THE
NORTHUMBRIA WAY

NHS England BestMSKHealth Collaborative
Shifting the Narrative

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ONE NIGHT
TRADE MARK
COUGH SYRUP
EACH OUNCE CONTAINS
ALCOHOL, (less than 1%) .... 4¼m.
CANNABIS INDICA, F.E., ... 4½m.
CHLOROFORM, ... 2⅘m.
MORPHIA, SULPH, ... ⅛gr.
SKILLFULLY COMBINED WITH A NUMBER OF OTHER INGREDIENTS

Northumbria Healthcare
NHS Foundation Trust

Advanced MSK Practitioner
Non Medical Prescriber

North East and
North Cumbria

MSK CHAMPION
VERSUS
ARTHRITIS

BestMSK Health Collaborative

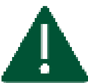
The aim of the BestMSK Health Collaborative is to recover and rebuild high quality high value personalised MSK provision, integrated across primary, community and secondary care and with mental health, social services and the third sector organisations.

This is in order to optimise delivery of evidence informed best practice guidance and pathways for prevalent MSK conditions (Osteoarthritis, back pain and fibromyalgia), core rheumatology conditions (inflammatory arthritis, autoimmune connective tissue disease and vasculitis) and fragility fractures (hip and vertebral fractures linked with fracture liaison services), driven by metrics of population health, quality and value.

Delivering whole pathway transformation

Through	Expanding capacity, prioritising diagnosis and treatment, transforming provision of elective care and better information and support to patients				To achieve
Partnership working across systems (National, region, ICS, Place) • **Co-production** • **Integration** • **Collaboration**	**Setting**	Primary/ community care *Pre-hospital*	Secondary /tertiary care *Hospital*	Primary /community care *Post Hospital*	30% more elective activity by 24/25 than pre pandemic Improved performance against all Cancer standards - by March 24 75% patients referred urgently by GP have diagnosis or Cancer rules out within 28 days Integrate 26000 additional primary care roles e.g. First Contact Practitioners, health coached and social prescribers - funded by Additional Roles Reimbursement Scheme (ARRS) by end 22/23 Prioritise and significantly reduce community service waits 95% patients needing diagnostic tests receive it within 6/52 by March 2025 Maintain eliminated 104 weeks waits from July 2022 Reduce 78 week then 52 week waits from 1st July 22 with 52 week waits eliminated by 2025 Reduce outpatient follow-ups by 25% relative to 19/20 activity by Mar 23
	Speciality				
	Orthopaedics Spinal services Rheumatology Falls, fragility fractures and osteoporosis (FFFO) Children and young people (CYP)	*Triage / referral optimisation / specialist advice* *(Emergency, urgent and high volume conditions)* *Diagnostics (Community Diagnostic Centres and MSK ambitions in Richards Report)* *Rehabilitation* *Supported self-management*	*Urgent emergency and high-volume low complexity work* *Supporting those waiting* *Diagnostics* *Personalised follow up care / Patient Initiated Follow up (PIFU)*	*Post procedural rehabilitation* *Support self-management*	
	Priority	Emergency, Urgent, High volume, Long term conditions			

Driving quality improvement through elective recovery



Core recommendations

Recommendation #1
System leaders, through agreed governance models, driving MSK restoration and transformation should have:
i. specialist knowledge of MSK
ii. An in-depth understanding of what matters to local people with lived experience to co-produce their restoration plan and transformational strategy
iii. understanding of local resource availability
iv. an appreciation of both local barriers and enablers for change

Recommendation #2
System leaders should identify principles of what works well to share with others, enabling them to adapt and adopt accounting for local resources and population needs

Recommendation #3
Engage in quality shared decision making at all times NHS England - Shared Decision Making utilising Decision Support Tools (DSTs) as appropriate.

Recommendation #4
Optimise primary and community care triage to facilitate timely, and appropriate, referral to diagnostics and specialist care

Recommendation #5
Support the majority of people with MSK conditions who do not require hospital care to live well within the community adopting a personalised care approach

Recommendation #6
Adhere to procedure specific High Volume Low Complexity pathways & deliver GIRFT standard against the relevant metrics across specialities

Recommendation #7
Adhere to the Effective Commissioning Initiative (ECI) recommendations NHS England » Evidence-Based Interventions: Guidance for Clinical Commissioning Groups (CCGs)

Recommendation #8
Optimise appropriate use of digital resources (platforms, apps, devices or other technologies)

Recommendation #9
Use patient initiated follow up (PIFU) where appropriate. NHS England - PIFU

Recommendation #10
Make use of virtual consultation where appropriate (telephone or virtual)

Recommendation #11
Minimise the risk of dependence and adverse drug reactions through stewardship of NSAIDs and dependence forming medicines

BestMSK Spinal MRI: Patient Advice

- MRIs provide a picture of the anatomy of the spine.
- MRIs cannot tell how someone feels and are not a diagnosis.
- MRIs can be used to plan treatment with you and rule out serious conditions such as cancer or fractures.
- MRIs are rarely needed for people with back or neck pain.
- MRIs should be requested after assessment by a specialist.

- Some of the words used in MRI reports can sound scary. However, we know that nine out of ten people with no pain have degeneration of discs on MRI[1,2].
- These findings are more common as we become older and can be signs of a naturally maturing spine.

If you have any questions in relation to your report, please discuss with the clinician who sent you for the MRI.

References:
1. Jarvik JJ, Hollingworth W, Heagerty P, Haynor DR, Deyo RA. The Longitudinal Assessment of Imaging and Disability of the Back (LAIDBack) Study: baseline data.
Spine (Phila Pa 1976). 2001 May 15;26(10):1158-66.
2.Nakashima H, Yukawa Y, Suda K, Yamagata M, Ueta T, Kato F. Abnormal findings on magnetic resonance images of the cervical spines in 1211 asymptomatic subjects. Spine (Phila Pa 1976). 2015 Mar 15;40(6):392-8

BestMSK Spinal MRI: Clinician Advice

I'll just send you for a scan!

- Most back or radicular pain settles within 3 months. Early unwarranted MRI scans are associated with higher intervention rates and worse outcomes.
- MRIs give an accurate picture of spinal anatomy which can help plan treatment in suspected serious conditions such as cauda equina syndrome, cancer, fractures, and infections.
- They cannot tell how someone feels and are not a diagnosis.
- MRI is rarely indicated for back or neck pain and should only be organised after assessment by a spinal practitioner.
- Spinal MRI findings always need to be interpreted in the context of a clinical assessment.
- Findings described in MRI reports are very common in people with NO PAIN, such as disc degeneration (91%), disc bulges (64%), disc protrusion (32%), annular tear (38%)[1]. These findings increase with age and can be signs of a naturally maturing spine.

- Nine out of ten people with NO neck pain have disc bulges on MRI and most people in their 20s have bulging discs[2].
- There is good evidence to suggest that unwarranted MRI scans are detrimental to patient wellbeing and lead to poorer outcomes[3].

Please follow BestMSKHealth pathways for management of patients presenting with neck, back and/or radicular pain: https://future.nhs.uk/NationalMSKHealth/view?objectId=30917712

References:
1. Jarvik JJ, Hollingworth W, Heagerty P, Haynor DR, Deyo RA. The Longitudinal Assessment of Imaging and Disability of the Back (LAIDBack) Study: baseline data. Spine (Phila Pa 1976). 2001 May 15;26(10):1158-66.
2. Nakashima H, Yukawa Y, Suda K, Yamagata M, Ueta T, Kato F. Abnormal findings on magnetic resonance images of the cervical spines in 1211 asymptomatic subjects. Spine (Phila Pa 1976). 2015 Mar 15;40(6):392-8
3. Sajid IM, Parkunan A, Frost K. Unintended consequences: quantifying the benefits, iatrogenic harms and downstream cascade costs of musculoskeletal MRI in UK primary care BMJ Open Quality 2021;10:e001287.

11/04/22

Back and Radicular Pain: Posterior Lumbar Decompression / Discectomy

Posterior Lumbar Decompression / Discectomy Surgery Pathway (1)

1st Presentation

- 1st presentation in primary care. No Direct GP Imaging
- SPOA Triage & Check For Red Flags
- Conservative treatment
- **Rehabilitation support** Physiotherapy, lifestyle & personalised care
- Physiotherapy Review
- Improved
- Self-management supportive self-care

Referral

- Triage & Treat Review / Assessment Including Imaging if required
- Virtual Triage review Treat and Triage Practitioner / Spine Surgeon / Pain Specialist
- Surgical opinion agreed
- **Medical History** Attempts at conservative treatment. Pain or functional disability. Smoking cessation support Weight loss support. Patient education on condition and options
- **Optimising patient for surgery** GP begin optimisation of comorbidities in primary care: Diabetes, anaemia, cardiac, respiratory

Surgical review & assessment

- OPD clinics
- 1st OPD appointment face to face within 6 weeks
- **Assessment by Spinal Team** Medical history & Imaging. Assess impact of pain on daily function. Physical examination. Discuss options including non-operative and operative options and their risks. If confirmation to proceed; discuss LoS & recovery; Identify high risk patients based on age and comorbidities and involve high risk anaesthetic assessment if needed.

Lists for surgery & preparation

- List patient for surgery triggering following actions
- **Pre-operative education:** BASS Booklets & further education as required. Complete British Spine Registry Including Patient Email/BSR Preop Outcome Scores
- **Consent before Preop Assessment by Operating Surgeon.** (May be undertaken Virtually or Face to Face 2-6 weeks before surgery. Must have been physically seen once by Operating Surgeon
- **Pre-operative assessment** 2 to 6 weeks prior to surgery inc anaemia; diabetic management ; infection control; medication checks; Identify need for care packages

Day of surgery

- Admission on day of surgery

Inpatient management

- 7 Day Services including senior review & physiotherapy to avoid delay in discharge
- Phase 1 enhanced recovery
- **Post Op** Monitor vital signs and Neurology. Pain Control. Mobilise asap following surgery usually day of surgery
- **Criteria led discharge;** Pain Controlled Analgesia. Voiding urine. Therapy goals achieved; stairs/transfer ability; Physio Advice on Post Op Exercises. OT equipment if required. Care packages in place as needed

Discharge & follow-up

- Patient information provided on ward prior to discharge
- Discharge (Target 24Hrs from admission)
- **Wound Care** Single point of contact with wound clinic; Telemedicine review of wounds if required; Avoid empirically treating with antibiotics; Suture removal at GP 7-10 days post op if non absorbable
- **Pain management** Analgesia provided for 7 days post-op. Encourage mobilisation
- At 2-3 weeks
- **Therapy on discharge** All patients have virtual review by physio with further physio reviews arranged only as needed. Check Analgesia reduction plan
- 6-8 weeks
- **Virtual Review (by surgical team)** No clinical concerns = patient officially discharged from pathway. Moves to patient initiated follow up (PIFU). Patient completes BSR outcomes
- At 6 months
- Patient completes BSR outcomes. Patients contacted if outlier
- At 1 year and after
- BSR data submitted by patient. Patient contacted if outlier

Not happy with outcome
Return to Virtual Triage Review

Notes: (1) **Pathway excludes patients presenting in primary care with red flags. Red flags include: suspected cauda equina syndrome (follow Suspected Cauda Equina Pathway), unwell/fever/night sweats, immunosuppression e.g. IV-DU, HIV, steroid use, chemotherapy, history of cancer, (to be referred urgently to Triage and Treat practitioner) Significant trauma – Refer to Local Emergency Department**

Shared decision making should occur at each stage of pathway

Version 13 11/04/22

Musculoskeletal: spinal pain/sciatica clinical guidance within primary and community care

Initial presentation in primary care	Confirmation of diagnosis/initiation of treatment in primary and community care	Conservative management in primary and community care	Clinical triage and assessment by integrated tier 2 MSK service/SPOA	MSK Specialist review	Surgical review and assessment in secondary care

Self referral
Primary Care:
GP, MSK Specialist Doctor, FCP
ED/111
Other non-MSK/ MSK specialist HCP

Red Flags

Clinical assessment and screening for serious pathologies. Exclude red flags
Back pain history, management and outcome, pain severity and % back and leg pain, impact on family, social and work ability, observation of spine, lower limbs, gait, pain behaviour neurological examination.
Identification of patients with good prognosis who can self-manage

Imaging is NOT needed for spinal pain with or without leg pain in a non-specialised setting, unless serious underlying pathology is suspected. Consider using iRefer

Consider the use of a stratification tool eg STarT to help determine the complexity and intensity of support needed
When to refer

Consider alternative diagnosis if features do not fit with low back and/or sciatic pain:
Most people will tend to suffer from back pain at some point in their lives and it may recur
Most back pain usually improves enough within a few days to a few weeks, to be able to return to normal activities
Sciatic symptoms may vary from mild to severe, may be related to or triggered by a particular movement or action or it may be spontaneous

As part of shared decision making conversation:
Discuss options for onward referral. Consider use of decision support tools
Discuss referral/self referral for conservative treatment /physiotherapy if not improving. If the patient is ready, consider a trial of appropriate conservative treatment, including strengthening and aerobic exercise, but consider referral if symptoms worsening despite treatment

Package of care tailored to the individual for up to 12 weeks from initial management:
Advice and promoting self-management
Analgesia and other pain management strategies
Exercise
Psychological therapy
Manual therapy
Low intensity Multi-disciplinary
Combined Physical and Psychological Programme (CPPP)
Consider directing to voluntary sector /third sector self-management resources

Clinical triage at SPOA:
Identification, investigation and referral of urgent spinal presentations
Identification and discharge of patients who can self-mange
Identification, investigation and referral of sciatic pain
Identification and referral of inflammatory disorders
Identification and referral of back pain related disability
Identification, investigation and referral of potential spinal surgical candidates

Refer to pain management/CPPP/MDT as appropriate

Imaging indicated if a suspicion of serious pathology or unusual pain/significant neurological deficit

SPOA/Tier 2 MSK service review

Consider imaging for people with low back pain with or without sciatica only if the result is likely to change management.

Consider referral for spinal injection if indicated and agreed with patient through shared decision making conversation

Consider onward referral to other specialities if symptoms not MSK in origin

Optimise patient for surgery and manage comorbidities:
Consider prehab referral, psychological support, pain management

ED review if suspected Cauda Equina Syndrome/Metastatic Spinal Cord Compression

Review by appropriate professional following transfer out of ED

Consider referral to primary/community care and 3rd sector/voluntary sector for ongoing management rehabilitation and support

Link to **GIRFT** pathways

Recommendations from NICE Guidance NG59
Pain relief for low back pain:
Consider oral non-steroidal anti-inflammatory drugs (NSAIDs at the lowest effective dose for the shortest possible period of time; consider weak opioids (+/- paracetamol) only if an NSAID is contraindicated, not tolerated or has been ineffective.
Consider the addition of a gastroprotective treatment
For low back pain DO NOT OFFER:
Paracetamol alone, opioids for managing chronic LBP, do not offer selective serotonin reuptake inhibitors, serotonin–norepinephrine reuptake inhibitors or tricyclic antidepressants, anticonvulsants including gabapentinoids
Pain relief for Sciatica:
If prescribing NSAIDs for sciatica consider the risk factors and side effects and use the lowest effective dose for the shortest possible period of time.
For Sciatica DO NOT OFFER:
Gabapentinoids, oral steroids or benzodiazipines opioids for acute or chronic sciatica. Do not use opioids for chronic sciatica (>12 weeks). Explain the risk of ongoing use of these medications if people are already taking them.

Offer tailored written and verbal advice:
Assess patient's knowledge, skills and confidence; if low, consider referral to health and wellbeing coach. Signpost to quality self-management education. Deliver consistent and concise health and wellbeing information and encourage patients to engage in conversation about their health
Information on the nature of low back pain and sciatic pain, reassure that improvement is likely. Encouragement to continue with normal activities and stay in work where possible. Use of Fit note if work not possible/modifications needed
Explain to people that if they are being referred to specialist triage they may not need imaging. Indications for early clinical review and emergency attendance
Engage with wider primary care team such as care coordinator, clinical pharmacist, health and wellbeing coach and social prescriber as needed. Consider directing to social prescriber, voluntary/third sector quality self-management resources, emotional/mental health wellbeing resources

Link to:
Outpatient transformation opportunities, relevant clinical standards and best practice resources

Outpatient digital opportunities, relevant digitally-enabled service case studies and best practice resources

MSK workforce opportunities across primary, community and secondary care settings

Early clinical review:
Review clinical presentation, stratification tool, medication and reassess for any urgent and emergency conditions
Consider directing to voluntary sector /third sector self-management resources

Consider Patient Initiated Follow Up (PIFU)

Engage with wider primary care team such as care coordinator, clinical pharmacist, health and wellbeing coach and social prescriber as needed

Holistic assessment including mental health, social and work status, sleep, weight, comorbidities, pain and function and collection of PROM and PREM data

Key:
Decision points

Shared decision making conversations (including holistic assessment, understanding what matters to the person, discussion of appropriate treatment options and associated harms, benefits and consequences, values and preference) to take place at each decision point on the pathway, using relevant in consultation decision support tools. Discuss options for onward referral.

Version 13 11/04/22

Back and Radicular Pain: Lower Lumbar Medial Branch Block/Facet Joint Injections

- Lower Lumbar Medial Branch Block/Facet Joint Injections (1)

1st Presentation	Referral	Physical & psychological education	Lists for injection & preparation	Day of Injection	Inpatient management	Discharge & follow-up

1st Presentation

- 1st presentation in primary care No Direct GP Imaging
- SPOA Triage & Check For Red Flags
- Conservative treatment
- **Rehabilitation support** Physiotherapy, lifestyle & personalised care
- Physiotherapy Review
- Improved
- Self management supportive self care
- SYMPTOMATIC

Referral

- Triage & Treat Practitioner Review / Assessment
- Stratification
- **Moderate Risk** Back Pain Class & Psychological Support
- **High Risk** Combined Physical & Psychological Rehabilitation Programme (Pain/Psychologist /Specialist Physio)
- Patient happy with outcome?
- Patient happy with outcome
- **Good Outcome** Discharged from pathway with opportunity to recontact Triage and Treat Service for 6 months
- Patient not happy with outcome

Lists for injection & preparation

- Virtual Triage review Treat and Triage Practitioner / Spine Surgeon / Pain Specialist
- **Medical History** Attempts at conservative treatment Pain or functional disability Smoking cessation support Weight loss support Patient education on condition and options History of Antiplatelet or Anticoagulation
- Diagnostic medial branch block Agreed
- Pain thought to arise from facet joints list for diagnostic L2-L5 Bilateral medial branch blocks.

Day of Injection / Inpatient management

- Admission/Assessment on day of Injection
- Injection must have recorded imaging
- Do NOT use steroids Local anaesthetic only

Discharge & follow-up

- Patient information provided on ward prior to discharge
- Same Day Discharge
- 3 weeks
- **Telephone Follow Up 3 Weeks** All patients have virtual review by Pain team performing block Reinforce rehabilitation
- Diagnostic response?
- No diagnostic response, patient not happy with outcome
- Good response short duration
- **Progress to RF denervation**
- 8 weeks
- **Telephone Follow Up 8 Weeks** All patients have virtual review by Pain team performing block. Reinforce rehabilitation
- **Good Outcome** Discharged from pathway with opportunity to recontact with Pain team for 6 months PIFU
- Patient happy with outcome
- Discharged from pathway with opportunity to recontact with Pain team for 6 months PIFU
- **Contact within 6 months** Pain team review
- Recurrent symptoms

Notes: (1) **Pathway excludes patients presenting in primary care with red flags. Red flags include: suspected cauda equina syndrome (follow Suspected Cauda Equina Pathway), unwell/fever/night sweats, immunosuppression e.g. IV-DU, HIV, steroid use, chemotherapy, history of cancer, (to be referred urgently to Triage and Treat practitioner) Significant trauma – Refer to Local Emergency Department**

Shared decision making should occur at each stage of pathway

Version 13 11/04/22

Back and Radicular Pain: Lower Lumbar Medial Branch Block/Facet Joint Injections

• Low

1st Presentation	Referral	Physical & psychol education

1st presentation in primary care
No Direct GP Imaging

SPOA
Triage &
Check For Red
Flags

Conservative treatment

Rehabilitation support
Physiotherapy, lifestyle & personalised care

Physiotherapy Review

Improved

Self management supportive self care

SYMPTOMATIC

Triage & Treat Practitioner Review / Assessment

Stratification

Moderate Risk
Back Pain Class & Psychological Support

High Risk
Combined Physical & Psychological Rehabilitation Programme (Pain/Psychologist /Specialist Physio

Patient happy with outcome?

Patient not happy with outcome

Patient happy with outcome

Good Outcome
Discharged from pathway with opportunity to recontact Triage and Treat Service for 6 months

SYMPTOMATIC

Stratification

Moderate Risk
Back Pain Class & Psychological Support

High Risk
Combined Physical & Psychological Rehabilitation Programme (Pain/Psychologist /Specialist Physio

Patient happy with outcome?

Patient not happy with outcome

Virtual Triage review
Treat and Triage Practitioner / Spine Surgeon / Pain Specialist

Diagnostic medial bran block Agreed

Patient happy

treatment
Pain or functional disability
Smoking cessation support Weight loss support
Patient education on condition and options
History of Antiplatelet or Anticoagulation

Telephone Follow Up 8 Weeks
All patients have virtual review by Pain team performing block. Reinforce rehabilitation

8 weeks

Progress to RF denervation

Discharged from pathway with opportunity to recontact with Pain team for 6 months PIFU

Good Outcome
Discharged from pathway with opportunity to recontact with Pain team for 6 months PIFU

Recurrent symptoms

Contact within 6 months
Pain team review

Notes: 1 **Pathway excludes patients presenting in primary care with red flags. Red flags include: suspected cauda equina syndrome (follow Suspected Cauda Equina Pathway), unwell/fever/night sweats, immunosuppression e.g. IV-DU, HIV, steroid use, chemotherapy, history of cancer, (to be referred urgently to Triage and Treat practitioner) Significant trauma – Refer to Local Emergency Department**

Shared decision making should occur at each stage of pathway

Sign in & Check out

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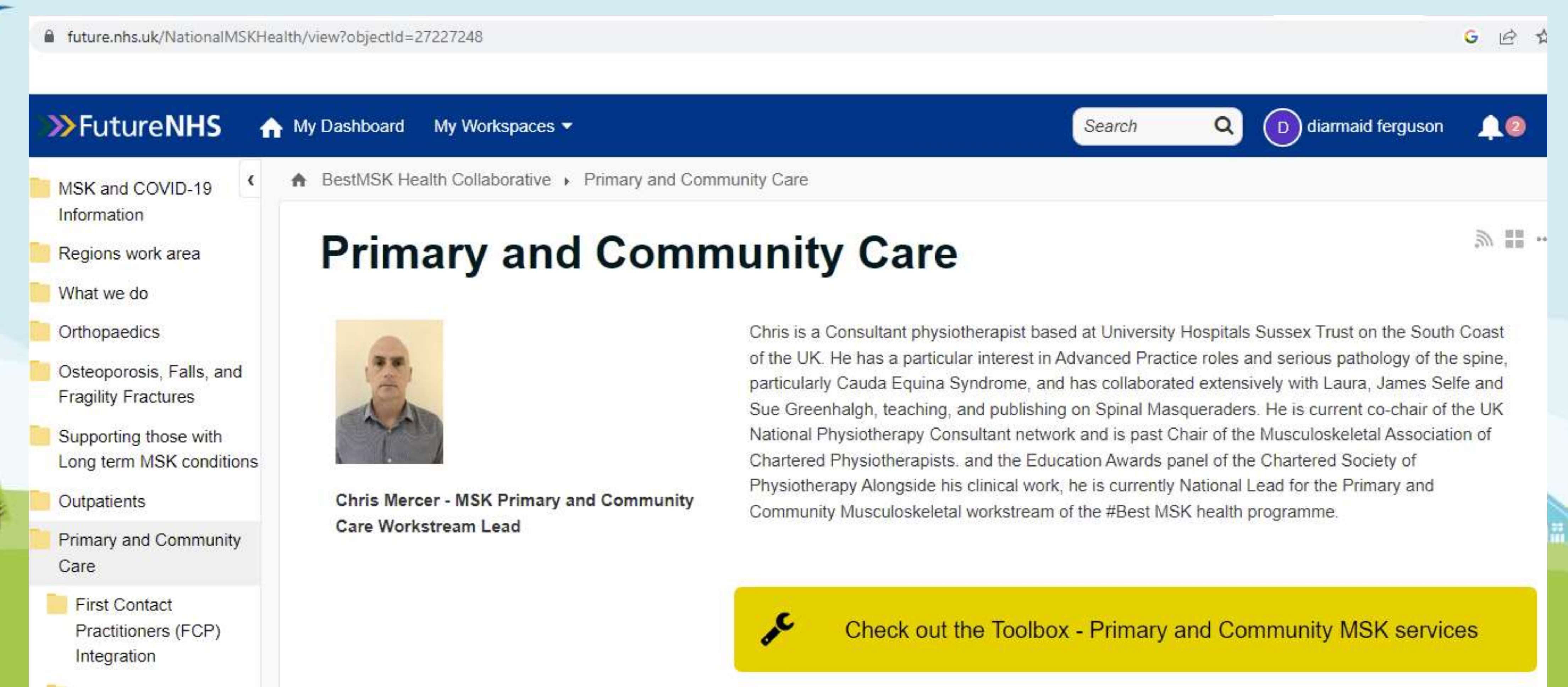
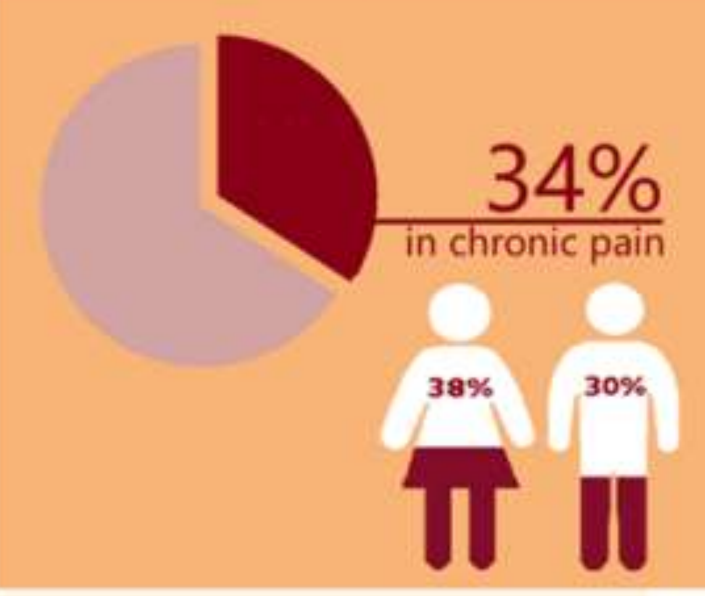
https://future.nhs.uk/NationalMSKHealth/groupHome

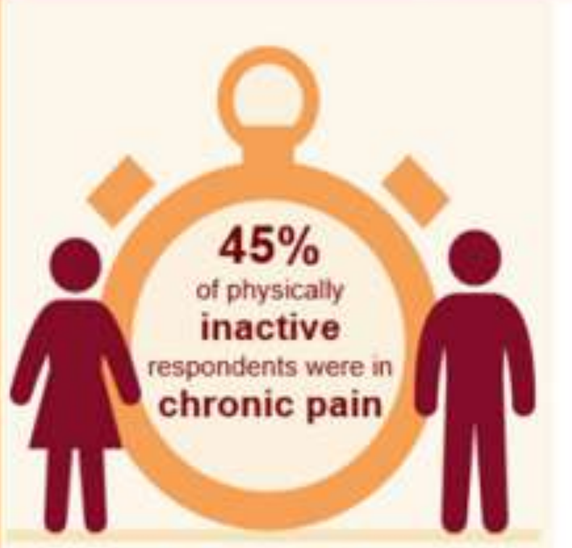


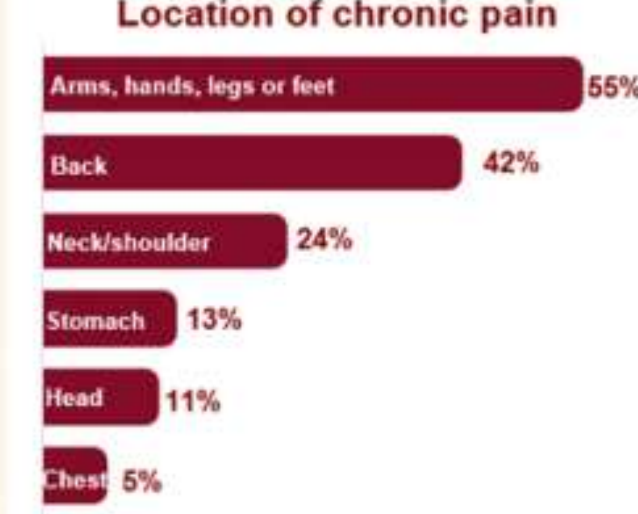
Shifting the narrative

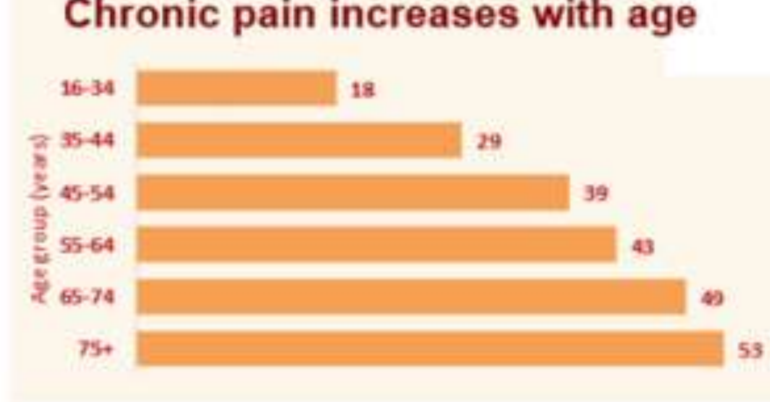
Chronic pain in adults 2017 - Summary

Source: Health Survey for England 2017









Opioids : Fake news

- Discrepancy between trial protocols and published paper is 79% in analgesic trials
  - 30% are unambiguous lies
  - Registered primary outcome not reported
  - Primary outcomes switched

- Spin was found in 80% of systematic reviews in LBP
  - Also in the vast majority of trials , Cochrane did better

Smith et al 2013 Pain

- Only 10% of people with chronic pain qualify for trials
  - 90% do not qualify
  - People with mood disorders - 75-85% excluded

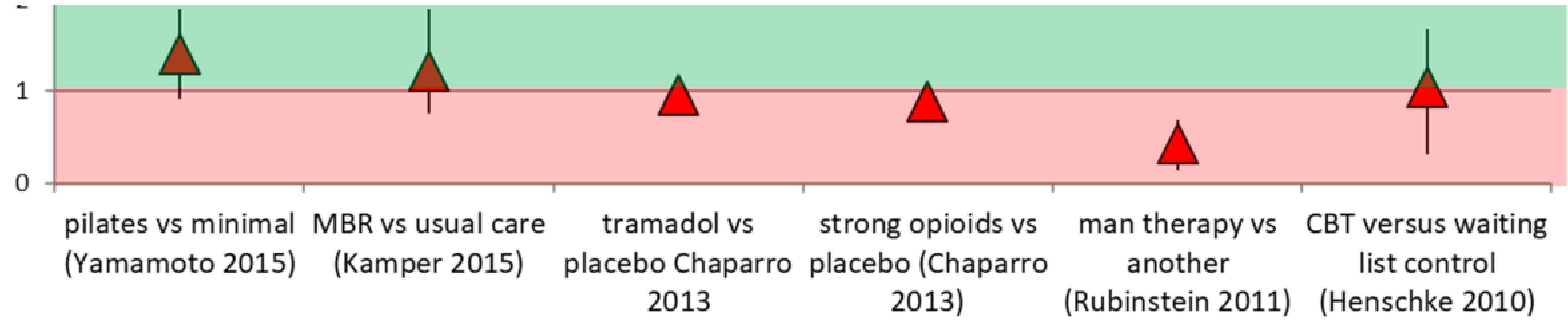
Lancet Psychiatry Humphreys 2017

Opioids:
untidy, unsatisfactory, probably unsuitable

- Withdrawal rates in trials of traditional opioids in CNCP are usually high
    - 40% over the first 3wks, 60% + over 12 weeks- , usually side effects.
- Biased Imputation methods
    - last-observation-carried-forward (LOCF) are used in most trials. take the pain score of someone who withdraws carries that forward to the end of the trial, even though they are not taking the tablets. Results Bias changes '*this drug works*' = '*this drug is no better than placebo*'.
- Only 2 quality studies show a traditional opioid can provide good long term pain relief
    - only 5%-10% of people ,oral morphine 120 mg daily .
- Opioid adverse events are common - observational evidence linking opioid use (especially high doses) to mortality, suicide, fracture, cardiovascular events, and hospital admission

Stannard , Moore 2020 *https://uk.cochrane.org/news/traditional-opioids-chronic-non-cancer-pain-untidy-unsatisfactory-and-probably-unsuitable*

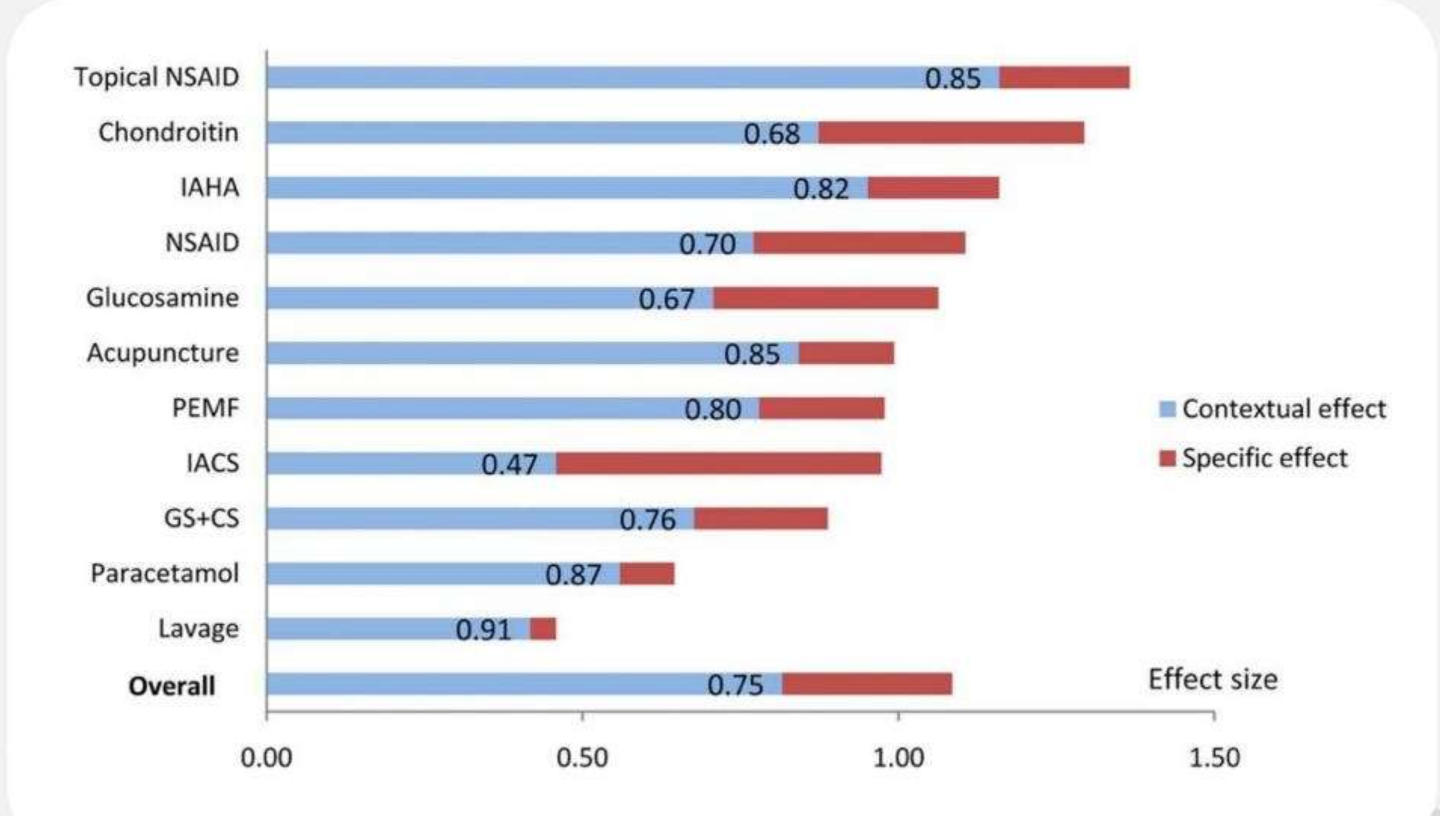
Chronic low back pain – Treatments



Slide courtesy of @NeilOConnel

Chronic Low back pain - Treatment effect sizes

The contextual effect is more STRONGER than specific treatment effect you deliver



Zou et al (2016). Examination of overall treatment effect and the proportion attributable to contextual effect in osteoarthritis: meta-analysis of randomised controlled trials

Chronic pain in over 16s: assessment and management

There is no medical intervention, pharmacological or non-pharmacological, that is helpful for more than a minority of people with chronic pain, and benefits of treatments are modest in terms of effect size and duration.

Additional morbidity resulting from treatment for chronic pain is not unusual, so it is important to evaluate the treatments we offer for chronic pain, to focus resources appropriately and to minimise harm.

The complexity of chronic pain and the association with significant distress and disability can influence clinical interactions. People often expect a clear diagnosis and effective treatment, but these are rarely available.

GPs and specialists in other fields find chronic pain very challenging to manage and often have negative perceptions of people with pain. This is despite the fact that in every specialty there are some people with chronic pain. This can have important consequences for the therapeutic relationship between healthcare professionals and patients.

A clear understanding of the evidence for the effectiveness of chronic pain treatments:

- improves the confidence of healthcare professionals in their conversations about pain, and
- helps healthcare professionals and patients to have realistic expectations about outcomes of treatment.

NICE Guideline: Chronic pain in over 16s: assessment and management, April 2021

https://www.nice.org.uk/guidance/GID-NG10069/documents/draft-guideline

Time for a paradigm shift

- Medicines- The drugs don't work ! (as well as we were led to believe)
- Hospital based care – more Pain services /clinics ?

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Time for a paradigm shift

- Time for a paradigm shift in pain management
- Shift from treating pain to living better lives with pain
- Shift back to the community !

Paradigm shift

- Move from offering fix/ cure

To

- Understanding and developing an individual management plan

- Behave more like a 'Gardener' less like a 'Tree surgeon'

- Act as a 'Guide at the side' not 'the Sage on the stage'

BIOPSYCHOSOCIAL MANAGEMENT OF MSK PAIN

Is like Teenagers and Sex;
Everybody talks about it,
Nobody really knows how to do it,
Everyone thinks everyone else is doing it,
So everyone claims to be doing it.

apologies to Dan Ariely .

Biopsychosocial Pancake

By the time the patient arrives seeking help they are often a fully cooked pancake and the ingredients of causation are inseparable.

@retlouping

https://causehealthblog.org/2021/01/11/whats-in-a-word-its-all-biopsychosocial-and-a-part-of-the-complex-human-ecosystem/

Person-centered care for musculoskeletal pain: Putting principles into practice

Biopsychosocial understanding of the person's experience

Person-focused communication

Supported self-management

Therapeutic relationship

Identification and goal setting

Identification
Shared decision making
Goal setting

Coaching to self-management

General self-management skills
Specific knowledge, skills and tools (including overcoming barriers)

Evaluation

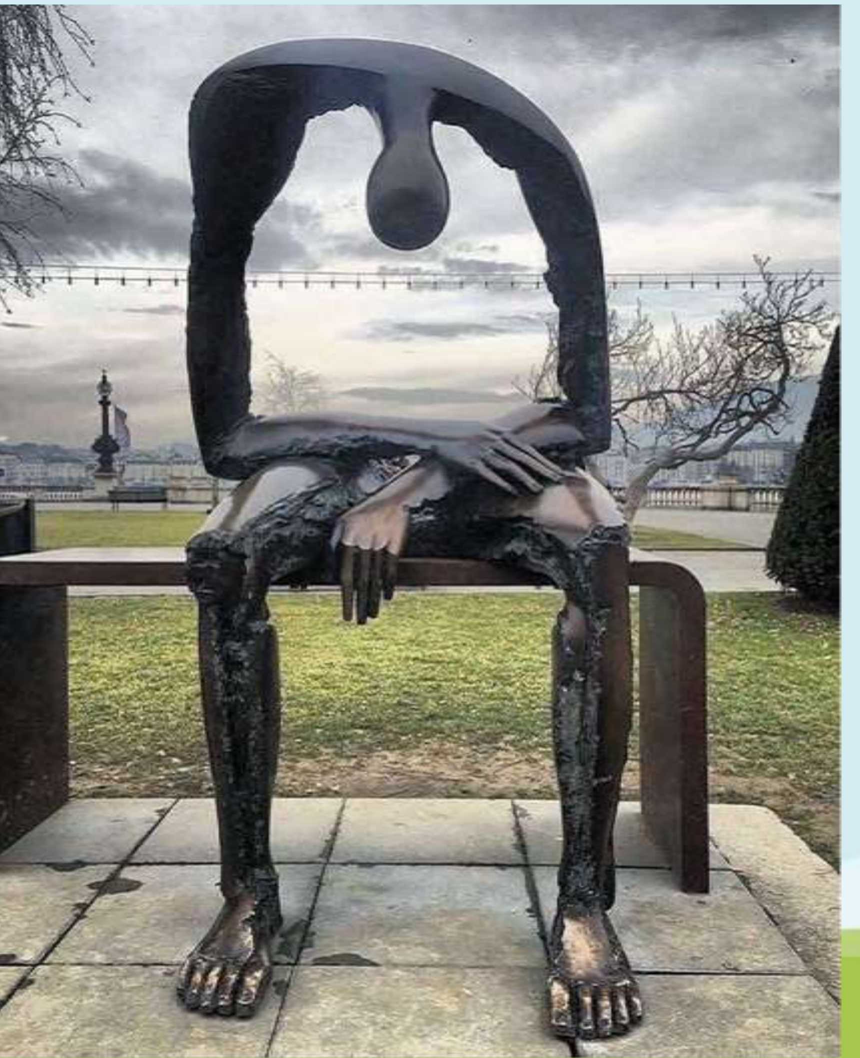
Evaluating goals
Planning for the future
Follow-up plan

Person-centered care for musculoskeletal pain: Putting principles into practice – ScienceDirect N Hutting 2022

Persistent pain

Your Door ?

Questions



Everyone you meet is fighting a battle you know nothing about
Be kind
Always

NHS
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