NHS National Services Scotland

Minor Review Report

Scottish National Residential Pain Management Programme (SNRPMP)

2022

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Document Revision History

V1	23 April 2019	First Published
V2	18 June 2019	Aims and objectives updated
V3	8 October 2019	Updated 1.4 (undertaken by PM/ SPM and overseen by PAD)
V4	3 February 2020	Section 2.6 updated

Executive Summary

Chronic pain affects 1 in 5 people in Scotland. Chronic pain is defined as pain that has been present for more than 12 weeks. In Scotland it is estimated that 5% of the population report to be living with severe chronic pain, which impacts daily activities and quality of life.

The Scottish National Residential Pain Management Programme (SNRPMP) aims to meet the needs of adults in Scotland with chronic pain whose needs require tertiary input. The service is aimed at adults who have previously been assessed and treated by local or secondary pain services, but who continue to experience significant psychological distress and physical disability associated with chronic pain.

Specialist secondary care outpatient pain management programmes are not available in all health boards. Especially smaller boards, who do not have local programmes to refer to. Programmes and pathways for management of chronic pain are not standardised across Scotland.

This is the first review undertaken for the Scottish National Residential Pain Management Programme since its designation in 2015-16. The service is provided by NHS Greater Glasgow and Clyde (NHS GG&G) and offers access to a highly specialist and intensive programme of interdisciplinary care for adults with chronic pain.

Originally designated as a residential service, the service was paused in March 2020 as a result of the Covid-19 pandemic and restarted in August 2020 as a remotely delivered programme. The service is planning to adopt a hybrid delivery model with a mixture of virtual and face to face appointments from April 2023 onwards.

Although designated through the National Specialist Services Committee, the service is currently funded directly by the Scottish Government Health and Social Care Directorate (SGHSCD) as opposed to the top slicing mechanism that is used to fund all other nationally designated services. The SGHSCD has requested that this service should be funded through top-slicing from 2023-24. The review will therefore inform the prioritisation of funding through NSD, NPPPRG and NSSC processes.

The service has consistently operated within the financial envelope and demonstrates good outcomes for patients, both through the face to face programme and the virtual programme which was developed as a result of Covid. The available evidence also highlights that the service performs well in respect of the other dimensions of quality.

The service meets most criteria for national commissioning. However, while stakeholders agree that the service addresses a distinct clinical need, it is evident that individual boards' utilisation is driven by the availability and configuration of local secondary care pain management services.

Recommendations:

1. The service should continue to be designated for another three years.
2. The service should restart face to face residential programmes from 2023-24.
3. The funded profile should be restored to £590,000 from 2023-24 to allow for the restart of face to face groups.
4. The service level activity for 2023-24 and 2024-25 should be revised to 56 patients across 6 groups to reflect service activity prior to the pandemic.

5. The service should continue to build an evidence base on clinical effectiveness of the remote programme. This should demonstrate remote delivery is providing the equivalent clinical value to patients and the programme is meeting the same aims as stated at designation.
6. The referral criteria should be amended to ensure that all patients have been reviewed by secondary care services prior to referral to the service. This may have to be phased in as boards without local provision develop local referral pathways.
7. Referral criteria should be further reviewed by the service, and changes agreed with NSD and referrers prior to the restart of face to face activity, to ensure that distinct principles are applied for access to the face to face and the virtual programmes respectively.
8. The service should offer a drop-in MDT clinic for referring clinicians to support appropriate referring.

Introduction

1.1 Role of National Services Division

National Services Division (NSD) commissions and performance manages national specialist services on behalf of NHS Scotland. National commissioning is reserved for those specialist services where local or regional commissioning is not appropriate and through national designation the aims are to:

- Ensure equity of access for all Scottish residents to specialist services
- Ensure the best possible clinical outcomes
- Provide a secure funded environment for the establishment and development of new national services
- Provide a risk-sharing arrangement for NHS Boards where incidence is sporadic and treatment involves specialist skills or expensive equipment.
- Avoid unnecessary and inappropriate proliferation of duplicate services, thus promoting clinical quality and cost effectiveness.

A nationally commissioned service is expected to deliver all aspects of the Quality Ambitions as set out in Scottish Government's Quality Strategy.

1.2 Aim and objectives of review

NSD is committed to ensuring that each service meets needs, provides equitable access, is clinically and cost effective and continues to require national designation. The review is also an opportunity to assess the remote service delivery model that was implemented as a result of Covid-19.

The aims and objectives of this review are to assess the service's fit against the National Specialist Services Committee (NSSC) designation criteria. The review will consider:

- Current and predicted future need for the service
- The extent to which the service provides equitable access to all residents of Scotland
- The performance of the service in achieving clinical quality standards / adherence to best practice
- The outcomes comparable with benchmarks in the UK and international standards
- Current costs which will include in depth analysis of staffing profiles and service costs
- Predicted future costs and how they compare with other UK Centres
- Service efficiency and effectiveness and potential to improve
- The sustainability of the current service
- Current issues faced by the service
- The change in service delivery model from residential to remote delivery
- Future funding of the service
- Whether the service continues to fit National Specialist Services Committee (NSSC) criteria or an alternative commissioning model is required

The review utilised routine data held by NSD and submitted by the provider (service agreements, annual reports, meeting minutes etc) as well information NHS England Commissioning documents (Service Specifications and Quality Dashboard Indicators). An

engagement event with referring clinicians was held on 23 June 2022 to gather the views of clinical service users.

2. Service Overview

2.1 Chronic pain

Chronic pain affects 1 in 5 people in Scotland. Chronic pain is defined as pain that has been present for more than 12 weeks. In Scotland it is estimated that 5% of the population report living with severe chronic pain, which impacts their daily activities and quality of life.[1] Chronic pain can affect many aspects of day to day life and wider health. Chronic pain can be associated with poorer mental health including depression, anxiety, fatigue and sleep issues.[2] People with chronic pain are also more likely to report lower life satisfaction and poorer quality of life compared to those without chronic pain.[3] [4] Healthcare and wider socioeconomic costs could result in chronic pain costing between 3% and 10% of Gross Domestic Product annually.[5]

2.2 Chronic pain services in Scotland

The Scottish Service Model for Chronic Pain (see Appendix A) differentiates between the following levels of pain management services:

1. **Self-management support in the community** – advice and information about pain, including resources available from third sector providers/organisations.
2. **Primary care support** – treatment and management provided by a GP, pharmacist or Allied Health Professional.
3. **Secondary care support** – specialist treatment and management provided by a range of healthcare professionals in the hospital setting, delivered by multidisciplinary teams, including outpatient Pain Management Programmes.
4. **Tertiary Care** – highly specialised treatment and interventions, including Spinal Cord Stimulation, Intrathecal Drug Delivery, specialist residential pain management programmes.

Standard treatment for Chronic Pain is outlined in Appendix B.

[1] Smith BH, Elliott AM, Chambers WA, Smith WC, Hannaford PC, Penny K. The impact of chronic pain in the community. Fam Pract. 2001 Jun;18(3):292-9. doi: 10.1093/fampra/18.3.292. PMID: 11356737.

[2] Nugraha B, Gutenbrunner C, Barke A, Karst M, Schiller J, Schäfer P, Falter S, Korwisi B, Rief W. Treede RD; IASP taskforce for the classification of chronic pain. The IASP classification of chronic pain for ICD-11: functioning properties of chronic pain. Pain. 2019;160(1):88-94.

[3] Boonstra, A.M., Reneman, M.F., Stewart, R.E. *et al.* Life satisfaction in patients with chronic musculoskeletal pain and its predictors. *Qual Life Res* 22, 93-101 (2013).

[4] Hadi MA, McHugh GA, Closs SJ. Impact of Chronic Pain on Patients' Quality of Life: A Comparative Mixed-Methods Study. J Patient Exp. 2019 Jun;6(2):133-141. doi: 10.1177/2374373518786013. Epub 2018 Jul 5. PMID: 31218259; PMCID: PMC6558939.

[5] https://www.scotphn.net/wp-content/uploads/2017/04/2018_10_11-Chronic-pain-HNA-Final.pdf

2.3 Policy and Strategic Context

2.3.1 Background to SNRPMP

The Scottish Government recognised chronic pain as a condition in its own right in 2009. As part of improving overall service provision, the Cabinet Secretary for Health and Wellbeing pledged to establish a specialist residential chronic pain service in Scotland in May 2013.

In line with the Cabinet Secretary's commitment, an expert short life working group was formed by NSSC in 2013, with full involvement of patients and service users. The group developed a service specification for a national specialist residential chronic pain management programme and NHS GG&C was selected as the provider of the service in 2014. The service was first designated in 2015-16.

2.3.2 Scottish Government Framework for Pain Management Service Delivery – Implementation

The Scottish Government developed a Framework for Pain Management Service Delivery[6] over the course of 2020-2021 which was published in July 2022. The Plan reiterates the need for services that deliver highly specialised pain management interventions. The document sets out a number of Actions, the most relevant for this service are listed below:

- Carry out a review of highly specialised pain service to enhance nationwide delivery of pain management.
- Convene a national expert working group to identify and scale-up improvements in pain service planning and delivery
- Update clinical guidelines for management of chronic pain to deliver evidenced-based care and support.
- Work with Public Health Scotland to improve capture and reporting of national data on pain management services.
- Enhance access to support for people with chronic pain by improving how local and national services are planned and delivered so they have a more consistent and better co-ordinated experience of care.
- Deliver a national approach to specialist interventions for chronic pain.
- Deliver new pain management training pathways for specialist and non-specialist healthcare professionals.
- Establish the NHS Pain Service Managers Network to improve co-ordination and planning of specialist pain services to improve access to specialist pain management support.

It is envisaged that the service will play an important role in supporting the implementation of the plan by providing expertise and guidance to support service improvements.

[6] https://www.gov.scot/publications/framework-pain-management-service-delivery-implementation-plan/

2.4 Overview of SNRPMP

The SNRPMP aims to meet the needs of adults in Scotland with chronic pain who require tertiary input (as defined by the Scottish Service Model for Chronic Pain). The service is aimed at adults who have previously been assessed and treated by local or secondary pain services, but who continue to experience significant psychological distress and physical disability associated with chronic pain.

The programmes aims to:

- Offer a detailed bio-psychosocial assessment which will include review of the referred diagnosis of chronic pain for appropriateness of their inclusion in the Scottish National Residential Pain Management Programme
- Reduce psychological distress and physical disability associated with chronic pain and promote the highest possible quality of life for patients
- Provide psychological and behavioural interventions that support patients (and their carers) to better manage their pain, enabling them to lead more normal lives with reduced disability
- Support clinicians and local care providers in managing their patients' care
- Reduce recurrent inappropriate admissions and attendances to other health care services by promoting self-management
- Increase social and physical functioning, promoting return to work and maintaining productivity through employment
- Promote independence and wellbeing for patients through the provision of structured self-management support

The programme is based on an Acceptance and Commitment Therapy model of change, integrated with current theories of the neurophysiology of pain. The programme consists of a combination of education, discussion, and opportunities to practise new skills and learn from others within a group environment. The Programme was set up to support for people with chronic pain to develop self-management skills via a three week residential interdisciplinary pain management programme at Allander House, Gartnavel Campus, Glasgow.

Referral criteria

- over 18 years of age
- has had longstanding pain of at least one year's duration
- has moderate levels of pain associated disability
- has activity levels determined by pain such that they are low or highly variable
- has moderate levels of pain related distress
- is willing to engage with a self-management approach in a group setting

Impact of Covid

In the majority of cases, the referral would follow the individual's participation in a local programme of chronic pain management and pain education. In recognition of the challenges of the geography of Scotland, the service is also available to individuals who are unable to access a local out-patient programme because of issues of remote geography, or who have difficulties in travelling to their local services.

Prior to Covid-19, an additional referral criteria had been the ability to self-care independently in self-catering accommodation for three weeks. Whilst services are being delivered remotely, this does not apply.

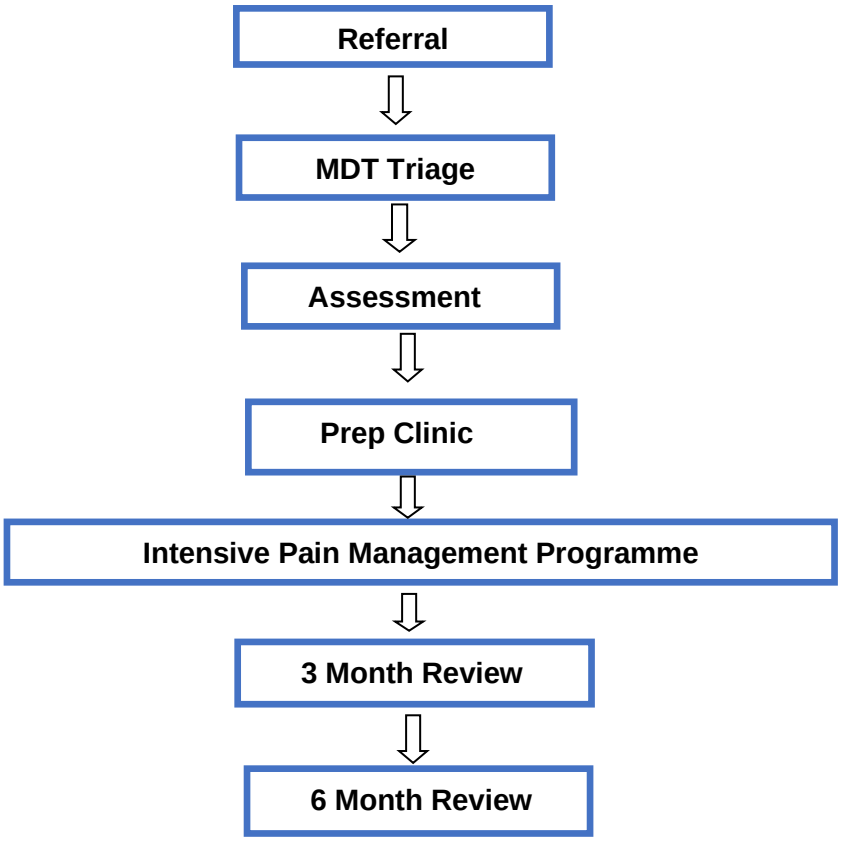
As a result of Covid-19, the service initially paused all group activity and restarted the programme in August 2020. In response to Covid-19 and the need for social distancing, the service model has been redesigned to provide a remotely delivered service through the Microsoft Teams platform for patients who require intensive interdisciplinary pain management.

In exceptional cases where the needs of an individual cannot be met by the SNRPMP, a pathway is in place to access specific programmes provided by specialist pain services in England. The current agreement with NSD is that liaison between the SNRPMP clinical team and the local pain team will determine whether assessment at SNRPMP is required in the first instance.

The service is staffed by a small interdisciplinary team with input from clinicians who specialise in management of chronic pain. The SNRPMP has input from Consultants, Psychologists, Physiotherapists, Occupational Therapists, Nursing and Support Staff.

2.5 Patient pathway

Both the remote and residential programmes follow the same basic abbreviated patient care pathway as shown below.



Patients can return to local teams at any point in the pathway.

2.6 Comparison between the Residential and Remote Programmes

The service delivery models for both residential and remote delivery are fully outlined in Appendix C. Table 1 highlights the main differences between the two delivery methods at each stage of the programme.

Programme Phase	Residential Delivery	Remote Delivery
Referral	**Referral criteria**	**Referral criteria**
	• Participants eligible for the programme required to be able to self-care in self-catering accommodation for 3 weeks	• More patients are now eligible for the programme • Potential for increased number of referrals to the service
Assessment	**1 assessment appointment**	**2 assessment appointments**
	• Participants attended 1 specialist MDT assessment appointment • Patients learn the outcome on the day	• Assessments are now often spread across 2 appointments • Patients learn the outcome on the day of second assessment if 2 are required or after MDT discussion
Preparatory Clinic	**Preparatory Clinic**	**Preparatory Clinic – technology check**
	• Offers potential participants further information or education regarding the programme • Group ground rules • Information regarding attendance • Preparatory work prior to group attendance • Optimises participants' readiness to attend and derive greatest benefit from the programme	• Technological equipment check • Technological ability check • Troubleshooting IT problems • Familiarisation with Microsoft Teams • Exploration of any home environmental barriers to engagement • Offers potential participants further information or education regarding the programme • Group ground rules • Information regarding attendance • Preparatory work prior to group attendance • Optimises participants' readiness to attend and derive greatest benefit from the programme
Group Block	**3 week residential block**	**5 week remote block**
	• 3 week block for day sessions at Allander House • Shorter block length due to more hours per day	• 5 week block for 3 hours per day on Microsoft Teams • + 1 group introductory session prior to 5 week block • + 4 individual reviews per participant • Longer block due to shorter intensive 3 hour periods online
Consolidation	**No change in the consolidation phase**	**No change in the consolidation phase**
Follow Up	**Follow up reviews**	**Follow up reviews**
	• Telephone review at 3 months post residential block • One day group review at Allander House after 6 months	• Video review at 3 months post intensive block • Half day group review on MS Teams after 6 months

Table 1 - Comparison between Residential and Remote delivery of the Programme

While the remote programme has allowed people to receive treatment who would have not been able to attend the residential programme (e.g. those who are unable to self-care or those with caring commitments), other patients are not able to take part due to digital exclusion, both in terms of access to required technology (devices and Wi-Fi) as well as competency and confidence.

The service trialled the use of mobile phones with a small number of patients who would not otherwise be able to participate through lack of appropriate IT equipment. Whilst this did enable participants to attend when they may not have been able to do so otherwise, feedback suggested it was difficult to see other group members/ group facilitators and at times hard to participate in group experiences. There was also an increased risk of screen fatigue. Some participants also voiced concerns about possible data usage if they did not have home Wi-Fi.

In addition, discussion at the referrers workshop highlighted the remotely delivered programme may be less suitable for people who avoid physical activity due to their chronic pain.

The service is currently scoping options for restarting residential service provision from 2023-24.

It should be noted that many local secondary care pain services are now making good use of technology and are offering remotely delivered appointments within secondary care. It is possible that some patients who were previously referred to SNRPMP because they were unable to attend local outpatient services for reasons of geography, may now be able to be seen within local services.

2.7 Links and inter-dependencies with other services

Optimum delivery of the service requires effective working relationships with the following services:

- Local Secondary Chronic Pain services
- Referring Clinicians
- General Practitioners

2.8 NHS England services and Bath Centre for Pain Services

NHS England has a standard service specification[7] for highly specialist pain management services which are commissioned through regional specialist commissioning units. The Bath Centre for Pain Services (BCPS) is a highly specialist pain management programme which has a similar residential service set up to SNRPMP. BCPS offers a range of interventions for people with chronic pain including pain management programmes for both adults and children. For the purpose of the review, comparison is made with the adult residential programme. The England commissioning policies and BCPS were used to benchmark and to highlight the similarities and differences between the Scottish and English services in terms of service specification and quality and performance indicators.

[7] https://www.england.nhs.uk/wp-content/uploads/2019/08/Adult-Specialised-Pain-Service-Specification.pdf

3. Service activity

The current Service Agreement activity levels for duration 2022-23 is for 50 participants split over 6 groups. From 2017-18 onwards, the SA activity levels for the SNRPMP was 32 to 40 group participants, allowing for up to potentially 56 participants per year.

3.1.1 Group participants

Figure 1 highlights the number of group participants starting the programme has been rising each year prior to the 2020-21 reporting period. 56 group participants started a group programme in each of the last two financial years prior to Covid-19, exceeding the Service Agreement activity levels. The data for 2021-22 shows activity is starting to recover as the service operates a virtual delivery model.

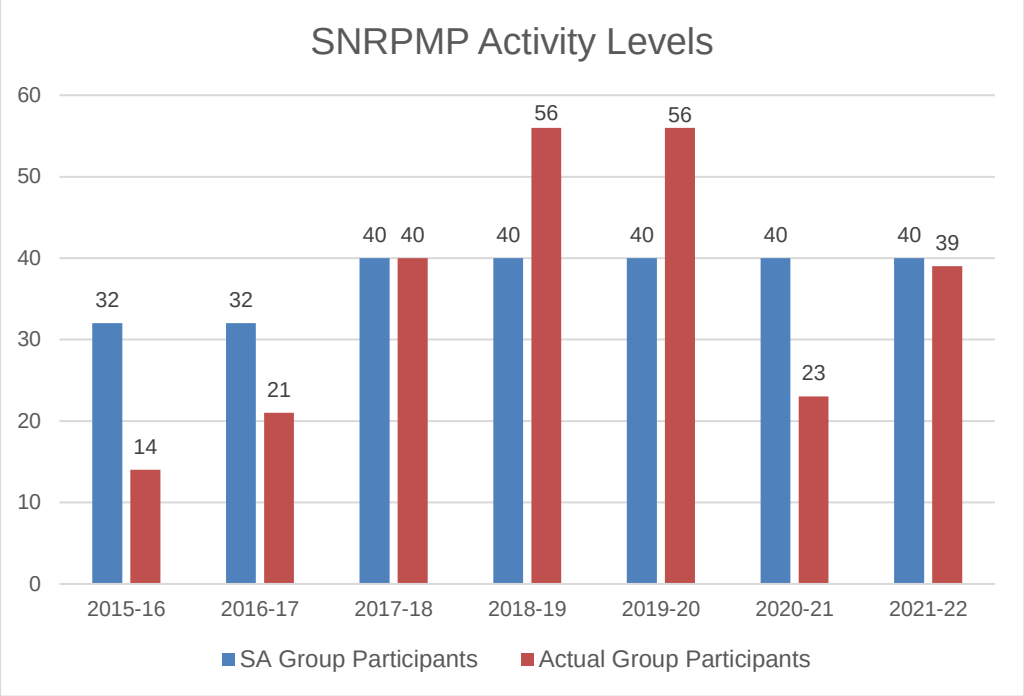


Figure 1 - SA level vs actual group participants

3.1.2 Referrals

Table 2 illustrates that until 2020-21, referrals to SNRPMP were rising year on year. The decreased number of referrals in 2020-21 is a result of paused activity in the first quarter of that year. It also reflects the uneven remobilisation of secondary pain services across the country due to Covid-19 leading to fewer referrals.

Referral activity has started to recover in 2021-22, however, the referral rate was still 54% lower than period prior to the pandemic.

Referral Activity	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
Referrals	68	77	104	137	140	39	76
Accepted for assessment	52	64	93	127	118	33	68
Referral does not meet criteria	16	12	11	10	21	6	7

Table 2 - Referral acceptance

3.1.3 Assessments

Feedback from referring clinicians highlights the comprehensive and multi-disciplinary assessments provided by the service are important therapeutic interventions even for those patients that are not accepted for treatment. The reports issued by the service often enable local teams so to provide appropriate pain management support locally.

New assessment activity recovered in 2021-22, but activity was still 55% lower than in 2019-20 prior to the pandemic. There has been a significant increase in return assessment appointments from 2020-21 onwards. Prior to Covid, assessments were mostly carried out face to face and in one appointment. The adoption of video assessments has allowed staff to break up the assessment process for patients who would struggle with a long assessment. In addition, online assessments are also prone to delays due to technical difficulties.

Assessment Activity	2017-18	2018-19	2019-20	2020-21	2021-22
Number of first assessments	75	89	113	28	63
Number of return assessments	<6	<6	<6	14	31
Number accepted for treatment	57	63	84	13	41
Discharged following assessment	18	26	29	10	22

Table 3 - Assessment activity

There is a difference between the number of patients accepted for assessment in Table 2 and the number of first assessments in Table 3. This discrepancy is in part explained by these figures being a snapshot of a specific time period. Some of the patients assessed within the year were referred in the previous year and some patients referred within each year will be assessed in the next reporting year. In addition, of those accepted for assessment, some individuals are not seen for assessment due to personal reasons (e.g. other medical issues, personal circumstances or preference for a face to face programme) or due to non-attendance at assessment and failure to respond to subsequent opt in letters.

3.1.4 Referrals to Groups Activity

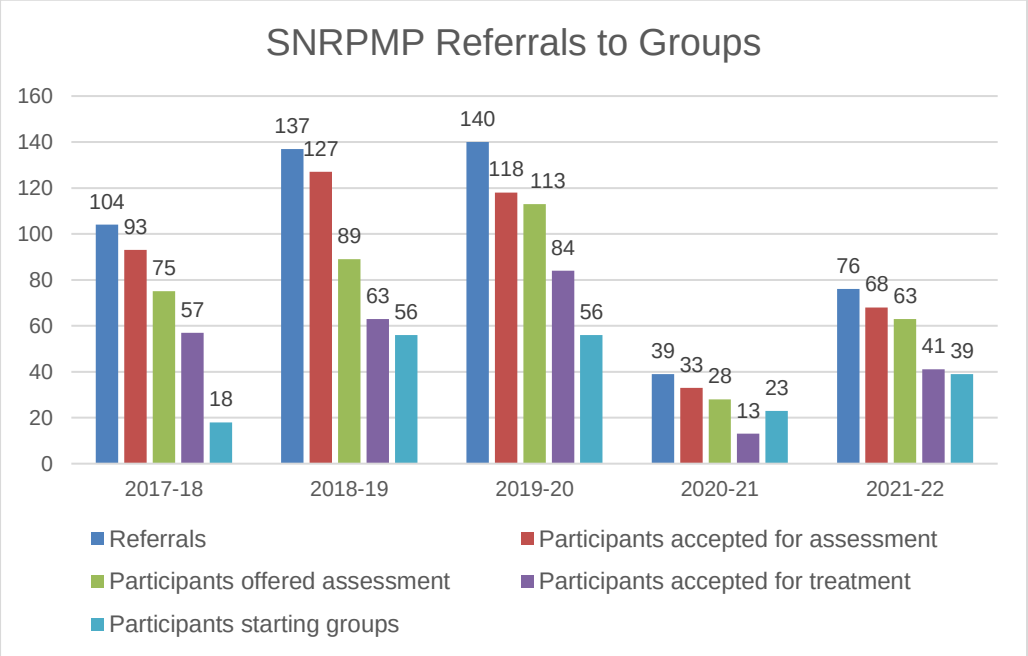


Figure 2 provides a comparison between referral, assessment and group activity. The discrepancy in figures for the participants starting groups in 2020-21 includes the 10 participants who had their group cancelled due to lockdown and had been carried over to the following year. Data for 2021-22 suggests that there is a much smaller gap between the number of patients accepted for treatment and patients starting treatment for the virtual programme than for the in person programme.

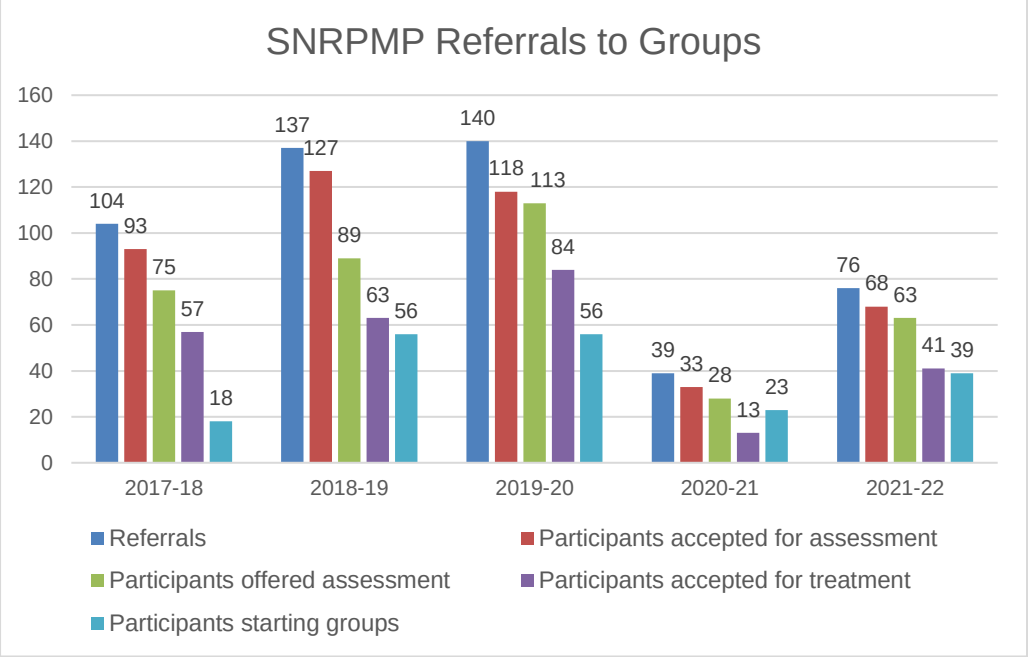


Figure 2 - Referrals to groups activity

3.1.5 Group Activity Levels

SNRPMP held 32 groups during the seven financial years under consideration. The 2015-16 reporting period was the only year in which 100% of participants starting groups completed the programme. Reasons for non-completion include participants declining their place on the programme as well as cancellations and non-attendance.

The number of groups per year steadily increased each year until the 2020-21 reporting period. On the 17 March 2020, Group 21 was discontinued on Day seven of the programme due to Covid-19. At the point of discontinuation, ten participants were in this group. The paused group was then restarted on a virtual platform in November 2020 and nine participants attended, one was unable to do so due to personal circumstances.

Group Activity	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
Participants starting groups	14	21	40	56	56	23	39
Participants completing groups	14	19	38	50	44	20	36
Number of groups	2	3	4	6	6	3	4

Table 4 - Group activity levels

The service reports that retention within the remotely delivered groups on Microsoft Teams has been high. Of the participants who started the remotely delivered groups in 2020-21 and 2021-22, 87% of patients completed the programme. The reason participants were unable to

complete their programme over the 6 years examined was predominantly due to personal reasons which were unrelated to their pain.

3.2 Equity of Access

All fourteen health boards are eligible to refer to SNRPMP with geographical spread of referrals shown below. In recognition of challenges of the geography of Scotland, the service is also available to individuals who are unable to attend a secondary care out-patient programme in their local health board due to issues of remote geography.

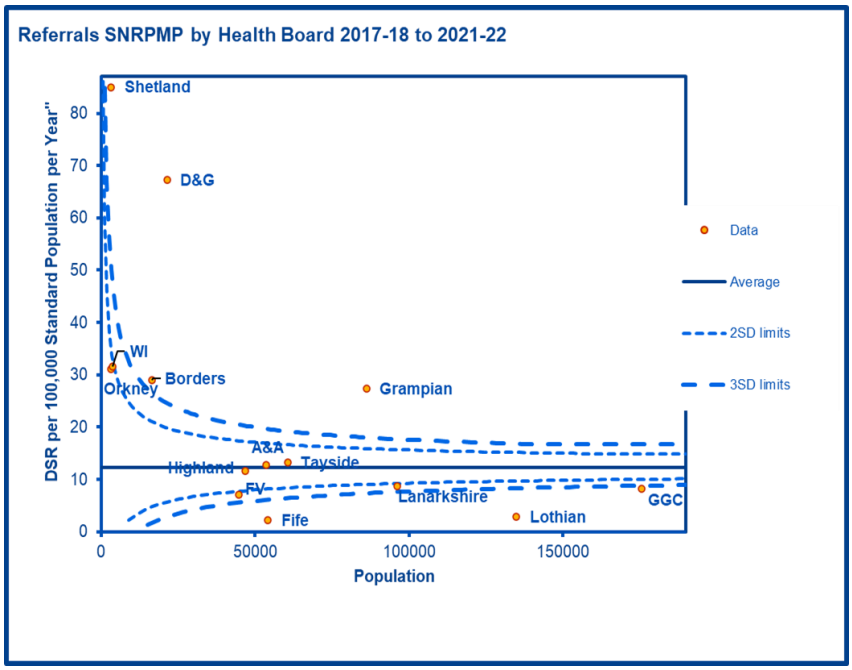


Figure 3 – Distribution of referrals by health board

Figure 3 shows that Lothian and Fife are under referring to the programme in comparison to the population size in these areas. With the change in referral criteria, increased referrals to the programme would be expected.

It is important to understand the reasons for lower referral rates from some health boards. The service has worked hard to raise awareness of the SNRPMP and maintain links with local services. Lower referring areas have established secondary care multidisciplinary services and tend to cover smaller geographical areas than other health boards. The pause on secondary pain management services because of Covid-19 has had a resulting effect on the number of patients being referred to the service.

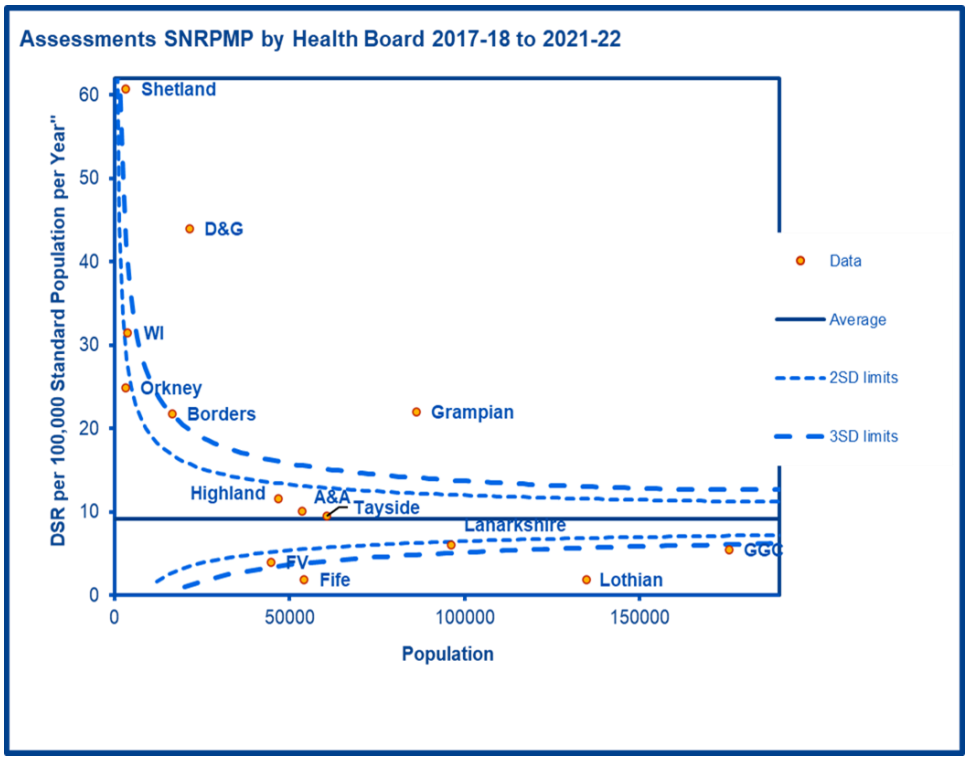


Figure 4 – Distribution of assessments by health board

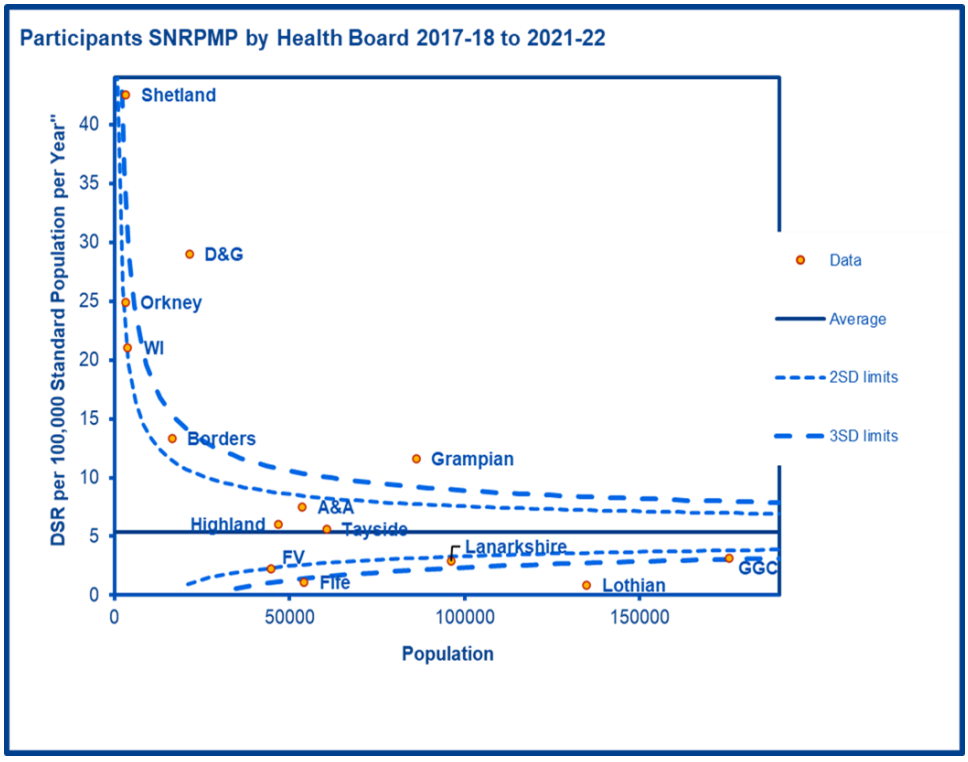


Figure 5 - Distribution of participants by health board

Figures 4 & 5 show activity related to residents from NHS Lothian are still significantly lower than expected for both the number of assessments and group participants. Dumfries and Galloway are significantly above the expected rates for both assessments and group

participants. This is due to there being no secondary pain management programme available in Dumfries and Galloway as well as the Western Isles at this time.

Social Deprivation

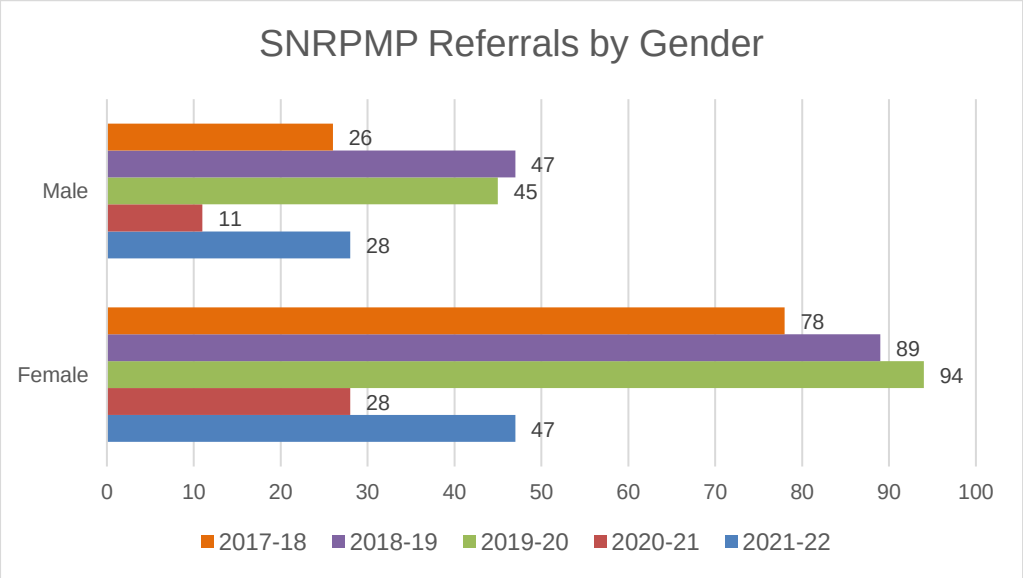
Conditions associated with chronic pain are also associated with deprivation.[8] People who have perceived income inequalities, and high levels of neighbourhood deprivation are more likely to experience chronic pain.[9] People who are not in employment because of ill health or disability are more likely to have chronic pain than those who are employed.[10]

An internal audit undertaken by the service in 2019-20 demonstrates patients referred to the SNRPMP are representative of the Scottish population as a whole with regards to social deprivation.

Following the change to a virtually delivered programme, there are some issues evident with regards to enabling access to patients from deprived backgrounds. For patients to participate in the programme, they must have social access to digital devices and have Wi-Fi or enough data on their device. In some cases, one device could be shared by a whole household which could prove difficult in gaining access for use. Patients will also require a room in their house with adequate space to carry out activities and to protect confidentiality.

Participant Gender

Demographics of patients referred to the service has been collected from 2017 onwards. The gender of group participants was predominantly female over the last 5 financial years with over 60% of referrals each year being female. This is in keeping with the evidence in the Scottish Government Pain Management Framework that women are affected by chronic pain more than men.



* LGBTQ+ participant numbers <5 for period 2017 to 2022

Figure 6 – Number of referrals by gender

[8] Brekke M, Hjortdahl P, Kvien TK. Severity of musculoskeletal pain: relations to socioeconomic inequality. Soc Sci Med. 2002 Jan;54(2):221-8. doi: 10.1016/s0277-9536(01)00018-1. PMID: 11824927.

[9] Green CR, Anderson KO, Baker TA, Campbell LC, Decker S, Fillingim RB, Kalauokalani DA, Lasch KE, Myers C, Tait RC, Todd KH, Vallerand AH. The unequal burden of pain: confronting racial and ethnic disparities in pain. Pain Med. 2003 Sep;4(3):277-94. doi: 10.1046/j.1526-4637.2003.03034.x. Erratum in: Pain Med. 2005 Jan-Feb;6(1):99

[10] Health Survey for England. Chronic pain in adults 2017. 2020

Participant Age

The Scottish Government Pain Management Framework reports the prevalence of chronic pain increased with age. Chronic pain affects 18% of 16 to 34 year olds and 53% of those 75 years and over[11]. Referrals to SNRPMP encompass a wide age range with participant ages ranging 18-75 years over the last 5 financial years.

An analysis of people referred to SNRPMP by age shows that the mean patient age ranged from 47 to 50 years. People aged 45 to 54 years (39%) are more likely to be affected by chronic pain than the average adult population which is in keeping with the mean age for the programme.

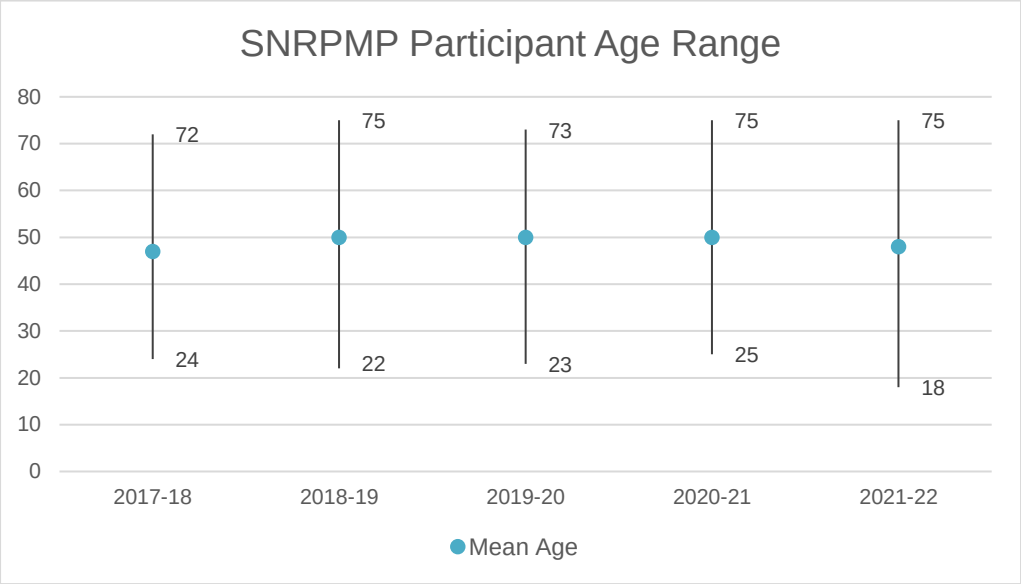


Figure 7 - Participant age range

[11] https://www.gov.scot/binaries/content/documents/govscot/publications/consultation-paper/2021/12/draft-framework-chronic-pain-service-delivery/documents/framework-pain-management-service-delivery-draft-consultation/framework-pain-anagement-service-delivery-draft-consultation/govscot%3Adocument/framework-pain-management-service-delivery-draft-consultation.pdf

4. Quality

4.1 Safe

4.1.1 Clinical Governance

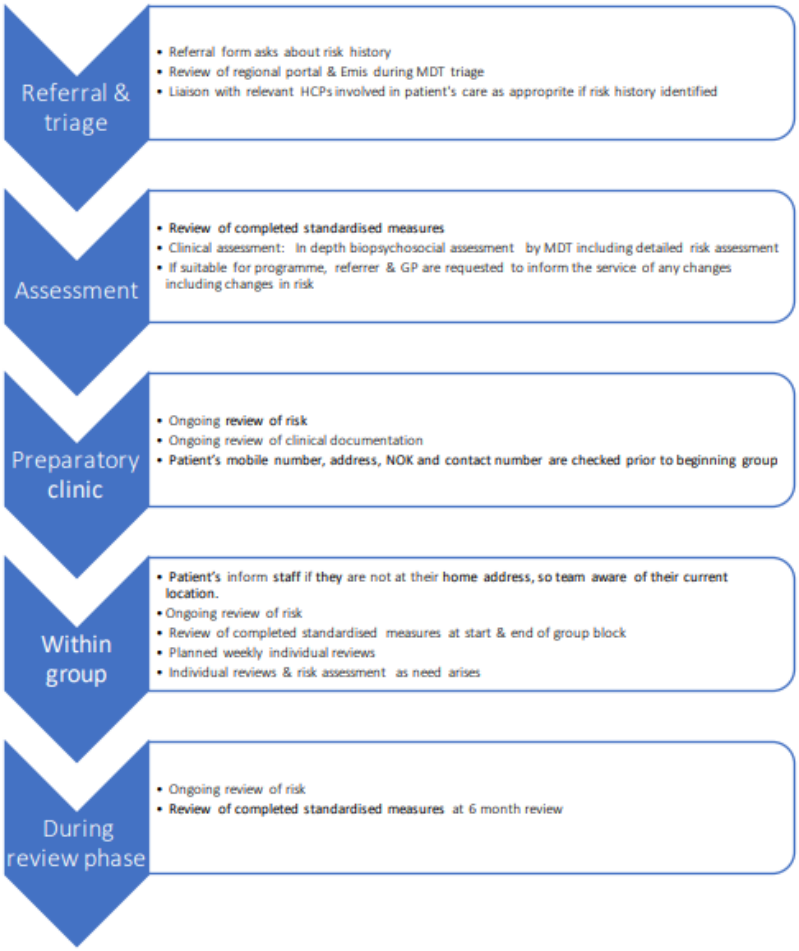
Accountability for the delivery of clinical governance within the Acute Services Division rests with the Chief Operating Officer who will discharge this responsibility through the local management structure. The responsibility for the development and assurance of effective arrangements is routinely delegated to and supported by the designated clinical governance leads.

The SNRPMP is part of the Clinical Governance Programme for the Pain Management Service and the North Sector of NHSGGC and issues would be channelled through these forums. SNRPMP also adheres to NHS Greater Glasgow and Clyde Healthcare Quality Strategy 2019/2023. SNRPMP adheres to all NHSGGC Healthcare Associated Infection and Scottish Patient Safety Programmes.

4.1.2 Safety Protocol Risk Assessments and Management

Risk assessment and management is an integral part of all aspects of service delivery within the SNRPMP and is supported by staff training & clinical supervision. Examples of relevant training includes SAFE TALK, available for admin staff and ASIST for all non-psychology staff. All staff are vigilant to signs of risk and address these as they arise.

The flowchart below provides an overview of how risk assessment is embedded within the SNRPMP.



Prior to remote delivery, possible risks of online delivery were considered. Concerns related to possible hazards of partaking in guided exercise and self-directed activity sessions in the home environment (e.g. possibility of falls) and also the management of significant psychological distress.

Risk assessments have been modified to mitigate for these issues. A risk assessment is undertaken to ensure patients are exercising in a safe environment and have a realistic appreciation of their physical capabilities.

Specific risk assessments in place:

- Management of risk to self during remotely delivered pain management programmes – includes planned actions for those that drop off an online session, do not log in for an online session, along with management of psychological distress with plans for escalation and liaison with local services as appropriate in line with wider NHS GG&C protocols for management of suicidal patients.
- For activity/physical sessions – includes actions for if patient has a fall during session.

If risks or issues are detected at any stage, this is managed promptly on an individual basis based on patient need/risk. Examples of support may include:

- Signposting to relevant support organisations e.g. the Samaritans & Breathing Space
- Liaison with NOK & relevant HCPs involved in patient's care
- In the unlikely event of unable to contact local healthcare teams, further escalation may be required, which may include contacting local police & requesting a wellbeing check or requesting an ambulance to their address.

4.1.3 Datix Incidents

Any incidents are reported using the Datix incident reporting and risk management software. There has been a small number of Datix incidents recorded since the SNRPMP was initiated. All incidents apart from one came under the slips, trips and falls category.

Reporting Period	Datix Incidents
2015-16	1
2016-17	4
2017-18	0
2018-19	0
2019-20	3
2020-21	0
2021-22	0

Table 5 - Datix incidents

4.2 Waiting Times

The 12 week waiting time to first assessment target over the past 5 reporting periods is shown in Table 6. The service was consistently meeting the 12 week target apart from the years affected by Covid-19 and has returned to a 100% rate in 2021-22.

Mean Waiting Times (days)	2017-18	2018-19	2019-20	2020-21	2021-22
% within target of 12 weeks	100%	100%	96%	77%	100%
Mean waiting time to be offered assessment	40	46	46	57	33
Mean waiting time to first assessment	49	51	49	48	36
Mean waiting time from assessment to group	107	81	119	157	96

Table 6 - Waiting times (days)

The mean waiting time from assessment to group increased significantly in 2020-21 despite the patient numbers being lower. This is due to the pause on all group activity until the service was able to start remotely delivered groups on 9th November 2020. All patients who had been waiting for a group prior to Covid-19 were offered a group before the end of the 2020-21 financial year.

All patients referred to the service during reporting period 2021-22 were offered an assessment appointment within agreed timescales. The average wait time from referral to assessment over the past year was 5 weeks.

Maximum Waiting Times	2017-18	2018-19	2019-20	2020-21	2021-22
Maximum wait to be offered assessment	96	77	181	138	68
Maximum wait to first assessment	159	155	205	178	68
Maximum wait from assessment to group	338	441	211	190	209

Table 7 - Maximum waiting times in days

There are several reasons why a patient may delay starting the group stage of the programme with most reasons relating to patient preference and desire. This in turn affects the maximum waiting time data and is out with the control of the SNRPMP.

For some patients, it is appropriate to have a period of therapeutic work up between assessment and starting the group. Appointment timeframes can also affect when participants start the group stage of the programme as groups run in cycles every 8-9 weeks. Patients may be deemed suitable at an assessment appointment a week prior to a group which is full starting therefore patients must wait for a space in the next group. There are also reasons relating to participants having to plan for taking time off work, working round educational commitments and arranging childcare.

4.3 Non Attendance Rates

Figure 8 provides a breakdown of the number of DNAs for each of the SNRPMP appointment types. Although the figures in Figure 8 display a higher number of DNAs in the past year compared to previous years, the overall DNA rate remains low, at 4% of all appointments.

It is likely that this increased non-attendance rate is in part due to the virtual method of delivery as patients may misplace links. Other reasons for DNA include forgetfulness, other appointments, fatigue and flare-up. Patients frequently contact the service following non-attendance to request their appointments are rebooked and so resume their journey within the service.

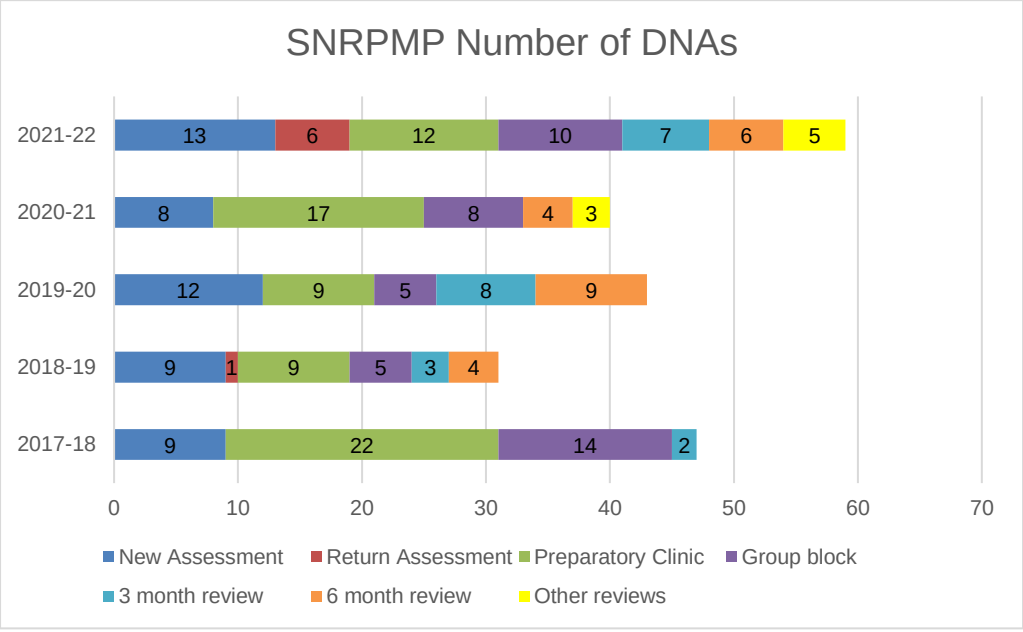


Figure 8 - Number of DNAs per Appointment Type

The 2019-20 Annual Report identified a need to improve attendance rates at the 6 month review appointment. Previously, 6 month reviews had been offered face to face at Allander house prior to Covid-19. It was anticipated that offering a remotely delivered individual review as an alternative may enhance attendance rates.

In reporting period 2020-21, when all 6 month reviews were offered by phone, only 4% of those who completed the group did not attend the 6 month review compared to 17% in 2019-20. Remotely delivered 6 month reviews seem to be improving the DNA rates and this should continue to be monitored.

SNRPMP accepted the first assessment DNA rate needed to be improved upon. The service have therefore changed the way the first assessment appointment is arranged. Due to the small number of referrals and the desire to progress patients as quickly as possible to fill groups, the service has been contacting patients by telephone rather than letter which was initially proposed which remains under review. Participants will then be sent the appointment confirmation and digital questionnaire via email. Anyone who is unable to complete a digital questionnaire will be offered a paper copy instead. This change will allow participants to choose an assessment slot that is convenient for them so potentially reducing cancellations. This new process has been included in the 2022-23 Service Agreement. This new method should reduce the number of missed assessment appointments going forward.

It is evident the preparatory clinic is the stage of the programme with the highest DNA rate with 57 missed appointments over the 5 years the data was collected. Efforts are underway to improve preparatory clinical attendance rates, for example by agreeing appointments verbally at assessment.

4.4 Outcomes

4.4.1 Outcome Measures

The patient reported outcome measures (PROMS) outlined in Table 8 are collected by the service.

Assessment Domain	Measure
• Perception of own disability	• Pain Disability Questionnaire (PDQ)
• Level of Distress; – anxiety – depression	• PHQ-9 and GAD-7
• Fear – extent to which fear of pain impacts on movement and activity	• Modified Tampa Scale of Kinesiophobia (TSK 13)
• Psychological flexibility – ability of an individual to cope with change	• Chronic Pain Acceptance Questionnaire (CPAQ)
• Fusion - extent to which an individual's thoughts impact their engagement in valued activities	• Cognitive Fusion Questionnaire (CFQ)

Table 8 – PROMS

PROMS questionnaires are now being sent to group participants to complete electronically via email. The service have highlighted this has been received very well by participants and a recent group has had 8/9 participant response rate.

4.4.2 Residential Programme PROMS

An audit was conducted to review the outcomes of participants completing to the 6 month review between 1st November 2015 and 31st March 2020 during residential delivery of the programme. Mean changes and effect sizes are detailed in Table 9.

Participants complete a range of standardised outcome measures as detailed in the table below. These are completed on 4 occasions: at assessment (Q1), Day 1 of the programme (Q2), Day 15 of the programme (Q3) and at 6 month review (Q4).

Measure	Range	Aim of PMP	Mean Day 1 (sd)	Mean Day 15 (sd)	Mean 6/12 (sd)	*d* (effect size) of change from Day 1 to Day 15	*d* (effect size) of change from Day 1 to 6/12 review
PDQ Total	0-150	Decrease -	112.40 (17.22)	89.96* (27.69)	97.42*$ (27.84)	0.97	0.65
TSK-13	13-52	Decrease -	32.48 (6.92)	25.52* (7.00)	27.46*$ (7.26)	0.99	0.71
CFQ	7-49	Decrease -	32.85 (10.21)	28.07* (10.89)	26.77* (10.12)	0.45	0.6
CPAQ Activity Engagement	0-66	Increase +	27.48 (9.95)	40.22* (10.14)	37.92* (11.27)	1.26	0.98
CPAQ Pain Willingness	0-54	Increase +	16.63 (8.88)	23.59* (8.23)	23.66* (8.79)	0.81	0.8
CPAQ Total	0-120	Increase +	44.11 (14.88)	63.80* (16.22)	61.58* (17.69)	1.26	1.07
PHQ-9	0-27	Decrease -	18.40 (5.08)	8.75* (4.70)	12.83*$ (6.29)	1.97	0.97
GAD-7	0-21	Decrease -	12.68 (4.88)	5.05* (4.35)	8.81*$ (5.94)	1.65	0.71

*= significant improvement found compared with Day 1

$ = significant deterioration found compared with Day 15

Table 9 - Outcome measure data from residential delivery audit (taken from 2019-20 Annual Report)

Results demonstrated patients who completed the 6 month programme showed significant improvement from Day 1 to Day 15, and from Day 1 to the 6 month review on all outcome measures.

4.4.3 Remote Programme PROMS

Data is presented in the table below from the 27 individuals who had completed both the assessment questionnaire (Q1) and end of group questionnaire. Analysis shows significant changes in the desired direction for all measures. For TSK, CPAQ and PHQ9, these changes were highly significant.

Measure	Range	Aim of PMP	Assessment	End of Group	Change	t-test p value	sig level
PDQ	0-150	↓	114.39	101.48	12.91	<0.05	*
TSK-13	13-52	↓	36.61	29.70	6.91	<0.001	***
CFQ	7-49	↓	34.56	27.93	6.63	<0.01	**
CPAQ Total	0-120	↑	39.17	55.89	-16.72	<0.001	***
PHQ9	0-27	↓	17.44	11.41	6.04	<0.001	***
GAD7	0-21	↓	12.94	8.93	4.02	<0.01	**

Table 10 - Matched pre and post group mean scores 2021-22 period Student's t-test, two sample (taken from 2021-22 Annual Report)

4.4.4 Residential Programme Physical Outcome Measures

The service conducted an audit to review the outcomes of participants completing the six month review between 1st November 2015 and 31st March 2019. It has been difficult to collect these measures reliably for the remote programme as these require close supervision from a physiotherapist.

Participants routinely completed a range of physical outcome measures:

- 5 minute timed walk
- 1 minute sit to stand
- 1 minute arm abduction
- Functional reach
- Lumbar flexion
- Days per week meeting physical activity guidelines (The Scottish Government 2017)

Changes between Day 1 and Day 15

Between Day 1 and Day 15 of the programme, mean performance improved on all five physical outcome measures. The functional reach test had the greatest improvement, with a 39% increase. Lumbar flexion had the lowest change, with an improvement of 21%, change in measures such as this are expected to be lower due to a ceiling effect and is less relevant to individuals who do not have low back pain.

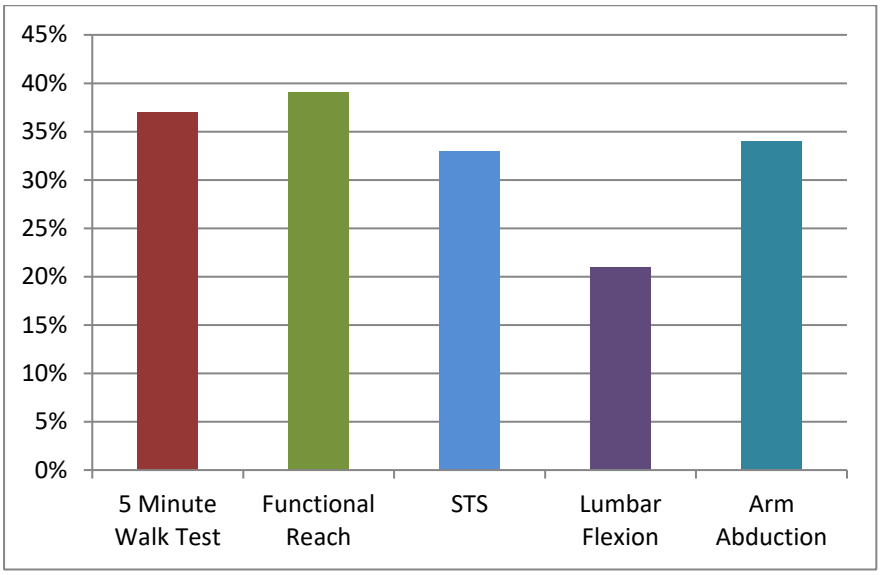


Figure 9 - Day 1 to Day 15 Mean percentage change on physical performance measures (Taken from 2018-19 Annual Report)

Changes between Day 15 and Six Month Review

The significant improvements in physical function were maintained and increased on 4 of the 5 measures at six month review.

Functional reach is the only measure in which a small decrease is seen between Day 15 and six month review. However, overall improvement on this measure from Day 1 to six month review remains over 35%.

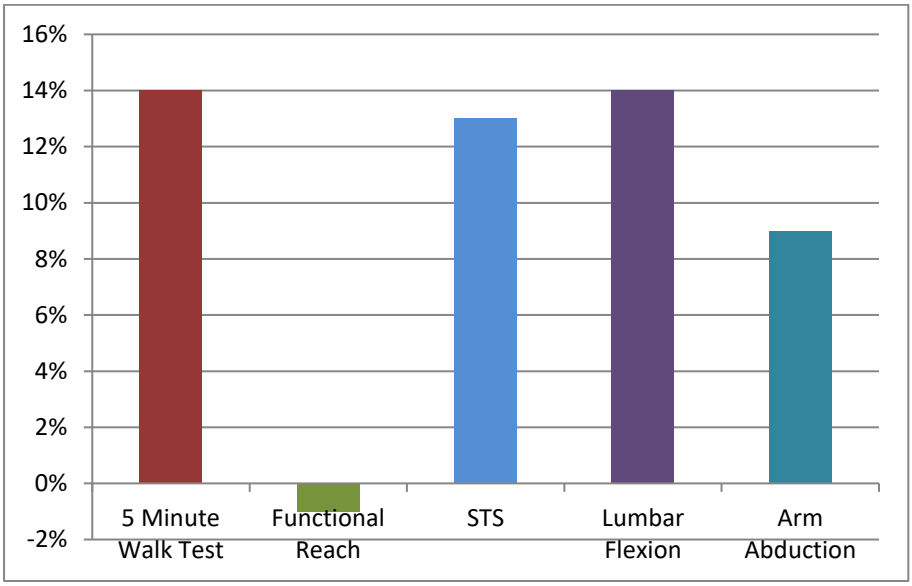


Figure 10 - Day 15 to six month review mean percentage change on physical performance measures (Taken from 2018-19 Annual Report)

It should be noted that the results are based on a small patient cohort.

4.4.5 Impact of the residential programme on medication and healthcare use

An audit was undertaken in 2019-20 exploring the impact of the programme on medication and healthcare use. A comparison of participants' self-reported use of medication and healthcare in the 3 months prior to the group with the 6 month review found significant

reductions in medication use and GP/hospital visits. These substantial reductions represent considerable cost savings within healthcare and shows the SNRPMP is providing an effective way for participants to manage pain.

Average reduction in healthcare use	
GP visits	40%
GP emergency call outs	39%
Hospital Visits	55%

Table 11 - Average reduction in healthcare use (2019-20)

Change to medication over 6 months	
Increased	16%
Reduced	54%
No change	30%

Table 12 - Change to medication over 6 months (2019-20)

4.5 Person Centred

4.5.1 Patient Satisfaction Questionnaire – Residential Delivery

All participants who completed the programme were invited to complete a patient satisfaction questionnaire. During the residential delivery reporting period 2019-20, 41/44 group participants completed the questionnaire. The mean overall helpfulness of SNRPMP was rated 9.4/10 and 100% of participants who completed the questionnaire would recommend the programme.

4.5.2 Patient Satisfaction Questionnaire – Remote Delivery

Questionnaire completion rates have been lower during virtual programme delivery in comparison to completion during a session at Allander House. Response rates over both years conducting the virtual programme is only 50% with 10/20 completed questionnaires in 2020-21 and 18/36 in 2021-22. Much higher response rates were received when the programme was being delivered residentially in previous years.

Over the last year the service has routinely replaced paper outcome measures with online digital versions, although paper copies remain available to those who prefer this option. As well as saving on paper and postage costs, online questionnaires provide more accurate and complete responses.

2020-21 Cohort

Overall, the 2020-21 cohort of participants felt they had a very good understanding of the purpose of the programme during remote delivery. Participants expressed the remote programme provided the advantage of being able try things within the home environment and discuss with family and friends. On a 10-point scale, all patients gave scores of 8 or higher for their satisfaction with the assessment and the length, organisation, and content of the programme. 89% of respondents gave scores of 7 or higher on a 10-point scale for their satisfaction with the assessment and the length, organisation, and content of the programme. 100% of participants would recommend the remotely delivered programme.

The service was faced with challenges involving equipment and internet connection but overall feedback received from participants was positive. All patients who completed the

questionnaire in 2020-21 reported some IT issues during remote delivery. These included difficulties logging on, occasional loss of connection and occasional issues at the presenter's side.

2021-22 Cohort

The 2021-22 cohort is the second reporting period where patient satisfaction questionnaires were completed virtually. Responses of particular note from this cohort are the four respondents who indicated they felt either quite or very uncomfortable when asked how they felt about the confidentiality of group discussions. The importance of maintaining confidentiality is standard practice and routinely discussed with the group prior to starting and during the programme. The weekly group process huddle sessions and individual reviews are embedded aspects which participants regularly utilise to raise concerns at the time they occur. The question wording may be contributing to a misunderstanding of what is being asked and may be impacting respondents' answers. Also, a more in-depth interpretation of these responses is limited due to the question format. To limit question ambiguity, the questionnaire will be modified to gather more specifics to respondent answers in the future.

When the 2021-22 cohort were asked about IT issues, some occasional one-off issues were reported including difficulties logging on, loss of connection, audio and video problems, screen sharing issues and returning from breakout rooms. Three respondents experienced issues throughout; one an inability to view chat function, another had to uninstall teams and reinstall the programme regularly and the other an inability to view all group members on screen at once.

Despite these experiences, patients reported very high satisfaction with the remotely delivered programme with 60% of participants rating the overall helpfulness as very helpful.

4.5.3 Person Specific Measure of Important Activities

During the programme, participants are supported to identify meaningful person specific activities they would like to be doing in their life in the domains of self-care, productivity and leisure. This measure is completed at the start of the programme, the end of the programme, and at six month review. This measure captures important activities as identified and reported by the patient and any changes in the patient's level of importance, performance and satisfaction with the activities over time.

Throughout reporting period 2019-20, an audit was conducted to review the person specific activity change scores for service users who completed Groups 12 to 17 (n=49). The results revealed from the start to end of the three week block, a +2 point-change for activity performance and a +3 point-change for activity satisfaction. These point-changes increased further at 6 months.

An electronic version of this measure has been used for the past 3 groups during reporting period 2021-22. Due to low response rate and a high number of incomplete measures received, it is difficult to generate any significant data at this stage. Early indications reflect that participants are rating their level of performance and satisfaction higher with their important activities from start to end of programme. The measure is being reviewed with the aim to make amendments that will help to increase response rates in the future.

4.5.4 Carer and Family Involvement

Participants continue to express their value in the opportunity for Carer and family involvement in their journey with the service. SNRPMP where appropriate, involve carers and family in the assessment and a Friends and Family session remains an integral part of the programme.

4.5.5 Programme Graduates

In March 2020, in collaboration with Pain Concern and in response to participant requests, the service launched an online forum for programme graduates. The forum provided the means for users to share experiences of implementing self-management strategies over the longer term with other graduates from their own and other cohorts. Graduates from the programme were trained to be forum moderators and had an active role in forum engagement. Due to low rates of participation, in collaboration with Pain Concern, in early 2022 an agreement was made to cease the Graduate Forum. The service continues to work alongside Pain Concern to identify an alternative means for graduates to be supported.

4.6 Referrer engagement and feedback

SNRPMP is actively engages in service promotion and works with health boards regularly to try and boost the referral rate. In the 2019-20 reporting period, road show visits were made to 3 health boards; Fife, Dumfries and Galloway and Greater Glasgow and Clyde to attempt to explore and address referral issues. In addition, a survey was undertaken to capture the views of clinicians who can refer to SNRPMP. The aim of this was to explore views on referring to the service, the visibility of the service and any improvements that could be made.

Prior to restarting the service virtually in August 2020, contact was made with all local services to inform them SNRPMP was offering remotely delivered assessments and groups. Several local pain services have commented that they have been in a period of redesign with staff changes. Some services have received fewer referrals than usual and were running reduced clinics.

Further meetings have been arranged with all health boards throughout 2021-22 including keep in touch visits with all local services. This was to primarily to promote the service, explore any obstacles to referral and determine any unmet needs. Due to service WTE capacity, this has been limited at times alongside aligning with capacity in the local pain management services to accommodate this. The team are also due to present an update on the service at a national event for Pain Clinicians in September 2022.

Workshop

As part of the review, a workshop was held on 23rd June 2022 with clinicians from secondary pain management services who refer to the SNRPMP. There was clinical representation from 9 of the 14 territorial Boards and all three regions. The purpose of the workshop was to discuss relationships between referrers and the service as well as perspectives of referring onwards to the SNRPMP to inform the review conclusions and recommendations.

The main themes from the meeting are summarised below:

- Overall, those present valued the service and had experience of referring to the service.

- It was explained that while specialist pain management expertise existed in most boards and many offered secondary care pain management programmes and interventions, these service did not have the resource to match the level of intensity of the SNRPMP.
- Nor was that level of intensity provided by SNRPMP programmes required for the great majority of patients with chronic pain.
- There was a small number of patients who would require the level of intervention offered by the service and it did make sense that there was one national team to deliver this level of service. Therefore, there was a need for a national or a tertiary intensive pain management service.
- Attendees valued the expertise of the service. For patients referred who are then discharged following the MDT assessment, the intervention informed local management of patients. The MDT assessment process at SNRPMP was seen as a productive appointment for patients due to the holistic approach. The assessment can often provide closure for patients.
- There was agreement that while digital solutions had improved access to specialist pain management services, remote delivery was not suitable for patients who struggled with digital exclusion, and those patients that avoided physical activity due to their chronic pain. Some had not referred patients for the remote programme for reasons of digital exclusion.
- Some attendees suggested that the referral process itself may lead to under-referral of suitable patients as clinicians are required to collate a significant amount of information. A drop in MDT session with the SNRPMP team to discuss potential cases was suggested.
- Potential extension in the scope of the service should be considered such as the potential of a service for Complex Regional Pain Syndrome patients. Currently patients are referred to Bath following advice from SNRPMP.
- It was also suggested to consider extending the scope of the service to include more one-to-one support. Some patients had anxieties around attending a group-based intervention. In addition, some patients would benefit from bespoke preparatory sessions to enable them to participate the group sessions.
- There was also support for extending the support available for family and carers such as appointments with individual families.
- There was support for restarting a residential programme to ensure access to tertiary care for patients who would benefit from frac-to-face contact (‘avoidant’ patients) and those who struggle with digital exclusion.

4.7 Clinical Quality Standards & Adherence to Best Practice

4.7.1 Service Clinical Standards

Service Standards included in current (2022-23) Service Agreement:

- SIGN 136: Management of Chronic Pain (2013)
- British Pain Society’s Guidelines on Pain Management Programmes (2013)
- Scottish Government Framework for Pain Management Service Delivery

4.8 Benchmarking

NHS England Highly Specialist Pain Management Services performance and clinical outcome indicators for Highly Specialist Pain Management Services[12] were used to benchmark SNRPMP against similar services in the UK.

Table 13 demonstrates the similarities between the two services in terms of commissioning indicators. There are however some differences evident between the two services with NHS England taking a focus on processes and protocols in their indicators. A detailed comparison between the performance and clinical outcome indicators for the Specialist Pain Management services in Scotland and England is outlined in Appendix D. NHS England did not share any outcome data to inform the review when approached.

Equivalent Quality and Performance Metric Indicators		
Scottish National Residential Pain Management Programme (2019-21)	**Scottish National Residential Pain Management Programme (2022-23)**	**NHS England Highly Specialist Pain Management Service**
Percentage of patients assessed within 3 months from referral	Percentage of patients assessed within 12 weeks from referral	Number of patients receiving definitive treatment within 18 weeks
Patient Reported Outcome Measures (PROMS) collected at the following intervals: – Assessment – 6 month review	100% of Patient Reported Outcome Measures (PROMS) collected at the following intervals: – Assessment – Day 1 of the programme – Day 25 of the programme – 6 month review	Number of patients demonstrating positive improvement completing treatment
Physical and Activity outcome measures collected at the following intervals: – Beginning of programme – End of programme	100% of Physical and Activity outcome measures collected at the following intervals: – Beginning of programme – End of programme	Proportion of patients with Quality of Life improvement on discharge
Number of adverse events	Number of adverse events	Number of never events reported
Patient satisfaction questionnaire	70% of patients returning the patient satisfaction questionnaire	Mechanism in place to obtain feedback from patients and families
Patients are provided with an agreed self-management programme during Phase 2	Patients are provided with an agreed self-management programme during Phase 2	Patients are given a personalised care plan
Number of complaints received within the reporting period is included in Annual Report	Number of complaints received within the reporting period is included in Annual Report	Number of complaints received within the reporting period

[12] https://www.england.nhs.uk/wp-content/uploads/2022/03/adult-highly-specialist-pain-management-services.pdf

Table 13 - Performance and clinical outcome indicator comparison

The service also meets or exceeds recommendation of the guidelines and standards that equivalent services commissioned by NHS England are asked to comply with (see Table 14).

SNRPMP Compliance with NHS England Standards	
Standard	Met
Faculty of Pain Medicine of the Royal College of Anaesthetists (FPM)[13][14]	SNRPMP meets most aspects of the staffing Standards (SNRPMP does not have a pharmacist on the clinical team but could access, if required) and all recommendations with FPM Core Standards. The Clinical lead for the SNRPMP contributed to the development of an audit tool to assess compliance with the first edition of these standards and reported on the compliance of the SNRPMP with these standards in the following publication: Torkamani, AM, Atherton, R, Dunbar, M & McLeod HJ (2019) Development and testing of a checklist to assess compliance with the faculty of pain medicine's core standards for pain management services: experience in a new national tertiary pain service. British Journal of Pain, 1-6.
British Pain Society (BPS)[15]	SNRPMP exceeds recommendations – 2019 published.
International Association for the Study of Pain (IASP)[16]	SNRPMP exceeds the recommendation.
Service specific competencies for Nursing	SNRPMP meets recommendations as guided by Pain Knowledge and Skills Framework – Royal College of Nursing[17]
Service specific competencies for Psychology	There are no formal requirements for psychologists when working in pain management. In addition to the guidance in the FPM as above, a couple of documents underpin the competencies required for psychologists within the team: IASP Curriculum Outline on Pain for Psychology[18] UCL Competency Framework – Psychological Interventions with People with Persistent Physical Health Problems[19] Cognitive and Behavioural interventions for chronic pain[20]
Service specific competencies for Physiotherapy	SNRPMP meets recommendations in PPA Physiotherapy Framework[21]
Service specific competencies for Occupational Therapy	There are no specific occupational therapy competencies. The occupational therapy standards included in the BPS publication

[13] Standards and Guidelines | Faculty of Pain Medicine (fpm.ac.uk)
[14] FPM-Core-Standards-Dec-2021_0.pdf
[15] Background (546 words) (britishpainsociety.org)
[16] Pain Treatment Services - International Association for the Study of Pain (IASP) (iasp-pain.org)
[17] Pain knowledge and skills framework | Royal College of Nursing (rcn.org.uk)
[18] IASP Curriculum Outline on Pain for Psychology - International Association for the Study of Pain (IASP) (iasp-pain.org)
[19] Psychological Interventions with People with Persistent Physical Health Problems | UCL Psychology and Language Sciences - UCL – University College London
[20] CBT for chronic pain web.pdf (ucl.ac.uk)
[21] https://ppa.csp.org.uk/documents/ppa-physiotherapy-framework-entry-level-graduate-expert-describing-values-behaviours

	along with the IASP recommendations for higher education OT pain curriculum are used as references to guide competencies[22]
Service specific competencies for Medical Staff	FPM & The Royal College of anaesthetist standards met as appropriate[23]
Core Standards for Pain Management Services in the UK. Faculty of Pain Medicine (2015)	SNRPMP meets most aspects of the staffing Standards (SNRPMP does not have a pharmacist on the clinical team but could access, if required) & all recommendations with FPM Core Standards.
Physiotherapy Pain Association & Chartered Society of Physiotherapy (2014) Physiotherapy Framework. Describing the values, behaviours, knowledge and skills of physiotherapists working with people in pain	SNRPMP meets recommendations
European Association of Urology. EAU Chronic Pelvic Pain Guidelines (2018)	SNRPMP does not currently provide condition specific care and as such would not seek to meet condition specific guidance/standards.
Commission on the Provision of Surgical Services: Report of a Working Party on Pain after Surgery. Royal College of Surgeons and College of Anaesthetists (1990)	SNRPMP does not provide condition specific care.

Table 14 - SNRPMP compliance with NHS England Service Specification Standards

[22] IASP Curriculum Outline on Pain for Occupational Therapy - International Association for the Study of Pain (IASP) (iasp-pain.org)

[23] Pain medicine | The Royal College of Anaesthetists (rcoa.ac.uk)

5. Cost of service

Figure 11 highlights actual service expenditure has been below allocation and on target for all financial years under consideration. Financial years 2018-19 and 2019-20 exceeded the SA activity levels for the number of group participants. Despite this, the service expenditure remained on target.

The actual budgets from 2020 onwards had been reduced as the residential costs are not required at present and the service chose not to recruit some vacant posts during the pandemic. As long as the service continues to operate as a virtual only programme, there will be no costs incurred for residential accommodation or patient travel during groups. The financial profile for the service mainly contains fixed costs. This official profile has not been permanently changed as result of the pandemic as there is an expectation that face to face provision will resume.

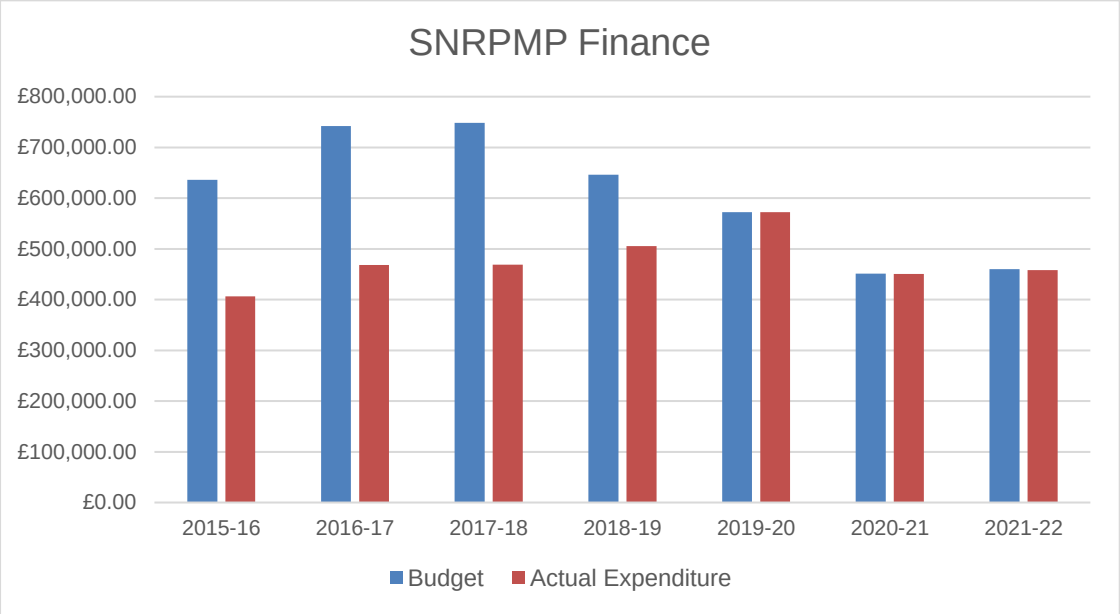


Figure 11 - Budget vs actual expenditure

5.1 Financial profile future costs

It is expected that the service costs will increase as the service restarts face to face activity. Prior to Covid-19, two participants shared an apartment, when the service resumes it is likely to be one participant per apartment. SNRPMP routinely used The Lofts Self Catering Apartments in Glasgow City Centre as accommodation for face to face group participants. The service has been advised there has been an excess demand on hotels for all NHS GG&C services. The board also has contracts with other hotels across Glasgow but the service have advised that these are more expensive than the previous provider.

6. Future Developments and Horizon Scanning

The evidence outlined in section 4 suggest that the virtual groups are effective and patient satisfaction remains high. SNRPMP clinicians and referrers, however, are concerned that the remote programme is not suitable for all patients, especially those that struggle with physical activity. In addition, continuation of a remote only service would mean that eligible patients who lack the required technology and digital confidence would not be able to access level four care for chronic pain or would require referral outside Scotland.

SNRPMP clinicians are keen to restart fact to face groups. The service is operating the remote delivery model for the full duration of financial year 2022-23 while planning for the resumption of face to face activity. SNRPMP colleagues are meeting with NSD on a monthly basis to update on planning progress.

6.1 Proposed Future Service Delivery Model

SNRPMP staff aim to retain the best aspects of the pre-Covid residential model and combine this with the benefits of virtual delivery.

The team is proposing to incorporate a tapered ending to the programmes that they offer which will be bespoke and tailored to patient need. It is envisaged that the SNRPMP will offer two programmes (based on patient demand) as outlined in the table below:

	Core residential service	Virtual groups
Duration	• 3 weeks face to face	• 5 weeks virtually
Schedule	• 4 full days per week at Allander House • Monday, Tuesday, Thursday, Friday (Wednesday group self-led activity)	• 3 hours per day on MS Teams • 4 or 5 days a week, TBC
Tapering	• Additional weekly virtual group session following conclusion of the residential programme delivered over three weeks – i.e. 3 sessions • Scope for tapered sessions to be by phone if required if patients are unable to access TEAMS	• Scope to taper
Reviews	• 6 month reviews – method of delivery to be agreed	• Individual 3 month video review • Group 6 month video review

Table 15 - proposed service models

This proposed model is at an early stage of scoping. Feedback from the referrer workshop suggests that referral criteria for the service should be reviewed as the core programme and the remote programme are likely to address the needs of distinct patient cohorts.

In addition, securing appropriate accommodation is an important step in the planning process and the availability of suitable accommodation may inform the configuration of the final model.

Proposals for permanent service accommodation (for clinics and groups sessions) were under consideration by NHS GG&C board management prior to the switch to the remote delivery of the programme. The service continues to operate in temporary accommodation within Allander House on the Gartnavel Campus. This current accommodation is suitable, but should social distancing be reintroduced, it would limit the number of people that can attend the same face to face group session.

Waiting times
The delivery of a hybrid model is also likely to impact on waiting times for some patients. While the team intends to operate the service in a way that that there will be overlap between clinical and admin activity for a face to face groups and a remote groups, there is no capacity for operating two groups concurrently within the current funding envelope and staffing profile.

Scope
As highlighted in Section 4, some referrers have suggested that the scope of the service should be amended to look at the possibility of:

- Condition specific programmes
- Expansion of 1 to 1 service provision
- Expansion of service provision aimed at families and carers

Referrers have suggested that there would be merit in expanding the service scope to increase engagement with secondary pain services. Some local pain services have highlighted the need for consultation and training regarding service delivery, as well as the provision of supervision.

6.2 Predicted future need for the service

The activity figures for 2020-21 in section 3 show a significant decrease in activity across most metrics compared to previous years which are driven entirely by Covid-19 related restrictions across the country. Prior to the pandemic referrals and first assessments had been increasing year on year and group activity for the two years prior to the pandemic had plateaued. It is also evident that utilisation of the service is related to the provision of local secondary care pain management programmes.

However, patient need and therefore activity levels for the service are difficult to forecast as demand will be driven by several factors:

- Uneven remobilisation of secondary level outpatient pain management programmes
- Uneven provision and access to secondary care level outpatient pain management services
- Availability of locally delivered remote secondary pain management programmes and outpatient appointments in some boards means that fewer patients may require referral due to issues of remote geography
- Lack of population-level data

- Referral process

6.3 Framework for Pain Management Service Delivery

It is apparent that while there is a need for a highly specialist pain management service, it is difficult to quantify demand for the current service, as utilisation is determined by the availability and configuration of local secondary pain management services.

The proposed establishment of a new Service Manager Network - to promote shared planning and service development across Health Boards, with a focus on opportunities to address key shared issues, including resourcing, waiting times and financial challenges – could improve access to secondary services in Scotland. At this stage it is unclear whether this will lead to an increase or decrease in referrals to the tertiary service provided by SNRPMP. Better access to secondary services should in time remove the requirement for the current ‘difficult geography’ exception outlined in the SNRPMP referral criteria.

7. Conclusions

This review considered the Scottish National Residential Pain Management Programme against the NSSC criteria for national designation.

Criteria	Met?	Comment
1. The clinical need for national commissioning of the service is significant and is within a clearly defined clinical area.	*Yes*	*There is a clinical need for tertiary level specialist pain management services. The intensity of the programme could not be replicated by secondary care pain management services. Utilisation of the service by boards is however linked to the availability and configuration of secondary care services.*
2. There is a clear target patient group or subset distinct for clinical reasons.	*Yes*	*There is a clear target patient group. The service remit always has been to provide an intensive interdisciplinary programme. Whilst this was previously delivered residentially, the intensity of the programme has remained for virtual delivery. The remote geography referral criterion however has meant that some people who would be suitable for less intense pain management support have accessed this service.*
3. The service is for a condition requiring diagnosis and/or treatment that is rare and/or unpredictable and has a low incidence. (Usually no more than 500 patients in one year period).	*Yes*	*Chronic pain as a whole is a common problem affecting between 18 and 50% of the population at any time to some degree.* *Around 5% of the population suffer from severe chronic pain that is intense and highly disabling.* *This requirement for intensive interdisciplinary input remains, whether this need is met in a face to face or virtual delivery format.*
4. The service has a proven evidence base and will have a greater clinical benefit than alternative forms of care.	*Yes*	*There is an evidence base that demonstrates that patients who complete the residential programme benefit from the intervention. There is early evidence for the efficacy of the remote programme.*

5.	The service is person centred demonstrating a clear clinical pathway which will include criteria for referral, discharge and follow up care.	*Yes*	*Referral criteria need to be amended and referral via secondary service implemented.*
6.	The service can demonstrate/has an explicit plan to provide the service equitably to all patients who are eligible for NHS treatment in Scotland.	*Partially*	*Due to Covid based restrictions, the service is not equitable for all patients due to digital exclusion and social deprivation. As soon as able to safely do so, the service plans to resume face to face programmes to address this need. Provision of a face to face programme enables access for some patients who would not manage a virtual programme. The link between secondary care services and boards' utilisation of this service needs to be addressed to ensure an equitable approach.*
7.	Provision requires at least one of the following: • a highly skilled multidisciplinary team • scarce clinical skills • specialist equipment and facilities	*Yes*	*Both the face to face and virtually delivered programmes require a highly skilled multidisciplinary team as the content and intensity of bother programmes are equivalent.*
8.	There will be significant benefits from national commissioning: demonstrating improved clinical quality, focused clinical expertise, more efficient use of NHS resources.	*Yes*	*Service outcomes including the reduction GP appointments and medication usage proves the service provides significant benefit to patients and efficient use of NHS resources.*
9.	There is evidence to support the cost of the service to determine that it will be cost effective that can only be provided clinically and cost effectively in one or two locations.	*Yes*	*There is evidence to support the cost of the service.*
10.	There are statements of support for the service.	*Yes*	*Scottish Government Policy Intention. Charities. Referrers. Cross Party Group on Chronic Pain.*

Recommendations

A summary of the recommendations is listed below:

1. The service should continue to be designated for another three years.
2. The service should restart face to face residential programmes from 2023-24.
3. The funded profile should be restored to £590,000 from 2023-24 to allow for the restart of face to face groups.
4. The service level activity for 2023-24 and 2024-25 should be revised to 56 patients across 6 groups to reflect to reflect service activity prior to the pandemic.
5. The service should continue to build an evidence base on clinical effectiveness of the remote programme. This should demonstrate remote delivery is providing the same clinical value to patients and the programme is meeting the same aims as stated at designation.
6. The referral criteria should be amended to ensure that all patients have been reviewed by secondary care services prior to referral to the service. This may have to be phased in as boards without local provision develop local referral pathways.
7. Referral criteria should be further reviewed, and changes agreed to ensure that distinct principles are applied for access to the face to face and the virtual programmes respectively.
8. The service should offer a drop-in MDT clinic for referring clinicians to support appropriate referring.

Appendices

Appendix A – Scottish Service Model for Chronic Pain

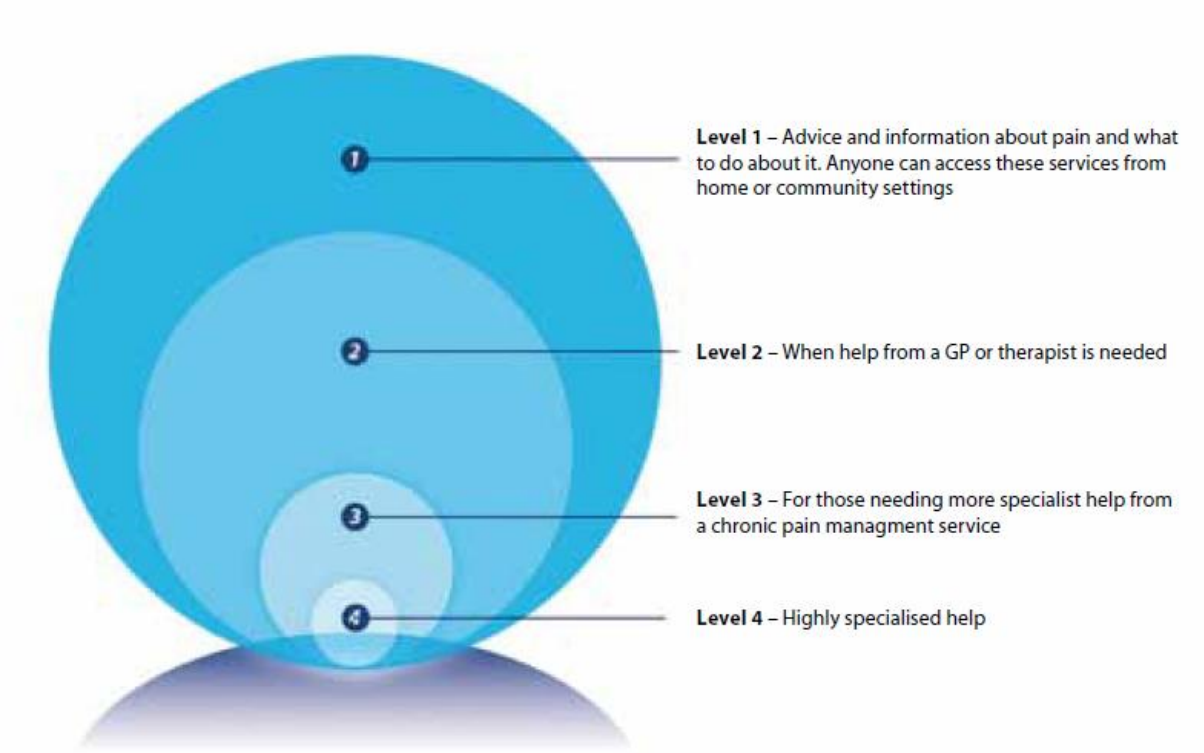


Figure 12 – Scottish Service Model for Chronic Pain. Taken from the Scottish model for chronic pain management services, British Journal of Healthcare Management, 2014

The Scottish Service Model for Chronic Pain sets out the range of services that should be provided locally (levels 1-3) through to the more specialised interventions that may be provided regionally or nationally (level 4). The model sets out a tiered model of care in the approach to pain management covering the range of support available.

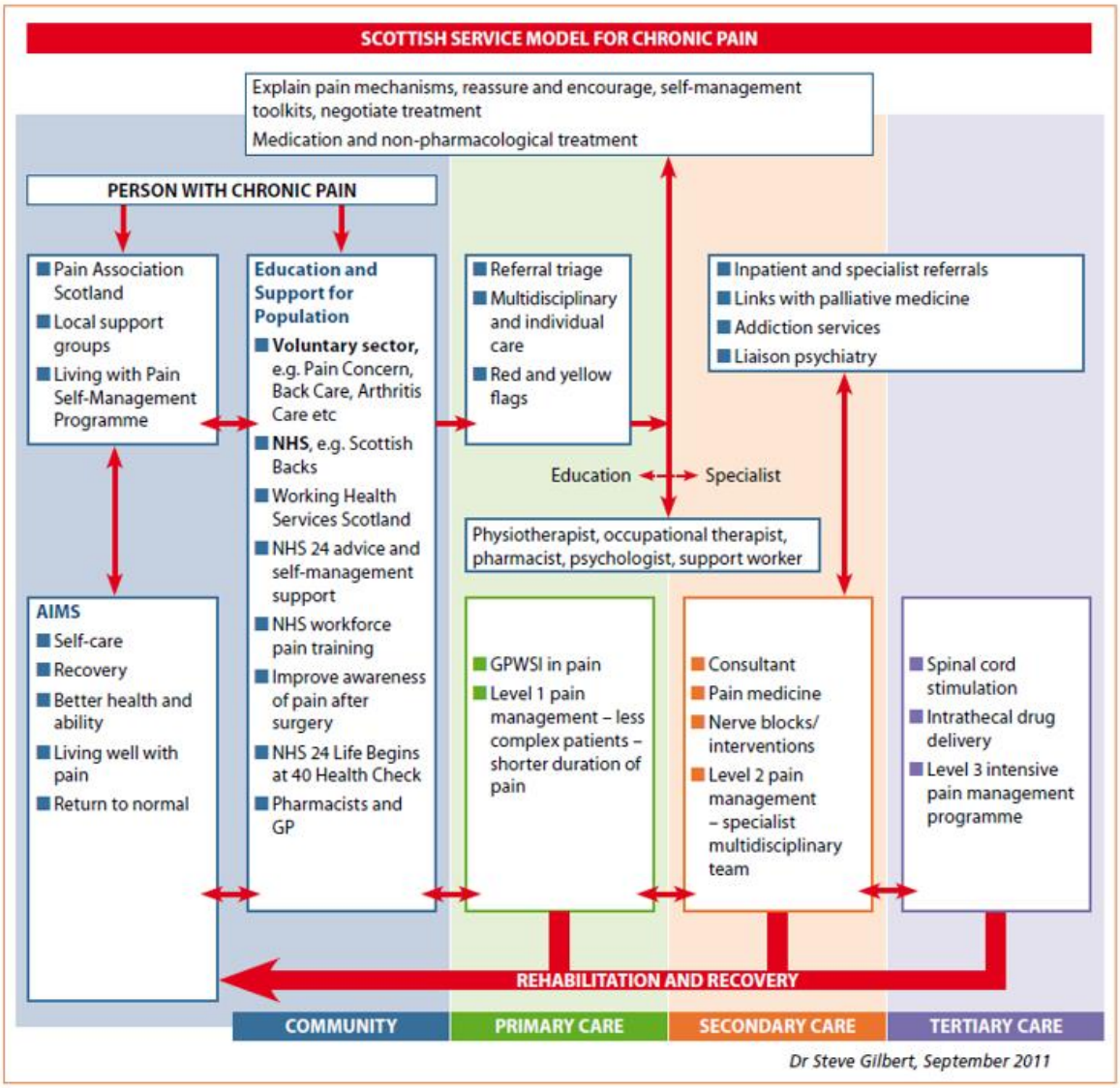


Figure 13 - Scottish Service Model for Chronic Pain. Taken from the Scottish model for chronic pain management services, British Journal of Healthcare Management, 2014

Appendix B – Types of Chronic Pain and Standard treatment

The International Association for the Study of Pain has defined pain as 'an unpleasant sensory and emotional experience associated with actual or perceived tissue damage'.

In some cases, chronic pain has no identifiable underlying cause. chronic pain is pain that persists or recurs for longer than three months. chronic pain can be associated with other diseases, but it is recognised as a separate condition in its own right and not merely an accompanying symptom of other diseases.

Chronic primary pain
Chronic primary pain has no clear underlying condition, or where the pain appears to be out of proportion to any observable injury or disease. Types of chronic primary pain include:

- complex regional pain syndrome
- fibromyalgia
- primary headache and orofacial pain
- primary visceral
- primary musculoskeletal pain

Chronic secondary pain
Chronic secondary pain is caused by an underlying condition. Types of chronic secondary pain include:

- endometriosis
- osteoarthritis
- rheumatoid arthritis
- ulcerative colitis

Management of Chronic Pain
Chronic pain management services can help to improve quality of life and the degree by which pain interferes with patients' lives (British Pain Society, 2012).

A wide range of both pharmacological and non-pharmacological management strategies are available for chronic pain. Where possible, treatment options should be guided by any known underlying chronic pain conditions. Specialist referral should be considered when non-specialist management is failing, the pain is poorly controlled, the patient is experiencing significant distress.

The management of chronic pain is broken down by the following categories as per SIGN 136 Management of Chronic Pain Guidelines.

- Supported self-management
- Psychologically based interventions
- Physical therapies
- Complementary therapies
- Pharmacological therapies

Condensed SIGN guidelines for management of Chronic Pain are listed below.

SIGN 136 Management of Chronic Pain Guidelines – Quick reference guide for Healthcare Professionals

ASSESSMENT

✓ A concise history, examination and biopsychosocial assessment, identifying pain type (neuropathic/nociceptive/mixed), severity, functional impact and context should be conducted in all patients with chronic pain. This will inform the selection of treatment options most likely to be effective.

✓ Referral should be considered when non-specialist management is failing, chronic pain is poorly controlled, there is significant distress, and/or where specific specialist intervention or assessment is considered.

✓ A compassionate, patient-centred approach to assessment and management of chronic pain is likely to optimise the therapeutic environment and improve the chances of successful outcome.

SUPPORTED SELF MANAGEMENT

C **Self-management resources should be considered to complement other therapies in the treatment of patients with chronic pain.**

✓ Healthcare professionals should signpost patients to self-help resources, identified and recommended by local pain services, as a useful aide at any point throughout the patient journey. Self management may be used from an early stage of a pain condition through to use as part of a long-term management strategy.

PHARMACOLOGICAL THERAPIES

✓ Patients using analgesics to manage chronic pain should be reviewed at least annually, and more frequently if medication is being changed, or the pain syndrome and/or underlying comorbidities alter.

Non-opioid analgesics (simple and topical)

B **NSAIDs should be considered in the treatment of patients with chronic non-specific low back pain.**

B **Cardiovascular and gastrointestinal risk needs to be taken into account when prescribing any non-steroidal anti-inflammatory drug.**

C **Paracetamol** (1,000-4,000 mg/day) **should be considered alone or in combination with NSAIDs in the management of pain in patients with hip or knee osteoarthritis in addition to non-pharmacological treatments.**

A **Topical NSAIDs should be considered in the treatment of patients with chronic pain from musculoskeletal conditions, particularly in patients who cannot tolerate oral NSAIDs.**

A **Topical capsaicin patches** (8%) **should be considered in the treatment of patients with peripheral neuropathic pain when first-line pharmacological therapies have been ineffective or not tolerated.**

B **Topical lidocaine should be considered for the treatment of patients with postherpetic neuralgia if first-line pharmacological therapies have been ineffective.**

B **Topical rubifacients should be considered for the treatment of pain in patients with musculoskeletal conditions if other pharmacological therapies have been ineffective.**

Opioids

B **Opioids should be considered for short- to medium-term treatment of carefully selected patients with chronic non-malignant pain, for whom other therapies have been insufficient, and the benefits may outweigh the risks of serious harms such as addiction, overdose and death.**

✓ At initiation of treatment, ensure there is agreement between prescriber and patient about expected outcomes *(see Annex 4 of the full guideline)*. If these are not attained, then there should be a plan agreed in advance to reduce and stop opioids.

✓ All patients on opioids should be assessed early after initiation, with planned reviews thereafter. These should be reviewed annually, at a minimum, but more frequently if required. The aim is to achieve the minimum effective dose and avoid harm. Treatment goals may include improvements in pain relief, function and quality of life. Consideration should be given to a gradual early reduction to the lowest effective dose or complete cessation.

B **Currently available screening tools should not be relied upon to obtain an accurate prediction of patients at risk of developing problem opioid use, but may have some utility as part of careful assessment either before or during treatment.**

C **Signs of abuse, addiction and/or other harms should be sought at reassessment of patients using strong opioids.**

D **All patients receiving opioid doses of >50 mg/day morphine equivalent should be reviewed regularly** (at least annually) **to detect emerging harms and consider ongoing effectiveness. Pain specialist advice or review should be sought at doses >90 mg/day morphine equivalent.**

Antiepilepsy drugs

A **Gabapentin** (titrated up to at least 1,200 mg daily) **should be considered for the treatment of patients with neuropathic pain.**

A **Pregabalin** (titrated up to at least 300 mg daily) **is recommended for the treatment of patients with neuropathic pain if other first and second line pharmacological treatments have failed.**

A **Pregabalin** (titrated up to at least 300 mg daily) **is recommended for the treatment of patients with fibromyalgia.**

B **Flexible dosing may improve tolerability. Failure to respond after an appropriate dose for several weeks should result in trial of a different compound.**

B **Carbamazepine should be considered for the treatment of patients with neuropathic pain. Potential risks of adverse events should be discussed.**

Behavioural therapies

C **Progressive relaxation or EMG biofeedback should be considered for the treatment of patients with chronic pain.**

✓ Clinicians should be aware of the possibility that their own behaviour, and the clinical environment, can impact on reinforcement of unhelpful responses.

Cognitive behavioural therapy

C **Cognitive behavioural therapy should be considered for the treatment of patients with chronic pain.**

PHYSICAL THERAPIES

Manual therapy

B **Manual therapy should be considered for short-term relief of pain for patients with chronic low back pain.**

B **Manual therapy, in combination with exercise, should be considered for the treatment of patients with chronic neck pain.**

Exercise

B **Exercise and exercise therapies, regardless of their form, are recommended in the management of patients with chronic pain.**

A **Advice to stay active should be given in addition to exercise therapy for patients with chronic low back pain to improve disability in the long term. Advice alone is insufficient.**

The following approaches should be used to improve adherence to exercise:

B • **supervised exercise sessions**

B • **individualised exercises in group settings**

C • **addition of supplementary material**

B • **provision of a combined group and home exercise programme.**

Electrotherapy

B **Transcutaneous electrical nerve stimulation should be considered for the relief of chronic pain. Either low or high frequency TENS can be used.**

B **Low-level laser therapy should be considered as a treatment option for patients with chronic low back pain.**

COMPLEMENTARY THERAPIES

Acupuncture

A **Acupuncture should be considered for short-term relief of pain in patients with chronic low back pain or osteoarthritis.**

Antidepressants

✓ Patients with chronic pain conditions using antidepressants should be reviewed regularly and assessed for ongoing need and to ensure that the benefits outweigh the risks.

A **Tricyclic antidepressants should not be used for the management of pain in patients with chronic low back pain.**

A **Amitriptyline** (25–125 mg/day) **should be considered for the treatment of patients with fibromyalgia and neuropathic pain** (excluding HIV-related neuropathic pain).

✓ It may be appropriate to try alternative tricyclic antidepressants to reduce the side effect profile.

A **Duloxetine** (60 mg/day) **should be considered for the treatment of patients with diabetic neuropathic pain if other first- or second-line pharmacological therapies have failed.**

A **Duloxetine** (60 mg/day) **should be considered for the treatment of patients with fibromyalgia or osteoarthritis.**

B **Fluoxetine** (20–80 mg/day) **should be considered for the treatment of patients with fibromyalgia.**

B **Optimised antidepressant therapy should be considered for the treatment of patients with chronic pain with moderate depression.**

✓ Depression is a common comorbidity with chronic pain. Patients should be monitored and treated for depression when necessary.

Combination therapies

A **Combination therapies should be considered for patients with neuropathic pain** (a pathway for patients with neuropathic pain can be found in Annex 3 of the full guideline).

A **In patients with neuropathic pain who do not respond to gabapentinoid** (gabapentin/pregabalin) **alone, and who are unable to tolerate other combinations, consideration should be given to the addition of an opioid such as morphine or oxycodone. The risks and benefits of opioid use needs to be considered.**

PSYCHOLOGICALLY BASED INTERVENTIONS

✓ Healthcare professionals referring patients for psychological assessment should attempt to assess and address any concerns the patient may have about such a referral. It may be helpful to explicitly state that the aims of psychological interventions are to increase coping skills and improve quality of life when faced with the challenges of living with pain.

Pain management programmes

C **Referral to a pain management programme should be considered for patients with chronic pain.**

Unidisciplinary education

C **Brief education should be given to patients with chronic pain to help patients continue to work.**

Appendix C – Residential and Remote Service Models

Residential Pain Management Service Delivery Model

Referrals
Referrals to the service will be accepted from consultants from local pain management services from all parts of Scotland. Referrals are triaged by the multi-disciplinary team.

Assessment
Following triage to assess suitability, individuals are offered an initial specialist multi-disciplinary assessment. Where appropriate, family and/or carers are involved in aspects of the assessment and are invited to participate in one half-day of the programme. All individuals are informed of the outcome of their assessment on the day, or via telephone following multi-disciplinary team discussion. All individuals appropriate for the group phase are contacted by telephone two weeks post assessment to provide support and practical information regarding attendance. If additional support is required beyond this (e.g. to support independent living in the accommodation) it is arranged dependent on clinical need.

Preparatory Clinic
Following assessment, all patients who are considered suitable for a group are offered preparatory clinic input. The nature of this work is driven by patient needs and offers potential participants further information or education regarding the programme, or preparatory work prior to group attendance. The aim is to optimise participants' readiness to attend and derive greatest benefit from the programme.

Residential Delivery
The residential pain management programme will run on an intermittent basis at Allander House, Gartnavel Campus, NHS Greater Glasgow and Clyde. Participants will stay in self-catering accommodation in Glasgow throughout the length of the programme. Patients will be invited to join a cohort of 8-10 participants who will be encouraged to offer peer support as well as benefiting from the expert inputs from the multi-disciplinary team.

Residential Programme Patient Pathway
The residential delivery of the programme has three phases:

- **Initial three week residential block:** Weekday attendance at Allander House, on the Gartnavel Campus in Glasgow, with self-catering accommodation provided in Glasgow city centre.
- **Consolidation:** Participants return home with an agreed self-management programme and are offered appropriate support to develop and practice their self-management strategies.
- **Follow up:** Telephone review at three months post residential block, followed by a one day group review at Allander House after six months.

Remote Pain Management Programme Service Delivery Model

Referrals
Referrals to the service will be accepted from consultants from local pain management services from all parts of Scotland. Referrals are triaged by the multi-disciplinary team. Prior to Covid-19, an additional referral criteria had been the ability to self-care independently in

self-catering accommodation for three weeks. Whilst services are being delivered remotely, this does not apply. The removal of this aspect of the referral criteria opens the service to participants who would not have previously been eligible for the programme.

Assessment
All suitable patients will receive an opt in letter asking them to arrange a convenient assessment appointment. Patients will then be sent confirmation of their appointment and a digital questionnaire via email to complete prior to assessment. Anyone who is unable to complete a digital questionnaire will be offered a paper copy to complete instead. The specialist assessment leads to the development of an agreed care plan to the individual needs of the referred patient. The adoption of remotely delivered assessments has enabled greater flexibility and assessments are now often spread across two appointments.

The assessment appointment includes:

- a review of the need for further investigations / pain interventions (may involve referral being returned to local / regional specialist team for action)
- a review of current pharmacological interventions
- a detailed bio-psychosocial assessment
- planning appropriate psychological and behavioural interventions

All individuals are informed of the outcome of their assessment on the day, or via telephone following multi-disciplinary team discussion.

It is expected that, where appropriate, the patient's family and/or carers will be involved in aspects of the assessment and will participate in the actual programme itself.

Preparatory Clinic
Following assessment, all patients who are considered suitable for a group are offered preparatory clinic input. The nature of this work is driven by patient needs and offers potential participants further information or education regarding the programme, or preparatory work prior to group attendance. The aim is to optimise participants' readiness to attend and derive greatest benefit from the programme. This appointment also covers group ground rules and provides information regarding attendance.

In response to the remotely delivered programme, the nature of the preparatory clinic also includes additional aspects such as access to technological equipment, technological ability, and exploration of any home environmental barriers to engagement. All participants attend a technology check appointment which gives them opportunity to become familiar with the platform used for remotely delivered groups and troubleshoot any IT problems.

Remote Delivery Platform – Microsoft Teams
To ensure continuity of service delivery during the pandemic, once a robust platform was available for group online interventions. The service began to offer a programme using Microsoft Teams. The development, design, delivery and evaluation of this programme were consistent with the emerging evidence base, current clinical consensus and in keeping with the British Pain Society's Guidelines on Pain Management Programmes (2013). This remotely delivered programme offers shared experiential learning for participants, alongside many of the other benefits of delivering pain management within a group setting.

Remote Programme Patient Pathway
The remote delivery of the programme has three phases:

- **Initial five week intensive block:** Weekday attendance for three hours a day from 09:30-12:30 on the remotely delivered platform.
- **Consolidation:** Upon completion of the remotely delivered programme, participants have an agreed self-management programme and are offered appropriate support to develop and practice their self-management strategies.
- **Follow up:** Telephone or video review at three months post intensive block, followed by a one day group review after six months.

Programme Phases

Phase 1 – Group block
Whether the group is delivered remotely or face-to-face, the content is identical. The group sessions involve a mixture of talks and activities with the chance to learn more about pain and learn new practical skills to help reduce the impact that pain can have on day to day life.

Each day of the programme is varied and can be a mixture of the following:

- group sessions
- working in a small group
- individual work
- practical physical and activity sessions

At one point during the group, there is a Friends and Family session, where a friend or family member can attend for a specially designed information session.

Phase 2 – Consolidation
Participants in the programme will normally be discharged with an agreed self-care programme and individuals will be offered appropriate support to develop their independence / independent living.

During the period from treatment to discharge, specific patient experience questionnaires are administered at appropriate time periods following discharge.

Shared care protocols must be in place with referring clinicians and GPs for the long-term care of the patient and appropriate contact between the service and primary and secondary care maintained and encouraged for the duration of treatment.

Phase 3 – Follow up care
Three months after the group phase the SNRPMP will arrange a telephone or video review appointment to discuss progress and help with any difficulties. This allows participants to practice their new skills at home after they have completed the group stage block.

Six months after the group phase, participants are invited to a follow up session with their group, with top-up sessions provided by the SNRPMP team. For the residential programme this is at Allander House, for the remote programme Microsoft Teams or via telephone. This session will allow participants to share progress with the other group members and explore

any challenges they may have had. If an individual is unable to attend the group session, they are offered an individual six month review.

Discharge from the programme will follow the six month post-programme session. In exceptional circumstances where further review is required, this will be undertaken via telephone.

Appendix D – Quality and Performance Indicator Comparison

Scottish National Residential Pain Management Programme	NHS England Highly Specialist Pain Management Service
Equitable	
• Referrals • Assessments • Group participants • 3 and 6 month reviews	
Efficient	
• % conversion from referral to assessment; assessment to eligible for group programme • % of eligible patients starting group phase within 6 weeks following assessment • Number of participants completing each phase of the programme	• Number of patients completing pain management programme
Timely	
• % patients assessed within 12 weeks from referral • Time from decision to treat to commencing group therapy	• Mean time from referral to treatment • Number of patients receiving definitive treatment within 18 weeks
Clinical Outcomes	
• 100% of Patient Reported Outcome Measures (PROMS) collected at the following intervals: – Assessment – Day 1 of the programme – Day 25 of the programme – 6 month review • 100% of Physical and Activity outcome measures collected at the following intervals: – Beginning of programme – End of programme	• Number of patients with EQ5DL-5L outcome improvement on discharge • Proportion of patients with Quality of Life improvement on discharge • Number of patients demonstrating positive improvement completing treatment • The service actively participates in audit and research • The service provides advice, support and training to referring organisations • Minimum 10% sub sample questioned at initial consultation/follow up about A&E visits, average score • Minimum 10% sub sample questioned at initial consultation and follow up during the reporting period about admissions, average score
Safe	
• 100% of patients have a risk assessment in place for activity based sessions • 100% of patients have ongoing clinical monitoring for safe participation in sessions	• Number of never events reported • Suicide risk assessment procedure in place • Multidisciplinary team meeting log registration process in place to ensure governance and appropriate safe practice

	• Protocol in place for safe practice of intrathecal opioids
Person Centred	
• 70% of patients returning the patient satisfaction questionnaire	• Information is available for patients on their condition and treatment • Patients are given a personalised care plan • Mechanism in place to obtain feedback from patients and families • Number of patients or carers specifying they received helpful information about their condition and treatment • Number of complaints received within the reporting period

Table 16 - Quality and performance indicator comparison between Scotland and England highly specialist pain management programmes