Faculty of Pain Medicine, Royal College of Anaesthetists

Response to the Academy of Medical Royal Colleges call for comments on the NICE Quality Standards topic list

The Faculty of Pain Medicine, Royal College of Anaesthetists and British Pain Society have discussed with the Department of Health the adoption of pain relief as a Quality Standard on a number of occasions. As yet, pain relief has not been adopted as either a published NICE standard or one that is under development. However, the Department of Health have recommended to NICE Pain Relief (to include young people) for further scoping. We ask the AoRMC to support this quality standard and recommend that it should be developed and adopted.

Pain is one of the best examples of a cross cutting quality standard and is at the core of patient experience in many situations. Furthermore, it is becoming evident that chronic pain is not just a symptom, it is a condition in its own right. Indeed, this has been accepted by NHS Scotland who has adopted pain as one of its leading quality issues. There is growing evidence in the literature that underpins this concept [Tracey et al 2009; Siddall et al 2004]. For example, imaging studies have shown conclusively that chronic pain is associated with specific and consistent functional, structural, and chemical changes in the brain consistent with a specific disease state. Even in patients where investigations have failed to show a clear cause for the pain, studies have shown changes in cerebral processing and loss of grey matter leading to impaired function [Tracey 2009, Apkarian 2004, Valet 2009]. In addition, most neuropathic pain conditions have a clear pathological aetiology e.g. post herpetic neuralgia, diabetic peripheral neuropathy, trauma, postsurgical pain.

In support of this proposal, this submission briefly reviews the prevalence and burden of pain, evidence of poor and variable quality in the way pain is managed in the NHS, how a quality standard could improve care and the benefits of a quality standard.

What is the prevalence of pain?
The following summary of published data demonstrates the high prevalence of pain in patients being treated by the NHS and social services:

1. In the UK, 7.8 million people (13% of the population) suffer chronic pain [Breivik et al 2006]; 7% have chronic pain that is severe and disabling [Smith 2001].
2. Repeated surveys show that chronic pain is presently more common compared with 40 years ago [CMO 2009].
3. The mean annual incidence is 8.3%; mean annual recovery rate 5.4% [Elliott 2002].
4. Chronic pain is a presenting condition in 22% of primary care consultations [Crombie 1993]; patients with chronic pain consult their general practitioners 5 times more frequently that those without pain [von Korff 1990].
5. In the UK, 1.6 million adults per year suffer with chronic back pain [CMO 2009].
6. The prevalence of chronic pain may be increased in some ethnic minority groups (e.g. the South Asian population is three times more likely to report chronic pain) [CMO 2009].
7. Poor housing and type of employment (e.g. heavy manual work) are significant predictors of chronic pain in the community [CMO 2009].
8. Pain becomes more prevalent with advancing years; persistent pain affects >50% of the elderly in the community and >80% of those in a nursing home [Ferrell et al 1995; Helme and Gibson 2001]. In 2009, pain affected 10 million elderly patients in the UK [Patients Association 2009].

What is the burden of pain?

Chronic pain carries a significant burden to the sufferer, carer and society as illustrated by the following published data:

1. Severe chronic pain is associated with an increase in 10-year mortality [Torrance et al 2009].
2. The global impact of chronic neuropathic pain on health is equivalent to that of heart disease or severe mental illness [Smith 2007]. Severe persistent pain is known to have adverse effects on employment status, daily activities, relationships, mood, sleep and all aspects of general health.
3. Unrelieved acute pain delays recovery and impedes convalescence [Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine 2010]
4. 49% of patients with persistent pain experience depression, 25% lose their jobs and 16% feel their chronic pain is so bad that they sometimes want to die [CMO 2009].
5. The risk of suicide is doubled in chronic pain patients [Tang et al 2006].
6. Waits of 6 months for chronic pain treatment are associated with significant deterioration in health related quality of life, psychological well being and depression scores [Canadian Taskforce 2006].
7. Children with persistent or recurrent pain experience high levels of distress, use more health services, have more mental health and social problems, are more likely to be absent from school and tend to do worse academically than those without pain. [Campo 2002].
8. Persistent pain is widespread amongst residents of care homes and may be considered by staff as an inevitable consequence of growing old. This has an enormous impact on the resident’s quality of life [Picker Institute 2007].
9. Musculoskeletal conditions are the foremost reason for short- and long term work absence [Chartered Institute for Personnel Development 2009]. These data are supported by the findings of a prospective study of sickness absence in a large working population [Watson et al 2008].
10. Chronic spinal pain is significantly associated with co-morbid mental health problems [Von Korff et al 2005].
11. Direct treatment costs of low back pain alone to the NHS in 1998 were £1.6 billion [Mandiakis 2000]. With no reduction in the prevalence of chronic pain since this time, the cost are likely to have risen substantially.
12. The indirect cost associated with back pain (e.g. wage compensation, lost production, long term incapacity benefits) was almost £12 billion in 2000. [Mandiakis et al 2000]. This is greater than the total costs associated with many other chronic health conditions e.g. coronary heart disease, diabetes [Liu et al 2002].
13. In February 2009, 2.468 million people in the UK were in receipt of Incapacity and Severe Disablement Benefit; 17% of these claimants had musculoskeletal pain as the cited reason for qualification for benefit. The weekly cost of benefits for these conditions was £27 million (DWP 2009). However, this may be an underestimate of the true costs. For example, a DWP report demonstrated that 40% of new Incapacity Benefit claimants gave musculoskeletal pain as the main reason they were unable to work irrespective of the reason for claiming [Kemp et al 2008].

14. Data from the GP research database showed that primary care management costs for chronic non-malignant pain were approx. £4.6 million. The number of appointments for pain per year in the UK were equivalent to 793 whole-time general practitioners [Belsey 2002].

15. The Chief Medical Officer for England reported in 2009 that £584 million was spent on prescriptions for pain.

What is the evidence of poor or variable quality?
There is a wealth of evidence demonstrating poor and variable quality of pain management and outcomes in many clinical scenarios in both primary and secondary care. The following lists various publications that have demonstrated this:

1. 150 years of the Annual Report of the Chief Medical Officer; On the state of public health 2008. March 2009. Pain: Breaking through the barrier. Each year, over five million people develop chronic pain but only two thirds recover. Much more needs to be done to improve outcomes for patients.

2. National Service Framework for Children Young People and Maternity Services: Children and Young People who are ill 2007: Standard 6 stated: "There is still evidence that pain is inadequately dealt with for children, requiring better prevention, assessment and treatment."

3. Improving health and work: changing lives. The government’s response to Dame Carol Black’s Review of the health of Britain’s working age population. November 2008. Unrelieved pain is a frequent impediment to returning to work, in the short term after an operation, and in the longer term after injury.

5. Joint working? An audit of the implementation of the Musculoskeletal Services Framework Arthritis and Musculoskeletal Alliance (ARMA) 2009 found that only 14 of 71 PCTs operated an integrated pain management service with interface services. Only 1 PCT of those responding to their survey stated that Integrated Clinical Assessment & Treatment Services (ICATS) were staffed with a pain psychologist despite such recommendations in the Musculoskeletal Framework.

6. A Sickle Crisis. NCEPOD, 2008. This report highlighted shortcomings in the management of pain in patients with sickle cell disease. The Department of Health has responded by requesting development of a clear pathway for pain management.

7. The MHRA and National Patient Safety Agency have recently issued guidance on opioids due to safety concerns regarding poor quality prescribing of strong opioids and the need for effective acute pain teams to monitor the effect of parenteral opioids.

8. Safe administration of parenteral opioids. Letter dated 23 July 2009 and signed by the Chief Medical Officers for England, Wales, Scotland and Northern Ireland. (Gateway reference 12266). Issued by the CMO with an instruction to cascade to “all hospital doctors and GPs”. This letter dealt with important issues concerning the safety of acute pain management.
9. *Getting to GRIPS with chronic pain in Scotland. NHS Quality Improvement Scotland.* 2007. One of the findings of this report was: “There is a general lack of knowledge about chronic pain and awareness of treatment options and services in NHS Scotland”. This led to the Scottish government recognising chronic pain as a long-term condition in its own right.

10. *Service Development and Commissioning Directives for chronic non-malignant pain. The Welsh Assembly Government 2008.* This highlighted the patchy provision of services in Wales and the need to provide services closer to home for the vast majority of patients. As a result chronic non-cancer pain was selected as one of five key areas for improvement.

11. *The Assessment of Pain in Older People. Royal College of Physicians, British Geriatrics Society, British Pain Society, October 2007.* This Guideline recognised the need to “provide professionals with a set of practical skills to assess pain as the first step towards its effective management”.

12. Poor quality pain management in the elderly and in care home residents has been highlighted by the Patients Association [Patients Association 2009] and the Picker Institute [Picker Institute (2007)].

13. *British Pain Society Education in Pain Survey 2009.* This survey of universities illustrated that pain management is significantly under-represented within the undergraduate curricula across a range of health care professionals.

14. The Long-term Medical Conditions Alliance, the Patients Association and Dr Foster survey of 2004 found the provision and organisation of primary care pain management services across the UK was unequal and inconsistent [Dr Foster 2004].

15. *The Department of Health’s Clinical Services Advisory Group (CSAG) in 2000 found a large variation in quality of care offered by specialist providers [CSAG 2000].*

16. General Practitioners often feel ill prepared to advice on working with musculoskeletal pain and report that they do not address work issues in clinical practice [Coole et al 2009].

**Can a quality standard improve care?**

There is a vast potential for improvement in the quality of pain management for millions of patients within the NHS if a quality standard were to be developed and adopted. The Chief Medical Officer in England recommended consideration of the following in 2009:


2. *For patients in hospital, a pain score should become part of the vital signs that are monitored routinely.* Measurement of pain is still not performed consistently despite reliable, validated measures. This can be achieved by utilisation of a multidisciplinary team with responsibility for ensuring the safety and quality of pain control [Vickers 2009].

3. *The feasibility of a national network of rapid-access pain clinics providing early assessment and treatment should be explored.* Improved management of acute pain can play an important role in the prevention of chronic pain; this is consistent with early effective intervention in a wide range of long term conditions. There is evidence that
acute pain, well managed, reduces chronic disability [Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine 2010].

4. **A model pain service or pathway of care with clear standards should be developed by experts.** This will lead to a reduction in the number of unnecessary emergency consultation episodes in primary care and emergency centres, acute hospital admissions, specialist referrals and diagnostics. There is a multitude of pre-existing evidence-based guidance to inform these guidelines (e.g. Bandolier’s Pain Site, NICE, Cochrane Reviews) and work is presently underway to develop some of these.

5. **All chronic pain services should supply comprehensive information to a National Pain Database.** A National Pain Audit (NATPAT) funded by the Health Quality Improvement Partnership undertaken by the British Pain Society and Dr Foster commenced in September 2009 in England and Wales. This three year programme could inform the development of a quality standard for pain in the NHS.

6. **Agencies involved in the management of patients with chronic pain should form local pain networks to work together to improve the quality of local services.** This has already been embraced by the Scottish Government who has made a step change in the standards of pain management offered to their population.

**What would be the benefits of improved care?**

A quality standard ensuring the utilisation of the evidence-base and appropriate changes in service delivery would deliver significant benefits to patients, NHS and society as a whole. Specific benefits would include:

1. Improved patient experience and quality of life.
2. A focus on care delivered in the community.
3. Improved management of chronic pain in primary care.
4. Facilitate an active life-style with all its benefits.
5. Reduce the burden on other services within the NHS e.g. mental health, acute and diagnostic services (e.g. Emergency Department attendances are reduced after attendance at a pain clinic [Audit Commission 1997]).
6. Significant reductions in direct costs to the NHS e.g. consultations, admissions to hospital, pharmacy.
7. Significant reductions in costs to the patient (e.g. loss of employment), other national agencies (e.g. social care, disability and unemployment benefits) and employers [Loisel 2005, Pilgrim 2008].
8. More emphasis on self care and prevention.
9. A better educated and informed healthcare workforce.
10. Reduced prevalence of chronic pain.
11. Underpin patient care pathways to improve early assessment, treatment and (if deemed appropriate) the criteria for referral for specialised care.
12. Early detection of conditions associated with chronic pain.
References

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