NHS Overview and Scrutiny Committee Briefing Note

Chronic Pain services

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Background

Chronic pain can be defined as continuous or intermittent pain over a long period of time that persists beyond the normal period of healing. It is increasingly understood that it is a disorder in its own right (possibly a neurodegenerative disorder) that may result from a number of painful triggers – or may have no obvious precipitating cause. The condition affects a significant proportion of the population (21%, according to a survey by the British Pain Society in 2005) and, by definition, is incurable. Examples of potential triggers include:

- cancer
- lower-back injury or disorders
- arthritis (inflammation of the joints), including osteoarthritis
- recurrent headache, including migraine
- peripheral neuropathy (damage to the peripheral nervous system), including trigeminal (facial) neuropathy, diabetic neuropathies, postherpetic pain (following shingles), pain from multiple sclerosis and post-stroke pain
- conditions causing abdominal pain, such as chronic pancreatitis and bowel disorders
- conditions causing pelvic pain, such as endometriosis and interstitial cystitis
- other conditions, such as fibromyalgia, myofascial pain syndrome and complex regional pain syndrome

Lower-back pain in particular is a very common ailment, affecting large numbers and leading to the loss of many working days. The need to recognise psychosocial risk factors at an early stage cannot be understated. Increasingly, the importance of multidisciplinary pain management at an early stage for those at risk of a poor outcome is being emphasised. The Musculoskeletal Services Framework, published by the Department of Health in July 2006, provides a way of managing demand and treating most common painful conditions.

A range of therapies (surgical and non-surgical) for chronic pain is available, from both mainstream and complementary/alternative fields of medicine – supported by evidence bases of varying quality. Modes of treatment include the following:

- acupuncture
- Alexander Technique
- aromatherapy
- cordotomy (spinal-cord surgery) – for a very limited number of cancer patients with mesothelioma
- epidural steroid injections/facet joint injections/nerve root blocks
- opioid drugs
- psychological therapies/counselling/Cognitive Behavioural Therapy
- self-help programmes

- radiofrequency lesioning (burning of the nerves)
- SCENAR (Self-Controlled Energy Neuro-Regulation)
- Tai chi or exercise programmes/physical therapies
- TENS (Transcutaneous Electrical Nerve Stimulation)
- spinal cord stimulation
- intrathecal drug therapy (injecting drugs into the spinal canal)
- Pain Management Programmes (inpatient and outpatient)

Pain management services are mostly delivered in an acute hospital setting – in outpatient clinics, by inpatient ward referrals, and through oncology and palliative care services. It has been recommended that a minimum of one whole-time equivalent consultant (*i.e.* 10 Programmed Activities under the consultant contract) dedicated to chronic pain management is necessary for each population of 100,000 people. However, this seems to have been a somewhat arbitrary standard; and it has not been achieved widely (if at all).

Provision of pain management services within the NHS appears to be limited; and there seem to be significant variations in the extent and type of services offered across the UK. Surveys indicate that a majority of these services have waiting lists; waiting times vary widely and can be significant in some areas. In all but a few areas, the NHS does not keep any register of patients who require chronic pain management.

The effect of NHS system reform

NHS acute Trusts in England are now substantially being paid by commissioners on the basis of the Payment by Results (PbR) system – and will be more so in future. Under PbR, work is paid for through "cost and volume" contracts according to the actual number of episodes of care ("spells") provided. This is in contrast to the old system of block contracts, whereby commissioners paid for pre-determined volumes of work.

Under PbR, payment for each procedure is made according to a standard national "tariff", based on average costs across NHS providers. (There is some adjustment in the tariff to allow for unavoidable differences in costs between regions – using the same Market Forces Factor that is used to adjust funding allocations to Primary Care Trusts.) The tariff is structured around Healthcare Resource Groups (HRGs), which are used to classify together treatments, and types of case, that are clinically similar and that use roughly the same level of resources, taking account of diagnosis, the actual procedure involved and other variables (such as the patient's age).

It is intended that various types of clinical activity in the pain management specialty, including surgery, will be covered by PbR from 2008–9 (rehabilitation will be covered from 2009–10). A lot of work has already been done by Expert Working Groups (with input from the British Pain Society) to develop appropriate HRGs. National "Reference Costs" (derived from costs across acute Trusts) have been compiled for these, preparatory to tariffs being fixed. Providers, especially Foundation Trusts, are now beginning to record pain-management procedures and map them onto the appropriate HRGs.

Current national tariffs are only available at a very crude level. Where procedures and activities do not match the HRGs available, other HRGs are used if a match cannot easily be made. It depends on the coder and decisions made locally as to what is actually charged, since, in the absence of proper codes, it is open to interpretation.
Originally, under HRG version 3.5, there were four HRGs specifically for pain

management, namely:

Outpatient (Specialty Code 191) – First Attendance
Outpatient (Specialty Code 191) – Follow-up Attendance
A07 Intermediate Pain Procedures
A08 Percutaneous Image Controlled Pain Procedures

Concern was expressed over these original HRGs covering pain management on the grounds that:

- being so few in number, they involved bundling together treatments with a wide range of cost, meaning that the HRGs failed to reflect true costs in respect of the more expensive procedures carried out in the specialty;
- they required nearly all pain management activity to be described in terms of treatment rather than diagnosis;
- they did not allow complex cases (especially complex assessments) to be assigned a proper code;
- they failed to take proper account of non-surgical modes of treatment;
- they did not recognise pain management treatments carried out in an inpatient setting.

The Department of Health says that steps have been taken to address some of the issues relating to the coding of pain management. A new system of HRGs (HRG version 4.0) was introduced on 1 April 2007 and will form the currency for the national tariff from 2009–10. It includes six HRGs for pain management:

AB01Z Complex Neurosurgical Pain Procedures
AB02Z Complex Major Pain Procedures
AB03Z Complex Pain Procedures
AB04Z Major Pain Procedures
AB05Z Intermediate Pain Procedures
AB06Z Minor Pain Procedures

These will more accurately reflect the treatments that are undertaken, although their breadth and complexity are still not fully described. Reference costs will need to be derived on the outpatient work and the extent to which this can be done will depend on data returns from Trusts. Currently in many places tariffs are negotiated locally by commissioners to reflect the work and case-mix better – this is more likely in the more specialised centres.

Dartford and Gravesham NHS Trust
It has recently been reported that the Chronic Pain Management Clinic at Darent Valley Hospital has stopped taking new referrals from West Kent Primary Care Trust. Dartford and Gravesham NHS Trust is charging the PCT above the national tariff rate for the service; the PCT is not prepared to pay at this rate, and the Trust is not prepared to subsidise the service (although it is continuing to treat existing patients). The clinic is reported to be open on a part-time basis and to have significant waiting times.

The PCT is now commissioning services from other providers outside the area (obliging patients to travel some distance) and planning to provide some services locally in a

primary-care setting.

East Kent Hospitals NHS Trust
The Chronic Pain Service provided by East Kent Hospitals NHS Trust is an outpatient service at the Trust's three main hospital sites. Therapies are provided by the service as follows:

Kent and Canterbury Hospital, Canterbury
- Acupuncture
- Alexander Technique
- Aromatherapy
- Counselling
- Patient support group
- SCENAR
- Tai chi
- TENS

Queen Elizabeth The Queen Mother Hospital, Margate
- Counselling
- Patient support group
- Reflexology
- Tai chi
- TENS

William Harvey Hospital, Ashford
- Acupuncture
- Counselling
- Patient support group
- Tai chi
- TENS

In addition, some of the therapies provided are offered on an outreach basis at the Royal Victoria Hospital in Folkestone and Buckland Hospital in Dover.

Patients can be referred to the Chronic Pain Service by their GP or from within the hospital system if they have already received treatment from the Trust for their condition.

The most recent Clinical Governance Report for East Kent Hospitals NHS (covering 2005–6) stated in respect of the Chronic Pain Service that:

- each site offered a different model of care to chronic pain patients, potentially resulting in inequity of provision;
- an increase in referrals had contributed to a lack of capacity within the service;
- there was a need to create extra capacity and expertise within primary care for high quality pain management.

It was reported that the Nurse Consultant for Chronic Pain, together with the PCT's Head of Commissioning and Service Redesign, had put forward a proposal for a "hub and spoke" model of care. This would allow most of the service to be delivered from primary

care, freeing up capacity within the acute Trust to treat more complex cases. A pilot service had begun, with the Nurse Consultant and a specialist chronic pain nurse running clinics and working one day a week in the PCT. A two-to-three-year plan was in place to develop the model to its full capacity.

The benefits of switching to primary care in this way were stated to be:

- shorter waiting times for treatment;
- improved access and choice;
- the development of support services that would help people;
- to live with their pain and improve quality of life;
- reduction in the number of referrals to secondary care.

It has recently been reported that services provided at the QEQM Hospital in Margate are to be transferred to the K&C Hospital in Canterbury.

Maidstone and Tunbridge Wells NHS Trust
Maidstone and Tunbridge Wells NHS Trust previously ran a Chronic Pain Unit at Maidstone Hospital. This was relocated to Pembury Hospital in September 2004, without consultation.

Since the Unit was moved, concern has frequently been expressed about the inconvenience and discomfort caused to patients in undertaking the lengthy journey from Maidstone to Pembury (around 15 miles). This involves using a poor-quality road connection and takes some time – using public transport (the Arriva No. 6 bus), it entails a round-trip journey time of around two hours (some chronic-pain patients who lack access to transport are taken in private cars by volunteer drivers).

The government stated in December 2004 that the Chronic Pain service provided at Pembury was significantly enhanced, as a result of £600,000 of additional resources being provided.[1]

Note
This briefing was prepared with assistance from Dr Cathy Price and Dr Joan Hester of the British Pain Society.

[1] *Hansard*, House of Commons Debates, 2 December 2004, Col. 883.