CHRONIC PAIN IN WESTON SUPER MARE

A health and care practitioner engagement event (10.6.25) report

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Executive Summary

This report summarises discussions by health and care professionals involved in chronic pain at a BNSSG ICB funded engagement event held in the For All Healthy Living Centre, Weston-Super-Mare on 10th June 2025.

Key points

- Concerns about the current state of care for chronic pain and need for improvement were raised.
- Agreed ultimate goals are to 1) improve the quality of life of all living with chronic pain within the Weston-Super Mare and Worle region, and 2) improve collaboration between providers within and across NHS and other organisations.
- Three themes emerged:
    - Community driven, patient centred, and integrated care
    - Increasing education and awareness about chronic pain
    - Medication prescribing and polypharmacy management

  (See Fig. 1)

- Quick wins were identified as sharing best practice through practitioner forums, involving patient experts in care, and better utilising community resources.

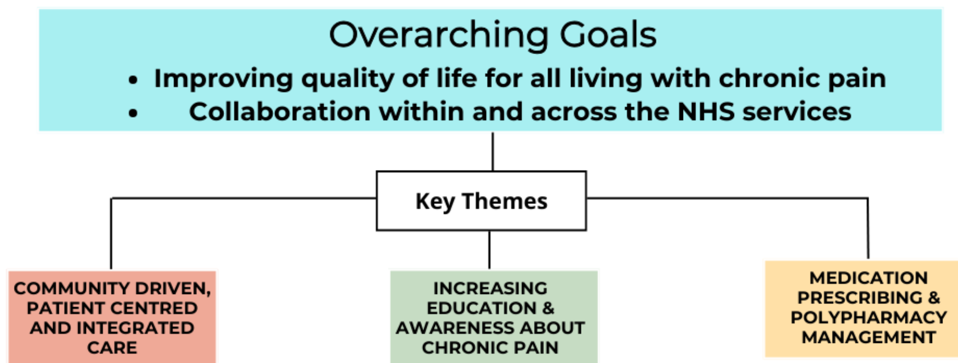

Figure 1. Overarching goals and themes

For further theme details see pages 3-8

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Detailed Report

Methodology

This information was gathered during an engagement event at the For All Healthy Living Centre in Weston-super-Mare (WSM) on 10th June 2025. Health and care professionals working in chronic pain were invited through professional networks to attend an event focused on improving outcomes for patients in Weston, Worle and Villages. Contributors (n = 15, 2 facilitators) came from a range of professions, including general practitioners, social prescribers, and nurses, and settings, primary care, secondary care, and allied sectors (see Fig. 2 A & B for details).

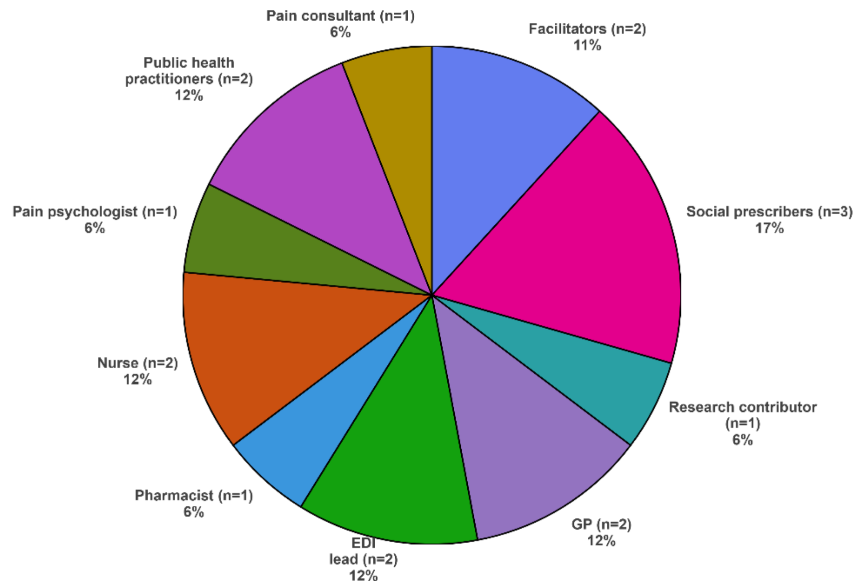

Figure 2A. Contributors by Profession

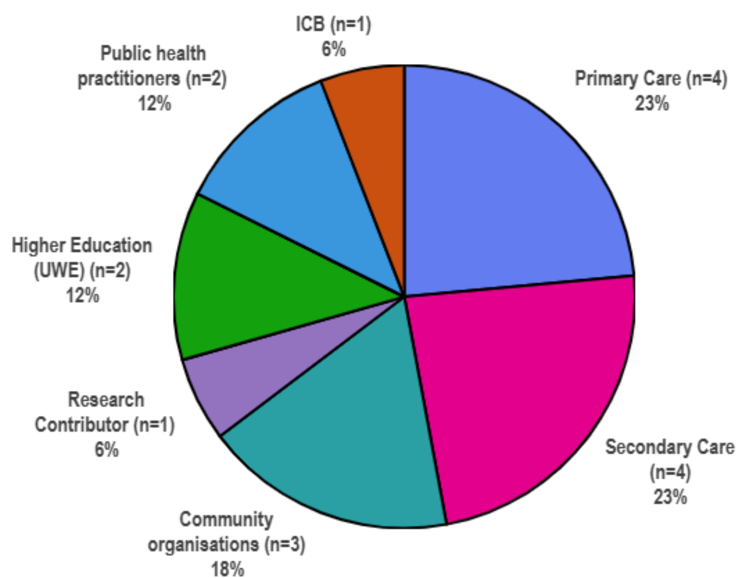

Figure 2B. Contributors by Setting

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The data was collected in two stages.

- The first stage utilised an online question and answer platform (Mentimeter) where attendees anonymously responded to relevant questions about chronic pain in WSM.
- The second stage involved a small-group based workshop.
  - Attendees were assigned to one of three groups based on their interest and expertise, with efforts to ensure diversity in professional backgrounds and practice areas.
  - Each group (A, B, and M) discussed responses from stage one relevant to their group topic and explored potential solutions.
  - Group A focused on quick, achievable wins and challenges to implementing them; Group B explored developing an alternative patient pathway; and Group M examined medication use and polypharmacy.

The session was audio-recorded and transcribed verbatim. Key themes from the Mentimeter responses and transcripts are summarised here, with workshop quotes presented in italics. For a detailed thematic map see Figure 3.

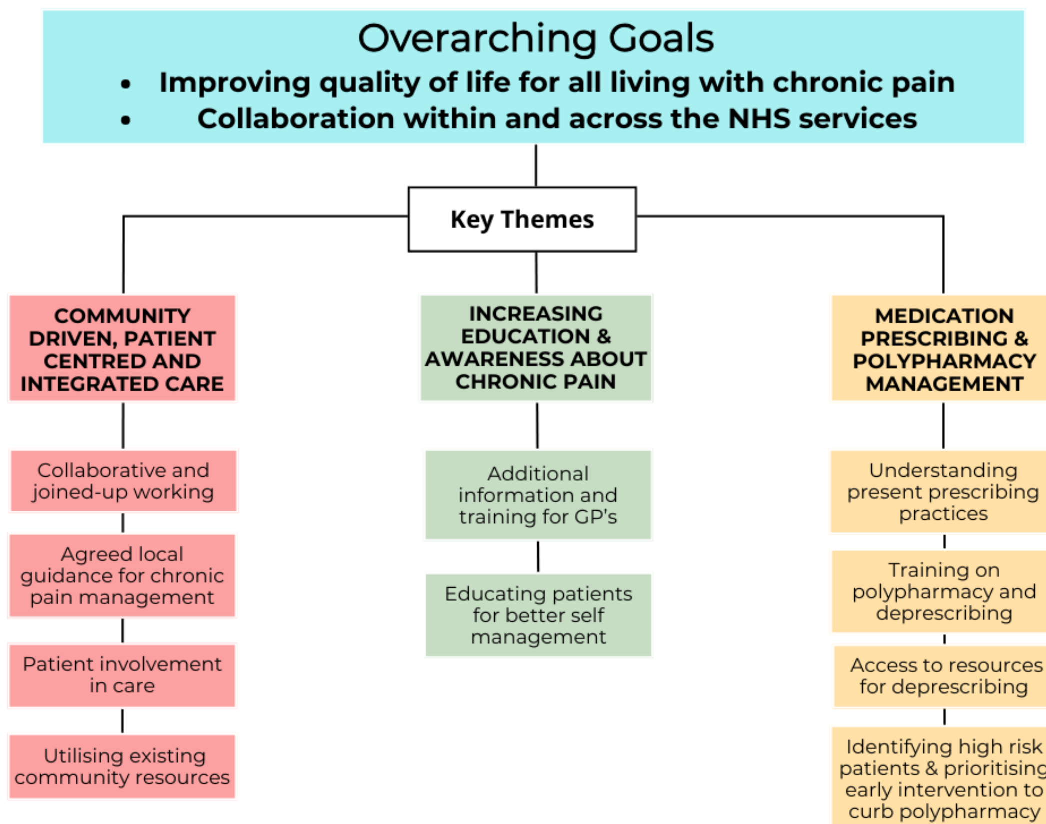

Figure 3. Overarching goals and detailed themes generated from the event

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Overarching goals

Improving quality of life for those living with chronic pain – improving patient lives in WSM can be brought about by raising awareness, increasing patient involvement, reducing health inequalities, and promoting non-pharmacological options. Contributors highlighted a lack of practitioner training, limited patient understanding, and the need for non-pharmacological patient pathways.

Greater collaboration – Improving collaboration and joined up working across and between primary care, secondary care and community organisations will improve patient outcomes. Care was described as fragmented, which patients found difficult to navigate and unsupportive. Utilising multidisciplinary teams in managing pain would provide more holistic care and reduce reliance on pain medication.

Theme 1: Community Driven, Patient Centred, and Integrated Care

Collaborative and joined up working: The fragmented nature of care within primary care and beyond was a recurring concern. Contributors emphasised the need to strengthen regional networks. Voluntary, community, and social enterprise (VCSE) organisations were seen as valuable providers for quicker, low-cost, or free services close to patients. Improved coordination between primary care, social prescribing, and pain management was emphasised to provide wraparound support. A hub for all pain management services and resources, such as a dedicated website or community hub, was recommended

“I think for me it's that joined upness in this of of, of in secondary care being able to make use of all those different resources ... it's about everybody knowing.” (Group A)

Agreed local guidance for chronic pain management: Contributors highlighted that GPs could provide limited support to patients without best practice guidelines to manage chronic pain. This resulted in a stronger reliance on medication and the traditional medical model. Attendees proposed developing local guidance that prioritises non-pharmaceutical approaches such as pain education and community support groups as the first line of treatment.

Patient involvement in care: Codesigning a pathway with patients was the main approach to improving services in Weston. Involving expert patients to share their success stories was also emphasised. Attendees noted that patient involvement and peer support could help advance new initiatives like the Pain Cafe, enhancing its sustainability, scalability, and reach in WSM.

"They were the most popular people for facilitating care because they live with … experience... they were going through hideous treatments... and had experience with it". (Group B)

"Peer support... that's the buy in... makes you feel better, understood, different and takes the shame away" (Group A)

However, some attendees also noted potential barriers. For instance, social prescribers reported patients’ reluctance to try non-pharmacological options or engage with their team.

"a lot of clients feel that they've been fobbed off by coming through to our team (Social Prescribers). They think they dont know what else to do with me, so they put me through to your team" (Group B)

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This highlighted the need for GPs to contextualise the role of social prescribers for their patients. Greater patient involvement in care would help them understand such referrals better.

[Patients should] "understand that it's for them to be empowered to actually manage it" [rather than putting their lives on hold waiting for appointments.] (Group A)

Locally driven pain management utilising existing resources: A unified point of access for pain management services and resources was recommended to simplify the patient journey. Redistributing patient engagement tasks (such as pain education) towards community resources and social prescribers was discussed to ease pressure on specialist services and GPs. The idea of a "community hub" was emphasised, offering patients access to multiple services in one location instead of navigating referrals between providers.

"It's like a community hub would work really well... if they are labelled as a chronic pain hub then all of us working that hub, yeah" (Group A)

"They don't feel like they're being really listened to... they're just being passed from pillar to post" (Group A)

Theme 2: Increasing Education and Awareness About Chronic Pain

Additional information and training for GPs: It was felt that GPs require training and updates on how to manage chronic pain effectively. Presently, the onus is on GPs to keep themselves informed about chronic pain management, which is difficult considering their workload. Practices or Practice 'Champions' need to support clinicians with training. Moving away from the biomedical approach and emphasising a more psychosocial approach with support was stated as being important for effective pain management. GPs will need support to keep up with local resources for pain management. This was envisioned as a centralised resource hub.

"Not everybody knows about the non-pharmacological type of options that are available" (Group M)

Educating patients for better self-management: Attendees highlighted the need for clear and accessible patient education and engagement strategies, including information sessions, and websites. Patients lacked resources to understand their pain, leading to an overreliance on medication. Providing resources at diagnosis could help set expectations and improve patients' quality of life. Equipping patients with information about pain management options and community support groups would help patients engage with social prescribers better and could be an important "quick win". Creating inclusive resources available in written and audio or visual formats and showcasing success stories of people living well with chronic pain without medications, was also discussed.

"it's about patients having impact and being empowered to access the bits that they need" (Group A)

Theme 3: Medication Prescribing and Polypharmacy Management

Improving Prescribing Practices: Attendees raised concerns about the high use of medication for chronic pain management. Audits are needed to help GP practices understand prescribing patterns and their impact on patients. Contributors noted that prescriptions were often given without considering drug interactions.

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Despite growing evidence of limited effectiveness, medication continued to be used as a long-term solution for chronic pain.

"You need to have a feedback loop... And there's somewhere to go back to when things go awry." (Group M)

Training on Polypharmacy and Deprescribing: Additional training for practitioners was deemed necessary to curb polypharmacy. Attendees reported that GPs lack confidence in helping patients taper their medication use. Social prescribers and GPs were identified as potential initiators of conversations around medication reduction. However, they require support to initiate discussions with patients and to create safe, effective deprescribing plans. Social prescribers may require additional support from the GP to contextualise their expertise and promote patient buy in.

"I think it's just getting an idea about the confidence of the titration as well" (Group M)

"[if a] GP is doing it they'll need to lean on the social prescriber, particularly for the time to have those [conversations about medication reduction] because they take much longer than 10 minutes" (Group M)

Access to Resources for Deprescribing: Structured programmes to support the deprescribing process, including clear guidance and protocols on starting and navigating the journey are needed. These would help healthcare providers feel more confident in initiating conversations and provide a clear framework to follow. Access to and support with using digital tools like calculators for polypharmacy were also suggested.

"I guess the more patients you get going through this [Deprescribing] programme, you can see the benefits. The clinician then feels more confident when new people are started on it" (Group M)

Identifying high risk patients & prioritising early intervention to curb polypharmacy: Identifying high-risk patients on multiple medications was expressed as an important first step in the deprescribing process. Once identified, supporting patients to engage with alternative treatments and reducing medication use was seen as essential.

Limiting medication use from the beginning is less time- and resource-intensive than tapering later. Multidisciplinary teams (MDT) and community-based resources to provide education on self-managing chronic pain were suggested as effective first-line approaches.

"When they're just starting to experience pain and need a bit of getting on the right track before, they even start going up [the medication ladder]" (Group M)

"Regular chronic pain information sessions one every month" "multi-disciplinary team... various people around it" (Group A)

Current Chronic Pain Service Initiatives

Pain Café –this BNSSG ICB RCF has contributed to the funding of a yearlong pilot Pain Café in WSM; following its success in Devon and Cornwall. Pain Cafés are peer-led spaces for people living with pain to come together and discuss evidence-based self-management strategies, connect with others and share experiences. This Pain Café is presently referral only and led by two social prescribers, Alison Polden & Jaqui Reeves under the guidance of Dr. Eleanor Holmes. However, it aims to become a peer-led, scalable,

and sustainable resource for the region with suitable funding. Presently, it is held at the For All Healthy Living Centre in WSM and is available to patients from the Horizon practices.

Pain Management Programme – This programme has recently launched in WSM through the UHBW Trust and is being led by Physiotherapist Owen Grant and Pain Psychologist Dr. Marianne Nolan. The programme uses evidence-based techniques like graded exposure and behavioural activation to help patients accept their new circumstances and live well with pain. The programme is presently referral only via UHBW Pain Clinic, secondary care.

Weston Pain Forum and Case Conference– Led by UHBW Pain Consultant Dr. Krisztina Kenesey, the forum provides an interface for primary and secondary care to discuss complex cases and share advice and good practice for pain management. Clinicians are from a range of backgrounds (like GPs, Nurses, secondary care professionals, pharmacists etc.). The forum has been running since 2024 and has received positive feedback from attendees.

Additional Resources: During the event attendees shared additional resources such as a the Wellbeing house in North Somerset (See Appendix A) and "Gabapentinoids Policy: Clinical prescribing, monitoring, and management" document created by Nurse Kerri Bradley, Advanced Mental Health Lead. This extensive document aims to improve gabapentinoid prescribing and highlights risks associated with use.

Suggested actions

The management of chronic pain in WSM is not serving patients effectively. The following actions were suggested. Attendees stressed the importance of co-creation and involving patients to ensure the success of future initiatives. Recommendations are not listed in any particular order.

Creation of a resource hub - Creating awareness of community-based resources and collating up to date options in the form of a website or in person space was discussed as a potential intervention. Practitioners could direct patients to this hub, or patients can access it themselves.

Multidisciplinary Forum - A periodic MDT forum for patients could be introduced to help patients better understand their condition. This would serve as a one-stop shop for patients to meet health professionals, discuss their case, and connect with peers. Including pharmacists and physiotherapists in the MDT could also help reduce polypharmacy.

Training practitioners to manage pain better – Moving away from the medical model was a strong theme throughout the event. To support this, practitioners require education and training focused specifically on chronic pain. GP practices should prioritise continuing professional development for their staff and ensure it is regularly updated. Additional support could include specialist-led talks or pain forums to discuss case management and share best practices.

Conclusions

Chronic pain in WSM is not managed as effectively as it could be. This event highlights the need for community driven changes to improve chronic pain management in WSM. The primary needs identified are improving integration across care providers and prioritising patient centred care; increasing education and awareness about chronic pain; and improving medication prescribing and polypharmacy management. Attendees also recommended ways to begin bridging these gaps. These include creating in person or online resource hubs, multidisciplinary forums for patients to discuss their condition and care, and additional training and tools for practitioners to improve their knowledge of chronic pain management. Considering these findings, the facilitators identified next steps as follows.

Next Steps

- Further consultation with healthcare providers to prioritise themes.
- Community engagement sessions with people with chronic pain living in the WSM region to explore experiences and priorities (17.9.2025).
- Consolidating patient and healthcare professionals' priorities to strategise future directions.
- Consolidating themes and priorities from engagement events with the aim of applying for stage 2 RCF BNSSG ICB funding in January 2026.

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Appendix A

Resources shared at the event

Wellbeing House North Somerset

A retreat where people can enhance their mental and emotional wellbeing

What is the Wellbeing House?

The Wellbeing House North Somerset is a spacious property in a beautiful, quiet village, where people can stay if they're experiencing low mood or a decline in their wellbeing. The retreat provides a free seven-day respite stay from Monday to Monday for anyone who lives in North Somerset.

We support people to stabilise themselves by providing mental health and wellbeing tools, one-to-one listening support, and weekly activities for those who want to take part. This is not a clinical service and people do not need a medical diagnosis to attend. It's a supportive, restful experience to promote self care and independence. People can return up to four times in a year, should they wish to.

How does it work?

We offer support to people throughout their stay, with our support workers on hand during office hours. We can help people recognise and develop their own strategies for crisis prevention and management. We provide comprehensive information about other available services, making referrals where appropriate.

What do we hope to achieve?

We use the 'Five Ways to Wellbeing' (Be active, Take notice, Give, Connect & Keep learning) to help people create simple ways to improve their mental health, while providing a calm, comforting space to relax and collect their thoughts.

How is it accessed?

To be eligible to stay for seven days – Monday to Monday – free of charge, people must:

- be aged 18 or over at the point of stay
- be a resident of North Somerset or be registered with a GP there
- have a home to return to after a seven-day stay (14-day stays may be offered, subject to availability)
- not currently demonstrate crisis behaviours that can put themselves or others staying at risk
- be mindful and respectful of others
- have their own coping strategies and support structures in place, as staff may not be on site every day
- be able to positively benefit from a period of peace, calm and additional support
- be able to share facilities, such as a kitchen and a bathroom (they will have their own lockable bedroom)
- be free from the influence of alcohol or drugs during their stay
- be capable of personal self-care and preparing and cooking their own meals
- be able to manage and take their own medications, or have support in place that can help them with this.

We encourage all health and social care professionals to refer people to the Wellbeing House. People are also able to self-refer.

Scan QR code to email us.

For more information give us a call on: 0300 123 2466
email: wellbeinghouse.northsomerset@curo-group.co.uk
or visit our website: curo-group.co.uk/wellbeing

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