Written evidence submitted by Chronic Pain Policy Coalition (PRI0169)

This submission will address the following aspects of the Inquiry:

- The quality and standards of care for patients
- Demand and access
- Commissioning

Background

The Chronic Pain Policy Coalition (CPPC) is a forum established in 2006 to unite patients, healthcare professionals and parliamentarians in a mission to develop an improved strategy for the prevention, treatment and management of chronic pain and its associated conditions. Organisations directly involved include academic institutions, service users/patient groups, parliamentarians, NHS bodies, commercial organisations, and royal colleges. The CPPC's work is steered by an Executive Committee made up of leading figures in chronic pain, including patient representatives, researchers and healthcare professionals.

No review of Primary Care can afford to omit a focus on the conditions which have the greatest impact on its resources and effectiveness, which is why the CPPC is keen to draw attention to the issues and solutions relating to the management of chronic pain.

About chronic pain

Chronic pain (of non-malignant origin) is recognised by the Department of Health (DH) as a long-term condition in its own right, and a component of other long term conditions.[1] Almost half of all people with a long-term condition report moderate or extreme pain, rising to 80% of people with three or more conditions.[1]

Chronic pain can be caused by specific conditions (such as arthritis, endometriosis, fibromyalgia), or it can result from nerve damage acquired after an accident/a surgical procedure, or it can be of unexplained origin. Patients may have two or more co-existing chronic pain conditions. It should be noted that four of the top 12 disabling conditions globally are persistent pain conditions such as lower back and neck pain, migraine, and arthritis.[2]

It is estimated that there are 14 million people living with some form of chronic pain in England, of whom 3.5 million said their pain had kept them from usual activities, including work, on at least 14 days in the last three months.[3]

There are several issues around chronic pain, which cause it to be under recognised, and under treated with low prioritisation. For example, it is still considered by many to simply be a sign of other disease processes and not a disease in its own right, despite the fact that chronic pain often persists independently of the original cause.

Chronic pain and Primary Care

The majority of chronic pain will present and be managed in primary care, so good assessment and management of chronic pain should be seen as a core skill in general practice. Pain is one of the most common reasons for which people seek medical treatment. Estimates are that people living with chronic pain consult their doctor up to five times more frequently than others – this equates to almost 5 million GP appointments per year.[4, 5]

Although the majority of chronic pain patients are managed in primary care, in a recent regional survey of GPs, only 11% of respondents reported completing some type of speciality training in chronic pain management.[6]

Studies have shown that the levels of opioid prescribing are rising in the UK,[7, 8, 9] however the deaths and addiction rates related to prescription drug misuse are also rising.[10, 11, 12]

CPPC's policy focus

The CPPC strongly believes that all patients who are routinely prescribed opioids for the treatment of chronic pain should be reviewed and re-assessed once per year by their GP or their pain team (if they have been referred).

The annual structured review should include re-evaluation of the biopsychosocial aspects of their painful condition and their treatment/management options, including a review of medications (with a potential up or down titration, review of side effects etc.). Despite the fact that many GP practices show that analgesics are often at the top of the most prescribed list, there is no recognised system for reviewing these medications.

Using a collaborative care approach, management options should be discussed with the patient, and a mutually-agreed, written, personalised action plan produced, to include a synopsis of what has been discussed, supported by appropriate self-management information.

The CPPC believes that an annual review of chronic pain patients being treated with opioid medication would greatly improve experience of care and outcomes for people suffering with chronic pain. This would in turn **reduce**:

- Avoidable GP appointments
- Avoidable steps and delays within chronic pain patient pathways
- Avoidable A&E attendances
- Avoidable emergency admissions
- Outpatient hospital appointments
- Prescribing costs (including management of side effects)
- Duplication and waste generation within the system

Pain management is best delivered by multidisciplinary and multiprofessional teams; the composition of such teams should be driven by the local needs of the population and the available workforce. Integrated primary and secondary care pain management services are emerging as an optimal model of care in the evolving NHS.

Appendix 1 – Chronic pain services within secondary and community care

GPs can refer chronic pain patients to (i) pain clinics and (ii) pain management programmes.

i. There are approximately 300 pain clinics in the UK, most of which are in hospitals and have multidisciplinary clinical teams, comprising occupational therapists, psychologists, doctors, nurses and physiotherapists. Alternative therapies such as hypnotherapy and acupuncture are sometimes also provided at pain clinics. There are a small number of community-based pain clinics, some of which are outreach clinics from the hospital, and some are set up entirely independently.

ii. Pain management programmes are a series of group sessions aiming to teach patients how to cope with pain and achieve a better quality of life, sleep and mobility through relaxation techniques and

other non-medical interventions. The programmes are held within hospitals or GP surgeries, depending on the local area.[13] In many cases, pain management programmes can be only accessed by attending a pain clinic first.

The National Pain Audit found that there is high variation in access to multidisciplinary pain care in the UK, and this variation is also reflected in patient outcomes. The Audit also found that attending specialist pain services improved quality of life for people suffering with chronic pain. In total, 56% of providers reported post-treatment improvement in EQ5D-3L score, and 76% reported improvement specifically in pain-related quality of life.[14]

Appendix 2 – Additional resources

Pain Management Services: Planning for the Future. Guiding clinicians in their engagement with commissioners. Royal College of General Practitioners, 2013 http://www.rcgp.org.uk/clinical-and-research/clinical-resources/~/media/Files/CIRC/Chronic-pain/RCGP-Commissioning-Pain-Management-Services-Jan-14.ashx

Putting pain on the agenda. The report of the first English Pain Summit. Chronic Pain Policy Coalition, Royal College of General Practitioners, The British Pain Society, Faculty of Pain Medicine of the Royal College of Anaesthetists, 2012
http://www.policyconnect.org.uk/cppc/sites/site_cppc/files/report/357/fieldreportdownload/cppc-puttingpainontheagendareport.pdf

Declaration of Montreal. International Association for the Study of Pain, 2010 http://www.iasp-pain.org/DeclarationofMontreal

Chief Medical Offer 2008 Annual Report. Donaldson Sir L. Chapter – Pain: Breaking through the Barrier.
http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/DH_096206

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[11] Office for National Statistics. Deaths Related to Drug Poisoning in England and Wales. ONS, 2013 http://www.ons.gov.uk/ons/dcp171778_375498.pdf

[12] National Treatment Agency for Substance Misuse. Addiction to medicine. NTA, 2011 www.nta.nhs.uk/uploads/addictiontomedicinesmay2011a.pdf

[13] NHS Choices. How to get NHS help for your pain http://www.nhs.uk/Livewell/Pain/Pages/Longtermpain.aspx

[14] The National Pain Audit Third Report 2013 – Focus on safety and outcomes. Dr Foster Intelligence, British Pain Society, Healthcare Quality Improvement Partnership, 2013. Available at: http://www.hqip.org.uk/assets/NCAPOP-Library/NCAPOP-2013-14/Pain-Audit-Report-2013.pdf

7 September 2015