LIVING WITH PERSISTENT PAIN IN WALES GUIDANCE

Consultation by the Welsh Government

Response from BMA Cymru Wales

14 September 2018

INTRODUCTION

BMA Cymru Wales is pleased to provide a response to the consultation by the Welsh Government on new guidance for living with persistent pain in Wales.

The BMA is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

RESPONSE

BMA Cymru Wales welcomes the opportunity to respond to this consultation. Our response to the following questions posed within the consultation document is as follows:

Q1. How can services be further developed to be more effective?

Without a full overview of current services having been presented to us as part of the consultation, our view is that it is difficult to fully answer this question. The concerning part that we can see within the proposed guidance is that there is little reference to education and training of health care professionals in improving pain expertise and in helping current health care and social care professionals to challenge the pervasive biomedical model.

We believe that education of such professionals must be viewed as essential if the culture of helping patients to live with persistent pain is to change and become more patient-centred.

Another key issue of concern, which some of our GP members amongst others have highlighted, is the current long waiting time for accessing treatment through pain clinics. We would observe that such
unacceptably long waiting times are a significant cause of the increasing number of prescriptions issued for strong pain killers, e.g. for patients who are waiting for joint replacement operations.

One of our members who suffers from chronic pain herself has spoken highly of the treatment she accesses through the pain management service provided in the Wrexham area, but notes that the specialist anaesthetist who leads this service has a waiting list of 30 months, or 24 months for an urgent case. Addressing such staggeringly long waiting times needs to be seen as a priority.

Some of our members also suggest that there may have previously been a better service when they saw a greater involvement from palliative care consultants who were able to provide specialist drug advice, and GPs had the ability to refer specific patients when appropriate for intensive residential input within secondary care. Instead our members note there has been a move towards the provision of clinics which offer a more medical/pharmaceutical approach to pain management. This may be seen as a retrograde step which has reduced access to multidisciplinary clinics that are also able to focus on non-drug related education and support for conditions involving chronic pain, such as chronic pelvic pain.

One of our GP members who was previously able to refer patients for residential support at Bronllys Hospital felt it offered more effective and holistic treatment than may currently be available for helping patients in coping with life whilst living with chronic pain and helping them to live in a manner which means they are less debilitated by it. We would suggest that consideration is therefore giving to returning to a truly multi-disciplinary approach rather than an over-reliance on a medicines-based approach.

Underlying this point, we would note that the BMA member referred to above who suffers herself from chronic pain deals with her condition by various means, some of which involve medication and some of which don’t. She observes that it needs to be recognised that everyone’s pain is different, and that perception of pain can vary between individuals. Based on her own experience, she strongly advocates the benefits of a holistic approach to help people in dealing with and living with chronic pain. In her own case, which involves taking medication as necessary, she is also using therapies such as Tai Chi and accessing the Wales National Exercise Referral Scheme (NERS).

We feel that greater account needs to be given to accepting that all patients are different. There is often a desire to identify what may be perceived to be the best treatment for a condition, but it needs to be understood this is not always best for everyone because not every patient responds in the same way as the average patient with that particular condition. This in turn may lead to an over-reliance on a “one size fits all” style approach which is something that we would caution against.

Another matter that we feel should be given consideration is the impact of the lack of capacity within secondary care for dealing with chronic pain management upon primary care services, including GP practices. Patients who are not able to access support within secondary care, or who experience a long wait to be seen within secondary care, can consume a disproportionate amount of primary care capacity at a time when such services are already under huge strain.

Q2. What are the key areas that health and social care professionals need to be aware of to treat and manage persistent pain effectively?

We would observe that the structure of the current benefits entitlement focuses on the biomedical model. Health care professionals currently experience little education in the management of persistent pain – approximately two hours in the medical curriculum over a five-years period. We therefore would suggest that in order to improve expertise in management, it would be necessary to provide detail of the time and resources that are needed to meet this gap.

We believe it would also be appropriate to include more detail regarding the role of social care, and the ability of health care professionals to refer patients on to social care. We also observe that there is no mention of the effect of socioeconomic issues on decisions to seek treatment of pain – e.g. changes to
housing and disability benefits that may affect a patient’s decision to seek help from health service or social care provision.

Q3. Is there any new research or evidence not included in the document that you are aware of which should be taken into account to better enable people to live with persistent pain?

The guidance cited (including the NICE guidance) appears to be based on a narrow range of conditions and is indicated to support treatment in non-specialist settings. We would caution providers and designers of services to be very clear about the difference between non-specialist and specialist settings so that access to therapies is not rationed or restricted.

Q4. What further support would provide help to patients and their needs?

Beyond a few quotes within the guidance we do not observe any evidence of a formal consultation, or focus group, having been undertaken with service users. We would therefore question if such a group has been consulted in the design of key performance indicators and health outcomes. If not, we feel this should be done to inform the development of this guidance.

We also feel that thought needs to be given as to how success can be measured beyond patient satisfaction – especially amongst those who are non-working, elderly or retired on medical grounds.

Q5. What are the most effective and accessible means of helping people with persistent pain to find information, assistance and advice?

We consider that more research is needed into how and where patients access advice about pain management. It should be noted that with the advent of the internet, most patients will do an internet search on their symptoms and this may inform their decisions about what sources of advice, treatment or services they can access.

Q6. What are the most effective and accessible self-management techniques?

The answer to this question depends largely on the persistent pain condition. For many patients with chronic musculoskeletal pain, a combination of exercise, non-pharmacological and some pharmacy therapy may offer relief. Patients with persistent neuropathic pain, e.g. post-mastectomy or complex regional pain syndrome, may require a multidisciplinary approach with some supported self-management and some input from pain specialist clinics. Children, the very elderly, and patients with complex psychological co-morbidities may need more input from specialist services to support self-management.

Q7. Does the guidance capture all the elements of a good therapeutic relationship and what effective help looks like? What else can be recommended?

Patients with persistent pain may require support from friends, family, health and social care professionals. We should consider how we can assist patients to be able to build such a team that is able to assist them. This can help support and reinforce self-management strategies such as pacing. It is essential, in our view, that the patient’s team can help with supporting them through the experience of living with an invisible disability.

Q8. How can local health boards, local authorities and third sector organisations support people with persistent pain to live as well as possible?

Social care professionals should view themselves as partners in the provision of care, recognising the benefits to patients of being able to deliver a collective approach. Existing communication barriers between health and social care professionals need to be broken down. Community “surgeries” that can
provide advice and help should, as far as possible, be co-located with facilities that support patients living with persistent pain.

Q9. Are there any terms or phrases in the document you feel would benefit from further explanation in a glossary?

None that we have identified.

Q12. We have asked a number of specific question. If you have any related issues which we have not specifically addressed, please use this space to report them:

One of our members who works as a prison GP, has pointed out that she sees significant numbers of patients who are seeking medication for chronic pain. She notes that inmates sleep on a two-inch thick mattress which often has to be replaced multiple times a year because of its poor quality, despite it not being particularly inexpensive.

We would suggest that the relevant authorities have a duty to provide adequate living conditions for detained people/patients to reduce their risk of poor sleep, low mood and resultant reduced pain thresholds. As such, we would therefore suggest that providing mattresses of a suitable quality for all prisoners (e.g. Casper mattresses which are portable and could be transferred along with an inmate should they be transferred elsewhere) could be considerably more cost-effective than the current practice of having to prescribe drugs such as dihydrocodeine, pregabalin or gabapentin.

Another suggestion we have is that consideration should be given to the labelling of strong analgesics regarding their impact on ability to drive as is done in Denmark.¹ This could simply be achieved for instance by using a red label or cap to signify that driving shouldn’t be undertaken, amber to signify that a patient needs to drive with care, and green to indicate that there shouldn’t be an impact.