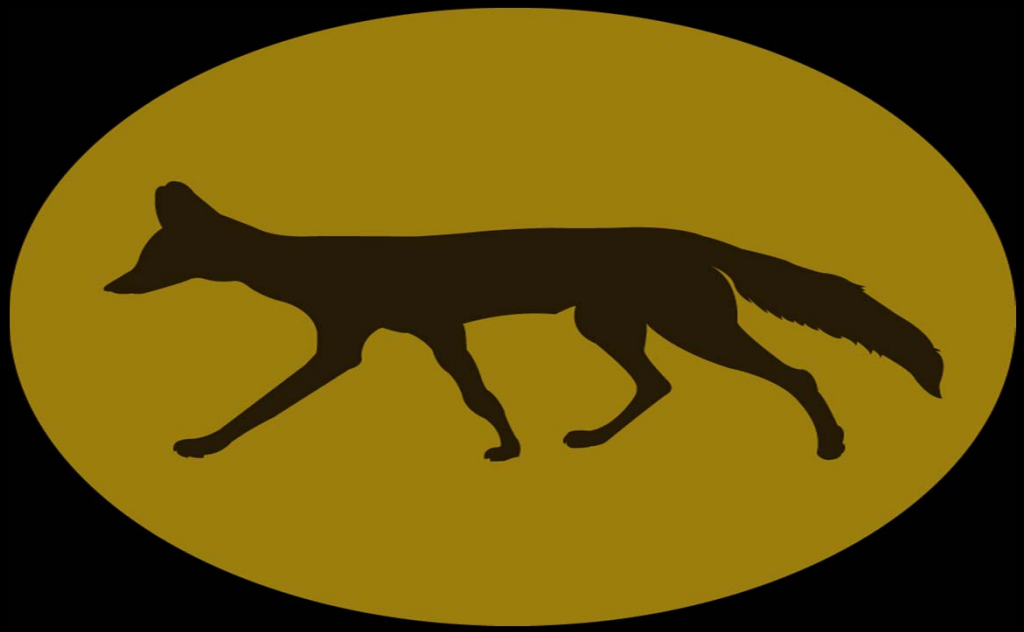

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Disclosure Statement of conflict of interest in the context of the subject of this presentation

Within the past 12 months, I or my spouse/partner have had following financial interest/arrangement(s) or affiliation(s)

Affiliation/Financial Relationship	Company
• Support for travel	……
• Honoraria for lectures	…..Grunenthal…
• Honoraria for advisory board activities	……
• Participation in clinical trials	……
• Research funding	……
• Financial shares and options	……

Counting the cost of pain

-

The whole system impact of poor pain management in the UK

15 May 2013

Jacqui Lyttle

Resourceful • Inquisitive • Adaptable

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The impact of pain on the NHS

- Pain represents an enormous burden to the NHS and the economy and society in the UK.
  - It has been estimated that back pain alone costs the UK economy £12.3billion per year (with the cost of all causes being much higher)
  - An estimated 11% of adults and 8% of children suffer severe pain representing 7.8M people in the UK
  - In addition to face to face activity more than £584million is spent annually on prescriptions for pain

System impact

- Patients in pain, especially chronic pain are high consumers of healthcare resources accessing primary and secondary on a frequent basis.
  - Primary care management of patients with chronic pain, accounts for some 4.6million appointments per year, this is the equivalent of 793 whole time GP's at a cost of £69 million
  - Patients with chronic pain are more likely to use the NHS 5x more frequently than patients who do not suffer
  - In addition to the healthcare burden there is a wider economic and societal burden due to absenteeism from work and the associated reductions in productivity

Current situation

- When pain is not well managed there is anecdotal evidence of :
  - avoidable visits to GP's
  - avoidable steps and delays in patient pathways
  - avoidable A&E attendances
  - avoidable emergency admissions
  - multiple visits to hospital
  - high analgesia cost
  - poor quality of life for patients
  - duplication and the generation of waste within the system

Whilst we can:

- **Calculate the burden on the NHS**
- **Provide the evidence**
- **Demonstrate the need for pain services**

‘THERE IS NO STANDARD APPROACH TO THE COMMISSIOING OF PAIN SERVICES IN THE UK’

Why? Because…….

- Pain has **NEVER** been seen as a priority **DESPITE** these facts
- Pain has never been seen as a **separate service**, more as an add on to others i.e. surgery, trauma
- **No one dies** from it directly
- We have never had a **political champion** or an **NSF**
- It has never been seen as a **LTC**

This is ‘DESPITE’ the fact that pain has a similar burden on the system as other Long term conditions

Pain compared to LTC's

- LTC's
  - Estimated **3** million patients are affected by COPD
  - Asthma affects between **3 & 5.4** million people per year
  - **2.6** million people are diagnosed with diabetes

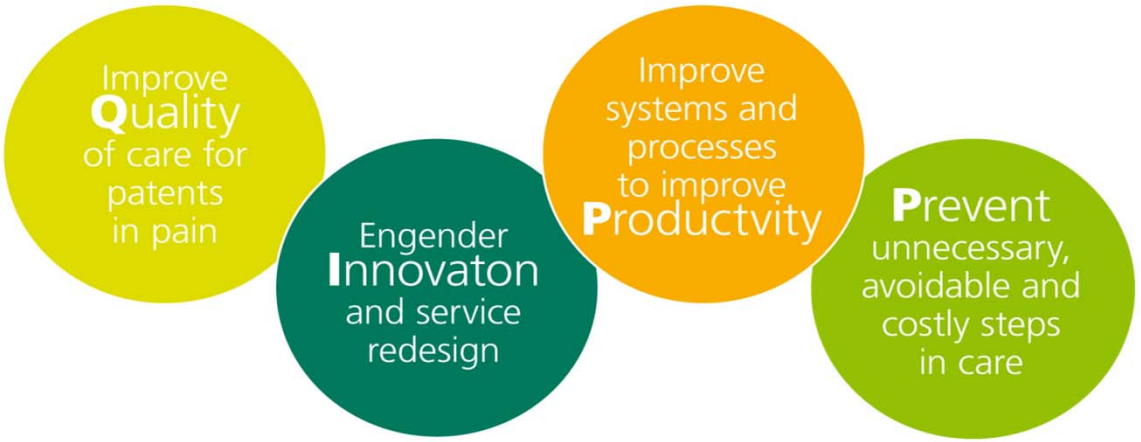
- Pain
  - **7.8** people live with chronic pain
  - Annually over **5** million people in the UK develop chronic pain, but only 2/3 will recover
  - Patients with chronic pain are more likely to use the NHS **5 x** more frequently than patients who do not suffer

Economic pressures

- The NHS currently faces its greatest financial challenge in its history, needing to find efficiency savings of £20billion by 2014
- These savings will only be made if we look at the system differently
  - We need to look at entire patient pathways not just discrete parts of them
  - Challenge historical behaviours
  - Validate and/or change historical patterns of service delivery
  - Innovate
  - Develop new care pathways

In order to

- Reduce clinical variation
- Reduce or eliminate waste
- Prevent unnecessary secondary care admissions and attendances
- Prevent or reduce primary care activity



SO AS TO MAKE THE SYSTEM MORE PRODUCTIVE OVERALL

The need to look at pain as a priority

- The management of pain is a huge NHS and wider societal issue in the UK, and should be seen as a key priority along with other long-term conditions
- By looking at pain as priority the NHS will have more success in achieving its QIPP priorities

Raising the profile

- A small task group was established in 2012 to look at the burden of pain within the system in the UK.
- The main aims of the group were to:
  - prove that the anecdotes were real
  - look at the issues facing patients when pain is not well managed
  - identify the waste within the system when best practice was not followed
  - calculate the burden across the whole pathway of care
  - gain an understanding of the impact on the system when best practice is not followed

Our approach

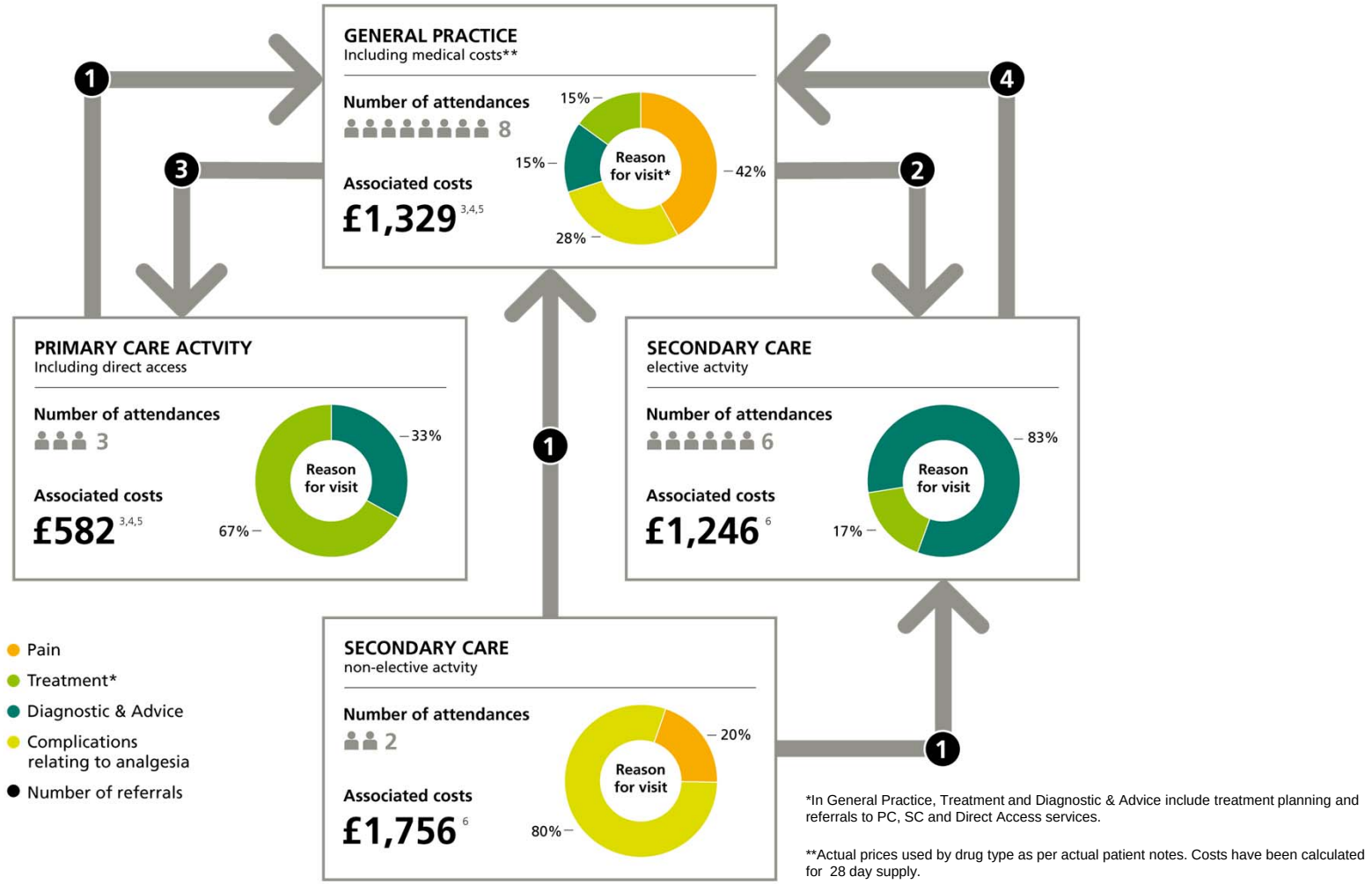
- Patients were mapped in great detail from initial presentation to their GP, to the point where there pain was successfully controlled
- The mapping took into all their healthcare costs, and took into account ,
  - their overall journey length
  - number of interactions with healthcare professionals
  - delays and waste within the system
  - the amount of time taken off from paid employment

Understanding the cost of pain

- The following diagrams summarise the number of steps, the cost and the multiple touch points for typical patients suffering from chronic pain
- The figures are drawn from the actual pathway data of 2 patients suffering back pain
- They aim to illustrate the impact on the healthcare system when pain is not well managed

Understanding the cost of pain

- **Ms JR-A. 47yo female:** This patient self treated with OTC painkillers for 4 weeks before presenting to her GP. The subsequent pathway ran over a period of 17 months

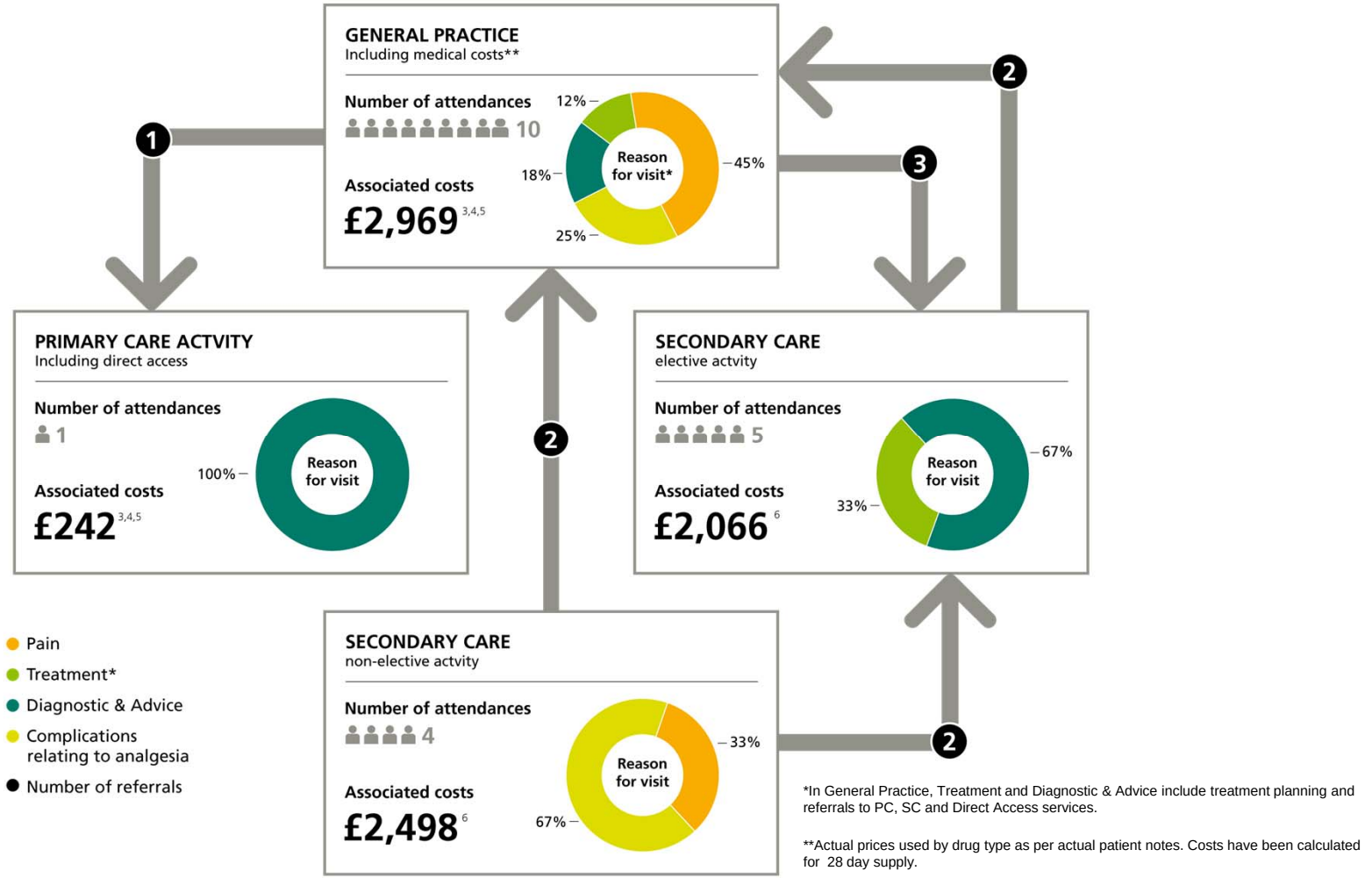


*In General Practice, Treatment and Diagnostic & Advice include treatment planning and referrals to PC, SC and Direct Access services.

**Actual prices used by drug type as per actual patient notes. Costs have been calculated for 28 day supply.

Understanding the cost of pain

- **Mr AW. 23yo male:** This patient self- treated with OTC painkillers for 14 months before presenting to his GP. This diagram shows the subsequent pathway over a period of 21 months



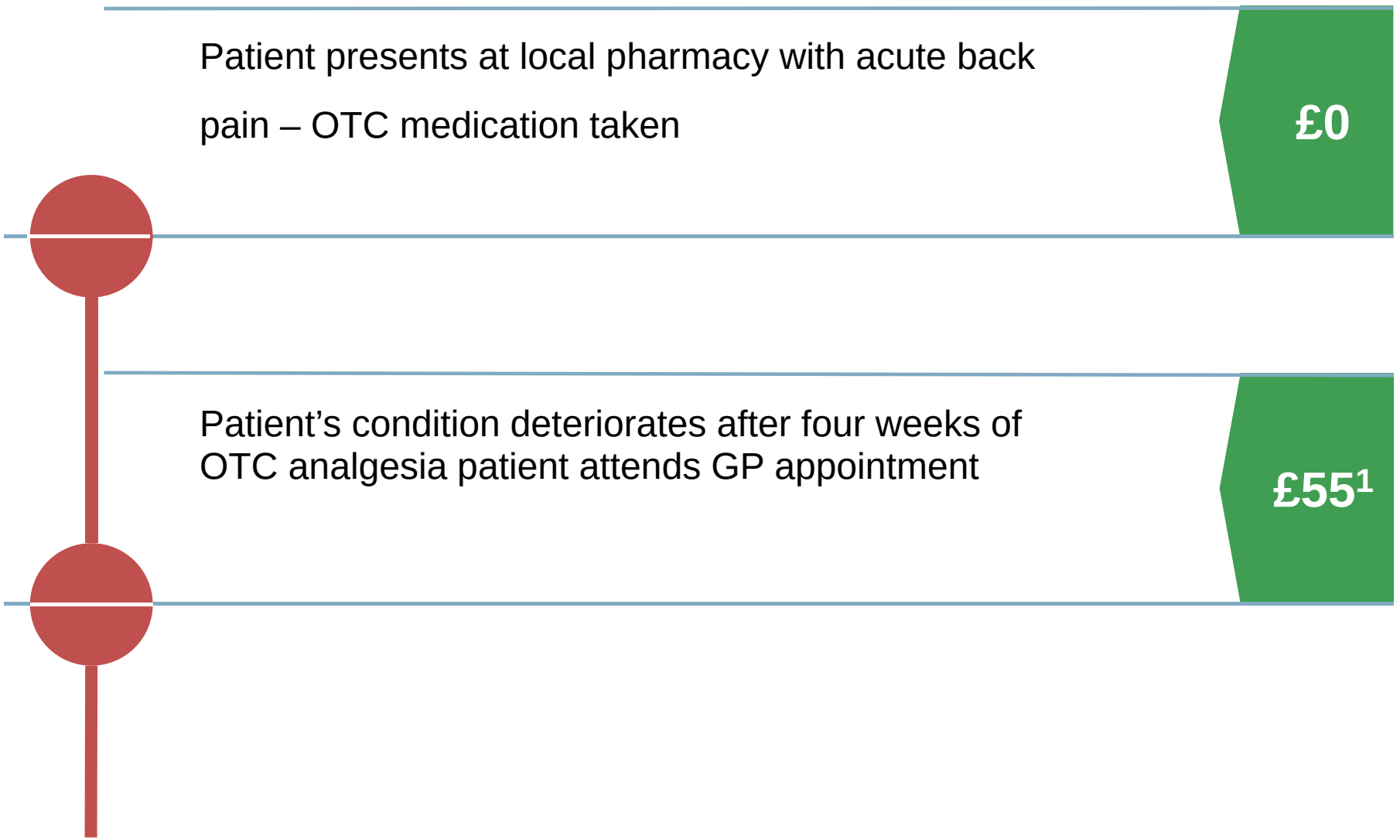
*In General Practice, Treatment and Diagnostic & Advice include treatment planning and referrals to PC, SC and Direct Access services.

**Actual prices used by drug type as per actual patient notes. Costs have been calculated for 28 day supply.

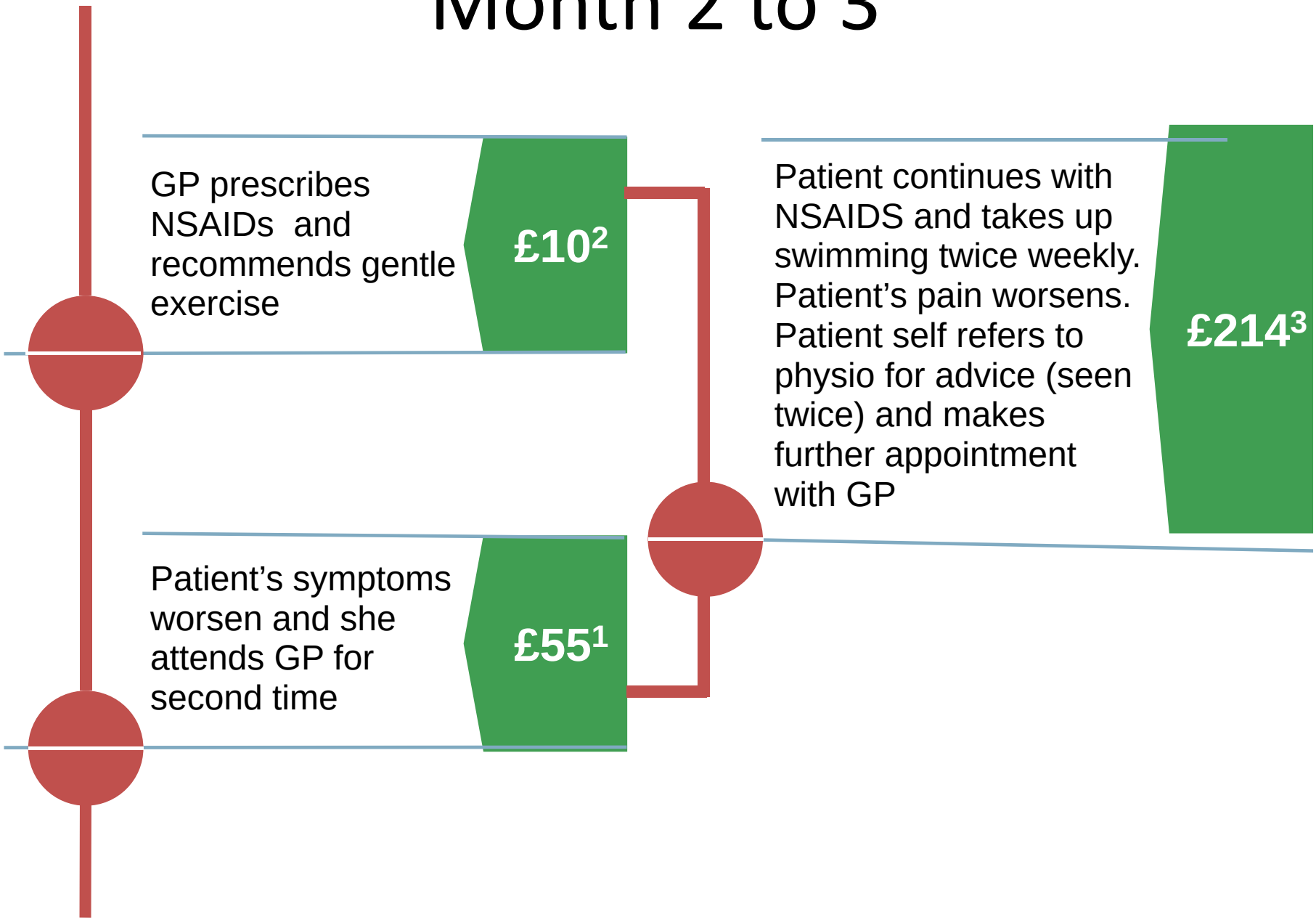
- The following patient pathway is a pictorial representation of the first patient detailed in the previous slides
- The mapping of their journey has been used to used to illustrate the cost, delays and waste which occurs when healthcare intervention and management of patients with back pain is not comprehensively coordinated

Patient journey example
47 year old female with
sudden presentation of acute back pain

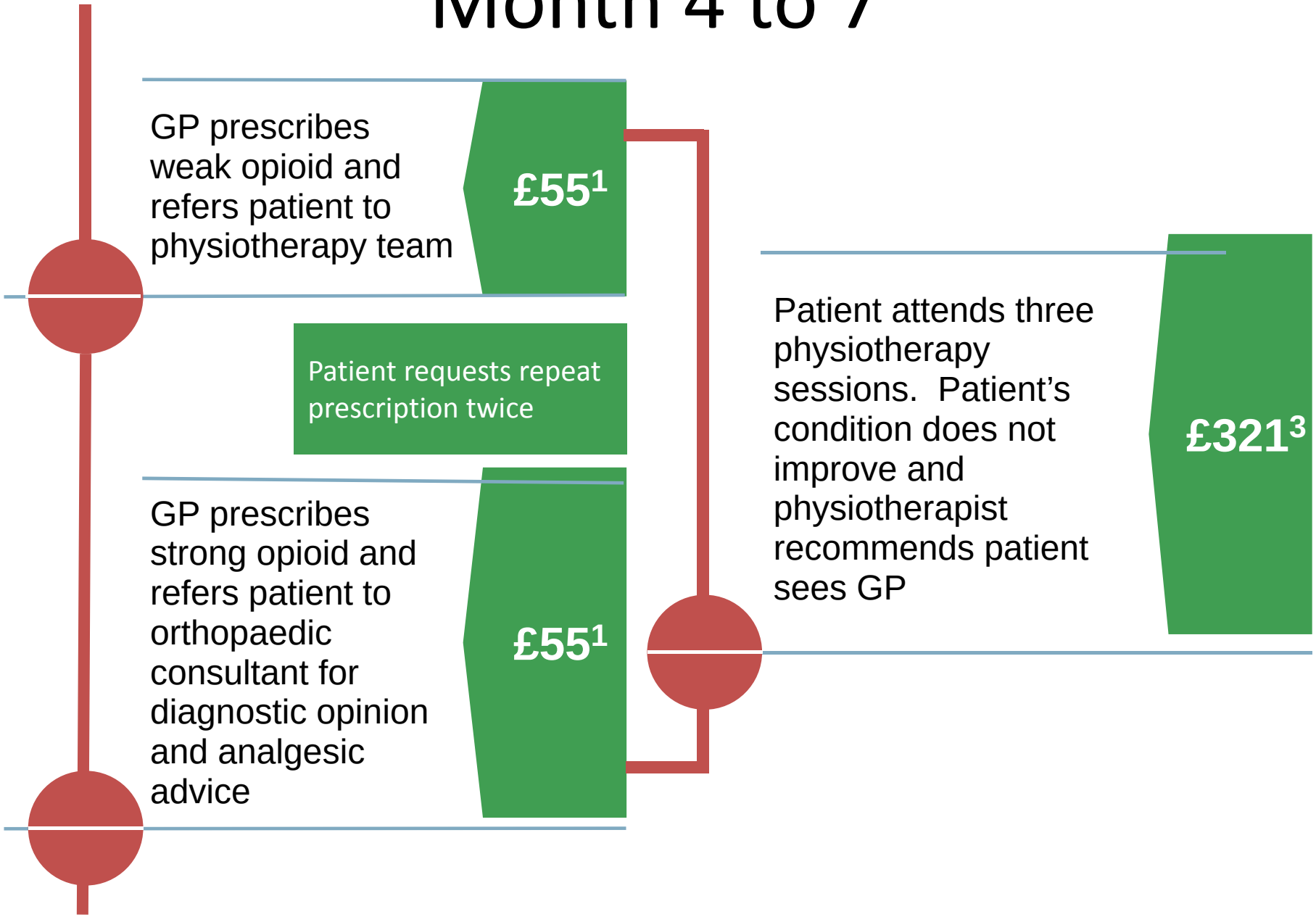
Month 0 to 1


Patient presents at local pharmacy with acute back pain – OTC medication taken
£0
Patient's condition deteriorates after four weeks of OTC analgesia patient attends GP appointment
£55[1]

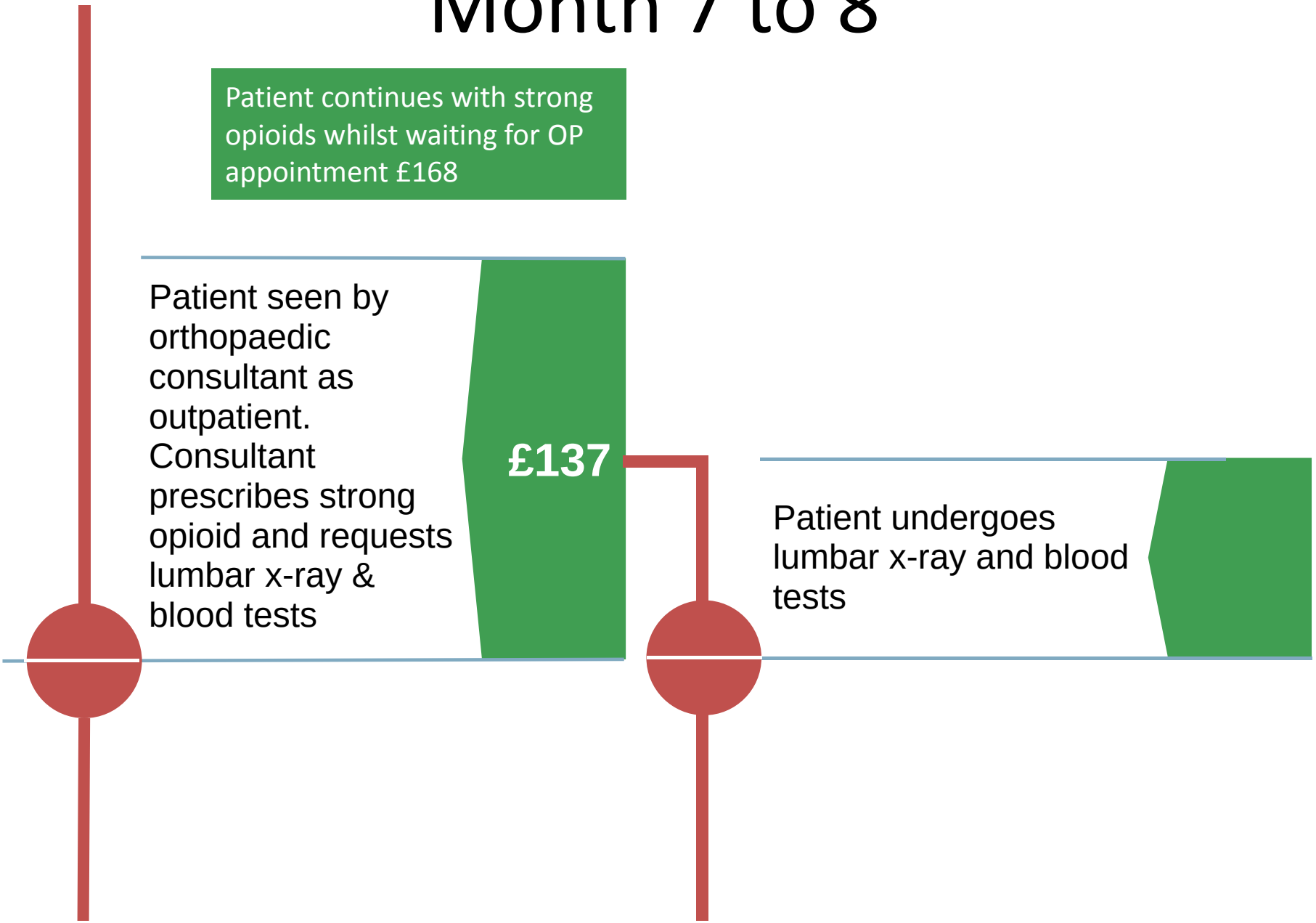
Month 2 to 3


GP prescribes NSAIDs and recommends gentle exercise
£10[2]
Patient's symptoms worsen and she attends GP for second time
£55[1]
Patient continues with NSAIDS and takes up swimming twice weekly. Patient's pain worsens. Patient self refers to physio for advice (seen twice) and makes further appointment with GP
£214[3]

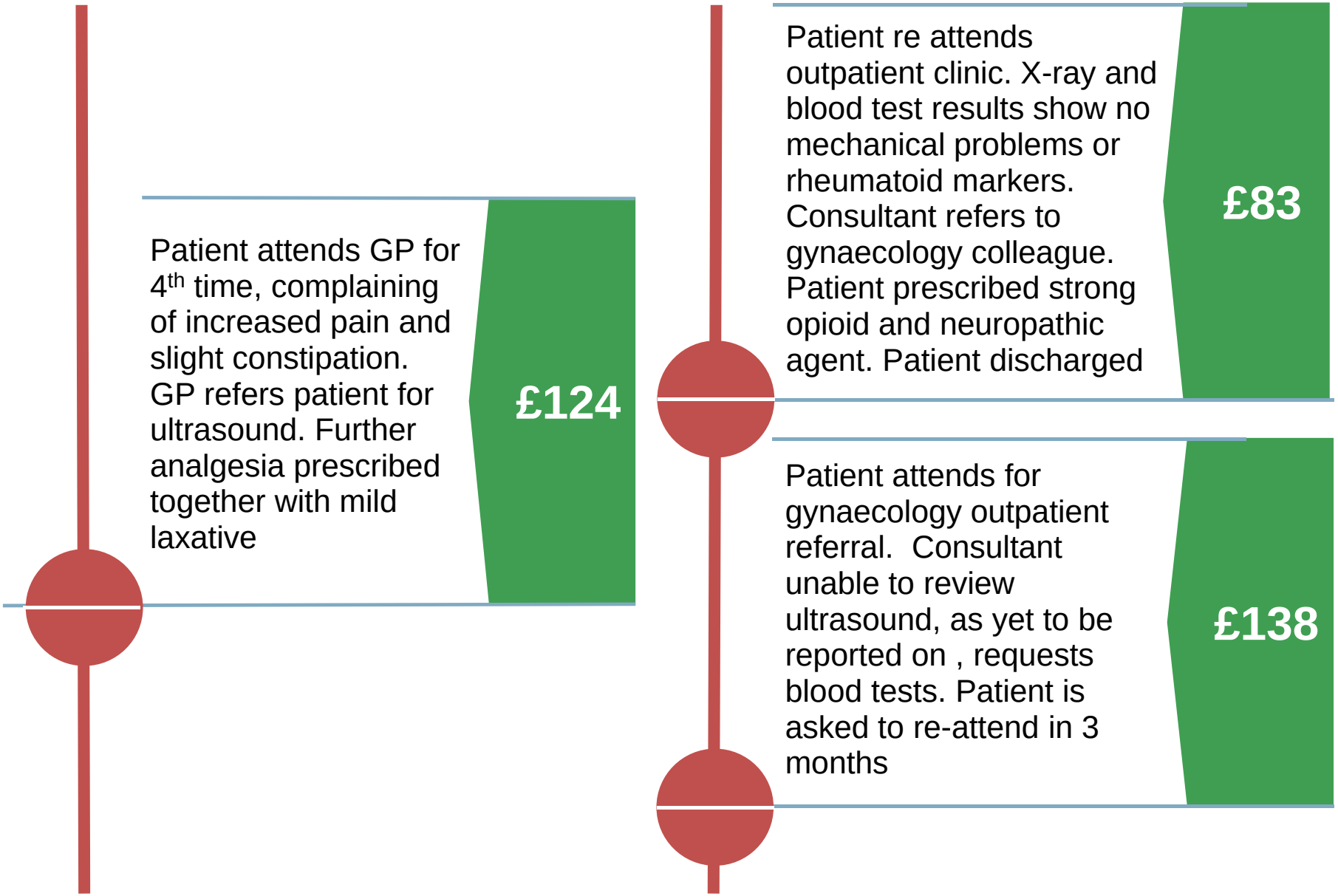
Month 4 to 7


GP prescribes weak opioid and refers patient to physiotherapy team
£55[1]
Patient requests repeat prescription twice
GP prescribes strong opioid and refers patient to orthopaedic consultant for diagnostic opinion and analgesic advice
£55[1]
Patient attends three physiotherapy sessions. Patient's condition does not improve and physiotherapist recommends patient sees GP
£321[3]

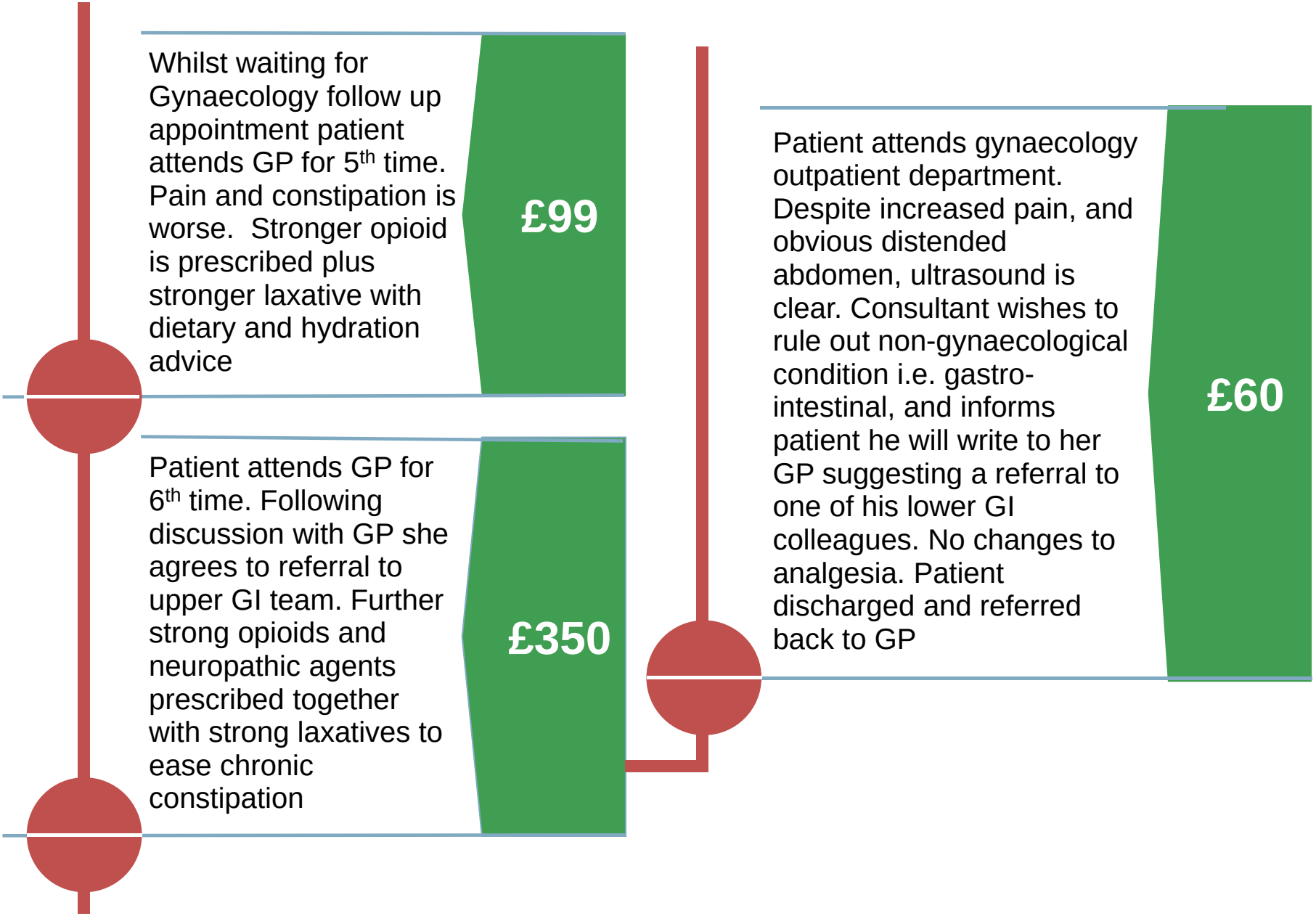
Month 7 to 8


Patient continues with strong opioids whilst waiting for OP appointment £168
Patient seen by orthopaedic consultant as outpatient. Consultant prescribes strong opioid and requests lumbar x-ray & blood tests
£137
Patient undergoes lumbar x-ray and blood tests

Month 8 to 9


Patient attends GP for 4th time, complaining of increased pain and slight constipation. GP refers patient for ultrasound. Further analgesia prescribed together with mild laxative
£124
Patient re attends outpatient clinic. X-ray and blood test results show no mechanical problems or rheumatoid markers. Consultant refers to gynaecology colleague. Patient prescribed strong opioid and neuropathic agent. Patient discharged
£83
Patient attends for gynaecology outpatient referral. Consultant unable to review ultrasound, as yet to be reported on , requests blood tests. Patient is asked to re-attend in 3 months
£138

Month 10 to 15



Month 16 to 17

Whilst waiting for upper GI appointment, patient admitted as medical emergency via local A&E department. Patient symptoms are chronic and intermittent acute pain with severe constipation. Patient admitted to medical ward for four days. Patient is found to be severely anaemic and receives a blood transfusion. Whilst an inpatient, the patient is seen by upper GI team and an urgent appointment is made for a colonoscopy. Patient discharged to care of GP awaiting appointment

£1756

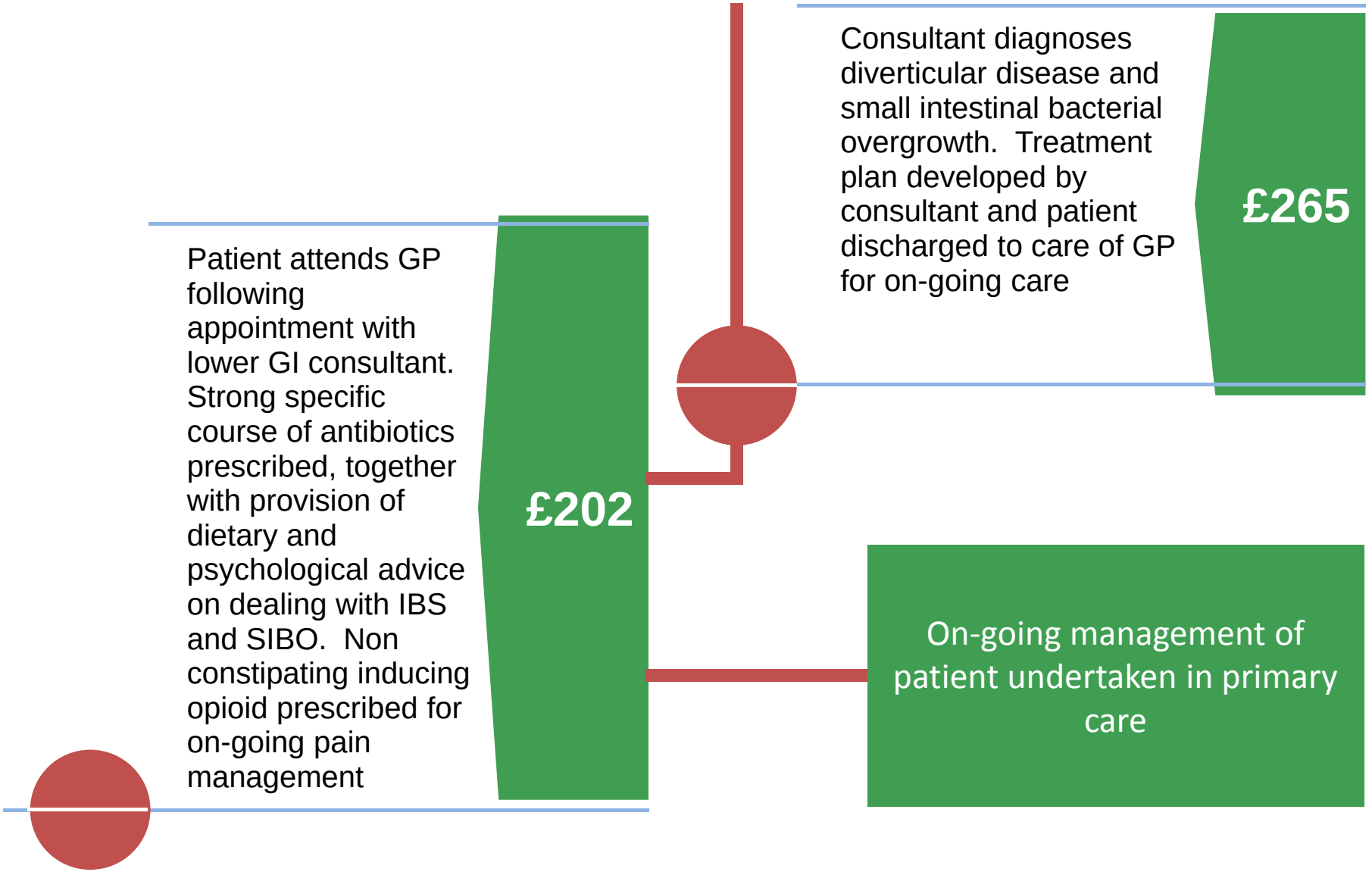
Patient's pain continues and she attends GP for 7th time. Strong opioids prescribed, together with mild laxative to prevent constipation

£203

Patient admitted as a day case and undergoes a colonoscopy. A follow up appointment is made with the consultant 2 weeks after the procedure

£563

Month 17 to 18



Rhetoric versus reality

- Overall length of patient journey 17 months
- Cost £5,081
- Avoidable steps 9
- Cost of waste in the system £3,723
- Time taken off work 42 days
- We proved that the anecdotes were in fact real!

Counting the cost of pain system impact

- The cost burden of these patients on the NHS was much larger than anticipated
- The WHO pain ladder was not consistently used, by the patients GP – none of the patients ever had a full medication review, with their medication merely being; 'topped up'
- All 6 patients had inadequate control of their pain resulting in
  - Unnecessary and avoidable visits to their GP, range 6 – 13, mean of 10
  - Multiple visits to hospital this range 4 – 11, mean of 7
  - High levels of analgesia costs, range £848 - £2364, mean of £1383
  - Avoidable steps and delays in their pathways range 5 – 9, mean of 7

Measuring the burden

- 3 of the patients had avoidable
  - Accident and emergency attendances, range 1 – 3, with a mean of 2
  - Emergency admissions, range 1 – 3, with a mean of 2
  - Invasive diagnostic tests, range 2 – 5,with a mean of 2
- Of the patient mapped a high proportion of their secondary care activity was directly related to the poor management of their pain, range 41% – 80%, with a mean of 60%
- In terms of overall costs this equated to mean of £1,935, which was more than the mean allocation per head of population to a PCT in 2012/13.
- All 6 patients took time off work due to their pain, range 11 to 127 days, with a mean of 37

Subsequent action

- The outputs of this work has now been used to raise the profile of pain with commissioners at a local level
- Work is now also underway with the BPS, RCGP, and RCoA (Faculty of pain) to raise the importance of pain at a more strategic level
- Commissioning guidance is also being developed for best practice pain management

Conclusion

- These costed patient stories clearly identified the REAL burden of uncoordinated pain management
- They highlighted not just the impact on the healthcare system and society but also the impact on patients as a person
- By adopting these and other approaches regarding the management of pain we can improve the system overall and get people back to work

Our final challenge is to get pain on the agenda of the NHS as a priority service area

Thank you

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