

Pain News

Government report reveals gaps in care

In 2000 the Department of Health published a report which identified unacceptable variations in pain services in UK. A government minister has called for change. Dr Beverly Collett looks at the findings which are causing a stir

Due to concern about the way in which specialist pain services were being delivered, government ministers asked the Clinical Standards Advisory Group to advise on standards and availability of care for NHS patients with acute and chronic pain.

What was done

A Clinical Standards Advisory Group committee asked researchers from the Universities of Manchester and Leicester to study the current service provision in UK. *Services for Patients with Pain* is the report of that study. The researchers undertook:

- In-depth interviews in twelve NHS Trusts with pain service staff, ward staff, post-operative surgical patients, pain clinic patients and carers.
- Site visits to interview hospital managers, health authority officials, hospital staff, patients, complementary therapists, GPs and community staff.
- A postal survey of all pain services in the UK.
- Focus groups with patients, GPs and other health care professionals.
- A survey of organizations involved with pain such as research institutes, professional associations and patient groups.

What they found

Seven per cent of people suffer chronic (long standing) pain. Chronic pain can have devastating effects on the lives of sufferers and families. Untreated pain can cause helplessness, depression, isolation, family breakdown and disability. On average, the patients interviewed by the researchers had suffered pain for five years. A quarter had suffered pain for more than eleven years. Ninety-one per cent of the patients were unable to perform all of the activities of daily living.

Provision of services

There is inadequate provision of services for the management of chronic pain. The Royal College of Anaesthetists recommends a minimum of ten consultant chronic pain sessions for every 100,000 people. However, typically there are only between one and two consultant sessions for every 100,000 people. Over a third of consultants were working alone, in spite of recommendations that there should be a minimum of two consultants in each district to ensure cover (for example, if a consultant is sick or on holiday). Only half of the pain services in the UK had a

specialist pain nurse. One third of the clinics had no office accommodation for secretarial staff and over half no office accommodation for professional staff, begging the question of how much organisation goes into these services.

Unacceptable variations

There is inequality in access to pain services and what is available varies.

- ◆ Half the patients attending a pain management clinic had been referred by their GP and half by their hospital consultant. The majority of patients (sixty-five per cent) had no prior knowledge of the existence of pain management clinics.
- ◆ A quarter of patients had waited more than twenty-two weeks for an outpatient appointment in the pain management clinic. The longest wait was ninety weeks.
- ◆ Shortages of specialist psychologists, physiotherapists, occupational therapists and pharmacists hindered a multi-disciplinary approach (where different specialists combine their skills by working together as a team).
- ◆ There has been little attempt to assess provision of pain services in relation to what local people actually need.
- ◆ Most of the pain management services felt that pain relief was not adequately recognized. Eighty-one per cent had recently tried to obtain additional funding but sixty-three per cent had been unsuccessful.
- ◆ Many patients were positive about their experiences from attending the pain management clinic. They said their pain had improved. They felt supported and relieved to discover that expert advice is available. Many felt that they should have been seen at a pain clinic earlier.
- ◆ Services discharged far fewer patients than they took on each year. This is unsustainable in the long term.

Acute Pain

Acute pain is the pain we all experience when we hurt ourselves. It includes the pain of illnesses such as appendicitis and pain after surgery. In 1990 the Royal College of Surgeons and the College of Anaesthetists produced a report called *Pain After Surgery* which highlighted the importance of post-operative pain relief. The researchers found that eighty-eight per cent of hospitals had followed this report and set up acute pain teams with a consultant anaesthetist and an acute pain nurse - though often these did not operate seven days a week. In contrast, pain management in Accident and Emergency departments is a low priority and could be improved by applying lessons learned in post-operative pain management.

Palliative Care

Palliative care services, providing pain relief for many patients with cancer, are generally well focused and well organized, with specialist nurses educating other professionals. Funding is often provided by charities, and some services have had a reduction in NHS spending.

The recommendations

Health Authorities and Primary Care Groups (which are responsible for buying health services for the area they represent) should:

- Review the provision of local pain services in relation to local need.
- Commission a range of specialist pain services across a number of centres.
- Set and monitor waiting times for chronic pain clinics, making sure that no one waits more than three months for a first appointment.
- Encourage evaluation of complementary therapy and develop guidelines for referring patients, to ensure that NHS funding is directed to effective treatments.

NHS Trusts (which are responsible for running health services for the area they represent) should:

- Make it easier for GPs to get the results of investigations and a prompt opinion from specialists.
- Make sure that patients have access, where appropriate, to a multidisciplinary chronic pain team, which will also educate other health professionals.
- Make sure that patients with high levels of distress or disability, as a result of chronic pain, have access to a pain management programme. Pain management programmes teach patients about pain, how best to cope with it and how to live a more active life.

Professional bodies (which oversee the education of health professionals and set standards for care) should:

- Make sure that teaching programmes and training at all levels adequately cover pain management.
- Make sure that GPs have good quality guidelines on the management of pain and the referral of patients to specialist pain services.

The Health Minister's response.

The government's Health Minister, Lord Philip Hunt, has welcomed the report and acknowledged the need to improve pain services. He commented, "Specialist services for acute and chronic pain exist in the majority of hospitals but there is a marked variation in their level and nature. There were a number of examples of excellent services, but others were poorly organized and lacked dedicated time from consultants and an agreed role for specialist nurses. In many localities demand was outstripping supply and there is a need to improve access and availability of services....We are determined to eradicate the unacceptable variations which have been identified."

Recognizing the problem is the first stage of solving it.

- *The full report, a summary report and the government's response are available on the website at <http://www.doh.gov.uk/point.htm> or free of charge from Department of Health, PO Box 777, London SE1 6XH.*

- *The Clinical Standards Advisory Group (CSAG) was established in 1991 as an independent source of expert advice to UK Health Ministers and the NHS. CSAG was abolished at the end of 1991, but similar service reviews continue under the new Commission for Health Improvement.*
- *Dr Beverly Collett is Consultant in Pain Management and Anaesthesia at University Hospitals of Leicester NHS Trust.*

What they told the researchers

The GP ...

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

The patients ...

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

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

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

The carers ...

“Need more (chronic pain) services like this – makes the world of different.”

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