

Chronic pain

Summary

- In Hampshire, about one in three people suffer with chronic pain. Back pain and osteoarthritis together account for over half of all cases.
- It is estimated that one in four people with chronic pain quit their job and have five times more GP visits than people who do not suffer chronic pain. Chronic pain is the second most common reason for claiming incapacity benefit.
- Two in every 100 people are admitted to hospital in Hampshire every year due to pain. People with severe chronic pain are four times more likely to be anxious or depressed than those without pain and are significantly more likely to have other longstanding illnesses.
- There is large variation in access to pain management services across England and in Hampshire. There is also a lack of standards in terms of quality of care consequently specialist service provision is patchy both nationally and locally.
- Most people with chronic pain are medically managed by their GP. Local service user groups describe inadequate support and the need for increased knowledge and awareness of services and education for healthcare professionals.

Recommendations

- Ensure prevention of chronic pain is included in strategies addressing inequalities and the wider determinants of health.
- A pain management network across Wessex could sit within the Academic Health Science Network. This would enable a stronger, integrated, more person based, academically rigorous approach to pain management, sharing of good practice (successes and failures) and stronger integration of care to ensure more timely implementation of high value interventions.
- Promote the mental and physical benefits of work and encourage employers to adopt simple low cost interventions to support employees with chronic pain.
- Strengthen health literacy and self-care, increasing knowledge and awareness of pain management (for example through expert patient programmes).
- Improve access to help via on line programmes and community pharmacists.
- Encourage use of chronic pain map of medicine pathways to support integrated care and provision of best value service at the appropriate time e.g. pelvic pain pathway to guide management with regular auditing of service provision and outcomes.
- Raise awareness of patient support groups in general practice and highlight them to people.
- Reduce variation and inequalities in service provision across Hampshire through changed commissioning by CCGs to meet local needs.
- Regular medicines management review (as per other chronic diseases).

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1. Introduction

Chronic pain is defined as pain or discomfort that troubles a person all of the time or on and off for more than three months¹. Chronic pain may be complex, often with no identifiable purpose or basis. Untreated, pain becomes entrenched and more difficult to treat¹.

Chronic pain has a significant impact on people's lives. It is associated with a number of negative outcomes including depression, job loss, reduced quality of life (mood and sleep), and impairment of function and limitation of daily activities. It is estimated that about 7.8 million people in the UK suffer moderate to severe pain that has lasted more than six months¹. Each year, over 5 million people in the United Kingdom develop chronic pain, but only two thirds recover. People with chronic pain are seven times more likely to quit their jobs due to ill health than the general population; this represents 25% of chronic pain sufferers¹.

Muscle, bone and joint pain are the main causes of chronic pain, with back pain and osteoarthritis together responsible for over half of all cases. The recorded prevalence of chronic pain is rising. Repeated surveys show that chronic pain is two to three times more common now than it was 40 years ago¹.

Pain is one of the most common reasons for which people seek medical treatment. It is estimated that those in chronic pain consult their doctor up to five times more frequently than others. This equates to almost 5 million GP appointments a year. It is estimated that the cost to society of back pain alone is around £12.3 billion per year¹.

Chronic pain is the second most common reason for claiming incapacity benefit. People with chronic pain often do not know when, or whether, they are going to recover. This makes it difficult for them and their employers to plan for their return. Very often, people fail to come off these benefits¹.

The Trades Union Congress reported that British businesses lose an estimated 4.9 million days to employee absenteeism through work related back pain, with each affected employee taking an average of 19 days off work. The National Rheumatoid Arthritis Society estimates that 9.4 million working days are lost through Rheumatoid Arthritis. A survey by the All Party Parliamentary Group on Endometriosis showed that on average women with this condition lose 55 days from work per annum². These are only a few of the many described diseases that can lead to chronic pain.

Psychosocial factors are known to play an important role in the generation of disability and distress secondary to pain. If people are very anxious about the sources of their pain, they tend to become more inactive. Pain management is therefore holistic in its approach, seeking to decrease distress, provide symptom control, increase patient confidence, enable people to undertake their daily activities (including work and education) and increase mood. There is large variation in access

¹ CMO report 2008:

http://www.pelvicpain.org.uk/uploads/documents/Pain%20call%20for%20network%20of%20clinics-%20DH_096233.pdf

² British Pain Society, societal cost of chronic pain: http://www.britishpainsociety.org/media_faq.htm

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to pain management services across England³. With an aging population, service use for pain management could increase substantially over time.

Pain is subjective and not easily measured. Pain perception has been shown to vary greatly across different cultures and countries. These variations in pain tolerance and ability to work are found between people with similar conditions and types of employment across different countries⁴. Staying within the workplace is well recognised as beneficial for mental and physical health. As much as there is a need for adequate pain management, there is an equal need to challenge apparent social norms and support and encourage individuals to continue with their daily activities where possible.

1.1 Preventing the development of chronic pain

At a population level, the occurrence of chronic pain reflects a combination of the occurrence of diseases and injuries which trigger painful experiences and a propensity for those experiences to become amplified and chronic. Primary prevention of diseases or injuries that cause pain, such as cancer or road traffic accidents, is one approach to the prevention of chronic pain, although the fraction of all chronic pain in the general population attributable to such diseases or to neuropathic pain remains unclear.⁵

The major group of conditions for which primary prevention might result in a substantial impact on population levels of chronic pain are the common chronic pain syndromes, such as musculoskeletal conditions and headaches. The disease model of prevention is relevant to some of these conditions – e.g. prevention of osteoarthritic change in the joints or prevention of migraine. However, the evidence so far suggests that, for people with back, neck, shoulder, joint, or head pain, the main determinants of who will go on to develop chronic symptoms relate to a broad biopsychosocial model of chronicity and to a general propensity for chronicity which appears or develops throughout the life-course.⁵

There are a number of potentially modifiable risks associated with the development of chronic pain. These include physical inactivity, overweight, low social status as measured by education or occupational class, psychological distress (e.g. anxiety and depression; cognitions, beliefs, and concerns about pain), physical and emotional stress in childhood, social inequality, and the cultural environment concerning pain and pain-related disability. Preventing the development of chronic pain is therefore rooted in improving the wider determinants of health, reducing inequalities and improving lifestyle choices.⁵

³ National Pain Audit: <http://www.nationalpinaudit.org/results>

⁴ *International variations in pain research study*

⁵ Chronic Pain Epidemiology. Croft et al 2010. OUP.

http://fds.oup.com/www.oup.com/pdf/13/9780199235766_chapter1.pdf

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2. Level of need in the population

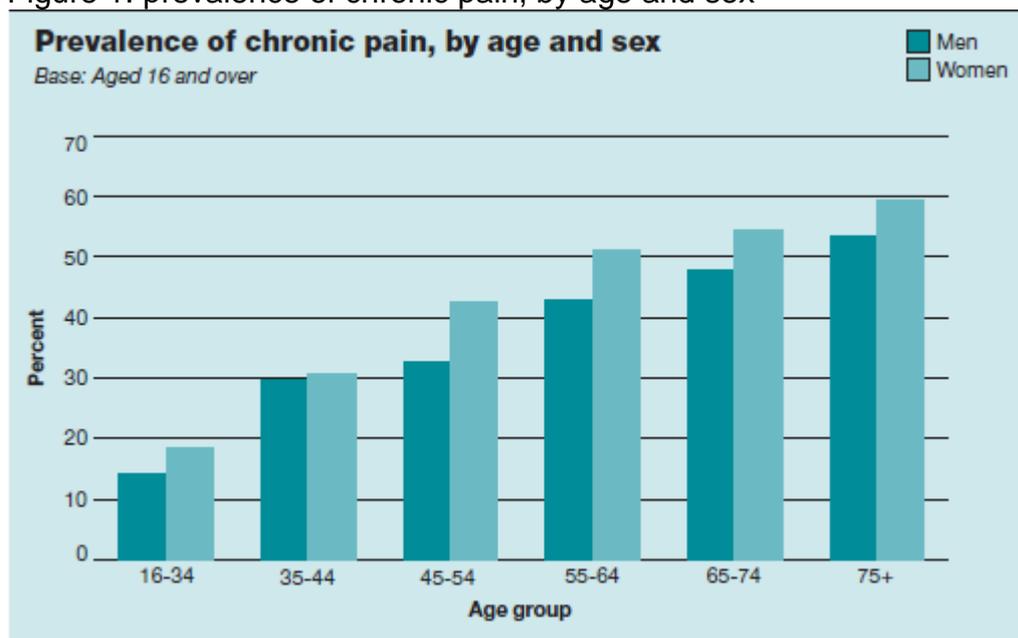
There are no data on chronic pain prevalence available at the Hampshire level. The Health Survey for England (HSE) 2011 included questions about chronic pain⁶ which are the latest and most robust indicators of chronic pain prevalence and severity.

Analyses have been undertaken across 'old' strategic health authority areas. For Hampshire, this was 'South Central' (population approximately 3.9 million). These analyses showed no statistically significant difference in prevalence or pain level across strategic health authority areas. Despite this, there are a number of factors which impact on pain such as age and socio-economic status. In applying estimates to local areas within the Hampshire population, it will be important to take account of these factors.

2.1 Gender and age

The Health Survey for England 2011 findings showed that slightly more women than men reported on going pain (31% of men and 37% of women respectively)⁵. The prevalence of chronic pain increases with age (figure 1).

Figure 1: prevalence of chronic pain, by age and sex



Source: Health Survey for England 2011

Reported chronic pain rose from 14% of men and 18% of women aged 16-34 to 53% of men and 59% of women aged 75 and over⁵.

⁶ HSE 2011: <https://catalogue.ic.nhs.uk/publications/public-health/surveys/heal-surv-eng-2011/HSE2011-Ch9-Chronic-Pain.pdf>

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2.2 Further indicators of pain prevalence

In a study of United Kingdom nursing homes, most residents experienced constant or frequent moderate to severe pain, despite the fact that 99% were on pain medication. Conversely, chronic pain affects a quarter of school-age children (a third severely), with pain lasting on average more than three years¹.

2.3 Incidence

A four year follow up study assessing the course of chronic pain in the community, identified an annual chronic pain incidence rate of 8.3% and average annual recovery rate of 5.4%⁷.

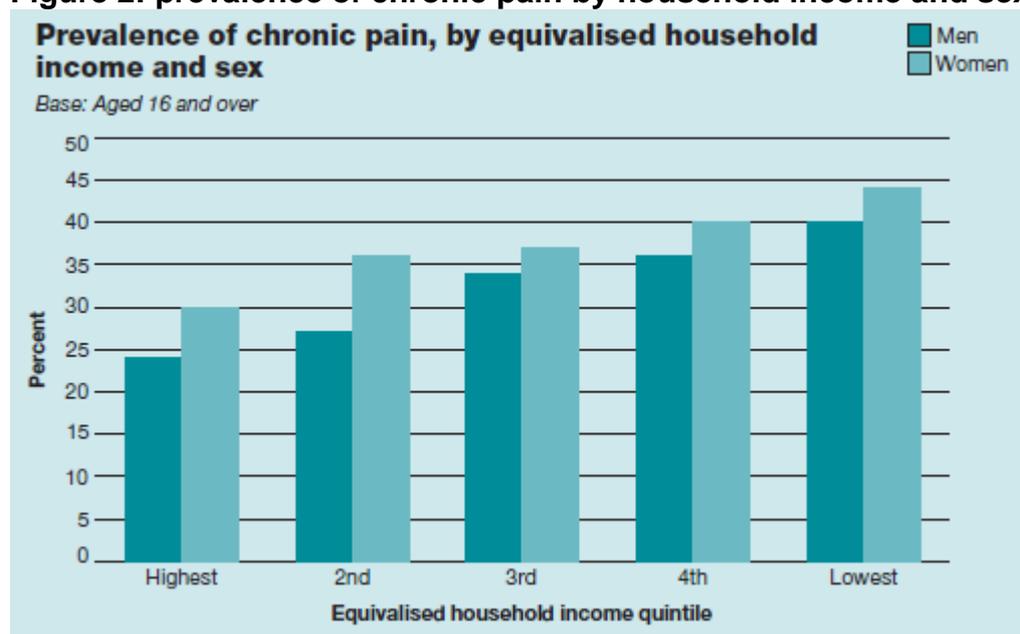
2.4 Ethnicity

United Kingdom citizens of South Asian origin are three times more likely to report disabling back pain than people from other ethnic groups¹.

2.5 Prevalence by socio-economic factors

The Health Survey for England reported that those living in the lowest income quintile of equivalised household income were more likely to report having chronic pain (40% of men and 44% of women) than those in the highest income quintile (24% of men and 30% of women respectively)⁵ (figure 2).

Figure 2: prevalence of chronic pain by household income and sex



Source: Health Survey for England 2011

Similarly, those living in the most deprived quintile of the Index of Multiple Deprivation (IMD) were more likely to report having chronic pain (36% of men and 42% of women) than those in the least deprived quintile (31% of men and 34% of women)⁵.

⁷ Elliott AM, Smith BH, Hannaford PC et al. The course of chronic pain in the community: results of a 4-year follow-up study. Pain 2002; 99: 299-307.

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2.6 Location of pain

The Chief Medical Officer's report in 2008 provided estimates of population experience of chronic pain. It reported that 1.6 million adults in the United Kingdom per annum develop back pain that lasts beyond three months. At any one time, a quarter of adults over the age of 40 years in the United Kingdom have knee pain, and in around half of them this pain is disabling. A half a million adults have rheumatoid arthritis, an autoimmune disorder with significant joint involvement¹.

Severe and recurrent headaches are common. Around 12% of the population experience migraine, and a further 9% of women and 3% of men suffer chronic daily headache. Pelvic pain lasting more than six months affects a million women in the United Kingdom; an additional one in eight women report severe menstrual pain. Up to 5% of the population are affected by chronic widespread pain of unknown cause. Among children and adolescents, the most common cause of pain is muscle-, bone- or joint-related, with headache and abdominal pain each responsible for a quarter of all cases of chronic pain in that age group¹.

The Health Survey for England 2011 found the most commonly reported sites of chronic pain to be arms, hands, hips, legs or feet. 58% of men and women reporting chronic pain said that this was a site of their pain⁵. Back pain was the next most commonly reported site of pain, with more women than men reporting this type of pain (44% compared with 37% respectively). This was followed by neck and shoulder pain, again reported more by women than men (25% and 22% respectively). Similarly, more women than men reported stomach or abdominal pain (12% and 9% respectively) and headache, facial and dental pain (10% and 6% respectively). For most pain sites, the likelihood of reporting pain increased with age⁵.

Overall, women were more likely than men to report multiple pain sites (14% of women reported pain in three or sites compared with 11% of men). Older people were more likely to report pain at multiple sites than younger people⁵.

2.7 Level of pain and impact on usual activities

Women reported a higher level of current pain than men in the HSE 2011 survey. Level of pain increased with age. The majority of HSE respondents with chronic pain reported that their pain had not kept them from their usual activities on any days. However, 24% of women and 22% of men said that their pain had kept them from their usual activities for more than two weeks in the last three months⁵.

The impact of chronic pain on limiting usual activities increased with age. 35% of men and 46% of women aged 16-34 years were kept from their usual activities which increased to 50% of men and 54% of women aged over 75 years. Pain was graded by severity and impact on daily activities. Pain grades increased with age and were higher for households with lower income levels⁵.

2.8 Chronic pain grades by longstanding illness

Respondents with moderate to severely limiting pain grades were more likely than those with lower pain grades and those with no pain to report have one or more longstanding illnesses. For respondents with the most severe pain grading, the two

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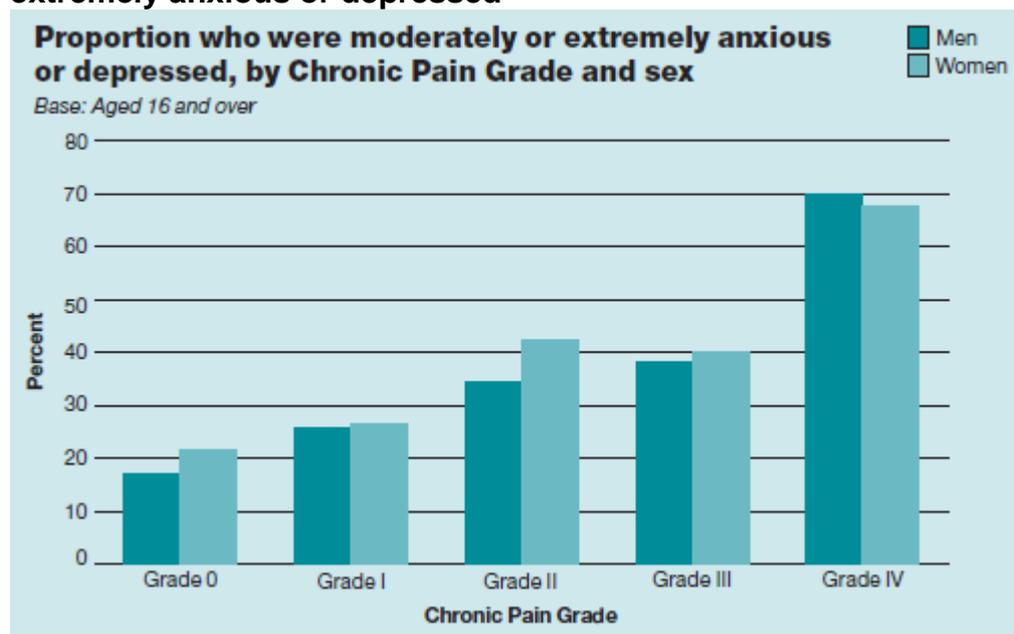
most commonly reported longstanding illnesses were musculoskeletal complaints and arthritis, rheumatism or fibrositis⁵.

2.9 Chronic pain and quality of life

Chronic pain reduces quality of life more than almost any other condition. Pain often becomes intertwined with the lives of people living with it. Pain has been described as 'exhausting' and 'mentally draining', and the experience of living with it 'frustrating', 'isolating' and 'humiliating'¹. Young people with ongoing pain have more mental health and social problems, miss more school than their peers, and tend to achieve less academically than expected. Taken together, all these factors have the potential to seriously harm a child's future¹.

Findings from the Health Survey for England 2011 showed that, for both men and women, the likelihood of reporting anxiety or depression increased markedly as pain grade increased. Men with grade IV pain were more than four times likely to report being anxious or depressed (70%) than those without chronic pain, while women with grade IV pain were more than three times as likely (68%)⁵ (figure 3).

Figure 3: proportion of people with chronic pain who are moderately or extremely anxious or depressed



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3. Projected service use and outcome in 3-5 years and 5-10 years

3.1 Programme budgeting

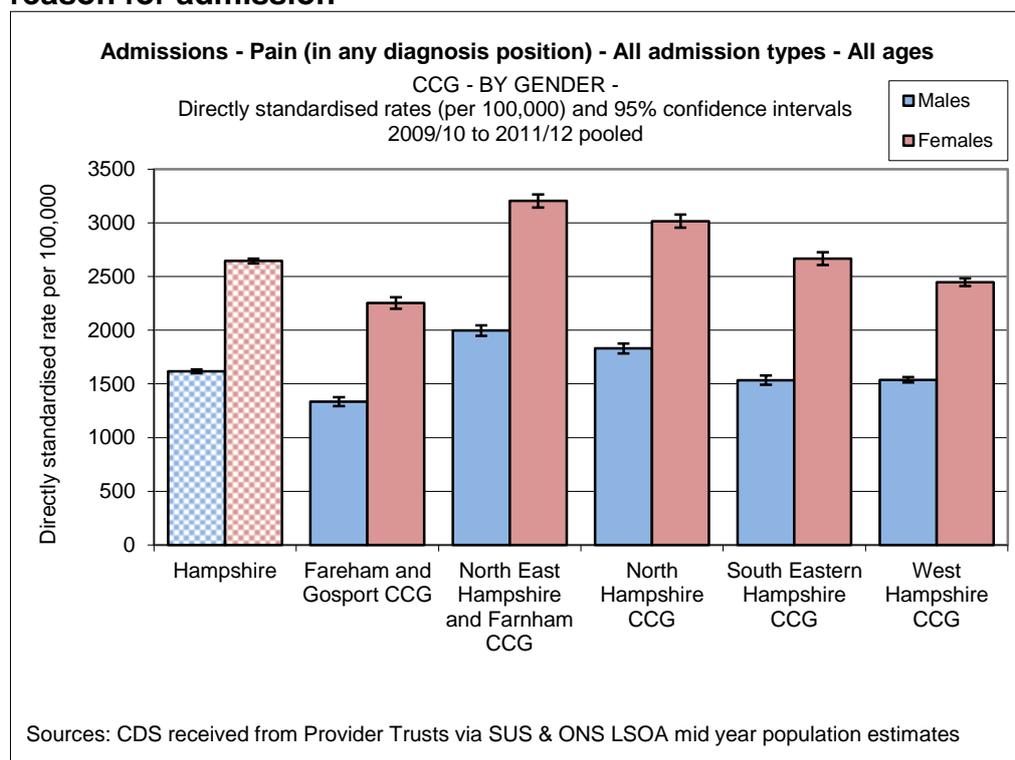
Conditions associated with chronic pain are among the most expensive to treat. Musculoskeletal diseases, such as arthritis, make up one of the most expensive disease groups for healthcare costs and 50% of this budget is spent on managing chronic pain.

3.2 Hospital admissions associated with chronic pain

It is not possible to accurately determine the number of hospital admissions associated with chronic pain. However we can estimate the number of hospital admissions within Hampshire that are associated with pain (ICD-10 codes determined by a nationally recognised Pain Specialist). Figure 4 shows directly standardised hospital admission rates associated with chronic pain by gender and CCG area during 2011/12.

The directly standardised hospital admission rate for chronic pain for Hampshire is 2125 per 100,000 population i.e. about 2 in every 100 people in Hampshire. As can be seen from figure 4, rates vary by CCG with significantly higher rates for females than males, mirroring national data.

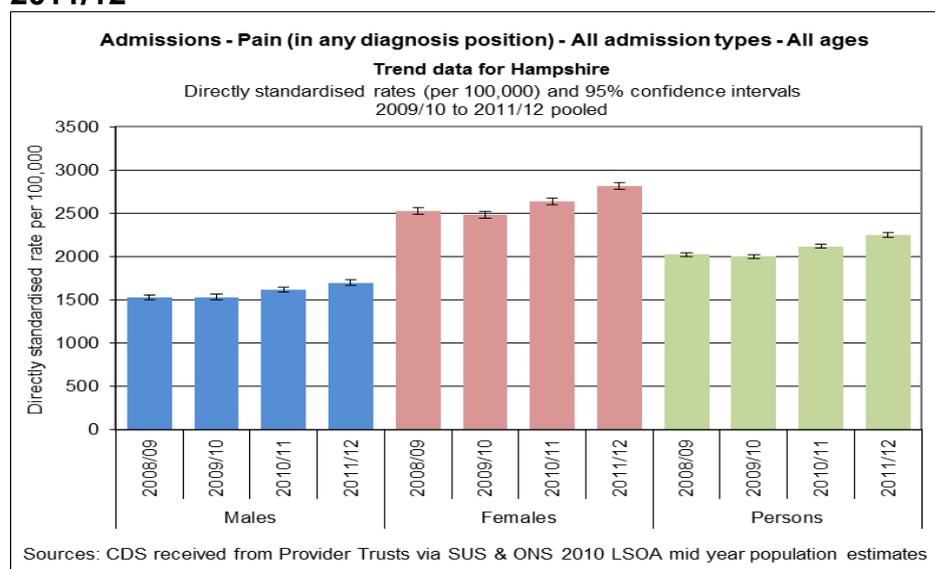
Figure 4: hospital admissions where pain is reason for or associated with reason for admission



Since 2008/09, there has been an increase in hospital admissions for men and women associated with pain in Hampshire (figure 5).

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Figure 5: trend in admission to hospital for pain in Hampshire, 2009/10 to 2011/12



4. Current services in relation to need

Pain services use a range of approaches to address the impact of pain on daily lives. However, NICE guidance does not include clear standards for the management of people with chronic pain. Instead, guidance on chronic pain is found for diagnoses known to be associated with chronic pain e.g. osteoarthritis, low back pain and neuropathic pain.

The first national report to address chronic pain and the variability of service provision was the Chief Medical Officer's report of 2008¹. Its recommendations included the need for improved data, increased training for healthcare professionals and improved services for people with chronic pain. Timely access to pain management was identified as a key issue³.

Current pain services include preventative, primary care, non specialist community services, specialist community services, non specialist secondary care services and specialist acute services and specialised services. Need for a service is defined by the level of pain severity, with a tiered approach to care provision. Specialist services in secondary and tertiary care manage complex pain³.

Best practice has been agreed nationally through a consensus in five key areas of high variation in care: initial assessment and management, fibromyalgia, pelvic pain, back pain and neuropathic pain. These were subject to rigorous peer review and publication has included the Map of Medicine.

The first national pain summit held in 2011 involved politicians, patients, professionals, researchers and other stakeholders. It identified four key areas that needed to change:

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- To reduce the time to satisfactory diagnosis and treatment of chronic pain from an average of 2.8 years to a few months, aspiring to be the best in Europe.
- To ensure that chronic pain becomes a “high street” disease, recognised and visible to all, with equitable access to treatment, care and education.
- To create integrated systems to eliminate the perpetual pinball currently faced by many people in pain.
- To create the right conditions to support people in pain to remain in, and return to, fulfilling work.

A strategy was agreed by stakeholders:

- a) Clear standards and criteria must be agreed and implemented nationally for the identification, assessment, and initial management of problematic pain to support non specialists in identifying those at risk of chronicity and ensure speedy action.
- b) An awareness campaign is required to explain the nature, extent, impact, prevention and treatment of chronic pain to the wider general and NHS community.
- c) Nationally-agreed commissioning guidance must be developed and agreed, describing best value care in chronic pain to reduce unwarranted variation.
- d) A data strategy for chronic pain should be agreed through creation of an Epidemiology of Chronic Pain working group to inform the process.

4.1 National Pain Audit

The development of a national pain audit was one of the recommendations in the Chief Medical Officer’s 2008 report. This audit was first undertaken in 2010-11 to improve information on pain services. The audit covers all specialist pain services in England and Wales³. It highlighted a number of areas for improvement, particularly around the provision of specialist multidisciplinary services for pain management. Audit data are described in the specialist centre section below.

4.2 Medical management

The majority of people experiencing chronic pain who access health services are managed with pharmaceutical pain relief. This includes paracetamol, opioids, anti-inflammatories and other medications such as some anti-depressant medications and some anti-epileptic medicines such as gabapentin. Prescribing costs for pain relief are consequently high. Figure 6 shows latest prescribing costs for pain relieving drugs overall in January and February 2013 by CCG.

If these two month costs are projected over a year, we could estimate a spend of over £10 million on pain relief for the population of Hampshire.

There is no easily available guidance on optimal drug management or pain relief. Pharmacists are a key source of information for the public with self help materials available in pharmacies; such as the Pain Toolkit.

The appropriate use of pharmaceuticals for pain relief not only ensures best care and efficiency but can also avoid unintentional health consequences.

Figure 6: Prescribing costs for pain relief by CCG area over a two month period

Total cost of prescriptions for pain relief for January and February 2013				
Clinical Commissioning Group (CCG)	Non-opioid analgesics and compound prep	Opioid analgesics	Prophylaxis of migraine	Treatment of acute migraine
Fareham and Gosport	£98,153	£141,698	£2,407	£19,542
North East Hampshire and Farnham	£65,154	£161,100	£2,039	£17,661
North Hampshire	£80,484	£151,889	£1,810	£20,375
South Eastern Hampshire	£97,350	£134,790	£2,199	£20,838
West Hampshire	£227,571	£383,367	£7,331	£63,160

4.3 Other forms of pain management

Physical therapy and/or appropriate rehabilitation programmes treat pain directly and give patients the knowledge and skills to maintain their own health and function. This may also help to maintain psychological well-being. Many areas have access to physical activity and leisure services or equivalent schemes, some of which are targeted at people with complex pain. These aim to reintroduce and maintain good physical function and health. Health trainers can also improve patients' confidence in doing things despite their pain. There is excellent evidence that increasing physical activity has an overall benefit on everyone's health.

Non specialist community services include the reablement teams. They are a key source of care for the housebound. However, they report difficulty with prescribing for pain related to falls, dementia and constipation.

Psychological therapies support some people with anxiety and depression where pain is a significant issue. However training is patchy and there is no systematic approach. Cognitive behavioural therapy is used to develop self-management and coping strategies, and to improve social and physical functioning, even where the underlying pain cannot be improved significantly.

4.4 Specialist pain services

Ideally, specialist pain services provide a leadership role in pain management. However, as described in the National Pain Audit report, their services are fragmented and patchy³. Currently, there are four specialist multidisciplinary pain centres in Hampshire. Some information on service provision and current delivery is shown in figure 7.

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Specialist services report being overwhelmed with referrals, especially for low back pain. In terms of patient outcomes, data returns from Specialist Centres were low and therefore difficult to interpret for this first audit round. All hospitals provide a service for emergency attenders in A & E and the hospital wards.

Figure 7: Specialist Multidisciplinary Pain Centres in Hampshire
Data from <http://www.nationalpinaudit.org/clinic> with additional information from Hampshire Hospitals Foundation Trust

	University Hospital Southampton FT	Portsmouth Hospitals	Frimley Park Hospital FT	Hampshire Hospitals FT
Population served	1m	600,000	400,000	600,000
Consultant in Pain Medicine*	1 WTE**	1.1 WTE	2.85 WTE	2 WTE
Physiotherapy*	0.7 WTE	0	3 WTE	0.46 WTE
Clinical Psychologist*	1 WTE	0	1 WTE	1 WTE
Nurse Specialist*	1.3 WTE	1 WTE	0.6 WTE	1.05 WTE
Other	Pharmacist 0.3 WTE (vacancy)	0	Nurse Consultant 0.6 WTE	0
Number of new patients seen (Apr 11 – Mar 12)	250	1236	1747	1600
Average waiting time (weeks)	10 (urgent and routine)	2 weeks (urgent) 6 weeks (routine)	4-6 weeks (urgent) 8-12 weeks (new)	12 weeks
Telephone consultations	150	346	1241	New service 960

*Staffing as at May 2013.

** Further Consultant level posts are provided by Solent 0.275 WTE, Southern Health 0.4WTE and there is a Consultant led ISTC injection service 0.2 WTE

4.5 Community Services

New Forest Pain Service provides an assessment service to GPs as well as less complex cases of chronic pain. It forms part of the Orthopaedic Choice service and was designed to offer a wider choice to orthopaedic patients beyond surgery or rehabilitation.

4.6 Workplace health

Helping patients remain in, or return to, work should be a primary objective of pain management. Patients with chronic or complex pain, their carers and employers, may see leaving the workplace as beneficial. Remaining in work is essential to physical and mental health, and improves quality of life and self-esteem¹. Employers

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play a key role in understanding and contributing to rehabilitation and the patient's reintroduction to work. A constructive approach, looking at flexibility of roles, retraining, modification of hours and other options, can yield rewards for the patient, the employer and society.

Within Hampshire, the vocational pain service (provided by Remploy) has recently been withdrawn. Remploy were unsuccessful in securing on-going funding from local funders. Estimates suggest that this service produced a societal return on investment of £2.55 for each £1 spent.

4.7 Employment services, housing and benefits

Many people reporting persistent pain problems are from lower socioeconomic groups. This means that finance and employment opportunities are more limited. Employment services are very restricted for people with pain. Most are focussed solely on mental health problems.

4.8 Personal Care Plans

The HSE 2011 asked respondents with chronic pain about their service use. Those with long standing illnesses were asked whether they had a personal care plan. Personal care plans are an agreement between a person and their health care professional which helps them to manage their health day to day. The proportion of respondents with long standing illnesses with a personal care plan differed by pain severity; those respondents with more severe pain were more likely to have a personal care plan⁵. It is unclear how many people with chronic pain in Hampshire have personal care plans.

5. User and provider views

User views were collected as part of the National Pain Audit. Patients stated that the time they waited to be seen was critical to a good experience. Research has established that patients with chronic pain deteriorate while waiting for treatment. The deterioration includes escalating pain and depression and decreased health-related quality of life.

Participation in expert patient programmes allows people with chronic pain to learn from the experiences of others. Patients gain the skills to become confident in managing their own pain and learn how to work in partnerships with their clinicians.

5.1 Local patient groups

There are a small number of chronic pain patient groups in Hampshire. The Fareham and Gosport groups are both capped to 30 members to ensure group support for individual needs is manageable. 'Friends through pain' in Fareham was established 12 years ago and 'Partners in Pain' (Gosport) has been running for two years.

Members feel that the groups have 'changed their lives...they no longer feel isolated...something to get up in the mornings for'. The groups describe challenges in GP medical management, particularly in relation to side effects of drugs and

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inadequate social service support. They have made the following recommendations to support their pain management:

- GPs receive training in pain management, are aware of patient support groups and inform others of their existence.
- Need for integrated working between professions and services.
- Specialist pain services are recognised as 'absolutely vital', widely variable and not accessible.
- Social care support is insufficiently resourced and could be reduced if pain services enabled patients to be more mobile.

A patient support group in the New Forest describes communication as the biggest issue for them. They are no longer able to afford the rooms they rent at a General Practice within the area and would like to run support groups for those who are attempting to work with chronic pain. They highlight that pain management services seem scarce with long waiting times and that they would like to develop some on-line support in the form of a forum.

6. Evidence of what works

NICE has produced public health guidance for primary care services and employers on the management of long-term sickness absence and incapacity for work (PH19)⁸. There are recommendations for employers in terms of ensuring initial enquiries and more detailed assessment regarding sickness absence are undertaken appropriately and next steps to aid return to work and/or support required are determined.

For those people with a poor prognosis who are returning to work, an intensive programme of interventions is recommended. Examples include cognitive behavioural therapy (CBT), counselling about a return to work, workplace modifications and referral to physiotherapy services or vocational rehabilitation (including training). More intensive specialist support is recommended for those with recurrent sickness absence. For those individuals with a good prognosis for return to work, the guidance proposes individually tailored advice on how to manage daily activities at home and at work (this could include advice on the benefits of being physically active and on relaxation techniques); encouragement to be physically active; referral to a physiotherapist or psychological services.

Evidence based psychological interventions proven to be useful for certain groups and conditions are as follows:

- Women with musculoskeletal pain: CBT (cognitive behavioural therapy) in small groups (involving 5–6 people), with one-to-one telephone follow-up.
- Men and women with stress-related conditions: CBT and contact with the employer.

⁸ PH19: <http://publications.nice.org.uk/managing-long-term-sickness-and-incapacity-for-work-ph19/recommendations>

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- Men and women experiencing low back pain: CBT in small groups (involving 5–6 people) combined with one-to-one sessions of behavioural-graded activity and liaison with the workplace to discuss a return-to-work plan.
- Men and women with psychological or musculoskeletal problems: solution-focused group sessions (using, for example, 'The road ahead course' format).
- Men and women with whiplash injuries: progressive goal attainment programmes combined with physiotherapy or multimodal programmes.

The guidance also recommends consideration of a multi-disciplinary back management programme to help employees with this condition return to work. It could be delivered by a GP with occupational health experience, a specialist professional (such as a physiotherapist) or a combination of others specialising in occupational health, health and safety, rehabilitation or ergonomics. Lastly, the guidance recommends commissioning of an integrated programme for people with health problems who are unemployed and claiming incapacity benefit or employment support allowance.

A recent systematic review of the effectiveness of community and workplace based interventions to manage musculoskeletal related sickness absence and job loss was published in 2011⁹. It concluded that the benefits of interventions were small and of doubtful cost-effectiveness. Employers' practice should be guided by their value judgements about the uncertainties. Expensive interventions should be implemented only with rigorous cost-benefit evaluation planned from the outset. Future research should focus on the cost-effectiveness of simple, low cost interventions and future explores impacts on job retention.

There are a number of further relevant NICE technology appraisals (TA) and guidance documents that relate to individuals in chronic pain (figure 8).

⁹ Palmer KT, Harris EC, Linaker C, Barker M, Lawrence W, Cooper C and Coggon D. Effectiveness of community- and workplace-based interventions to manage musculoskeletal-related sickness absence and job loss – a systematic review. *Rheumatology* March 16, 2011; 1-12.

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Figure 8: NICE Guidance or Technology Appraisal relating to chronic pain

NICE Guidance or TA	Guidance priority areas or TA recommendations
CG88 Low back pain: Early management of persistent non-specific low back pain*	Information, education and patient preference, physical activity and exercise, Manual therapy, combined physical and psychological treatment programme, assessment and imagining, referral for surgery
TA97 Depression and anxiety - computerised CBT	The use of 'Beating the Blues' for people with mild and moderate depression and 'FearFighter' for people with panic and phobia
CG59 Care and management of osteoarthritis in adults	Exercise should be a core treatment for people with osteoarthritis. Offer paracetamol in addition to core treatment. Consider offering topical NSAIDs**. Referral for joint replacement should be considered for people with osteoarthritis who are refractory to non-surgical treatment and experience joint symptoms
IPG 234 Laparoscopic uterine nerve ablation (LUNA) for chronic pelvic pain	Not efficacious and therefore not recommended.
Pain (chronic neuropathic or ischaemic) - spinal cord stimulation (TA159)	Spinal cord stimulation is recommended as a treatment option for people with chronic neuropathic pain meeting specific criteria. It is not recommended for people with ischaemic pain except within a clinical trial.

* NICE guidance in progress Workplace health - employees with chronic diseases and long-term conditions

**Non-Steroidal Anti-Inflammatory Drugs

6.1 Public Campaign

In Australia, a mass television campaign that encouraged people to stay active in spite of their pain had a prolonged effect on sickness absence¹⁰. A state wide public health campaign ran over 2 years in Victoria and comparison was made with New South Wales where the campaign wasn't in place. The campaign was designed to alter beliefs about back pain, influence medical management and reduce disability and costs of compensation.

The campaign resulted in a significant increase in awareness of back pain advertising in Victoria and this was accompanied by a self reported change in beliefs about back pain as a consequence of advertising. There was also a clear decline in number of claims for back pain, rates of days compensated and medical payment for claims of back pain over the duration of the campaign. There was no change in New South Wales.

Over time, doctors in Victoria were 3.6 (2.4 to 5.6) times as likely as doctors in New South Wales to know that patients with low back pain do not need to wait until they are almost pain free to return to work. They were also 2.9 (1.6 to 5.2) times as likely to know that such patients should not be prescribed complete bed rest until the pain goes away and 1.6 (1.2 to 2.3) times as likely to know that x ray pictures of the

¹⁰ Buchbinder R, Jolley D and Wyatt M. BMJ Volume 322: 1516-1520. 23 June 2001. Population based intervention to change back pain beliefs.

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lumbar spine are not useful in the investigation of acute low back pain. Doctors in Victoria were also less likely to order tests for low back pain either because the patients expected them to or to conform with normal practice patterns of their peer group.

7. Recommendations

- Ensure prevention of chronic pain is included in strategies addressing inequalities and the wider determinants of health.
- A pain management network across Wessex could sit within the Academic Health Science Network. This would enable a stronger, integrated, more person based, academically rigorous approach to pain management, sharing of good practice (successes and failures), stronger integration of care and ensure more timely implementation of high value interventions.
- Promote the mental and physical benefits of work and encourage employers to adopt simple low cost interventions to support employees with chronic pain.
- Strengthen health literacy and self-care, increasing knowledge and awareness of pain management (for example through expert patient programmes).
- Improve access to help via on line programmes and community pharmacists.
- Encourage the use of chronic pain map of medicine pathways to support integrated care and provision of best value service at the appropriate time e.g. pelvic pain pathway to guide management with regular auditing of service provision and outcomes.
- Raise awareness of patient support groups in general practice and highlight them to people.
- Reduce variation and inequalities in service provision across Hampshire through changed commissioning by CCGs to meet local needs.
- Regular medicines management review (as per other chronic diseases).