

# Pain: Equality of Care and Support in the Community (PEACS)

Year One  
Report

November 2023

**StockWellBeing**  
PRIMARY CARE NETWORK



KHP   
**Mind & Body**

## A Bio-Psycho-Social Approach to Chronic Pain

Delivered in partnership between Stockwellbeing Primary Care Network, Thriving Stockwell, King's Health Partners Mind & Body Programme, and Comuzi. Funded by Impact on Urban Health.

### Dedication

The success of the project would not have been possible without the commitment and engagement from the patients. This process began with lived experience involvement, and we will continue to honour this as part of our long-term commitment to supporting local people with chronic pain.



[Pain: Equality of care and support in the community \(PEACS\) workshop in Lambeth - YouTube](#)



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- Mind & Body – Research and Evaluation Team
- Centre for Active Lifestyle Management (CALM)

Special thanks to our Funders:

Impact on Urban Health

Special thanks to our patients:

Finally, a huge thank you to all of the patients that participated in the programme. Your involvement, participation and engagement made this a huge success. Thank you all for being our guiding light, and for giving our work purpose.



## Foreword by Dr Mike Dilley, Dr Siobhan Gee, and Prof Mark Edwards, Clinical and Academic Directors, Mind & Body Programme

The Mind & Body programme advocates for the integration of mental and physical healthcare, and for all individuals to be offered holistic whole person care. We know that those with physical long-term conditions and those with serious mental illness face barriers to accessing the support that they need with their respective mental and physical healthcare needs and have poorer outcomes. We also know that addressing the mental health needs of those with physical conditions and addressing the physical health needs of those with mental health conditions improves their quality of life. Additionally, we recognise that healthcare systems and services are often not designed to acknowledge and support the cultural and individual needs of marginalised groups.

The PEACS programme has proactively set out to be different – in both its approach and delivery.

First, and most importantly, central to all elements of the project has been incorporating the voice of people living with chronic pain, in particular those from Black communities living with chronic pain. Based in Lambeth, PEACS acknowledges the disparities for Black women living with chronic pain in Lambeth compared to the general population of Lambeth. PEACS therefore proactively set out to amplify those voices throughout its co-design and its delivery.

Second, the PEACS pathway has been explicitly built on a Bio-Psycho-Social foundation to healthcare and the lifestyle medicine framework. Therefore, all participants have their health and lifestyle needs considered as part of the support that they receive, with topics such as nutrition, movement, and trauma, all covered as part of the intervention workshops.

Third, this has been a true collaboration between primary care, secondary care, and community organisations. We know that we cannot make improvements to people's health unless we work together across organisational boundaries.

The impact of adopting this new approach has been extremely positive. Participants have consistently praised the project, highlighting the impact it has had on their engagement with healthcare services, their building of relationships and their feelings of empowerment. We have also seen positive health outcomes relating to increased knowledge, better self-management, improved social connections and better quality of life measures reported.

As we look ahead, we're excited about what can be achieved in the second year of delivery. There will be a particular focus on creating a sustainable model, embedding the PEACS approach further into primary care and ensuring that the key elements of the project can be taken forward as standard practice, as well as identifying how the learning from this project can be spread to supporting people with other long term health conditions.

We offer a huge thank you to all that have been involved in delivery of the project, with a particular thanks to those living with chronic pain who have continued to shape and direct delivery, offering suggestions for improvement and openly sharing their experiences.



## Foreword by Joseph Casey, Director of Partnerships and Programmes, King's Health Partners

Our mission and hope as King's Health Partners is to work with people from across the breadth of our local communities, and health and care systems (including statutory, voluntary, community, charity, and academic partners) to improve health outcomes for all. I genuinely believe the PEACS programme is an exemplar of how we could and should be working together to improve the health outcomes that matter most to people.

There are many aspects of the PEACS programme that I could highlight. However, I have chosen to focus on two that I think should continue to inform our work within all that we do at King's Health Partners:

- **Focusing on what matters most to people:** PEACS was established in response to people from Black communities experiencing higher prevalence of chronic pain. By embedding listening and learning in delivery they have been able to create and embed an approach that responds directly to the needs of the local population.
- **Valuing experience and expertise in codesign:** Critically, co-design was embedded in the work from project conception. We worked with experts by experience to further understand and define the challenges the project is seeking to address and the opportunities to improve people's outcomes and experience.

The PEACS project has not only been informed by the work of the Mind & Body programme at King's Health Partners, but it also has and will continue to inform our commitment to integrate mental and physical health in everything we do.

I would like to acknowledge and thank all the people and organisations whose hard work, commitment and support has made this project possible.





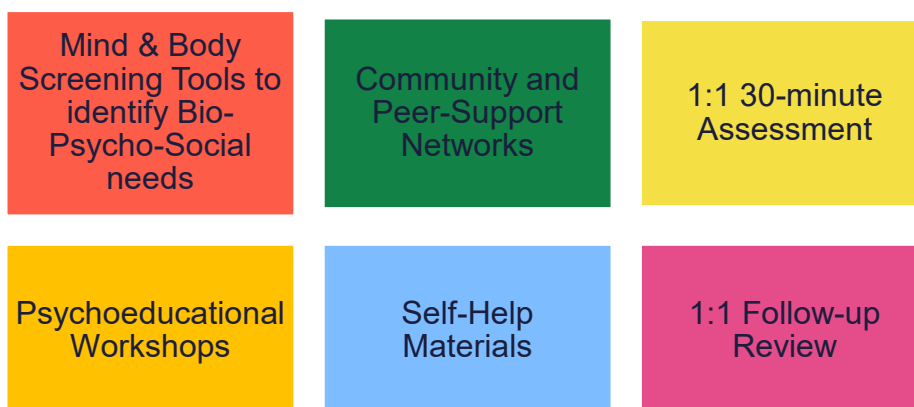
## Executive Summary

The Pain: Equality of Care and Support in the Community programme (PEACS) was established to provide an alternative solution to supporting people living with chronic pain, and particularly those from Black backgrounds. People living with chronic pain, and in particular Black people, have unacceptably poor outcomes compared to those of white people, caused by a number of interrelated and consequential barriers around accessing and receiving care. Unlike more traditional approaches, the PEACS model was developed using Bio-Psycho-Social and Lifestyle Medicine Frameworks, to equip patients with the necessary skills and knowledge to allow them to better manage their experience of living with chronic pain.

In order for us to truly understand the needs of the Black community living with chronic pain, we worked with a Black-led design agency to codesign the pathway. During this work we centred the voices of people from Black communities bringing the lived experiences of local people together to help codesign valuable solutions to a very complex and challenging problem. This allowed the project team to better understand the issues and challenges they experience within the healthcare system, with the intention of creating a more appropriate approach that addresses these barriers and responds to the key factors around access, experience, and outcomes.

Working with patients living with chronic pain, their carers, and expert clinicians, we codesigned PEACS, and have now successfully delivered the service across five GP practices supporting a total of 597 people.

The codesign process allowed us to develop an end-to-end pathway allowing patients to receive comprehensive care in a more structured and uniform way. The pathway is built on the foundations of holistic care, and involves a number of key elements including:



The pathway has been externally evaluated by the Tavistock Institute of Human Relations (TiHR), working in collaboration with King's Health Partners and Stockwellbeing Primary Care Network (PCN) to understand the impact and effectiveness of the intervention.

Analysis of both quantitative and qualitative data demonstrated that;

- Patients felt less isolated as a result of their participation;
- Patients naturally developed peer-support networks and a sense of community;
- Patients relationship with their pain had positively changed as a result of their participation;
- Patients felt an increased sense of knowledge about chronic pain;
- Patients developed new skills and techniques to better manage their chronic pain.

A number of lessons have been learned throughout delivery in year one. We are committed to continually improving and enhancing the quality of the pathway and proactively engage in continuous formal learning cycles. As a result recommendations have been formulated with the help of our experts by experience and evaluation partners, TiHR, and have been embedded into our year two strategy. These can be summarised as follows:

- Revisit the overarching aims and scope of the project in the context of time and resource;
- Increase opportunities for peer-support and small group discussion;
- Better practical support on accessing voluntary, community, and social activities;
- Improved clarity around roles and responsibilities, and investment into existing roles across primary care, e.g. social prescribers and health coaches;
- Wider engagement and focus on sustainability, replication, and scaling out of the model.

This has been an incredibly successful year for the PEACS programme. Our ongoing conversations with patients, in combination with independent evaluation data has demonstrated the positive effect that the pathway has had on the lives of local people living with chronic pain. Patient involvement is the foundation of this project, and we have been determined for black patients, specifically, not to be excluded through a top-down approach that further perpetuates the structural racism that we know exists within healthcare provision and creates barriers to access and positive outcomes. In the beginning, through the codesign work, we saw the vulnerability of this patient group and how many struggled with feelings of isolation and helplessness, coupled with mistrust of health care services. It has since been encouraging to see the value of this programme as patients have reported a reduction in feelings of loneliness, along with an increased sense of knowledge about their pain in relationship to wider social, emotional and





behavioural factors, and skills that will ultimately support them to being able to lead more fulfilling, more autonomous lifestyles.



## Report Overview

The purpose of this report is to capture the evolution of the PEACS programme. The report will outline the background and context to our work, describe the codesign and implementation phases, and then finish by describing some of the early findings from year one, key reflections and conclusions, before exploring recommendations for year two. Below is a brief overview of each section.

### ➤ Introduction

The introductory section is there to set the scene. It provides an overview of the project, intended aims and objectives, and highlights the values that structured our work.

### ➤ Codesign Phase

This section of the report provides a detailed summary of the scoping phase of the programme. It describes the stages of the codesign process and includes extracts from the transcripts used from patients, carers, and clinicians that helped provide valuable insight into the key issues and challenges facing those living or working with chronic pain. Also within this section we highlight some of the key outputs that were developed as a result of the codesign work, which helped shaped and strengthen our overall approach.

### ➤ PEACS Pathway

This section provides a comprehensive look at the end-to-end pathway, the different stages and activities involved.

### ➤ Implementation

This portion of the report provides an outline of the mobilisation process for year one. It explores activities associated with the implementation of the pathway across primary care and in the community, and highlights how year one was structured and delivered. It then provides more detail around some of the intricacies and opportunities of patient engagement.

### ➤ Impact and Outcomes

The purpose of this section is to lay out the findings from year one as they relate to patient experience and outcomes. The information in this section is taken from a number of data sources. These include; detailed qualitative and quantitative data analysis gathered by Tavistock Institute of Human Relations [TiHR] who are carrying out an independent evaluation of the project, as well as analysis carried out by the project team gathered from business-as-usual operations as part of the programme.



### ➤ Project Evaluation

This section seeks to review the key learnings taken from year one of delivery. It begins with a short summary reviewing the year, and then moves into discussing some of the key reflections. It draws on insights gathered from TiHR, programme governance and ongoing conversations amongst the project and delivery teams, as well as pieces of feedback taken from key stakeholders and our experts by experience group. It is intended to be transparent, identifying the areas of improvement and those that are in consideration for year two.

### ➤ Looking Ahead

Here, we outline our current position and what we want to achieve within year two. It considers key recommendations as identified by TiHR, in addition to suggestions made by patients that participated in year one. It outlines our vision for the next year of the programme and how we aim to ensure its sustainability for the future.

### ➤ Conclusion

The purpose of this section is to conclude the report, finishing off with a sentiment with one of our experts by experience.

### ➤ Team Reflections

This outlines individual reflections, thoughts and feelings regarding year one from members of the team.



## Introduction

### ➤ Project Overview

**“The first doctor I talked to said that the pain can be all in the patient head. So I was so upset that day, that when I came home, I started crying because the pain is so real. The pain is so there.” Patient [Rebecca]**

This is the reality of many people living with chronic pain today. The Pain: Equality of Care and Support in the Community (PEACS) programme was codesigned in order to better support the needs of people living with chronic pain, and particularly people from Black communities living with chronic pain. We know that structural racism exists within healthcare services and that the lack of culturally appropriate services can lead to poorer access, experience, and outcomes for Black communities. This contributes to mistrust of professionals and services. There are several additional challenges that influence these outcomes including difficulties with navigating the system, understanding rights and being able to challenge or call out poor standards of care, as well as considerable historical issues related to the mistreatment of Black people to benefit western medicine that contribute to an overall feeling of distrust and medical scepticism. PEACS aims to improve health outcomes for patients by conceptualising chronic pain within a bio-psycho-social model and within a culturally appropriate framework that supports patients to develop essential knowledge and skills to improve self-management. Additionally, the programme intends to:

- Codesign a holistic approach which understands, identifies, and supports people’s holistic needs, to achieve better health outcomes and enhance their healthcare experience.
- Test the effectiveness and feasibility of the approach in being able to address inequalities and understand the impact on outcomes experienced by Black people living with chronic pain.

### ➤ Context

Funded by Impact on Urban Health, a charity supporting disadvantaged people living within inner cities, the Mind & Body programme at King’s Health Partners, partnered with Stockwellbeing PCN, to design a new approach to supporting local people living with this very challenging and sometimes debilitating condition. People living with chronic pain, and in particular Black people living with chronic pain, have unacceptably poor outcomes and suffer disproportionately. This is represented across the United Kingdom but is amplified when we look more locally across Lambeth, specifically; 34% of black women in Lambeth live with chronic pain, compared to 18.3% of the black ethnicity male population and 19.8% of white females (Ashworth, 2022).



## ➤ Activity

PEACS aims to shift the conversation away from a traditional biomedical focus to treating chronic pain. It is the first local pathway codesigned to produce real-world interventions by drawing on a bio-psycho-social and lifestyle medicine approach. By delivering the pathway across primary care and the community, we were able to make the intervention more accessible as a holistic community-based offer, bringing greater awareness to some of the very complex health and lifestyle challenges faced by this patient group, and breaking down some of those barriers that are typically faced by marginalised communities.

Patients are able to engage with the pathway in several different ways depending on personal choice, previous experience with similar initiatives and/or other prior commitments. Whilst many have participated in every stage of the pathway, from onboarding and assessment to the intervention workshops and follow-up reviews, for many others their engagement fluctuated at different stages. Acknowledging these variances, we coproduced a unique toolkit specifically designed for all patients on the pathway which has proved to be a valuable resource. The toolkit gives patients the opportunity to review content and information as it relates to the intervention; space for them to actively reflect on what they have learned; a place to record any goals; and aims to empower them to take more ownership in managing their health to maximize their overall wellbeing.

During the first year of delivery which concluded in September 2023, PEACS supported a total of 597 people across Lambeth living with chronic pain. Of those, 296 were from Black communities. Although we have supported many through our pathway, there is still a lot of work to do to create genuine change across our local systems. We are very proud of what we have achieved in our first year but do not underestimate that supporting patients with chronic pain needs to be a long-term commitment and priority.

**“I think sometimes the patients, because they've been passed around quite a lot, because they've had this for a long time, they're very stuck and not sure what to do”**

**– Acupuncture Specialist.**



## Our Values

PEACS was established in 2022 and is delivered in collaboration with primary care and community services within south east London. We are a multidisciplinary team of healthcare professionals, clinicians, community champions, and project managers. We have different areas of expertise, and we are all passionate about promoting a mind and body approach to healthcare and providing person-centered support that takes into account both physical and mental health needs at all times. Both the delivery and project teams are made up of people who live locally, use local services, and come from diverse backgrounds. Having diverse representation on the team, but also amongst our delivery partners, was a significant priority and helped bridge the gap between patients and those delivering the intervention. To help maintain this authenticity, we have codeveloped a set of values that act as the framework for what we set out to achieve. Our values are as follows:

- › **Providing Person-Centred Care:** Respecting the needs of the communities we work with and providing equitable solutions to their care and treatment;
- › **Dissolving barriers and Improving Access:** Delivering an inclusive and comprehensive provision of services from beginning to end;
- › **Being Bold and Brave:** Shifting the conversation around chronic pain from a biomedical focus to social and lifestyle factors, using culturally appropriate interventions;
- › **Making Space:** For collaboration and innovation.

Our values shape the way we work. They allow us to work effectively as a team and alongside patients as equals to be able to provide better, more integrated care.







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## Meet the team



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## Literature Review

### ➤ UK and Global Research

Chronic Pain is an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage, and that persists or recurs for more than three months. Chronic pain is one of the most prevalent conditions and affects between one-third and one-half of the population of the UK (approximately 28 million adults). Chronic pain is disproportionately experienced by people from lower socioeconomic backgrounds with those living in the most deprived areas twice as likely to experience chronic pain (30%) compared to those in the least deprived areas (15%) (*Chronic Pain in England: Unseen, Unequal, Unfair, n.d.*). More women experience pain than men. Black people are more likely to experience chronic pain (44%) than people from other ethnic backgrounds such as White people (35%) or Asian people (34%) or those from mixed ethnicities (34%) (*Chronic Pain in England: Unseen, Unequal, Unfair, n.d.*). (Shoenthaler & Williams, 2022) highlighted that the disparities between Black communities living with chronic pain and other ethnicities is multifactorial, identifying that racism and discrimination are an important factor, as well as other socio-demographic factors. To supplement this understanding of the disparities between black communities and others, Morris, et al (2018) carried out a metanalysis of 65 studies and found that the prevalence of local back pain was significantly higher across African countries (47%) than globally.

### ➤ Local Research

Across Lambeth, the picture is not dissimilar. Ainsworth et al (2022) examined the health inequalities in working and older age adults as they relate to a person's ethnicity, environment, and gender across Lambeth. They found that chronic pain was amongst the





top recorded long-term conditions across the borough with greatest frequency amongst black communities. Black ethnicity women appear particularly disadvantaged compared to both Black ethnicity men and White ethnicity women, with double the rates compared to the general adult population (34.4% vs 17.3%); almost double the rate in Black ethnicity male population (18.3%); almost double the rate in White ethnicity female population (19.8%).

### ➤ Models of care

Historically, chronic pain has been treated through a medical model that views pain as a warning sign of injury. More recently this has been criticised for failing to explain, for example, how non biomedical factors such as psychological or social factors play a role in the experience of pain (Quintner et al, 2007). More so existing literature on the treatment of chronic and persistent pain highlights the lack of efficacy of medical interventions and their iatrogenic consequences (NICE 2016, 2017, 2018). Healthcare practitioners often feel ill equipped and poorly supported to meet the needs of ethnically diverse patient groups (Kai et al, 2007). The NICE guidelines (NG193) recommend a range of non-pharmacological interventions including exercise, psychological therapy, acupuncture, and electrical physical modalities for the treatment of chronic primary pain, and if necessary, the prescription of antidepressants as opposed to painkillers. Studies demonstrating how the presence of biological pathology does not consistently correspond to chronic pain (Endean et al., 2011) and vice versa (Krismer and Tulder, 2007), the literature on placebo (Colloca et al., 2013) and nocebo (Benedetti et al., 2007) effects of medication, all highlight the need for more diverse and holistic and idiosyncratic treatment approaches. A number of models of pain modulation have been developed to better understand chronic pain (pain gates (Melzack & Wall, 1965), pain neuromatrix (Melzack, 1999), salience network (Lanelli & Mouraux, 2011), and central sensitisation (Woolf, 2001).

A bio-psycho-social framework (Gatchel, 2004) better accounts for these models, conditioning experiences, social, cultural and language contexts and meaning associated with chronic pain experiences. George Engel, psychiatrist and medical scientist defined the bio-psycho-social approach as “a dynamic, interactional, but dualistic view of human experience in which there is mutual influence of mind and body” (Borrell-Carrio et al, 2004) . In other words, to better understand the patient’s needs, staff and healthcare systems must acknowledge the social, psychological, and biomedical factors contributing to the condition. The lifestyle medicine approach to treating chronic conditions including pain (Nijs & Reis, 2022; Hayes et al., 2017) accounts for holistic factors and offers more promise in improving the lives of those living with chronic pain. The pillars of the lifestyle medicine approach include physical activity, healthy eating, sleep, minimizing harmful substances, mental wellbeing, and healthy relationships (What Is Lifestyle Medicine? - Find Out From British Society of Lifestyle Medicine, 2023)

### ➤ Primary Care

Pain management is the greatest cost to healthcare. General Practice is an overwhelmed service with delays in appointments leading to clinicians feeling rushed, burnt out and unsafe, and patients feeling not heard, rushed, and experiencing disjointed treatment and varying levels of dissatisfaction. Recurrent previous studies have estimated 20-40% of GP appointments could be best dealt with by experts other than GPs. Many of these



appointments deal with 'social determinant' issues. Freeing up these appointments so that patients are seeing the right person at the right time would allow GPs to appropriately apply their expertise to more complex medical situations and potentially offer longer appointments to those who need them. Reducing demand on appointments would help relieve some of this pressure.

Work carried out by Rebecca Malby and her colleagues at South Bank University and Datasyrup (a team specialising in data analytics to transform healthcare and provide better more informed decisions) analysed appointment usage across GP practices in south London. They found that approximately 5% of the registered population utilise between 20-30% of the annual appointments offered by the practice. A key element of their analysis looked at long-term frequent attenders which refers to patients that have been using high levels of appointments.

Stockwellbeing PCN worked with Data Syrup to carry out this work on their registered population of 45,000 patients. Overall, across the PCN the same 4% (approx. 2000 people) of the population used up 25% of all the appointments that were offered across five GP surgeries every year for the last three years. This includes appointments during and outside the pandemic. Interestingly a code of chronic pain was the most frequent diagnosis that appeared of all the long-term conditions in this cohort. Out of the 2,000 patients identified, approximately 800 (40%) had chronic pain listed as a condition. Over a period of time these findings will provide a consistent baseline from which to measure the impact of any intervention. It will allow interventions such as PEACS to show a reduction in appointment usage of patients known to be long-term frequent attenders and in doing so having a significant impact on the capacity of general practice to offer appointments. PEACS will help bridge the gap between a holistic community-based offer, and the need for system thinkers to evaluate potential impact of the approach, some of which has already been used as an exemplar in the Lambeth Primary Care Incentive scheme KPI for chronic pain management.



## Codesign Phase

The PEACS pathway was developed through experience-based codesign. Led by Comuzi (a black-led research and design agency specialising in coproduction and service development), we worked with patients, carers, and clinicians across the field to identify current gaps in healthcare, outline needs and complexities of the patient group, and map out a more effective model of care encompassing the mind and body. The process began by redefining our key objectives and developing some opportunity questions looking at what we might want to achieve through the work. These opportunities can be defined as follows:

1. How can we improve the quality of life for Black communities by better identifying (and addressing) bio-psycho-social needs of people living with chronic pain?
2. What if we can create a joined-up pathway that enables GPs to support people with chronic pain, with the support of other healthcare and voluntary sector workers?
3. What if we can create a pathway that puts codesign with the patient and an understanding of their social and cultural background at the centre?

These questions set the direction of travel for the project and were the drivers that enabled us to create a new offer to improve the patient experience, helping us to think creatively about the possibilities, and establish the underlying principles for our work. Once these had been formalised, members of Comuzi conducted 1:1 interviews and focus groups to better understand the experiences of Black patients living with chronic pain and identify the contributing factors and key challenges placing greater emphasis on social factors that often get neglected. The team engaged with 19 patients from Black backgrounds, five carers and 16 clinicians from multidisciplinary backgrounds including GPs, psychologists, social prescribers, and others working within the community. The interviews were analysed, drawing out key themes and insights from the conversations. These themes provided invaluable insight into the worlds of Black people living and working with chronic pain, and brought to the surface some of the limitations in care and support, allowing us to explore a variety of potentials with which we were able to develop the PEACS pathway.



**“ To have my independence back. That's what I really want...I used to walk to work, walk it back home, do my eight-hour shift and walk. I'm a walker. I can't do that no more. ”**

**- Patient**

**“ It's like, it's just pain. I don't know how to explain. ”**

**- Patient**

**“ I don't think anyone will understand. Unless you go through it, you wouldn't know. ”**

**- Patient**

**“ I think sometimes the patients, because they've been passed around quite a lot, because they've had this for a long time, they're very stuck and not sure what to do. ”**

**- Clinician**

**“ The moment you start asking questions then you become combative to them or you become a problem. ”**

**- Patient**

**“ You know what I would need the most? If there was a place throughout the daytime, that my dad could go or someone that could take him to day activities. ”**

**- Carer**



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### Importance of Coordinated Care

- Patients consistently said that they carry the weight of treatment. They have to repeat their story every time they see someone new.
- Health and Wellbeing is multilayered. A holistic approach involving multiple professions is required to address complex needs of chronic pain patients.



### Improving Chronic Pain Education

- Educational support for patients to better understand chronic pain could relieve pressure on GPs and allow patients to find a pathway that works for them.
- Setting realistic expectations is helpful for patient engagement, as well as clearly articulating the link between mind, body and social factors and how they can impact pain.

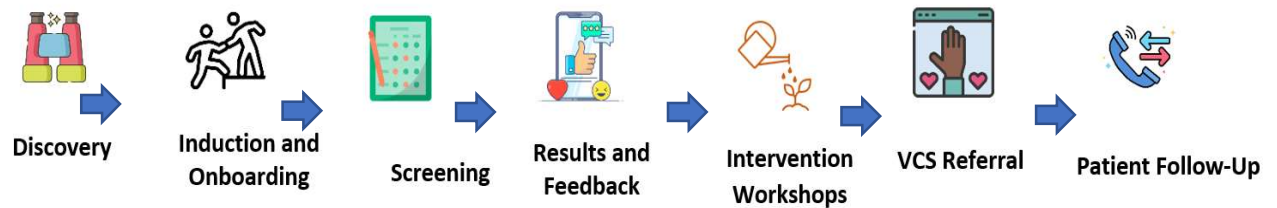


### Empowering People to Self-Manage

- Self-management is necessary, in addition to better support and resources for ongoing care, whether patients are waiting for a referral, re-referral or once discharged.
- Temporary relief may help to support other areas of treatment e.g. physio.

These themes went through further testing through a process known as ideation, in which key stakeholders were given the opportunity to articulate solutions in response to the insights gathered from the data. This process was thorough and allowed us to begin to cement initial plans for what the PEACS offer could be. Eventually the data and feedback was developed into an initial sketch of the service blueprint, formed of seven stages:





To continue to meaningfully co-design the final pathway, three experts by experience were recruited from among the residents and carers that were involved in the codesign work. They played an active role in the design of the pathway, data collection tools, and workshop content. Their thoughts and comments were included into revisions that were made to the final pathway before going live. Involvement of experts by experience is at the centre of PEACS and each expert was invited to sit as a regular member of the PEACS Steering Group providing consultation, advice and guidance on the ongoing programme activities based on their lived experience.

## Codesign Outputs

**“Some of the resources that were provided were exceptional, exceptional” Patient [Christina].**

### ➤ Mind and Body Health Check

Identifying and addressing physical, mental health or social needs early and in a joined-up way are key elements of the pathway. As established through the codesign work, psycho-social factors often play a significant role in physical health experiences, and so great importance was placed on the identification of bio-psycho-social needs as an early intervention, as well as for those patients who may have already had chronic pain for some years. As a result, one of the essential outputs of this work was to codevelop a web-based assessment which seeks to understand, identify, and support the holistic needs of the patient group, by collecting patient-reported outcome measures. The tool seeks to detect specific needs and better inform the 1:1 assessment that follows on in the pathway, but in particular, it highlights those who would benefit from psychological input or social prescribing approaches. The tool is completed prior to the clinical assessment, and then again before the follow-up review to be able to monitor progress and support the consultation process. The results play an integral part of the patient’s GP record and enables the assessing clinicians to more meaningfully and efficiently interact with the results to provide more informed care. [View demo here.](#)

### ➤ PEACS Patient Toolkit

The team partnered up with local social enterprise, GoodPeople, to codevelop a PEACS patient toolkit that would act as an informative resource as well as a journal, allowing patients to record their goals, learning, thoughts, and feelings in response to



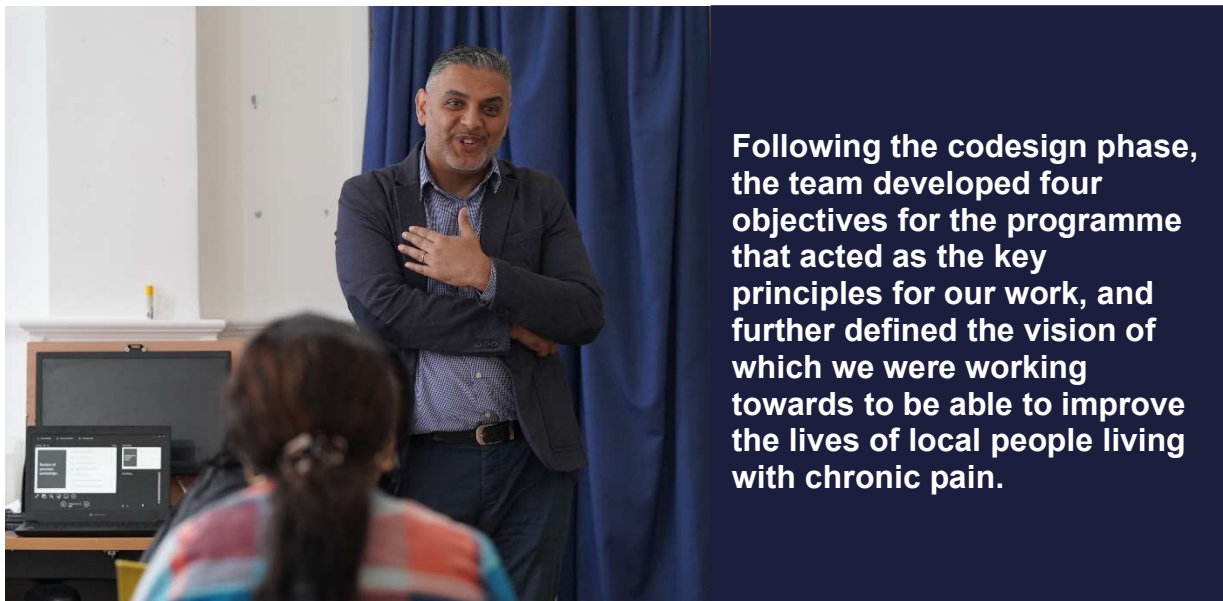
the intervention. The toolkit was designed to further highlight the different themes explored in each of the intervention workshops, as well as provide patients with key facts and knowledge about chronic pain. After each workshop patients were encouraged to reflect on the content and bring these for discussion as part of their follow-up review. [View demo here.](#)

#### ➤ Recruitment and Representation

One of the key priorities was to ensure that the delivery team was representative of the target audience, so that they would be able to understand the challenges experienced particularly around racism and inequality, but also the cultural dynamics impacting on their experiences. Therefore, significant efforts went into ensuring that those carrying out patient-facing work were representative of people from Black communities, with relevant experience skills and knowledge. Additionally, we wanted to guarantee that the intervention itself was informed by individuals from Black backgrounds, and so the content of the workshops was also developed in partnership with professionals who understand the interrelationships between the pillars of lifestyle medicine, race and culture.



## Project Objectives



1. **Improved Quality of Life:** We want to reduce feelings of isolation and loneliness and improve a range of health outcomes relating to physical and mental health, lifestyle choices and behaviors such as diet and exercise, and perceptions of pain.
2. **Reduced Health Inequalities through more accessible care:** We will provide access to bio-psycho-social support that draws on a range of expertise. In addition, we will foster links for patients into culturally relevant local community activities.
3. **Improved Understanding of Chronic Pain:** We will deliver chronic pain education for both patients and clinicians, in particular GPs, to improve understanding around the causes, triggers, and manifestations. We will work with GPs to improve their skills to understand how to communicate with patients and have an improved understanding of cultural and ethnic differences that often interplay with chronic pain.
4. **Effective Utilisation and Coordination of Care:** We aim to improve patient experience of quality healthcare, leading to patients feeling held, listened too, and understood.

These objectives helped us to refine our approach until we finalised the PEACS pathway.



# PEACS Pathway

## 1. Discovery

During this stage patients are contacted and invited to join the pathway. Patients are also sent the PEACS toolkit.

A 'chronic pain search' codeveloped specifically for this work is used to identify eligible patients. This process is now multi-layered as this identification also involves those that are deemed, Long-Term Frequent Attenders.

## 2. Induction and Onboarding

Once patients have agreed to participate, they are invited to the Introductory Workshop. Patients are given the opportunity to learn more about the process, meet the team, connect with others in their cohort, and ask any questions. They are also presented with different concepts, theory, and Bio-Psycho-Social information around chronic pain.

## 3. Screening

Patients complete the Mind & Body Health Check (MBHC); a digital web-based assessment co-developed through this programme. The tool aims to assess patients' quality of life, thoughts and attitudes to pain as well as other lifestyle, medical and emotional factors.

## 4. Results and Feedback

The results of the MBHC are then shared with their individual GP practices, as well as the assessing clinician. Patients are then assessed by a clinician or link worker depending on their level of need.

Assessments last for 30 minutes and are offered online or in-person.

## 5. Intervention Workshops

Patients are invited to participate in a series of weekly workshops specially designed using the six pillars of lifestyle medicine. The workshops take a psychoeducational approach and focus on a different theme each week exploring the interplay between the subject matter and chronic pain. The themed workshops are: *Movement, Nutrition, Sleep, Trauma, Wellbeing, Relationships, Society and Community*. The final workshop includes a graduation ceremony where patients are handed certificates for the commitment and engagement.

The workshops are delivered using a multi-disciplinary approach, with one clinical facilitator per session and is supported by the Link Worker.

## 6. Voluntary and Community Referral

We aimed to create an environment where patients do not feel chewed up and spat out. Patients are signposted to attend a 'Community Living Room' hosted by Thriving Stockwell where they can continue to build on the relationships developed with each other.

We also work with colleagues to individually match interested patients to local voluntary and community activities.

## 7. Patient Follow-Up

Patients are offered a Follow-Up Review with either the Clinical Lead or Link Worker, online or in-person. During these reviews patients feedback their experience of using the pathway, explore impact, and define what changes they have made to their daily routines and discuss their learning. Further support is also discussed, and information provided.



KHP 

**Mind & Body**



## Implementation

Following a comprehensive codesign phase, the first year of the programme was implemented on Monday 5 September 2022 and was completed on Wednesday 20 September 2023. As set out above, the pathway was delivered using the expertise of those from multidisciplinary backgrounds, but most importantly drawing on the skills and knowledge of those from Black backgrounds. This was to ensure that the both the intervention and the spaces created allowed patients to feel safe, listened too and understood. It was intended to provide genuine wraparound support for a patient group that had felt so neglected by the healthcare system for many years.

Year one of delivery was made up of four 'cycles' of delivery, with two cohorts of patients in each cycle; one face-to-face and the other virtual to enable equitable participation. Each cycle followed the approach outlined above and delivered the same core functions. The 90-minute workshops were delivered in person at Coronation Hall (within Springfield Medical Centre), Morley College, and virtually via Zoom. The codesign work enabled us to develop an end-to-end pathway, where patients could comfortably journey through each of the stages, knowing what the next would bring. Nonetheless there was a sense of flexibility allowing patients to participate in the elements that best suited them. Exploration of the patients' needs was a collaborative endeavour between the link worker or clinician and the patient.

There were various opportunities for patients to discuss their healthcare needs and existing challenges, for example during the assessments in which the patient history, day-to-day experience, contributing factors were discussed in detail. Patients were also given the space to explore their goals for participation and what they want to get from the programme was identified. Similar questions were again explored during the follow-up reviews approximately two months later in which patients were asked to identify their learning, adoption of new skills, and whether they required any further support. Although patients were supported throughout the pathway, there was also a significant degree of choice embedded within the core principles, to help patients to feel more empowered in their healthcare choices and decision making.

Using a Bio-Psycho-Social framework, the intervention focused on equipping patients with knowledge and information to help them develop better coping skills and strategies to manage their chronic pain. Examples of this can be noted at every stage of the pathway. For example, once patients had completed the MBHC tool a detailed analysis of their health against key indicators including physical health, mental wellbeing, sleep, the environment, diet, and relationships as well as any specific issues that needed highlighting and recommendations. These are then discussed in detail with a clinician during the 1:1 assessment, and appropriate advice and guidance is given based on the results. The intervention workshops were designed to include an interactive and informative presentation, themed activities so





participants were able to learn new skills, information on local community activities offering tailored support around specific needs, as well as space for connection and networking. This latter point around connection and development of relationships became more and more prominent through each cycle, in that patients really valued being around others that understood and could empathise with their individual stories. Here is what they had to say:



[Mind & Body | Pain: Equality of Care and Support in the Community \(PEACS\) workshop at Art4Space - YouTube](#)



## Impact and Outcomes

**“My kids asking ‘Why are you looking so happy today? Oh, you’re going to your pain group, aren’t you?’” Patient [Ronaldo]**

This section of the report outlines the patient experience, engagement, and outcomes for year one. The evidence has been drawn from a number of different data sources, of both internal activity and from the work carried out by the programme’s evaluation partner; Tavistock Institute of Human Relations (TIHR). TIHR is undertaking an independent evaluation adopting a developmental and theory-driven mixed-methods evaluation approach, integrating both process and impact evaluation elements. The main data points used to develop the findings have included learning taken from surveys, observations and fieldwork, follow-up reviews, data monitoring activity, patient interviews, ‘GP conversations’, MBHC, appointment, medication, long-term conditions analysis, and expert by experience workshops, to name a few.





# 79%

of survey respondents agreed with the statement: **“I know more about the connections between physical, social and psychological factors influencing chronic pain”**.

Three Domains in the Quality of Life measure of the MBHC showed a **statistically significant** improvement from baseline to follow-up: (p<.05)



76% of patients attending an Introductory session went onto have a 1:1 clinical assessment

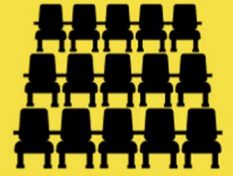


**PEACS** pathway patient toolkit for people living with chronic pain

Cycle 4 attracted the largest workshop attendance with

## 33-37

attendees on average



83% felt they had gained new knowledge



# 139

Patients attended at least one Intervention Workshop

**(63%)** of survey respondents said their experience compared *favourably* to other interactions they had with health services.

# 296

People from **Black Communities** supported

# (p<.01)

Analysis showed a significant reduction in Pain Catastrophising from assessment to follow-up

**“I came away from it with, I suppose, the reassurance that I wasn't alone, I wasn't mad, and that people cared.”**

# 753

Patient **Conversations**

**Black Women** aged between 45 & 74 made up the majority of the population supported

Unlike other ethnicities engagement of Black communities increased with each engagement level. Across all cycles **54%** identified as Black within level 1, **62%** within level 2 and **66%** within level 3

## Two-Thirds

of patients surveyed reported feeling **‘seen’**, less isolated and better **understood**



**597** People Supported

**296** People from the Black community

### ➤ Engagement in Numbers

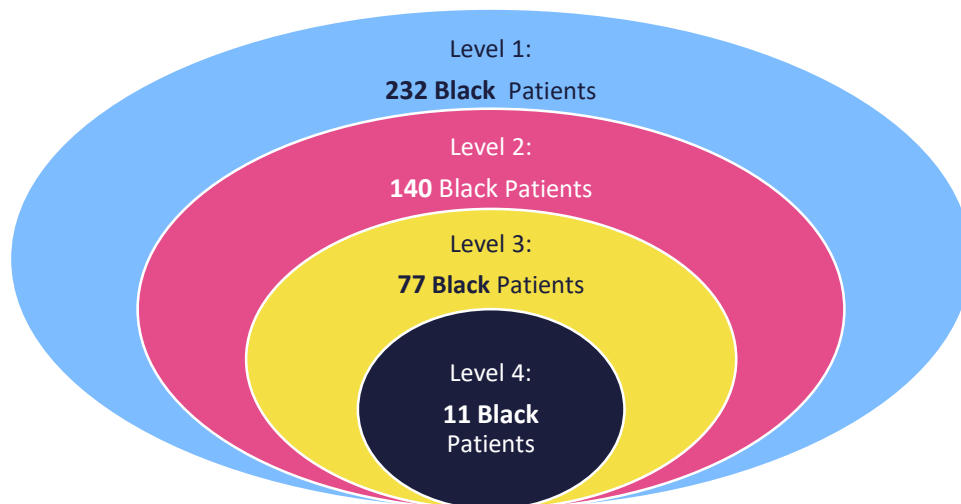
597 people received support from the PEACS pathway in year one of delivery, and of those, 296 (49%) were from the Black community. Starting with those early patient conversations, of which there were a total of 753 across four cycles, eligible patients were informed about the pathway, told of the ways that it could offer an alternative solution to managing their chronic pain, and were encouraged to participate. All of these eligible patients were sent the patient toolkit and had the option to join the additional levels of the pathway, with increasing levels of support and engagement.

As outlined earlier on in the report, engagement looked different for everybody based on their personal circumstances, so it was crucial to acknowledge and identify different levels of engagement and interaction. These are as follows:

- Level 1: Number of eligible patients who booked to attend an introductory workshop;
- Level 2: Number of patients who attended an introductory workshop and/or completed a 1:1 assessment;
- Level 3: Number of patients who attended at least one intervention workshop;
- Level 4: Number of patients who were matched or signposted to opportunities in the community (e.g., attendance at Art4Space sessions, exercise classes, volunteering opportunities, education classes etc.).

The aim of the programme was to support marginalised groups living with chronic pain, with a specific emphasis on those from Black communities. The initial target for year one was to support 200 people from Black backgrounds to access the PEACS pathway. The project surpassed this target by an additional 48%. A breakdown of participation for Black participants is below:





As each level of support intensified within the main intervention, so did the levels of representation and engagement from people within the Black community. Of the total population supported, 49% supported through level 1 were from a Black background, 62% for level 2, and 68% for level 3. 48% of those supported to access local community and voluntary sector services through were from a Black background.

Of the total population supported, 77% identified as female, and like with participants from the Black community, engagement increased as the levels of support intensified. Black females between the ages of 45 and 74 made up most patients supported. That is 296 of the total population of black communities supported (224) were black women. 77% of people supported through level 1 were female, 76% for level 2, and 85% for level 3.

The average age of patients supported ranged from 55 to 62 years old across the four cycles. Across all cycles, the youngest participant was 18 years old and the oldest was 94 years of age.

### ➤ Patient Experience

***“[...] It made me feel like I wasn't alone - with chronic pain you become so isolated, and the workshops let me meet so many people with my shared experience.” Patient [Davina]***

Patient involvement has remained central to the project since its inception. We seek to continually improve the quality and effectiveness of what the pathway can deliver and to ensure that it meets the needs of this patient group. Therefore, gathering data directly from patients and participants, on both the positives and the areas for improvement, continues to be a significant priority.



Upon the completion of year one of delivery, our GPs met with some of the patients to hear their views and better understand their experience of using the pathway. Patients reported to feeling seen, empowered, and connected. We will look at each of these in turn.

**“You’re listening and understanding. Like the way you speak to people with pain. I can’t explain it but you lot just weren’t like my doctors”. Patient [Barbara]**

Patients expressed their relief at finally being seen and heard in the context of their pain. They explained their happiness at being part of a programme where they were able to be their authentic self, and not as a collection of symptoms and illnesses. They felt **“like it was ok to be vulnerable” Patient [Diane]**. Previous negative experiences in their medical care had left them feeling like a burden to the healthcare system. This had reinforced a sense of a ‘them’ versus ‘us’ mentality when interacting with medical professionals, particularly amongst the Black community. The lack of understanding or ability to consider the patient’s background, cultural experiences and diversity perpetuates this cycle. Feelings of mistrust between the community and healthcare professionals was actively present in conversations, and this contributed to the greater sense of inequalities felt by certain people. Patients feel that PEACS has helped to start the conversation around helping to break down these barriers and encourage a healthier engagement with health services.

**“When I found out about the PEACS project I thought thank God!.... finally something where I can talk to others who understand about how I feel.....something as well which doesn’t involve painkillers” Patient [Rachael]**

PEACS has begun to form the foundations of a health-promoting community and is starting to cultivate a sense of camaraderie and belonging between local people. Feedback has shown that patients now realise how many people locally also suffer with chronic pain, which in turn has made them feel less alone. The patients recall how they appreciated the small things such as, how the team made efforts to encourage patients to introduce themselves at the beginning of the workshops, or how they introduced healthy snacks that helped sparked discussions during the breaks, and made the patients feel more comfortable and at ease. This growing network has provided them with an invaluable source of inspiration and support giving participants a chance to start believing in themselves again and to find their purpose. These new connections have also brought the chance for new opportunities, for example, enrolling in college courses to help get them back into work. The concept of change and empowerment is explored further below.

**“I keep a positive attitude, you can’t let things get you down.” Patient [Malcolm].**





Readiness for change and feelings of empowerment varied immensely across the patient group. The spectrum ranged from patients that felt hugely encouraged and able to make positive changes in their life to support their pain management, whilst others considered making changes but seemingly lacked the confidence to make them. Some patients have a clear idea of what they want to achieve, whilst others have not given this any consideration at all. The patients that were motivated to set goals and make changes tended to have a greater baseline awareness of self-management techniques and lifestyle changes that could help their pain. Often these patients had higher levels of education attainment, which may explain why they appeared more engaged with the goal setting process, for example, having clearer ideas for personal goals, greater engagement with materials such as the patient toolkit and a willingness to review progress with their goals independently. Goals are linked to a future desire for change meaning they are dependent on an individual being 'ready for change.' There was a large sample of people in the precontemplation stage of the behaviour change cycle. They had a strong desire for the pain to improve or stop however they felt powerless to change it.

Despite these differences, the PEACS pathway has educated people living with chronic pain on small changes they can make to help manage their pain. The majority of the patients sampled said that they felt better informed on how pain affected them and what they could actively do to help themselves live better with their pain. This is because the pathway facilitates personal exploration of reasons why change matters and the potential barriers to behaviour change. The key to its success is that a plan for change can be created that is highly personalised, meaningful and solution focused.

Patients also shared some helpful reflections for us to consider as part of the year two implementation. Some of these suggestions include feedback on the workshop structure, in which they ask for more time spent around the activity to help them grow confidence in learning practical tools or for socializing. This feedback and suggestions will be continued to be built upon as we continue to consult the programmes experts by experience and those that participated in year one, to help improve the overall quality of the pathway.

### ➤ Health Outcomes

Overall, patients have responded positively to the pathway. We have seen improvements in a number of health outcomes for patients following their participation, including being better informed about chronic pain; being better able to manage their pain; having improved social connection; and greater access to community activities. Data from the evaluation indicated that 87% of survey respondents said they would recommend the course to friends or family if they had chronic pain, only 4% said they were unlikely to do so. There were a few challenges



outlined as part of the evaluation that may have contributed to this latter finding such as, timings of the workshops, and conflicts with other commitments.

In this section we will first consider the evidence taken from our evaluation partner, before outlining some of the key learnings and analysis from internal project qualitative and quantitative monitoring data gathered throughout delivery of the pathway.



## ➤ Qualitative Data

### Improved Social Connections

**“(The PEACS project) has opened doors for me and helped me make connections (in the community)” Patient [Ama]**

Linked to the patient experiences outlined above, patients reported a greater sense of connectedness, and suggested that attending the intervention workshops alongside other people with chronic pain was extremely helpful in building social connections and other related social benefits. Half of the evaluation survey respondents and people interviewed, reported that they had ‘spent more time with other people’ as a result of taking part in the workshops. For a group of individuals that had expressed high levels of social isolation this points to being a truly valuable experience, this is further supported by one patient who highlighted that **“I think everybody on it says nice things like ‘have a good day everyone’ and that kind of thing and that's always nice to be part of a group that wants everyone to be feeling better”**. This outcome in particular speaks to the sentiment of feeling ‘seen’, in that patients felt recognised and understood.

Supporting this and in keeping with the social opportunities provided by the course, nearly two-thirds (63%) of survey respondents reported that participating in PEACS made them feel less isolated. Although being part of a group activity is likely to have helped with this, one of the strongest insights from the qualitative data analysis from the evaluation was the importance to participants of there being a shared experience of pain among members of the group. This feature appears to have had a significant impact on reducing the experience of social isolation. Throughout the qualitative data collection, participants described feeling less alone and better understood. The benefit of attaining recognition and validation from one's peers, as well as from clinicians, appears to be a significant motivating factor and beneficial to the patient's wellbeing. This motivation continued beyond the pathway as there was continued contact after the course had finished, mostly in the form of WhatsApp groups, and others had even developed ongoing friendships, with some reported taking a trip to the theatre one evening. The follow-up data indicated that patients described the WhatsApp group as a space where they can gain support when things are difficult, but also offer similar encouragement for others.

### Improved Knowledge about Chronic Pain

**“All these different sessions had something I have learned [...] I have gained a lot of knowledge, .... understand like health and mind” Patient [Derek]**



Most of the participants indicated that they had developed new knowledge from the programme - 83% of evaluation survey respondents agreed with the statement 'I have gained new knowledge about chronic pain'. Patients reported an increased sense of knowledge because of the information and resources available, with the most commonly cited reference being the nutrition workshop, closely followed by learning about the importance of exercise and movement, mental health and emotion, and relationships to managing chronic pain. Reassuringly, a great majority (79%) of survey respondents agreed with the statement: 'I know more about the connections between physical, social, and psychological factors influencing chronic pain'.

## Better self-management of chronic pain

**“It’s saved my life. I was really struggling with my chronic pain, and this helped me learn a lot.” Patient [Alex]**

Not only did participants obtain new knowledge, majority of patients also surveyed through the evaluation (79%) recognised having gained new skills which have been actively implemented into their daily routines to being better able to self-manage their chronic pain. Interviewees described making changes to their diet, exercise regimes, and sleeping patterns since attending PEACS workshops.

Most interestingly, patients described how the workshops influencing their self-management of pain was the ones that helped individuals think differently about their pain. For instance, there were indications of people reframing or re-orientating themselves to their pain, and in so doing, making it more tolerable. This qualitative insight is supported by analysis of the Pain Catastrophising Scale (used as part of the MBHC), which showed a reduction from assessment to follow-up. The decrease from 19 to 17 equates to a statistically significant improvement ( $p < .05$ ). Steps taken by participants to better manage their pain included approaching relationships differently, by drawing stronger personal boundaries and managing demands on themselves. The support offered had also equipped some patients with greater confidence to be able to ask for help, space or more time. This was further supported by the evidence gathered during the follow-up reviews in which patients inferred a sense of hopefulness and looking to the future. A considerable number of patients described the tangible things they have been doing to positively impact their lives such as changing how they manage their finances, setting different boundaries in relationships or starting to put in place arrangements, such as finalising an application for a weekly pickup service to take them to appointments as well as other activities without depending on a carer. Allowing them to be more independent in their everyday lives.



**“I learned that it was ok to tell people to ‘hold on a minute’, it was ok to tell people, ‘Actually I’m in pain can you wait a minute.’ It was ok to go to the supermarket and say, ‘actually can someone help me because I can’t lift that.’ [...] that you don’t need to hide all the time and don’t need to hurt yourself to think you’ve got to do it [...]” Patient [Anna]**

Additionally, there was evidence that participants were managing their medical treatment and contact with health professionals more effectively. 42% of evaluation survey respondents agreed with the statement ‘I have felt more confident that I know when to go to the doctor and when I can take care of myself’. This was supported by comments from health professionals during their interviews with participants. They felt that some appointments were more effective, with more meaningful and helpful conversations between clinician and patient, due to engagement with the PEACS service.

### Improved Coping Strategies and Awareness of Local Services

**“I’m quite sedentary and my pain can be really quite severe. But I’m setting myself goals” Patient [Joan]**

Patients reported to have engaged in more activities since the workshops and felt better in being able to care for their physical health needs. For instance, over half of survey respondents agreed with the two following statements: ‘I have felt more in control of my health’ (54%) and ‘I have felt more confident to deal with my health’ (57%). It appears that some of this improvement is related to changes patients have made to their lifestyles, particularly around diet, exercise, and sleep.

#### ➤ Quantitative Analysis

One of the outputs from the codesign work was the development of the Mind and Body Health Check (MBHC) which is a digital screening tool. The MBHC questionnaire is completed by PEACS participants as part of the screening before they begin the intervention workshops. Participants are also prompted to complete the questionnaire a second time after the intervention workshops. The MBHC questionnaire covers the following sections:

- Background of the person: Gender, age, ethnicity, and location;
- Quality of Life: The brief version of the WHOQOL (World Health Organization Quality of Life) 1 scale;
- Thoughts about Pain: The short version of the Pain Catastrophising Scale 2 and healthcare appointments in the last three months;
- Diet: Four questions about healthy eating derived from the Healthy Eating Assessment 3;





- Medication: Prescribed medication including type, adverse effects, and missed doses;
- Substance misuse: Heaviness of Smoking Index Score<sup>4</sup> and use of alcohol or drugs.

It includes three validated scales and one derived scale which are described below:

- **WHOQOL-brief:** The brief version of the WHOQOL scale measures quality of life with 26 items. Of these items, 24 items are combined into four domains: physical health (seven items), psychological health (six items), social relationships (three items), and environmental health (eight items). Each item is to be rated on a five-point Likert scale. Sum scores are transformed so that final scores range from 0 to 100 for each domain, with higher scores indicating higher quality of life. WHOQOL-brief also includes one item to measure the overall quality of life and one about general health – range from 1 to 5.
- **Pain Catastrophising Scale (PCS):** The PCS measures three aspects of catastrophic cognitions about pain: rumination, magnification, and helplessness. The MBHC assessment used a short version consisting of seven items. Sum scores range from 0 to 28 with higher scores indicate a greater degree of pain catastrophising.
- **The Healthy Eating Scale:** The Healthy Eating Scale is a derived scale from the Healthy Eating Assessment which consists of ten items. The Healthy Eating Scale adjusted two items and added two further items asking people about their healthy eating behaviours. As the scale is used for the first time, the evaluation team conducted some further scale and item analysis to assess the performance of the scale. This showed that in the current form the reliability of the scale (i.e. internal consistency) is poor – Chronbach's Alpha=.59. Further exploration reveals that the last item 'How many times do you have takeaway in a week?' is not correlated with any of the three other items. Removing the last item would result in an increase of Chronbach's Alpha .70. Values above .7 can be seen as acceptable.
- **Heaviness of Smoking Index:** This index is derived from the Fagerström Test for Nicotine Dependence and consists of two questions about time to first cigarette and number of cigarettes smoked per day. It is used to assess the dependence on tobacco.

It is important to hold in mind that we have supported a diverse group of participants, not only in relation to their demographics but also in terms of their backgrounds, experiences, cultural views, and lifestyle choices. These too will undoubtedly have an impact on the results of the MBHC. It also worth noting that compared to the general population, patients taking part in this programme had much lower levels of



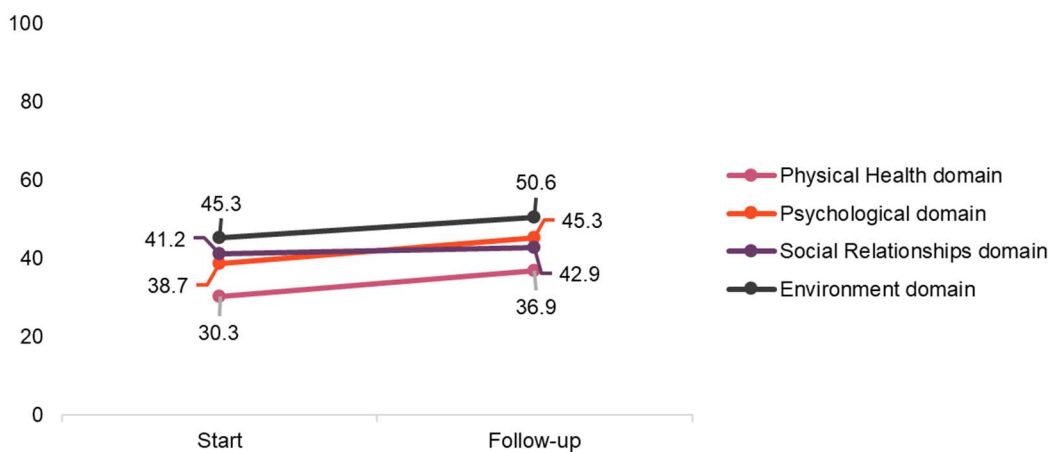
physical health. In total, 124 people completed the MBHC tool before their one-to-one assessment.

Quality of Life Outcomes

**“It’s helped me get out and about and make new friends. The service changed my life in a big way. My diet has changed as well thanks to the nutrition workshop”. Patient [Ade]**

Prior to their participation in the pathway, on average, respondents rated their quality of life as ‘neither poor nor good’ and as ‘dissatisfied’ with their health. Amongst the four domains of quality of life, physical health which includes mobility, daily activities, functional capacity, energy, pain, and sleep had the lowest average score with 31.5 and environment the highest with 43.5 (the scale ranges from 0 to 100). PEACS participants had an average PCS score of 18.8, ranging from 0 to 28. All but four of the PEACS respondents had a higher PCS score than the cut-off points of 7, predicting clinically significant depressive symptoms across the patient group. Following participation, three of the domains within the Quality-of-Life measure of the MBHC showed a statistically significant improvement from baseline to follow-up (p<.05). These included, the physical health, psychological, and environmental domains (see table one). Evaluation survey data supported these benefits that patients had begun to see materialise in their lives as it indicated that 87% of respondents said they would recommend the course to friends or family if they had chronic pain.

**Table One: WHOQOL-brief domains change over time analysis [Tavistock Institute of Human Relations]**



Note. N=35-40. Source: MBHC pre and post data.





## Health and healthcare utilisation Outcomes

**“I’m really glad it happened for me. I’m not going to say that it changed my life overnight [...] but for me, it came at the right time. I wanted to improve the quality of my life and it’s given me a few tools and it’s given me some information and knowledge I didn’t have before. So, for me, it’s a winner.”**  
**Patient [Patricia]**

For around two-thirds (63%) of survey respondents, the workshops compared favourably to other interactions they had had with health services.

TiHR carried out some detailed analysis on the Education Management Information System (EMIS). They found that based on the baseline and follow-up MBHC data showed that there was no statistically significant change in medication usage before and after participating in PEACS. Of the 38 patients who agreed to share data on pre-existing comorbidities for the purpose of the evaluation, 24 (63%) had at least one additional long-term condition recorded on the system. The most common ones were asthma, diabetes and essential hypertension. This data adds more insight into the complexity of the target audience. It is reasonable to conclude that in addition to the social and environmental factors, there are a diverse range of health factors, which could be influencing overall quality of life and healthcare utilisation. This was further supported by the insights gathered during the follow-up reviews in which patients described how their pain sat in the context of wider physical and mental health difficulties. Specifically, some would talk about other chronic physical and mental health issues that they are also managing. They were, however, able to point to an increased awareness of the interaction between their other health challenges and their pain. This was particularly evident for patients reporting difficulties with their mood which often triggered increased pain, or increased pain triggered lower mood, thus impacting their activities and motivation. For these patients, managing all these aspects of their health created additional complexity and challenge, which was sometimes exacerbated by difficulties accessing services and many still awaited further investigation or treatments beyond the scope of the programme.

In terms of healthcare visits, the MBHC data suggests that three-quarters of patients (72%) had visited the GP in the three months prior to their engagement with the pathway; and more than half (64%) had visited hospital or similar setting. A minority of patients reported to have visited A&E (22%), and 14% of respondents reported to have been hospitalised for factors relating to their chronic pain prior to their participation. EMIS provided a broader overview of some of this data and helped provide some more detailed analytics. Of the 62 people who consented for their medical data to be shared, the vast majority (94%) went at least once to the GP in the last 12 months before participating in PEACS, this averaged to approximately 10.5 times within 12 months. Prior to participation, there were less visits to A&E - 25



people (40%) were seen in hospital or A&E in the last 12 months before PEACS (see table two below).

At this stage it is difficult to summarise that patients had a reduction in healthcare visits. TiHR highlight that the relationship between 'healthcare utilisation and engagement in the PEACS service is complex and looks different for different participants'. They found that some patients did feel that they needed to access their local GP or other healthcare services less because of their participation in PEACS. For instance, within the group of survey respondents (21%), agreed with this, whilst others (33%) disagreed that this was true for them (see table two for more detailed analysis). This is discussed further in the staff and wider healthcare outcomes section below. As more data is gathered in Year two, analysis of appointment visits will seek to understand the relation between frequency of visits and other participant characteristics.

**Table Two: Comparison of visits to GP, hospital, and A&E**

Visits in the last 3 months to:	More after PEACS		Stayed the same		Less after PEACS	
	N	%	N	%	N	%
GP	3	11%	22	79%	3	11%
Hospital	5	18%	17	61%	6	21%
A&E	1	3%	25	83%	4	13%

*Note.* Numbers represent number of PEACS participants who have completed the MBHC at baseline and follow-up (28-30). *Source.* MBHC pre and post questionnaires

## Lifestyle Measures

**“It’s saved my life. I was really struggling with my chronic pain, and this helped me learn a lot.” Patient [Olu]**

In line with the intentions of the programme, patients interviewed as part of the evaluation reported going on to access further recreational, health, and community activities. Over two-thirds of survey respondents (71%) agreed that they had 'learned more about voluntary and community services for chronic pain.' These included attendance at the Art4Space sessions, as well as the activities patients were matched to with the direct support of team members and those that were motivated to attend an activity following their participation. Some of these included beginning courses at Morley College, Yoga and Pilates Classes, learning a new language, and so on.

The evaluation also illustrated that patients made positive changes to their diet, exercise regimes, and sleeping patterns. Follow-up review data suggested that patients felt that increasing their level of activity has helped their pain and their mood. Many described integrating going outside, walking the dog, going to the park,



or doing activities with others, employing useful strategies to help them cope with their pain and use helpful distraction techniques. There were also notable differences made to patients' diet after the PEACS intervention. Comparing responses from assessment to follow-up, the data reveals small changes to patients eating habits ( $p > .05$ ). Positively, prior to their participation patients indicated that they eat two to three home cooked meals per week, two to three portions of fruit/vegetables per day and have less than one takeaway food per week. For some patients this stayed the same, whilst others made overall improvements to their diet.

Prior to their participation a minority of respondents (14%) reported to smoking tobacco products. Of those, eight reported a low addiction and eight a moderate smoking addiction according to the Heaviness of Smoking Index Score. In addition, 14% of respondents reported to having used alcohol or non-prescribed drugs to help cope with pain. The evaluation noted that there were no reported changes to these patterns following participation, although these were relatively minor in their first instance.

### ➤ Staff and Wider Healthcare Outcomes

**“I think what patients have learned is some of the stuff that they could do at home, they didn't realise.” Health Service Professional [Claire]**

The data gathered paints a mixed picture, but this is in line with expectations particularly for a project of this kind that has only just concluded the pilot year. This section therefore explores what has been learnt up to this point, sharing analysis of data that has been gathered around two key intended outcomes including: improved understanding of chronic pain amongst GPs; and better utilisation of healthcare resource for patients with chronic pain.

#### Improved GP/PCN understanding of chronic pain

The evaluation cited early indications that PEACS had raised awareness of chronic pain amongst healthcare staff, as well noting explicit examples where staff are referring their patients onto those involved in PEACS indicating that they believe their patient would benefit from the bio-psycho-social approach to dealing with their chronic pain. There was also an indication that the project has helped increase awareness of chronic pain, which could be seen as a first step to increasing knowledge, embedding the project, and changing the culture of the PCN in relation to how chronic conditions are addressed. The project is placing significant emphasis on providing training to colleagues across the PCN for year two and there are also discussions underway for how best to embed the approach across the practices in a more sustainable way. This is outlined in more detail below in the 'looking ahead' section of the report.



## Improved utilisation of (healthcare) resource for patients with chronic pain

A key outcome for the programme was improved healthcare utilisation by patients through reduced visits to GPs, A&E, and other healthcare services. This was based on the assumption that individuals would have better self-management of their chronic pain and therefore less need for the support of services. However, it is fair to say that the relationship between healthcare utilisation and engagement in the PEACS service is complex and looks different for different participants, for different reasons. Most promisingly, although the quantity of healthcare visits may not be decreasing, there are indications that in some cases, the quality of healthcare visits is improving. Healthcare professionals who were interviewed by the evaluation team found that 'some appointments were more effective, with more meaningful and helpful conversations between the clinician and patient, due to engagement with the PEACS service'.

What seems to be emerging from both participants and healthcare professionals who have engaged with the external project evaluation, is that the PEACS service is reaching some individuals who have not been engaging a lot with their GP. In some cases, they had lost trust in healthcare services, and were perhaps not accessing healthcare support that was available and which they could benefit from. Additionally, a sizable number of people surveyed (43%) agreed that they were able to access other support services, with some participants now accessing other services that either they did not know existed, or because they now had the confidence to, or knew how to, contact services that would be appropriate for them.

### Co-Design Effectiveness

Our evaluation partners conducted some early analysis on the effectiveness of the codesign process. They sought to answer the following evaluation question: 'How effective is the co-design approach, working with Comuzi and people from Black communities living with chronic pain and what is the impact of this on the project?' They found that stakeholders were satisfied with the diversity of professionals involved, and that they had enjoyed the workshops and activities of the process. They found that 'stakeholders agreed that the co-design process was an appropriate way for creating an initial design of the new service'. They concluded that 'several stakeholders expressed a high level of confidence in the service because it was codesigned'.





## Project Evaluation

People living with chronic pain have complex emotional and social needs that impact on their long-term condition. This often leads to poor self-management and over reliance on medication and healthcare services, plus premature mortality particularly for the black community. Through this initiative we aimed to change individual relationships and attitudes towards pain by raising awareness around the relationship between the mind and body. We also aimed to develop and provide culturally relevant interventions to be able to address health inequalities and improve access and care. In the longer-term we would also want to see a reduction in healthcare costs particularly around visits to primary care services, and better utilisation of healthcare services in general with improved access and engagement with local community opportunities.

Our evaluation team highlighted that 'It is important to note that from the data gathered so far, the project does seem to have been successful overall, whilst trying to address a complex and multifaceted condition, for a diverse population group, with limited resources, in order to create something replicable beyond the local area'. Below we explore the learning taken from the process and delivery of year one.

### ➤ Key Reflections

Learning opportunities were continuously explored throughout the lifecycle of the programme, and the evaluation of our practices, delivery and implementation were an essential driver that supported us to ensure that improvements translated into key results for our patient group. The findings have highlighted some lessons for the continued success of the programme, and then eventually the potential expansion or replication of the model across the ICS.





1. Firstly, it is positive to see that as patients progressed through the pathway the levels of engagement, attendance, and participation from black women grew stronger. Considering this is the most impacted group, which sees the highest prevalence of chronic pain locally, this is excellent for the programme and a testament to the codesign work.
2. Linked to the above the data suggests that as the support levels intensified at every stage with increasing opportunities for one-one support, learning or networking the engagement levels from people other than those in the black communities slightly declined; across all cycles 49% identified as black within level 1, 62% within level 2, and 66% within level 3. The premise of this work was to support those from black communities, and so it is rewarding to see that.
3. People from these communities had higher levels of engagement. However, for the purposes of reporting and knowledge sharing it is reasonable to highlight that early engagement included a proportion of people from other ethnicities including those from mixed or multi-ethnic groups (17%), white (18%) during level 1 compared with (14%) of people from mixed or multi-ethnic groups (13%) of those from White backgrounds at Level 3. Only 3% of participants across the cycles were Asian or Asian British. Consistently, the ratio of men to women remained significantly low throughout with on average (24%) supported at the baseline level compared to (18%) at level 3, and (11%) at level 4.
4. It is common for a programme like this to experience reasonable levels of attrition. PEACS found the same, and we noticed attrition levels generally fluctuated throughout. This was most noticeable at the beginning, in-between those early conversations and patients' actual attendance at the introductory workshops. Initial discussions around the reasons for patient dropout were reported to be due to two main factors: prior commitments with other types of support, typically physiotherapy, or conflicting schedules.
5. We saw that once patients had completed their participation in the pathway, they wanted more support. It appears for those interested patients this type of support offered an attractive alternative, and they were therefore hoping for a more permanent offer that would allow them to manage their chronic pain. The findings would suggest that a significant part of this appeal was around the opportunities for connection, the development of authentic relationships with those who 'understand' and ongoing peer-support.





6. The goal setting process was not executed as well as we had intended. Our reflections around this are based on our conversations with patients, but also pre-existing knowledge and expertise. Amongst the patient group, there was varied awareness of, and experience with, goal setting. If we accept that patients are at different stages in the cycle of change, we could focus goal setting support on a smaller number of patients who are 'ready' and motivated to make lifestyle changes in future. For some, the pathway may simply help shift them from not having contemplated change, to considering this. Health and wellbeing coaches are highly skilled at this, and the project team will consider how behaviour change and goal setting are better supported for year two.
7. During patient interviews, patients continued to report issues with engaging with professionals in the wider healthcare system. More specifically, there is a sense that current health and social care systems don't account for the unpredictable nature of chronic pain. Consulting a wider range of stakeholders from the local integrated care system e.g. adult social services and employment support agencies, could be beneficial, particularly when preparing to deliver at scale. This notion is further reflected upon under the heading year two recommendations below.
8. The evaluation found that in the few cases where patients were less satisfied with the programme, a key issue appeared to be their expectation about what would be on offer. Therefore, being clearer about the aims of the programme, but also exploring specific topics in more detail during the workshops for example around navigating the healthcare system and discrimination is something that will be considered for year two.

### ➤ Test Practice Feedback

To supplement our feedback and hear from the healthcare professionals across the Primary Care Network, we facilitated some more detailed discussions. In early October the team provided an overview, progress update, and early findings to the Stockwellbeing PCN Executive board. During this meeting we were able to reflect on some of the specific challenges there have been in embedding this way of working within normal working routines. For the purposes of this report, we wanted to highlight some of the key reflections for the year ahead. These are outlined below:

- Although year one focused on recruiting through searches of long-term frequent attenders, for year two we will move to a more open referral process for all GPs. GPs supported this idea and requested for this to be clear and simple.
- There was a discussion around how high-quality in-depth consultations like PEACS creates a set of actions that are then passed back to the regular GP with a raised expectation in the patient. Therefore, we were challenged



- to think about the knock-on impact, and additional work that might be created following patients' involvement with the pathway.
- Providing more frequent communication channels between PEACS and the practices on how the project is evolving would be greatly welcomed.

We will continue to work closely with colleagues from across primary care to delve into the topics highlighted above and formulate realistic and feasible plans for the second year of implementation.



## ➤ Learning Review Process

The implementation of the programme was continually reviewed by the project team using a standardised approach at the end of each cycle known as a learning review. A learning review can be defined as a process that encourages critical thinking plus wider reflection and analysis on specific issues to be able to improve current practices. It involves systematic and action-oriented strategies to solving a problem with the aim of ensuring measurable improvement.

The learning reviews presented a unique opportunity for the team to come together and evaluate the previous cycle, with the collective aim of improving delivery but also the quality of our outputs to ensure improved overall outcomes. Each learning review followed the same format and was split into two sessions; the first focused on defining the successes and challenges, and the second session involved action-based learning where the team collectively developed solutions to live issues. All other issues that required a more long-term plan were moved into business as usual and discussed as part of the Steering or Operational Groups. As each cycle progressed so did our governance structures, but also our confidence and ability to respond to issues in a meaningful and coherent way.

During the first session the team were asked to identify the areas of achievement. This was to support the quality assurance process; in that it allowed us to measure our impact and progress towards the overarching objectives. The session was therefore positively framed from the beginning, and then we moved onto a wider discussion about the challenges experienced during that particular cycle thinking specifically about issues relating to the delivery, roles and responsibilities, patient facing work or the wider programme. The second session involved wider discussions structured by Action Learning Sets to creatively solve the challenges that had been identified. Taking collective responsibility for defining the problem and identifying practical ways of addressing different obstacles, increased our learning, developed team morale, and helped us to be able to combat significant challenges. Below we highlight some of the themes that came through from this work and describe some of the ways we were able to respond to some of the key challenges.

### Areas of Achievement

Lesson Theme	Item Description
<i>Patient Response and Engagement</i>	Patient Feedback; social media content, feedback forms, comments to the team
	Ongoing Expert by Experience recruitment, involvement and consultation.
	Patients have been proactive in developing peer-support networks and relationships with each other; i.e. the development of WhatsApp groups for each cycle with an appointed admin lead to disseminate relevant information and resources.



	Engagement and enthusiasm displayed during the workshops
Wider Influence	Establishment of the community group with local provider; Art4Space
	Wider Interest in the 'PEACS approach'
	Embracing of the Chronic Pain Search across all of Lambeth GPs
Process	Evidence-Based Measures
	Joined-up work with GoodPeople, providing more personalised support into VCS
	Reliable Workshop Framework
	Development of the Link Worker Role as the Continuity of Care
	Introduction of Graduation Ceremony and Certificates

## Areas of Improvement

Lesson Theme	Item Description	Resolutions
Resource Constraints	Capacity to manage onward referrals and signposting	Developed partnership with GoodPeople, to help individually match patients to local activities
		Ongoing work with GP Lead and PCN colleagues to find solutions to best manage long-term support. Developing proposals for Year 2 and beyond.
	Workshop Location	New workshop space identified (Morley College) with better accessibility.
Patient Engagement	Feedback and Evaluation	Developed feedback forms and Feedback Tree. Produced comms and vox pops to gather patient feedback and experience.
	Uptake of the MBHC	Printed hard copies of the MBHC, which allowed patients who were less digitally confident to complete the tool. Embedded more time in the follow-up reviews so patients could be supported to complete it.
	Patient Contact	Adapted our search to include the identification and contact of those deemed, Long-Term Frequent Attenders.
	Team Capacity	Acquired more administrative support from the PCN to help with patient contact and coordination. We will revisit staffing model as part of year 2.

The learning reviews improved the way that we were able to deliver the pathway, but also how we think about improving and embedding practice for longer-term sustainability. They helped provide space for the project and delivery teams to reflect, review, and evaluate their existing processes and work proactively to address some very present issues to improve quality and effectiveness of the practices and procedures. Working developmentally and making the time to address issues and



challenges as they arise ensured that we were able to continually translate our learning into improving the overall outcomes.

## Looking Ahead



1. PEACS is committed to providing more integrated care and supporting the Bio-Psycho-Social needs of those living with chronic pain. The evaluation highlighted this in their report, suggesting that 'team members' shared values, dedication and commitment to the success of PEACS cannot be underestimated'. As we move into year two of delivery we will continue to build upon the learning and feedback from the pilot year. There are three key ambitions that we will be focusing on: We will continue to adjust and adapt the PEACS intervention based on feedback from our patients and people with lived experience, plus the learning we have taken from delivery in year one. This will include further development of our community offer to patients, increasing accessibility to the intervention and increasing and amplifying the patient and participant voice in all elements of the pathway.
2. We will embed the PEACS approach and pathway more systematically across primary care. We will continue to evolve the PEACS pathway to a point where it starts to feel a natural part of GP workflows that clinicians across the PCN prioritise and are comfortable using for patients with chronic pain. working with local and regional commissioners to identify sustainable options for continued delivery beyond the lifespan of the PEACS project. the second year. This will include establishing GP referral pathways and working closely with GPs across





the local system to understand facilitators and barriers to adopting the PEACS approach.

3. We will increase our capacity to share learning across primary care and the wider health system that includes detail on how the pathway was co-designed, suggestions for delivery of the pathway and the impact and outcomes that PEACS has achieved. Additionally, we will also provide a more formal package of training and education to other professionals and key stakeholders, particularly those within general practice, in order to spread and scale the PEACS approach.

By the end of year two we hope to introduce new ways of working across primary care and in the community that could be applied to both patients with chronic pain but also other patients who:

- Are experiencing inequalities in health outcomes;
- Show high usage of GP appointments;
- Would benefit from a more holistic approach to their condition;
- Would benefit from local community involvement.

The ability to adapt and transfer the PEACS approach to other health conditions or groups of patients is important for the overall sustainability of the programme. Most GPs would agree that a one size fits all traditional model of GP appointments is not appropriate for the variety of conditions seen, and the variability in their complexity. We want the PEACS approach to enable GP practices to shift working culture to a new approach, offering variable appointment times to suit the needs of patients, utilising allied health professionals, and working with community partners to deliver true holistic interventions. Simultaneously we would like to ensure that some of the more traditional benefits around continuity, accessibility, trust and long-term relationships that are currently valued across primary care are not jeopardised.

#### • Year Two Recommendations

Building on this, the evaluation team and experts by experience had some key recommendations for the programme. These are outlined below:

1. The evaluation suggested revisiting the overarching aims and scope of the project in the context of resource. This project encompasses a broad spectrum of desired outcomes and effects that extend to patients, staff, and service levels. However, given the limited amount of time, funding, as well as the limited number of allocated staff to support project management, delivery, and implementation it could be trying to achieve too much. The project team should therefore revisit some of the key priorities for year two and be specific about what they would like to achieve.



2. TiHR also suggest better practical support on accessing Voluntary, Community and Social Activities. The evaluation points to an opportunity for PEACS to sustain and embed benefits to participants if it can find a more sustainable way to support their participation in local activities within the community.
3. The patient group felt that the team should provide increased opportunities for peer-support and small group discussion for next year. There was a clear appreciation of the work in small groups and a desire in general for more social time to be provided within the sessions. Given the findings consistently pointed to the positive impact the pilot has had in terms of allowing patients to build social networks and feel more connected more time embedded within either the workshops, or in the pathway itself for patients to be able to socialise would be beneficial.
4. The evaluation team noted that 'team members have been willing to adapt, be flexible and take on other tasks when needed, such as when team members have left. However, they and the team acknowledge that there is a requirement for improved clarity around roles and responsibilities, as well as investment into existing roles across primary care, i.e., social prescribers and health coaches. TiHR note that team members require greater capacity, as well as a better understanding of the tasks that can be achieved without adding pressure to existing roles and responsibilities. The team are one of passion and commitment, and ultimately, they want to provide the best service for their patients. However, working to identify additional roles within the local infrastructure to help to reduce the burden on members, will lead to greater sustainability in the long-term.
5. Wider Engagement and focus on sustainability, replication and scaling out of the model. Year two will require more focus on these key factors, particularly when thinking about embedding the approach into the PCN, but also more widely, for instance through the work of Integrated Care Boards. To do this, some resource will need allocating to communicating with and influencing through wider networks, potential identification of funding sources, building the business case, and ensuring work that is delivered in Year two, supports learning for the project and the wider healthcare system.



## Conclusion

The ambition for the PEACS programme was to improve the quality of life for people living chronic pain, particularly those from the Black community, by offering them a holistic approach to help them to better manage and live more fulfilled lives.

The data outlined in this report demonstrates a range of outcomes for PEACS participants. The Black community are a heterogeneous group, and with that there is obvious variation in the outcomes for different participants depending on their background, context, and experiences. While there are differences in outcomes for the patients depending on their background, context and experience, as a whole group, the primary outcomes identified through the evaluation can be summarised into a) immediate outcomes such as increased knowledge about chronic pain, learning new ways to cope with pain and awareness of other services, and b) intermediate outcomes such as application of skills to self-manage and increased social connections. PEACS was able to reach communities who have otherwise felt alone and helpless and create meaningful change in their social networks, as well as the way that they are able to cope and respond to their pain. Patients have specified that these changes occurred as the result of the support they had received from PEACS. Therefore, we can be confident that these outcomes can be attributed to the pilot.

We are immensely proud of what PEACS has achieved within its first year, and we look forward to building upon these successes as we move into year two of delivery. We want to continue to work with local communities to improve patient experience with local healthcare systems; remove harmful barriers that prevent access to treatment; and create safe spaces that draw on evidence-based frameworks to deliver improvements to patient health outcomes.

**“I thoroughly enjoyed all of the sessions, in fact I looked forward to the weekly sessions where we were able to share our life's experiences. I fully recommend participating to anyone who suffers from chronic pain and have told quite a few people about speaking to their GP about it. And finally, I can say for sure that you will learn a thing or two and maybe find some lifetime friends like I have”.**

**- Angela Price-Rowe, PEACS Expert by Experience**



## Team Reflections

Dr. Vikesh Sharma – Lead PEACS GP

“As a GP who knows that there is a better way to do things but feels too overwhelmed and has little headspace to try and make those changes. It has been inspiring and rejuvenating to work within a team that is so passionate to create change even though the task has felt so daunting at times. Key to this is a team, where each member with their different perspectives and expertise has been equally valued, has a strong learning and reflective culture, support each other and never lose focus of the main goal in all the planning – the wellbeing and voice of the patients involved”.

Misha Gardner – Project Manager

“I was pleasantly surprised to be taking on PEACS as soon as I joined the team. I had no idea what to expect, and neither did anybody else! I feel very honoured to have been a part of a project aimed at tackling blatant injustices in the form of addressing health inequalities and improving patient experiences for people that look just like me. As a project manager you don’t often get to see the results of the work, or work alongside a team of truly admirable, kind and thoughtful people that always put their best foot forwards, are not afraid speak up or make mistakes and hold the patients in mind with everything they do. Everyone has a ‘seat at this table’! What’s more, working in partnership with local people to codevelop an approach that they can use without numerous hoops to jump through has been so rewarding, and seeing the impact that the pathway has had on their lives only enriches this. It has been an incredible journey from start to finish, and I am excited to see what next year brings”.

Feysiara Mendes – PEACS GP

“My involvement in this project over the past year has re-invigorated my passion for General Practice. This is one of the bravest and most authentic approaches to addressing racial health inequalities that I have observed in the NHS. There is a focus on addressing the social determinants of health which are the foundation of health and wellbeing in primary care, yet commonly overlooked. The voice of the community is at the heart of the PEACS pathway, and this perhaps explains why the level of engagement and satisfaction is so high. I have observed from those engaging with the pathway that the greatest value often came from accessing community networks and social connection. When evaluating the success of this



project we should be mindful that this may not be easily quantifiable or measurable against conventional performance metrics. Instead, it may be something slightly more intangible however we should not assume that it is any less impactful”.

### Dr. Sarfraz Jeraj – PEACS Clinical Lead

“It has been a real privilege to work on this innovative project to develop a service for people with chronic pain codesigned with people living with chronic pain, channelling their voices into service delivery – real collaborative working in action! Evolving this service through year one with a compassionate, dedicated, fearless and intelligent team of PEACS colleagues and experts by experience has been inspiring and helped me learn so much. The changes that this work has made to people’s lives has regularly brought me tears of joy and filled my heart with love, and in doing so has made this work the pinnacle of my career as a clinical psychologist”.

### Dr. Naomi Stent – PEACS GP

“What a year! It has been an absolute pleasure to work with a team of such committed, hardworking, and motivated individuals. The passion we all have for this project has been palpable and has noticeably rippled through our participant groups and growing PEACS community. As a GP I have found it incredibly satisfying being able to provide patients with a community based holistic pathway, helping to support them as they navigate their persistent pain journey. This year we got to plant the PEACS seed and watch it sprout, grow and begin to grow roots. I am excited to see what the second year of growth brings”.





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