

Airing Pain 145 | Rethinking Pain: Pain Management in the Community

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Edition features:

Dr Barbara Phipps, Practising NHS GP and Teaching Fellow at the University of Edinburgh, currently running a community based Chronic Pain management service within the NHS. Barbara has a special interest in Lifestyle Medicine, and is a trustee of the British Society of Lifestyle Medicine.

Dr Jackie Walumbe, Clinical Academic Advance Practice Physiotherapist in the Complex Pain Team at University College London Hospitals NHS Foundation Trust and Honorary Research Fellow at University of Oxford.

Professor Mark Johnson, Professor of Pain and Analgesia and Director of the Leeds Beckett Pain Team (Centre for Pain Research) at Leeds Beckett University.

Dr Kate Thompson, Senior Lecturer and Researcher at Leeds Beckett University, with a background in physiotherapy and special interest in pain research.

Kerry Page, Programme Lead for Rethinking Pain, the chronic pain community service based in Bradford District and Craven.

The edition is presented and produced by Paul Evans. The interviews were recorded at the British Pain Society's Annual Scientific Meeting, 2024.

Transcript begins

Paul Evans: This is *Airing Pain*, a programme brought to you by Pain Concern, the UK charity providing information and support for those of us living with pain, our family and supporters, and the health professionals who care for us. The recordings for this edition of *Airing Pain* took place at the 2024 Annual

Scientific Meeting of the British Pain Society, held at Nottingham University. Each year, this international event is a major platform for pain management professionals, researchers, clinicians and industry leaders to come together and exchange insights and explore the latest developments in the field of pain. And as always, we're grateful to the British Pain Society for their support in providing facilities to record these interviews. I'm Paul Evans.

Mark Johnson: Pain is a context driven experience, so if you go into a medical setting, the context in which your narrative is going to occur with the clinician is going to be medically orientated. If you're going into a community setting, the narrative that you're going to have is going to be a more socially constructed narrative.

Jackie Walumbe: You had to come to us, for us to tell you how to self-manage and that was just not useful.

Page: Those professionals are right outside your door. They want to connect with you. They want to link with you. You have your skills and they have theirs, and together you're going to do something for that person you're trying to support much more holistically.

Johnson: In the clinical setting, often the narrative is about fixing pain using medical interventions or even psychological interventions, and I think there's a bit of a mismatch going on there.

Evans: Is the one-to-one face to face consultation, doctor to patient, the best we can do? Is it even affordable? In this edition of *Airing Pain* we'll be looking at alternatives, improvements even, to that clinician-patient relationship. Let's start in primary care, the GP surgery to you and me. GP Doctor Barbara Phipps has a special interest in Lifestyle Medicine. She's a fellow of the British Society of Lifestyle Medicine, a community of healthcare professionals and patients whose aim is to support patients to prevent, manage and reverse certain chronic conditions using supported behaviour change skills and techniques to create and sustain lifestyle changes. She's a GP in Edinburgh, where they've been developing group consultations for people with long term pain.

Barbara Phipps: We were trialing some group consultations in our GP practice for diabetes, and one of my colleagues and I thought, “Hmm, it's quite interesting. Could we try it for our patients who have chronic pain?” So pain that people have had for more than three months, and particularly chronic primary pain. We're not looking for people say, for example, who are waiting for a hip replacement or for surgery or anything like that, but people who have chronic primary pain, conditions like chronic low back pain or fibromyalgia.

Evans: I'm trying to envisage this now because the group sessions I've been with, not for consultations but, say, with third sector organisations, they can be quite intimidating, especially when you start off and say, “Tell me something about yourself. Let's go around the room.” How do you sort of get around that? How do you manage it?

Phipps: That's a good question. And actually we don't, kind of, go round the room at the very beginning. The patients, before they come, have already met with this coordinator, Alexandra. And they've already had a sort of pre-consultation with her and she lets them know exactly what the format is. It's a very easy-osey kind of space, so there's no pressure for anybody to speak at all if they don't want to. They don't have to divulge any information about themselves. At the beginning all we have is a little name sticker so that we can introduce ourselves by name. But that's just their first name. So there's no pressure to do anything, and we try and create a really nice safe space, making sure that everybody knows that it's confidential and that really whatever is said in the room stays in the room. Thus far we haven't had any problems, but we do make that quite clear, so it's a really safe space and we don't expect anybody to divulge anything if they don't want to. But naturally what happens is that over the weeks people become much more comfortable, they get to know each other, they realise that it's a really safe space and they can then start to talk a bit more openly about things if they wish.

Evans: And they're dealing with you, a GP in primary medicine.

Phipps: Yes.

Evans: The thing about that is that getting the diagnosis of chronic pain being believed in the first place is ever so important, and people in your groups they've had that.

Phipps: Yes. They've had pain for a long time. I mean most of them laugh when I sort of start talking about chronic pain, that it means that you've had pain for over three months, and you can see them smiling because they're like, "If only! It's been more like three years, ten years, thirty years!" So you can self-refer, but most of them are referred by their healthcare professionals. That could be the GP, the practise nurse, it could be the link worker. We have been around the GP practices making sure that people understand that it is primarily for people who have chronic primary pain. We do have people though who have mixed conditions. So we've had, you know, people with rheumatoid arthritis who also have fibromyalgia as well. The principles of what we talk about can be used really for people who've got any type of pain to be honest. But obviously if somebody was waiting for a hip replacement then it's a bit more difficult to discuss the other parts of their lives that might be impacting their pain.

Evans: Is it a bit like a pain management programme "lite", if you like?

Phipps: I'm not sure it's *lite* because we do go into a little bit of emotional stuff, asking them, you know, to draw up things like timelines of when their pain started and what was going on for them at the time. We do some practices like journaling... but I suppose "lite" in the sense that we're not going to go into any deep psychological issues. And if you have extremely complex situations with a lot of other issues and mental health issues then that would definitely be more appropriate for a secondary care service.

Evans: I think what I meant by "lite" was – do you have the full complement of psychologists, occupational therapists, physiotherapists?

Phipps: Right, no, we don't. (*Laughs*) It's just me and the coordinator, Alexandra, who has a background in psychology and is training in CBT, but it's essentially just the two of us. Although we do have the support of the third sector charity that Alexandra works for and they have mental health support

services. They've got CBT therapists and they have mental health support groups, etc. So we do have that plus we've also got the links with the GPs if there's any issues. I see what you mean, yes, it is "light" in the fact that we're not a pain management programme with a big multidisciplinary team. That would be marvellous, actually, if we could have that! But there's such a huge *need* in primary care and I see ourselves as the first port of call for people, which should allow the more complex people to be referred more appropriately to secondary care, whereas hopefully we can see a large number of people and they maybe won't have to go any further because we'll be able to give them enough tools to help.

Evans: And a large number of people who are there because they've actually been believed that they do have pain.

Phipps: Yeah, well, absolutely. And that's essentially the first thing I say. "If you don't take anything else away from this session today, I want you to know that your pain is real. It is not your fault and there is hope that things can improve." And actually sometimes that in itself... people get quite emotional with that, you know, there's sometimes a few tears. Just, like, finally somebody is saying, "Your pain is real. You're not making it up. There's no way you can make this up."

Evans: How do you help people move on from that? That you believe them, but the rest of the world, if you like, may not believe them because pain is largely invisible.

Phipps: Yes. We go back a wee bit to how we perceive pain, or how pain has been perceived for a long time, really the very ancient Descartes model that tissue damage equals pain, more tissue damage equals more pain. I say "Look, that's from the 1600s! It's a bit out of date and times have moved on and we know that pain is so much more complex than that." And we talk all about the new research and even things like the use of functional MRI scans that *can* show the way a brain works and somebody who's got long term pain is different from somebody who hasn't got long term pain. So yeah, it might be invisible, but actually we can see it now. We can see these things on



functional MRI scans. And isn't that brilliant, that we can do that now? But you know, I often say: you can't see love, but we know it's there. For people who suffer with depression it's not something that necessarily you can see, but we know it's there. And pain is the same. We know it's *there*.

Evans: Do you have any sort of evidence of how well your service is working?

Phipps: We've been collecting data from the very beginning. The very first questionnaire we used and we continue to use is the patient activation measure, which essentially asks people how *empowered* they feel in managing their own healthcare and how activated they are. So essentially a single point of change in the patient activation measure is statistically significant in terms of how people use the healthcare system and how *costly* they are - so it's quite good for people who are funding that. If you can show an improvement in that, you can show that essentially a patient will cost less and that's what the funders are interested in. But we do measure other things. We use the pain catastrophizing scale and then numerical rating scales for pain intensity and pain interference. So those are things we measure. But there's also verbal feedback, and it's a whole spectrum. So for some people they have moved very little. For a large number of people they have made some good improvements. For some it's literally life changing. We have one girl who's off travelling at the moment, pain free. Never thought she would do that.

Evans: That's Edinburgh GP Barbara Phipps. Well, she brought up the dreaded F word – funding. Somebody holding the purse strings has to decide whether a treatment programme is value for money or not. Jackie Walumbe is a clinical academic physiotherapist at University College London Hospitals NHS Trust. Her research is focused on understanding how the term and practice of “self management”, which is an accepted and effective pain management strategy, is understood and acted on by people living with chronic pain, particularly those who don't have ongoing contact or access with specialist pain services.

Jackie Walumbe: I spoke to policymakers, the people who make decisions about money and where things end up and who gets what services, and I also looked through a lot of documents that are produced by the government, for

example, and I tried to find where they reference chronic pain or persistent pain or self-management, in that order. The issue seems to be is that there's very little political will to engage with what I'm going to call the "pain community". So a lot of political stakeholders and decision makers are hoping that pain will be included by default. They are not doing anything specific for pain, but they're doing stuff around person-centred care, multiple health conditions and personalised care. And they're hoping that that will catch people who have chronic pain.

Evans: Give me examples of what you found.

Walumbe: I looked at meaning. What *meaning* was the literature telling us about self-management of chronic pain? There were three things: that self-management is an intervention, something that is *offered* to people. The second is that self-management is a *behaviour*, a desirable behaviour, a way of being that is sanctioned by healthcare. And then the third was that self-management is a way to contain costs. When I spoke to people who were living with pain they almost immediately rejected that it as a useful concept because they said, "I live with this all the time. It has no meaning to me." And they particularly did not like the term "management", because what is manageable about pain? Rather, they preferred "care". They talked about, "I care for myself and I care for my pain." Some of them talked about pain as an integral part of who they have become and they cannot fight it or fix it or chase it away. They also said to me that the way people lived with pain was not individual, it was community. It was *relational*, as the term I ended up using, and that the environment really mattered. Whether that was their home, where the pharmacy was, the local GP practice. The allotment featured very heavily in those who had access to one, and they felt that sometimes when people interacted with the health system, it sometimes derailed them a little bit. So they might have been doing really well and then perhaps they got a new diagnosis, such as rheumatoid arthritis on top of their chronic pain condition. And then they felt they had to perhaps be told, "You shouldn't lift weights," for example. Or, "This is bad for you." So I found that really, really striking.

Evans: Because the thinking now – well, it's more than thinking, let's call it the *fact* – that chronic pain is a condition in its own right. It's not a *symptom* of everything else.

Walumbe: Exactly.

Evans: It needs to be treated as the top of the pile.

Walumbe: Exactly. There's a report by Versus Arthritis about inequalities and disparities in chronic pain being very, very prominent, so services are less available in places where people need them the most. So they reflect wider inequalities in society. So the finding that the politics, the big “P” people, do not want to deliberately engage with people with chronic pain – is a little bit worrying. The other thing that I found, another key finding, was that in that vacuum of formal decision makers other things have emerged. So different communities have come up that are now making the decisions and influencing how and where services are made up. And the biggest one is what I call “member-led” collaboratives. So people living with pain, their families, their carers, inviting different healthcare professionals and, I suppose, *forming* their own peer support. And *growing* and having an advocacy voice that is loud enough that is influencing policy.

Evans: So, person-centred care hasn't been recognised for that long, but now it's not just the person, it's the *community* that needs it.

Walumbe: Yes, the value of communities in building and shaping what is best for them rather than dictated to by, traditionally, the likes of us who come in and say...Self-management, for example. The criticism is that “self-management” as it's currently used in the UK, for example, has no specific meaning. And it's not useful because we're all using it as shorthand for different things. And the interesting thing for me is that for something that's supposed to be “self”-led, the practitioner community, so the multidisciplinary people – we have co-opted the idea. So now you have to come to *us* for us to tell *you* how to self-manage. And for the participants in my study that was just not useful at all and so they rejected it.



Evans: So, we all live in completely disparate conditions. Socioeconomic, racial, language, gender, all those things. That's who we are. And bringing people into, let's say, an NHS hospital, which suits the people *running* the service more than the people *needing* the service, that has to be changed.

Walumbe: Absolutely. Shifting the model so that we have a lot more grassroots, patient-centred – but maybe not “patient-centred” in the way we use it in healthcare – but having the patient, not the patient but a *person*, at the centre, with their community, *in* their community locally. So they don't have to travel vast distances and wait to invite *us* into their specific spaces. So I think more of that – yes, please.

Evans: That's Jackie Walumbe of University College London Hospitals NHS Trust. Well, Rethinking Pain is a community-based service for adults living with long term pain in Bradford District and Craven. The team work one to one and in groups to connect people living with persistent pain to appropriate pain information, including education, support and community-based activities. Mark Johnson is professor of pain and analgesia at the Centre for Pain Research, Leeds Beckett University. Kate Thompson is a physiotherapist, teaching and doing pain research also at Leeds Beckett University. But first we'll hear Kerry Page who is Programme Manager for the Rethinking Pain service.

Kerry Page: It's actually led by a charity called Keighley Healthy Living. They're a well-established charity in Keighley. They've been running for twenty-five years. And they were asked some time ago to pilot a new way of working with people with persistent pain from socioeconomically deprived backgrounds who may have learning and language skill deficiency, additional needs. And they were just asked by a courageous commissioner to see what happened if we did pain differently. So Rethinking Pain grew from there and it is a community-based pain support service which connects in with people's clinical care. We are clinically governed and we also work with our academic partners, so we're a multidisciplinary team. But for the person accessing the service, that's not so evident. They're accessed in their place and they're worked with in place. But they have that confidence and trust that we're

connected clinically to their GP and MSK service. We then work with them in terms of their individual needs, preferences and circumstances.

Evans: So how does that differ from other community pain management programmes, Kate?

Kate Thompson: Having worked myself in therapy led pain services previously, the difference I see with the Rethinking Pain programme is that it is truly de-medicalised and embedded in community settings, in community places. And what people experience when they access the service is a different set of rules to what they experience when they access therapy or a medically led pain service, in my experience.

Evans: What do you mean by “a different set of rules”?

Thompson: I think in a medical setting, in a clinical setting, the context that you're in facilitates the conversation about a medical or a clinical underlying driver to why you're experiencing pain, and the conversation therefore naturally goes that way. You're in a clinical setting with a clinician who's often in a clinical uniform, (*laughs*) and that's what you know in that setting, and that's what type of conversation you have. When you go to talk about your pain in *your place*, in *your community*, it's a different conversation about your pain.

Johnson: Pain is a context driven experience, right? As are all our human experiences. So if you go into a medical setting, the context in which your narrative's going to occur with the clinician is going to be medically oriented. If you're going to a community setting the narrative that you're going to have is going to be a more socially constructed narrative. And that's the difference for people who are living with pain; they're getting a *social narrative* that helps them move on. In the clinical setting often the narrative is about fixing pain, using medical interventions or even psychological interventions. And I think there's a bit of a mismatch going on there because we know that there's been a challenge in pain, in terms of the fact that none of these treatments actually do fix pain that's become *stuck*. So, it's the stickiness of pain that's the issue. Because we know that when a person has pain for a long time, they seem to



get stuck in it and they're looking for a biomedical, for example, quick fix, because that's what society has set us up to expect. But it ain't there. So we got loads and loads of treatments for pain but we've still got a massive problem with the prevalence of chronic pain. One in five people in the community have chronic pain. So all of these treatments are not fixing people's pain. And the National Health Service, Public Health England, suggest that we need to now shift the focus away from helping people, supporting people to recover and to live well with pain, to removing the context from it being within the health service to more embedded into a community setting. And that's what Rethinking Pain does. Which means the focus is much more about being a human, not about trying to fix pain. And *then* things start to happen.

Evans: So you're fixing people, you're not fixing pain.

Johnson: Well, I don't even like the word "fixing" people, because people are not broken. People are *being*. People are living and, and experiencing their lives. So one of the key things about pain is the meaning of pain. What does pain *mean*? So the social narrative at the moment is a biomedical narrative of pain meaning tissue damage, that can be fixed, and that you need to fight it. It's a war-mongering language. That war-mongering language puts people into a state of fight, flight, fright. And it's really interesting because it's that narrative which you find across the whole globe now. That narrative is gluing together lots of insidious forces out there in society that have vested interest in that narrative happening. Whether it be forces associated with, you know, some of the pharmaceutical or medical device industries, the health service itself... But also it's mismatched against the way that we're telling our, our patients to live well. So they need to exercise more, or eat better food. But actually, that's really hard to do! It's hard to do in a modern society. Because from an evolutionary perspective, we don't *like* exercise. We don't want to *move*! You know, we're trying to conserve energy, we get lots of pleasure doing that. What Rethinking Pain does is look at these sorts of issues from a completely different context, socially connecting people back into their



communities. Because we know that isolation is a problem and social connectedness is one of the answers.

Evans: So you're taking the *solution* to the person with pain rather than the person with pain having to come to the establishment.

Johnson: Yes, and the person with pain has the solution. That's the key, they produce the solution. It's a co-production. When you go into the health service, they expect the solution from someone else. So it's about empowering humans because *they* know the answer, actually. And that's the fascinating bit that I've become aware of. When you talk to normal humans, they know the answer and they know the answer isn't about quick fixes. Because they don't actually want to take the drugs. They don't *really* want to go into surgery often, especially when they're in a state of chronic pain and persistent pain. And that's what Kerry's team does.

Page: We're taking a service into their place and we're doing that not just through our team, but by connecting with community partners embedded across settings across Bradford. And some are *incredibly* difficult to access and to get those people talking to you about their pain. So, through the referral process, although trust is built via that referral process coming from their GP or an MSK service, that creates a trust between- the link between the voluntary community sector and that person. One of the things that comes up with non community-based pain services is time. And what we're finding out from people working with us is that the thing which is most important to them, every time more or less you talk to them, is having some time with somebody. Being *heard* and listened to and being able to tell their story. Those are fundamentally the most important things to them. And when I talk to a lot of clinicians and people working in the NHS, I understand their pressure and their time pressure. But I keep advocating to them that by connecting into their communities you're going to give that person time, just by creating networks and connections with others. And those people then might go to a social group and they have time with somebody. They may get some emotional well-being support. They may get some support and sleep. And it's kind of like you're creating- One of our clients said to us, "Kerry, it's like you've given me a

toolbox. And suddenly rather than just this one tool, I used to just have this one tool and that was my pills. Now I'm like, I've got all these different tools in my toolkit and I kind of understand I need to be dipping in and using all those tools to manage better." And also that conversation about what will help you, what do you think will help you? That coaching call and that support from their coach, really does genuinely – and the time they get - enable them to actually work out the solutions for themselves. And for some people, it's kind of quite rapid and they go, "Oh, it's that! Yeah, I've tried that, I already feel better!" For some people, we need to work with them for much longer. They may be more marginalised, lonely, isolated. Their confidence can be low. Their *trust* in systems that have been letting them down for years and years and years. A lot of them are *angry*. Their first conversation with the health coach is just *anger* and we just let them get that all out. Then when they've got that all out, we begin to work with them. So I think that's some of the difference, it's just that time and more intensive resource and support. Nobody wants to hear that, because it's more expensive. But actually, and I advocate for this all the time, is that by giving that resource now we're actually creating real sustained change for some individuals. You would be *astounded* – and I am genuinely *astounded* from the two pilots and from what's happening now – how many people who, from a first call, are not moving, at all – and are afraid to move - are going into sustained and regular movement opportunities. And really understanding that movement matters, and really feeding back to us on what movement has done for them. And probably a quarter of the people we've worked with in the last twelve months are now sustainably and regularly exercising. Which I just think is unbelievable, really.

Johnson: Well, just on the context though of that, if you go to a physiotherapist and you get some exercise, it's exercise *prescription*. It's already medicalised, right? The way that you want to get people to move is to do things like dance, yoga, gardening, stuff that we do that we enjoy, which is serving the tissue well. It's out of medical context.

Evans: It occurred to me when you were talking that you were talking about health *coaches*, not health professionals, not a physio coming in to tell you

something. A *coach* is somebody who works *with* you rather than delivers *at* you.

Page: Yes. So I've heard about some wonderful work that's going on in communities. But one of the things that strikes me continually is it's GP's saying, "I'm going into the community and I'm delivering X, Y and Z." I'm going to be honest with you – and our clinical team would tell you exactly the same - we set off on that track when we first set off. So we had this workshop, "Understanding Pain". "Understanding Pain" is just about organically working with people to say what pain is, how the body responds to pain. But the whole point of the session actually is to bring them to a point where they'll understand that medications might not be the answer. And we do have a tipping point where we try and introduce the idea of more holistic support. And at first we had GPs delivering that session. And they were brilliant at it! But it immediately medicalised the whole session. And after watching that session a few times I had a chat with the GPs on our team who was really, really well qualified to do this, you know, we have an educational expert in pain in our session. I said, "I think we should let our coaches deliver these sessions. Let's see what happens." And it transformed it. As soon as we didn't have the GP in the room, in terms of opening up the conversation, discussion, avenues for peer support, people connecting. And it took away that, sort of, angst about the NHS. For people in the room, trying to deliver a message about pain from a GP was just working against what we were trying to achieve. So now our health coaches deliver *all* of our workshops, and "Understanding Pain", and it seems to work much better for us.

Evans: Who are the health coaches? What fields do they come from?

Page: Our health coaches come from all kinds of fields, so being community based, we've got a former estate agent (*laughs*). We've got a former physiotherapist, people's social prescription. We have people with nutrition degrees, we've got people who did sports therapy, community workers, community engagement workers. So they're really from all kinds of fields and areas. I think when they've come into the service, we've done a lot of pain training with them and we actually use a lot of Pain Concern's resources with

our team as well. Again for things like trauma informed training, suicide prevention training, crisis management training, and we look at things like drug and alcohol misuse. Somebody else asked me from an NHS Trust just before I came in the room, “How would you train them?” And I said, “Well, we do pain but we do *all* the other things around it.” Because when people phone up, or when they're first phoned or contacted, it's not the pain they want to talk about. The pain is the dominant issue we're working with, but actually there's so many other things they want to talk about. So the team have really sort of, um, humanistic skills. The other thing we do, which is never popular with anybody, is we have a directory in Bradford of things that go on in Bradford that can support pain. And that is so wide and vast and varied, you know. It can be from a knit and natter group to drug and alcohol misuse. It can be from housing support, citizen advice to... laughing yoga. We never know what they're going to tell us about things happening! And you'd be amazed, laughing yoga is extremely popular.

Johnson: So you go to the GP and the GP may say, “OK, you need to get out a bit more, you need to eat a bit better, you need to go down your local gym, go to your local yoga session.” But do you know how hard it is to do that as an individual? The health coaches hold a person's hand and get them through the door and make them feel welcome. And that is *massive*, absolutely massive to get that connection back to the community in that way. It is about injecting the *humanness* back into humans because modern society is slowly sucking what makes a human out of being human. So I'm just in awe of the health coaches, I love them. They're doing a great job.

Thompson: In the previous projects that I worked on, in a previous study, I interviewed some people who'd been to a community-based intervention to help them with their pain. And one lady in particular, who – I particularly remember the interview – it took her three attempts to get through the door, because she was so anxious. I'm just picking up on what Mark said there. She'd got out of the car but she couldn't walk through the door because she was *so anxious* about what would happen. The health coaches are really critical for that, in giving people the confidence to make their own choices, to

do these things. I think there's *choice* that people get in what they want to go to, but they're given the confidence to do that. But those tools then don't disappear. They *are* community assets. Maybe you're not on the Rethinking Pain books anymore, but all those community assets are still there and people know them and they've got confidence to go to them. Or maybe a bit of confidence to try something else that they would then not have been able to do previously.

Johnson: This model is something that the community generally - the pain community, the science community, the clinical community - have been wanting for a long time. We've been talking about biopsychosocial for a long time. And the challenge has always been scalability, you know, and scaling up and how to operationalise this. Well, Public Health England have got two reports out that were actually produced by health promotion members of Leeds Beckett. They outline how you put a community-centred public health approach together and then roll it out and make it scalable. They've been doing it for obesity. I think we should be doing it for pain. With obesity we talk about obesogenic environments. With pain I think we should talk about... "painogenic" environments. The way to overcome that and to help people live in these environments is to give them community support. So the Public Health England reports have a number of principles for actually operationalising these types of services. Some of the principles are around co-production of solutions with communities, which is what Rethinking Pain does, and redesigning the system and shifting the mindset, which is what Rethinking Pain does. Bold leadership to adapt radical approaches - that's what Rethinking Pain does. And collective bravery by everybody involved, for taking the sort of risks of changing the status quo. And that's what Rethinking Pain is doing.

Page: I think one of the important things with Rethinking Pain was when we started to plan for this work, Keighley Healthy Living, were able to - as a voluntary community sector - were built *into* the funding and the planning and the proposal. They weren't an afterthought. They needed to be thought of right at the start and to be thought of as equal partners. And what they

could achieve for the programme and the clinical priorities that were there as well as they could go out into their community. They could connect with their community. They knew it and they could connect with other organisations. And if they didn't know them already they could go and *find* the other organisations who could achieve some of the work we're doing. Especially for example we're now delivering some of our workshops and "Understanding Pain" in mosques. We're delivering it in multiple languages. We're delivering it to varied age groups, and that's what an organisation like Keighley Healthy Living can do.

Evans: Speaking there were Kate Thompson and Mark Johnson, both of Leeds Beckett University, and Kerry Page of the Rethinking Pain service. And you can find out more about Rethinking Pain at the website, which is rethinkingpain.org.

As in every edition of Airing Pain I'd like to remind you of the small print, that whilst we in Pain Concern believe the information and opinions on Airing Pain are accurate and sound based on the best judgments available, you should always consult *your* health professionals on any matter relating to your health and well-being. They're the only people who know you and your circumstances and therefore the appropriate action to take on your behalf.

Now, it's important for us at Pain Concern to have your feedback on these podcasts so that we know that what we're doing is relevant and useful, and to know what we're doing well and maybe not so well. So do please leave your comments or ratings on whichever platform you're listening to this on, or on the Pain Concern website of course, which is painconcern.org.uk. That will help us develop and plan future editions of Airing Pain. But to end this edition of Airing Pain, last words to the Rethinking Pain team.

Page: One of the gentlemen in our service who's become, you know, a peer support person and an advocate for the service, he was so grateful for the work his GP had done with him. But he said when he came into Rethinking Pain, it suddenly felt like he was being held and supported by many hands.



Thompson: This is what we do (*laughs*) in the volunteer community sector. This is our skill set and this is what we're good at.

End

Transcribed by Cara Manning

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