentage compliance with standard 9 for the department having protected time to discuss relevant research developments*

Within the English regions, compliance ranged from 22.22% in the East of England to 36.36% in the North of England. For sites which reported they did not meet the standard (unmet), this ranged from 41.67% of sites in the South of England to 33.33% in the East of England and London.

There was a contrast between Tier 1 and Tiers 2 and 3, with Tier 1 having no sites reporting the standard was unmet, two sites reported met, with the remaining site reporting partially met. Whilst the highest percentage of sites reporting the standard was not met was within Tier 3 services (45.45%), this was almost as high in Tier 2 (43.06%),

with only just over a quarter of Tier 2 and 3 services reporting protected time to discuss relevant research and newer developments (29.17% and 27.27% respectively).

Free text responses indicated that relevant research and newer developments were discussed during meetings, IST programmes, MDT, clinical governance meetings, away days, in-service training and the British Pain Society Annual Scientific Meeting. However, there were other responses which suggested there was little time or support for these discussions. Those who were involved in research were doing this in their own time due to their interests.

Standard 10: Consultation facilities, Chapters 4.1 and 4.2

Standard 10 was addressed in questions 18, 19 and 20.

Q18: General facilities are well signed, accessible, comfortable and welcoming in compliance with the Equality Act 2010.

A majority of sites reported they met this standard (67.01%) with only three sites reporting it was not met (2 in England and 1 in Northern Ireland, see Figure 26). 21.65% of UK sites reported they partially met the standards; this was 19.74% of services in England, and 3 out of 4 services in Wales.

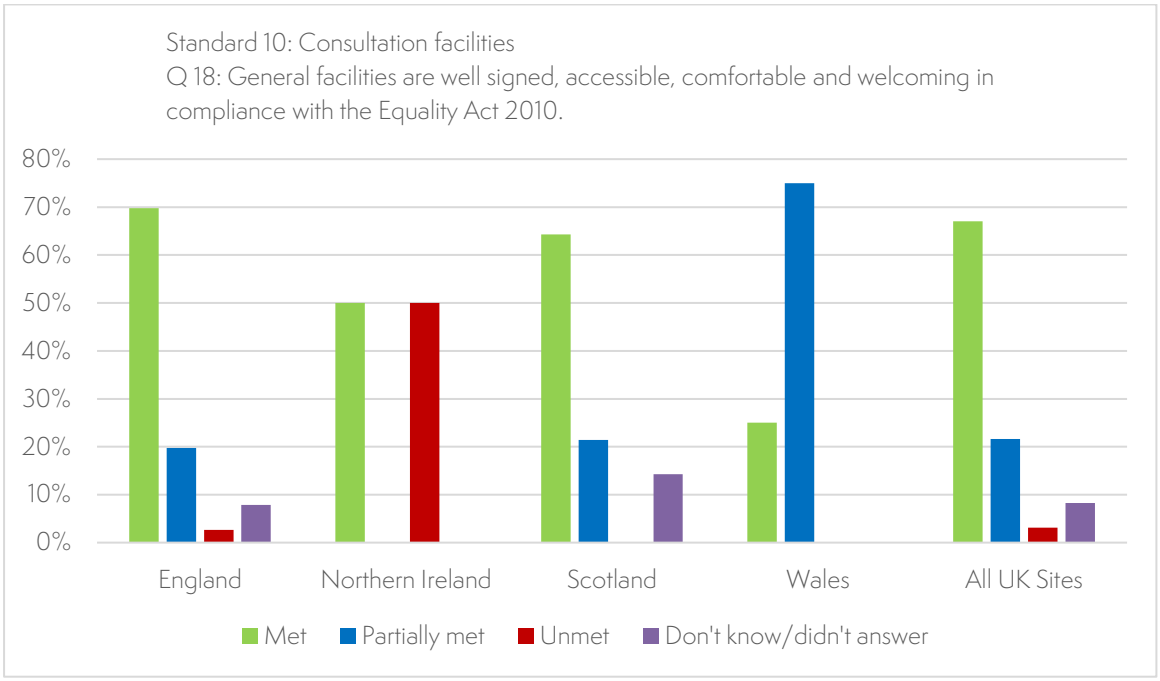


Figure 26: *Percentage compliance with standard 10 for accessible consultation facilities*

Within the English regions, only two commissioning regions had a respondent who reported their sites did not meet the standard. The North of England and South commissioning regions each had a single site which reported it was unmet. The region with the highest percentage of sites reporting it was met was London, with 83.33% (10/12) saying it was met and 8.33% (1/12) reporting it was partially met. The Midlands had the lowest percentage of sites reporting it was met, at 62.5% (5/8).

The three sites within the UK who reported the standard for signed, accessible and comfortable facilities were not met were all Tier 2 level sites. All Tier 1 sites reported the standard was met, as did 65.28% and 68.18% of Tier 2 and Tier 3 sites respectively.

Q19: The service is able to communicate to patients of delays and current waiting times.

The communication of delays and current waiting times was reported to be met by 60.82% of services. Just under a quarter responded it was partially met (24.27%), with just 6 out of 97 reporting it was unmet (6.19%). Scotland had the highest proportion of respondents stating it was met (78.57%), while Northern Ireland had no sites stating they were fully able to communicate delays and waiting times (see Figure 27).

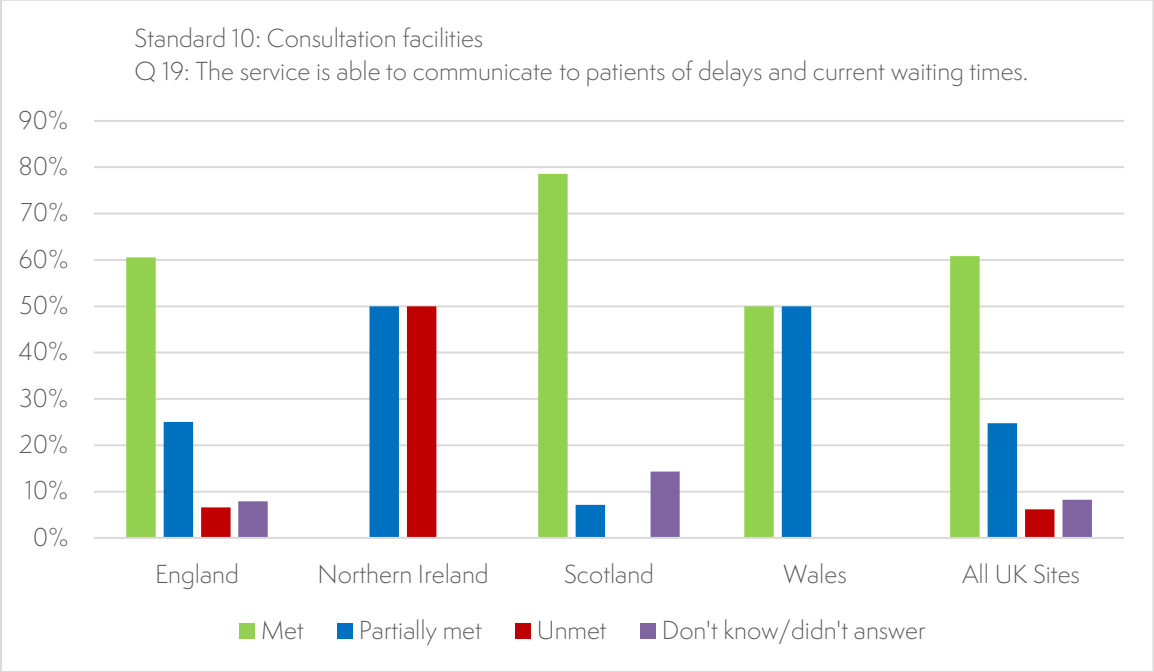


Figure 27: *Percentage compliance with standard 10 for communication of delays and current waiting times*

60.53% of English sites reported the standard was met, with 25% stating they were able to partially meet the standard, and 6.58% reporting it was unmet. The region with the highest percentage of sites reporting compliance was the East of England with 77.78%, compared to the South of England, who reported only 41.67% of sites met the standard. However, 3 out of the 24 sites in the South did not complete this question.

Again, all Tier 1 services reported they were able to communicate delays and current waiting times, with 56.94% and 68.18% of Tier 2 and Tier 3 services reporting they met the standard. Only Tier 2 services reported not meeting the standard (8.33%, 6/72) but a further seven Tier 2 sites did not provide an answer.

Q20: The service has provision to provide patient information leaflets.

76.29% of sites reported being able to provide patient information leaflets, with a further 14.43% saying they partially met the standard; only 1 site of 97 reported they did not meet the standard (see Figure 28). Eight sites did not answer the question.

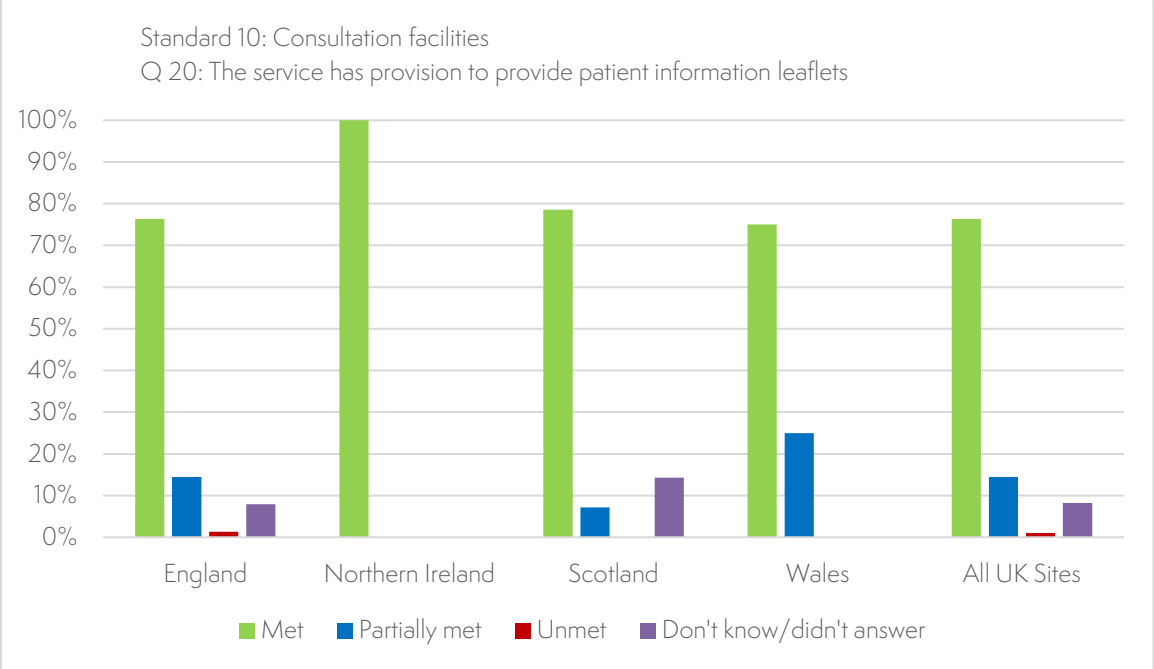


Figure 28: *Percentage compliance with standard 10 for the provision of patient information leaflets*

The single site which was unable to meet the standard was located in the South of England commissioning region. East of England reported that 8 of its 9 sites met the standard, with the remaining site partially meeting it. While London had the lowest percentage of sites fully meeting the standard (66.67%), other sites returning an answer all reported partially meeting the standard.

The one site who did not have the provision to provide patient information leaflets was in Tier 2, with a further 9.72% of Tier 2 sites not providing an answer. All Tier 1 sites met the standard, with 76.39% and 72.73% of Tiers 2 and 3 reporting meeting it fully.

A key theme for this standard was that patient resources, including patient information leaflets and web-based information sources (e.g. own website) were digital. Services also had provision to provide patients with hard-copy (paper-based resources) when appropriate so that those who do not have access to digital technology are able to access the required information. Despite this, some respondents acknowledged their service primarily relied on hardcopies and digitising resources was an area of improvement, especially to reduce costs associated with printing and to improve environmental impact. Leaflets included those from the FPM and those created in-house, and there were procedure-specific consent forms.

Regarding general facilities, although there were reports of new and upgraded facilities, other respondents acknowledged there were facility-related difficulties. For instance, there was ongoing building work which affected access and presented challenges to patients with mobility issues, rooms were small, and doorways were narrow which was difficult for wheelchair users. Some facilities had water ingress, were difficult to locate and their security was impacted. There were also examples of services being spread over multiple buildings which was confusing for patients. Poor car parking arrangements, poorly maintained x-ray gowns, excessive temperature changes in theatre and reduced accommodations following COVID-19 were also noted.

There were positive comments about good managerial support, hard-working booking teams, communication to patients regarding the service including via different methods (telephone, text and digital communications) and providing patients with choices for appointment location, date and time. However, other feedback suggested that delays and current waiting time were not always communicated to patients and within the team.

Standard 11: Safeguarding, Chapter 10

Q21: A chaperone is available for the pain clinic outpatients and theatre.

More than three quarters of services in the UK reported they were able to offer a chaperone in both outpatients and theatre settings (80.41%; 78/97). Seven sites reported they were partially able to meet this standard (7.22%), with three sites (3.09%) saying this standard was unmet. Nine sites did not answer the question. All sites in Wales and Northern Ireland reported being able to fully meet the standard, with England at 80.26%, Scotland at 71.43% (with a further 7.89 and 7.14% respectively partially meeting the standard, see Figure 29).

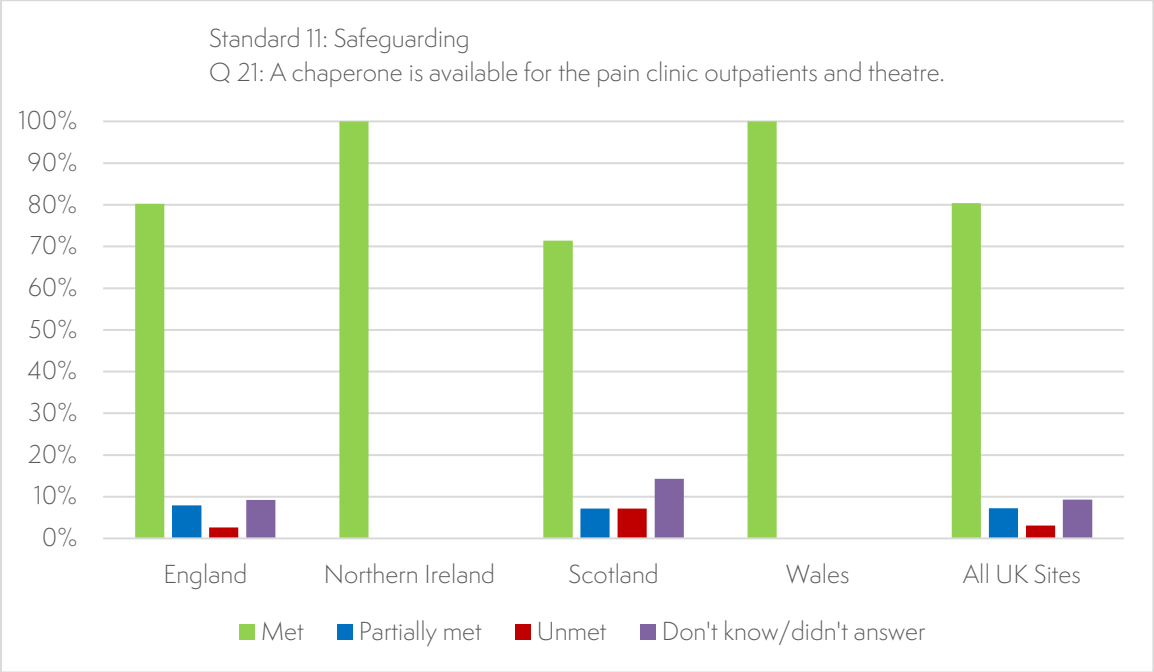


Figure 29: *Percentage compliance with standard 11, availability of a chaperone*

Two regions in England had sites who reported the standard was unmet; the Midlands (1/8) and the South of England (1/24). The region with the highest proportion of full compliance was North of England, who had 90.91% of sites reporting the standard was met, and partially met by 4.55%.

The sites which reported the standard was unmet were all Tier 2 level services (3/72), with Tier 1 fully meeting the standard (3/3), Tier 3 having 19/22 sites able to offer a chaperone wherever needed, and two sites being able to partially offer this service. 8 of the 9 non-reporting sites were Tier 2 services.

The primary theme for this standard from the free text responses was that a chaperone was available most of the time and required a request. For some services, this was only available in outpatients and could include a member of the admin team, a nurse or a health care assistant. For others, if a chaperone was not available, the team would

need to call in a chaperone from an adjacent clinic. This was compounded by the fact that some teams had one nurse covering multiple clinics and there were staffing challenges.

Standard 12: Access to specialised pain management services, Chapter 3.2

Q22: The service ensures that national standards as per Core Standards for Pain Management Services in the UK (CSPMS UK) for access to pain management services are met, irrespective of whether the service is situated in the community or in a hospital setting.

Only just over half of all services reported being able to meet this standard (54.64%; 53/97). 26.80% (26/97) reported it was partially met, and 9.28% (9/97) reported it was unmet. Scotland reported the highest level of compliance, with 64.29% (9/14) fully meeting the standard, followed by 55.26% of sites in England, and 50% of sites in Wales (see Figure 30). A further 21.43% of sites in Scotland and 25% of sites in both Wales and England reported partially meeting the standard. Eight sites in England (10.53%) and one site in Wales (25%) said the standard was unmet. In Northern Ireland, both sites stated they partially met the national standard for access to pain management services. Nine sites did not report an answer.

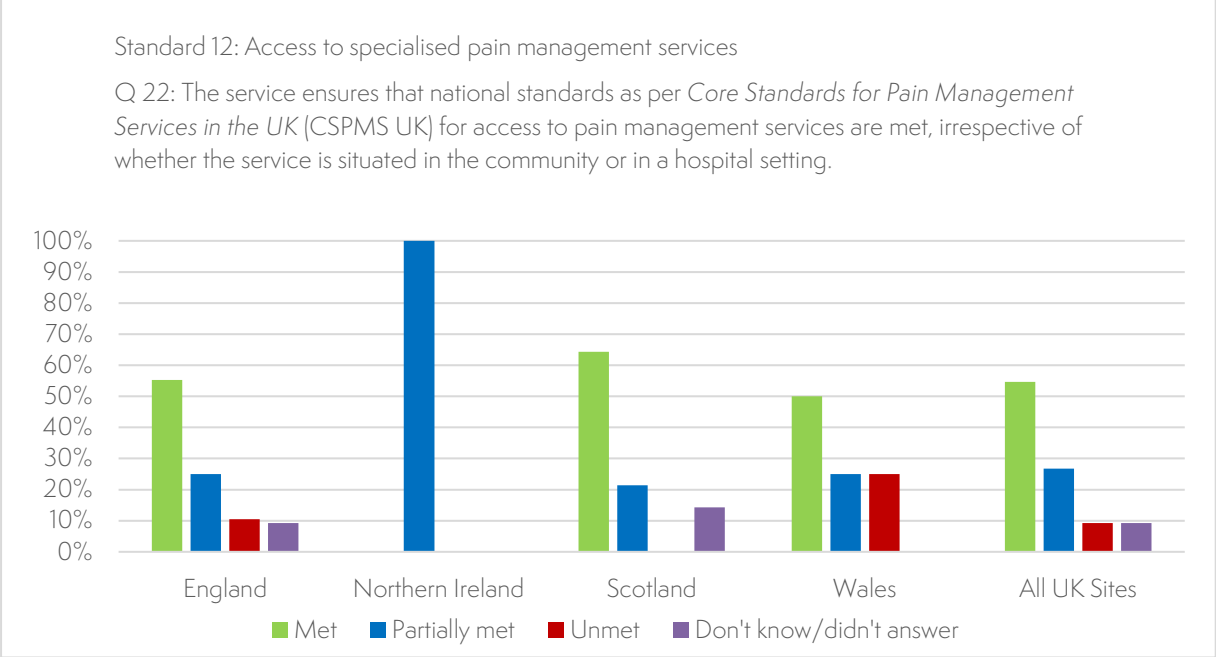


Figure 30: *Percentage compliance with standard 12 for access to pain management services*

Within the English commissioning regions, London reported the highest proportion of sites meeting the standard for access to pain management services, with 75% (9/12) reporting this was met. The region with the lowest compliance with the standard was the South of England commissioning region, where only 10 of the 24 sites (41.67%) reported being able to meet the criteria, 8 sites partially meeting it (33.33%) and 3 sites unable to meet the standard (12.5%).

Sites with a Tier 3 level of service were most likely to be meet the standard, with 68.18% (15/22) reporting it was met, compared to 51.39% (37/72) of Tier 2 and 33.3% (1/3) of Tier 1 sites. A further 18.18% (4/22), 29.17% (21/72) and 33.3% (1/3) sites reported partially meeting the standard for Tiers 3, 2 and 1 respectively.

A key theme for this standard was delayed access and long wait times. Respondents noted they strive to work in accordance with national guidelines and aim to provide tailored care to patients but do not have the capacity to see patients in a timely fashion, primarily because demand outstrips supply. One respondent reported long waiting times for every aspect of patient care, with around one year wait for new appointments, a similar wait for follow-ups and physiotherapy, 18 months for most procedures, over two years for psychology and over one year to see an occupational therapist (OT). These issues were highlighted many times to Trust management and commissioners. Another key theme was limited or no OTs, pharmacists and/or psychology.

Standard 13: Information website, Chapter 6.3

This standard was addressed by questions 23 and 24.

Q 23: Patients have access to online information on the services available to them.

Less than half of all sites reported that patients had access to online information about available services (47.42%), 30.93% reported partially meeting the standard, with 11.34% saying it was unmet. Scotland and England had the greatest percentage of sites reporting the standard was met (50%; 7/14 and 38/76 respectively), with Wales reporting 25% (1/4). In Northern Ireland, no service reported they were either able to fully or partially meet the standard; both sites reported it was unmet (see Figure 31).

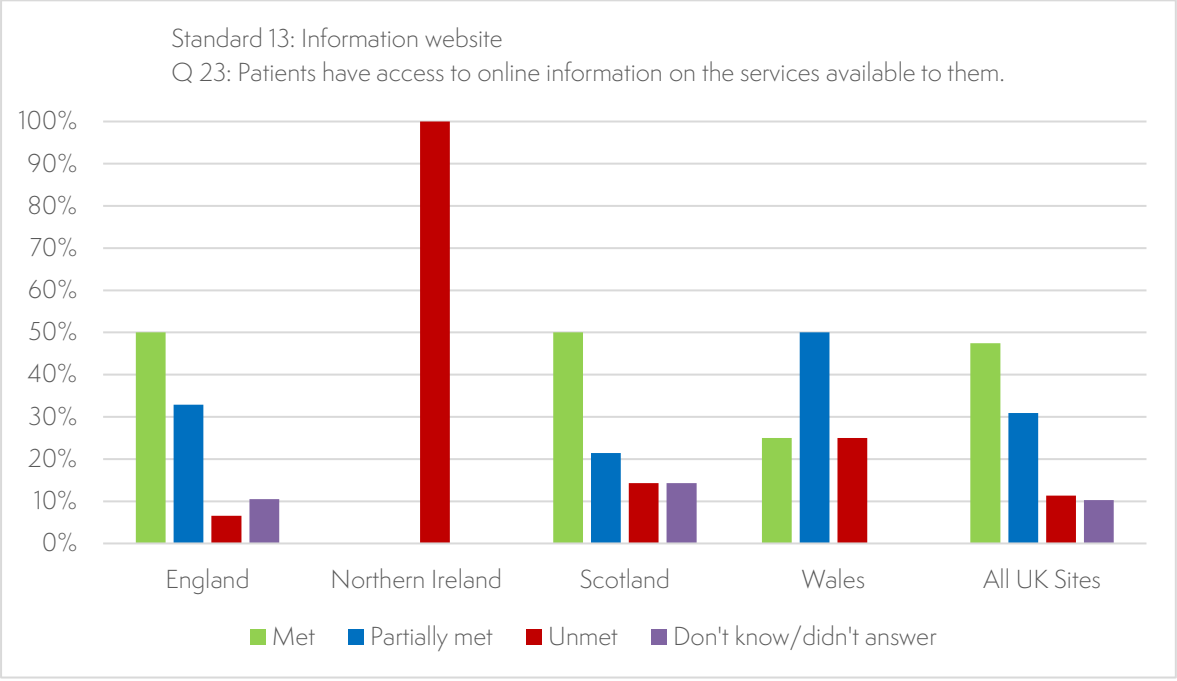


Figure 31: *Percentage compliance with standard 13 for online information on services available*

The North of England commissioning region had the lowest percentage of sites reporting they fully met the standard for access to online information about available services (27.27%; 6/22) with more than twice the number stating they partially met the standard (63.64%; 14/22). The East of England had the greatest percentage of fully compliant sites (66.67%; 6/9), followed by the South of England (62.5%; 15/24), London (58.33%; 7/12), then the Midlands (37.5%; 3/8) who had an equal number of sites stating they partially met the standard. Three regions had

sites stating the standard was unmet; the East of England (3/9), London (1/12) and the Midlands (1/8). Eight sites in England did not provide a response.

All Tier 3 level services met the standard. Within Tier 2, less than half of services met the standard (48.61%; 35/72) with just over a quarter stating it was partially met (26.39%; 19/72) and 12.5% (9/72) saying it was unmet. Nine of the Tier 2 sites did not provide a response. For Tier 3 services, fewer services reported meeting the standard (36.36%; 8/22) with half (11/22) stating it was partially met. Two services stated patients did not have access to online information about available services, with one site not providing a response.

Q24: The service offers video consultation.

Overall, just over half of all UK sites could provide a video consultation facility (51.55%). Across the nation, the picture was mixed, with 78.57% of sites in Scotland saying this standard was met, compared to 48.68% of sites in England, one site (50%) in Northern Ireland and no sites in Wales. 17.53% of sites in the UK reported the standard was not met; this was 18.42% of sites in England (14/76), 1 site in Scotland and 2 of the 4 sites in Wales (see Figure 32).

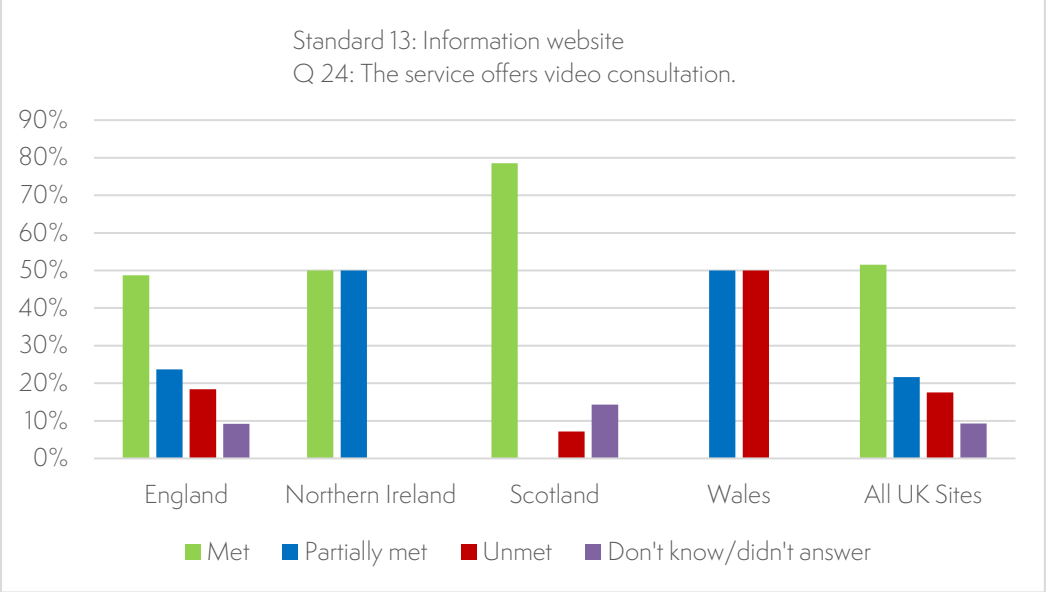


Figure 32: *Percentage compliance with standard 13 for services offering video consultation*

Both the South of England and East of England commissioning regions had higher levels of respondents saying they met the standard for providing video consultation (70.83% and 66.67% respectively), with the Midlands and London reporting 50% (4/8) and 41.67% (5/12). The North of England reported the lowest level of compliance, with only 22.73% of sites reporting they met the standard, with 36.36% stating they partially met and 31.82% stating it was unmet.

All Tier 1 services stated they were able to offer video consultation. Half of both Tier 2 and Tier 3 services (36/72 and 11/22) met the standard. While 16.67% and 22.73% of Tier 2 and 3 services stated the standard was unmet, 8 Tier 2 level sites and 1 Tier 3 level site did not provide an answer to the question.

Free text responses highlighted the widespread use of websites for providing patients with digitised information. However, some comments highlighted the need for more modernised and up-to-date platforms which required better co-ordination with clinical teams. Comments also demonstrated that as well as some teams offering video consultations, telephone and face-to-face were also provided. Some even provided patients with a choice of face-to-face, telephone or video to ensure patient's needs and preferences were met whilst also decreasing differential access. Looking in more detail about the comments particularly concerning video consultation, some respondents noted this medium was provided during the COVID-19 pandemic and had subsequently decreased, whilst others did not provide video consultations.

Standard 14: Availability of community/MSK services, Chapter 3.3

Q25: There is a link between community pain/MSK services and the chronic pain services.

Over half of all sites in the UK reported that they had a link between community pain/MSK services and their chronic pain services (55.67%; 54/97, see Figure 33). A further 24.74% (24/97) stated the standard was partially met, with 10.31% (10/97) stating it was unmet. Nine sites did not provide a response. Scotland had the highest percentage of sites reporting full compliance (71.43%; 10/14), with England reporting 53.95% compliance, and Wales and Northern Ireland both having 50% (2/4 and 1/2 respectively). In both Northern Ireland and Scotland, there were no sites who reported that no link existed between the community and chronic pain services, whereas one site in Wales and nine sites in England reported the standard was unmet.

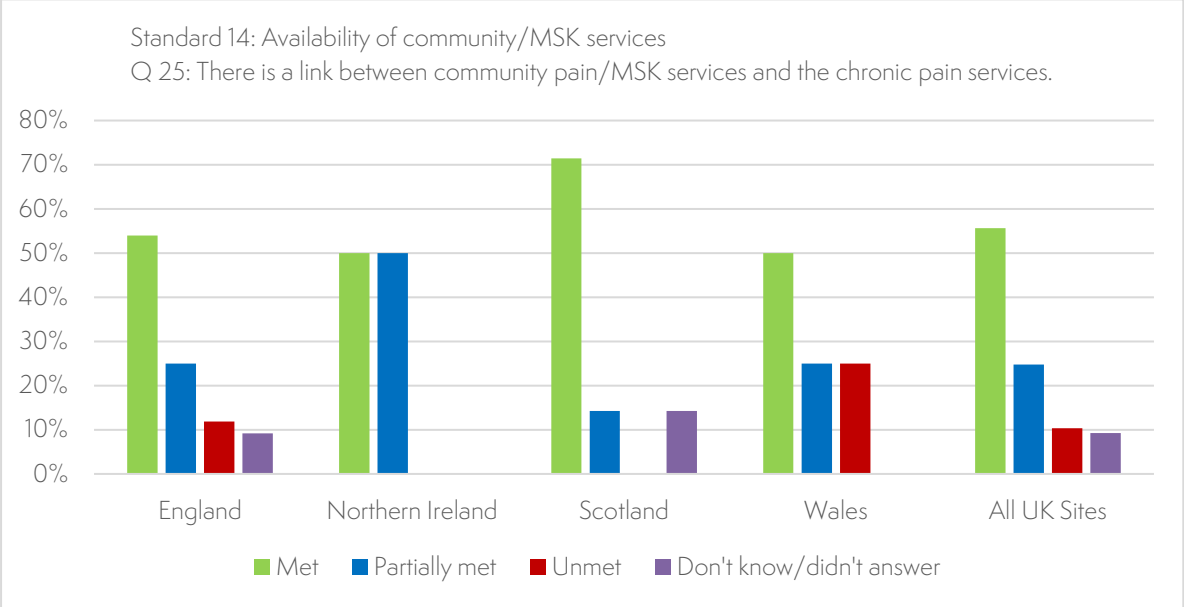


Figure 33: *Percentage compliance with standard 14 of a link between community pain/MSK services and the chronic pain*

The ability to meet the standard varied across England, with the East of England reporting only 33.33% compliance, compared to the North of England, of whom 68.12% reported they met the standard. London, the Midlands and the South of England reported 58.33%, 50% and 50% compliance respectively. All sites except the South of England had sites who reported there was no link between the community and chronic pain services, but three sites within the South of England commissioning region did not provide a response to the question.

Within the different service levels, Tier 1 reported 66.67% compliance with the standard, Tier 2 reported 56.94%, and Tier 3 reported 50% compliance. No Tier 1 services reported the standard was unmet, compared to 8.33% of Tier 2 services (6/72) and 18.81% of Tier 3 services (4/22).

Free text responses indicated there were links between the chronic pain services and community pain/MSK services. This included links with MSK services within the same Trust through governance, linking with programmes in MSK designed for people with chronic pain and links with the pain clinic within the acute Trust via scheduled monthly meetings. Although some respondents suggested links were informal and had little coordination, others emphasised collaborative working across teams and a proactive approach with MSK services with referrals, triaging and regular MDTs.

Standard 15: Mental health support, Chapters 2.2, 6.1 and 5.8

Standard 15 was addressed by questions 26 and 27.

Q26: There is a psychologist working within the service.

Overall, 63.92% of UK sites reported they had access to a psychologist working within the service (see Figure 34). Within the different countries, this varied from 50% in Northern Ireland, up to 75% (3/4) in Wales. 65.79% (50/76) of sites in England reported the standard was met, and this was 57.14% (8/14) in Scotland. All countries had sites who reported they did not have a psychologist working for the service (15.46%, 15/97), with nine sites not providing an answer to the question. This service was not available in private practice.

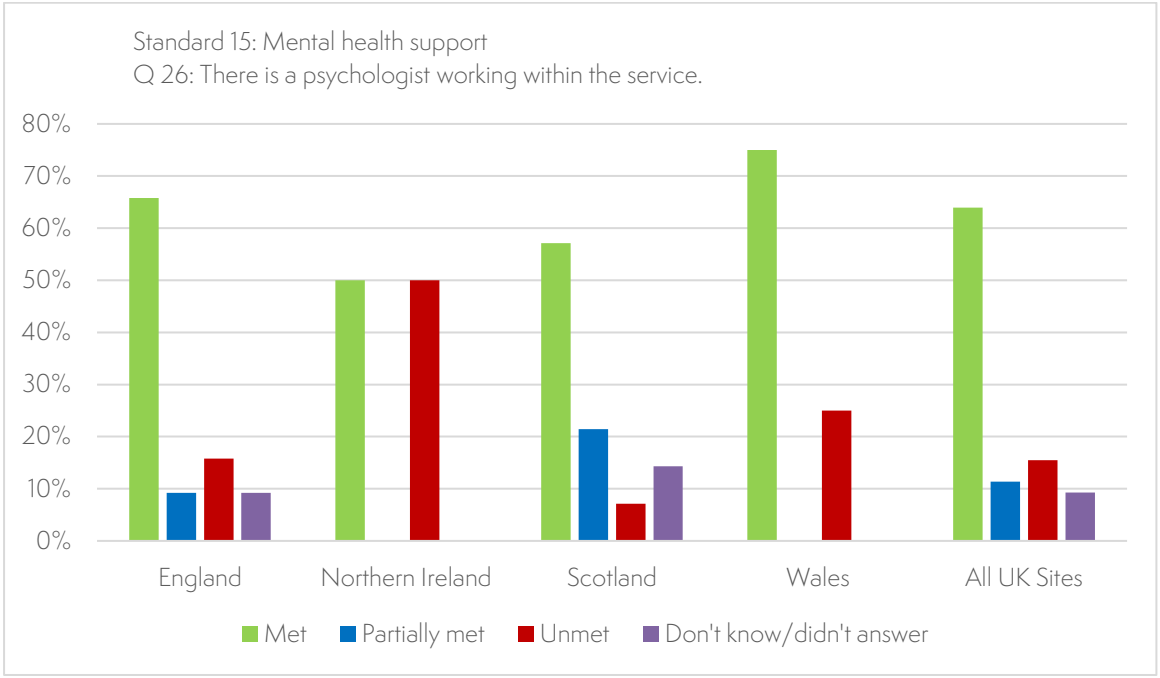


Figure 34: *Percentage compliance with standard 15 for the provision of a psychologist*

The availability of a psychologist within the pain service varied between the England commissioning regions, from the South of England reporting 79.17% of sites meeting the standard, to London only meeting the standard at 58.33% of sites. The North of England reported 59.09% compliance, and the Midlands reported 62.5%

compliance. A third of sites within both the East of England and London commissioning regions reported that the standard was unmet.

Within the levels of service, Tier 1 had 100% compliance with the standard, Tier 2 sites had 63.89% and Tier 3 sites reported 59.09% compliance. The standard was unmet by 15.28% of Tier 2 and 18.18% of Tier 3 level sites.

Q27: The service ensures that there is provision for early assessment of psychological/suicidal risk for patients referred to the service.

Within the UK, 44.33% of sites reported the standard was met, with 29.9% reporting it was partially met (see Figure 35). The early assessment of psychological/suicidal risk was met by MoD facilities but not met in private practice. Scotland reported the highest levels of services meeting the standard (64,29%; 9/14), while no sites in Northern Ireland reported meeting the standard. England had a compliance rate of 42.11% (32/76) of sites, with Wales reporting it was met by 25% (1/4).

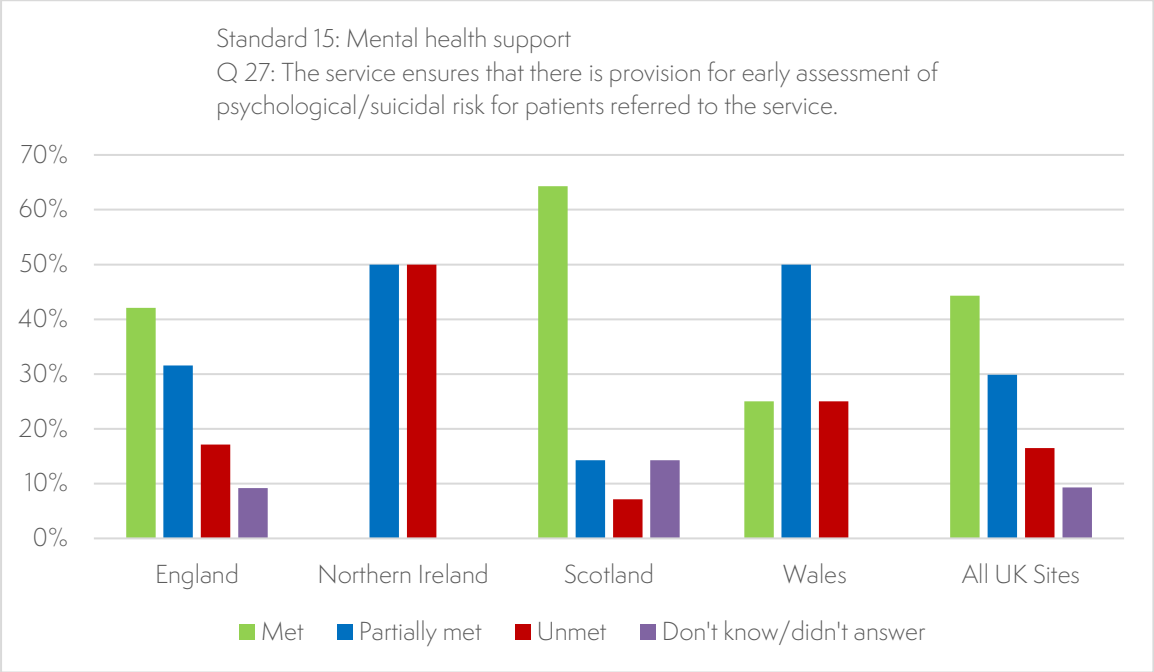


Figure 35: *Percentage compliance with standard 15 of early assessment of psychological/suicidal risk for patients*

The South of England had the highest reported incidence of sites meeting the standard (58.33%; 14/24) and 16.67% partially compliant; while the East of England had the lowest provision for assessment of psychological or suicidal risk (22.22%; 2/9), although 66.67% reported it was partially met. The Midlands had the greatest percentage of sites reporting the standard was not met (25%), and the East of England had the lowest at 11.11%, although again the South of England region had the greatest number of unanswered questions (3/24).

Tier 3 services all reported they were compliant with the standard. There was a substantial drop in the proportion of sites reporting provision for early psychological assessment in both Tier 2 and Tier 3 level services, with 41.67% of Tier 2 reporting the standard was met, and 31.94% reporting it was partially met. This was 45.45% and 27.27% in Tier 3 level services. More than one in five of Tier 3 services reported the standard was unmet (22.78%; 5/22), compared to 15.28% (11/72) of Tier 2 services.

Free text responses indicated that provision of a psychologist working within the service was mixed. This was driven by long wait times and limited availability, and patients with psychological/suicidal risk assessed (e.g. by an initial questionnaire or during telephone conversations with team members), escalated, triaged by consultants or psychologists and referred to mental health services. There was a common theme of issues with staffing for psychology, particularly related to recent and historical vacancies, with demand outstripping supply, particularly following the COVID-19 pandemic. Furthermore, a respondent noted that having a psychologist within the service was an area of struggle, compounded by management feeling there was no benefit. Other comments suggested there was a significant gap in the area of pain psychiatry where pathological mental health and pain co-exist. This, combined with no available pain psychiatry service, demonstrated that some patients are too mentally unwell to engage with pain psychology.

Standard 16: Medical Consultants – education, appraisal and revalidation, Chapters 5.9, 5.2.1, 8.1, 8.3 and 9.1

Q28: The pain specialists (Medical Consultants) participate in relevant MDT meetings and joint peer learning.

Across all UK sites, 75.26% reported that medical consultants participated in MDT meetings and joint peer learning, with a further 8.25% reporting this standard was partially met (see Figure 36). 6.19% (6/97) sites reported it was unmet, with a further 10 respondents not providing an answer to the question. Reported compliance ranged from 100% in Northern Ireland to 50% in Wales.

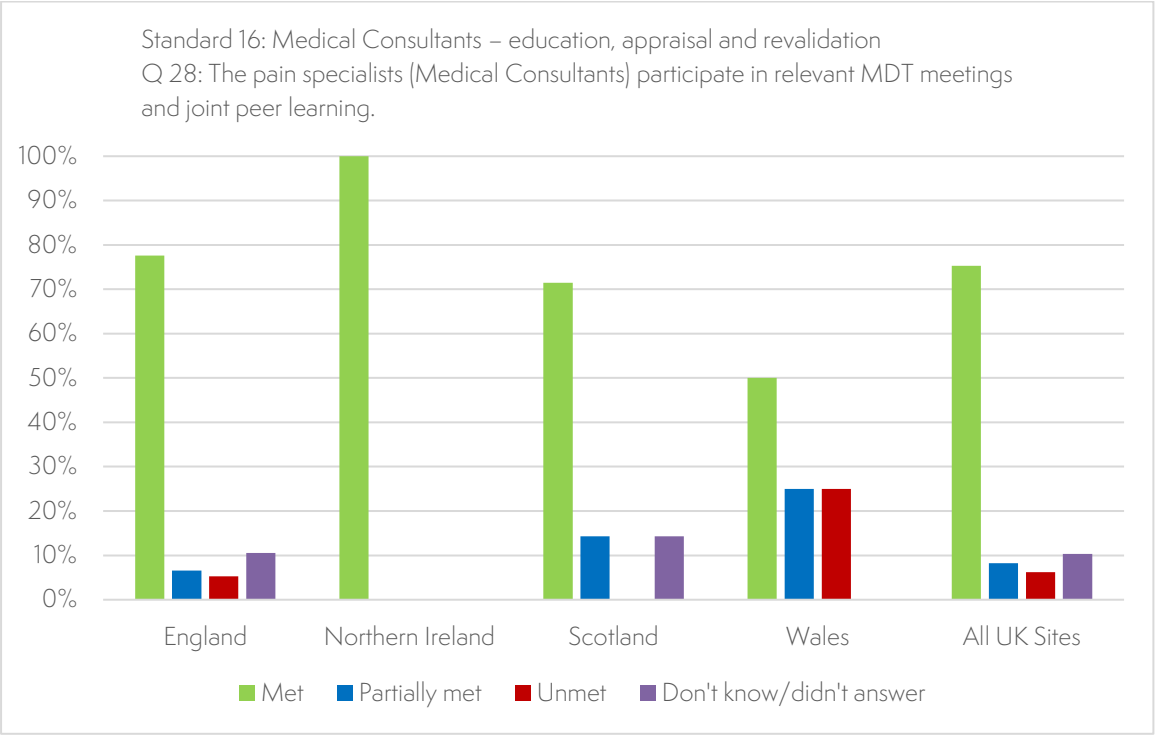


Figure 36: *Percentage compliance with standard 16 for pain specialists participating in relevant MDT meetings and joint peer learning*

All sites within the East of England commissioning region reported this standard was fully met. Other regions reported less compliance with London commissioning regions sites reporting 83.33% (10/12), North of England reporting 77.27% (17/22), Midlands reporting 75% (6/8), and South of England reporting 66.67% (16/24) fully met

the standard. The South of England had the most sites reporting the standard was unmet (three sites) with a single site in the Midlands also not meeting the standard.

Just one of the Tier 1 level services reported the standard was met. 76.39% of Tier 2 and 77.27% of Tier 3 level services stated they were fully compliant, with 5.56% of Tier 2 not meeting the standard.

Peer-led learning was a key theme from the free text responses with some suggesting this was regular and related to MDT meetings. However, other comments highlighted peer learning was limited, unpaid, on an *ad hoc* basis, not job planned, availability-dependent and was not an interest of their employer.

Standard 17: MDT working, Chapters 5.9, 5.2 and 5.4

Q29: There is provision for regular MDT meetings in pain at least once a month.

76.29% of sites reported there was provision for at least monthly MDT meetings, with 9.28% stating the standard was partially met (see Figure *37*). 5.15% (5/97) of sites stated they were not compliant with the standard, and 9 sites (9.28%) did not provide an answer.

Again, Northern Ireland had the highest percentage of services reporting they met the standard (100%), followed by Scotland (78.57%), England (77.63%), then Wales, with only a single site reporting they were compliant, one reporting partial compliance and two sites (50%) reporting the standard was unmet.

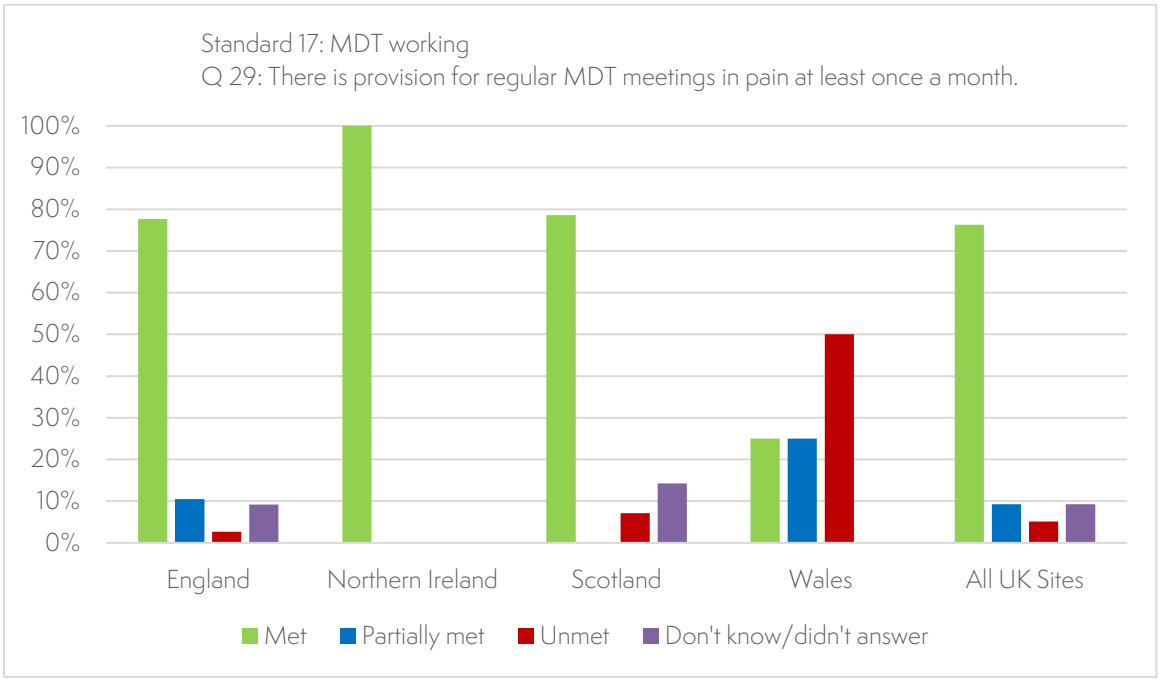


Figure 37: *Percentage compliance with standard 17 of prevision of MDT meetings in pain at least once a month*

Only two sites within England reported that they did not have provision for regular MDT meetings; these were one site in the Midlands commissioning region, and one site in the South of England commissioning region. All sites in the East of England reported they fully met the standard. The lowest level of compliance was in the Midlands (50%; 4/8), with the North, London and the South reporting 86.36%, 83.33%, and 66.67% respectively. Seven sites in England did not provide a response.

Only one Tier 1 site reported that the standard was fully met, with the remaining two sites reporting it was partially met. Tier 2 reported that 75% of sites were compliant, with 8.33% partially compliant and 5.56% not meeting the standard. Eight of the Tier 2 services did not provide an answer. Tier 3 services reported full compliance in 86.36% of locations, with 4.55% reporting partial compliance or not meeting the standard (a single site each).

Most free text responses indicated that regular MDT meetings in pain occurred on a weekly basis. However, there were a number of respondents who indicated that MDT meetings were conducted fortnightly, monthly or once every 6-8 weeks. These included formal MDT meetings with a formal agenda in protected time as well as contributing to other MDTs e.g., MSK, neuromodulation and secondary care spinal. However, other respondents noted that MDT meetings were not job planned and done in an informal way instigated by clinicians to ensure patient care in unpaid time. Furthermore, one respondent reported their weekly MDT meeting was associated with accessibility issues as there was no provision for staff working elsewhere on the day or provision for those on off days.

Standard 18: In hospital pain service, Chapter 6.5

Standard 18 was assessed by questions 30 and 31.

Q30: The in-hospital pain service has access to a Pain Medicine specialist who satisfies the training standards as outlined in the RCoA curriculum for pain training.

72.16% of all sites reported they met the standards for pain training, with a further 9.28% reporting it was partially met. 6.19% reported their site did not meet the standard, and 12.37% (12/97) did not provide an answer. England had the highest proportion of sites reporting they fully complied with the standards (77.63%), with Wales the lowest at 25% (1/4, see Figure 38).

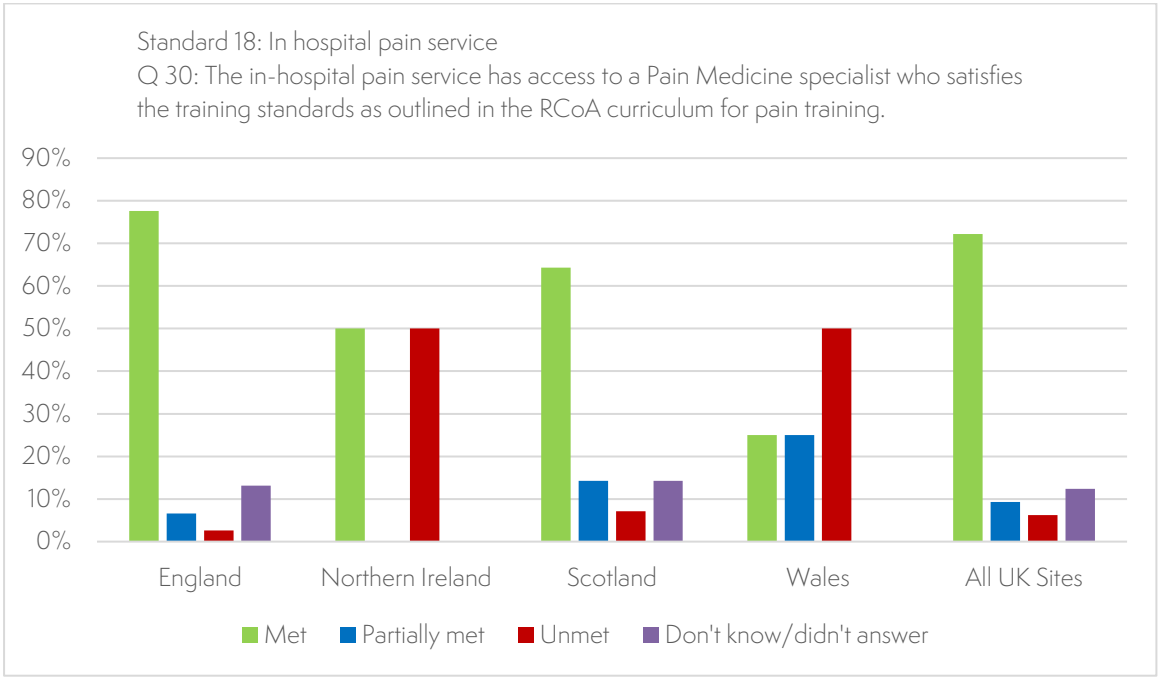


Figure 38: *Percentage compliance with standard 18 for the in-hospital pain service having access to a pain medicine specialist who satisfied the training standard as outlined in the RCoA curriculum for pain training*

London had 11 completed responses, all of which stated the standard was fully met (91.67%). East of England respondents all completed the answer, with eight reporting fully met (88.89%), and the remaining respondent reporting it was partially met (11.11%). The North of England reported 81.82% compliance, with 9.09% partially meeting the standards for having access to a pain medicine specialist; two sites did not provide a response. The Midlands reported 62.5% for fully met, and 12.5% for partially met, with 25% blank responses. The South of England was the only English region to have a site which reported they had no access to a pain medicine specialist (8.33%; 2/24), with a further 20.83% not providing an answer to the question (5/24).

No service in Tier 1 either fully or partially met the standard. Tier 2 level services reported 75% met the standard, with 72.73% of Tier 1 level services meeting the standard. Nine level two services did not provide a response.

Q31: There is a referral pathway between the in-hospital pain team and the chronic pain service.

65.98% of all services reported there was a referral pathway between the in-hospital pain team and the chronic pain service, with a further 15.46% reporting this standard was partially met (see Figure 39). 8.25% (eight sites) reported this standard was unmet, and ten respondents did not provide an answer.

England had the highest proportion of respondents stating their service fully met the standard (71.05%) with Wales and Scotland both reporting 50% of sites with full compliance. Neither of the two sites in Northern Ireland stated they complied with the standard.

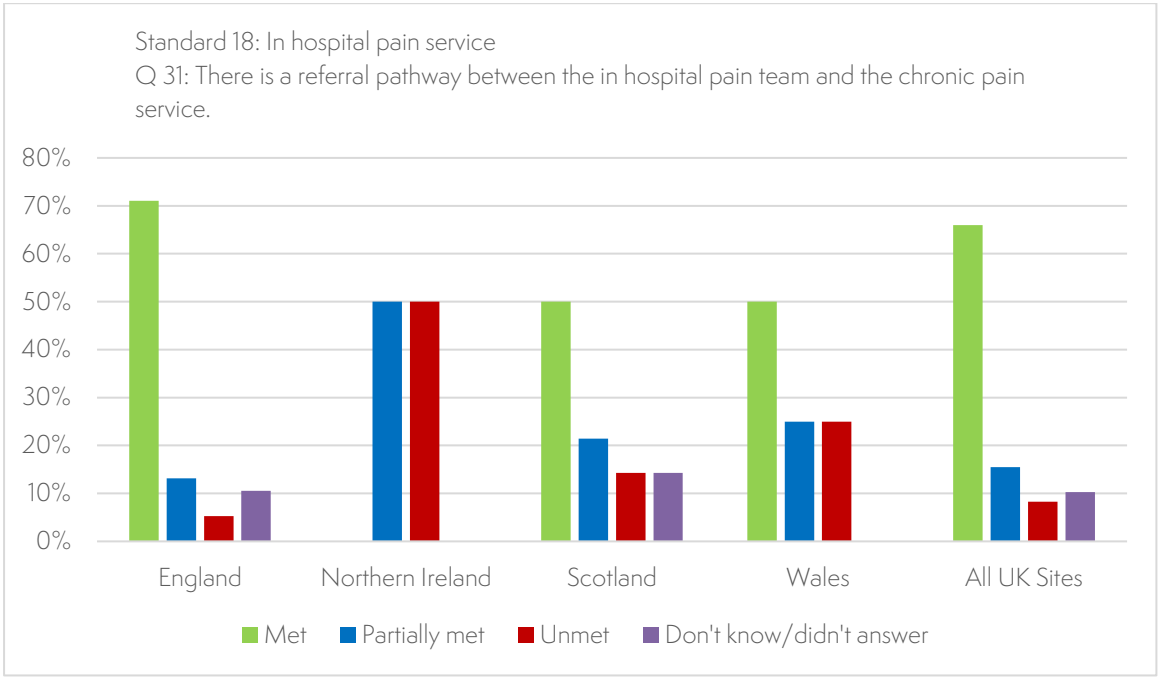


Figure 39: *Percentage compliance with standard 18 for the presence of a referral pathway between the in-hospital pain team and the chronic pain service*

The East of England provided full responses for this question (nine sites), with all sites either fully compliant (88.89%) or partially compliant (11.11%). Both London and the North of England had no sites who reported not meeting the standard, with 66.67% and 77.27% fully meeting the standard, and 25% and 13.64% partially meeting the standard

respectively. The Midlands (1 site) and the South of England (3 sites) both had sites who reported not meeting the standard.

Tier 2 had the largest proportion of sites reporting they had a referral pathway between the onsite hospital pain team and the chronic pain service, with 68.06% reporting full compliance and 15.28% reporting partial compliance. In Tier 3 services, this was 63.64% and 18.18% respectively. Each level of service reported not meeting the standard with one Tier 1, four Tier 2 and three Tier 3 sites stating it was unmet. Most blank responses were from Tier 2 level services, with 8 (11.11%) not responding.

Free text responses showed there were some strong links between respondents and the in-hospital pain service (characterised by chronic pain consultants having sessions and regular ward rounds and providing support/advice to in patient pain services). However, other respondents noted their link was informal, did not include regular ward rounds and comprised telephone advice only. Regarding the referral pathway between the in-hospital pain service and the chronic pain service, most responses indicated there was a standardised referral pathway and process which facilitated good, rapid access from inpatient to outpatient clinics and was underpinned by close and collaborative working between both teams. Nevertheless, other comments suggested the referral pathway was fragmented and informal (with teams advised to act via the GP) and referrals were on an ad hoc basis (though there were mechanisms in place to manage these).

Standard 19: Physiotherapy services, Chapter 5.1

Q32: There is a specialist pain physiotherapist working within the service.

More than two thirds of all UK sites reported having a specialist pain physiotherapist working within the service (70.1%, 68/97), with a further 8.25% (eight sites) reporting this was partially met (see Figure 40). 12.37% of sites reported the standard was not met, with 9.28% of respondents not reporting an answer.

Northern Ireland reported 100% compliance, with England and Scotland reporting 71.05% and 64.29% respectively, where Wales reported 50% compliance. The service offering private practice had access to a specialist pain physiotherapist.

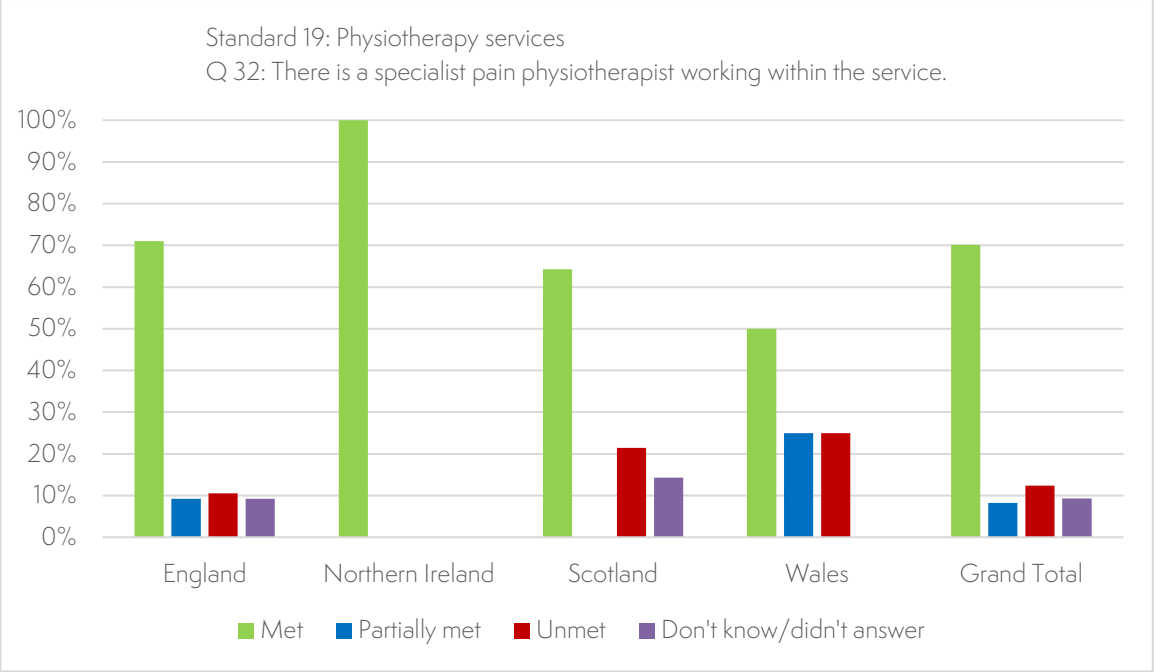


Figure 40: *Percentage compliance with standard 19 for the provision of a specialist pain physiotherapist*

Within the English commissioning regions, the area reporting the greatest compliance was the South of England (79.17%; 19/24) with the East of England (77.78%; 7/9) and the Midlands (75%; 6/8) all having at least 75% of sites meeting the standards. London reported 66.67% (8/12), with North of England reporting only 59.09% (13/22) of sites having a specialist pain physio working within the service.

All Tier 1 level services fully met the standard. Tier 2 had 69.44% (50/72) compliance, with Tier 3 reporting 68.18% (15/22). Again, the largest percentage of incomplete answers were from Tier 2 level services, with 11.11% (8/72) not supplying an answer.

The primary theme from the free text responses was there tended to be no specialist pain physiotherapist working within the service. However, physiotherapy was available and could be accessed by patients through a referral to the MSK team in the community. Some respondents noted they had a team of specialist pain physiotherapists who provide advanced diagnostic skills as well as therapy guidance with specialist spinal and MSK skills. Furthermore, another respondent acknowledged they had a physiotherapist in the service who worked as a specialist pain practitioner along with specialist nurses. This team member performed a similar role rather than a physiotherapy role despite having specialist knowledge. Comments also suggested that access to physiotherapy was dependent on capacity, with evidence of staff recruitment and retention issues.

Standard 20: Pain Management services, Chapters 3.4, 5.9 and 7.1

Q33: The service has access to a pain management programme.

More than two thirds of all sites met the standard (71.13%; 69/97), with a further 11.34% (11/97) reporting it was partially met. Eight sites reported they did not have access to a pain management programme (8.25%), and Nine respondents did not answer the question (9.28%, see Figure 41).

All sites in Wales and Northern Ireland reported they fully met the standard, with England reporting 71.05% compliance (54/76),) and Scotland reporting 64.29% (9/14). Only eight sites reported they did not have access to a pain management programme, six in England and two in Scotland.

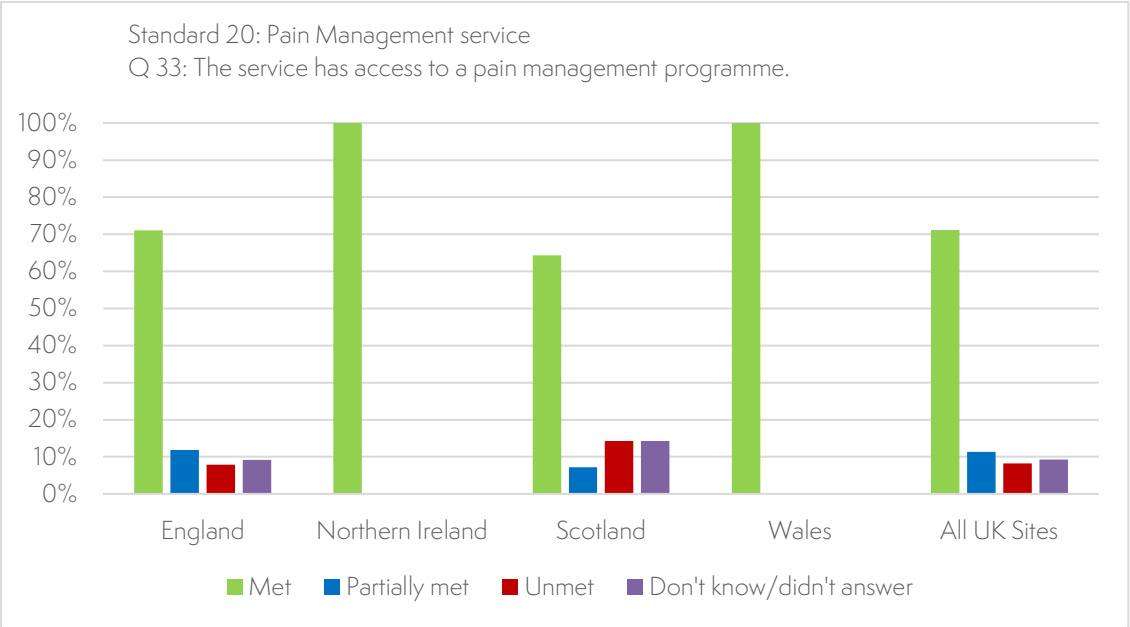


Figure 41: *Percentage compliance with standard 20 for services having access to a pain management programme*

The South of England commissioning region had the highest level of compliance with the standard, with 79.17% of sites reporting they were fully able to meet the standard, although one site reported being unable to meet the standard and a further site did not answer the question. London and the East of England had the lowest level of fully compliant sites at 66.67%, with a further 16.67% and 11.11% reporting partially meeting the standard, respectively.

All community Tier 1 level sites reported being compliant with the standard. Tier 2 level services reported 72.22% compliance, with a further 9.72% reporting partial compliance, with Tier 3 services reporting 63.64% and 18.18% respectively. Five Tier 2 and three Tier 3 sites reported the standard was unmet. 9 of 97 sites did not answer the question, eight of which were Tier 2 services.

The primary theme for this standard was that services referred patients to a pain management program (PMP). This included PMPs in the community, elsewhere, to GPs who in turn refer patients to the PMP and a private provider. Some respondents felt patient access to a PMP was a postcode lottery as due to the configuration of the community MSK service and PMP having been subsumed under their umbrella. Other respondents indicated a comprehensive PMP in their service which delivered different programs e.g. Living Well with Pain, ACT/mindfulness, Moving Well with Pain and a young persons' programme. If patients required an individualised programme, this was achievable. Comments acknowledged this is an area of improvement, and respondents were working collaboratively with specialists from different groups to be able to offer PMPs in the future.

Standard 21: Interventional pain procedure, Chapter 7.3

Q34: The service offers interventional pain procedures for suitable pain patients.

Over three quarters of all UK sites reported they fully met the standard (79.38%; 77/97), with a further six sites reporting they were partially compliant (see Figure 42). Five sites (5.15%) reported they did not offer interventional pain procedures, with nine sites (9.28%) not answering the question.

All sites in Wales and Northern Ireland offered interventional pain procedures, as did three quarters of sites in Scotland and England (78.57% and 78.95%).

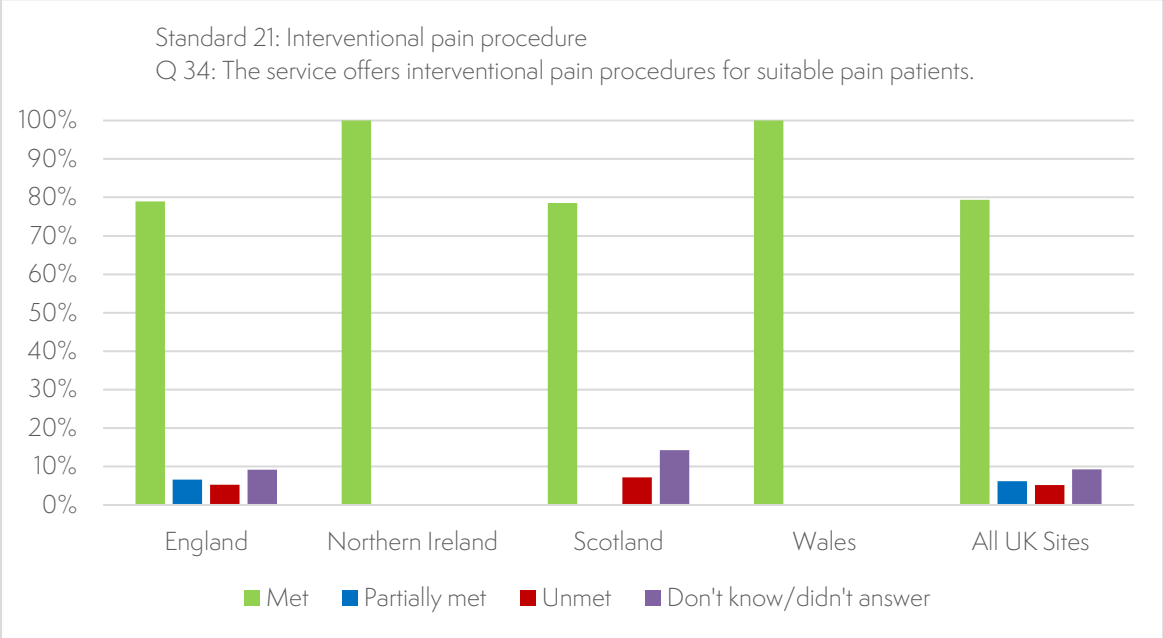


Figure 42: *Percentage compliance with standard 21 for services offering interventional pain procedures*

Every site within the East of England commissioning region reported being fully compliant with the standard (9/9), with all services in London who completed the question (11/12) also offering interventional pain procedures. The North of England reported 81.82% full compliance with a further 9.09% saying they were partially compliant; none reported being unable to meet the standard, although two sites did not give an answer. The Midlands and South of England both had sites which reported being unable to meet the standard (both 12.5%), with the South of England saying 66.67% and 62.5% of the Midlands sites saying the standard was fully met.

No sites based in the community (Tier 1) reported meeting the standard, although one stated they were partially able to. The highest level of compliance was seen in Tier 3 services, with 90.91% reporting full compliance, although one site reported they were only partially able to offer interventional pain procedures, and one site did not answer. Tier 2 level services reported 79.17% compliance (57 sites), with four sites partially compliant and three sites not meeting the standard. Eight Tier 2 services did not give a response.

Free text responses indicated there were some limitations with offering interventional pain procedures for suitable pain patients. This included limited scope with implementation and quality issues, no ringfenced theatre space due

to small numbers, long waiting times, equipment not replaced or available for each clinician, limited funding and a lack of evidence for providing interventional procedures. Other comments comprised services linking up with pain clinics at Acute Trusts to provide interventional pain procedures and working with neurosurgeons to deliver the procedures. However, some respondents noted that patients had a choice of three hospitals, including an expedited radicular pain pathway in their service. Another noted they had two chronic pain consultants offering interventional pain procedures.

Discussion

This novel nationwide survey received 164 responses from 102 sites of which 97 responses were valid and were included. Questions assessed individual pain service's perceived compliance with the 'gold standards' for practice developed by the FPM. The survey had questions pertaining to 21 standards. Overall, in the UK, for all the 21 standards, 58.22% of pooled responses to these standards reported fully met, 19.65% were partially met, 15.08% of the standards were unmet with the rest being classed 'as don't know/didn't answer'.

The majority of respondents worked in secondary care (74.23%), followed by 22.68% in tertiary care and finally 3.09% from primary care, suggesting that community pain services may not have embedded FPM trained professionals or medical consultants trained in pain medicine within them.

No single standard was met by all sites, and the number of sites meeting each standard varied from 29.9% to 80.4%.

Staffing/structure

The majority of services (65%) reported that they had a clearly defined medical involvement in their service. However, this represented a reduction from the 85% of pain clinics who reported in 2013 that they had a consultant presence in their service.[15] It should be noted that even in Tier 3 services, a clearly defined medical involvement was 63.64%. The FPM guidance on 'Improving the Lives of People with Complex Chronic Pain'[16] states that "delivering treatment of complex health conditions in silos with a reliance on reductionist and single modality approaches often renders treatment ineffective, wasting considerable resource. This in turn results in delays in accessing the right care by the right professionals at the right time and is likely to contribute to dependency on addictive pain medications and the declining potential for functional rehabilitation." Increasing the number of Tier 1 services who provide input from medically trained pain professionals and establishing clear and pragmatic pathways between the various tiers of pain services is likely to improve the patient treatment journey. This would also mean that GPs, physiotherapists, nurses and pharmacists who are involved in pain management delivery are involved in developing these pragmatic pathways.

High degrees of variation in a service's ability to meet the standards were commonly observed both between countries and between the different commissioning regions. Where this was related to staffing needs or service structure, it was noted to impact on the provision of psychological and physiotherapy services, a situation compounded by difficulty recruiting and unfilled vacancies, and long waiting times for the services. Nationwide, pain psychology support, a key component of biopsychosocial pain management[17] was offered in slightly over half of responding services. The lack of staffing impacted on many aspects of the service, including training, supervision, consultant input, patient resources and the provision of chaperones. The lack of provision of chaperones remains a safety issue in this vulnerable group of complex patients.

Process and Pathways

Most services reported that data regarding waiting times was collected, and that long waiting lists existed; a situation which had been impacted by COVID-19, industrial action and staffing/resources shortages. It is clear that demand for specialist pain medicine services significantly exceeds capacity. Pain medicine departments were heavily impacted by the closure of services and redeployment of staff throughout the pandemic, leading to backlogs developing. Many services reported these backlogs still remained despite the use of alternative models of service delivery, and the provision of additional clinical sessions both during the week and at weekends.[18] Although current waiting times were not investigated by the survey, free text responses from respondents indicated that the duration of waits could be as long as 18 months to two years before having medical involvement, one year for occupational therapy input and over two years for psychology input. This is a situation seen throughout the NHS, with large variations between regions and clinical specialties.[19] In 2011, results from the National Pain Audit[15] showed that 80% of clinics in England met the government target of 18 weeks to first appointment, with median waits for clinics who did not meet the target, of 20 weeks in England and 33 weeks in Wales. Innovative solutions need to be developed here to reduce waiting times for patients before they receive a medical opinion.

Provision of interventional pain services, although high (79%), was impacted by lack of resources. This figure represents a reduction from 2013[15], when 96% of specialist pain services reporting offering this service. Respondents highlighted a range of barriers to provision including a lack of theatre space, long waiting times, and limited funding.

There was good provision of MDTs with input from consultants (76%), although this was a reduction from the 88% in 2013; a lack of provision of resources was consistently reported throughout the survey, with some clinical activities, research and tuition taking place in the clinicians' own time and largely unsupported by employers.

A lack of formal pathways or links between teams was notable, with large regional variations in the numbers of services having links with community pain/MSK services. An increase was reported in access to PMPs (71%) compared to 2013[15], when 61% of clinics provided PMPs, although access to these was again subject to regional variation in compliance.

However, 66% of services reported the existence of a formal referral pathway between the in hospital and chronic pain services, which was an improvement on the findings of a 2017 survey which found only half of respondents felt the services were integrated.[20]

Training in pain medicine is vital for creating a well skilled and knowledgeable future medical workforce and with the onset of GMC credentialling represents a priority for the specialty.[21, 22] Two thirds of pain services provided Stage 1 and 2 pain training that complied with RCoA requirements, however, only half of pain services were able to provide supervision for Stage 3/SIA training. The survey was unable to determine whether this was due to some of the respondents working exclusively in pain medicine with no sessions in anaesthesia.

Pain is reported by 30% of cancer patients at diagnosis[23], and for many, this persists after treatment. Between 33% and 40% of cancer survivors live with chronic pain[24, 25] and approximately half of patients with advanced incurable cancer experience moderate to severe pain[26]. The GAP analysis revealed that cancer patients generally were not well served by specialist pain teams, with less than a third of services providing specialist care. This is despite the use of intrathecal drug delivery treatment being centrally commissioned by NHS England for patients with refractory severe cancer pain[27] and the publication of the guidance by the FPM.[28]

Children also suffer from chronic pain and need pain services tailored for children. Chronic pain is a leading cause of morbidity in children,[29] but less than half of teams (36.6%) provided a service for paediatric patients. Only one third of adult pain services provided a visible referral criterion to paediatric patients. This survey could not ascertain where or by whom paediatric chronic pain is being managed outside of pain management services.

Outcomes

A good service needs to collect outcomes related to the efficacy of the service. The FPM has published guidance on this.[30, 31] Clinical operational research to improve outcomes is critical to improve the lives of people living with chronic pain. Less than 20% of services had any form of database for pain research and the collection of PROMS data was low (29%), with inconsistent collection or recording noted, despite services being expected to carry out research and evaluation of patient outcomes.[15] This too was impacted by staffing resources.

Digital services available differed between regions, with the use of video consultations having decreased since the pandemic (when almost 80% of respondent services reported using either telephone or video consultations[18]) to a current situation where half of sites undertook remote consultations, with significant regional variation. Provision of information for patients was good, with the use of digital and hard-copy information leaflets reported.

Strengths and limitations

One of the strengths of this report is that all countries within the UK are represented, however the models for service provision have nuanced differences with funding provision and staffing models; this may have impacted on the regional variation seen in compliance with the standards. The previous National Pain Audit[15] did not include Scotland and Northern Ireland in their analysis.

The results of this survey are limited due to unequal representation of the regions within the UK, with the South of England having the greatest representation. Some sites had submitted multiple responses, it was not always clear if responses were inadvertent duplicates or represented the views of different clinicians. Where obvious separate responses were present from the same site, sometimes disagreement on compliance with standards between clinicians was evident; only the most clinically senior response was used for the quantitative analysis. However, all free text responses were used in the thematic analysis to add further context and insight to the findings; this may explain why comments were sometimes seemingly at odds with the overall compliance data.

The survey also did not provide an option to report 'unknown' to questions, which may have explained why there were a high number of unanswered questions in the responses.

Future directions

With this report we have mapped the current performance of pain services (against the 'gold standard') as reported by FPM members from 97 sites within the UK. This report will be submitted to the FPM board and the results communicated to all the participating sites as well as considerations given to emailing the executive summary to each of the NHS sites' senior management team.

Finally, we hope that NHS sites providing Chronic Pain Services will have a careful look at this report and decide upon the most appropriate improvements required in their local Chronic Pain Services.

Conclusion

This GAP analysis was a nationwide survey to benchmark the current state of pain services against the desired 'gold standard'. The percentage of standards that were reported as fully met (as defined by the 'gold standards') ranged between 48-63% across the four UK countries. The percentage of standards that were reported as completely unmet ranged from 9.4-26% across the four UK countries. The following areas need urgent attention across the UK:

a) Provision of paediatric pain services
b) Provision of cancer pain services
c) Provision of outcome data (PROMS) support to pain services
d) Provision of support for research and innovation to pain services
e) Increased support of psychological services and PMP access

References

1. Treede R-D, Rief W, Barke A, Aziz Q, Bennett MI, Benoliel R, et al. Chronic pain as a symptom or a disease: the IASP Classification of Chronic Pain for the International Classification of Diseases (ICD-11). *pain.* 2019;160(1):19-27.
2. Collier R. A short history of pain management. *CMAJ.* 2018;190(1):E26-E27.
3. Mills SE, Nicolson KP, Smith BH. Chronic pain: a review of its epidemiology and associated factors in population-based studies. *British journal of anaesthesia.* 2019;123(2):e273-e283.
4. Faculty of Pain Medicine. https://fpm.ac.uk/, 2024.
5. Faculty of Pain Medicine. Core Standards for Pain Managment Services in the UK. https://fpm.ac.uk/sites/fpm/files/documents/2021-07/FPM-Core-Standards-2021_1.pdf. Accessed 31/01/2024, 2024.
6. Fayaz A, Croft P, Langford RM, Donaldson LJ, Jones GT. Prevalence of chronic pain in the UK: a systematic review and meta-analysis of population studies. *BMJ Open.* 2016;6(6):e010364.
7. Phillips CJ. The cost and burden of chronic pain. *Reviews in pain.* 2009;3(1):2-5.
8. Puntillo F, Giglio M, Brienza N, Viswanath O, Urits I, Kaye AD, et al. Impact of COVID-19 pandemic on chronic pain management: Looking for the best way to deliver care. *Best Practice & Research Clinical Anaesthesiology.* 2020;34(3):529-537.
9. Faculty of Pain Medicine. COVID 19: FPM statement on the ongoing impact on the provision of Higher and Advanced training https://fpm.ac.uk/covid-19-fpm-statement-ongoing-impact-provision-higher-and-advanced-training.
10. Faculty of Pain Medicine. *Survey: Re-opening of Chronic Pain Services during COVID-19*2021.
11. Weiss A, Wilkinson P, De Gray L. *FPM guidance on resumption of pain services following disruption by the COVID-19 pandemic*2020.
12. Royal College of Anaesthetists. Guidelines for the Provision of Anaesthetic Services. https://www.rcoa.ac.uk/safety-standards-quality/guidance-resources/guidelines-provision-anaesthetic-services, 2023.
13. Iqbal S, Pipon-Young L. Methods-the delphi method--A guide from susanne iqbal and laura pipon-young. *Psychologist.* 2009;22(7):598.
14. Taylor E. We agree, don't we? The Delphi method for health environments research. *HERD: health environments research & design journal.* 2020;13(1):11-23.
15. Price C, de C Williams AC, Smith BH, Bottle A. The National Pain Audit for specialist pain services in England and Wales 2010–2014. *British Journal of Pain.* 2019;13(3):185-193.
16. Faculty of Pain Medicine. Improving the Lives of People with Complex Chronic Pain: How to Commission Effective Pain Management Services in England. https://fpm.ac.uk/sites/fpm/files/documents/2020-06/Commissioning%20guidance%20draft%20design%20FINAL_0.pdf.
17. Wade DT, Halligan PW. The biopsychosocial model of illness: a model whose time has come. *Clinical Rehabilitation.* 2017;31(8):995-1004.
18. Faculty of Pain Medicine. Clearing the backlog caused by the pandemic; Inquiry. Written evidence submitted by The Faculty of Pain Medicine of the Royal College of Anaesthetists (CBP0046)2022.
19. Warner M, Zaranko B. *The past and future of NHS waiting lists in England*2024.
20. Rockett M, Vanstone R, Chand J, Waeland D. A survey of acute pain services in the UK. *Anaesthesia.* 2017;72(10):1237-1242.
21. McGhie J; de Gray, L, Miller, B; Hughes, J; Waeland, D; Goodwin, J. *Faculty of Pain Medicine: Curriculum for the Credential in Specialist Pain Medicine (Version 1)*2023.
22. General Medical Council. Credentialing. https://www.gmc-uk.org/education/standards-guidance-and-curricula/guidance/credentialing. Accessed 05/04/2023, 2023.

23. Breivik H, Cherny N, Collett B, De Conno F, Filbet M, Foubert A, et al. Cancer-related pain: a pan-European survey of prevalence, treatment, and patient attitudes. *Annals of oncology.* 2009;20(8):1420-1433.
24. Paice JA. Chronic treatment-related pain in cancer survivors. *Pain.* 2011;152(3):S84-S89.
25. Seretny M, Currie GL, Sena ES, Ramnarine S, Grant R, MacLeod MR, et al. Incidence, prevalence, and predictors of chemotherapy-induced peripheral neuropathy: a systematic review and meta-analysis. *Pain®.* 2014;155(12):2461-2470.
26. Van den Beuken-van Everdingen M, De Rijke J, Kessels A, Schouten H, Van Kleef M, Patijn J. Prevalence of pain in patients with cancer: a systematic review of the past 40 years. *Annals of oncology.* 2007;18(9):1437-1449.
27. NHS England. Clinical Commissioning Policy: Intrathecal Pumps for Treatment of Severe Cancer Pain. Reference: : D08/P/b. July 2015.:https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/10/d08pb-intra-pumps-trtmnt.pdf. Accessed 03/08/2021, 2021.
28. Bennett M, Miller B, Weiss A, Wilkinson P, Davies A, Tillett T, et al. Framework for Provision of Pain Services for Adults Across the UK with Cancer or Life-limiting Disease. https://fpm.ac.uk/media/4856. Accessed 25/03/2024.
29. World Health Organization. *Guidelines on the management of chronic pain in children*2020. 9240017879.
30. Faculty of Pain Medicine. FPM release joint Outcome Measures guidance. https://fpm.ac.uk/fpm-release-joint-outcome-measures-guidance.
31. Faculty of Pain Medicine. Outcome Measures. https://fpm.ac.uk/sites/fpm/files/documents/2019-07/Outcome%20measures%202019.pdf.
32. Royal College of Anaesthetists. Anaesthesia Clinical Services Accreditation. https://www.rcoa.ac.uk/safety-standards-quality/anaesthesia-clinical-services-accreditation. Accessed 05/04/2023, 2023.

Appendices

Appendix A:

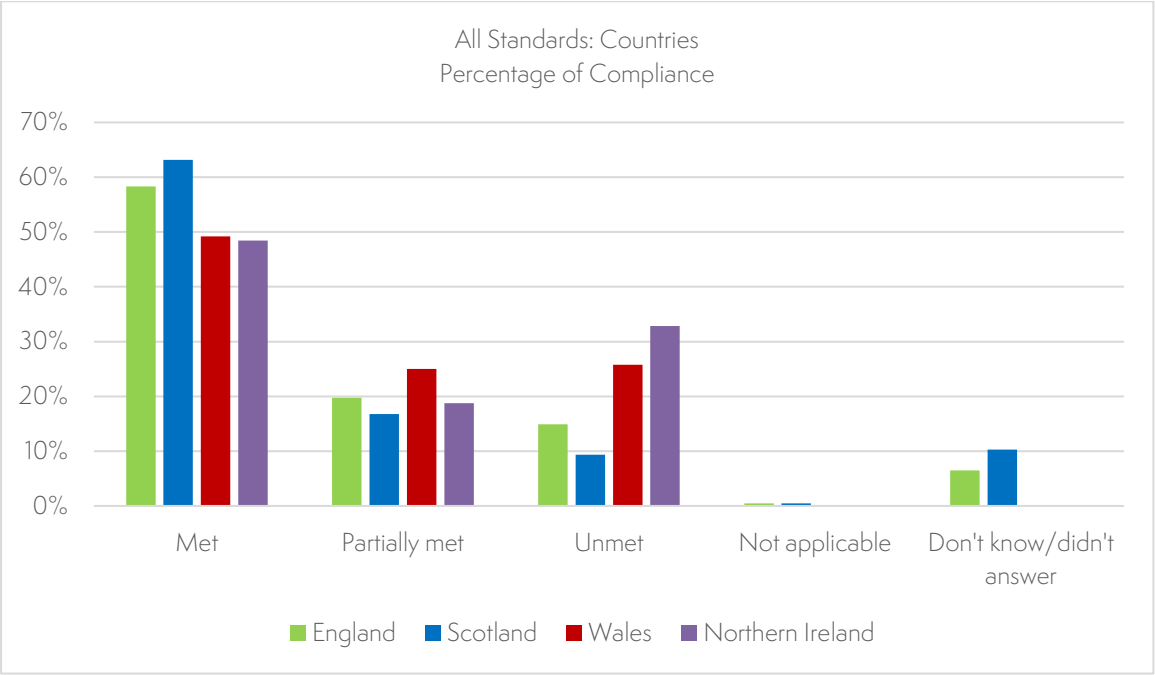
Tabular summary of survey questions including their relation to the CSPMS standards.

Standard number	Standard heading	Question	Standard details	CSPMS chapter
	Service and contact details	1.	Respondent contact details	-
		2.	Role	-
1	Medical involvement	3.	Safe delivery of all clinical services demands that they are commissioned to include medical involvement within the care pathway. The scope and place of medical involvement is clearly defined for each pain management service, including routes of accountability	3.3
2	Waiting list times	4.	The service collects information on waiting times to both first appointment and treatment.	3.1 and 3.2

		5.	The service manages patient flow through service pathways, with managers and commissioners, to ensure that long waiting lists do not develop.	
3	Availability of paediatric pain services referral pathway	6.	The service manages paediatric patients with pain. If not, the service has a referral pathway to a centre which offers paediatric services.	6.7.1, 6.7.2 and 6.7.3
		7.	The service provides visible referral criteria to referrers and patients for paediatric pain patients.	
4	Availability of neuromodulation services	8.	The service provides neuromodulation services. If not, the service has functioning links with a centre offering neuromodulation.	7.3
5	Pathways for chronic pain	9.	The service's pain management pathways for chronic pain in adults meet the current evidence based standards as outlined in *Core Standards for Pain Management Services in the UK* (CSPMS UK).	6.4
		10.	The service collects Patient Reported Outcome Measures (PROMs) data.	
6	Pain trainees	11.	The service is able to provide supervision for Stage 1 and 2 pain training as per the RCoA curriculum	5.2.3
		12.	Your centre is able to provide supervision for Stage 3 and Specialist Interest Area (SIA) pain training as per the RCoA curriculum.	
		13.	The service has a member of staff who acts as Faculty Tutor for pain training.	
7	Availability of cancer pain services	14.	The service is able to provide cancer pain services.	6.6
8	Effective data management support available	15.	Clinical governance systems are in place to allow appropriate reflection and discussion on the outcome data, in particular to highlight areas of concern and/or areas that require change or improvement.	3.7.5 and 5.1
		16.	The service has a pain database for research and it has either Research Ethics committee [REC] or Caldicott Guardian approval.	
9	Research and development	17.	The department has protected time to discuss relevant research and newer developments.	9.3
10	Consultation facilities	18.	General facilities are well signed, accessible, comfortable and welcoming in compliance with the Equality Act 2010.	4.1 and 4.2
		19.	The service is able to communicate to patients of delays and current waiting times.	

		20.	The service has provision to provide patient information leaflets.	
11	Safeguarding	21.	A chaperone is available for the pain clinic outpatients and theatre.	10
12	Access to specialised pain management services	22.	The service ensures that national standards as per *Core Standards for Pain Management Services in the UK* (CSPMS UK) for access to pain management services are met, irrespective of whether the service is situated in the community or in a hospital setting.	3.2
13	Information website	23.	Patients have access to online information on the services available to them.	6.3
		24.	The service offers video consultation.	
14	Availability of community/MSK services	25.	There is a link between community pain/MSK services and the chronic pain services.	3.3
15	Mental health support	26.	There is a psychologist working within the service.	2.2, 6.1 and 5.8
		27.	The service ensures that there is provision for early assessment of psychological /suicidal risk for patients referred to the service.	
16	Medical consultants – education, appraisal and revalidation	28.	The pain specialists (Medical Consultants) participate in relevant MDT meetings and joint peer learning.	5.9, 5.2.1, 8.1, 8.3 and 9.1
17	MDT working	29.	There is provision for regular MDT meetings in pain at least once a month.	5.9, 5.1 and 5.4
18	In hospital pain service	30.	The in-hospital pain service has access to a Pain Medicine specialist who satisfies the training standards as outlined in the RCoA curriculum for pain training.	6.5
		31.	There is a referral pathway between the in hospital pain team and the chronic pain service.	
19	Physiotherapy services	32.	There is a specialist pain physiotherapist working within the service.	5.1
20	Pain Management service	33.	The service has access to a pain management programme.	3.4, 5.9, 7.1
21	Interventional pain procedure	34.	The service offers interventional pain procedures for suitable pain patients.	7.3

Appendix B:



Graph showing % reported compliance with standards by country

Appendix C:

Descriptive statistics of responses to questions. Available to view in full on our website.

FACULTY OF
PAIN MEDICINE
of the Royal College of Anaesthetists

www.fpm.ac.uk
@FacultyPainMed
contact@fpm.ac.uk
0207 092 1540

Churchill House
35 Red Lion Square
London WC1R 4SG