NHS England

The NHS Prevention agenda:

Can we ‘prevent’ pain persisting?

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National Clinical Director for Prescribing, NHSE

Statement of interest

- As National Clinical Director for Prescribing for NHS England I have had responsibility for addressing overprescribing nationally through implementing the recommendations from the National Overprescribing Review
- As a clinical academic, the University of Nottingham receives non-commercial research grants focused mainly on improving prescribing and patient safety
- I have no other interests to disclose

Plan for the presentation

- The NHS Prevention agenda
- GIRFT Chronic Pain Workstream
- Can we prevent pain persisting?
  - Primary prevention
  - Identifying early people at increased risk of developing chronic pain
  - Early intervention for people with chronic pain
  - Later intervention for people with chronic pain
- What works?

Acknowledgements

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- Graham Syers
- Chloe Stewart
- Matt Fagg
- Brad Kay

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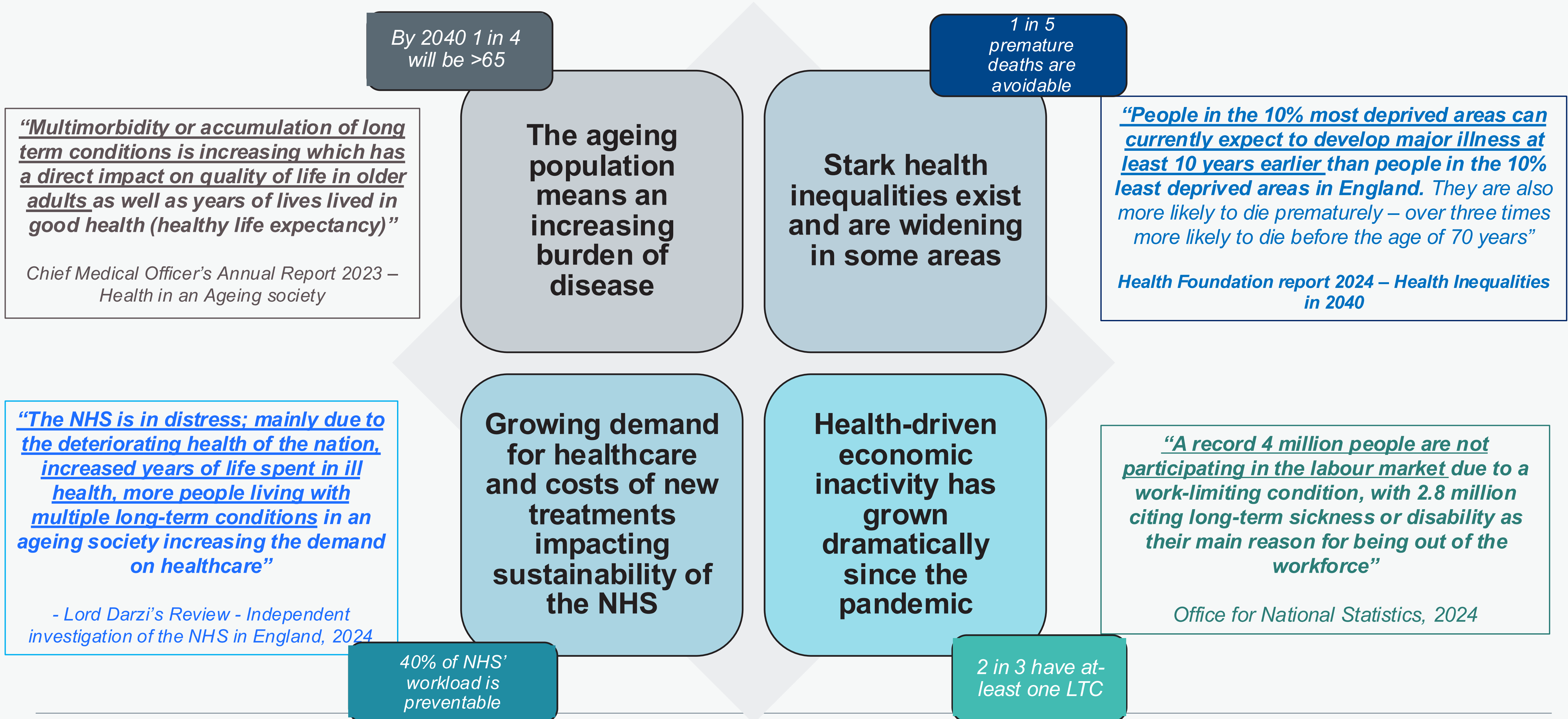
The NHS Prevention agenda:

Improving prevention and long-term conditions management

Slides from Matt Fagg, Director Prevention and Long-term conditions

Context: Four major public health challenges



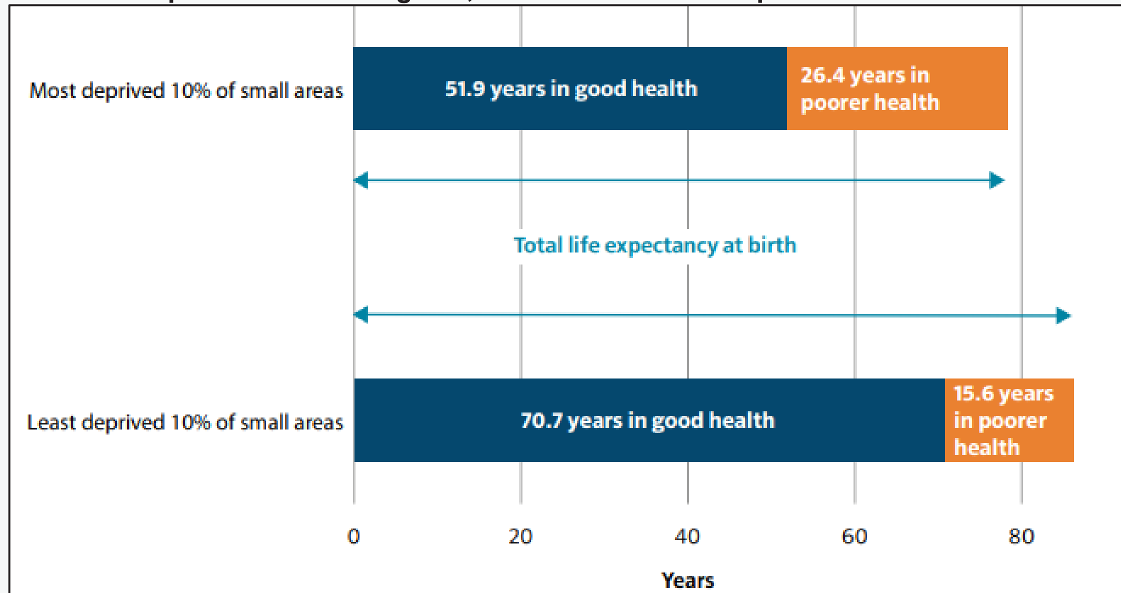
Wide health inequalities will persist unless targeted action is taken

Mortality: A **~10-year gap in life expectancy** between the most and least deprived groups, driven largely through premature mortality

Morbidity: A **~20-year gap in healthy life expectancy** which means deprived populations will develop disease and then multiple long term conditions earlier. 10% of people in the most deprived areas have major illness in their 40s, rising to 38% in their 60s.

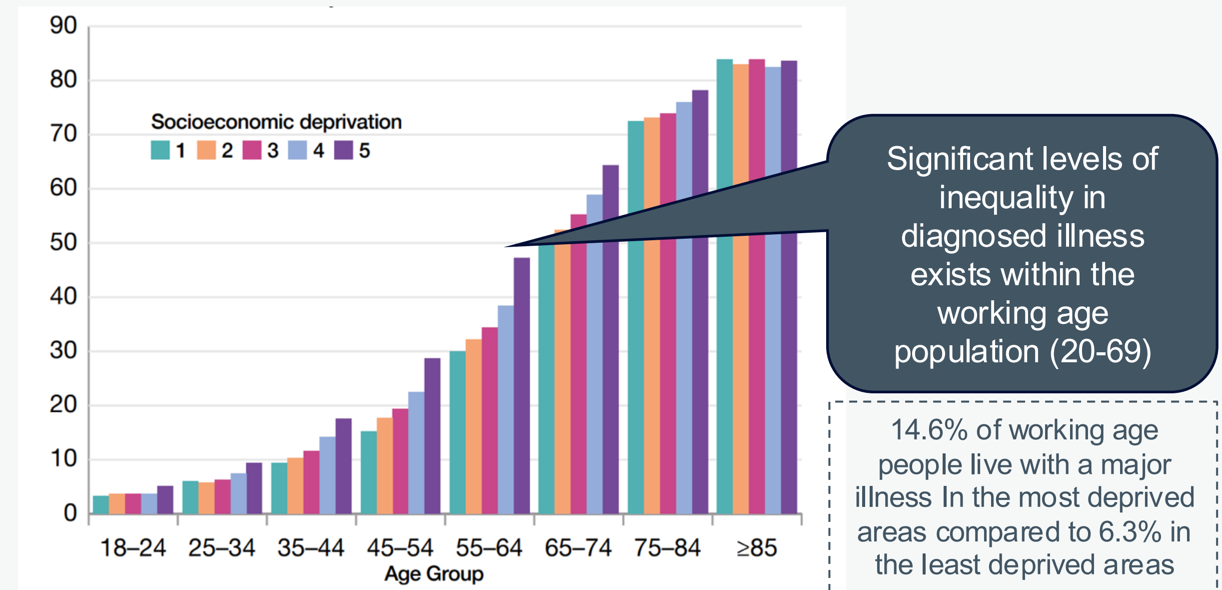
Current inequalities are **projected to persist** (Health Foundation, 2023), and the past three years have seen inequalities in CVD mortality increase.

Inequality in life expectancy and healthy life expectancy at birth for females in the most and least deprived areas in England, 2018 to 2020. CMO Report 2023



Source: Chief Medical Officer's Annual Report 2023: Health in an Ageing Society
Data: Office for National Statistics (ONS), Health state life expectancies by national deprivation deciles, England: 2018 to 2026

Prevalence of 2+ LTCs (Multi-morbidity) by age and deprivation In England



Source: Cassell A and others (2018). The epidemiology of multimorbidity in primary care: a retrospective cohort study. British Journal of Gen Pr
Image from: Chief Medical Officer's Annual Report 2020, Health trends and variation in England

NHS 10 Year Health Plan for England

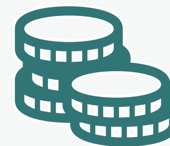
10YP Commitments - From sickness to prevention

We will reach patients earlier, to catch illness before it spreads and prevent it in the first place, by making the healthy choice the easy choice:

By banning energy drinks for under 16s and increasing access to nutritious foods.

Introducing new screening programmes, including home kits to test for cervical cancer.

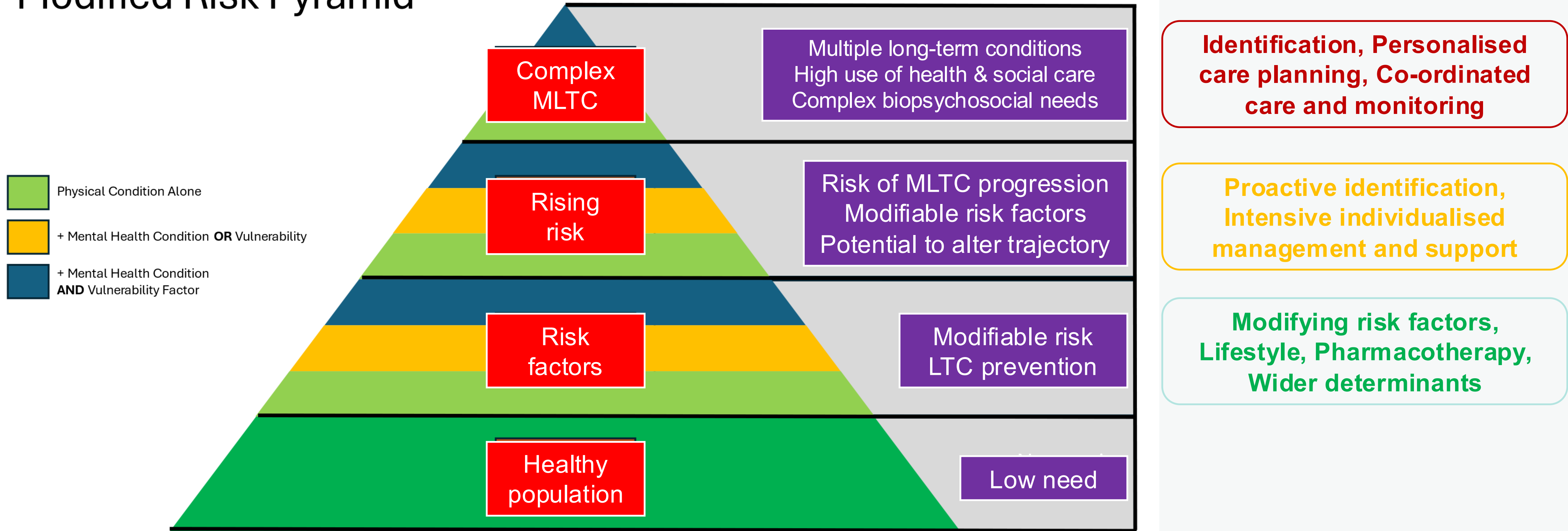
Opening up access to new weight loss services and treatments to tackle obesity.



With more financial support for those on low incomes to help give kids the healthiest start in life

Multi-Morbidity and Neighbourhood Health

Population groups to target



Identification, Personalised care planning, Co-ordinated care and monitoring

Proactive identification, Intensive individualised management and support

Modifying risk factors, Lifestyle, Pharmacotherapy, Wider determinants

The Neighbourhood health model is intended to use population health management, to stratify the population according to the risk and offer better coordination of the care of people with long-term conditions with better analytics to support the delivery of the ambition

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GIRFT Chronic Pain Workstream

Slides from the GIRFT team

NHS IMPACT
Improving Patient Care Together

Introduction

- GIRFT is working in collaboration with the Faculty of Pain Medicine and the British Pain Society to help address challenges in service delivery for pain management.
- The clinical leadership team for this workstream will undertake system level peer reviews on the provision and delivery of pain management services for chronic pain across the community, primary, secondary, and tertiary care services, and across the whole life course.
- The aim is to identify variation and challenges across the whole pathway and develop a structured model to ensure patients receive personalised, holistic and evidence-based care at each stage, with seamless transitions between services – in turn, improving the patient experience

"This GIRFT programme is an exciting and long-awaited opportunity for the field of chronic pain management, and I am delighted and privileged to lead it. I know that there is much excellent work and innovation occurring in all parts of the system and we will be looking to shine a light on best practice, while identifying ways to share this equitably around the country. Importantly, this work will link closely to other relevant GIRFT workstreams and key stakeholders. Through liaison with multidisciplinary health and social teams, third sector organisations and patients, we will provide recommendations for improvement which are both fit for the future NHS and benefit the large number of people of all ages experiencing chronic pain."

Professor Tim Briggs, GIRFT Chair and NHS England National Director for Clinical Improvement and Elective Recovery

The team

Clinical Lead – Dr Helen Makins

Helen is a consultant pain medicine anaesthetist, working clinically with both adults and children in Gloucestershire, and has worked extensively on projects for people with pain, from community-based social prescribing projects for children to holistic clinical pathways and evidence-based criteria for pain interventions. She is also a board member of the Faculty of Pain Medicine.

Clinical Advisor – Dr Graham Syers

Graham is a GP partner at Alnwick Medical Group in Northumberland, and a clinical lead with the North-East and North Cumbria (NENC) ICB, where he chairs the Northumberland System Transformation Board and is vice chair of Northumberland Health and Wellbeing Board

Clinical Advisor (CYP) – Dr Jacqui Clinch

Jacqui is a consultant in paediatric and adolescent rheumatology and rare bone disease at the Bristol Royal Hospital for Children, and medical lead of the Bath National Pain Service for children and young people

New GIRFT workstream for chronic pain

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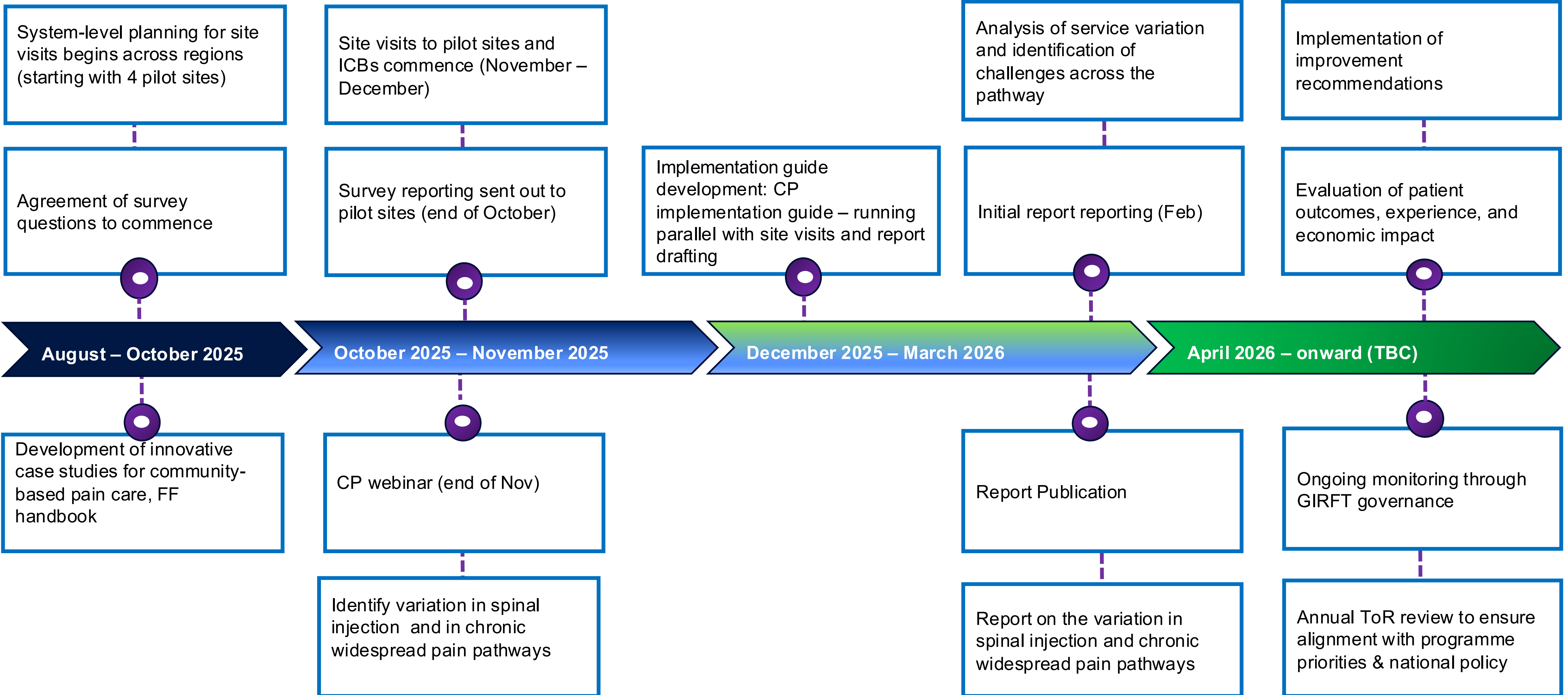
Clinical advisor: Dr Graham Syers

Clinical lead: Dr Helen Makins

Clinical advisor (CYP): Dr Jacqui Clinch

Chronic Pain Timeline



Primary prevention

- Promote all the things that are recognised to increase healthy lifespan:
  - Diet, including preventing obesity and the MSK problems associated with this
  - Regular physical activity
  - Not smoking
  - Limit alcohol use and other unhealthy habits
  - Sufficient good-quality sleep
  - Chronic stress prevention/management
  - Strong social connections
- Promote strategies aimed at reducing likelihood of emotional trauma, particularly in childhood
- Prevention of accidents at work, promote good posture and promote healthy work-life balance

Can we prevent pain persisting?

Secondary prevention: optimal management of acute pain

- Adequate use of analgesics for acute pain may reduce risk of chronic pain, particularly post-operatively
- Within limits, mobilise early
- Consider physio to help with rehabilitation
- Manage stress around the pain (negative thoughts, upset feelings, unhelpful behaviours)

Secondary prevention: early identification and management

- Early identification of people where acute pain may be more likely to persist:
  - When distress is a key part of the presentation
  - Co-existing mental health problems
- Early identification of chronic pain, particularly chronic primary pain
- Avoiding unnecessary investigations, referrals and medication
- Avoiding distressing language, e.g. ‘bone on bone’
- Early biopsychosocial interventions

Early intervention for people with chronic pain

- Let the person tell their story
- Validate the person’s experiences
- Recognise links with trauma
- Identify triggers
- Provide lay explanations of links between pain perception and mood/emotion
- Aim to reduce secondary effects of pain, e.g. fear/avoidance behaviours
- Offer biopsychosocial interventions

Later intervention for people with chronic pain

- More challenging because pain experience and unhelpful beliefs around pain are likely to have become entrenched, and the person is likely to be taking a range of medicines that may be doing more harm than good
- Similar approach to people with shorter duration of chronic pain, but likely to require more intense (and specialist) input

What works? NICE guidance for chronic primary pain

Exercise programmes and physical activity

1.2.1

Offer a supervised group exercise programme to people aged 16 years and over to manage chronic primary pain. Take people's specific needs, preferences and abilities into account.

1.2.2

Encourage people with chronic primary pain to remain physically active for longer-term general health benefits (also see NICE guidelines on physical activity and behaviour change: individual approaches).

Psychological therapy for chronic primary pain

1.2.3

Consider acceptance and commitment therapy (ACT) or cognitive behavioural therapy (CBT) for pain for people aged 16 years and over with chronic primary pain, delivered by healthcare professionals with appropriate training.

Cognitive–behavioural group treatment

Specialised Treatment for Severe Bodily Distress Syndromes, STreSS trial

- Danish study
- Population aged 20-45 with a wide range of functional somatic disorders
- Participants receiving STreSS had a greater improvement in 36-itemShort Form Health Survey (physical functioning, bodily pain and vitality) and on most secondary outcomes.

e	Letter with management recommendations for functional somatic symptoms sent to primary care physician
f	Treatment manual, including schedule, symptom diary, educational material, worksheets and homework assignment for the nine treatment modules. Patients were handed relevant chapters at the beginning of each module. Non-attending patients received the chapters by post
g	Consultancy service by telephone for primary care physicians and specialists
h	Nine treatment modules, 3.5 h each, based on a cognitive–behavioural approach, delivered in groups of 9 patients by two psychiatrists, at weeks 1, 2, 3, 4, 6, 8, 10, 12 and 16 (see Appendix). Each patient was allowed to receive two supplemental individual consultations in case of new important physical symptoms or major psychiatric problems. Psychiatrists had at least 2 years of training in cognitive–behavioural treatment, experience with group treatment, and expertise in the field of functional somatic symptoms
i	Close cooperation with social authorities or the patient's employer, when needed

The British Journal of Psychiatry (2012) 200,499–507.doi:10.1192/bjp.bp.111.098681

Pain Reprocessing Therapy: RCT in low back pain

INTERVENTIONS Participants randomized to PRT participated in 1 telehealth session with a physician and 8 psychological treatment sessions over 4 weeks. Treatment aimed to help patients reconceptualize their pain as due to nondangerous brain activity rather than peripheral tissue injury, using a combination of cognitive, somatic, and exposure-based techniques. Participants randomized to placebo received an open-label subcutaneous saline injection in the back; participants randomized to usual care continued their routine, ongoing care.

- 151 participants: 50 intervention (PRT), 51 placebo, 50 usual care.
- **66% of intervention patients were pain-free or nearly pain-free post-treatment** vs 20% randomised to placebo and 10% randomised to usual care
- Treatment effects maintained at one year
- Longitudinal fMRI showed improvements with PRT

JAMA Psychiatry. 2022;79(1):13-23. doi:10.1001/jamapsychiatry.2021.2669

- The NHS Prevention agenda has potential to help with pain prevention and also with preventing pain from persisting
- The GIRFT Chronic Pain Workstream has potential to ensure that all parts of the country have access to pain services that provide personalised, holistic and evidence-based care at each stage, with seamless transitions between services
- Identifying and intervening early for people with (or at increased risk of developing) chronic pain is likely to be an effective strategy for preventing pain persisting
- Even for people with established chronic pain biopsychosocial interventions can be effective
- Growing, strong, evidence for interventions including CBT and application of Pain Reprocessing Therapy
- So, we can prevent pain persisting!

Resources

- Materials from the 2020 global year for the prevention of pain: https://www.iasp-pain.org/advocacy/global-year/prevention-of-pain/
- Materials from the European Pain Federation on preventive healthcare for chronic pain: https://europeanpainfederation.eu/sip/preventive-healthcare-for-chronic-pain/
- Flippin Pain: Flippin' Pain | The Science of Pain, Explained
- Curable: Curable: A Different Approach to Chronic Pain
- Pain Reprocessing Therapy: https://www.painreprocessingtherapy.com/
- The Way Out: A revolutionary, scientifically proven approach to healing chronic pain: Alan Gordon (available from multiple book sellers)

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