Report on Chronic Pain Management Services in Scotland:

Purpose

To consider how best to accelerate implementation of the Scottish Chronic Pain Service Model in order to support NHS Boards to fulfil the recommendations of Healthcare Improvement Scotland’s GRIPS Report 2007. (Appendix 1)

To agree that the Scottish Chronic Pain Service Model supports the Business Case for Quality and that the Aim and Actions outlined below will support NHS Boards to realise the 20:20 Vision for Sustainable Quality.

Aim

• To improve the effectiveness and quality and outcomes of chronic pain management in Scotland by 2015.

Actions

• We will rationalise pathways and treatment of chronic pain, resulting in less waste, less unwarranted variation and faster access to more effective and efficient care

• We will reduce potentially harmful investigation and treatments for chronic pain.

• We will promote a more enabling, person centred and holistic approach to chronic pain, through education of the public and health professionals and increased support for self management.

The context for change

Gerry Marr, Chief Executive of NHS Tayside recently set out a Business Case for Quality which stated:

“Value in any field must be defined around the customer, not the supplier. Value must also be measured by outputs, not inputs. Hence it is patient health results that matter, not the volume of services delivered. But results are achieved at some cost. Therefore, the proper objective is the patient health outcomes relative to the total cost (inputs). Efficiency, then, is subsumed in the concept of value.(2)”

This business case recognises that, in Scotland, we are uniquely placed to meet the challenge of restraints in finance while continuing our ambitions to improve the quality of our services. However it is clear there remains significant unwarranted variation in the care
we provide and the outcomes we achieve. Waste exists in many of the processes designed to deliver our current system of care.

Demographics

The incidence of significant chronic pain is 14% and 6% of the population suffer severe chronic pain which constantly interferes with work and other normal activities. (3)

However over the next ten years the proportion of over 75 year olds in Scotland’s population will increase by over 25%. By 2033 the number of people over 75 is likely to have increased by almost 60%. There will be a continuing shift in the pattern of disease towards Long Term Conditions, including chronic pain, with growing numbers of people with multiple morbidity and complex care and support needs. Over the next 20 years demography alone could increase the demand for health care by 16-22%.

There is therefore a real need not to simply focus short term tactical efficiency and productivity gains, but to think fundamentally about how we transform Public Services, including chronic pain services.

The Scottish Service Model for Chronic Pain will support this transformational change. It will deliver an affordable, sustainable and integrated model of chronic pain services by:

- designing clear pathways which deliver care as locally as possible in the community
- better co-ordination, continuity and communication between users of the services, their carers and providers of the service
- collaborating with the third sector and, in particular, utilising their expertise in providing emotional and psychological support and helping people with chronic pain to manage their condition
- developing enabling services which build on people’s strengths, maximise their independence and opportunities for work and meaningful participation
- eliminating waste, reducing inappropriate referrals and improving appropriate, cost effective and safe prescribing.

Progress to date

Both the Regional Planning Chief Executives (RPCE) sub group and Regional Directors of Planning Group have confirmed their support in principle for the proposed integrated model of care for chronic pain. Clarification was sought on four issues;

1. More detail on the current level of service provision in Scotland and whether there is evidence of a link between gaps in service and referral to the Residential Pain Management Service in Bath.
2. What are the Chronic Pain Steering Group’s (CPSG) plans to develop a range of national supports including audit?

3. What are the service and financial consequences of introducing, or not introducing aspects of the proposed model of care?

4. What is implementation of the Scottish Chronic Pain Service Model expected to achieve?

This paper provides an update on each of these issues.

Q1 What is the current level of service provision in Scotland and is there evidence of a link between gaps in service and referral to the Residential Pain Management Service in Bath?

**Benchmarking Report on Scottish Chronic Pain Services**

This Benchmarking report describes pain services provided in each NHS Board including referral rates, staffing levels, services provided by voluntary groups and the audit and information resources available. These are key to supporting the implementation of the Scottish Chronic Pain Service Model. (1)

**The Multidisciplinary Team**

In many regions, chronic pain services depend on a Consultant Anaesthetist, who is trained to manage medication or to perform interventional techniques (injections or other nerve blocking techniques) to manage chronic pain. This is the traditional service model for chronic pain management and helps some patients, but over the last 20 years it has been realised that a multidisciplinary approach, utilising Psychology, Physiotherapy and Occupational Therapy advice in conjunction with medical treatment is the most effective treatment for Chronic Pain, especially in reducing the disability and suffering associated with persistent pain. Patients who have more disability and suffering need more intensive therapy with a multidisciplinary Pain Management Programme. These more complex patients constitute around 5 – 10% of patients referred to the secondary care pain management service or around 0.5 – 1% of the general population with chronic pain.

Data from the Benchmarking Report on Chronic Pain Services; year 1/4/2010 – 31/3/2011 shows that NHS Dumfries and Galloway and NHS Orkney have no multidisciplinary team aligned to management of chronic pain while several other Boards have provision that is less than a whole time equivalent.

The graph, (pg 4) shows that there is considerable variation in the provision of members of the multidisciplinary team, which is not in proportion to the NHS Boards populations. The composition of the services has mostly evolved from availability rather than being planned to meet the needs of the population.
For example, there are 10WTE chronic pain nurses in NHS Greater Glasgow and Clyde corresponding to 1WTE for 120,000 people, compared to 1.3WTE in NHS Lothian or 1WTE for 550,000.

Only Fife and the Borders have a fully multidisciplinary chronic pain service in secondary care and have support from occupational therapy. In many services, the members of the team have fractions of a WTE dedicated to chronic pain management.

The Voluntary Sector

Supporting patients to self-manage their pain will 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 reduce the costs for 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 cooperation between the Pain Association Scotland and most Scottish Health Boards. The Cabinet Secretary has encouraged boards to consolidate this collaboration by entering into service level agreements with the Pain Association Scotland. At present there is no SLA with NHS Ayrshire, NHS Borders, NHS Grampian, NHS Orkney and NHS Shetland.
Primary Care Pain Management

Triage and targeted treatment has recently been found to substantially increase efficiency and effectiveness of services in Chronic Low Back Pain.\(^{(4)}\)

The great majority of people with chronic pain are managed in the community and in Primary Care. However to date there is little provision of primary care multidisciplinary pain management in Scotland with the exception of Fife and Lanarkshire.

Improving the skills and knowledge of chronic pain amongst staff working in primary and community care is a priority. The CPSG has undertaken a learning needs assessment as well as discussions with the RCGP and key stakeholders at the Scottish Government to design ways of achieving this. There are also opportunities to improve knowledge and skills among Primary Care AHP’s, community nurses and community pharmacists who could provide much support to GPs in managing pain at an earlier stage, preventing unnecessary prescribing, appointments, referrals and investigations.

Integrated working with Secondary Care Pain Services can foster local champions in Primary Care. There is work in progress, involving the GMC, the Education Special Interest Group of the British Pain Society and the Faculty of Pain Medicine to improve training in pain management for all health professionals at an early stage of their studies.

Telehealth links and networking could improve remote consultations, provide mentoring and support for primary care practitioners as well as contribute significantly to the delivery of peer support and self management.

Secondary Care Pain Management

The establishment of an MCN in Glasgow has led to provision of a PMP which has produced comprehensive outcome data demonstrating improved patient outcomes. Similar PMP’s have run in NHS Lothian, NHS Borders & NHS Fife for many years.

PMP’s have also been introduced, in the last year, in NHS Ayrshire, NHS Lanarkshire and NHS Highland. There remain several NHS Boards with no such service, most notably, NHS Tayside, NHS Grampian, NHS Forth Valley and NHS Dumfries and Galloway. Overall, 25% of the population in Scotland do not currently have access to a PMP in their NHS board.
The Provision of Multidisciplinary PMPs and referral to the Bath Residential PMP
April 2010 - March 2011

The overall cost of the 32 referrals which were financed through NSD was £313,339. NHS Tayside and NHS Grampian accounted for £182,881 (58%) of the total, despite these Boards having only 18% of the total Scottish population.

Comparing costs for April 2011 to 9th Jan 2012 shows a similar expenditure, which would be projected to total £309,000 for the year up to 31st March.

<table>
<thead>
<tr>
<th>NHS Board</th>
<th>2010 - 11</th>
<th>2011 - 9.1.12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ayrshire &amp; Arran</td>
<td>57,516</td>
<td>30,680</td>
</tr>
<tr>
<td>Borders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fife</td>
<td>9,627</td>
<td>16,440</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>16,472</td>
<td></td>
</tr>
<tr>
<td>Grampian</td>
<td>104,388</td>
<td>38,109</td>
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<tr>
<td>Greater Glasgow &amp; Clyde</td>
<td>16,471</td>
<td>47,062</td>
</tr>
<tr>
<td>Highland</td>
<td>13,850</td>
<td></td>
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<tr>
<td>Lanarkshire</td>
<td>9,547</td>
<td></td>
</tr>
<tr>
<td>Lothian</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orkney</td>
<td></td>
<td></td>
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<tr>
<td>Shetland</td>
<td></td>
<td>9,944</td>
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<tr>
<td>Tayside</td>
<td>78,543</td>
<td>89,522</td>
</tr>
<tr>
<td>Western Isles</td>
<td>6,925</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£313,339</strong></td>
<td><strong>£231,757</strong></td>
</tr>
</tbody>
</table>

The blue areas have a PMP
- Numbers seen in PMP
- Numbers referred to Bath
1.4.10 – 31.3.11

Only 8 of the total 40 referrals to the residential PMP at Bath were made from areas with their own PMP. These included 3 adolescents.
Q2. What are the Chronic Pain Steering Group’s (CPSG) plans to develop a range of national supports including audit?

A comprehensive national audit of Pain Management Services is under development, based on the English National Pain Audit and the e pages system, currently used in the GGC MCN.

Utilisation of medical care will be an important measure for the national pain audit to build stronger evidence for the economic as well as health benefits of a comprehensive pain management approach. The Information and Measurement Group aim to produce preliminary data by the end of 2012.

Q3. What are the service and financial consequences of introducing, or not introducing aspects of the proposed model of care?

**Financial Implications**

The economic burden of chronic pain is known to be significant. (5) Conventional medical treatment of chronic pain carries substantial costs, for medication, medical and paramedical appointments and investigations.

Over the last 4 years; (6)
- The overall spend on pain medicines in Scotland is approx £300m.
- £7m spent on Butrans patches across Scotland.
- £33m spent on pregabalin.
- Increasing rate of use of opioids, gabapentin and pregabalin across Scotland.

The variation in prescribing costs for the Scottish Health Boards suggests that more rational use of medication, within a multidisciplinary pain management model holds the potential for significant cost savings.

<table>
<thead>
<tr>
<th>PREGABALIN costs 2007 - 11</th>
<th>Total spend</th>
<th>Average cost per head population</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Ayrshire &amp; Arran</td>
<td>£2,048,701</td>
<td>£5.29</td>
</tr>
<tr>
<td>NHS Borders</td>
<td>£767,699</td>
<td>£6.63</td>
</tr>
<tr>
<td>NHS Dumfries &amp; Galloway</td>
<td>£731,843</td>
<td>£4.72</td>
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<tr>
<td>NHS Fife</td>
<td>£3,440,519</td>
<td>£9.24</td>
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<tr>
<td>NHS Forth Valley</td>
<td>£3,211,527</td>
<td>£10.45</td>
</tr>
<tr>
<td>NHS Grampian</td>
<td>£2,601,738</td>
<td>£4.59</td>
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<tr>
<td>NHS GG&amp;C</td>
<td>£7,854,113</td>
<td>£6.01</td>
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<tr>
<td>NHS Highland</td>
<td>£2,533,734</td>
<td>£7.89</td>
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<tr>
<td>NHS Lanarkshire</td>
<td>£5,357,903</td>
<td>£9.09</td>
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<tr>
<td>NHS Lothian</td>
<td>£2,366,952</td>
<td>£2.72</td>
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<tr>
<td>NHS Orkney</td>
<td>£157,900</td>
<td>£7.75</td>
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<tr>
<td>NHS Shetland</td>
<td>£16,926</td>
<td>£0.75</td>
</tr>
<tr>
<td>NHS Tayside</td>
<td>£2,528,862</td>
<td>£6.07</td>
</tr>
<tr>
<td>NHS Western Isles</td>
<td>£150,107</td>
<td>£5.45</td>
</tr>
<tr>
<td><strong>Sum:</strong></td>
<td><strong>£33,768,522</strong></td>
<td><strong>£6.19</strong></td>
</tr>
</tbody>
</table>
These data show significant variation in costs between Health Boards. Chronic Pain Pharmacists in NHS Fife are involved in education and guideline implementation, as well as review of chronic medication prescriptions. This is expected to result in significant reduction in unnecessary prescription as well as improved safety and adherence to guidelines.

The CPSG intends to work together with the prescribing team at the Scottish Government to take this forward.

Improving the management of chronic pain will make an important contribution to the Efficiency Portfolio Board’s Prescribing work stream and the work to reduce unwarranted polypharmacy for people with multiple morbidity.

A study of chronic pain patients attending a PMP found 47% less pain related medical appointments 6 months after the PMP with a cost saving of £6,300 (£109 per patient).

It is likely that those patients who don’t need a PMP also require less medical care following their treatment. (6)

Q 4. What is implementation of the Scottish Chronic Pain Service Model expected to achieve?

Effective and efficient care – as outlined in previous sections.

Safety - The rise in analgesic prescription raises safety concerns both in primary care and around reconciliation of medicines in hospital.
Person centred

The Scottish Service Model for Chronic Pain takes a holistic approach with a focus on Prevention, enabling self management, enhancing wellbeing through emotional and psychological support and increasing participation and opportunities for work and activity.

NEXT STEPS

The Scottish Government has offered NHS Boards pump priming funding of £50,000 per year for 2 years, to help facilitate the redesign of local pain services, either using a Chronic Pain Service Improvement Group or a Managed Clinical Network approach.

Service Improvement Groups or MCN’s are established in Ayrshire and Arran, Glasgow, Fife, Lanarkshire and Lothian.

A research application to study the increase in opiate prescription in primary care is under preparation by the Scottish Pain Research Community (SPaRC)
The CPSG can facilitate improvement using the experience gained in these NHS Boards. We would urge other NHS Boards to use this funding to help them transform services to deliver the anticipated quality improvements and the efficiency gains across all Levels of the model.

Community: Investing in and consolidating voluntary sector supported self management programmes through formal SLAs with the Pain Association as well as encouraging support & coordination with other voluntary organisations. Improving public awareness of Chronic Pain Management & prevention.

Level 1: Improving provision of primary care and community multidisciplinary pain management, supporting GP, pharmacist and other healthcare professionals’ education to help deliver high quality care to people as close to where they live as possible

Level 2: Investing resources to deliver cost effective and efficient pain management programmes in secondary care, ensuring that people who need to, can access specialist pain services and receive the most appropriate treatment in the most appropriate setting, including access to Tertiary services.

Level 3: Tertiary care services include spinal cord stimulation and residential pain management. We aim to reduce inappropriate referrals to residential pain programmes in England, through adequate provision of Pain Management Programmes.

**Sustainability**

The pump priming funding is time limited and must generate and evidence sufficient efficiency to sustain the improvement infrastructure. This is in addition to any investment required to develop community based services to better manage demand.

The available MCN or service improvement group pump priming funding could be put to good use to kick start improvements at all levels of the Scottish Service Model for Chronic Pain. It is envisaged that some of the savings generated from reducing inappropriate prescribing costs could be reinvested to support the running costs of these groups to continue to drive improvements once SG pump priming comes to an end.

For example, opportunities to fund the required community based chronic pain services include reinvesting prescribing savings and closer working with the Pain Association to refer less severe cases as early as possible and help reduce outpatient clinic demand.

The Scottish Centre for Telehealth has also suggested a number of ways in which telemedicine could help to develop the sort of services people with chronic pain are looking for. These include:

- video-linked sessions to help people in remote and rural areas to access a range of services;
- providing regular follow-up and review clinics using a video-link, to reduce the travel involved for all concerned; and
• using tele-education for the range of staff involved in supporting people living with chronic pain.

There are also further opportunities to explore with third sector partners through the Self Management Fund, the development of generic self management support for people with multiple conditions including chronic pain.

Boards should also consider how the Reshaping Care Community Capacity building work stream can help enhance community based services which enable healthy ageing, offer peer support and promote independence for older people with chronic pain.

**Conclusion**

The challenge faced by public services is that of delivering high quality and cost effective services in the context of competing priorities, and within the financial resources available to them. This includes reducing unwarranted variation and waste in our systems.

We believe that the innovative Scottish Chronic Pain Model will meet this challenge. This is supported by the continuing endorsement from Scottish Government for the chronic pain service model set out in the following annex.

In order to make progress, the support and endorsement of the Directors of Regional Planning and the Chief Executives on this paper’s proposals are sought. You are invited to consider how the Scottish Chronic Pain Service Model can best be taken forward, in order to realise the improved patient outcomes, efficiencies of cost and clinical effectiveness that it could produce.

References;

4. Comparison of stratified primary care management for low back pain with current best practice (STaRT Back): a randomised controlled trial
   *The Lancet, Volume 378, Issue 9802, 29 October-4 November 2011, Pages 1560-1571*
   Jonathan C Hill, David GT Whitehurst, Martyn Lewis, Stirling Bryan, Kate M Dunn, Nadine E Foster, Kika Konstantinou, Chris J Main, Elizabeth Mason, Simon Somerville, Gail Sowden, Kanchan Vohora, Elaine M Hay


8. The GRIPS Report 2007
APPENDIX 1 – PRIORITY ACTION POINTS FROM THE GRIPS REPORT 2007 (8)

**Priority Action 1**
Scottish Government to designate chronic pain as a condition in its own right, welcome the inclusion of chronic pain on the agenda of the Long Term Conditions Alliance and support uptake of Managed Clinical Networks (MCN) in Chronic Pain

*Update* - Service Improvement Groups or MCN’s exist in Ayrshire and Arran, Glasgow, Fife, Lanarkshire and Lothian.

**Priority Action 2**
NHS Boards to develop core secondary services, clear referral pathways from primary care to secondary care chronic pain services, and for tertiary services such as Spinal Cord stimulators (SCS), Intrathecal Drug Delivery (IDD) and Pain Management Programmes (PMP). These should take into account the administrative reforms recommended by the McEwen Report, Chronic Pain Services in Scotland, 2004 and will support the development of chronic pain services at Managed Clinical Network and Community Health Partnership (CHP) level

*Update* - The Scottish Service Model for Chronic Pain addresses some of these aims, but there is little chronic pain management in the community or primary care.

**Priority Action 3**
Information Services Division of National Services Scotland to develop and roll out a minimum data set with associated monitoring reports through the Core Data Set Group based in the Information Services Division and aligned with the eHealth strategy. This must be aligned with the Scottish Government’s (SG) long term conditions toolkit

*Update* - A national audit is under development.

**Priority Action 4**
NHS Quality Improvement Scotland to build on NHS QIS Best Practice Statement and NHS Education for Scotland to develop and roll-out a competency framework based on a training needs assessment

*Update* - A needs assessment has been carried out and work is underway with NES to improve pain management education and skills.

**Priority Action 5**
Scottish Government to review current SG funded provision of Pain Management Programmes provided outwith Scotland and consider investment in the development and provision of Scottish regional and local pain management programmes, including a residential facility for patients unable to attend as outpatients.

*Update* - There has been some improvement in provision of pain management programmes, although 25% of the population still have no service in their Health Board. A scoping exercise in 2009, found insufficient evidence for an economic case to support the development of a Residential Pain Management Programme, but this will be re-examined in 2012.
**Priority Action 6**
NHS Quality Improvement Scotland to consider the development of clinical standards for secondary care chronic pain

Update - A SIGN Guideline for Chronic Pain; Assessment and Management in the Non Specialist setting is under development.