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Chronic Pain Health Integration Team (HIT)

Strategy Document 2024-2027

This strategy has been produced by Bristol Health Partners Chronic Pain Health Integration Team (CP HIT) and sets out the HIT focus for the next three years (2024-27) based on present needs, strengths and emerging opportunities.

Definition

We adopt the International Association for the Study of Pain (IASP) definitions of pain[1]:

i) An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage
ii) Chronic pain persists or recurs for more than three months

Context of Chronic Pain

Estimates indicate that around 1 in 3-5 (34-43%) of the adult population[2,3] are affected by Chronic Pain (CP) representing a major global burden in terms of years lived with disability and the economic impact due to health resources used and work absenteeism.[4]

Chronic pain can be due to an ongoing illness, regional diseases, chronic systemic conditions or originate from an acute injury, surgery or a medical intervention.[5] Chronic pain most commonly presents as non-specific low back pain, regional joint pain, neuropathic pain and widespread musculoskeletal pain/fibromyalgia. These conditions are the most frequent cause of disability in the UK.[3]

The World Health Organisation (WHO) International Classification of Diseases 11th revision (ICD11) [6] now recognises chronic primary pain as a disease in its own right and as secondary pain caused by an underlying condition such as osteoarthritis or endometriosis. Chronic pain has been subcategorised into chronic primary, cancer-related, neuropathic, post-surgical or post-traumatic, secondary headache or orofacial, secondary musculoskeletal, and visceral. [7]

From a public health perspective, the challenge is to prevent the development and/or progression of disabling CP.[8] Significantly, the prevalence of CP is increasing as predisposing conditions (such as obesity, diabetes mellitus and malignancy) become more common and as a consequence of the ageing population, with people living much longer, often with multiple long-term conditions including CP.[9]

National disparities

There are disproportionately higher rates of CP affecting the following people across the UK:

- **Women:** 38% compared to 30% of men[9]
- **Those living in lower socio-economic areas:** 41% in IMD1 compared to 31% in IMD5 [9]

- **Minority ethnic groups:** 44% in Black British compared to 34% in White British[2,9] *accurate estimates of prevalence in minority ethic groups in the UK are yet to be determined
- **Those aged 75 and over:** 53% compared to 29% in 35-44 year olds[2]

National impact on healthcare

GP attendances for CP equates to 4.6 million per year and approximately £584 million for prescription pain medications.[8,9] Over five and a half million people (13%) in England rely on opioid pain medications.[5] People with CP commonly experience poor response to current treatments, may be very disabled, and their care is primarily focused on self-management of persistent pain.[5]

Chronic Pain: Regional

The Burden of Chronic Pain in Bristol, North Somerset and South Gloucestershire Report (2024) produced by Bristol North Somerset and South Gloucestershire (BNSSG)[12] has captured valuable regional data about chronic pain based on the 1.1million population living within BNSSG.* It is important to note that there is no equivalent dataset for BSW ICS

BNSSG System wide dataset of patients registered with consenting BNSSG GP practices (excluding GPs= 9.5% of population) was used. For the purposes of the BNSSG report, chronic pain was defined by four prescriptions or more for pain medication in 12 months (part of the Cambridge Multimorbidity Score)[12]

Regional disparities

There are disproportionately higher rates of chronic pain affecting the following people in BNSSG*[12]

- **Women:** 63% compared to 37% of men
- **Those living in lower socio-economic areas:** Weston Super- Mare (Bournville), Worle & villages and South Bristol (Hartcliffe & Knowle West) (129 Indirectly standardised rates ISRs)[1] compared to the whole BNSSG CP population (100 ISR). People living in the Inner city & East Bristol and/or are aged 80+ years
- **Some minority ethnic groups:** Chronic Pain prevalence rate amongst the Black Caribbean group is 110 per 1,000 population compared to the overall BNSSG prevalence of 91 per 1,000 population. Those speaking Arabic or Somali as their primary language have significantly higher rates
- **Most impactful in the over 50's:** 60% aged 60 or over
- **Those with long-term health conditions:** anxiety, depression, high blood pressure and diabetes
- **Those who are homeless:** 4.1 times higher than the whole BNSSG CP population

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[1] Indirect Standardization of Rates (e.g. Mortality: SMR) - StatsDirect

** It is recognised that these data only capture those individuals registered with a consenting GP practice* ***and*** *on 4 or more pain medications for a year. This excludes people not registered and/or not prescribed or on three or less pain medications. Therefore it is not fully representative of the chronic pain population in the region.*

Chronic Pain Health Integration Team

Under the Directorship of Associate Professor Jenny Lewis, the CP HIT brings together those with chronic pain, senior clinicians, researchers and local and national health commissioners across Bristol and Bath regions. The HIT covers the BNSSG ICS (Bristol, North Somerset and South Gloucestershire Integrated Care System) and BSW ICS (Bath, Swindon and Wiltshire Integrated Care System), given the national pain services based at the Bath National Pain Centre, Royal United Hospital in Bath.

In 2023 there was a brief suspension of HIT activities due to changes in the leadership, as Dr Jenny Lewis took over from Prof Candy McCabe as the new Director. This change in leadership provided a timely opportunity to review and 'refresh' the work of the HIT and develop a new three-year strategy that builds upon the HIT's achievements to date. The team is supported by a HIT Project Manager and HIT Project Officer from the BHP core team. The new team have sought to achieve a more extensive and diverse representation from different organisations and patient partners within the region that share an interest in pain. This includes representation from new patient partners, Sirona and OneCare reflecting community, healthcare and patient voices.

People with chronic pain

We aim to seek a broader representation of experience, in particular to give a voice to representatives from groups with a higher pain prevalence (as previously described) therefore more reflective of our region's chronic pain population.

Vision

Everyone living with chronic pain in our community has access to the support they need.

Mission

To ensure that people living with chronic pain in our region will have equal access to timely treatment and support from appropriately trained health and social practitioners. Health professionals, commissioners and policy makers will be aware of and prioritise chronic pain to reduce the significant personal and societal burden on individuals living within our community.

Aim 1: Share HIT members' areas of good practice, education and research activities to influence commissioners and policy makers across community, primary and secondary care services and improve outcomes

Objectives:

1. Bring together members to share practice, knowledge and research
2. Increase the impact of our HIT by raising awareness of chronic pain and our profile
3. Use data and resources to better understand the needs of those living with chronic pain and actively influence commissioners and policy makers to improve and optimise services and healthcare

4. Address gaps in chronic pain resources for patients and clinicians regarding pharmacological and non-pharmacological treatments and service provision

Aim 2: Work collaboratively to reduce health inequalities for those who are disproportionately impacted by chronic pain within our community

Objectives:

1. Facilitate better representation of these communities to enable voices to be heard
2. Identify gaps and barriers through lived experience and relevant data including those that are not captured by current data methods and/ or not engaging with health services
3. Raise awareness amongst service providers and commissioners
4. Work collaboratively with partners and other stakeholders to identify and action ways that reduce these inequalities and improve outcomes

Aim 3: Increase community, primary and secondary care cross-organisational working across our region to facilitate pain management/education options delivered earlier in the treatment pathway that reduces pain associated long-term health impairments.

Objectives:

1. Increase networking and sharing of best practice of chronic pain healthcare professionals across organisations in health and social care
2. Develop networks to improve care across the system/patient pathway including high impact users in Emergency Departments (ED)
3. Support improvements in access to non-pharmacological options for patients earlier in the treatment pathway

How aims will be achieved

Workstreams will be developed to address the above stated aims and objectives, with key colleagues across our partners supporting the work. We will endeavour to work closely with other HITs and healthcare groups where appropriate including Bristol, Bones and Joints HIT, Drug and Alcohol HIT, Women's Health Hub, the BNSSG ICS Research Engagement Network, the Bristol Research Action Coalition for Race Equality and Bristol Women's Commission Health Task Group.

HIT membership and management

At the time of drafting this strategy, the HIT is comprised of approximately 60 members.

The Executive Committee meets quarterly.

Executive Committee:

Jenny Lewis	BHP HIT Director
Carla Southworth	BHP Senior Project Manager
Rosie McGahan	BHP Project Officer
David Wynick	Consultant in pain medicine UHBW, UoB

Jeremy Gauntlett-Gilbert	Principal Clinical Psychologist- Bath Centre for Pain Services, RUH
Lorna Harvey	MSK Clinical Lead UHBW
Owen Grant	Pain Clinical Lead UHBW
Edmund Keogh	Professor in Psychology, Deputy Director of Bath Centre for Pain Research, University of Bath
Hazel O'Dowd	Senior Psychologist, NBT
Lucy Murrell	Clinical Lead (Long Term Conditions) One Care
Debbie Campbell / Lisa Pottenger	Medicine Optimisation at BNSSG ICB
Paul Haworth	Specialist Services Manager (MSK) at Sirona
Paul Watson	Consultant in Pain Medicine, RUH Bath
Mike Smith	PPI Representative
Mieke Hart	Clinical Lead, Vita
Primrose Granville	PPI Representative

An annual work plan will describe how the objectives in the strategy will be delivered. The HIT Director and Project Manager are responsible for developing the plan for endorsement by the Executive Committee. Delivery will be co-ordinated by the HIT Director, Project Manager and Project Officer with individual tasks delegated to HIT members.

The CP HIT is committed to promoting and developing equality and diversity and will follow best practice to support inclusivity in all of its activities.

We will follow best practice guidance and use local and national education and training resources (INVOLVE, People in Health West of England, Bristol Health Partners Digital Health Training) to equip our research partners to be integral members of our research teams.

Other organisations

We continue to build links with other regional groups that are pertinent to our HIT work.

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