



Footsteps to Change Conference 2026

Poster Exhibition Abstracts

We would like to extend our sincere thanks to all delegates who have contributed poster abstracts to this conference. Your work represents a vital part of advancing the field of pain management, showcasing innovation, clinical insight, and a shared commitment to improving patient care. Poster presentations provide an important platform for exchanging ideas, highlighting emerging research, and fostering collaboration across disciplines.

The breadth and quality of contributions featured in this booklet reflect the dedication of our community to addressing the complex challenges of pain and enhancing outcomes for those we serve. We are grateful for your efforts and for the valuable knowledge and perspectives you bring to this conference

Dr Laura Hissey
Conference Organiser

Dr Emma Davies
Conference Organiser

Ancient Wisdom and Pain Management: Uniting Yoga and Psychology

Anna Solly – Clinical Psychologist

A pilot group has been trialled within a community MSK pain management service. The group is an experiential, skills-based group, with a focus upon three key components:

The Body: By using gentle joint releasing practices, we encourage individuals to be curious about the movement of their joints, move with the breath, and provide education about the importance of joint mobility. Participants are encouraged to become aware of links between posture, mood, bracing, tension and movement habits.

The Breath: An individually tailored approach is taken to support individuals to breathe more effectively (diaphragmatic breathing) reduce breath holding, increase self-awareness of breathing patterns, and extend the exhalation (to promote parasympathetic nervous system activation). The breath is used as an anchor to bring participants back to the present and as a tool for increasing self-awareness.

The Mind: Lifestyle principles that derive from Patanjali's yoga sutras, the Yamas and Niyamas, are given a CBT and ACT perspective. Participants are asked to reflect upon The Yama, Ahimsa (non-harming) which is framed as 'self-compassion' and the Niyama, Santosha (contentment) which is framed as 'acceptance', and 'Isvara Pranidhana' (surrender to a higher power) which is framed as 'letting go of trying to control', through a series of reflective questions e.g. in what ways do you harm yourself in your thoughts and actions?

The yogic Kosha model provides an holistic understanding of the interactive links between body, breath, mind, wisdom and eudaimonic wellbeing which is not dependent upon transient experiences. Awareness of how suffering relates to the Klesha's (misunderstandings, ego, attachments, aversion and fear) can all be applied to the experience of pain. Group participants are encouraged to discover inner resources, become more aware and feel empowered to influence their pain experience.

Motion is lotion; exploring yoga-based movement for chronic pain

Rose Nichol, with support from Pat Schofield and Louisa Taylor

Background

Chronic Pain causes disability worldwide, resulting in reduced physical function, fear of movement and mood disturbance (Gupta 2022, Rose 2019). Clinical guidelines (NICE 2021) state management should include a non-pharmacological, holistic, multidisciplinary approach.

Yoga is an ancient discipline encompassing breathwork, movement and meditation. Regular practice can positively enhance health, wellbeing, self-management and function (Cheshire 2022, Fox 2022, Rose 2019). For patients living with chronic conditions, yoga may improve mind-body connection, mood and quality of life (Fox 2022, Hall 2024, Kinkel 2022). Limited studies into yoga as an intervention in pain management clinics exist, with many focusing on yoga for back and neck pain (Hall 2024). More research is needed to consider the inclusion of yoga-based movement for Chronic Primary Pain.

Aim

To evaluate the outcome of a 6-week yoga-based movement course for patients with Chronic Primary Pain conditions in an outpatient pain management clinic.

Methods

Participants were recruited by pain management clinicians. They needed to attend weekly in person and be able to transfer on and off the floor; this was adapted to encompass a seated practice, increasing accessibility.

The group was facilitated by an occupational therapist with extensive yoga experience but no professional qualification. The course ran for 6 consecutive weeks. A graded approach was used; sessions included breathwork, grounding, gentle movement (floor, seated and standing poses), pain education, relaxation and group reflection.

A Brief Pain Inventory (BPI) collected baseline scores prior to commencing and was repeated on completion of the course. Participants also completed a post-treatment evaluation form on completion and outcomes were analysed to identify changes and themes.

A literature search was completed on CINHAL (EBSCO), AHMED and Medline. Search terms “yoga, chronic pain, BPI” identified evidence supporting yoga for pain management, and gaps in practice and research.

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The Lived Experience of Living Well with Chronic Pain

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Background:

25% of the UK adult population lives with chronic pain that persists beyond 3 months and affects all aspects of life.[1] Traditionally, research has focused on identifying, treating, or managing symptoms that contribute to disability.[2] Less is known about how to

to achieve and maintain a “good life” in the presence of chronic pain.

Aim:

To understand what ‘living well with chronic pain’ means to those with lived experience of chronic pain.

Method:

A convenience sample of 21 English-speaking volunteers aged 18+ and living with chronic pain, participated in semi-structured interviews. Qualitative analysis of the transcript data is underway using reflexive thematic analysis.

Interim Results:

Participants were aged 22-76, with the majority female (74%), white (82%) and living in England (87%). The following preliminary themes have been formulated to support data analysis: Treatment management & navigation, impact of chronic pain (positive & negative), support network, living well (what it means and involves, personal attributes).

Conclusions:

Interviews created a space for participants to reflect on their experience of achieving and maintaining a successful adjustment to life with chronic pain. Preliminary results add to the growing evidence that living a full and purposeful life with chronic pain is possible. Data also suggests the importance of the under-researched influence of altruism and finding meaning in life with chronic pain. Understanding these contributory factors has the potential for enhancing patient care and influencing clinical practice.

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[2] Landmark, L., Sunde, H.F., Fors, E.A., Kennair, L.E.O., Sayadian, A., Backelin, C. and Reme, S.E.. Associations between pain intensity, psychosocial factors, and pain-related disability in 4285 patients with chronic pain. *Sci Rep*, 2024; 14(1), p.13477.

M-POWER – Mindfulness Prior to Orthopaedic surgery to improve Wellbeing and Enhance Recovery

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Background

Behaviour changes such as mindfulness can improve the quality of life for adults with osteoarthritis. Despite this, over 230,00 people in the UK have joint surgery with many not exploring conservative interventions first. This is a protocol for an NIHR-funded doctoral programme exploring the feasibility of delivering mindfulness-based interventions through three different modes for people with osteoarthritis waiting for joint surgery.

Aims

1. To explore healthcare staff viewpoints around offering mindfulness to people with osteoarthritis waiting for joint surgery.
2. To test the acceptability and feasibility of a proposed randomised controlled trial (RCT)

Methods

Work Package 1

A national survey of healthcare staff to explore views around offering mindfulness to people waiting for joint surgery.

Work Package 2

A focus group with healthcare professionals to explore concepts in greater depth.

Work Package 3

A parallel multi-centre, multi-arm randomised feasibility study. People with osteoarthritis waiting for joint surgery (n=99) in three different hospitals will be recruited. They will be randomised to one of three different mindfulness training groups:

1. 8-week mindfulness course with 10-minute daily mindfulness practice
2. Leaflet with a 10-minute daily mindfulness practice
3. Leaflet with a 1-minute daily mindfulness practice

All participants will watch an education video developed with patients. The video gives advice about diet, exercise, activity, sleep and how to manage pain before and after surgery.

Feasibility outcomes will be collected three months after surgery. These include recruitment, retention, acceptability of randomisation and adherence. Clinical and

health economic data will be collected through patient reported outcome measures and assessed for completion.

Work Package 4

Qualitative interviews will be conducted with a purposive sample of participants to explore their experience of taking part in the study.

The information from the four work packages will be collated to inform whether progression to a definitive RCT is warranted.

Controlled Drugs Prescribing Safety Audit – Patients Receiving More Than 13 Issues in 12 Months

Mary Jebanesan

Controlled drugs such as pregabalin, morphine, gabapentin and tramadol are associated with significant risks of dependence, diversion and prescribing related harm, particularly when issued frequently over long periods in primary care.

This quantitative quality improvement project examined high frequency prescribing of these drugs within a single GP practice to identify potentially unsafe patterns and inform targeted changes to prescribing governance.

A retrospective EMIS search identified adult patients who had received more than 13 prescriptions for any of the four drugs over a 12-month period. For each drug–patient pair, data were extracted on the total number of prescriptions, total quantity prescribed and the interval in days between consecutive issues.

Descriptive analysis focused on the proportion of patients whose average prescription interval was shorter than the expected duration of supply, and on those with high cumulative annual quantities, stratified by drug class.

Findings were shared with the practice team and used to introduce process changes such as including a CD repeat prescribing safety check and more consistent prescribing instructions aligned with expected days of supply.

Remeasurement will assess whether these interventions reduce high frequency and high quantity prescribing, supporting safer and more accountable controlled drug use in general practice.

Embedding Nordic Walking Instructors Locally to Improve Pain Management: Initial Findings

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Background:

Nordic Walking is an enhanced walking technique using specialised poles to improve physical and mental wellbeing. Compared to standard walking, it has been shown to produce greater improvements in muscle function and balance. Additionally, learning a new skill, social engagement, and time spent outdoors are associated with improved mental wellbeing. Welsh guidance on persistent pain emphasises function and the 'Six Pillars of Pain Management', with Nordic Walking aligning directly or indirectly to all six pillars.

Aim:

To explore the perceptions of healthcare professionals who completed Nordic Walking Instructor training and examine its impact in practice.

Methods:

A questionnaire comprising multiple-choice and open-ended questions was distributed to participants (n=10) following completion of the instructor training. The survey explored expectations, application in practice, and perceived barriers to implementation. Data were collected and analysed descriptively.

Results:

Response rate was 50% (n=5).

- 100% reported the course met their expectations.
- 60% reported applying their Nordic Walking knowledge in practice (e.g. advice, signposting, 1:1 delivery, or local group facilitation).
- 80% identified barriers to implementation, including financial pressures, competing service priorities, equipment costs, weather, and risk assessment requirements.

Conclusion:

The instructor course was well received and is influencing practice. However, practical and systemic barriers limit wider implementation. Further exploration of these barriers, alongside formal evaluation of patient outcomes, would support potential expansion within pain management services.

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4. Welsh Government. *Understanding and Managing Persistent Pain*. 2024.
5. British Nordic Walking. 2025.



Power Over Pain is the UK's first primary-care-based clinic designed to help people with chronic pain move from dependency and distress toward understanding, confidence, and self-management. Developed in Kent by physiotherapist Ben Sims, the programme provides a structured, evidence-based alternative to medication-led pain management by reframing pain as a whole-person experience that can be influenced, not simply endured.

Delivered over six weekly group sessions by a multidisciplinary team, Power Over Pain integrates insights from biopsychosocial medicine, pain neuroscience, psychology, physiology, philosophy, and physiotherapy. Participants follow a carefully sequenced curriculum combining scientific explanation, lived experience, reflection, and practical skills.

Sessions such as *Pharmacy is a Work of the Heart*, *It's Not All in Your Head*, and *East Meets West* explore how trauma, stress, beliefs, relationships, and bodily processes interact to shape pain. Real patient stories normalise complexity, reduce shame, and show that meaningful change is possible.

The programme is fully interactive and grounded in the belief that people with chronic pain are not broken, but capable. Rather than passive recipients of care, participants become active partners in recovery through guided discussion, peer learning, and supported self-inquiry. Clinicians act as mentors within a holistic framework, helping individuals develop insight, resilience, and practical strategies for living well with pain.

Now in its second year and ninth cohort, the clinic has supported around 200 patients. Outcomes include a 35% reduction in opioid use and a 50% improvement in confidence on the Pain Self-Efficacy Questionnaire, alongside consistently positive patient feedback.

“Meeting new people in similar situations who truly understand how I feel has made a big difference. The team has been incredibly supportive, taking the time to explain things we didn't know and helped us feel more informed. Listening to others share their experiences has also been empowering and has helped me process the pain.”

Health outcomes of Live Well With Pain Ten Footsteps approach in a Primary Care Mental Health and Social Prescribing Service, NHS

Sebastián Senociaín, Paul Chazot, Frances Cole, Norah Alanazi

Background: Chronic pain affects between one third and one half of adults in the UK, contributing to poor mental health, functional decline, and overreliance on pharmacological treatments, including opioids. In St Austell Healthcare, a primary care network in Cornwall, high prescribing rates have prompted innovation in pain care. This project piloted a hybrid model integrating the Live Well With Pain “Ten Footsteps” self-management approach with lifestyle medicine, trauma-informed care, and patient-led group clinics.

Method: Fifty-five adults (43 female, 12 male; mean age 54, range 20–82) with persistent pain were enrolled via referrals from GPs, pharmacists, and allied health professionals. Participants attended a structured 11-week group programme (6 groups in-person, 1 online), facilitated by a Mental Health and Wellbeing Practitioner in collaboration with social prescribing team, a pharmacist, and patient experts. The model drew on principles from Polyvagal Theory, Lorimer Moseley’s pain neuroscience education, behaviour change theory (Stages of Change, Learning Zone), and mindfulness techniques. Outcome measures included the Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS) and the Pain Self-Efficacy Questionnaire (PSEQ-10), taken pre- and post-intervention.

Results: Forty participants completed the programme (73% retention). Preliminary findings suggest improvements in mental wellbeing and pain self-efficacy scores, alongside strong qualitative feedback regarding empowerment, emotional safety, and connection. Patients valued the trauma-informed, psychologically safe environment and reported greater confidence in self-managing their pain.

Conclusion: This early evaluation supports the integration of lifestyle medicine, psychoeducation, and peer-led approaches within primary care for chronic pain. Delivering this through a structured group clinic model appears both feasible and impactful. Future work will explore healthcare utilisation and long-term outcomes, but early data indicate this intervention may reduce reliance on medication and improve patient agency in living well with pain.

Effectiveness of CBT-based Lifestyle Interventions in PCOS with Limited Evidence on Predictors of Weight loss and Dropout, a systematised review.

Saloni Chouhan (MSc in Advanced Physiotherapy I HCPC)

Abstract Objective: To assess effectiveness of multicomponent interventions (CBT+LI) and predictors of weight loss and dropout in women with Polycystic ovary syndrome (PCOS). DESIGN Systematised review

Literature Search: A systematic literature search was performed in PubMed, PsycINFO, CINAHL, Medline, Scopus and ISRCTN registry from inception up until 15 July 2025.

Study Selection Criteria: Randomised controlled trials and observational studies including lifestyle interventions (LI) combining Cognitive behavioural therapy (CBT) in women aged between 18-50 years with PCOS diagnosed by Rotterdam criteria (2003).

Data synthesis: Patient characteristics, prognostic factors, between-group differences were extracted with assessing risk of bias by ROB2 and QUIPS tool with GRADE certainty appraisal. A tabulated summary and narrative discussion incorporated similarities and differences across included studies.

Results: Across six studies (5 RCTs, 1 PF) weight, metabolic, psychological-distress, behaviour (sedentary and eating) and quality of life (QOL) improved significantly within LI plus short messaging service (SMS). However, between-group differences with modest improvements were limited to eating, weight loss and metabolic outcomes. Most studies had follow-up every 3 months within intervention. SMS-supported groups had greatest effects yet dropout remained a consistent limitation. No significant between group differences were found in anthropometrics and physical activity, though waist circumference and aerobic capacity showed greater improvements in SMS+. Metabolic syndrome prevalence and severity (cMetS z-score) decreased with weight loss. Lower depression (OR 0.549, $p=0.013$), weight, poor body image, and high restraint-eating predicted successful weight-loss while, high baseline weight, androstenedione levels predicted dropout with highest in SMS-participation (OR: 4.424, $p=0.002$).

Conclusion: This review indicates that CBT-based lifestyle interventions improve psychological well-being, behaviour and quality of life in women with PCOS, with modest weight and metabolic improvements, highlighting SMS as a contributor to improved outcomes. Lower depression predicted successful weight loss, while dropout was predicted highest in SMS-participation groups. Although, larger methodologically robust and digitally enhanced trials are warranted addressing high dropout. KEY WORDS PCOS, multicomponent interventions, CBT, LI



Pain Behind Bars: Empowering Prisoners Through Social Prescribing and Peer Support for Chronic Pain

Karen Lawson Regional Social Prescribing Lead, Practice Plus Group

Chronic pain is highly prevalent within prison populations, where individuals often experience complex physical, psychological, and social challenges. Within custodial environments, pain management frequently relies on medication, while opportunities for education, self-management, and meaningful support can be limited. This poster presents an innovative peer-support pilot that integrates social prescribing with the accredited Live Well With Pain framework to support prisoners living with persistent pain.

The programme is delivered in a challenging custodial environment by Social Prescribers in Yorkshire working alongside key stakeholders and peer supporters. Participants are introduced to practical strategies focused on pain education, pacing, movement, and wellbeing, helping individuals better understand and manage their pain. A central feature of the initiative is collaboration with lived-experience ambassador Darrell Price, supported by clinical expertise from Dr France Cole a Live Well With Pain founder, ensuring the programme combines evidence-based practice with authentic lived experience.

One of the most powerful early outcomes reported by participants is the feeling of being listened to. In an environment where many individuals feel overlooked or unheard, peer-led conversations create safe spaces for prisoners to share experiences of chronic pain and explore practical ways to cope. This sense of validation and understanding appears to increase engagement and builds trust within the programme.

Despite the operational challenges of delivering interventions in custody, early indications show an extremely positive response from prisoners suffering with chronic pain. The pilot highlights how peer support, pain education, and social prescribing approaches can empower individuals, reduce reliance on medication-focused solutions, and improve wellbeing by ensuring that people living with pain feel heard, understood, and supported.

An Audit to Inform the Development of a Chronic Primary Pain Pathway in a Secondary Care Pain Service

**Dr Liam Blaney, Pain Consultant & Dr Laura Hissey, Pain Psychology Lead
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Background

An audit of Advice & Guidance (A&G) and ERHA referrals was undertaken to evaluate referral patterns to the Pain Service, with a particular focus on Chronic Primary Pain (CPP). This was prompted by a perceived increase in CPP referrals and the complexity of this patient cohort. All referrals were reviewed through referral documentation, clinical portal entries, and the GP Shared Care Record.

Methods

A random sample of patients triaged by the lead author over two separate one-week periods (approximately nine weeks apart) in 2025 was selected. Both A&G and ERHA referrals were included for analysis.

Results

A total of 114 A&G and 102 ERHA referrals were reviewed over the two-week period. The majority of referrals were for female patients (84% A&G; 86% ERHA).

Musculoskeletal (MSK) pain was the most common referral type; however, there was a notable and increasing proportion of CPP cases. A disparity was observed in the number of CPP referrals between A&G and ERHA pathways.

A significantly higher prevalence of co-existing mental health conditions was identified in CPP patients (84%) compared to MSK patients (45%). Previous involvement with the Pain Service was documented in approximately one-third of cases.

Discussion

A key finding is the rising number of CPP referrals, particularly among younger patients. CPP presentations frequently overlap with other functional and chronic conditions, including irritable bowel syndrome (IBS), functional neurological disorder (FND), migraine, and non-epileptic seizures, alongside mental health comorbidities.

This highlights the complexity of CPP and the limitations of existing referral and management pathways in addressing patient needs effectively.

Conclusion

The development of a dedicated CPP pathway has the potential to improve patient management by facilitating more appropriate triage, assessment, and intervention. This may also enhance service efficiency and patient outcomes.

Application to Clinical Practice

A CPP pathway steering group—comprising multidisciplinary team (MDT) clinicians and administrative staff within the UHB Pain Service—has been established. This group will guide the development and implementation of a new pathway aimed at ensuring timely triage, assessment, and referral to appropriate interventions for patients with CPP.

A clinical evaluation of a LWWP 10-Footsteps-informed NHS Pain self-management programme in the West Midlands: early findings.

Laura Hissey, Meghan Linscott, Frances Cole, Constance Pollard & Paul Chazot

Persistent pain, defined as pain lasting or recurring for longer than three months, significantly impacts the quality of life of individuals, impeding daily activities, mental health, and overall well-being. The complex nature of persistent pain, influenced by a variety of biological, psychological, and social factors, necessitates a comprehensive approach to management. This has led to the development and implementation of Pain Management Programmes (PMPs), which aim to improve the quality of life of individuals living with persistent pain through a multidisciplinary approach, focusing on self-management strategies. The "Ten Footsteps to Living Well with Pain" is an engaging, interactive self-management programme developed through a collaboration between a team of pain specialists—including individuals with lived experience, a Clinical Psychologists, GPs, and Physiotherapists and researchers from the Wolfson Research Institute for Health and Wellbeing Pain Challenge Academy, Durham University.

The UHB Pain management programme aims to help people to live well with chronic pain by helping them to learn ways of dealing with the disabling effects and distress caused by its impact of pain.

The PMP has been developed based on the British Pain Society pain management programmes for adults guidelines (2019) guidance, and the content is based on the PCI-accredited Live well with Pain Ten Footsteps to self-management Framework (www.livewellwithpain.co.uk). The programme is a 6-week course which consists of a 3-hour weekly session and a follow up session 6 weeks after the PMP. All sessions were facilitated by a specialist pain physiotherapist and specialist pain psychologists. Each session has an educational and practical elements, where people used a health needs assessment approach to identify their health priorities and to set specific personal goals. The people learn in a group setting from the programme content about pain and ways to try and manage the pain (Ten Footsteps), and how to exercise safely and build up activity levels. Participants comprise 80.2% female, 15.2% male. Parameters were determined before and after the training programme (N=76). Parameters measured included Pain Frequency, Intensity and Burden scale, Tampa scale of kinesiophobia, Pain self-efficacy questionnaire 10, Generalised anxiety disorder assessment-7, Patient Health questionnaire-9 and Chronic pain acceptance questionnaire-8.

The intervention resulted in a highly significant ($p < 0.001$) reduction in pain frequency, intensity and burden (PHQ-9), fear avoidance of pain (TSK), anxiety (GAD-7) and depression, and a concomitant increase in chronic pain acceptance (CPAQ-8) and confidence in dealing with pain (PSEQ).

In summary, the clinical data collected to date shows significant positive changes in all dimensions tested including mental health, acceptance and confidence, with concomitant reduction in pain frequency, intensity and burden. We are currently analysing a further 24+ participants.

What do the Live Well with Pain's Health and Wellbeing check self-complete outcomes tell us?

Frances Cole, , David Andrassy, Paul Chazot, Emma Davies

The Health and Wellbeing Check is on Live Well with Pain web resources as a paper questionnaire for patients to use from their clinicians. Feedback consistently shows it is highly effective at helping patients to identify their needs and move forward with their pain self-management. In September 2025, an online version of this tool was launched. This interactive version is designed to be simple to use and puts the tool directly in the hands of people with pain. Users are encouraged to save their results as a PDF and share with their healthcare worker. The Health and Wellbeing Check is completely anonymous and no personally identifiable information is collected. We are, however, able to collect aggregated data which, over time, which enables to understand:

1. levels of emotional wellbeing among users of the tool, based on WHO mental wellbeing scale;
2. the levels of pain and distress people report at the time of completing the check, and over the previous week;
3. users' levels of confidence despite their pain – in terms of day-to-day life and ability to do work (of any kind);
4. other areas of users' lives impacted by pain, and the frequency with which these are cited by users.

The Health and Wellbeing Check is a four-step process. Step 1. the person to complete uses the WHO Mental Well Being scale which asks them to rate how they have been feeling over the past fortnight in relation to five statements representing different areas of emotional wellbeing. They are asked to rate how often they have felt this way, on a scale that ranges from 'all of the time' to 'at no time.' Step 2. This is about aspects of pain intensity and pain distress levels. The higher the score the worse the level. A pain distress of level of 7 or more indicates emotional wellbeing is significantly affected and addressing psychological care is indicated. The second part of step 2 is about confidence to self-manage. Score is out of a maximum of 12. The higher the score, the greater the level of confidence to self-manage. Scores below 4 indicate a severe impact of pain on confidence.

Step 3. This is the health needs assessment component of the Health and Wellbeing Check developed by Cole in 2004. It helps both the individual and clinicians see the wider picture of the impact of pain on their health function across 13 areas of health needs.

Results: The Health and Wellbeing Check was completed anonymously by 1,225 people over 14 weeks. On completing the tool, users were invited to complete a feedback questionnaire to share about their experience of its use.

127 people completed this feedback questionnaire and their responses are summarised.

123 of 127 people who completed feedback found the Health and Wellbeing Check very easy, quite easy or reasonably easy to complete. Four found it quite difficult or very difficult. 72 people found the Health and Wellbeing Check very helpful or quite helpful. 22 people found it not very helpful. 33 people were not sure whether or not it had helped them. 102 people said they would use it again (80%), with 25 answering no (20%).

From the data of steps 1, of the health needs self-assessment, the majority woke up feeling fresh and rested, active and vigorous on no occasions. From Steps 2, the majority had a pain distress of level of 7 or more which indicates emotional wellbeing is significantly affected. Confidence of self-management score is out of a maximum of 12. The higher the score, the greater the level of confidence to self-manage. 75% of completers confidence score was 4 or less to live a normal lifestyle and 64% scored 4 or less in confidence being able to work.

Data from the health needs self-assessment Steps 3 and 4 indicate the top three priorities that people with pain need health and other practitioners to address collaboratively. Sleep difficulties and becoming more physically active are the two top priorities. Pain relief and managing moods of depression and anxiety are a joint third priority. This is a pattern seen repeatedly over populations or communities where Steps 3 and 4 data is aggregated.

Health need priorities show the dysregulation of the key health regulation systems of sleep, physical activity and social connection resulting from chronic pain. These are all changeable with therapeutic sleep management, movement and

activity approaches and community engagement as in the widespread uptake by individuals in emerging self-care communities “pain cafes” in the UK in the last four years. It shows the valued outcome of enabling individuals to self-assess their health needs to explore their health choices. The aggregated data offers person centred health needs driven pathways of care with a range of services and community rather than dependence on just pain relief and medication use. Sleep management and increasing physical fitness is well evidenced and all these priorities can be addressed within existing more economic resources than reliance on yet more medication.

Community-Based Peer Support for Chronic Pain in Somerset

Vicky Wright: M.Sc: Neighbourhood Transformation Lead; NHS Somerset

Jaki Smith: PG Dip: Lived Experience Volunteer; ARK at Egwood

Ann Livingstone: B.A (Hons): Founder and Director; Community Pain Hubs Somerset CIC

Chronic Pain is a prevalent and complex health condition that significantly affects a person's quality of life, social participation, and mental well-being. Of the estimated 593,000 Somerset residents (2026 estimate¹) it is predicted 254,980 will experience some level of persistent (chronic) pain; of this number nearly half live in rural areas. The initiative which is being introduced throughout the county is to offer an alternative to the traditional medical and clinical model.

This initiative is developing community-based Supported Pain Self Management Workshops based on Live Well with Pain's Ten Footsteps tools and resources and Pain Cafes, a socially driven concept where attendees can share experiences, exchange practical coping strategies, and build peer support networks.

These Workshops and Pain Cafes use venues in local communities and neighbourhoods, reducing many barriers and obstacles associated many have in accessing more centralised venues for support.

Preliminary observations from these Pain Cafes which are being delivered in community settings suggest that they reduce social isolation, improve participants' confidence and mental well-being, lead to behavioural change and better lifestyle choices improving quality of life.