Changing our approach to back pain in Liverpool

Background

About 80% of us get back pain in our lives and the vast majority is manageable in the community by self-care or GPs. 90% of back pain settles within 6 weeks with simple primary care interventions.

Back pain represents 50-60% of MCAS activity. AQP Spine is now an additional provider with a single tariff (regardless of the number of sessions) of £156. Although AQP spine is in its infancy and we have no good figures of activity, there is the potential for activity in this area to rise relentlessly and become a significant cost to the CCG.

The Problem

Back pain for the most part is a benign condition, which improves almost regardless of how you manage it. The pain can usually be managed with fairly simple analgesia. However, it is often associated with emotional distress. Presence of this distress can impair recovery, and so these patients are relatively high risk of developing chronicity. Current models of assessment and care emphasise the biopsychosocial approach to back pain, but this area can prove very challenging to the relatively inexperienced therapist who will tend to default to manual therapy. Although frequently inappropriate, this helps the patient feel that something tangible is being done to address their problem and it provides comfort for the therapist who is in more familiar territory.

Current referral mechanisms are poor at identifying the high risk groups and targeting resources towards them. Evidence suggests that 55% of patients who present with back pain in first contact settings are low risk and require minimal input.

AQP spine creates an artificial divide between spinal pain and the rest of musculoskeletal pain. It runs the risk of the focus being solely on the spine, and so failing to recognise that the spinal pain may also be related to significant other msk problems that are not part of the AQP spine service (shoulder and hip problems are the obvious ones). That is to say it fragments the holistic approach that should be at the heart of any msk assessment and treatment service.

Anecdotal evidence from the physiotherapists working in the AQP spine service suggests that there is little discrimination between the problems sent to them and to MCAS, and that waiting time seems to be the biggest factor in GP decision making. This evidence also suggests that more junior therapists are much less likely to discharge the patient after initial assessment, and the physiotherapy view that I have canvassed on this issue attributes this approach to inexperience and lack of confidence.

For Discussion

There is a simple questionnaire (STarT Back - attached) that stratifies this risk and so allows more targeted use of resources. This questionnaire could easily be applied in GP at the time of referral. GPs can feel reassured that they are using a simple and quick assessment tool that will help to inform and streamline further management. Such a system is already operating quite effectively in Sheffield. I understand there was some initial resistance and complaints but compliance is now 100%.

Low risk groups can be given reassurance and simple advice with supporting literature, and for the most part will not require any other intervention.

The medium and high risk patients can be assessed in an intermediate service that has more experienced clinicians and access to diagnostics. Resources are therefore targeted to the patients with greatest need and highest risk of developing chronicity.

The proposal

AQP spine was intended to provide care for the less complicated end of the back pain spectrum. I would argue that GPs should take responsibility for the majority of these patients who should need minimal input anyway. We can agree a simple and cost effective strategy for dealing with these patients, using analgesia, advice, supporting literature, and Exercise for Health.

Commitment to this approach will help to improve the management of back pain in primary care, reduce the unnecessary use of scarce resources , and target the patients who need the greatest input; those with the highest risk of developing chronic problems.

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