ARMA
Arthritis and Musculoskeletal Alliance

Support for people living with chronic pain

Roundtable report

31 October 2019

Arthritis ACTION
Backcare The Charity for Back and Neck Pain
BASRaT British Association of Sport Rehabilitators
British Chiropractic Association
BDA The Association of UK Dietitians
British Medical Acupuncture Society
British Orthopaedic Association Caring for Patients, Supporting Surgeons
British Society of Rehabilitation Medicine Promoting quality through education and standards
Chartered Society of Physiotherapy
The College of Podiatry
College of Occupational Therapists
EDS Ehlers-Danlos Support UK
The Faculty of Sport and Exercise Medicine (UK)
Fibromyalgia Action UK Fighting for Freedom from Fibromyalgia
HMSA Hypermobility Syndromes Association
iO The Institute of Osteopathy
MACP Musculoskeletal Association of Chartered Physiotherapists
NASS For everyone affected by axial spondyloarthritis
nras National Rheumatoid Arthritis Society
PRCA
PMR GCA UK
The PCR - Improving MSK Medicine & Rheumatology
The Royal College of Chiropractors
Royal College of Nursing The voice of nursing in the UK
SRUK Scleroderma & Raynaud's UK
SOMM The Society of Musculoskeletal Medicine putting theory into practice
The Society of Sports Therapists
UK Gout Society
Versus Arthritis

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ARMA is an alliance of charities, health professions and research organisations for the musculoskeletal community. Our member organisations are:

Arthritis Action
BackCare
The British Association of Sport Rehabilitators (BASRaT)
British Chiropractic Association (BCA)
British Orthopaedic Association (BOA)
British Society of Rehabilitation Medicine (BSRM)
Chartered Society of Physiotherapy (CSP)
College of Occupational Therapists (COT)
College of Podiatry
Ehlers-Danlos Support UK (EDS UK)
Faculty of Sport & Exercise Medicine (FSEM)
Fibromyalgia Action UK (FMA UK)
Hypermobility Syndromes Association (HMSA) UK
Institute of Osteopathy (iO)
Musculoskeletal Association of Chartered Physiotherapists (MACP)
Myositis UK
National Ankylosing Spondylitis Society (NASS)
National Rheumatoid Arthritis Society (NRAS)
Podiatry Rheumatic Care Association (PRCA)
Polymyalgia Rheumatica & Giant Cell Arteritis UK (PMRGCA UK)
Primary Care Rheumatology Society (PCRS)
Royal College of Chiropractors (RCC)
Royal College of Nursing (RCN) Rheumatology Forum
Scleroderma & Raynaud's UK (SRUK)
The Society of Musculoskeletal Medicine (SOMM)
The Society of Sports Therapists (SST)
UK Gout Society
Versus Arthritis

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ARMA held this roundtable because of the close association between pain and musculoskeletal conditions. We know that people living with chronic pain too often don't receive the support they need. Our aim was to bring together people working on chronic pain from a range of perspectives to discuss what might be done to improve the experience of people living with chronic pain.

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Support for people living with chronic pain

About musculoskeletal conditions

The term musculoskeletal (MSK) conditions includes a broad range of health conditions affecting the bones, joints, muscles and spine, as well as rarer autoimmune conditions such as lupus. Common symptoms include pain, stiffness and a loss of mobility and dexterity. An estimated 18.8 million people in the UK live with a musculoskeletal condition[1].

MSK conditions fall into three broad categories:

- Inflammatory conditions: rheumatoid arthritis, axial spondyloarthritis, gout, juvenile idiopathic arthritis
- Conditions of musculoskeletal pain: osteoarthritis, back pain, joint pain and complex multisystem syndromes such as fibromyalgia, Ehlers Danlos Syndrome (EDS).
- Osteoporosis and fragility fractures.

About pain

It is difficult to find agreed terminology to describe pain. Chronic pain is usually taken to mean pain that has lasted for more than three months. The new *World Health Organisation's 11th International Classification of Diseases* is the first to include chronic pain. It distinguishes chronic primary pain which represents chronic pain as a disease in itself from chronic secondary pain where the pain is a symptom of an underlying condition. Chronic secondary pain is organised into six categories, including chronic secondary musculoskeletal pain[2].

When developing their *Roadmap for Pain*[3], Versus Arthritis found that chronic pain is not a term which is well understood by people living with musculoskeletal pain. The report *Chronic Pain: this is how it feels*[4] found the professionals interviewed had different interpretations of the term including: pain that doesn't have a good reason; pain that has lasted beyond the time of expected healing; pain that people feel they can't manage or endure. Terms such as persistent or long-term pain are often used in place of chronic pain. All three were used by different participants during the roundtable.

The *NICE guideline on low back pain and sciatica*[5] moved away from a definition based on duration and considered low back pain to be a "continuum where poor outcome at any time point is more important than the duration of symptoms." For consistency we use the term chronic pain throughout this report, with the understanding that the important issue is the risk of poor outcomes rather than a specific duration.

There is a lack of reliable data on chronic pain, but in the *2017 Health Survey for England*[6], 34% of adults in England reported chronic pain. Around 10–14% of people (6 – 8 million) experience moderate to severely disabling pain[7]. Not all of this pain is musculoskeletal, but osteoarthritis and back pain are associated with over half of all chronic pain. Other categories of secondary chronic pain included in the ICD-11 include neuropathic, post-surgery and visceral. Many people living with musculoskeletal conditions also have neuropathic pain. Many people experiencing chronic pain do not have an identifiable pathology associated with their condition.

We know that chronic pain impacts on people's everyday lives. Around 25% of people with chronic pain say that it interferes with daily activities, including work, on more than 14 days in the previous three months[8].

Presentations

Personal experience of pain

The roundtable began with showing a 90 second video montage of different people with arthritis. They were asked what life with arthritis means to them. They all expressed the isolation and loneliness of arthritis; that it means not being able to work, enjoy a social life, be hugged without it being painful. The invisibility of their arthritis pain was talked about; that others can't see how they are feeling. That the pain means self-care is just plain difficult. Loud and clear was a desire to be independent and mobile and some expressed the fear they'd felt in certain situations: "I couldn't get off the bus, my pain was so bad."

Chronic pain, this is how it feels

This was a piece of qualitative research conducted in 2019[9]. Sixty-minute telephone interviews were held with 24 people who had lived with chronic musculoskeletal pain for more than three months and 20 health care professionals with responsibility for managing chronic pain.

The survey found that the management of chronic pain in the UK is deficient and inconsistent. Living with chronic pain affects all aspects of a person's life; it places a huge ‘mental burden’ on people exacerbated by a lack of clear answers about how best to manage daily life. People living with chronic pain reported high levels of dissatisfaction with current management approaches. This relates to not being taken seriously enough and long waits to get to the next “stage”. People reported delays and setbacks in gaining access to healthcare support services and treatment. Access to specialist pain services is difficult and is inconsistent across the UK.

GPs also face hurdles at almost every stage of treating and managing chronic pain due to difficulties accessing specialist services, lack of confidence in knowing the right approach and the high prevalence. “A big part of our consulting is pain, pain for all various reasons. Almost everyone that walks in has some sort of pain.” (GP, South Wales) GPs do not feel adequately supported in managing people living with chronic pain. They find it difficult to diagnose and referrals to pain clinics are not straightforward.

There was a high degree of agreement among respondents of the need for improvements:

- More joined up care for people living with chronic pain – ideally an MDT approach.
- The optimum treatment model would treat pain in the same way as other long-term conditions and work in partnership with people living with chronic pain.
- Almost all respondents felt that an annual pain review would be beneficial.
- More equitable access to specialist pain services.

Versus Arthritis Pain Research Roadmap

Versus Arthritis developed a pain research roadmap to inform their work on addressing pain. They recognised that:

- Research into the complexity of pain is underfunded.
- Public understanding and recognition of the impact of MSK pain is low.
- Current treatment options for those with chronic pain are often ineffective.

The roadmap was developed between 2016 – 2018. The aim was to identify and understand the unmet needs of people touched by chronic pain (people living with chronic pain, carers, clinicians, clinical researchers, academic researchers, funders, policy makers and other charities).

The work was guided by a group of experts that included a patient insight partner, rheumatologist, psychologist, physiotherapist, industry representative. The process identified 14 research priorities in four categories:

- Understanding complexity: Unravelling the complex and fundamental mechanisms of musculoskeletal pain.

- Stratification: Personalising musculoskeletal pain research and care.
- Management and support: Identifying models of care and support across all environments.
- Prevention: Preventing future musculoskeletal pain.

In September 2019, Versus Arthritis announced an advanced pain discovery platform in partnership with UK Research and Innovation[10]. This seeks to generate new understanding of the biology and complexity of chronic pain in humans through a pioneering combination of pain biology, artificial intelligence and machine learning.

Further insight into the complexity of pain will enable a re-appraisal of pre-clinical models and systems and the identification of new biomarkers, treatment targets and pain mechanisms. It includes an open-access online data sharing platform for the international research community.

Work is now being developed to support research to find non-medical solutions. Through the management and support theme this will look at:

- Identifying models of supported self-management.
- Developing practical support for the workplace.
- Designing new products and solutions.
- Revisiting the organisation of healthcare services.

Discussion

Biopsychosocial and biomedical approaches

A biopsychosocial approach recognises biological, psychological and social factors and their complex interactions in understanding health and illness. A biomedical approach considers only the biological mechanisms associated with ill health, whereas a biopsychosocial approach requires the healthcare professional to consider which biological, psychological and social are most important in understanding a person’s pain.

When a person first experiences pain, the underlying cause and appropriate interventions should be explored. Identifying and beginning any appropriate treatment should be prioritised ahead of referral to a pain service, although a biopsychosocial approach should be taken from the outset. People with some musculoskeletal conditions experience long delays in accurate diagnosis and therefore appropriate treatment, for example the average time to diagnosis for axial spondyloarthritis is 8.5 years.

In some people, no identifiable cause for the pain can be identified or the pain persists even after the cause has been healed or has been optimally managed. The psychological and social factors are likely to have a significantly bigger impact as pain becomes more chronic.

The best predictors of risk around pain transitioning to become chronic are psychosocial. 'Yellow flags' describe psychosocial factors for the development of disability following the onset of musculoskeletal pain. These include factors such as unhelpful beliefs about pain, emotional responses such as worry, fears, or anxiety[11]. Screening tools such as STArT Back[12] can be used to identify people at risk of developing chronic pain.

Hill 2019[13] has proposed that there are pre-injury behavioural propensities that indicate a risk that acute pain may become chronic. A cognitive behavioural model first described for CFS (chronic fatigue syndrome) has been successful in predicting the transition from acute to chronic states in a number of conditions and could be applied to long term pain.

Biopsychosocial approaches to pain

The experience of pain is individual and personal. We know that there is little correlation between structural damage in the body and the experience of chronic pain. What is important is the recognition of the individual experience of pain and the impact on a person's life, which cannot be predicted from biological markers of disease alone. Once the pain becomes chronic a purely biomedical focus is inadequate and maintaining this narrow focus can become part of the problem. However, framing pain in a biopsychosocial framework is complex and difficult for people living with chronic pain to understand. One of the nurses interviewed for the chronic pain survey spoke of the *"fine line to walk between sounding like you believe the patient, which we do, but when we talk about psychological work, many of them hear 'you are mad and we don't believe you'".* Not being believed was a common factor in the dissatisfaction of survey participants. It is vital that considering psychological factors does not make people feel they are not believed.

There are a number of factors which encourage persisting with a narrow biomedical model. Within the NHS it is reinforced by the way activity is divided up according to which specialty you see, rather than the issue you face. The fact that the pathways inevitably start in health services suggests that the end point will be found within a biomedical framework.

Public expectations also serve to reinforce the medical model. Health beliefs are a fundamental driver of behaviour. For example, the public understanding of MSK pain is that it is always an indicator of damage and that movement should be avoided in case of causing further damage. This can lead to a general perception that engaging in physical activity indicates that a person is not in pain, which impacts particularly on people in receipt of disability benefits. A survey in 2018 found that 47% of respondents were fearful of losing benefits if they are seen to be more active[14]. Employers require reassurance from a medical professional before agreeing a return to work for a person living with chronic pain. These factors all tend to maintain a purely a biomedical understanding of pain.

A biopsychosocial approach indicates that it is important to think of chronic pain in the same way as other long-term conditions. This shifts the focus to what's important to the individual living with chronic pain, and how can we reduce the distress it causes and the impact on their quality of life, rather than a focus on the cause of the pain. This support needs to address what it is that matters to the individual and everyone's needs and priorities will be different.

Both people living with chronic pain and healthcare professionals need to accept that pain related disability is complex but not an inevitable consequence of living with chronic pain. The focus of professional support should be on reducing the impact of the pain and any related disability.

Shifting the focus of chronic pain management towards a biopsychosocial model requires:

- Community place-based approaches to pain.
- Social prescribing.
- Education and training.
- Public messaging.

None of these are currently happening at scale; all are needed to shift the paradigm.

The role of community and primary care

Primary care is usually the first entry point for people seeking help with pain. People often come to their GP with an expectation of referral to a specialist to find a solution to their pain. However, we need to move away from the idea of this process as a linear pathway, with people progressing along steps. Many respondents to the chronic pain survey spoke of delays in getting to "the next step". Instead we need to ensure that the person sees the correct professional - the person who is appropriate to meeting their specific needs - first time.

As the survey outlined above shows, GPs do not feel confident or supported managing chronic pain. With average appointment times now under 10 minutes, engaging people in a biopsychosocial approach is challenging and we know that not feeling rushed is important to people living with chronic pain. We need a broader understanding of general practice; increasingly people have first contact access to a range of different practitioners, e.g. AHPs, nurses, pharmacists, First Contact MSK Practitioners who often have longer appointment times.

There is also a need to develop community services so that chronic pain can be managed in the community as much as possible. This helps to de-medicalise as well as to offer personalised support at the scale required.

People living with chronic pain access lots of different parts of the NHS, so aren't served well by a system of siloed specialities. Currently different parts of the system don't truly work together. Primary Care Networks moving towards a networked system, rather than a pathway with lots of gateways, could help move

Case study

Liverpool: Community-based specialist MDT for chronic pain

Liverpool CCG identified chronic pain as an area for transformation based on insights from RightCare data, namely spend on admissions for pain, bed days for musculoskeletal pain and frequency of pain management injections were all higher than similar CCGs. Prescribing costs for pain accounted for 8% of the CCG's total prescribing budget; in excess of 933,000 items issued at a cost of £6.4million.

There were no community NHS pain services in Liverpool. People were treated either within primary care by their GP or through specialist secondary care services with significant waiting times.

A chronic pain multi-disciplinary team was established across secondary and primary care to review new and current referrals into specialist pain services and assess their need for specialist care. Community-based support can be offered as an alternative to consultant-led face-to-face appointments.

The MDT includes:

- consultant pain specialist
- GP with special interest
- pain psychologist
- pain physiotherapist
- pharmacist with special interest

Where appropriate, people are invited to attend a community MDT appointment with the required clinicians from the MDT group. Clinics were held at a local health centre with appointments of 45mins to 1 hour where people would see two or more clinicians from the MDT (dependent on their needs). The MDT also delivered a chronic pain education session to GPs within one of the neighbourhoods.

People living with pain vary in complexity, therefore the stratification approach required flexibility in the pain management approaches offered. In order to fully assess the person, a full notes summary for the GP record is required as well as any information on previous attendance at pain services. It was important to establish the MDT as a face to face model to build trust and relationships across the difference services and disciplines. In future, an MDT triage could be held virtually to review referrals which would reduce resources and time.

away from the stepped pathway approach. A networked approach requires a move from working in silos to supporting each other, understanding that we can all learn from each other and from sharing collective resources. The current system and commissioning create barriers to this.

These issues are not unique to chronic pain. The whole NHS is moving in a similar direction towards delivering integrated, personalised care closer to the person. This presents opportunities for learning and for engaging in change which is already underway to ensure that chronic pain is included.

Supported self-management and peer support

There is growing evidence that meeting others in the same position for peer support is really important and beneficial for people living with chronic pain. The evidence for self-management isn't strong, but there is evidence that it works as part of an overall management strategy. Pain management programmes are designed to equip people to self-manage. Self-management needs to be supported to be effective and some people will need a lot of support.

The NICE guideline on low back pain and sciatica states:

"The Guideline Development Group therefore agreed that although there was no conclusive evidence in favour of self-management provided in isolation of other management strategies, it was still important to provide advice to people about their condition and encourage them to continue with normal activities. The GDG therefore felt that a good practice statement to support self-management was justified. The GDG intended self-management to apply as a principal alongside all treatment for people with low back pain and sciatica as part of routine practice. If we want to deliver value-based healthcare, then promoting people looking after themselves had a key role to play. However, people need support to be able to manage their own pain and to be able to take responsibility. Sometimes they need a lot of support."

One practical attempt to do this was the Health Foundations Co-Creating Health Project.

Case Study

Co-creating Health: an approach to implementing self-management

The Health Foundation's Co-creating Health programme 2007 – 2012[15] involved the piloting of an approach to implementing self-management support that comprised:

- self-management training for people with long-term conditions
- training in self-management support skills for clinicians
- a service improvement programme to put systems and processes in place to support patients and clinicians in their self-management activities.

The first phase involved eight sites working in pairs on long-term conditions: chronic obstructive pulmonary disease, Type 2 diabetes, depression and musculoskeletal pain. In the second phase, seven of the sites went on to work on achieving local sustainability of the Co-creating Health approach to implementing self-management support and secure its spread within the original long-term condition and to a wider population within the local health economy.

Two of the sites worked on people living with pain. The benefits identified in these two sites included:

- Surveys and case-note sampling showed clearly that a culture shift had started to take place after seven clinical teams took part. The use of agenda-setting, goal-setting and follow-up was becoming the norm for clinical consultations in every team involved.
- Consistent use of agenda setting with individuals before clinic consultations led to increased confidence to discuss issues important to them.
- People's confidence to manage their condition improved, leading to less use of medication and fewer encounters with health professionals.
- A large number of individuals successfully achieved personal goals such as losing weight, giving up smoking, becoming more active, and developing their own support networks.

Lessons from Co-creating Health phase 2[16] from the perspective of a new health economy looking to adopt the Co-creating Health approach to self-management and suggest that there are three key messages to share:

- Embrace Co-creating Health as a 'whole system' change
- Take a strategic approach to implementation
- Adopt a targeted but flexible approach to delivery

Social prescribing could be extremely beneficial, provided link workers are equipped to provide enabling support and have access to suitable local services which can support self-management. This is not helped by a culture dominated by a medical model which creates fear of including people living with chronic pain in mainstream services. This is particularly the case for providers of physical activity, such as leisure centres. All the stakeholders in the system need some input to overcome these.

Funding

The current system is already spending a lot on people living with chronic pain but not in a joined-up way that would make most efficient use of the resource. A strategic approach is needed to ensure that money is redirected to the community and self-management support we know works, as well as to public health. A population approach enables shifting money around the system to ensure we have the right balance of services from peer support to specialist interventions. These services need to be co-ordinated so that people can easily access the management that is right for them. Commissioning still tends to follow traditional patterns and it as suggested at the roundtable that this is a significant barrier to establishing the whole system changes required to effectively support people with chronic pain.

Solutions

Solutions were felt to be needed in three areas:

- De-medicalising chronic pain
- Population health approaches
- Change of language and narrative

Discussion at the roundtable focused on the first of these which was felt to be the most complex as it requires a 'paradigm shift'. Health care professionals are trained in a biomedical approach are not familiar with concepts such as living well with, rather than fixing, chronic pain.

Many things draw healthcare professionals back to the biomedical. Red flags remain important and can't be ignored, so healthcare professionals cannot ignore the biomedical. People living with chronic pain often focus on biomedical concerns and healthcare professionals need to know how to ensure that discussion includes the full breadth of the biopsychosocial.

Education

Understanding pain should be included at undergraduate level for doctors, nurses, allied health professionals and in GP registrar training. This needs to include an understanding of the impact of chronic pain on a person's life and how to support someone to self-manage. To do this, healthcare professionals need the skills and confidence to have the necessary, sometimes difficult, conversations about chronic pain.

Training doesn't work without reinforcement. The type of reinforcement used to change antibiotic prescribing behaviour is a good example. Involving behaviour change experts will be helpful in this.

Providing options

A biopsychosocial approach requires the availability of a range of services. People living with chronic pain, and often healthcare professionals, don't always know what options are available. In most areas, biopsychosocial community services are unavailable or underdeveloped. Addressing this is vital, as is ensuring that first contact healthcare professionals know what is available and how to refer.

It needs to be made just as easy to social prescribe as to prescribe medication, which will require availability of a range of peer support, self-management support and community facilities with capacity and confidence to support people living with chronic pain.

There also needs to be a lot more focus on 'physical literacy' for adults as people living with chronic pain often don't have the confidence and motivation to be more active. Involving professionals with expertise in physical activity such as physiotherapists, sports therapists, sports rehabilitators can be helpful.

Team working

More needs to be done to embed the benefits of a multi-disciplinary biopsychosocial approach to managing chronic pain in community and primary care settings. Moving the support out of hospital and into the community but still working in the same way will not deliver the change that is needed. Services and professionals need to knit together so that they work as one team no matter where they are located.

Healthcare professionals need to co-ordinate with each other, rather than expecting the person to navigate the system. Teams need the support of colleagues when dealing with difficult problems or complex cases. They need neighbourhoods of clinicians, tech-enabled: a pain MDT without walls.

This is not just about tech, but also about building relationships that support team working, for instance, GPs need to know specialists by name so they can

Case Study

Project ECHO: use of videoconferencing to provide a learning community for primary healthcare professionals

The Extension for Community Healthcare Outcomes Project (Project ECHO) is an innovative telemedicine-based mentoring strategy that seeks to help primary healthcare professionals in remote rural communities to manage people living with chronic, complex, and common conditions. The first ECHO project in Canada was funded by the Ontario Ministry of Health and Long-Term Care in response to the need for more and better chronic pain management[17].

The project uses videoconferencing to connect an interdisciplinary team of experts with a group of primary healthcare professionals. The programme delivers weekly sessions lasting 90 minutes. Each session includes a 20-minute lecture presented by one of the experts, followed by presentation of one of more anonymised cases by the HCPs. After presenting the case there is a round of questions, followed by a round of suggestions from the HCPs. Finally, the expert team will make their recommendations.

There are 21 presentations which are delivered on a cycle. Healthcare professionals can join at any point in the cycle and attend as many sessions as they choose; average participation is 15 sessions. Through the ECHO Model, community providers and specialists learn from each other, acquire knowledge, skills, increase competency and build a strong community of practice.

Evaluation of the project[18] shows that participation in ECHO was associated with significant improvement in self-efficacy and knowledge about chronic pain for all participants, but it was more pronounced in participants who can prescribe opioids than allied professionals who do not prescribe medications. Participants who present cases during ECHO sessions are more satisfied with ECHO than those who only attend and do not present cases.

have a conversation. It should be easy for people living with chronic pain to access services and professionals with the right level of expertise to ensure that their condition is neither under- nor over- managed.

Language

The language we use is important as it frames how both the healthcare professional and the person consulting them perceive the issue. We have used the term “person living with chronic pain” rather than “patient” as this better expresses the situation and the relationship we are discussing. The term patient tends to medicalise the conversation and suggests that the person with pain is in a passive role, dependent on the expertise of the professional. There is a need to focus on living well with chronic pain, rather than fixing or curing it, on managing chronic pain rather than seeking a solution.

Safe prescribing

Raising awareness of the risks of drug treatment of chronic pain is important. There has been a lot of focus recently on dependence forming prescription medication, including opioids. This includes the recent PHE report[19]; the review currently being carried out by the MHRA[20]; a national overprescribing review by NHSE/I reporting to the Health Secretary. Reviews of NICE guidance on opioids have raised similar issues to this discussion, for example, skilling health care professionals to have the difficult conversations about medication withdrawal.

For people living with chronic pain to be able to make a choice about non-medical approaches, they need to be aware of the alternatives. It is important, therefore, to ensure that alternatives are available before professionals start talking to people living with chronic pain about their use of strong medication. NHSE/I are investing in skills in shared decision making, which could support the conversations, but without a range of support options, decisions are restricted. People living with chronic pain need support, and some will need a lot of support, not all of it from the public sector. The third sector provides a lot that can help and needs to be effectively integrated into the system, part of the network, if people living with chronic pain are to get the best outcome.

Issues of inequality are important: both chronic pain and high levels of opioid prescription are more prevalent in deprived areas[21]. The opportunity provided by the concerns about opioids might help drive a more strategic approach to addressing some of the underlying equality issues.

Recommendations

Local health economies

- Changing commissioning, taking a strategic population health approach to ensure money is focused on the right things.

- Developing community, place based, networked, biopsychosocial approaches to pain - a pain MDT without walls.

- Social prescribing to provide support for self-management and peer support at scale.

- A local group with representation similar to that at the round table to drive change in each area.

- There are opportunities presented by the current direction in the NHS, such as the way commissioning is changing through Integrated Care Systems and Primary Care Networks. People working in or advocating for pain services locally should engage with this work.

National bodies

- HCP education to include understanding and management of pain.

- Education and reinforcement messages to emphasise the biopsychosocial approach.

- Public education – including employers and public attitudes.

Attendees

Laura Alexander, Versus Arthritis
Nuzhat Ali, Public Health England
Fizz Annand, Public Health England
Sue Brown, ARMA
Karin Cannons, RCN Pain forum
Jonathon Canty, Versus Arthritis
Nav Chana, National Association of Primary Care
Alf Collins, NHS England/Improvement
Diarmuid Denneny, Chartered Society of Physiotherapy
Patrick Hill, British Psychological Society
John Hughes, Faculty of Pain Medicine
Ursula James, NHS England/Improvement
Martin Johnson, Royal College of GPs
Jenny Nicholas, British Pain Society
John Scott, Health Foundation
Asim Suleman, GwPSI Pain Management
David Vaux, Arthritis Action
Amanda Wooley, NHS England/Improvement

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Arthritis and Musculoskeletal Alliance

Tel: +44 (0) 203 856 1978
projects@arma.uk.net
www.arma.uk.net
@WeAreArma

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