

How to help support and manage the challenges of living with persistent pain in every-day clinical practice

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Aims

What are the consequences of living with pain?

Identifying the At Risk Patient

What do scans really tell us and how do we discuss this with our patients

Why is Language so important – does it really matter?

What Works the evidence - NICE guidance April 2021

The benefits and obstacles to physical activity

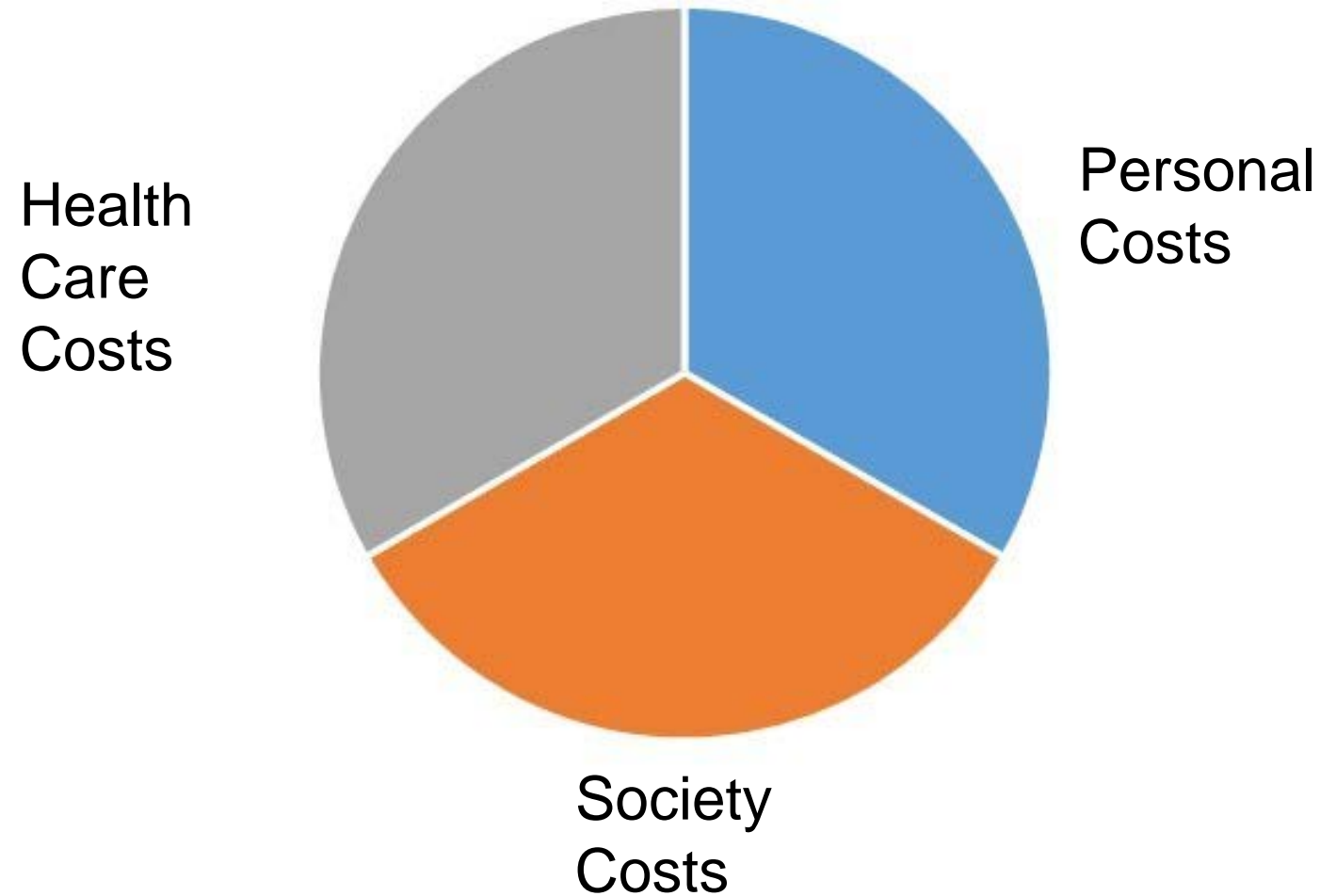
Patient activation and Goal Setting

Activity/exercise – what is the dose?

Obstacles to recovery

What can you do – key messages

What Are The Costs of Pain?



Statistics of Sequelae of Persistent Pain

Health

Distress

Life Expectancy

Social
disadvantage



It's not all bad news



Cochrane Review Aus

Identifying the At Risk Patient

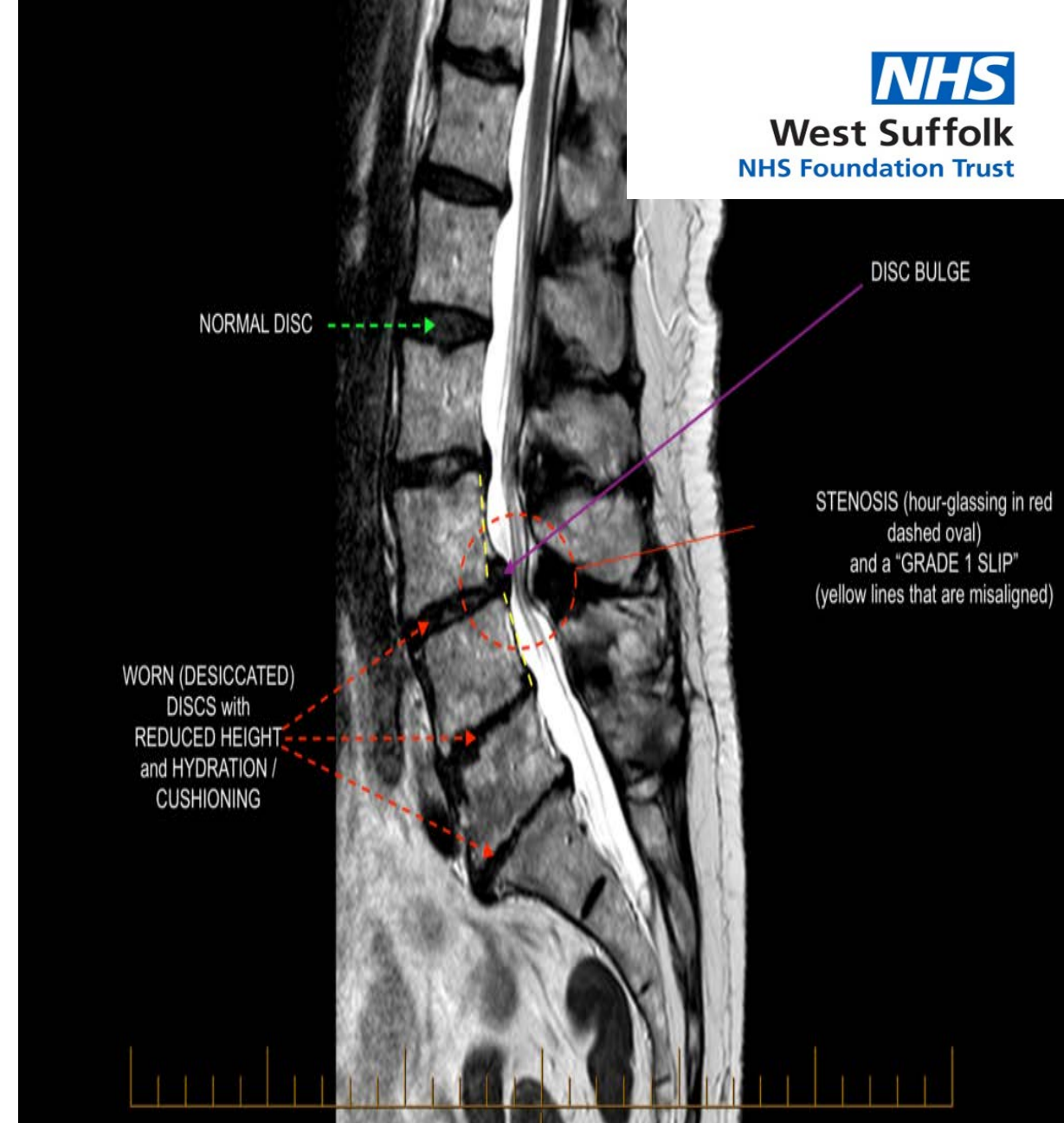


Why Scan?



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MRI scans – the whole picture?



Correlation Of Scans and Symptoms

USS Shoulder :

50% of 70 year olds and 80% of 80 year olds have RC tears

MRI lumbar spine:

80% of people with NO LBP show age-related disc changes on MRI scan

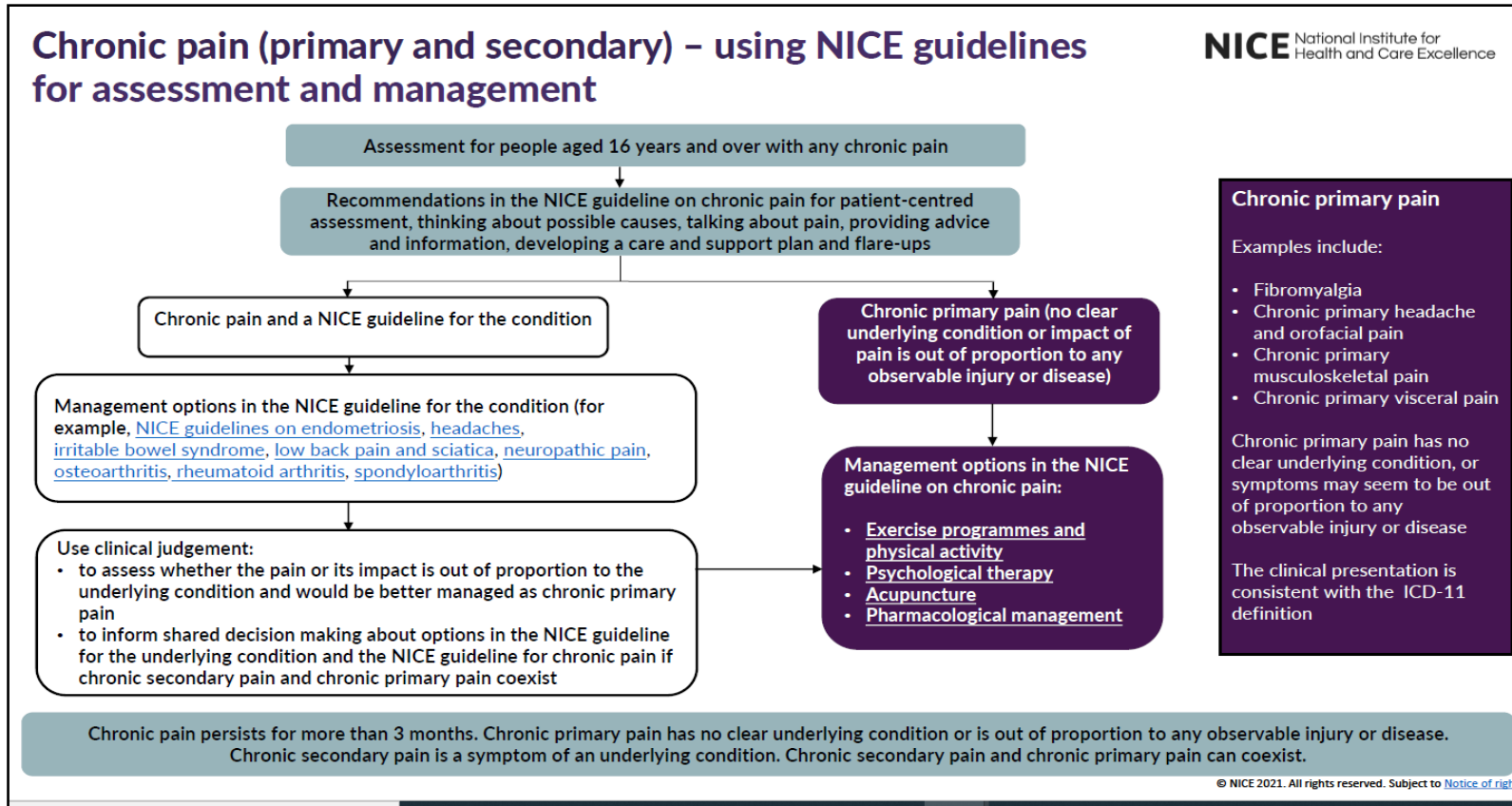
Language

Clues



Messages

Chronic pain (primary and secondary) in over 16s: assessment and management



Overview | Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain | Guidance | NICE NG193 Visual summary (nice.org.uk)

The Evidence - NICE guidance supports Physical Activity and Exercise

Chronic Primary Pain

Exercise programmes and physical activity for chronic primary pain

Chronic Secondary Pain

Osteoarthritis: [CG177] 11 December 2020

Low back pain and sciatica in over 16s: [NG59] 11 December 2020

Spondyloarthritis in over 16s: [NG65] 02 June 2017

How physical activity helps



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Recommendations on Physical Activity

Nice Guidance Physical activity: brief advice for adults in primary care
[PH44] May 2013

WHO guidelines on physical activity and sedentary behaviour
25 November 2020

Barriers to Exercise for people living with pain



Beliefs

Cost

Low Mood/Motivation

Misinformation

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Patient Activation

Change Theory

Prochaska and DiClemente
(1983)



Problem Solving/Solution Focused

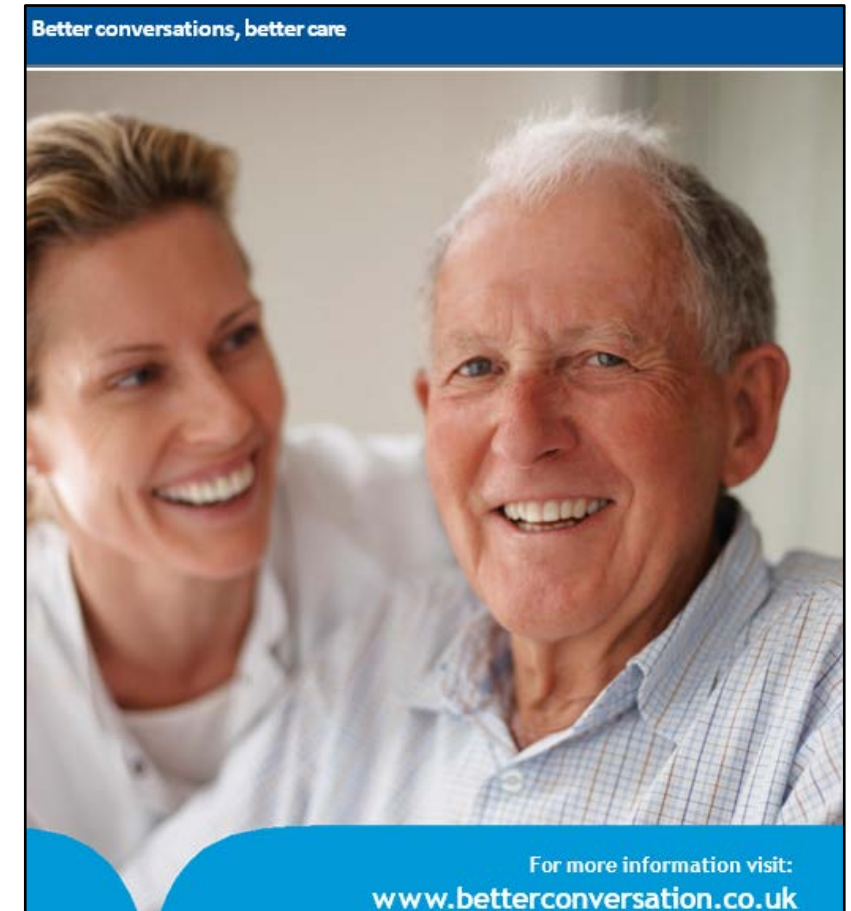
Behaviour Change Training

<https://www.nice.org.uk/guidance/ph49>

Health Coaching

health.coaching@wsh.nhs.uk

Motivational Interviewing



Obstacles to Recovery

Low Activation

Fixed Beliefs

Low engagement

Co-morbidities both physical and psychological

Previous Experience

Socio-economic circumstances – Maslow

Ourselves HCP's



Overcoming Fear of Movement



Movement Matters

Type

Goals

Dose

Enjoyable



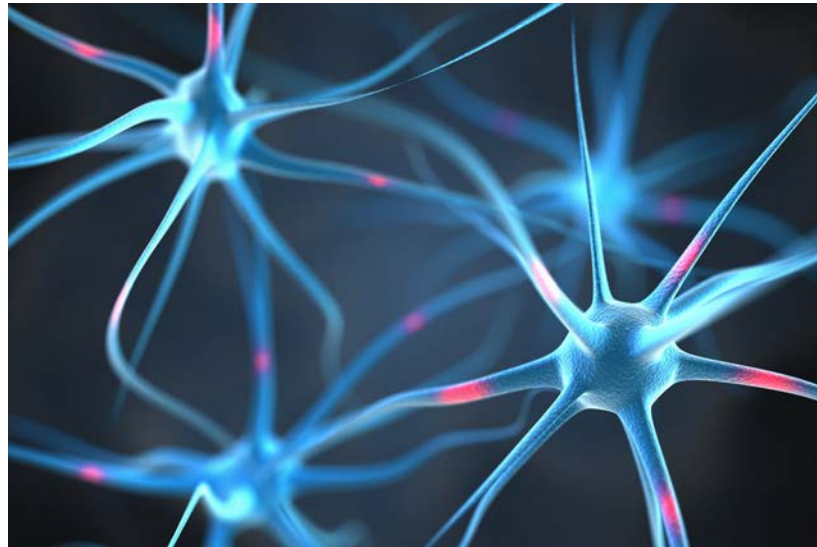
Why Movement and Exercise Helps Manage Pain

Biologically

Psychologically

Socially

Safety and Security



GET SMART

My SMART goals

Use this to set your own SMART goals to achieve by the end of 4 weeks. A guide to what a goal looks like is on the next slide.

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Area of my life	Examples of goals to give you inspiration	My SMART goal (you don't have to fill these all in)
Social/Free activities	Go out for a walk, watch a film, have a coffee with a friend, do an hour's gardening	
Work	Find an voluntary, develop my current role, reduce/eliminate stress, relax	
Hobbies	Gardening, fishing, drama, walking, guitar	
Household tasks	Cleaning and making beds, cooking meals, mowing, shopping, managing finances	
Physical activity	Swimming, walking to the shops, football in park, yoga, gardening	
Caring for myself	Having a bath, putting my own social and stress on, cooking a nice meal	

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My goal ladder

Use this to set your own SMART goals to achieve by the end of 4 weeks. A guide to what a goal looks like is on the next slide.

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My goal is:

My SMART goal at the end of 4 weeks is for:

Steps on the way to reaching the goal	Things that will help my progress	Things that might hold me back
Step 1		
Step 2		
Step 3		
Step 4		
Step 5		

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<http://resources.livewellwithpain.co.uk/ten-footsteps/footstep-4-setting-goals/>

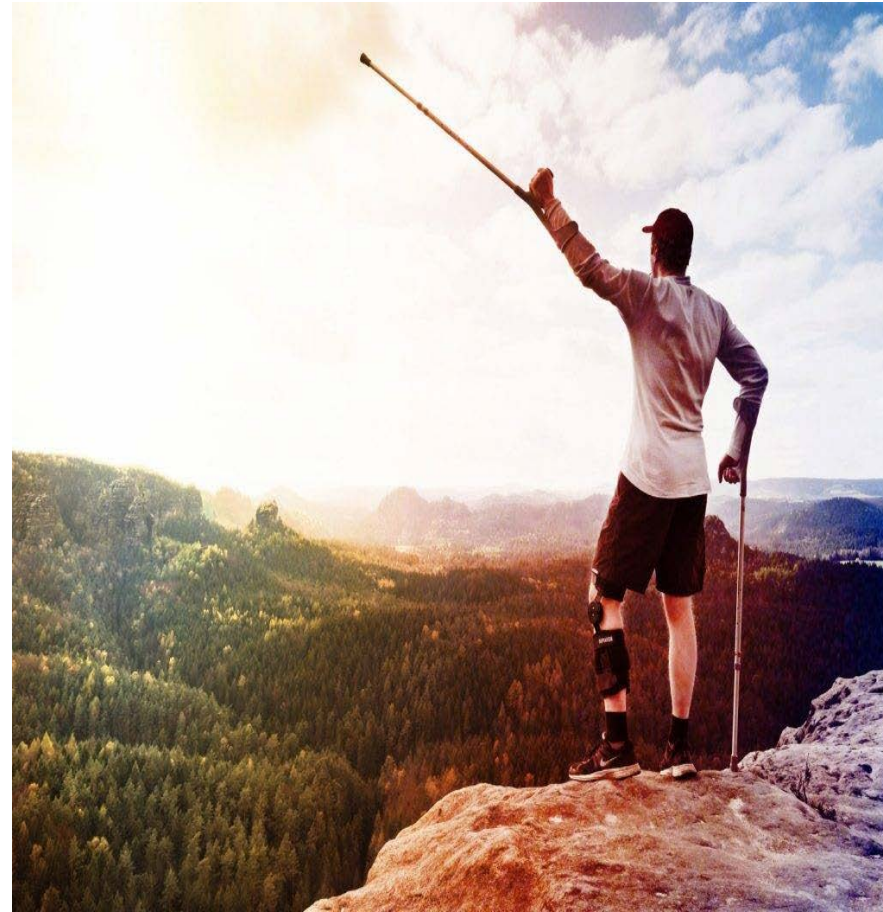
What Can You Do In All This?

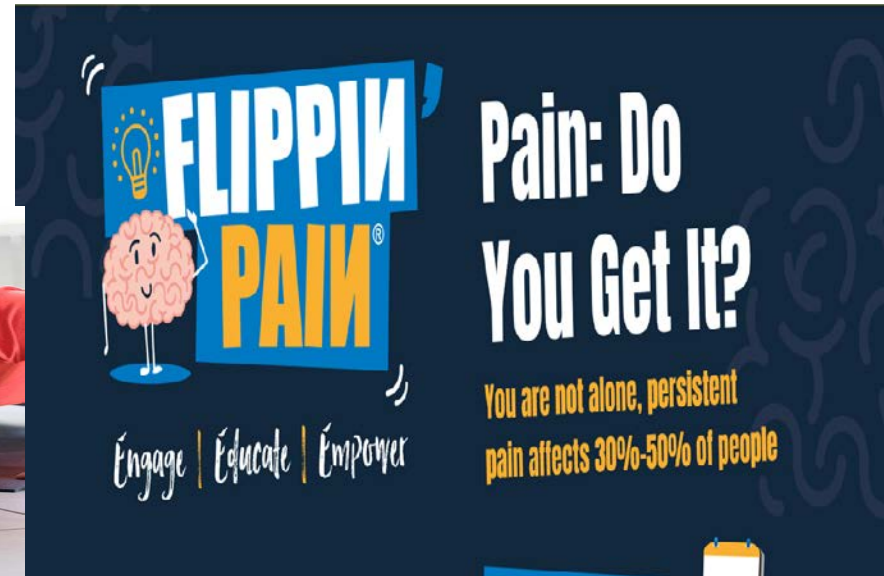
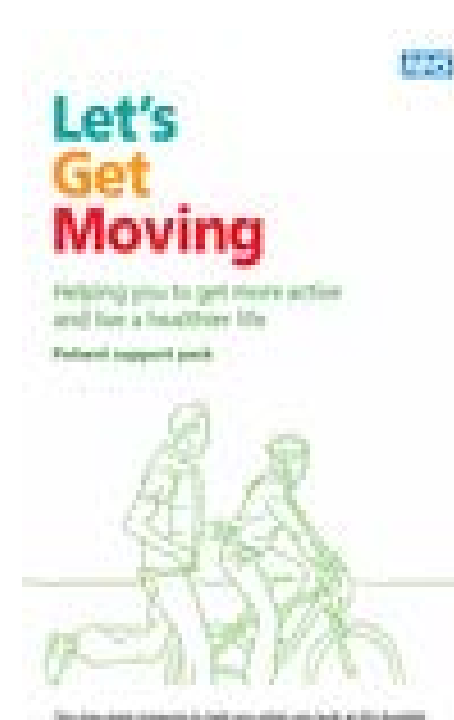
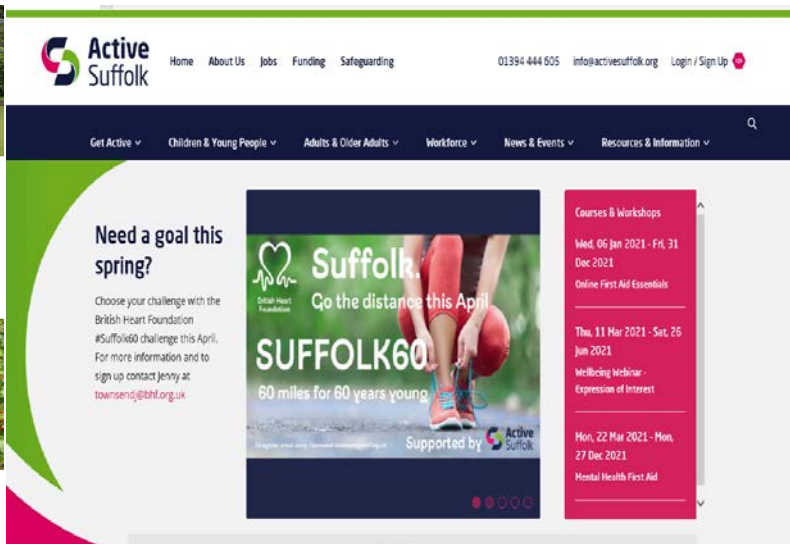
Role

Expectation

Messages

Empowerment





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Referral WSIPMS



West Suffolk Integrated Pain Management Service (IPMS) pre referral guidance

Introduction

The West Suffolk Integrated Pain Management Service (IPMS) is provided by the Suffolk GP Federation and West Suffolk NHS Foundation Trust under an alliance agreement. The service comprises of specialist pain management practitioners utilising a multidisciplinary biopsychosocial model of treatment. Patient care is provided in both hospital and community settings with a specific aim of enhancing the patient's quality of life and reducing their dependency on healthcare services. All referrals come through Single Point of Access.

Referral Criteria: In order to provide the best possible service for patients, the IPMS has identified specific referral criteria. This ensures that patients are referred to the most appropriate Service in the first instance thus avoiding delays in their treatment.

Exclusions: To ensure patient treatment is maximised, specific exclusion criteria have been identified. This

Please do not refer patients to the IPMS if:

Exclusion Criteria	Explanation
Patients who are waiting to be seen by another specialty for the same problem	Patient acceptance and commitment to self-management strategies is hindered when they are expecting further investigation or a solution/cure for their pain.
Severe unstable psychiatric illness, severe personality disorders, severe untreated depression. ¹	This is unproductive for the patient and often results in a poor outcome. The IPMS clinical psychologists do not provide general psychology services. A referral to secondary care or wellbeing services should be considered in this instance.
Addiction to prescription medications or other recreational substances including alcohol. ¹	The patient needs to be stabilised by an addiction service and a referral to local addiction services should be considered. Once the patient is deemed stable, a referral to the IPMS may be considered.
Standalone injection therapy	The IPMS offers a multidisciplinary, holistic, biopsychosocial approach to self-management and there is strong evidence suggesting standalone injection therapy is ineffective.
Patients with outstanding litigation relating to injury or pain. ¹	This is often a barrier to the acceptance of self-management strategies.
Cancer pain	Referrals to the IPMS should come via oncology or palliative care
Patients under 16	Referrals to the IPMS should come via a paediatric specialist
Housebound patients.	We do not provide a home visiting service.
Patients awaiting definitive treatment for the problem, for instance awaiting surgery.	There is no point in embarking on a biopsychosocial pain management program, if a possible solution is still awaited. You can contact us directly if you require medication advice in the interim.

Criteria	Explanation
Have had pain for a period of more than 6 months.	A referral should be considered if the patient is not improving with optimised prescribed therapies in line with the WSCCG analgesic ladders: https://www.westsuffolkccg.nhs.uk/clinical-area/prescribing-and-medicines-management/formularies-and-guidelines/
Musculoskeletal conditions that have been worked up thoroughly by MSK services.	All patients with MSK conditions must access standardised physiotherapy services prior to referral to the IPMS. If patients fail to respond to standard treatment, they should be considered for a referral to the IPMS.
All "red flags" have been ruled out	The IPMS is a routine service. Patients with suspected 'red flag' pathology should be referred to the appropriate specialist service within secondary care.
Patients have completed their involvement with other clinical services and are now discharged.	Patients should not be seeing other teams for the same problem as this hampers acceptance and often confuses pathways.
Patient has been thoroughly investigated for treatable pathology and the diagnostic pathway has been completed.	Patient acceptance and commitment to self-management strategies is hindered when they are expecting further investigations or a solution/cure for their pain.
Patient requires specialist assessment for medication management	Our specialist consultants offer specialist advice on areas such as renal/hepatic impairment and/or multiple medication intolerances.
Scope of care is beyond current WSCCG guidelines for primary care	https://www.westsuffolkccg.nhs.uk/clinical-area/practice-support/primary-care-commissioning/



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West Suffolk Integrated Pain Management Service (IPMS)

Single Point of Access Patient Referral form

Referral Date:

Patient details:

Surname:		First name:	
DOB:		Contact No:	
NHS No: / Hospital No:		Diagnosis:	
PHQ-9 Score:		PHQ9 Q9 score:	GAD 7 Score

*If question 9 of the PHQ 9 is >0, has appropriate action taken place (such as a referral to AAT)? No ☐ Yes ☐

Pain location and brief history:

Current medication ¹ (including dosages)	
Relevant investigations and results	
List other medical problems	

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What Is Recovery?

Living well with challenges of pain

- Pain is manageable
- Valued living
- Acceptance
- Function
- Fitness
- Resilience
- Flares can be managed
- Recovery

Take Home Messages

Hurt does not always equal harm

Everything matters when it comes to pain

Movement is Medicine

What we think impacts on if we experience pain and how much pain and distress we experience

Negative inaccurate language increases the sensitivity of the nervous system

We can heavily influence outcomes

Persistent pain is often the work of an over sensitised nervous system we can retrain pain systems

