

Airing Pain Programme 50: Pain services in the community

GP's surgery, telephone call or pain clinic: where should pain management take place?

'Good pain services, based in the community will make a huge difference to the lives of individuals and the NHS', says Sue Beckman, speaking on behalf of the NHS's Delivery and Support Unit at the Welsh Pain Society Annual Scientific Meeting. But what does moving pain services into the community mean?

Beckman, together with pain specialists Mark Ritchie, Mark Turtle and Rob Davies debate the key issue of where pain management should take place.

General practitioners (GPs) are often those closest to 'the community' – they often see patients over the course of years, but limited training in chronic pain and lack of time in appointments pose problems. The panellists also discuss the challenges of bringing services closer to the isolated communities of rural Wales, while ensuring that as many people as possible can access pain services by public transport. Finally, could moving services away from the pain clinic 'de-medicalise' chronic pain by causing healthcare professionals and their patients 'to think outside the box'?

Paul Evans: You're listening to **Airing Pain**, brought to you by Pain Concern, a UK based charity working to help, support and inform people living with pain and healthcare professionals. I'm Paul Evans, and this edition has been funded by an 'Awards for All' grant from the Big Lottery Fund in Wales.

The Welsh Pain Society (Cymdeithas Poen Cymru) holds its annual scientific meeting each autumn, and for a country that's – how can I put it? – geographically challenging, it's an invaluable opportunity for people working in the field of pain in Wales to get together, discuss best practice – and yes, pain politics – and ultimately create a better service for the patient. Its Chair is Dr Mark Turtle, consultant anaesthetist specialising in pain management in Carmarthenshire. And at this year's event I asked him whether the prevalence of chronic pain in Wales is any different to other countries in the UK.

Dr Mark Turtle: There is nothing which would suggest that the prevalence in Wales is any different from anywhere else – somewhere between upper teens and lower twenties in terms of per cent. What might be different, and one of the things we have been discussing in the last day or so, is the impact on individuals, how different people cope with pain. For example, we had a lot of talk about people in the valleys, people in certain areas in south Pembrokeshire, where perhaps they're encountering considerable social difficulties, whereas people in other areas of rural Wales, for example, cope in a totally different way. So it's not so much the prevalence of the problem, but the way that people cope and deal with it which might be...certainly it is an issue that has to be taken into account.

Evans: From the patients' point of view, do patients around Wales, from different areas of Wales, have more or less difficulty than their counterparts elsewhere?

Dr Turtle: In accessing services...

Evans: In accessing and knowing about services.

Dr Turtle: Yes, yes. I think that one of the things that actually has come across quite strongly in the last day or so is the disparity between different areas. Both in terms of overall service – so there are one or two areas where people will have to travel a heck of a long way to get any sort of services – and there is also what that service is made up of. It is quite interesting. For example, somebody showed us an audit of the services, and Powys, which is a very sparsely populated area, it has got very good services in some respects, even though they are not centred round a major District General Hospital, for example. There are areas such as Ceredigion for example, where there are hardly any services at all. There are different clinics, which have different spreads of different disciplines so the make-up is different.

Then we've also hardly scratched the surface to look at the relationship between the services available and the actual population size. So for example, nothing seems to have taken to account that in a particular area the population may be very large and therefore the services ought to be a lot better. Now, that is even before we start looking at how people access them, how they are publicised, for an individual how they know what there is to access and that's certainly something which needs more work.

Evans: Dr Mark Turtle. Well, the focal point of the day was a session devoted to that very topic in which a panel of three prominent health professionals in the field of pain explored issues around community pain services. The panellists were Dr Rob Davis, a specialist in pain management in Cwm Taf Health Board, Dr Mark Ritchie, a Swansea GP with a special interest in pain, and Sue Beckman of the Welsh Government Delivery and Support Unit.

That was established by the Welsh Assembly Government, referred to later as WAG, to assist NHS (National Health Service) Wales in delivering its key targets and level of service. Another term or acronym here mentioned is QOF, or Quality and Outcomes Framework. This is an incentive scheme for GP (General Practitioner) practices in the UK, rewarding them for how well they care for patients across a range of areas through a points system. Put simply, the higher the score, the higher the financial reward for the practice. There is no QOF for pain. So with all that jargon behind us, let's join the debate. It's chaired by Dr Mark Turtle.

Dr Turtle: We have picked three people who are confident, *not* couch potatoes, so I hope that they will chew this debate with vigour. Sue.

Sue Beckman: Thank you Mark, and thank you very much, I feel quite privileged being here, actually, to be honest. It is quite exciting this is, and to be considered that I might be somebody who would know about pain I also find quite flattering, because if you'd asked me a few years ago about the importance of community services for pain I wouldn't have had a clue. I'm a diagnostic radiographer by trade – I've X-rayed many people in my time who are suffering from all kinds of conditions and terrible pain. But not once I think – and I'm ashamed to admit it – not once I think had I given much thought to how they access control of that pain in their lives.

And there are only really two things that have made me think about it in recent years. One was the focus on work that we did from the delivery unit and I am sorry that it is couched round orthopaedics, but that became our only vehicle to do this. One was the neck and back

pain, when suddenly my eyes were opened to the importance of pain for people in this scenario, suffering with neck and back pain, and what pain actually does to people, which I hadn't given much thought to before because I have been fortunate in that I do not suffer much myself. The second is watching my mother on a daily basis struggle with her pain and not be able to access the kind of pain control that I would love that she should have.

So those two things made me really think. Now you would have thought that would've been obvious so that made me think, 'Well, if it is not obvious to you Sue, who else is it *not* obvious to?' And I have to say that sadly it is not obvious to a lot of people, which is why I think probably we have not had as much investment in pain services in the community that I am sure all of you folk here would like, and actually I believe *very* passionately that good pain services based in the community will make a huge difference to the lives of individuals and will have a very positive and cost-effective effect on the NHS as a whole.

Twenty-eight million pounds I believe was quoted to me as the cost in neck and back pain in prescriptions alone for Wales. I think that is well worth thinking about and aside from that, think of all the people who very quickly could access something that makes their quality of life so much better than it currently is. So, on that basis alone, I rest my case that they're a *really* important thing to push forward.

Dr Turtle: Thank you Sue. Rob.

Rob Davis: Eighty per cent of all medical (with a small 'm') contact that patients have with clinicians across the board, 80% of all contact has pain as an element in it. Now put that against 0.9% of the time spent as an undergraduate is pain training. So I think there is a big ask here. The whole idea of actually moving pain into the community, in terms of the service that we deliver, we have got to ask a huge number of questions. What we mean by moving pain into the community? What is the community? And do we really want to lose all those places and people that already provide a service? So I would just like you to think about those two questions: What is moving pain into a community all about? Who do we deal with? Where do we deal with it? And how do we deal with it?

Turtle: Thank you. Mark.

Mark Ritchie: What is pain? To me pain is not the lovely textbook definitions we get, but it is what the patient tells me it is at the end of the day. And Rob very succinctly put that 0.9% of training is in pain. He is right, that's including acute pain, that's not chronic pain. When you look at chronic pain in undergraduate training in this country in medical professionals, it's between 4 and 6 hours depending on which university you are lucky enough to attend. Considering that, I think our general practitioners probably handle pain pretty well, considering the little training we have bothered to give them.

If we could spread that training a bit more, then it could become more community based, but that should by no means mean that we throw away our secondary care colleagues or throw away those secondary care clinics. They are still going to be needed to some extent but it is how we interact that with a good community based service. And I think it should be an interactive and interlinked service, not community verses a secondary care: I think it needs to be interlinked.

Turtle: Ok, thank you very much. Those are the opening stalls of our panellists. Now let's see if we can perhaps challenge those views or get them to expand a little bit with some questions. The first question I have got here is: 'On its own is not the most efficient way to treat chronic pain in a multidisciplinary, a multimodel service model? Patient access, transportation, clinician access to imaging results, team communication when spread out over a population area – how can we overcome these problems?' Rob.

Davis: OK. Taking the second point first: the distribution of the population that we are dealing with and the ability to actually get staff together suggests that we need a base to work from. We have done clinics in GP practices where consultants have gone out to the practices – you end up travelling a long way, maybe seeing three patients. So it makes the case for me to have a base and bringing the patient to that base. And then there is the question about, 'OK, how do we get them there?' The issues of transportation, the issues of car ownership, and deprivation indices all come into that.

Patients, if they have a hospital on their doorstep, they would like to be able to use that hospital for everything. And this is what we found moving into one of the community hospitals because our existing hospital was on a recognised bus route, it was close to the motorway, people knew where it was, people could get there. For quite a while I had complaints from patients turning up saying, 'What are you doing it up here for? We can't get up here, there are no buses to get up here.' It is an important point to think about – if you are going to move things into the community that is fine as long as it is local for that particular patient. If you have a big catchment area you have got to think strategically in terms of where you are going to base part of the service.

Turtle: Mark.

Ritchie: I would not want to denigrate that potential issue at all. However, there are very strong advantages of being closer to where the patients are. Some of those advantages are, we can start de-medicalising this problem, and as we see when we go to the British Pain Society... the last British Pain Society meeting I went to, something like half of all the lectures were no longer about drugs. They were on psychology, they were on physiotherapy techniques, they were on physical techniques rather than pharmaceutical techniques.

A lot of these patients when they come into a hospital setting believe they have come for another injection or another medication. I am not going to 'poo poo' those treatments at all; where they are appropriate they should be used. But what I am going to say is that if we move this out of a hospital setting, people start to think out of that box, and they start to think about a wider and more diverse approach to their problem, and we have certainly seen some pretty good results.

Turtle: Sue.

Beckman: The word 'community' – I can say for a fact that this is absolutely right, there is now a dichotomy of the way we talk and I am as guilty as anybody else. I say, 'Are we talking about community care or secondary care?' Actually I'm going to stop doing that and I'm going to start saying secondary care and previous primary care is now *the* community of treatment that we have. And I think what we need to do about this question is we need to say, 'Well, what *does* our population look like? What way *have* we got in the vicinity? And what is the *best* way to provide those services?' So it isn't one size fits all. It isn't the old-

fashioned outpatients/GP scenario. It is, 'There's our demographics, that's our rurality – how are we going to manage that?' Now, that will take some quite clever planning and I am jolly sure, when we do it, make huge mistakes – but we'll get there.

Turtle: Just to take this on a little bit further, and then Mark I will let you in, can I just point out another question which actually really links in very closely to what we are talking about here. There seems to be an ongoing debate as to what community actually means. What does the panel regard community to mean? Patients' homes? GP practices? Medical centres? Peripheral hospitals? District general hospitals? etc., etc., etc. ... Until we resolve this, the way forward remains somewhat difficult.

Ritchie: All of the above.

Davis: I think it is all of the above, but what is interesting is service within five days. There is no way you are going to get that in any hospital arranged treatment, unless it is an emergency treatment for quantified symptoms. But, having said that, so where is that treatment going to come from? It is going to come from a general practice and that merely pushes forward what I was saying earlier; we need to educate our practitioners at undergraduate level so that they all to some extent can deal with these problems, so that we do not have the massive problem arriving in so-called clinics, whether they are community based or in a hospital.

I think, what is community in this case? It is all of things you have mentioned. How we embrace that community is how we pull those different things together. And yes, maybe we are going to need to pull in different technologies, whether that is Skype, the internet, telly conferencing, whatever – all of those things become possibilities. They will only become possibilities of course with money. So it is going to be a case of balancing the accounts and deciding how we can give our community – total community now – the best service with the amount of money we have available. That of course is going to be something for the politicians and for our pay masters to sort out.

Ritchie: Can I come in with a point about telly medicine and the rurality issue? I think that what we have to recognise in Wales is that there are, if you like, areas of Wales where the solutions will be different. We also have to look at that fact that deprivation has an effect; you are not going to effectively use telly medicine where you have got people whose reading age is six and their ability to assimilate a piece of medical information is questionable at best. So you are going to be dealing with face-to-face description and explanation for people like that – they won't get to you over Skype.

Turtle: Can I refer to another question at this point here? 'It does not appear currently that there is overwhelming interest in managing pain outside a medical model in primary care. Is this reasonable? And if not, how do we change the engagement of fellow health professionals who work outside hospital practice?'

Davis: I'm going to stand up and be controversial. I find it difficult to engage with many of my colleagues in primary care. They have a 10 minute appointment system, dictated to by the government, which says you have to see 6 patients every hour, and if they reduce the number of patients that they are seeing, they then tell them they are not seeing enough patients. So for a start we have got this model which is dictated to by the state saying you have got to see so many patients every hour – that is the first problem. The second problem

is – which is a solution in many areas – is QOF and QIP as they now call it as well, where we are trying to raise standards, but there is not a QOF for pain. So what happens is the concentration of general practice goes into where there are QOFs.

I am not surprised there is not a QOF on pain because it is such a large and vast area, that the money that would have had to be put into it would've been considerable. So that is probably why it has been avoided up state. But the problem is that they are focusing their attention on the areas they have been told to focus their attention on, and also where the money goes. It is amazing how well diabetes has done since QOF came in. Diabetes has done magnificently and we are getting *really* good results in diabetes because the money has been put into that direction and the results have followed.

I don't believe enough money has been put into pain. I do understand there are limitations of a budget, I am not an idiot who believes that there is a limitless or bottomless pit, but what I do think we are going to have to do is we are going to have to be a little bit more diverse in how we approach it. One way we can get into general practices is when we mix pain in with something else. So for instance, if we look at something that has been sold well to the general practitioners like diabetes, if you give a lecture, or a lecture is given which can be sponsored by industry or whatever, on various different forms of diabetic control, and you bring into that same lecture neuropathic pain, and maybe erectile dysfunction; by bringing those three things which are all relevant to diabetes, you suddenly capture the audience's interest.

Turtle: Can I just pursue a little bit with the QOF business. A lot of people talk about the QOFs and of course people working in secondary care don't fully understand all that. It seems to be expressed by a large number of people that know QOF for pain is a problem. Do you agree with that? And is it something that stands any chance of changing?

Davis: Whether there should be a QOF for pain, I mean ultimately government will debate that for a while yet to come. What does QOF do with any diseased area within a practice? What QOF does, is the first thing is, you have to draw up a register of all the patients who have that problem. So in diabetes, you had to create a diabetic register, so it immediately tells you how many patients in your practice have diabetes.

At the moment there is no such register in pain. So the general practitioners have no actual way at the moment of coming out and saying, 'This is how many people we have with acute pain and this is how many people we have with chronic pain'. So if nothing else, if that was the only bit of QOF that came in, if they just said two points a year for creating a register showing how many people have pain that has been ongoing past the time of normal repair, past the 12 week mark. Even if they just did that, it would be a massive starting point because it would at least give us an idea of the size of the problem for budgeting for the future and for the provision of clinics.

Turtle: I want to get Sue's opinion on this as a non-doctor, and to tease that out I am going to just quote this question here: 'Having been on secondment for my secondary care paying service to set up a community service, I have worked with GPs and I have been exposed to their systems. It seems to me that it is still a huge divide between primary and secondary care services. How do we see that we can get these two camps coming together?'

Beckman: Thank you Mark. Well, just listening with great interest to that. It is lovely to hear a group of *really* enthusiastic people who want to see things change, and I am going to ask you a question: Does anybody know whether the commissioning directives for chronic non-malignant pain that were devised in 2009 have ever been rescinded?

Turtle: They have not been rescinded.

Beckman: No. Excellent, they have not been rescinded. Can I take just a moment to remind you of what some of them say? They actually say that by March 2009 planners and commissioners will ensure that plans to reconfigure existing secondary care pain specialist services, based on assessment of local patient needs, are established, to ensure patients with complex CNNPR triaged are referred to appropriately using evidence-based care pathways. Now there are actually three or four of those that go on to explain what the aim of all of that work was. Now, we must not lose that work, and I think somewhere along the way we have kind of lost that a little bit.

Now, if I am not mistaken – and this is one of the last times I am going to use this Rob – primary care and secondary care are now embraced in local health boards. So we should be using these directives to encourage local health boards to start to put in place those kinds of services. That is what we should be doing. I am coming from a more strategic approach than my colleagues, who are actual clinicians, are coming from. Mark, do not look at me when you mention budget, it frightens me! Because this is why I say to people, 'Don't please, I'm not from WAG, I am from the NHS. OK. Not my responsibility to set the budget!'

[Laughs]

Davis: Sorry.

Beckman: It's OK, it happens all the time and that is why I was keen to mention it. So we straddle that for you and I have been looking for a way in now for a while, because certain things happened, which I do not need to talk about in WAG, about how the chronic conditions work, and it has come to a stalling point. And I am going to go back and find a way in again. I have tried several ways in because clearly, as you said, back pain... massive. Back and neck pain is my zone on focus on and I am desperate to see how we can get that right, sorted out with a proper community approach to it. So do not forget about these guys. You need to be asking your health boards, 'What are we doing about these directives that came out? Where is my role in them? How are we going to take this forward, because they are four years behind.'

Turtle: Yeah, that was a point I was about to say.

[Laughs]

Turtle: I mean, I think this is the problem that those words have appeared and many of us have contributed to those words. But you used the word 'stalled'.

Beckman: Stalled, yeah.

Turtle: And that actually is the problem, isn't it? The process has stalled.

Davis: We should not be surprised about that because I was just looking for the actual date that this was signed off. You know, the actual document was generated in June 2008. We have had a financial maelstrom hit the health service so it is hardly surprised that we have stalled on this. There have been a lot of things that have been deemed to be more worthy, maybe that is because we have not shouted loud enough, but things have stalled financially. There has been no money to pump prime a lot of things. We have had to do things on a shoe string and the reason that I am the only representative from my health board, is that the rest of them are having to make sure that they are in work because future funding is predicated on certain requests and demands that have been placed on us by politicians to actually fulfil this document.

Beckman: Can I just pick up on that point? I think that is a very good point that you raised Rob. I think one thing that we are not very clever at doing – all of us, and I include myself in this, though I have tried on occasions, it was very hard – is actually really emphasising the economic element of it. We do not like talking about finances, do we, because, you know, it is not our first port of call. But sometimes we have to, because if that is what is driving us at the moment then we have to prove why the pain agenda is so effective financially. And we are not, unfortunately, at the moment, too clever at doing that. So if anybody is, please help me because I would love to do it.

Turtle: Right, I am just going to throw a spanner into the works. Of course actually the problem is disinvestment and we all know that buckets of money are thrown at things which are worse than unhelpful, a post to dismantle. Until we master the disinvestment thing, we are not going to move forward.

Beckman: It's a case we have tried to argue from the delivery unit's perspective a number of times. If we can avoid some of the burden of pain on the prescription, for Wales that is a direct either redirection of money you are saving, because we have free prescriptions. If you were arguing this in England it would be a different debate, but here that is a direct saving of money because we have free prescriptions.

Now you are clearly not going to save £28 million but you may well save a quarter of it, which would be a massive amount of money. So the more help we can get on trying to explain this and get this financial element worked out would be gratefully received. Remember, it is only neck and back pain the figures I have quoted, only neck and back. For North Wales, the prescription cost – that is all we're talking about here – is quoted at £6.4 million.

Turtle: OK Mark, did you want to reply to that?

Ritchie: I wasn't suggesting there were not ways we could find a list of these patients. What I was aiming with saying would be useful having a QOF register, is it would highlight it for each GP individually because they have to... with the other QOF you have got to put somebody as lead for diabetes, etc. As soon as you have created a QOF in pain, somebody in the practice would have to be a lead for pain, and therefore somebody would need a bit of education within the practice for pain and so it would spread the word that way. So, I was not meaning we could not find the data, and I am sure if we searched we could find it. As regards to pretend you cost savings from prescriptions, they are astronomical.

A few years ago before we became a joined trust, Swansea made a very considered effort to save money, and I remember when I was prescribing leader in my practice for seven years, and when I first took up my practice we were prescribing 44% generic. By the time I left, when we were in the top three generic prescribers for Swansea, and in the last year that I ran the budget for my practice on prescribing I saved £330 000 from my budget of which not one penny went into chronic pain, and that is the problem.

We can get people involved in saving money but if they are not going to see...If they are going to see that money disappearing into a mass called the trust and vanish into orthopaedic surgery or something, then it is going to achieve nothing. If I look at our own trust at the moment, I know of one patient who is costing £4000 a month and I know that there are about 50 of these across the trust, and the patient in question has lower back pain and uses 18 800 microgram fentanyl lollies a day. Work that out quickly money wise, and you will find that it is about £4000.

At the moment if I managed to change him, not a penny of that would come into the chronic pain budget, but quite frankly that is what I would like because I would like to set up a separate clinic once a week to see just those patients. Take their prescribing away from that poor GP who has been landed with that horrible prescription. Take it away from them and let's convert that patient onto appropriate medication that won't destroy his teeth and may well help him with his back, and at the same time save about half a million a year, because that is the potential, just on that small group of patients within our trust. So, and I am sure that there are similar patients out in yours, unless we are the worst trust around.

Turtle: Now, time is pressing. I have just got one more question and I am just going to give each panellist the opportunity to give two or three sentences, and then I am afraid we are going to have to call it to a halt.

Evans: I am just cutting across before we get to that final question because there is just time for me to say thank you to all those who took part in that debate at the Welsh Pain Society: Annual Scientific Meeting. That's Drs Mark Turtle, Rob Davis, Mark Ritchie and Sue Beckman, and I will be following up on their theme in the next edition of *Airing Pain* when I will be joining a community pain management programme in the largest, yet most sparsely populated, county in Wales.

I will just remind you of Pain Concern's usual words of caution, that whilst we believe the information and opinions on *Airing Pain* are accurate and sound based on the best judgments available, you should always consult your health professional on any matter relating to your health and wellbeing. He or she is the only person who knows you, and your circumstances and therefore the appropriate action to take on your behalf.

All editions of *Airing Pain* are available for download from Pain Concern's website and CD copies can be obtained direct from Pain Concern. All the contact details, should you wish to make a comment about these programmes via blog, message board, email, Facebook, Twitter or pen and paper are on our website, which is painconcern.org.uk. So with all that said, here is the final question.

Turtle: How do we engage with primary care to enable progress towards community-based service? Moving current secondary care services to a community is only part of the issue, but in order for secondary care to concentrate on the most needy there is a need for earlier

care of patients presenting with pain. How do the panellists think this could be addressing pain problems early?

Davis: We have to train the staff working at that stage in the patient's journey. We need to give them the necessary academic tools to deal with it. We need to give them the necessary skills and confidence to deal with it. It is a training issue.

Ritchie: I agree with Rob in that it is a training issue, but I think it is more than just a training issue for medics. I think the training needs to start with our population. We need to be speaking to our patients out there and encouraging self-management to a large extent. The only way we are going to do that is by patient education as well as doctor education. Ultimately, though I agree education is going to be the answer so that a larger portion can be handled at a lower level and then move up to the ones that really do need to be in secondary care.

Turtle: OK, Sue.

Beckman: I think the education debate is fantastic and brilliant, but I would like to combine the education with that new sense of community so the education is where it is needed. We do not have those artificial boundaries anymore, but let's have the right people in the right place, wherever that is.

Turtle: Thank you very much Sue, Rob and Mark and thank you very much audience. I am sorry we can't go on any longer.

[Applause]

Contributors

- Mark Ritchie, GP specialising in pain management
- Mark Turtle, Consultant Anaesthetist, West Wales General Hospital
- Rob Davies, Consultant Anaesthetist, Pontypridd & Rhondda NHS Trust
- Sue Beckman, Welsh Government Delivery and Support Unit

Contact

Pain Concern, Unit 1–3, 62–66 Newcraighall Road,

Fort Kinnaird, Edinburgh, EH15 3HS

Telephone: 0131 669 5951

E-mail: info@painconcern.org.uk

[Helpline](tel:03001230789): 0300 123 0789

Open from 10am–4pm on weekdays.

Email: helpline@painconcern.org.uk

To make a suggestion for a topic to be covered in [Airing Pain](#), email

suggestions@painconcern.org.uk

Follow us:

facebook.com/painconcern

twitter.com/PainConcern

youtube.com/painconcern