Update Report on Scottish Pain Management Services
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Acknowledgements

The information in this report was provided by NHS boards and we would like to thank them for their input to this work. We would also like to thank the members of the Scottish Chronic Pain Steering Group for their oversight of our work. Dr Steve Gilbert, National Lead Clinician for Chronic Pain has led this work and continues to drive forward the improvement of chronic pain services in Scotland; Healthcare Improvement Scotland warmly acknowledges his ongoing energy and commitment.
Executive summary

Background

Since 1994, a number of reports have been published on chronic pain services in Scotland\(^1\)\(^-\)\(^3\). They all highlighted that the provision of pain management services varies across Scotland and does not fully meet the needs of people with chronic pain. In 2007, NHS Quality Improvement Scotland published the GRIPS report 2007\(^4\), a comprehensive stocktake of chronic pain services which set out key priority action points aimed at improving services. Its main finding was that the provision of pain management services was patchy across Scotland. In many areas, there was also difficulty in finding out the staffing of pain services.

The GRIPS report clearly expressed the frustration that little had happened despite several reports and commitments to improve chronic pain services. Healthcare professionals, and the public, including those living with chronic pain, shared the frustration. GRIPS provoked a positive response from healthcare services and from the Scottish Government and was reissued in 2008, with an endorsement from Nicola Sturgeon, the then Cabinet Secretary for Health and Wellbeing. The Scottish Government pledged support for improving pain services and has delivered this since then by:

- funding a lead clinician since 2009, to co-ordinate and champion the development of pain management services. Scottish Government has now funded additional support to drive forward implementation of the Scottish Service Model for Chronic Pain
- requiring national organisations including NHS Education for Scotland (NES), NHS National Services Scotland (NSS) Information Services Division (ISD) and Healthcare Improvement Scotland to work together to support NHS boards
- using policy directives such as the Mental Health Strategy for Scotland: 2012–2015\(^5\) and the National Delivery Plan for the Allied Health Professions in Scotland, 2012–2015\(^6\) to drive short referral times which will provide faster assessment and referral (the Musculoskeletal service pilots have led this work)
- providing two-year funding for the start up of local service improvement groups or managed clinical networks (MCNs) for chronic pain
- including questions on patient experience of chronic pain in the national ‘Better Together’ patient experience survey, to find out the prevalence of the condition across Scotland, and
- engaging with the Cross Party Group on chronic pain.

Dr Pete MacKenzie was appointed as the first National Lead Clinician on chronic pain in 2009. He established the National Chronic Pain Steering Group and developed the Scottish Service Model for Chronic Pain. Both the Regional Planning Chief Executives (RPCE) Subgroup and the Regional Directors of Planning Group have confirmed their support in principle for the proposed integrated model of care.

In 2011, co-ordination of support for improving chronic pain services became the responsibility of Healthcare Improvement Scotland. Dr Steve Gilbert was appointed as successor to Dr MacKenzie and continued to drive this work forward through the National Chronic Pain Steering Group. He focused on ensuring chronic pain services had a high profile in NHS boards and initiated further discussions aimed at implementation of the model at the RPCE Subgroup meeting in June 2011. To support implementation planning Dr Gilbert was asked for further information on provision of current pain management services across Scotland, identifying any gaps and variation. The subgroup was also interested in the economic consequences of implementing, or not implementing, the Scottish Service Model for Chronic Pain, and robust audit of outcomes from pain management.

The purpose of this report is mainly to meet the request for further information on current pain management services. The report uses data collected from April 2010 to March 2011. Further work on
other issues raised is under way and a report on the economic case for pain management can be found at http://www.knowledge.scot.nhs.uk/pain/resources-library.aspx.

**Chronic pain – what is it and why is the topic important?**

Chronic pain can be defined as continuous, long-term pain lasting more than 12 weeks or pain persisting after the time that healing would have been expected to occur after trauma or injury. Chronic pain can be associated with diseases such as arthritis, but can also occur as a condition by itself.

Almost 10 million people in Britain suffer pain daily resulting in a major impact on their quality of life, employment status, daily activities, relationships, mood, sleep and all aspects of general health. Significant pain is estimated to affect 14% of adults and 8% of children. The cost of back pain alone accounts for about £1 billion of the UK’s health expenditure and between £5–10 billion total cost to the UK economy in 2008.

We know from a range of reports that pain is not consistently managed across the whole health and social care system at present. Specialist services in secondary and tertiary care are generally tasked with managing complex pain, often with limited resources. In recent years, more chronic pain services have been set up in primary care, although little is known about the population served, the services offered and resulting outcomes for people living with the condition.

Healthcare Improvement Scotland and the Scottish Government aim to support the implementation of an effective service model for chronic pain services. This requires understanding of chronic pain in its early stages in the community and primary care so that its consequences can be improved.

**The update audit: purpose and data collection**

The 2007 GRIPS report surveyed NHS boards on service provision at that time. Healthcare Improvement Scotland has since conducted a detailed audit of the provision of pain management services and the numbers of patients seen by these services for the period 1 April 2010 to 31 March 2011 across NHSScotland.

This audit aimed to establish the gap between the services available in 2010–2011 and those required to deliver the Scottish Service Model for Chronic Pain. The model sets out the pathway for treatment of chronic pain and provides guidance on the desired level of input at each level of care (community, primary, secondary and tertiary). By understanding the gap between services provided and services required, NHS boards will be able to target resources to close the gap and meet people’s needs more effectively. While the audit covered the general provision of local pain management services it also explored:

- referrals for assessment as well as to residential pain management programmes (PMPs)
- collaboration between different services including acute and primary care, the voluntary sector and from the National Managed Knowledge Network and local websites, and
- children and young people’s pain services

We collected data and information by contacting the lead clinician for secondary care pain management services in each NHS board and collecting further information from other members of services as necessary. We also met with a number of boards for further discussion about their data.

The analysis of the information provided by NHS boards has been ratified by the senior management team and heads of planning in each NHS board. All 14 territorial NHS boards participated in the audit and has signed off their data as accurate at that time.
Our findings

Every NHS board fully participated in this audit. This is a positive development as when NHS Quality Improvement Scotland carried out the previous audit in 2007, a number of NHS boards did not respond to all of the questions asked. In summary, the latest audit findings show the following.

General provision of pain management services

- All NHS boards reported they have pain management services and all have a lead clinician responsible for these. These services are all based in secondary care and the clinical leads are all anaesthetists. While not all services have all the components of the Scottish Service Model for Chronic Pain, this represents a considerable improvement since the GRIPS survey, when four NHS boards provided no information about the services and other NHS boards’ information was incomplete.

- Average waiting time from referral to first appointment was 11 weeks.

- There has been improvement in the provision of local PMPs across Scotland since 2007. At that time, only three NHS boards reported having a PMP which met the standards of the British Pain Society. Two further NHS boards provided a PMP, in conjunction with the voluntary sector, which did not meet these criteria.

- Over 64.9% of the population now have access to a PMP in their NHS board area although waiting times to access these do vary.

- There was improvement in the provision of multidisciplinary pain management teams. These had increased from seven NHS boards in 2007 to 12 in 2010–2011. Not all teams had all disciplines, and in the remaining two NHS boards, there is a service although this is mostly provided by a doctor.

- At present, there is no residential PMP service in Scotland. However, NHS boards fund a national arrangement that allows patients to attend these services in England and Wales. This audit has provided an opportunity to consider the current arrangements and the latest evidence on the benefits of this approach, particularly as it is essential to make sure that patients are properly supported when they return home.

- Primary care provision of multidisciplinary pain management is available in NHS Fife and NHS Lanarkshire, with a partial service in NHS Lothian. All other NHS boards reported that they are providing community-based pain services, not all clinician-led.

Referrals

- Reported rates of referral to secondary care pain management services ranged from 0.2–0.9% of the population in Scotland.

- Given that audit shows 14% of the population have chronic pain, defined as pain lasting more than 3 months\(^7\), it would appear that the majority of the chronic pain population are not referred directly into secondary care pain management services. They may be being managed effectively in primary care, or referred into other condition-specific services such as cancer or musculoskeletal services.

Collaboration between services and with the voluntary sector

- There is improved collaboration with the voluntary sector with most NHS boards providing some funding to Pain Association Scotland to deliver self-management support. Several NHS boards have entered into formal service level agreements with Pain Association Scotland.

Services for children

- Specific multidisciplinary pain clinics for children are provided in the children’s hospitals in Edinburgh, Glasgow and Aberdeen.
Conclusion and recommendations

There is still variation in the provision of pain management services which is not related to the populations of the NHS boards, but seems to be a result of how services have evolved in local circumstances. There is also variability across Scotland in referral rates to chronic pain services.

There is enthusiasm and energy across Scotland with many examples of excellent and innovative practice. In particular, there has been investment in musculoskeletal services with physiotherapy leading on much of this work. Pharmacy is also taking on a growing role in service provision and in spring 2013 there will be a pharmacy poster campaign aimed at raising awareness through community pharmacies across Scotland.

There is no doubt there have been improvements in the provision of pain management services since the GRIPS report, but gaps remain in the provision of services. Our recommendations aim to support NHS boards to address those gaps and further improve chronic pain services. These recommendations are made in the context of the Chief Executive letter of July 2012 (CEL 29 2012) from Derek Feeley and Sir Harry Burns which sets out how an MCN approach to service improvement can support and deliver safe, effective and person-centred care.

Our recommendations are as follows and are explained in more detail on page 13.

- **Recommendation 1:** Implementing the Scottish Service Model for Chronic Pain
- **Recommendation 2:** Working with patients and the voluntary sector
- **Recommendation 3:** Data collection and measurement
- **Recommendation 4:** Collaborating for success

More details about the work of Healthcare Improvement Scotland and the Chronic Pain Steering Group can be found at:

Detailed findings

This section provides more specific findings of the audit. The headings used in the executive summary have been used to present these.

General provision of pain management services

The multidisciplinary team

The Scottish Service Model for Chronic Pain recommends a multidisciplinary approach to chronic pain care, with provision of treatment, support and advice for chronic pain in the community and primary care as well as in specialised chronic pain clinics in hospitals. While this service model sets out the ideal provision of services, NHS boards need to consider how best they can implement this model taking into account local needs and circumstances. Not every NHS board has ready access to all the specialties and facilities needed to provide a full multidisciplinary service. However, all NHS boards can ensure people are able to access multidisciplinary services through partnership arrangements with other boards and the voluntary sector. Healthcare Improvement Scotland is aware of innovative solutions where NHS boards have tapped into condition-specific pain services including cancer and diabetes.

Setting out how resources are used to provide pain management services remains a challenge for some NHS boards. In some areas, there is a well defined chronic pain service that can specify funding and staffing for chronic pain. In other boards, staffing and resources are shared across services that support a range of conditions. For example, NHS Greater Glasgow and Clyde reported one whole time equivalent pain specialist nurse to 165,840 people, while NHS Lothian reported one pain specialist nurse to 547,272 people. Redressing this variation in service will require sharing of knowledge and skills between different disciplines in the multidisciplinary team as well as utilisation and enhancement of resources in other areas such community pharmacy, leisure services and the voluntary sector.

Table 1 summarises the members of the dedicated multidisciplinary chronic pain team in primary and secondary care that are available in each NHS board. Every NHS board has a pain service and pain management support in other services such as physiotherapy, rheumatology, neurology or palliative care.

Table 1: Members of dedicated multidisciplinary chronic pain team

<table>
<thead>
<tr>
<th>A&amp;A</th>
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<th>D&amp;G</th>
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<th>GG&amp;C</th>
<th>Grampian</th>
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</table>

Provision of multidisciplinary pain management

The average waiting time for a first appointment to a pain service was 11 weeks from referral. It was more difficult to get a clear picture of internal waiting times for review appointments and treatment by AHPs or a PMP (which is usually developed to reflect personal and clinical needs after an initial consultation with the pain service). Access to all elements of a PMP can range from 4 months to over 1 year.

Scottish Government published the Mental Health Strategy for Scotland: 2012–2015 in August 2012. Commitment 13 states: “We will continue our work to deliver faster access to psychological therapies. By
December 2014, the standard for referral to the commencement of treatment will be a maximum of 18 weeks, irrespective of age, illness or therapy.” Although psychological therapies are only one element of pain management services, this commitment does apply to chronic pain.

The National Delivery Plan for the Allied Health Professions in Scotland published in June 2012, also says: “AHP directors will drive the delivery of AHP waiting times within 18 weeks from referral to treatment, inclusive of all AHP professions and specialties (except diagnostic and therapy radiographers) with a target of 90% by December 2014. NHS boards will be expected to deliver a maximum wait of no more than 4 weeks for AHP musculoskeletal treatment within the same period.”

NHS boards should consider what investment is needed in relation to multidisciplinary pain services to make sure they are able to meet these commitments.

**Multidisciplinary pain management programmes**

A proportion of people with chronic pain cannot be cured or have their pain level reduced. However, a multidisciplinary PMP can make a significant improvement in the patient’s quality of life; giving them the tools to manage their pain themselves and in turn reduce their reliance on NHS services. PMPs involve assessment, treatment and advice from doctors, psychologists, physiotherapists, pharmacists and occupational therapists. A programme is usually carried out in an outpatient group setting for 2–3 hours a week over 8–12 weeks. PMPs are now available to 64.9% of the Scottish population in their NHS boards.

In NHS Fife, where an outpatient PMP is available, 1 in 10 patients with chronic pain are referred to the local PMP. In NHS Grampian and NHS Tayside, where there is no local outpatient PMP available, 12 patients from each of these two NHS boards were referred to the Bath PMP. This equates to 1 in 100 and 1 in 132 patients respectively. Thirty-four patients from Scotland were sent to the Bath PMP at a total cost of £313,339 during the year 2010–2011. Most live in NHS board areas where there is no local PMP provision. Feedback on the services provided by Bath is very positively and the National Services Division of NSS monitors the use of this service carefully. It is important to factor in the travelling and expense involved, although this is met by the referring NHS board.

Healthcare Improvement Scotland is currently considering a range of PMP models, including whether a residential option would be appropriate and there are a number of recently established and innovative approaches to review and test.

**Audit activity on outcomes from pain management**

This audit found that most pain management services collect data on a range of measures including access to services, treatment modalities and outcome measures. Collecting information on outcomes is challenging as these are often specific to each individual and are based on effective, shared assessment of goals such as returning to work or reducing opiates.

A wide variety of validated outcome measures are used across NHSScotland, including: The Brief Pain Inventory, Tampa scale of Kinesiophobia, the Pain Self Efficacy Questionnaire, Oswestry Disability Index, Hospital Anxiety and Depression Scale, Beck Depression Inventory and SF – 36. These are well-established tools and many support effective self-management and can be used to chart change and improvement over time.

Local audit and development of action plans are an important element for local service improvement and also help prioritise resources. Healthcare Improvement Scotland’s focus at present is on developing a small set of national indicators that can be used to measure the use of services and attendant outcomes. Healthcare Improvement Scotland will work collaboratively with ISD to make it as easy as possible to collect and interpret the data required.
Referrals

Reported rates of referral to secondary care pain management services ranged from 0.2–0.9% of the population in Scotland (see Table 2). These data are skewed by the significantly higher referral rate in NHS Shetland where the pain clinicians carry out interventional radiology procedures. If these data are excluded, the rate ranges from 0.2–0.57% of the population, with an average rate of 0.29%. The reason for variation in referral rate is not clear and requires further investigation. It may reflect differences in awareness of the availability of pain management services or differences in practice in secondary care management. It could also reflect differences in the incidence of chronic pain.

Given that audit shows 14% of the population have chronic pain, defined as pain lasting more than 3 months, it would appear that the majority of the chronic pain population are not referred directly into secondary care pain management services. They may be being managed effectively in primary care, or referred into other condition-specific services such as cancer or musculoskeletal services.

Table 2: Referral to secondary care pain management services

![Graph showing referral rates across different regions of Scotland]

Collaboration between services and the voluntary sector

Supporting patients to self-manage their pain can reduce demand on both primary and secondary care resources, investigations and treatments. Early intervention and improved primary care management of chronic pain, through collaboration with the voluntary sector, could reduce the likelihood of developing severe chronic pain, reduce inappropriate referrals and help reduce the demand on acute and secondary care services.

Pain Association Scotland is a voluntary organisation, able to provide self-management training and support for people with chronic pain. There has been close co-operation between Pain Association Scotland and most NHS boards. NHS Ayrshire & Arran, NHS Borders, NHS Grampian, NHS Orkney and NHS Shetland reported at the time that they did not fund Pain Association Scotland to deliver self-management support. The previous Cabinet Secretary for Health and Wellbeing has publicly encouraged NHS boards to collaborate with the voluntary sector by entering into service level agreements with Pain Association Scotland. This agreement provides a formal context for self-management support where no alternative arrangements exist at present.

Other voluntary organisations also support patients with chronic pain, with some funding coming from the Health & Social Care Alliance self-management fund (formerly known as the Long Term Conditions
Alliance Scotland (LTCAS)). LTCAS has also developed the national awareness raising campaign My Condition, My Terms, My Life. The Pain Toolkit is also useful.

**National managed knowledge network and local websites**

Details of all NHS boards’ chronic pain services are on the National Chronic Pain website. This includes information on referrals, services provided and contact details for patients and professionals. Some NHS boards also provide more detailed information on medication and non pharmacological management of chronic pain.

**Services for children**

The prevalence of chronic pain is slightly less in children than adults\(^8\). Nevertheless, it is estimated that 8% of children have significant pain which can interfere with their education and quality of life. This may equate to 80,000 children and young people in Scotland. There are multidisciplinary children’s pain management services in the children’s hospitals in Glasgow, Edinburgh and Aberdeen. There are also clinics that care for children in NHS Fife and Tayside.

Table 3 shows provision of staff for children and young people’s chronic pain clinics in March 2011. The development of children’s pain services in Scotland is at a relatively early stage and is another key element of NHS board implementation of the Scottish Service Model for Chronic Pain.

**Table 3: Scottish children and young people’s chronic pain services 1 April 2010–31 March 2011**

<table>
<thead>
<tr>
<th>NHS board</th>
<th>Fife</th>
<th>Grampian</th>
<th>GG&amp;C</th>
<th>Lothian</th>
<th>Tayside</th>
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</thead>
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<td>19</td>
<td>78</td>
<td>37</td>
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<td>0.033</td>
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NHS boards will need to consider what investment is needed in relation to children’s multidisciplinary pain services in order to meet the Mental Health Strategy\(^5\) for Scotland commitment on access to psychological therapies. The National Delivery Plan for the AHPs\(^6\), which says that NHS boards will be expected to deliver a maximum wait of no more than 4 weeks for AHP musculoskeletal treatment.
Conclusions and recommendations

Surveys of the prevalence of adult chronic pain have found significant pain in around 14% and severe pain in 6% in the general population. This report has found that approximately 0.3% of the chronic pain population were referred to secondary care pain management clinics. This suggests that the majority of people living with chronic pain will be cared for in the community and primary care.

Primary care management of patients with chronic pain has been estimated to account for 4.6 million appointments per year in the UK, equivalent to 793 whole time general practitioners, at a total cost of around £69 million and of course, chronic pain causes considerable distress, disability and economic impact. It is important that this work is supported and well integrated with secondary care services.

Therefore, the Scottish Government and Healthcare Improvement Scotland expect every NHS board in Scotland to implement the Scottish Service Model for Chronic Pain, while taking into account the needs and priorities of their local populations. This model provides a patient pathway through services which is not prescriptive, but is dependent on local planning and service redesign to make sure pain services are:

- accessible
- multidisciplinary, and
- person-centred, including self-management.

NHS boards need to underpin these services with the necessary infrastructure including support for measurement and improvement. Importantly, other services need to know how to refer into, and take referrals from, pain services.

**Recommendation 1: Implementing the Scottish Service Model for Chronic Pain**

All NHS boards should establish SIGs or MCNs to implement the recommendations of the GRIPS report and the Scottish Service Model for Chronic Pain. Pump prime funding of up to £100,000 over 2 years for each NHS board is available from the Scottish Government to assist with the establishment of chronic pain MCNs or SIGs.

**Update**

An MCN on chronic pain has operated effectively in NHS Greater Glasgow and Clyde since 2008, and has delivered real improvements in the management of chronic pain. Plans for the establishment of MCNs or SIGs have been funded for NHS Lanarkshire, NHS Ayrshire & Arran, NHS Dumfries & Galloway and NHS Lothian. Other NHS boards are considering adopting this approach and are receiving support from Healthcare Improvement Scotland and the Scottish Government to develop their plans.

**Recommendation 2: Working with patients and the voluntary sector**

Patients are key partners in the management of chronic pain. NHS boards need to develop strong participation models and work collaboratively with the voluntary sector to harness the patient voice and support self-management.

NHS boards should consolidate this collaboration by entering into service level agreements with the Pain Association Scotland to make sure that self-management support is provided, where none exist at present.

**Update**

The Patient Experience Survey of GP and local NHS Services 2011/12 carried out by the Scottish Government was published in May 2012. It found the rate of chronic pain, lasting more than 3 months, in a survey of 145,569 people in Scotland, to be 13%. Almost 60% of respondents had received NHS treatment or advice because of something that was causing them pain or discomfort. NHS boards should also consider how they can promote the national awareness raising campaign My Condition, My Terms, My Life and the Pain Toolkit.
**Recommendation 3: Data collection and measurement**

Healthcare Improvement Scotland, ISD and NHS boards should work together to develop a small set of national indicators to provide core measurement data on pain management services to support improvement in patient outcomes. Central to this is effective data collection and analysis locally and nationally. ISD is leading on the development of a national approach to this. This work is overseen by the chronic pain steering group in conjunction with local chronic pain services as it is essential data are used and reviewed locally if services are to be improved.

**Recommendation 4: Collaborating for success**

A number of organisations are involved in supporting the delivery of effective chronic pain services. It is essential they work together to a shared programme of work which reflects the pressures that NHS boards face in delivering all that they are responsible for. Healthcare Improvement Scotland’s work indicates that three of the most important elements of support are education, evidence and self-management.

The chronic pain steering group needs to continue to oversee a programme of support for the implementation of the Scottish Service Model for Chronic Pain.

Core to this is the work of:

- Healthcare Improvement Scotland in contributing to the SIGN Guideline on Chronic Pain – this will be important in providing evidence and standards for chronic pain management
- NES in developing educational tools for the public and healthcare professionals
- the Scottish Pain Research Community
- voluntary sector organisations, and
- the Health and Social Care Alliance Scotland.
References

3. Chronic Pain Services in Scotland; Report by Professor James McEwen. 2004
4. Getting to GRIPS with Chronic Pain in Scotland , NHS Quality Improvement Scotland 2007/8
13. The Patient Experience Survey of GP and Local NHS Services 2011/12
Appendix 1: The Scottish Service Model for Chronic Pain

The model is designed around the Kaiser Permanente pyramid.

- Improve understanding, prevention and management of chronic pain (lasting longer than 3 months or after healing would have been expected).
- Improve services at all levels.
- Make sure people get the earliest possible and most appropriate treatment locally, but with ready access to specialist services when needed.

It sets out a tiered model of care.

- **Community** which uses voluntary sector organisations, including Pain Association Scotland, Pain Concern, NHS 24 and NHS Inform, to provide people with the education, and information they need to manage their pain and where appropriate, help them return to work. GPs, primary care staff and community pharmacists would assist patients to access the best advice on non-pharmacological and pharmacological pain management.

- **Primary care** delivers education and support to make sure people living with pain are treated effectively and their medication appropriately managed. Multidisciplinary pain management in primary care will identify problems sooner rather than later and help reduce disability. Primary care pain management may be delivered by GPs and AHPs with knowledge of pain management.

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**Legend:**
- Community
- Primary Care
- Secondary Care
- Tertiary Care
- Rehabilitation & Recovery
- **Secondary care** for people whose pain is more complex. The model aims to make sure that essential specialist PMPs are available in secondary care. This service will be delivered by doctors, physiotherapists, occupational therapists, psychologists and pharmacists with specialist qualifications and more advanced knowledge in pain management. The secondary care level will provide education, training and support to the primary care tier.

- **Tertiary care** access to highly specialised interventions such as spinal cord stimulation or a more specialised management programme, where appropriate.
Appendix 2: 2012–2013 priorities for Healthcare Improvement Scotland and the Chronic Pain Steering Group

Work for which Healthcare Improvement Scotland and the chronic pain steering group will primarily be responsible

1. Supporting NHS boards to implement the chronic pain business model through MCNs or service improvement groups.
2. Advise and inform Scottish Government on chronic pain matters.
3. The use of data for improvement.
4. Participate in and advise on the development of the SIGN Guideline on Chronic Pain.
5. Supporting improved primary care management of chronic pain.

Work in which Healthcare Improvement Scotland and the chronic pain steering group will be a partner

6. Data collection.
7. Education - Raising primary care awareness and supporting boards in shifting the balance of care.
8. Scottish Pain Research Community (SPaRC).

Work which Healthcare Improvement Scotland and the chronic pain steering group will contribute to

9. Promoting self-management in association with voluntary sector groups such as Pain Association Scotland.
10. Improve pharmaceutical care in conjunction with the polypharmacy group.
11. Input to the Cross Party Group on chronic pain.
12. Work closely with the Long Term Conditions Alliance Scotland and other stakeholders.

Full details of the priorities are on the Chronic Pain, Managed Knowledge Network website http://www.healthcareimprovementscotland.org/programmes/long_term_conditions/chronic_pain.aspx