

Clinical Standards Advisory Group

Terms of reference

Ministers asked CSAG to advise on standards of clinical care for NHS patients with acute and chronic pain and on access to and availability of services.

The Approach

A CSAG committee, chaired by Professor Alastair Spence, oversaw a study of services in a sample of UK districts and boards, in relation to clinical needs, standards and available evidence of clinical effectiveness.

A combined team from Manchester and Leicester Universities carried out the study in 1997 in 12 acute NHS Trusts.

The research team and the Committee undertook studies and local visits. Data were obtained from hospitals, primary care, community services, complementary therapists and purchasers.

A national survey was conducted of heads of all pain services in acute NHS Trusts in the UK. A wide variety of national organisations with an interest in pain control was also surveyed.

Services for Patients with Pain

*A summary of the CSAG report on services for NHS patients with acute and chronic pain.
March 2000*



Pictures: Oxford Medical Illustration

Summary

- ❑ Pain is a common consequence of ill health, and long-term pain can have a devastating effect on the lives of sufferers and families.
- ❑ The subjective nature of pain makes it difficult to evaluate interventions, and professional differences lead to a wide range of treatments.
- ❑ Specialist services for acute and chronic pain exist in the majority of general hospitals, but there is marked variation in their level and nature. Some services were poorly organised, and lacked dedicated time from consultants and an agreed role for specialist nurses.
- ❑ Specialist palliative care services were usually better organised, with clearer policies and better funding than those for chronic non-cancer pain.
- ❑ Specialist acute pain services concentrated on post-operative pain: the same priority was not given in A&E departments.
- ❑ A total of 20 recommendations are made to health authorities, primary care groups, trusts, commissioners of research and development and to professional bodies. These recommendations seek to ensure that services are more equitably provided, better organised and managed, and that they are based on the best clinical evidence for effectiveness.



Points from the Report

- Long standing pain can have a devastating effects on the lives of sufferers and families.
- Untreated pain can cause helplessness, depression, isolation, family breakdown and inappropriate disability, but there is a great deal that can be done to treat pain and to alleviate its effects.
- Acute pain teams have been established at the majority of Trusts, and this can now be considered to be normal practice in the UK.
- Expertise in treating chronic pain is scarce; typically, there is under-provision of services, and significant unexpressed demand.
- Many specialist pain services are too poorly resourced to meet local need, and there are unacceptable waiting times for many patients. There is a significant lack of specialised and general nursing.

What the report found

Approximately 7% of the population suffers chronic pain at any one time. A quarter of the population suffers from bouts of musculo-skeletal (particularly back) pain. Most people self-medicate or seek help from their GPs.

Specialist services were first started by anaesthetists and now exist in the majority of teaching and district general hospitals, with the aims of controlling acute and chronic pain and associated disability. Pain management programmes are designed to improve quality of life.

The subjective nature of pain makes it difficult to evaluate interventions, and professional differences lead to a wide range of treatments.

In this study, most health authorities and trusts considered pain relief to be 'part of the package'. Explicit contracts for pain relief were the exception and little work had been done on needs assessment.

Few clinicians or managers appeared to be aware of the large body of published guidance relevant to pain services. Clinicians wanted guidelines to advise on the management of complex conditions and local referrals. However, local guidelines were too often of poor quality.

Acute pain

In this study 88% of hospitals had followed The *Pain After Surgery* report (1990) in setting up acute pain teams, but a few had a token or no service. Doctors leading these services felt excluded from contract discussions and frustrated at a lack of understanding of their potential. Some trusts had developed staffing or funding and most had debated the merits of specialist pain nurses. These nurses played a strong educational role in some centres but were rejected in others for fear of de-skilling generalist nurses. Pain management often had a lower priority in A&E departments than in post-operative services, where it has become a major consideration.

Chronic pain

Chronic pain services were so poorly resourced that many could not meet local need, and waiting times were often unacceptable. The number of consultant sessions was too low, and only half of the services had a specialist chronic pain nurse. Shortages of specialist psychology,

physiotherapy, occupational therapy and pharmaceutical support hindered a multi-disciplinary approach. Service providers and GPs considered waiting times excessive, but trust boards were reluctant to consider cost increases.

Routine information on activity, cost and need was not available and it was not possible to measure outcomes. Professionals felt that pain relief was not recognised to the same extent as palliative care, and they were frequently unsuccessful in attempts to increase funding.

The study demonstrated a need to improve knowledge of chronic pain services throughout the NHS. Any extra referrals so generated would require extra capacity. If clear referral routes were introduced locally, the most specialised units could operate as tertiary services.

Pain management and rehabilitation

Half the Trusts had pain management programmes offering posture training, relaxation techniques, medication review or psychological intervention. Back pain management programmes in primary care or as part of rehabilitation have been shown to reduce disability, distress and the need for medication or surgical intervention. GPs would support more back pain initiatives in the community.

Cancer pain

Palliative care services, providing pain relief for many patients with cancer, are generally focused and well organised, with specialist nurses educating other professionals. GPs are generally satisfied with palliative care. However, funding is often provided by charities and some reductions in NHS spending were reported.

Complementary therapy

Most complementary therapies are provided outside the NHS but many chronic pain relief services offer acupuncture, hypnotherapy, reflexology, homeopathy or aromatherapy. A third of patients in pain clinics had tried complementary therapies. GPs would welcome guidelines and systematic reviews of effectiveness.

Pain in children

Where they exist pain services for children are well-organised, but implementation of recent national guidelines appeared to be poor.



Points from the Report

- Psychologically based approaches can be effective but are offered to only a few patients.
- There was minimal formal joint working between chronic pain and other medical specialities.
- Services discharged far fewer patients than they took on each year. This is unsustainable.
- Professionals felt poorly supported within their Trusts. Service heads frequently reported unsuccessful attempts to increase funding.
- GPs are more satisfied with palliative care than with pain management services.
- There is a demand from patients and professionals for access to complementary therapies. More research is needed to evaluate the outcomes.
- Many patients felt that professionals had not believed that their symptoms were genuine.

Recommendations to

Health Authorities

- ▶ Review provision of local pain services in relation to local need.
- ▶ Commission a range of specialist services across a number of centres.
- ▶ Set and monitor waiting time targets for chronic pain clinics, ensuring that no-one waits more than three months for a first appointment.
- ▶ Specify pain relief quality standards for surgical agreements.
- ▶ Ensure that cancer patients have access to palliative care pain services.
- ▶ Encourage evaluation of complementary therapies and develop referral guidelines to ensure that funding is directed towards effective treatments.

NHS Trusts

- ▶ Improve GP access to investigations and to prompt opinion from specialists.
- ▶ Ensure that patients have access where appropriate to a multi-disciplinary chronic pain team, which will also educate other professionals.
- ▶ Ensure that patients undergoing painful procedures have access to an acute pain team led by a doctor and at least one specialist nurse, working closely with pharmacists and physiotherapists.
- ▶ Ensure reasonable access to a pain management programme for patients with high levels of distress or disability as a result of chronic pain.
- ▶ Give a higher priority to effective pain management in A&E departments.
- ▶ Ensure that staff who provide pain services for children are trained and experience in paediatric and family care.
- ▶ Ensure that staff who manage patients with pain are adequately trained.

Commissioners of Research and Development

- ▶ Assess guidelines centrally for the NHS and disseminate the best examples.
- ▶ Develop evidence-based guidelines for some conditions and therapies.
- ▶ Support research into the epidemiology and impact of unrelieved pain.
- ▶ Support research into the effectiveness of therapies, particularly those that may prevent acute pain becoming chronic pain, and review the existing research.
- ▶ Review the value and appropriate use of pain assessment tools for children.

Professional bodies

- ▶ Ensure that teaching and training at all levels adequately covers pain management.
- ▶ Make available to GPs good quality guidelines on the management of pain and the referral of patients.

Services for people with pain – How to obtain the full report

The Department of Health has welcomed this report. It is publishing its response to this and to three other CSAG reports with the four reports themselves and these summaries on its website at <http://www.doh.gov.uk/pointh.htm>.

Printed copies of the CSAG report [ISBN 0-11-1 84182 157 8, this summary, and the Department of Health's response are all available free of charge from Dept of Health, POBox 777, London SE1 6XH.

Further information about CSAG can be obtained from the CSAG Support Team, The Unit of Health-Care Epidemiology, Institute of Health Sciences, Oxford, OX3 7LF ☎ 01865-226991 FAX 01865-226993.