



A British Pain Society & Dr Foster Intelligence Joint Press Release

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First ever National Pain Audit finds that patients with long- term pain experience a very low overall quality of life that is helped by services

A British Pain Society and Dr Foster Intelligence joint Audit finds that many pain services make a substantial difference to patients whose quality of life is extremely poor with high reliance on emergency care.

The first ever National Pain Audit, carried out by the British Pain Society and Dr Foster Intelligence, was used to measure the availability and activity of NHS specialist centres for the diagnosis and management of complex chronic pain disorders in England and Wales. This three-year study was commissioned by the Health Quality Improvement Partnership (HQIP) in September 2009 in response to the Chief Medical Officer's report of 2008: 'Pain: Breaking Through the Barrier' which expressed concern that the needs of people with chronic pain were being poorly served by the NHS and wider society.

The key findings of the audit were:

- **Quality of life:** The overall mean quality of life score (EQ5D-3L) of 0.4 represents severe impairment, and is lower than many individual conditions. This low score might be attributed to the collective impact of the comorbidities present in these complex cases. In total, 56 per cent of providers reported post-treatment improvement in EQ5D-3L score, and 76 per cent improvement in specifically pain-related quality of life.
- **Healthcare resource utilisation:** 16% of respondents recalled visiting A&E in the six months prior to clinic attendance, seeking additional help, despite having seen their GP. By contrast only 9% of respondents recalled visiting A&E in the six months after attending their pain clinic for pain related events.
- **Variation in availability of services:** Only 81 out of 204 English pain clinics (40 per cent) were able to fulfill the criteria for a fully multidisciplinary pain service, as defined by the presence of a psychologist, physiotherapist and physician. In Wales, 60 per cent of pain clinics were multidisciplinary.

Dr Cathy Price, Clinical Lead for the National Pain Audit said: "We were very concerned by the extremely poor quality of life endured by many patients. Although we were pleased that pain services are addressing this issue and importantly patients are satisfied with their involvement in their planning care, we hope that future audits will build on our findings. Particularly on content and quality of services, so that there is a greater equity of care for patients."

The National Pain Audit has been a three-year partnership covering details of organisation and delivery of care by specialist providers, detailed health information on the patients attending these services and the patient experience and outcomes of these services.

The final Audit Report recommends ten key areas for improvement:

1. **Identification of services:** a treatment specialty code (191) is needed to be applied to all specialist pain services regardless of setting, in order to identify them.
2. **Access to services:** nationally recognised sources of information on services should ensure that information on local pain services is readily available to patients and timely access is provided.
3. **Staff skills mix:** physical therapists, psychologists and senior medical support should be routinely available.
4. **Staffing competencies:** specialty interest groups in each profession should provide guidance on which competency and skills are required in order to meet patients' needs.
5. **Service commissioning:** commissioners and providers should ensure a health needs assessment is carried out at a local level to determine the level of need for specialist pain services.
6. **Quality of care:** quality standards that include integrated and timely working are needed.
7. **Information for patients:** providers of pain services need to improve the quality of information given to patients on managing their pain and ensure non-specialists understand this requirement.
8. **Coding and classification systems:** providers should ensure that co-morbidity data should be collected in addition to a pain diagnosis.
9. **Impact on healthcare resource use:** research funding bodies such as the National Institute for Health Research should ensure that research on optimal models of care for people with chronic pain include economic modelling.
10. **Treatment information:** future audits should capture what treatments patients have actually received and whether these were provided in a timely fashion to patients as determined by peer review.

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Notes to Editors:

1. The National Pain Audit Final Report is being launched at the Science Museum within the Pain Less Exhibition on Monday 17th December 2012, 19:00-21:00. The free exhibition, explores the future of pain relief and the different ways that pain management is being developed.
2. People with long-term, persistent or chronic pain that is refractory to usual pain care are seen in outpatient facilities by specialist pain services. This type of pain can significantly disrupt lives. Patients attending an English Pain Summit held in October 2011 highlighted the impact that pain had on their lives as exemplified by Keira Jones, a student:
"Everything I do now has a price in pain...it's not really the pain itself that's the problem. It's the consequences of the pain that have the biggest disruption on my life."
3. Physicians are currently the only group to have a recognised training programme in pain medicine and formal assessment of competency.
4. In total, 161 pain clinics were located in the audit. Some PCT's had multiple providers within the same locality but 28 PCTs did not appear to have any pain services available for their patients. Just 91 clinics (56 per cent of the total amount identified) returned information on 9,588 patients who completed the questionnaires about themselves and the impact of pain on their lives. There were 4,414 patients that returned follow up questionnaires at six months, 3,192 of these were complete and provided a good understanding of what is happening to patients in 80 of these services.
5. The Welsh Assembly published a report entitled "Service development and Commissioning Directives for chronic non-malignant pain, 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. Following on from this a series of directives have been issued for local health boards to comply with that are felt will improve standards of care. The English Pain Summit recommended better identification of likely persistent pain

in primary care, a health campaign on persistent pain, commissioning guidance and improved information at a population and individual level: <http://www.painsummit.org.uk/>.

6. The British Pain Society is the largest multidisciplinary professional organisation in the field of pain within the UK. Our membership comprises medical pain specialists, nurses, physiotherapists, scientists, psychologists, occupational therapists and other healthcare professionals actively engaged in the diagnosis and treatment of pain and in pain research for the benefit of patients.
7. Dr Foster is the UK's market-leading provider of information, analysis and targeted communications to health and social care organisations. An independent organisation, Dr Foster Intelligence was launched in 2006 and is a joint venture between Dr Foster Holdings LLP and the Department of Health. Dr Foster aims to set a new standard in information for health and social care providers and their users and is legally required to follow a code of conduct that prohibits political bias and requires it to act in the public interest
8. Dr Foster can be followed on Twitter @DrFosterIntel for regular updates on hospital data, other data analysis, and news
9. A copy of the report can be downloaded from www.nationalpinaudit.org and http://www.britishpainsociety.org/members_articles.htm

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