A COMMUNITY APPROACH TO SUPPORTING PATIENTS LIVING WITH CHRONIC PAIN

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Presenters:

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FOUNDRY

SOAR
Supporting people to make positive changes

A neighbourhood partnership

Why did we do it: Simply put we have been doing this type of work for years but not in a coherent way. Integrated neighbourhood working and development of personalised care teams have given us the permission and resources (in part) to:

- **Create** 'a new relationship between patients, professionals and the health & care system'.
- **Give** 'patient choice and control over the way their care is planned and delivered. Based on 'what matters' to them and their individual strengths and needs.

Through the 'lens' of chronic pain management, this has led to the following developments:

- Creation of a neighbourhood chronic pain offer
- Co-led by SOAR Community (VCSE) and Foundry (PCN)
- Utilising community buildings
- Matrix management of Additional Roles Reimbursement Scheme (ARRS) staff
- Combining ICB health inequalities (PCN) and SCC People Keeping Well (VCSE) investment
- Aspiration to create a wider partnership with shared vision and learning across one locality, involving SOAR as Social Prescribing lead.

Chronic pain support offer

TYPE	OFFER	FREQUENCY	DELIVERY
ONE-TO-ONE	• Tailored support plan • Goal setting • Structured reviews • Practical resources	• 1 hour, fortnightly • Up to 12 weeks support	• GP surgeries • Community building(s) • Local green space • Virtual/online.
PAIN CAFÉ	• Informal drop-in • Light exercise, Breathing and relaxation methods • Talk from different health professional(s) • Assessment to understand wider health need(s)	• 1.5 hours, weekly • Ongoing support • Separate women and men groups	• Firvale Community Hub • Vestry Hall • Burngreave Library
PAIN DROP-IN (if need requires)	• ‘peer led’ learning • Health education/literacies • Practical resources	• 1 hour, weekly • Ongoing support	• Community building

Neighbourhood chronic pain roles

Allied Co-workers Providing complementary and post intervention support and activities. Relationship based on local knowledge, expertise and client need. Who?

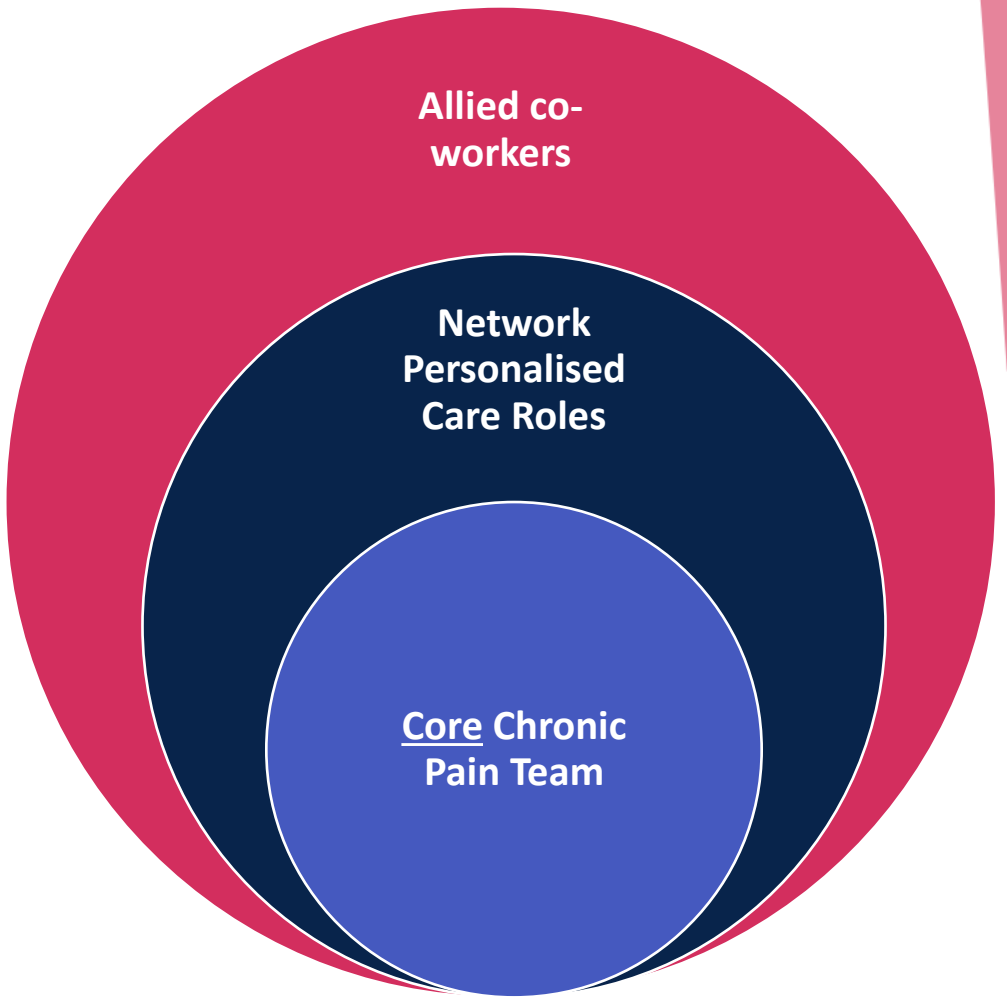
- Welfare Coach
- Emotional Wellbeing Worker
- Mental Health Practitioner, Sheffield Talking Therapies, etc

Wider Network Personalised Care Roles Working together with some patients, groups and projects, meet regularly to share information and support each other, health professionals provide clinical advice when needed. Who?

- Care Co-ordinator
- Pharmacist

Core Roles Working closely together with patients, GP providing clinical advice when needed and regular support. Who?

- GP
- Movement Specialist (Nuffield Health)
- Wellbeing Coach
- Interpreter



Our work

Our Tasha

"This group is great. The way information is explained to help people relate and understand. It is brilliant".

Interpreter - Pain Café

Key areas of work (to date)

DRIVERS

Patient need and demand is growing

Creating a space for both medical & social models

Development of neighbourhood approach through a PCN & VCSE partnership

AREA	EXAMPLE/S
SERVICE DEVELOPMENT	• Service specification • Referral guide • Referral pathways • Café's x 3
WORKFORCE DEVELOPMENT	• Health Coaching Advanced • Persistent Pain MDT • Trauma informed practice
EVALUATION	• Evaluation framework • Appointment ledgers • ¼ PCN report
GOVERNANCE	• Project team • Management/clinical supervision • Reflective practice

Outcomes

PATIENT: Feeling in control	TEAM: A sense of togetherness	NEIGHBOURHOOD: Working together to tackle health inequalities	SYSTEM: Invest to save potential
Time to talk & engage, ensures patients feel in control of services they participate in, and their voice is heard.	A clear sense of purpose and appreciation of individual roles & backgrounds.	VCSE/PCN partnership model increases capacity to deliver wider social/economic benefits to patients.	Embedded ways of working amongst roles improves time efficiency & reduces duplication.
Patients receive the support they require, at right time and place in their life.	Peer support complements formal management and clinical supervision.	Improved workforce planning & evidence ensures roles are recruited that meet changing patient needs.	Locally planned workforce training & development improves retention and skill set of staff.

Outputs (November 23-March 24)

190 REFERRALS

66 CASES CLOSED

1,523 PATIENT INTERACTIONS

43 DAYS SUPPORT (average)

PAIN CAFÉ	SESSIONS (no of)	ATTENDANCES (no of)
BURNGREAVE VESTRY HALL (Women only)	20	175
FIRVALE HUB (women only)	17	48
BURNGREAVE LIBRARY (men only) Started 6th March	7	12
TOTAL	**44**	**235**

"I love Tasha's great sound effects, the promoting healthy eating with free fruit... This group helps with depression and I love the movements we do as it shows me that I can do it!"
Patient-Pain Café

Case Study

1

Beryl attended the Pain Café then suffered a stroke. Tasha (Wellbeing Coach) supported her over the phone on a 1-1 basis until she could return to the group.

20/11/23 - present
Total number of contacts:
- **6 phone calls**
- **12 text reminders**
- **4 group attendances**

2

At the Pain Café, Beryl saw:

- Pharmacist about the negative effects of long-term opioid painkiller use as well as learning about simple ways to manage every day pain.
- Nutritionist regarding the need for a varied diet and the importance of getting enough protein in the diet as well as the effect of foods and drinks on blood sugar levels.

3

While recovering at home, Beryl received weekly telephone calls from Tasha, providing support around:

- Changes to persistent pain symptoms post stroke
- Nutrition, gentle movement and emotional wellbeing.

Beryl is still recovering physically but has returned to the Pain Café to be around other women who are also experiencing pain and changes to their bodies and lives.

TAKE HOME: ‘If you build it, they will come’

POLITICAL WILL: Be very clear on what the need is and how it fits in with network priorities. Draw up a service specification that both PCN and VCSE buy in too.

SHARED LEADERSHIP: Manage this through a project steering group with equal representation from both parties and decision making is shared (**VERY IMPORTANT**).

RESOURCING: Have open and frank conversations about how much time this takes to develop, measure and cost. Be pragmatic about ‘here and now’ BUT LOOK at the long term – 2024/25 onwards!

INTEGRATION: As the project offer grows and ways of working become embedded SO DOES the wider set of services (outside ARRS) that patients can access, i.e. welfare/benefit, employability, links to external system partners, i.e. MSK Community Appointment Day (CAD).

CAPACITY BUILDING: Build organisational capacity and utilise VCSE entrepreneurial approach to service development and it’s position rooted within neighbourhoods.

WORKFORCE DEVELOPMENT: Make every opportunity to train staff together, build relationships and ensure VCSE colleagues have access to NHSE workforce development opportunities (**VERY IMPORTANT**).

Contacts

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