

ALL IN THE MIND

**WHY THE NHS MUST CHANGE
ITS ATTITUDE TO PAIN
MANAGEMENT SERVICES**





Is this a chronic pain patient

or the healthcare professional
trying to help them?



If you're looking for ways to improve chronic pain services, PACE provides solutions. By connecting chronic pain services nationwide and providing practical support, we can help you to change pain management for good.

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FOREWORD

The silent epidemic

Chronic pain can devastate lives, yet it is not routinely assessed and pain services are patchy. The Chronic Pain Policy Coalition is working to improve its prevention, treatment and management.

This past decade has been a significant period for the NHS, with unprecedented growth in capital investment, better access and waiting times for many patients and significant progress in the management of major chronic disease.

But, for the 7.8 million people in the UK with chronic pain, services for their condition are relatively under-resourced in expertise in the community and in hospitals.

The effect of this silent epidemic on the lives of those in pain and their families is enormous. Chronic pain can leave people marginalised, depressed, unable to undertake even the most basic of activities and struggling to maintain relationships with friends, family, employers and colleagues. Around half of those who suffer chronic pain develop depression and go on to lose their jobs.

Positive steps are being taken with the agreement of a chronic pain pathway within the 18-week wait programme.

Although pain services exist in hospitals in the UK, these vary.

There are no national guidelines for



the treatment and management of chronic pain in England and there is no cohesive plan for this, as exists in Scotland and Wales.

It is essential that more work is done to improve care closer to home, to provide specialist care in the community and more cost-effective services, and to encourage closer working between primary and secondary care. PACE

(Pain: Collaboration and Exchange) is one of a number of excellent initiatives addressing these.

The CPPC unites patients, professionals and parliamentarians seeking to develop an improved strategy for the prevention, treatment and management of chronic pain and its associated conditions.

Last summer the CPPC launched its five-point pain manifesto which presents a number of forward-looking and cost-effective policy recommendations.

Central to these is the campaign to have pain adopted as the fifth vital sign – if pain were routinely assessed with the same priority as blood pressure, temperature, pulse and respiration rate, a great deal of unnecessary suffering, stress and anxiety could be avoided. ●

Baroness Rennie Fritchie is president of the Chronic Pain Policy Coalition.

A NOTE FROM THE EDITOR

Pain deserves to be a priority

An effective pain management service has huge benefits for not only the NHS but also the whole country.

The longer someone is off work with pain, the less likely they are to return. Ensuring appropriate patients are referred quickly to a multidisciplinary pain management clinic can help prevent pain becoming chronic through effective treatment and rehabilitation. This reduces dependence on state benefits, the prescribing of unnecessary painkillers and the costs of other ongoing treatment.

By redesigning pain services, commissioners have the opportunity to make savings and improve patients' experiences. This *HSJ* supplement looks at how some trusts have made improvements by changing referral pathways and moving services into the community. It also discusses some of the challenges that must still be faced.

Ingrid Torjesen, supplement editor.



OVERVIEW

Chronic pain has huge economic and human costs but is a neglected area of healthcare. Rob Finch looks at how pain affects life – and at action to give it the attention it deserves

THE PAINFUL TRUTH

Chronic pain can only be ignored by those unaffected by it. Its invisible yet debilitating effects often go unnoticed, yet it is one of the most significant burdens on the NHS and creates an enormous drag on the UK's economy.

Chronic pain is defined as pain that persists beyond the usual healing time (often around three months) or in disease where no healing occurs. There is often no identifiable structural cause for chronic pain, but this does not mean it is not real.

In 2000, the Independent Clinical Standards Advisory Group report, commissioned by the government, highlighted significant evidence of variation in access to and quality of pain services, and recommended regional reviews. However, according to representative group the Chronic Pain Policy Coalition, there has been a frustrating unwillingness to act or even to attempt to collect data to assess the hidden impact of chronic pain.

That impact is most telling for the patients who have to endure chronic pain. Ian Semmons, chairman of the charity Action on Pain, who has suffered from chronic pain from injuries sustained 18 years ago, says that one of the main difficulties is that pain generally becomes chronic after just three months. The chances of somebody with chronic pain seeing a specialist for treatment in that time is "pretty remote", he says.

"It took three years before I discovered that my pain would be with me for the rest of my life," he says. "That was a turning point. It changes you and my experience is why I set up Action on Pain – I felt that people shouldn't be put through what I went through."

When poorly managed, conditions associated

with pain can have a devastating impact on the quality of life of individuals and their families.

The charity Arthritis Care says that patients often react to their condition with shock, anxiety, depression and even anger. It advises that pain can be caused by and add to these emotions. Everyone reacts to and manages pain differently; how a person deals with pain affects the way in which they feel it, the charity says.

This is borne out by surveys which have showed that one quarter of those who have been diagnosed with chronic pain go on to lose their jobs and, in 22 per cent of cases, chronic pain leads to depression.

Domestic and social life also suffers, as Mr Semmons explains: "Maybe the breadwinner, because of their pain, is unable to work. That has obvious implications within the household, especially when the other people inside the family can't see the pain and understand it. The reduced income creates social problems.

"That person can lose confidence and get demoralised from not being able to work. You

'It took three years before I discovered that my pain would be with me for the rest of my life. I felt that people shouldn't be put through what I did'

certainly lose your independence and get overwhelmed by the system."

Having been part of that system for nearly two decades has given Mr Semmons deep insight into the problems. He says: "There is expertise out there but it tends to be quite fragmented. In primary care, people often want to set up a community pain service but don't know where to start."

The financial imperatives not only for the NHS but also for UK plc should already be driving the commissioning of such services. There are 4.6 million GP appointments for pain per year, each costing an estimated £31. Often these consultations end without resolution, leading to further appointments, while referral to a pain management specialist costs £134 for the first attendance. In England in 2005, 66 million NHS analgesic prescriptions were made at a cost of £510m, and a massive amount is spent on over-the-counter pain relief.

Added to that, the Pain in Europe survey in 2003 found that three quarters of people affected by chronic pain in the UK were of working age, causing a huge loss of productivity and an annual £3.8bn spend by the government on incapacity benefit payments. Pain is the second most common reason given by claimants of incapacity benefit and the government is planning to tighten up eligibility criteria for it.

Dr Andrew Bamji, president of the British Society for Rheumatology, says part of this problem is caused by the often intractable nature of chronic pain. He says: "You see people who've gone out of work and they're never going





PAUL PRICE

2◀ to go back – no matter what carrots or sticks the government provides.”

The true cost of chronic pain is impossible to know because it is tricky to pin down the exact number of people affected who have accurate diagnoses. As a condition that is invisible and not measurable by physical tests, prevalence estimates vary, but international academic and government estimates range from 10-50 per cent of the population, with some degree of consensus at around 20 per cent.

Ceri Phillips, professor of health economics at the University of Wales, Swansea, says the difficulty stems not only from a lack of tests but also from the relapsing nature of pain and how patients express their pain. He cites a recent Scottish study of patients with painful conditions such as angina, arthritis or bad backs, which reported that 46 per cent had pain.

Professor Phillips believes that the lack of a clear picture on how many people are affected allows politicians and commissioners to ignore the issue. He predicts that the prevalence of chronic pain will continue to rise over the next five years. He says: “I do think it’s a substantial problem whichever way you look at it – it’s a major healthcare problem. But, in terms of the attention it gets, there’s an inverse relationship to the extent of the problem. Studies of people with chronic pain show they are bottom of the league table for effect on quality of life.

“The big thing is that pain is a major cause of disability and long-term sickness absence. Current figures from the Department for Work and Pensions suggest that around 24 per cent of people on incapacity benefit are there because of pain-related problems. Add in the people suffering stress and it’s over 50 per cent.”

Professor Phillips suggests that commissioners in the UK should look at Canadian models, where the private sector has cost-effectively set up pain assessment and treatment under one roof in a “health mall”. The Canadian model comprises a GP, pharmacist, pain team and alternative practitioners, as well as cafes and shops. All services, except surgery, are located together.

But the health economist has doubts about the political and financial will to set up such services in the UK. He says: “Commissioners are not very keen to commission the sort of multidisciplinary pain programmes because they are quite expensive to set up. They’re often run within the anaesthetic department and can be quite resource intensive, and can detract from the other, more lucrative aspects of anaesthetics, such as surgery lists.”

Even where services appear adequate, dealing with chronic pain is far from simple. As a specialist, Dr John Lamberty sees the clinical sharp end of the problem. Dr Lamberty, a consultant pain management specialist who works at the Hove Polyclinic in East Sussex, says: “We are overwhelmed by the commonest thing, which is back pain – it accounts for two thirds of our work. It is also the least satisfactory. It is the commonest because no-one can treat it – but there are things you can do.

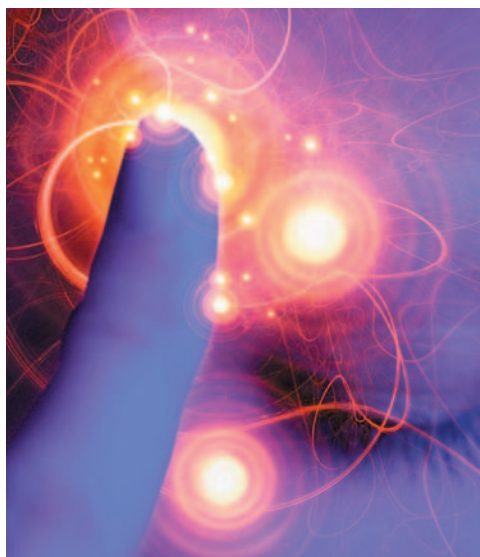
“There’s no blood test for pain. The best you can do is visual analogues or verbal rating scales. The trouble with those is that they don’t tend to work well chronically, as people tend to forget how much pain they had.”

Although the causes of chronic pain are often clearly clinical – for instance post-operative pain, cancer pain or pain caused by musculoskeletal

disorders such as arthritis – Dr Lamberty points out that, rather than being a medical problem in which doctors are expert, chronic pain tends to present as a “bio-psycho-social” problem.

“A lot of our patients are unemployed, often because of their pain. They predominantly come from non-professional, non-middle class backgrounds. An awful lot of the people are socially deprived and on benefits and that translates into a bio-psycho-social thing. Much more commonly people, get into a syndrome of ‘chronic pain behaviour’ where they’ve been off work for so long and they become dependent for so long and the whole family becomes involved.”

The statistics are stark: when people have been on incapacity benefit for two years, they are more likely to die or retire than return to work. Dr Lamberty believes that provision lags way behind demand.



‘You see people who’ve gone out of work and they’re never going to go back – no matter what carrot or sticks the government provides’

“There is a shortage of chronic pain psychiatrists and the treatment they offer does take a very long time. If they were going to see a patient, they might have an hour with them and see them seven or eight times in a year,” he says.

“You need to have a team working with that psychiatrist and that would include a clinical nurse specialist in chronic pain and a specialist physiotherapist. If you want to run an ordinary good service, that would be a minimum standard.”

The lack of that standard translates into problems for primary care. Dr Louise Warburton, a GP with a special interest in musculoskeletal medicine in Shropshire, says that the wait to see a pain management team in her area is six months.

“It would be helpful to have better access – they don’t seem to be adhering to the 18-week pathway,” she says.

Dr Warburton’s view is backed by a 2004 survey by the Royal College of General Practitioners, which found that nearly one quarter of patients waited more than a year to be

seen by a secondary care pain management service. It also found that only 13 per cent of secondary care pain clinics had waiting times of three months or less.

As a GP specialist, she sees her role as taking some of the heat out of the system by not referring to secondary care. She adds: “You are helping preventing that person being to-ed and fro-ed around the system.”

Yet commissioners appear reluctant to set up dedicated pain services in primary care. In 2004, a Dr Foster report found that only 36 per cent of primary care organisations allocated any specific funding for pain management services and just one in five provided a formal or structured chronic pain service.

So GPs are dealing with a huge burden of overt or covert chronic pain in patients. Dr Martin Johnson, a GP in Barnsley, South Yorkshire, is chair of PACE (Pain: Collaboration and Exchange) – the national network supporting the development of primary care pain services. He sets out his forthright view: “Pain management is a basic human right – it’s fundamental to everything we do. It has long been realised that most healthcare professionals are poor at managing pain, so we get poor outcomes and people returning to work with back pain.

“There’s a clear need for more medical education right through from undergraduate level to GP registrars. And it’s got to be both that and continuing education. You’ve got to keep on delivering the message.”

He points out that the largest caseload of chronic pain for GPs comes from musculoskeletal conditions such as bad backs. Only 10-20 per cent of these patients will ever need an operation, he says, yet far too many still get to the stage of seeing orthopaedic surgeons.

“You can give guidance on referrals, so that doctors can judge if there are any other options before referring patients,” he says. “We’re putting things in place to say ‘you shouldn’t refer before you have done this, this and this’”

The good news is that chronic pain may at last be getting the attention it deserves at the highest levels. Last June, Patrick Hall, Labour MP for Bedford, tabled an early day motion in the House of Commons which received 110 signatures. His motion urged the government to consider action to deal with what he called a “silent epidemic”.

Pressure on the government is also coming from patient groups. Mr Semmons’ charity, Action on Pain, is urging the government to set equitably accessible minimum standards of the pain management services that patients should be able to expect from their primary care organisation. It also wants a concerted awareness campaign to ensure patients are able to insist on those standards.

Mr Semmons says: “If you look at this from a business sense, it wouldn’t cost the NHS any more money. If you look at getting effective prescribing, a lot of people in pain are getting unnecessary medicine. People get back to work quickly so they need less benefits. There’s a real cost exercise that needs to be done here that will benefit the NHS and the Department for Work and Pensions as well as patients.

“We want to show the interested parties and politicians what can be done. We’re unusual as a charity in that we’re not asking for more money. We are told sometimes that our ideas are simplistic – but sometimes that’s the only way to break down the barriers.” ●

Northern Ireland

The health administration's current focus is on the integration of primary and secondary care services, with local commissioning groups influential in planning services. Long-term goals include better access and a wider range of services in primary care, with an emphasis on long-term conditions. Northern Ireland is also trialling clinical assessment and treatment services for pain, using a model similar to that in England.

Scotland

Primary and specialist services are being integrated into community health partnerships. These partnerships are developing action plans to ensure that chronic disease services are integrated, responsive and of a high quality. A chronic pain managed clinical network for Scotland that will link all levels of care from the community to tertiary care together is being planned.

England

The 18-week waiting target for secondary care treatment following GP referral is the main policy driving the English health system. GPs aim to hit this target by investing in services locally through practice-based commissioning. Payment by results gives practices a financial incentive to keep patients out of hospital. Clinical assessment and treatment services are being developed to improve referral pathways and triage for musculoskeletal conditions.

Wales

The 10-year *Designed For Life* strategy envisages primary care managing long-term conditions, with hospital admission under pathways only. Service developments need to be aligned with the pathways and the Welsh 13-week waiting target for hospital appointments, diagnostic services and therapy.

PRIMARY CARE

GPs acknowledge that the management of chronic pain in primary care has been poor. Training and specialist clinics should make pain less of a disability. By Ingrid Torjesen

REHABILITATION ABOVE PAINKILLERS

Around a quarter of the time GPs spend managing chronic diseases is on pain. Only mental health issues take up more time – and half of these patients will have pain management problems as well.

Dr Martin Johnson, committee chair of PACE (PAin: Collaboration and Exchange), chair of the Royal College of General Practitioners' pain management committee and a member of the Chronic Pain Policy Coalition, says many GPs think they are good at managing pain – but they are not.

"A lot of their armamentarium is painkillers and that is not actually what patients need," he says. "It is all about active rehabilitation for many painful conditions."

It is not surprising GPs' pain management skills are lacking, as there are no guidelines on general pain management for primary care. The British Pain Society and the RCGP are writing some but, at present, there are only the BPS and RCGP guidelines on neuropathic (nerve) pain launched last March and the National Institute for Health and Clinical Excellence guidelines on pain management in osteoarthritis.

GP practices are given no motivation to improve their management of painful conditions through the quality and outcomes framework.

What tends to happen is a GP attempts to manage the patient for several weeks, then refers them to a physiotherapist. By the time the patient gets to see the physiotherapist six or eight weeks later, three months have gone by and the likelihood of them going back to work has fallen dramatically. Studies show that after six months off work, only 50 per cent people will go back.

Long waiting times, particularly for physiotherapy and secondary care consultations, makes pain more likely to become chronic, says Dr Johnson. "The longer they stay off work, the less likely they are going to get back. We create a sick society, unfortunately."

He adds GPs manage pain holistically and independently in short consultations, when ideally it is best managed in collaboration with other professionals, such as physiotherapists and specialist pain nurses, who also have more time.

Patients frequently end up taking three or four painkillers and/or are told to rest inappropriately, he says. "In the past, people used to use collars for neck injury and bed rest and that sort of mentality unfortunately is ingrained within general practice. The patient then of course goes and sees a physiotherapist and the physiotherapist tells them something entirely opposite: exercise."

Sheffield primary care trust has established a multidisciplinary pain service, including GPs with a special interest (GPSIs), and a pain consultant. The service was developed by an independent provider, Pain Management Solutions, and holds clinics at a community hospital and three primary care locations. This approach has improved access for patients in terms of convenience and waiting times, as well as cutting costs.

Dr Johnson, who works at a satellite clinic of the services in Barnsley, says: "This model reduces patient dependency and GP prescribing, so they are less likely to be on multiple drugs."

GPs have traditionally referred patients with chronic lower back pain patients to orthopaedic departments, but Dr Johnson is proposing a different approach for the 18-week pathway.

Dr Johnson says: "Most orthopaedic surgeons would run a mile rather than deal with a lower-back pain problem. As surgeons, they operate on things. Most lower-back pain patients do not require surgery, so are simply referred back to the same physiotherapist the GP already sent them to, but for four times the cost in terms of tariff."

Instead, patients who fail to improve adequately with physiotherapy and analgesics are put through a specific pain model, with links to MRI/neurosurgery for those with conditions like sciatica who do not respond to conservative treatment.

GPSIs: bridging the gap in services

Five years ago if a GP wanted to be a GPSI they could just go along to a pain clinic and say "I would like to sit in and see what happens" and that would be considered training, but that is no longer the case. At that time, there were only a handful of GPSIs in pain management but, as their numbers grow, a need for some form of

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We create a sick society, unfortunately'

Dr Martin Johnson

accredited training to ensure consistency of standards is being recognised.

Dr Chris Barker, a GPSI in pain medicine for North Liverpool and Sefton PCTs, and a member of the PACE network, became a GPSI in 2003 after following the ad hoc route.

Originally an anaesthetist, Dr Barker decided to train as a GP and, during this time, he attended one session a week at a local pain clinic. On completing his GP training, he began attending weekly educational meetings at his local tertiary pain clinic, the Walton centre. After becoming a GPSI, he took a year's sabbatical to complete the advanced training that anaesthetists undertake to become consultants in pain management.

Although this level of in-depth and comprehensive training is not something most GPs interested in pain medicine would require or be able to commit to, some level of formal competency training is clearly required. This is why the RCGP, the British Pain Society and the Royal College of Anaesthetists are developing a curriculum for GPSIs in pain management.

Dr Barker, who has been helping develop the curriculum, says GPSI training will be tailored to meet local priorities. Local commissioners will decide what education they would like the pain clinic to provide, which will be agreed with the potential GPSI and the pain clinics themselves.

This training is likely to have to be delivered by RCA-recognised training establishments. GPSIs will not sit an exam but instead will be appraised every three to six months. Training would last 12-18 months and take up to one day a week.



The training will teach a GPSI to take a bio-psycho-social approach to pain assessment, which means assessing the medical and psychological aspects and how pain affects patients' psychological and social well-being. They will learn to assess disability and distress within the consultation, because those are major markers of pain and influence the types of treatment offered.

GPSIs will also be expected to be able to assess nerve-related and muscle-related pain and, importantly, whether the cause of the pain requires further investigation as it could be an indicator for something more sinister.

"The traditional view of a pain clinic where people stick needles in or do funny things to patients is rapidly dissolving," Dr Barker explains. "There are very few scenarios where medical interventions work for chronic pain and a very poor evidence base for a lot of things done in the past."

"Most interventions that go on in a chronic pain clinic are about helping people adjust and perhaps optimising medication and physical functioning, which can improve the pain as well."

Dr Barker says: "It is having the all-round ability to be able to recognise the balance of when pain is being driven by other factors, which may not necessarily be the musculoskeletal factors that may be the cause of the pain initially. There may be other factors – maybe stress or anxiety or prolonged disability – those kinds of things can actually perpetuate the pain."

The expertise at community clinics will vary according to local priorities, with some providing

'There are very few scenarios where medical interventions work for chronic pain and a very poor evidence base for a lot of things done in the past'

Dr Chris Barker

specialised services, such as those for diabetic neuropathy or nerve pain, and others providing a more generalised service. GPSIs will work with other clinicians, such as physiotherapists, psychologists, pain nurses, pharmacists and occupational therapists, to provide a multidisciplinary approach.

These clinics will offer rapid access to GPSIs who can do simple procedures such as trigger-point injections into painful muscles, and provide advice on physiotherapy and self-management and access to and advice on TENS machines. Secondary care will continue to offer high-tech procedures, such as neuromodulation (spinal cord and deep brain stimulation).

Dr Barker emphasises that GPSI services have to work within defined boundaries to ensure any patients outside the clinics' expertise, such as those with multiple problems or who have very intense pain or disability, are identified early on and referred to a specialised centre.

He admits persuading secondary care pain centres to train GPs might take some doing. "Payment by results induces competitions between primary and secondary care – why would secondary care want to train primary care to take their patients away from them?" he asks.

"If done properly, there will be a collaboration between primary and secondary care and they would all agree on who sees who and patients would get a much better deal out of it, they won't have to wait ages to see someone – but it is actually quite difficult to negotiate around that political minefield." ●



SECONDARY MEASURES

Acute care providers have adopted a number of measures to improve pain management. Historically, secondary care pain services across the UK have been beset by problems of poor access and unmet patient need. In the past few years, a number of initiatives to solve these problems – such as specialist pain clinics and redesigned services – have yielded some dramatic results. Many improvements have come about through shifting specialist pain services from secondary to primary care, making better use of GPs, nurses and allied health professionals. Waiting times have in many places been cut from over a year to a few weeks. However, maintaining good pain services is made difficult by frequent organisational change and short-term funding. Emma Baines reports

NORTHERN IRELAND

PAIN OUTREACH CLINIC IN BANDBRIDGE



“One or two sessions a week will not meet the targets. That will require significant investment.” Dr Peter Wright, Daisy Hill Hospital

Dr Peter Wright, consultant in pain management at Daisy Hill Hospital in Newry and PACE committee member, works one session a week at an outreach primary care pain clinic to reduce outpatient waiting times to meet national targets.

His one-man operation is a “skeleton” service to meet immediate need, he says. “It’s not a great model. It’s a short-term solution to meet the short-term needs of the service.”

He set up the clinic this year after the merger of two trusts brought his hospital together with Graigavon hospital.

Dr Wright explains that although the waiting list where he worked at Daisy Hill was well within the three-month target, waits at Graigavon could be as long as 18 months. “So they asked me if I’d be prepared to set up a clinic

to help out the other hospital,” he says.

The clinic is in a polyclinic. However, Dr Wright operates alone.

Although the clinic is cutting waiting times, Dr Wright believes a more extensive service will be needed if the trust is to meet the target of 13 weeks from referral to treatment that has been set for March 2009.

He wants to add nursing and physiotherapy and is holding meetings with his manager to identify longer-term funding. “One or two sessions a week will not meet the targets. That will require significant investment,” he adds.

He is planning to meet purchasers from the new local commissioning groups to try to establish multidisciplinary pain clinics in primary care. These would be modelled on the nurse-led Belfast City Hospital clinics which have improved access and patient outcomes. ●



NORTH WEST WALES

TARGETED EARLY ACCESS TO MUSCULOSKELETAL SERVICES PROGRAMME



“The waiting lists were so long that GPs often referred a patient to several departments in the hope that one would be able to see them sooner.” Dr Rhian Lewis, TEAMS

Since 2002, waiting times to see a pain specialist in North West Wales have dropped from 15 months to 10 weeks, largely thanks to the targeted early access to musculoskeletal services programme (TEAMS).

Under this scheme, referrals to orthopaedics, rheumatology, physiotherapy and chronic pain are all made through a single referral pathway.

Dr Rhian Lewis, PACE committee member and one of the pain management consultants who runs the programme, says that waiting lists used to be “extremely long” in pain, rheumatology and, particularly, orthopaedics.

One of the main reasons for this was that many patients were given multiple referrals. “The waiting lists were so long that GPs often

referred a patient to several departments in the hope that one would be able to see them sooner,” she says.

GPs now indicate in which department their patient should be seen.

Nurses have taken over a lot of follow-up.

Dr Lewis says her department is seeing many more acute cases, reflecting improvements in the quality of referrals.

“There is better communication between departments now, and a better understanding of what the different specialties have to offer, which means that patients end up in the right place sooner,” she says. ●



WEST OF SCOTLAND

PAIN GUIDELINES AND MANAGED CLINICAL NETWORK FOR PAIN



"The idea is to identify what services we already have in primary and secondary care, and co-ordinate them in a more efficient way"

Dr Mick Serpell, Gartnavel General Hospital

Dr Mick Serpell, consultant in anaesthesia and pain management in Gartnavel General Hospital in Glasgow and PACE committee member, helped develop and launch a set of primary care chronic pain guidelines in 2002. These have standardised pain management prior to referral.

"The challenge was to get GPs to make better diagnoses and to initiate appropriate therapy in primary care," he says.

The guidelines were developed with users including GPs, nurses and other specialists. They include sections on general management of pain, and on the three commonest pain problems: lower back pain, osteoporotic pain and neuropathic pain.

The guidelines were sent out to GPs as a pain pack, which included assessment tools and referral forms. They were given a high-profile launch to raise awareness.

"The hope was that if patients were being better managed, then the number of referrals would go down," Dr Serpell says. In fact, the number of referrals has gone up, but so has the quality of care given before referral.

"It's much less common to have completely inappropriate referrals. And most patients have already had the appropriate drug treatment or care from other healthcare services," he says.

Dr Serpell is now setting up the pilot of a managed clinical network for pain, commissioned by the Scottish government. Although funding is provided for an administrator, there is no cash for new services.

"The idea is to identify what services we already have in primary and secondary care, and co-ordinate them in a more efficient way," he explains. "Hopefully, we'll then be able to make a business plan to get resources to address those deficits, or it may be a matter of restructuring the services with the existing resources and changing the way we work."

The network will be based on existing models, such as the stroke network in Scotland. Outreach clinics with secondary care staff working in primary care centres are planned.

One of the aims is to improve access to pain services in rural areas. "We want to set up the network so that GPs from other parts of the West of Scotland can refer in," he says.

The project has been funded for only two years. If it is to run beyond that, Dr Serpell says, it is going to have to show improvements in cost-efficiency as well as patient quality of life.

"If it is successful, the plan is to roll the model out and make it a national one for Scotland," he says. ●

ENGLAND

SOUTHAMPTON MANAGED CARE PATHWAY



"We changed the clinical model so it's not about curing but managing"

Dr Cathy Price, Southampton University Hospitals trust

In 2002, the secondary care pain service at Southampton University Hospitals trust was in crisis. Waiting times were up to 12 months and, to clear the backlog, new referrals were suspended three times in a 12-year period.

Thanks to a service redesign based around a managed care pathway that sets clear goals, and the introduction of a multidisciplinary triage service, waiting times are now down to under six weeks.

Dr Cathy Price, a consultant in pain management at the trust and PACE committee member, believes that although it was an extreme case, the problems in Southampton were fairly typical: "Long-term pain affects large swathes of the population, and patients can end up with very long waits to see a specialist."

She says that the hardest part about changing the service was drawing up a plan to change. "It had been bad for so long that people accepted it as it was. They didn't think it could change."

The first step was to shut down the service, in a planned way, with support from the trust management and the primary care trusts. A project board was then set up. This consulted with stakeholders and worked with both primary and secondary care to identify the

outcomes that could be achieved with a pain management service. "We changed the clinical model so it's not about curing but managing," says Dr Price.

The new service was designed to shift pain management from secondary care into primary care as much as possible. There is now a single referral pathway with a specialised pain assessment early in the patient journey. This multidisciplinary triage service is staffed by personnel from secondary care, but based in the community.

Implementation was in 2003-04 and the outcomes have been good. As well as drastically reduced waiting times, patients are highly satisfied with the service, and failure to attend rates have dropped from 25 per cent to 6 per cent. And 65 per cent of patients given specialist assessment are subsequently managed in primary care.

Dr Price identifies frequent organisational changes and the introduction of payment by results as the greatest challenges. "Payment by results targets mean we are no longer in financial balance. The national tariffs do not allow for multidisciplinary assessment and management," she says.

Southampton is now using the new HRG 4.0 tariff groupings, which allow tariffs to be split into component parts of diagnosis and treatment, to see if there has been an improvement. ●

GOOD MANAGEMENT

SERVICE REDESIGN

It is possible to overhaul and commission pain services, even when resources are tight. Ann Shuttleworth explains how

Pay and provide

While many healthcare providers need to improve their chronic pain services, most will be able to achieve a significant amount by restructuring existing services or developing clear referral pathways.

With finite resources and specialist pain practitioners, this will usually be the first step. Remaining gaps may need to be filled by commissioning new services.

This article looks at some of the key issues to consider when reviewing and developing existing services and commissioning new ones.

More detailed information and a range of resources are available in the PACE (PAIN: Collaboration and Exchange) toolkit for developing pain management services, for example (see box).

The need for pain services

The diverse range of conditions that can cause chronic pain make identifying local need a complex task. Patients may have, for example, neurological or musculoskeletal conditions, infections, trauma, diabetes or cancer, and will present to a range of primary and secondary care services.

With clear treatment and referral guidelines, many with simple and diagnosed pain can be managed by non-specialist services, leaving pain services to manage those with more complex or undiagnosed pain. However, without clear referral pathways these patients may not even be brought to the attention of specialist pain services.

The first step in making any significant improvements to existing pain services or in developing new ones therefore

usually involves taking a step back. Any decisions must be informed by a clear understanding of local need and the way primary and secondary care services respond to patients with chronic pain.

You need to quantify how many patients are likely to need pain services and where they are likely to present. You also need to understand what happens when they do present. How is their pain addressed? When are they referred to specialist services – and which services are they referred to? Who decides on those referrals and how?

Since most patients will initially present to their GP – even if they are then referred on elsewhere – GP practices can provide invaluable information and are well worth involving from an early stage.

An audit of GP medical information systems, such as EMIS, and practice records can be an effective way of assessing local need. For example, a search for disease-specific codes can identify patients who may have consulted their GP about pain, and therefore the likely extent of need.

The patient pathway

GP information systems can also demonstrate how well need is being met. Reviewing a selection of relevant records can illustrate the number of steps individual patients have taken – and over what period of time – before achieving a satisfactory outcome. These individual patient pathway reviews can yield a range of information such as:

- When the patient's pain was first identified;
- How many GP appointments were related to pain assessment and management;
- The number and type of pain management referrals;
- The period of time over which the patient has consulted for pain-related needs;
- The costs to the NHS of each step of the pathway;
- The outcome of referrals.

Comparing the data from the initial audit with data from your existing chronic pain services should highlight any gaps in provision, and inadequacies in services and referral systems.



Setting this information in the context of local and national policies and targets such as the 18-week referral-to-treatment target can show you what you need to do and how to set your priorities.

Choosing a service model

There are different models of chronic pain services, with a range of referral pathways and professional input. In deciding how to structure yours, you should consider a range of factors including:

- What will the service offer?
- Who is qualified to deliver it – or interested in becoming qualified?
- What support do you have and need from other services and departments?
- Where would the service be based?
- How would it expand?

Chronic pain can be affected by a complex range of factors, which means patients often require intervention from a number of specialist professionals such as pain

PACE – PAIN: COLLABORATION AND EXCHANGE

PACE connects multi-disciplinary healthcare professionals and managers who have an interest in chronic pain management and improving service provision in the UK.

It began in 2004 when Pfizer invited over 50 healthcare professionals interested in improving community pain management to a

series of meetings in England, Northern Ireland, Scotland and Wales.

These were followed by a national meeting involving regional delegates later in the year to collate ideas and issues, and to discuss potential solutions.

The national PACE delegates identified the need to find the right

people locally with whom to share their ideas, to share examples of best practice and to provide practical “how-to” resources to support healthcare professionals in delivering change.

These resources are available through the resource suite at www.paceconnect.org.uk

RESOURCES

18-week website: Information and support in achieving 18-week targets

→ www.18weeks.nhs.uk

Good practice information: Information on what pain services offer

→ www.rcoa.ac.uk/docs/painservices.pdf

Pain management programmes: Recommendations on what to offer

→ www.britishpainsociety.org/book_pmp_main.pdf

PACE – Pain: Collaboration and Exchange

→ www.paceconnect.org.uk/resourcesuite.asp

Includes: *Good Practice Guide* and *Toolkit for Developing Pain Management Services*, as well as policy and service target overviews and data



stakeholders including primary care trusts (see page 8).

Nigel Arden, reader in rheumatology at the hospital, says the redesign has cut the waiting times to six to eight weeks and reduced failure to attend rates from 25 per cent to 6 per cent, while patient satisfaction is at 85 per cent. He believes strong communication between primary and secondary care was critical to the success of the redesign.

Presenting a business case

You need to present a solid business case for any new services or extensions to existing ones that have resource implications. If your organisation does not have a proposal and business case template, you should draw up a business plan. This should include:

- background information;
- a summary of current services and local need;
- a description of the proposed service;
- details of any proposed integration with other services;
- relevant national targets and local priorities;
- timing and initial steps for implementation;
- funding requirements;
- evaluation plans.

It is also worth checking whether your organisation requires any other criteria in proposals.

While many providers will need to commission some new services, much demand can be met using existing resources and staff. A great deal can be achieved by streamlining and developing clear referral guidelines, and by supporting non-specialist practitioners such as GPs to manage non-complex cases.

Where new services are needed, costs will often be offset by the reduction in inappropriate referrals to other specialties, while freedom from pain will not only transform many patients' lives but also reduce their need for other health and social services as they regain lost independence. ●

consultants, GPs, nurses and allied health professionals. Deciding what you need to do also involves considering who will do it and how.

Pain services should be run by practitioners with the appropriate qualifications and experience, and many providers will find they have a shortage of these specialists.

However, not all patients with chronic pain will need dedicated pain services – other specialties such as rheumatology or orthopaedics may be better placed to offer treatment. For some, GP practices can take responsibility for ongoing care with the appropriate support. Good communication between these services can transform their effectiveness in managing patients.

Poor understanding between services led to the pain service at Southampton General Hospital being overwhelmed with inappropriate referrals and forced it to suspend its waiting lists three times. A service redesign, with clear referral pathways was undertaken with the involvement of all primary

PACE – TOP TEN TIPS

TEN TOP TIPS TO SUPPORT SERVICE CHANGE

- | | | |
|---|--|---|
| <ol style="list-style-type: none">1. Ensure those involved have appropriate specialist qualifications and experience.2. Convene a working group to map out existing services, identify key issues to be addressed and set improvement priorities.3. Encourage local pain champions to look at referral pathways and protocols to improve existing referral systems.4. Encourage local champions to involve and communicate with other stakeholders to gain their involvement and engagement and to develop an integrated care pathway. | <p>Stakeholders should include:</p> <ul style="list-style-type: none">● Clinicians and managers of linked or affected services;● Commissioners;● Service users. <ol style="list-style-type: none">5. Ensure your champion and working group are clear about for which group of service users the service is being developed.6. Help your champion and working group to demonstrate clearly how their service aims to meet the needs of proposed service users.7. Ensure your champion/group use the business case template in the PACE toolkit for | <p>developing pain management services as a guide to developing business cases.</p> <ol style="list-style-type: none">8. Encourage those developing business cases to be clear about the interventions they need and will benefit most from, and to present the evidence to support their assertions.9. Ensure your champion/group appreciate the importance of demonstrating that their proposals will offer value for money.10. Ensure your champion/group are realistic about what they can achieve. |
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WORKING LIVES

SERVICE REDESIGN

Simple changes, big difference

Pain services can be improved with small changes and without incurring extra costs, as one trust found. By Ann Shuttleworth

The lack of adequate chronic pain services means many healthcare providers will need to significantly restructure existing provision or develop entirely new services.

This sort of work can take time to plan and implement but, as the short case studies show (see boxes), can yield excellent results in a cost-effective manner.

Not all changes need to be radical. Sometimes a review of existing services can identify sticking points and inefficiencies that are relatively easy to address.

In some cases, a simple change like making a different person responsible for talking to a patient at a particular time can have a real and positive impact.

When staff in Mid-Yorkshire

Hospitals trust's outpatient pain management service changed their process of gaining informed consent for invasive pain management techniques, they enabled a consultant to treat two extra patients in each theatre session and see one extra patient in each clinic session. All this was achieved at no extra cost, since it simply relied on optimising the use of fixed resources.

The service is based at two sites – one in Dewsbury and one in Pontefract – and offers multidisciplinary care by consultants, nurses, physiotherapists and a psychologist. Around 70 per cent of its patients have chronic pain of a spinal origin. Others have neuropathic pain, multi-joint osteoarthritis, post-surgical pain, cancer or complex regional pain syndrome.

A number of invasive techniques are available to treat chronic pain, including lumbar and caudal epidural, lumbar facet joint injection, lumbar paravertebral injection, trigger point injection, intrathecal injection, piriformis block and intravenous regional anaesthetic block. These techniques can be extraordinarily effective in

reducing or eliminating pain, and can transform patients' quality of life. However, they are not without risk, and it is vital to ensure patients are able to give informed consent or decline the intervention if they believe that is best for them.

Gaining consent is not simply a form-filling exercise. If they are to be enabled to give truly informed consent, patients need to understand the nature of the procedure, its likely benefits and any risks. They also need the time to ask questions and discuss any anxieties – and the more complex the intervention, the more time-consuming this process can be.

In many services, consultants will delegate the process of obtaining consent for this type of procedure to named junior medical staff who are deemed competent to do so. However, the Mid-Yorkshire pain service had no junior medics to whom the task could be delegated. This meant patients offered invasive procedures were being referred back to the consultants for consent.

The requirement for consultants to see patients again increased pressure on appointments and meant they had less time to spend in theatre to perform the

procedures, which had a knock-on effect on waiting lists.

The service proposed to allowing named nurses and physiotherapists to take delegated consent for a list of specific procedures following training.

The proposal was developed by the service's clinical lead, consultant in pain management Ian Wilson, with the help of clinical specialist colleagues and the Pain: Collaboration and Exchange (PACE) toolkit for developing pain management. The trust approved an initial implementation at Dewsbury, the smaller of the sites.

Dr Wilson drew up a training and assessment framework for the nurse and physiotherapist, as he would be delegating the consent-taking procedure in the initial phase. Patient information literature was updated and improved.

The training made patient safety the key priority and involved the practitioners observing all the procedures they were to take consent on. They also had to conduct supervised discussions with patients, use the patient information leaflets and take informed consent.

Dr Wilson assessed their

CASE STUDY RESTRUCTURING SERVICES

In South Tees Acute trust, around 30 per cent of patients being referred to the pain management service could have been managed by their GP with suitable medication and lifestyle advice.

The team set up pain clinics in primary care locations and remodelled the

secondary care service to ensure patients were triaged to the most appropriate clinic. This gave patients with simple and diagnosed pain easy access to early intervention, freeing up secondary care to manage those with more complex pain.

Three local clinics are now run by a specialist

nurse. These prioritise referrals directly from GPs but where capacity allows they accept patients referred from secondary care. Patients needing secondary care interventions can be triaged directly onto the appropriate consultants' treatment lists.

Funding is provided by the primary care trust

and primary care clinics, and covers not only backfill for the nurse's time but also ongoing training for the pain service practitioners. A fourth primary care clinic is being planned.

The service redesign has reduced waiting times for secondary care from 21 to 10 weeks, while discharge from the

primary care clinics is around 70 per cent at the first review appointment. Without the primary care clinics, the secondary care team would have needed an additional consultant and supporting infrastructure at an annual cost of around £130,000. The cost to PCTs is around £20,000

for three clinics per week.

The service has also made access to pain services quicker and easier for patients requiring simple pain management, and increased awareness of pain management among local GPs and allied health professionals.



Ian Wilson oversaw the pilot consent-taking project.

competence through observation, role-play and in-house examination.

The delegated consent-taking initiative was implemented in 2005. Clinical physiotherapy specialist Martin Hey says it works well.

"It is a more efficient use of the skills in the team," he says. "It improves consistency and quality in the provision of consent and frees up extremely valuable consultant time to take on tasks that can only be done by them. I know our consultant finds it highly beneficial and the others are embracing it too."

Patients can ask to see the consultant if they wish to discuss their procedure before giving consent, while the nurse and physiotherapist can refer patients to the consultant if they do not feel confident about taking consent from them. In practice, Mr Hey says these situations rarely if ever arise.

Delegated consent-taking has reduced the administrative burden on the consultant and extended the roles of the practitioners taking delegated consent. This has been achieved with no additional costs – after the initial time investment in training and assessment, it is simply making better use of resources.

Annual audits assess the service against the Clinical Negligence Scheme for Trusts consent standards and local policy. In the most recent audit, both practitioners achieved 100 per cent compliance in documenting the process.

The pain service's larger site in Pontefract is preparing to introduce

delegated consent-taking, while the trust recently accepted a proposal from the Dewsbury site to extend the initiative. Staff are undergoing training to enable them to take consent from patients who have been offered cervical epidural injection, lumbar sympathetic block, cervical facet joint injection, stellate ganglion block, pulsed radiofrequency lesioning and radiofrequency lesioning treatments.

Mid-Yorkshire's initiative demonstrates how taking a fresh look at how services are organised can reveal opportunities where people seem to be operating at full stretch. Simple developments like these are easier to achieve than radical restructuring or setting up new services, and can yield results quickly.

Well-organised pain services benefit all concerned. They help healthcare providers to achieve national targets such as the 18-week wait requirement in a cost-effective manner and to meet the needs of the population they serve. Non-specialist professionals to whom patients with chronic pain present, such as those in primary care, can be empowered to take on some of the management of simple and diagnosed conditions effectively, and to refer on complex cases appropriately. In turn, this means the skills of pain specialists are used to their best effect on these complex cases.

More importantly, patients can be relieved of a distressing symptom and experience a significant improvement in their quality of life. ●

CASE STUDY **EXTENDED NURSE-LED CLINIC**

In December 2005, the longest wait was five years for a first appointment to see a pain management consultant at Musgrave Park Hospital, part of Belfast Health and Social Care trust.

When a target was set to reduce maximum waiting times to six months by March 2007

and 13 weeks by March 2008, a nurse-led pain clinic was extended to include assessment and review of patients referred for lumbar epidural steroid injection.

The clinic is held alongside the consultant clinic so the two nurse specialists can obtain advice. The

nurses use pro formas for assessment and review, and see all patients referred.

The waiting list was initially reduced by 53 patients (23 per cent); to date, 144 patients have been assessed and 97 reviewed at the clinic following a lumbar epidural steroid injection.



Ian Wilson oversaw the pilot consent-taking project.

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Chronic Pain Policy Coalition

Patients • Professionals • Parliamentarians

Mission: To improve the lives of people who live with chronic pain by developing and sharing ideas for more effective prevention, treatment and management of chronic pain in the UK

Education

So that pain is an integral part of all professional training

Empowerment

To support people to make decisions about their condition

Collaboration

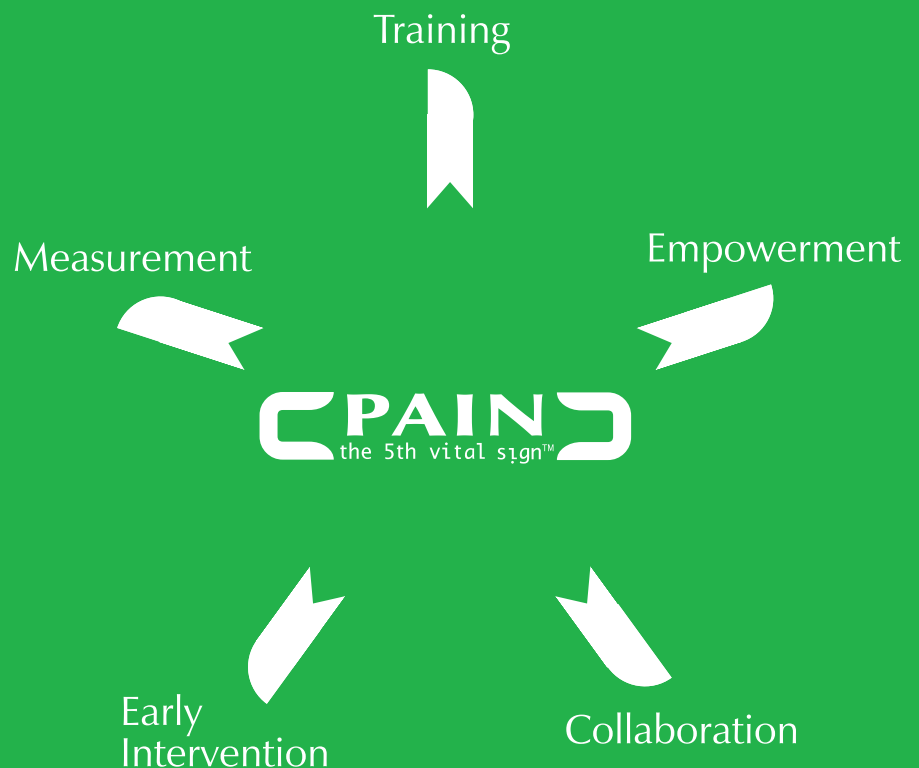
So that all stakeholders share in a joined up strategy

Early Access

To prevent acute pain becoming chronic pain

Measurement

Of pain as the 5th Vital Sign



For further information about the Chronic Pain Policy Coalition, please contact: Melanie Jones, Project Manager, Chronic Pain Policy Coalition, c/o Policy Connect, CAN Mezzanine, 32 – 36 Loman Street, London SE1 0EH T 020 7202 8580 E info@paincoalition.org.uk

The corporate members* of the Chronic Pain Policy Coalition are:



*Corporate members provide funding for the Chronic Pain Policy Coalition through unrestricted educational grants. This partnership is vital in allowing the coalition to maintain a full programme of activities, providing an essential link between industry, professionals and patients.