

BPS PLC Annual Voluntary Seminar, 2010
Bringing Pain Management Closer to Home
Held on Tuesday 12 October at Churchill House, London

Summary of consensus and agreed action

A. Introduction

The seminar was attended by 34 people from a variety of backgrounds. About 60% of delegates were people living with long term pain or representing a voluntary organisation with an interest in pain; the remaining delegates were working in the field of pain – mostly as health professionals.

The day was structured to include some formal presentations on the current situation with respect to pain management in a community (as opposed to hospital) setting, followed by two workshop sessions designed to elicit views on how best to deliver pain management in the community.

B. Presentations

There were three presentations.

- a) Dr Martin Johnson, Chair of the Special Interest Group for Pain (Pain SIG) at the Royal College of GPs (RCGP) and Vice Chair of the Primary Care SIG at the BPS, outlined the policy context for changing the way in which pain management services are delivered.
- b) Mr Pete Moore, Senior Trainer at the Expert Patient Programme, designer of the Pain Management Expert Patient Programme and author of the 'Pain Toolkit', described the way in which lay-led pain management programmes can help people and the content of such courses.
- c) Ms Val Conway, Chair of the Primary Care SIG at the BPS and Clinical Lead and Nurse Consultant with Eastern and Coastal Kent Community Services, described the community pain management service she has set up in her area and how it fits into the local health economy.

C. Workshop A: What aspects of pain management should be delivered in the community?

- (i) Triage/assessment - key to ensuring people access help they need quickly
- (ii) Information on –
 - why pain persists
 - what treatments
 - local voluntary organisations
 - other sources of help
 - local services (exercise, libraries)Information written clearly & also in other forms (spoken, pictures)
- (iii) Regular Medicines review – by practice nurses or pharmacists?
- (iv) Pain management programmes – whether EPP or run by voluntary organisation or within health service
- (v) Access to different disciplines – e.g. physio, OT, psychological therapies
- (vi) Access to hospital services if needed
- (vii) Safety net – information about what to do and who to contact in event of a flare-up or emergency
- (viii) Employment advice – how to continue working

There were some vital components/qualities of a pain service that emerged:

- (i) Being believed that one is in pain
- (ii) Being enabled to self-help
- (iii) Being empowered
- (iv) Being asked what one wants
- (v) Partnership between patients and health professionals – eg using personal health plans and HP/patient contracts, co-creating health
- (vi) Accessible with good transport and ability to deliver at home if necessary
- (vii) Ideally allowing self-referral
- (viii) Accessible – in being visible, so people know they exist
- (ix) Flexible – allowing people to move between different parts of the service as necessary
- (x) Liaison with, and education of, GP practices
- (xi) Good referral letters from GPs to pain service

D. Workshop B: How does a community pain service fit within the health economy?

The consensus was that GPs should refer to the pain service:

- (i) after investigations
- (ii) after diagnosis
- (iii) when GP no longer able to manage symptoms effectively, but
- (iv) early enough to improve chances of effective treatment (no longer than 6 months?)

However many believe that patients should also be able to self-refer to the pain service.

After referral, GP's still have responsibility to ensure that their patients have their medication reviewed regularly and have a personal health plan.

People who have been referred to a community pain service should have written instructions about what to do in the event of a flare-up of their pain.

The divide between primary (or community) and secondary (or hospital) services is much less important to patients than the quality of the service and its accessibility.

The decision about where a service sits should depend on the need within an area.

Pain services should be widely publicised:

- (i) on local radio
- (ii) at bus stops
- (iii) in supermarkets
- (iv) at GP surgeries
- (v) on websites – NHS Direct, voluntary orgs., PALS

E. ACTIONS

There were some suggestions for actions to be taken forward by PLC:

- (i) Carry out survey on medication reviews for people with long term pain
- (ii) Design a HP/patient contract for people living with long-term pain