



Dear Colleague

**CHRONIC PAIN SERVICES IN SCOTLAND:
REPORT BY PROFESSOR JAMES MCEWEN**

1. I enclose a copy of the report of the review into chronic pain services in Scotland commissioned by the Scottish Executive and carried out by Professor James McEwen. Professor McEwen's remit was:

"Through a process that includes consultation with key stakeholders, including NHS Boards, the Pain Association and Pain Concern (as representatives of the interests of patients), the Scottish Network for Chronic Pain Research, the Physiotherapy Pain Association, Aberdeen Pain Research Group and individual clinicians with a particular expertise, which includes some members of the Scottish Parliament Cross Party Group on Chronic Pain, to produce a report that:

- reviews referral protocols for the treatment of chronic pain;
- reviews the current range of services in each of the health boards for treating chronic pain;
- draws conclusions about the level of services for treating chronic pain across Scotland, compared to the recommendations made by the 1994 report by a working group of the National Medical Advisory Committee on the Management of Patients with Chronic Pain and the 2000 Clinical Standard Advisory Group Report on Services for Patients with Pain;
- makes recommendations on how to improve the level of service across Scotland."

2. Professor McEwen's recommendations are constructive and far reaching and provide a helpful framework within which pain services can be enhanced. He has identified that, while good quality services are available in many parts of Scotland, there is too much variation in both the structure and functioning of services.

23rd December 2004

Addresses

For action

Chief Executives, NHS Boards

For information

Local Health Councils
Chief Executives, Special Health Boards
Voluntary Health Organisations with an interest in chronic pain

Enquiries to:

Miss K Glancy
St Andrew's House
EDINBURGH
EH1 3DG

Tel: 0131-244 2544
Fax: 0131-244 2866

E-mail:
Kathleen.Glancy@scotland.gsi.gov.uk

3. The report contains a number of recommendations which call for action or consideration by NHS Boards. The report is therefore commended to Boards, who are asked to give particular consideration to local issues in respect of the services they provide for chronic pain.

4. The Executive intends, within the next few months, to invite key stakeholders, including representatives from Boards, the voluntary sector, patient groups and members of the Parliamentary Cross Party Group, to attend a consensus conference to discuss the report. The recommendations in the report are also being taken into account as part of the work of the National Framework for Service Change on new approaches to the management of long-term conditions.

5. For further information or additional copies of the report, please contact Kathleen Glancy on 0131 244 2544 or Lee-Anne Smith on 0131 244 2507.

Yours sincerely



J T BROWN
Public Health Division

CHRONIC PAIN SERVICES IN SCOTLAND

Professor James McEwen
Emeritus Professor in Public Health

July 2004

INTRODUCTION

This review was carried out at the request of the Scottish Executive. In 1994 the Scottish Office had published “The Management of Patients with Chronic Pain” which gave “an account of the definition, classification, and management of chronic pain”, described “existing arrangements in Scotland”, and “made recommendations for future developments”. The report showed that there was “an excellent basis upon which to build in Scotland in order to provide a service of high quality from the level of primary care to the specialist national centre”¹.

In 2000 the Clinical Standards Advisory Group published “Services for Patients with Pain”² which covered both acute and chronic pain and services for adults and children. With respect to chronic pain it produced a number of recommendations directed at those health authorities responsible for providing services as well as professional and other bodies concerned with policy, training, etc.

In 2002 the SPICE Report was prepared for the Parliament’s Health Committee and provided an overview of services in Scotland³. During the last session of the Scottish Parliament, the Cross-Party Group on Chronic Pain had been established with a wide membership and had argued for developments in services for chronic pain⁴.

In the introduction to the 1994 Report, it was stated “Chronic pain management is probably one of the most challenging problems in medicine today. Its origins, assessment and treatment are complex. Chronic pain is a debilitating condition. Its prevalence is known to be widespread and it is a major claim on health care resources and the national economy”. In the note by the Scottish Office Home and Health Department “Health Boards are invited to decide what priority to give to these developments and the level of resources that they would wish to direct towards them”.

Accordingly, this seemed an appropriate time for a Scottish wide review of services for chronic pain.

THE REMIT

To produce a report that:

- Reviews referral protocols for the treatment of chronic pain;
- Reviews the current range of services in each of the health boards for treating chronic pain;
- Draws conclusions about the level of services for treating chronic pain across Scotland, compared to the recommendations made by the 1994 report by a working group of the National Medical Advisory Committee on the Management of Patients with Chronic Pain and the 2000 Clinical Standards Advisory Group Report on Services for Patients with Pain;
- Makes recommendations on how to improve the level of service across Scotland.

It was considered that there was no need to repeat a “needs assessment” as this had been thoroughly covered in other fairly recent publications. Similarly, as there had been detailed comparisons of individual health boards or trusts in recent publications such as Dr Foster in consultation with the Pain Society⁵, (see also note on limitations of data), it was decided to take advantage of the direct contact in this review to concentrate on the key issues affecting chronic pain in Scotland at present.

The review covers adult services for chronic pain, but will discuss links with acute pain and palliative care services.

Comparison of the present position will be made with the findings of the 1994 Report and the recommendations made for further development.

THE PROCESS

A letter was written from the Scottish Executive to the chief executives of all the Scottish Health Boards informing them of the review and inviting them to identify a contact within the Board. While the named contacts were generally the lead clinician for chronic pain, some boards selected a member of senior management, a consultant in public health and a senior pain nurse. This may be indicative of the way that boards perceive their services for chronic pain. All these individuals were contacted and visits were paid to all the mainland health boards. In many boards other individuals were also seen or contacted by telephone. Lothian Health Board arranged a half-day meeting of the full range of people involved with their chronic pain services. The information from the island health boards was obtained by telephone interview and the compilation of a schedule by the lead clinician.

In addition to the contacts with health boards a number of individuals and organisations were visited or contacted by letter or telephone covering academic and research, voluntary organisations and patient representatives. I also attended a meeting of the Scottish Parliamentary Cross-Party Group on chronic pain. It is recognised that this is only a small percentage of the total number of people involved with chronic pain in Scotland, but as the review went on there was a remarkable consistency in the views expressed and the information obtained.

It would have been desirable to undertake a detailed survey of both patients at all levels of care and of general practitioners, but this would have required a different study approach and substantially greater resources. It should be noted that the main care of patients with chronic pain, both in the early and in the longer term, is carried out in primary care. General practitioners and primary care staff have vital roles both in diagnosis and assessment and in providing treatment to limit disability and maximise patients potential. The current position is summarised in the section on Primary Care and new developments in primary care or linked to primary care are identified throughout the report.

OVERVIEW

In carrying out this review, the most impressive aspect was the enthusiasm and commitment of all those who were interviewed. Most of the early pain services had begun with an individual who irrespective of clinical background had been aware of the needs of those with chronic pain and had worked to develop a service and obtain the necessary support and facilities. Virtually all services began within anaesthetics departments and the majority remain there. There have been a number of new services established and others expanded since the 1994 Report. All health boards have some provision for chronic pain, but not all the health boards provide a comprehensive service.

Alongside the enthusiasm, there is an equally universal view that current provision is inadequate to meet the need, that services are unequal both between and within boards and that few services attain the ideal of comprehensive and seamless care. Virtually all staff exceed their contractual hours, often quite substantially, and some services are maintained by staff providing for chronic pain in their own time – e.g. lunchtime. Few services have an identified budget and one contact described ‘stealth’ as the means of developing the service. Few services have identified or dedicated premises. In one board there were 13 potential places to see patients. Yet within all the constraints the services are providing high quality care to patients.

Developments are taking place such as new links between primary and secondary care, and new dedicated back pain services. There are clear views as to future developments and a willingness to evaluate different forms of provision. There is a desire to have a recognised national strategy and a clear commitment by each health board to a high quality chronic pain service. All those interviewed agreed on the need for a formally recognised and labeled service for chronic pain.

BACKGROUND

Only a brief summary will be provided here as it is well covered in the other reports.

Pain services began in the UK in the late 1940s and were provided by anaesthetists who were able to provide specialised interventions for those in severe pain. Since then services have gradually extended their scope and are now multi-disciplinary. The three areas that are now identified are acute pain, chronic pain and pain in palliative care. While in most places there are separate services, they are often linked through the host department of anaesthesia.

There has been considerable debate over the definition of pain and chronic pain.

Pain: an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.

Chronic pain: pain that either persists beyond the point at which healing would be expected to be complete or that occurs in disease processes in which healing does not take place. Chronic pain may be accompanied by severe psychological and social disturbance. Chronic pain can be experienced by those who do not have evidence of tissue damage⁶.

Duration of three or six months is the time that is usually accepted for the definition of chronic pain. In the Pain in Europe Survey 2003⁷ the working definition of a chronic pain sufferer was defined as:

- Adult (18 years old or older)
- Has suffered from pain due to illness or medical condition for at least six months
- Has experienced pain within the past month
- Has experienced pain at least several times a week
- Rates intensity of pain as 5 or higher on a 1-10 scale where 1 = “no pain at all” and 10 = “the worst pain imaginable”.

From the perspective of the patient a practical definition is “pain is whatever the experiencing person says it is, existing when he/she says it does”⁸.

For the purpose of this review the first definition of chronic pain was generally used, but it is important to note that strict adherence to a time period of six months must not be used to discourage early intervention with the aims of early treatment and rehabilitation.

Studies that have sought to quantify the size and extent of chronic pain in the community are inevitably linked to definitions. Only a few of the more recent references will be included in this review. The key findings from the Pain in Europe Report summarise the position:

- Chronic pain strikes one in five (19%) adults across Europe. **The figure for Scotland is 18.1%.**
- Two-thirds of chronic pain sufferers experience moderate pain while one-third experience severe pain (as rated on a 1-10 scale)
- The most common source of pain reported by chronic pain sufferers is the back (24%) and the most common cause is arthritis/osteoarthritis (35%).
- People with chronic pain have been suffering on average for 7 years, some for 20 years or more (21%)
- One-third of patients suffer chronic pain at all times – 24 hours a day, 365 days a year.

Some caution is required in these international statistics but they are consistent with other studies and provide an indication of the overall picture.

In a study in Grampian^{9,10,11,12}, 14.1% reported “significant chronic pain” and this was more prevalent among women and older age groups. A total of 6.3% reported “severe chronic pain” and this was more common in older age groups. In a four year follow-up 79% of those with pain at baseline still had it at follow-up. Overall 45.5% of the study sample at baseline complained of chronic pain and this had increased to 53.8% at follow-up. Back pain and arthritis accounted for one-third of all complaints.

The impact of chronic pain is enormous on the individual, family members and the state. In the Europe study one-third of sufferers were so weighed down with pain that they could not “tolerate any more”. Of those suffering pain 25% are unemployed because of pain, and those employed were forced to take more than 15 days off work every year because of pain. In addition one in five chronic pain sufferers had been diagnosed with depression as a result of their pain. In the Grampian study chronic pain was associated with poor health as measured on all dimensions of the SF36 scale and with unemployment. Similar findings were noted in a study in Glasgow testing a new measure of self rated health¹³.

As far as use of services is concerned, chronic pain is one of the most common reasons why people seek medical care and patients with chronic pain use health services up to five times more frequently than the rest of the population. The Grampian study described the extensive use of health services – 67.2% had seen their GP, 34% a hospital specialist, 25.9% a physical therapist and 18.2% an alternative therapist in the preceding year. Prescription medicines had been taken by 57.4%, non-prescription medicines by 57.4% and alternative medicine by 15% with chronic pain. The majority (67%) of individuals with chronic pain who sought alternative health care did so in conjunction with conventional health care.

In 1994 describing pain relief clinics in Scotland, the Report stated “Because of the responsive nature of the development of pain relief clinics in Scotland, service provision has tended to be piecemeal and unstructured with an uneven distribution of facilities. Little recognition has been accorded in terms of funding to professionals working in these clinics and most exist on what they can obtain through goodwill in terms of time and equipment from the parent anaesthetic departments. Similar situations exist with regard to clinical psychologists treating chronic pain. Given this background, it is not surprising that workloads have always exceeded clinical time and the facilities available to meet them”.

A pain management programme has been defined by the Pain Society as “ a psychologically-based rehabilitative treatment for people with chronic pain which remains unresolved by currently available medicine and other physically-based treatments”¹⁴. The aim is to reduce disability and distress and patients are taught to be as self reliant as possible.

While chronic pain may be said to affect approximately half of the adult population depending on definitions of severity, between 5% and 20% could be labelled as chronic pain sufferers. In 1994 the Scottish Office Report stated that there are about 500,000 people in Scotland who might benefit from the services of a pain relief clinic and that 150,000 people with some disability have unrelieved pain. Using the 'severe' category of chronic pain from the Grampian study, Blair Smith states that in Scotland there are 221,000 sufferers and that chronic pain is a common, persistent problem in the community with relatively high incidence and low recovery rates. "It is associated with significant disability, unemployment and loss of other physical roles. These produce social and financial problems, which included reduced earning capacity, family disharmony and isolation". CSAG accepted that although cure is seldom an option, there is a great deal that can be done to treat pain and alleviate its effects".

Although this report does not include a comprehensive literature review, it is essential that new ideas and research, both national and international are assessed for their potential to improve care. Internet technology is providing new opportunities for self-management programmes. Evidence of the benefit of early detection of post-surgical pain and changing approaches to drug therapy, such as the use of opioids appear to be promising. In a number of areas with chronic conditions the concept of the "expert patient" has been established¹⁵. This would seem to have potential in chronic pain.

In the Systematic Review of outpatient services for chronic pain control published by the Health Technology Assessment Programmes¹⁶, the findings showed that there was a lack of evidence for some commonly used treatments such as most of the physical interventions, good evidence for some pharmacological treatments and that on the basis of evidence from 35 trials in pain therapy, cognitive behavioural therapies demonstrated large and sustainable improvements in targeted outcomes. However it was found in the Europe study that only 23% of people had been referred to pain management specialists. The Health Technology Assessment concluded on cost that while there is evidence that chronic pain clinics use interventions which provide pain relief for patients, there is little information on costs and benefits of chronic pain treatments. Carefully planned care can reduce the over consumption of drugs.

In a review from The Centre for Health Economics in 1995¹⁷ the cost of back pain alone to the NHS was estimated to be between £265 and £383 million and back pain was likely to account for between 5.8 and 8.6 million GP consultations every year. Maniadakis and Gray in 2000¹⁸ estimated the direct cost of back pain to be £1632 million in the UK with approximately 35% of this borne by patients and families themselves through private sector services. They also estimated that including employment and informal care costs, the cost was £10668 million, implying that the indirect cost of back pain alone was greater than the cost of coronary heart disease. The full spectrum of back pain has been described by Waddell and colleagues and they provide a model of approaches that can be taken^{19,20,21}. They note the contribution of occupational health services and others also emphasise the contribution of vocational rehabilitation²². It is accepted that these are not universally available.

The evidence that is available suggests that pain clinics reduce overall direct health care costs by about £1000 per patient per year. The evidence indicates that pain clinics generate direct health service savings equal to twice their running costs. Thus there may be substantial savings available to the NHS by caring for patients and minimising unnecessary consultations and investigations. In addition there may be financial gains for patients through employment and reduction in other areas of state spending such as social security or other benefits¹⁶.

The International Association for the Study of Pain²³ has published “Desirable Characteristics for Pain Treatment Facilities”. They indicated that a multi-disciplinary pain clinic should have on its staff a variety of health care providers capable of assessing and treating physical, psychosocial, medical, vocational and social aspects of chronic pain. These can include physicians, nurses, psychologists, physical therapists, occupational therapists, vocational counsellors and social workers. If one of the physicians is not a psychiatrist, physicians from two specialties and a clinical psychologist are the minimum required. They recommended that there should be adequate support staff and designated spaces with provision for inpatient and outpatient services.

There have been a number of professional recommendations on staffing in a pain service. The Association of Anaesthetists and the Pain Society in 1993²⁴ recommended a minimum of 10 chronic pain consultant sessions per 100,000 population and in the Royal College of Anaesthetists Guidance 1994²⁵ proposed a minimum of two consultants per service to avoid cancellation of outpatient clinics and theatre sessions when a single handed consultant takes leave. The 1994 Report recommended that in addition to consultant anaesthetist input, each pain relief clinic should have one whole-time dedicated nurse and one whole-time secretary. Two clinical psychologists should be deployed on the basis of one whole time equivalent per 200,000 population.

Recently The Royal College of Anaesthetists and the Pain Society²⁶ published a good practice for pain management services. In summary they stated that effective and safe management of acute and chronic pain in hospitals requires:

1. The provision of services for acute pain management in all hospitals.
2. The provision of core services for chronic pain management in all district hospitals and most specialist hospitals.
3. The provision of specialised services for pain management on a regional basis.
4. Adequate resources to provide an appropriate number of fixed sessions for (specialists in pain management), other healthcare professionals, secretarial and administrative staff, as well as appropriate accommodation, facilities and equipment.
5. Recognition that anaesthetists who have sessions in pain management need to have job plans that differ from those of most anaesthetists who work in operating theatres, obstetric units and critical care units.
6. Close liaison between pain management services and other healthcare groups (including primary care and palliative services) in order to provide an individualised, inter-disciplinary approach to the management of pain for each patient.
7. Specific arrangements for the treatment of vulnerable groups such as the elderly, children, non-verbal, disabled, intellectually handicapped and those whose language is not English.
8. Equity of access and service provision for all patients taking into account clinical, socio-economic and cultural factors.
9. The provision of properly constructed pain management programmes which aim to promote restoration of normal physical and psychological function, and to decrease the inappropriate use of health care resources by patients with chronic pain.
10. An active programme of education in the understanding of pain, its presentation and its management, for all health professionals who care for patients with pain in both the primary and secondary sectors.
11. Continuing evaluation and audit of pain management services.

The CSAG Recommendations of 2000 were that local chronic pain teams should:

- Advise local GPs on the range of services available, appropriate criteria for referral, appropriate expectations from referral, and the respective roles of GPs and pain team in the long term care of referred patients
- Be led by a named individual whose role is clearly defined
- Be multi-disciplinary including, for example, doctors, nurses, psychologists, pharmacists, physiotherapists and occupational therapists.
- Have adequate administrative support and office space
- Have a recognised role in education of professionals in the management and prevention of chronic pain
- Devise care plans for all new patients
- Discuss care plans with patients and carers
- Make care plans available to other clinicians involved in the patient's care
- Ensure that chronic pain services are audited.

In summary CSAG recommended that NHS trusts “ Ensure that patients have access where appropriate to a multidisciplinary chronic pain team, which will also educate other professionals” and “ ensure reasonable access to a pain management programme for patients with high levels of distress or disability as a result of chronic pain”.

THE PRESENT POSITION IN SCOTLAND

It is appropriate to begin with a note indicating that caution needs to be applied to some of the information gathered for this report. While I was able to obtain a very full picture of the services within the Boards known to my contacts, some other services may not have been fully identified, and indeed some “emerged” during discussions. In some boards, there is not a clearly identified “board broad service” but rather one or two discrete services. Relatively few boards could identify the total funding available for chronic pain, as much of the service was not separately identified within a larger budget, generally anaesthetics. Some of the routine data, such as numbers on the waiting list, were difficult to identify. Therefore I have tended to use such data to illustrate the key points rather than in a comparative fashion.

There was very considerable variation between the services as to what were regarded as the key objectives. This is inevitably dependent on the staff available, other services within the board and the length of time the service has been established.

Recommendation: 15

PRIMARY CARE

Although as indicated earlier neither a detailed study of patients nor of general practitioners was possible, it was considered that it would be useful to include a brief overview on primary care to link with the other sections in the report. This section was prepared collaboratively with Dr. Blair H. Smith of the University of Aberdeen.

Chronic pain is a frequent and important problem in primary care. “It stimulates a huge number of prescriptions, investigations and referrals, causes frustration in its resistance to treatment, and leaves patients and doctors with low expectations of successful outcome”²⁷. While studies vary it is estimated that between 15 and 22% of patients seen in primary care have chronic pain. They are frequent attenders, using primary care services up to five times more frequently than the rest of the population.

A diagnosis of chronic pain is important, as is the diagnosis of any other treatable condition. There is evidence to suggest that patients who accept their pain’s chronicity rather than continuing to seek further investigations fare better with therapeutic intervention. Many patients report that the moment the doctor diagnosed chronic pain was the moment when acceptance and a degree of resolution began.

General practitioners have the opportunity for early intervention in pain and through active treatment and rehabilitation may prevent the onset of chronicity. This may involve early referral to specialist services, but as noted later in the report this may be frustrated by long waiting times. With his or her knowledge of and access to patients’ medical and social histories, the general practitioner is uniquely placed to assess patients appropriately.

With respect to management, the key is for patients and professionals to agree realistic goals of treatment and equally to agree what cannot be cured. In addition to appropriate and well-monitored drug treatment, the primary care team can include nursing care, physical and occupational therapy, psychological support and involves a range of professionals.

Whatever use is made of other services, patients will return to primary care and the general practitioner will have responsibility for long term continuing care. This has substantial implications for resources both human and financial.

In addition to the more medical aspects of primary care, as indicated elsewhere in this report there is the need for substantial community support with respect to a whole range of support from local authorities, leisure services, transport, and voluntary organisations as well as from other statutory agencies concerned with vocational rehabilitation.

Recommendation: 5

CURRENT SERVICES

There is great variation between boards and within boards and in some places there has been recent or current expansion and attempts to fill in gaps. However, it was noted by those interviewed that all services were in some way inadequate to meet the population needs and there was either a missing component of what is identified as core for a chronic pain service, e.g. a multi-disciplinary pain management programme, or the pain service only covered part of the health board. Virtually all mainland health boards considered that they were inadequately staffed and that patients had a long wait to be seen and often a further long wait for treatment.

In the Island health boards and in parts of some of the other boards covering a relatively small population, there were more informal and flexible arrangements – such as appointments being quickly arranged to suit patients, rather than having formal pain clinic slots. These worked well, and patients were seen rapidly by a consultant anaesthetist, although access to other disciplines was more difficult and sometimes lacking.

The problem of coverage within a health board and hence access by patients is a considerable one, especially remembering that by definition patients have pain and are often older. Highland Health Board does not claim to provide a comprehensive service, but consultant led pain clinics are held at Caithness General Hospital and Belfort. At present in Greater Glasgow, services are provided in the five main hospitals, in Lothian at Astley Ainslie, the Western General and the Royal Infirmary. In Grampian, services are concentrated at the Royal Infirmary, whilst in Tayside, although the main service is at Ninewells, there is also provision at Perth and Stracathro. In Argyll and Clyde, chronic pain services are only available at two of its hospitals – Inverclyde Royal Hospital and Lorne and Islands Hospital. In Borders, a number of outreach clinics have been established and this clearly makes it easier for patients to be seen closer to home, although they may have to move to the main hospital for further treatment. Elsewhere, services are provided at the main hospitals within the board, and many patients may have to travel quite considerable distances. In general in parts of the country where there is no service, referral elsewhere (either within the same board or to another board) is available but this is likely to result in a reduced service to the patient.

Most services provide a broad range of care – review of medication, TENS, specialised injections and blocks and some form of psychological support, counselling and education. In addition to pain management programmes (which are discussed separately), acupuncture and hypnotherapy may be provided by one or more team members.

All services offer outpatient clinics, most see inpatients in other wards (this seems to vary from a relatively small percentage to nearly 50% of the workload) but as most are informal and not recorded this is difficult to quantify. Generally the services operate from 9.00 am to 5.00 pm although there may only be one or two clinics per week in certain hospitals. There is, generally, no formal provision for emergency cover, although some consultants provide on call cover. Some consultants do a small number of domiciliary visits and some see patients in long stay facilities or day hospitals.

With the increasing number of acute pain nurses in hospital it was felt that there was an opportunity for early detection, and through close links with those working in chronic pain, to identify in every ward in hospitals those patients with potential long-term problems, who could benefit from active and early intervention²⁸.

Some of the services, especially Grampian, Tayside, Lothian and Greater Glasgow, had substantial numbers of referrals from other boards.

Linked to the service variation is the problem of premises. Lothian and Tayside are well placed with a clearly defined base for the chronic pain service. In Fife there is a suite of rooms for the service in Dunfermline, but with the use of shared accommodation in Kirkcaldy. The advantage of dedicated staff rooms, clinic rooms, group meeting rooms and a secretariat office are very considerable. Elsewhere, the accommodation for anaesthetists, nurses, physiotherapists and psychologists depends on what the general provision for these professionals is in a particular hospital.

As far as the patients are concerned, apart from the few places where there are these dedicated premises, the usual outpatient, day care and inpatient facilities are used. Venues for group work may be problematic and include a hospital chapel and, in one hospital, 13 separate sites were identified where patients could be seen. Equally many staff were based in different sites and there were considerable difficulties with respect to access to I.T., records, clinics and staff meetings. In one hospital, the outpatient clinic was held in the Genito-Urinary Medicine Department, which was clearly regarded as providing an unacceptable setting.

One big difference is whether the provision is seen as an integral board-wide service, or a series of separate clinics based in more than one hospital which, when put together are taken to comprise the board service. However this usually does not provide a full range of provision to all patients within the board.

A board wide integral service may be associated with a defined budget, but there is variation. Grampian, Lothian, Tayside, Fife and Borders come nearest to such an approach (although they are not all comprehensive services). Greater Glasgow, although the services are still based in individual hospitals and co-ordinated through the North and South Glasgow University NHS Trusts, has a board wide committee, close links with Public Health and substantial funds have been distributed from the Board to bring up the separate services to an equivalent standard. Similarly new developments are being planned on a Glasgow wide basis. There is also a central link to public health in Forth Valley, although this is a less developed service.

Although terminology varies, the vast majority of services are based within anaesthesia departments, which may fall within surgery or acute services. In Lothian, the main service base and funding is at Astley Ainslie with links to anaesthetics at the Western General and the Royal Infirmary. In Tayside the chronic pain service is based in the Division of Clinical Neurosciences. In many boards some of the key team members may be within a different directorate or trust – for example psychology within primary care. The fragmentation of staff between different departments with different budgets and responsibilities for wide services (with pain often being seen as a minor responsibility) means that it is difficult to maintain staff levels, there are no easy routes to plan developments and there is lack of co-ordination and a clearly defined team. Health board restructuring may make it easier to organize a board wide service.

Although not covered in this report it is noted that individual clinical specialties, for example rheumatology along with related voluntary organizations such as Arthritis Care make substantial contributions to pain management but this is difficult to describe and quantify.

In summary, there is enormous variation in the services available within the Scottish Health Boards. Most lack a formally identified comprehensive board-wide service for chronic pain. There is no national strategy for chronic pain.

Recommendation: 1, 2, 3,12,14

THE TEAM AND STAFFING

The members of a comprehensive chronic pain service may include lead clinician (anaesthetist by training), psychologist, nurse, physiotherapist, occupational therapist and administrator/secretary. A pharmacist and liaison psychiatrist were also noted.

All boards with the exception of Highland have one or more identified consultant anaesthetists with special responsibility for chronic pain. All the mainland health boards with the exception of Highland employ nurses with special responsibility for chronic pain. There are more flexible arrangements in the Island boards with two having nursing provision, while the third has a close link with primary care. Nine of the 15 health boards have identified physiotherapy with a further 4 being able to refer to the general physiotherapy service. Nine out of 15 have an identified psychology input (although this is not necessarily available to all the individual hospital based services). Three of the boards have defined input from occupational therapy.

In Greater Glasgow there is the opportunity to refer to The Glasgow Homeopathic Hospital with its special emphasis on integrative and holistic care. Many health boards provide acupuncture and some other complementary therapies, and in other boards there is the possibility of referral to the Homeopathic Hospital in Glasgow.

A number of these multi-disciplinary teams depend on quite small amounts of contracted time and make it difficult to ensure that regular pain management programmes can be maintained.

Although enthusiasm and commitment were the clear characteristics of those met, there were some references to 'turf wars' between professionals and some mixed views towards voluntary organizations. As new services develop with nurse led clinics and physiotherapy led back pain services along with possible new generic staff, new understandings of team working may need to be developed along with closer collaboration between different components of the overall service. The advantages of more rapid appointments and early appropriate treatment are clear, but for those patients with more serious or complex problems, easy referral into multidisciplinary assessment or a specialist clinic is essential.

All services considered that they were inadequately staffed to meet the demands on their service. A number of boards provided a core service which consisted of a consultant-led service with outpatient clinics and appropriate investigations. The doctor to population session rates ranged from 0.5/100,000 to 15/100,000 for the mainland boards. (This figure is based on the total health board population, not on the hospital catchment area.) Higher levels are found in Tayside Greater Glasgow Forth Valley and Borders, but the first three receive substantial numbers of referrals from other boards. As noted in the introduction this overall figure masks an uneven provision depending on the catchment area of the hospital where the consultant was based. Where nurses were employed (12 of the 15 mainland boards, boards which relied on OP staff are not included) there was a similarly wide range of sessions – 1/100,000 to 19/100,000. Tayside had the best provision of doctors and nurses but lacked staff to provide pain management programmes. They would seem to be the one board in Scotland to match the recommended levels for doctors and nurses.

Eight of the mainland boards had dedicated psychologists. Lothian Health Board had the best provision, but no other board was near the 1994 recommendation of 1 WTE/200,000 population.

The major problem identified in all boards was with recruitment of psychologists. While the smaller boards had the possibility of seeking support from the local psychology service the larger boards usually had an identified psychology provision for the pain service but in all cases this was uncertain due to staff changes and vacancies and was never considered adequate even when the full complement of staff was in post. Locally and nationally there was a clear shortage of psychologists.

While the smaller boards had the possibility of referring patients to physiotherapy and occupational therapy, some of the larger boards had a dedicated allocation (physiotherapy in 6 boards, occupational therapy in 2 boards). As will be noted in the section on recent developments, a number of new approaches, particularly in community settings, showed varying use of health professionals. Pharmacy and liaison psychiatry were rarely incorporated into the pain service, but provided interesting examples worthy of wider consideration. The work and staffing of The Greater Glasgow back pain service is not included in this report, but it is recognised as providing an imaginative new approach to back pain management with early intervention and rehabilitation.

Where there was not a formal recognition, but the possibility of referral to other services, this was usually regarded as providing very limited support due to the very heavy pressure on these services.

While the island boards were quite well supplied with consultant time, and there was some local support, if a service was not available on the island either regularly or visiting, it was a long journey to another board. Similar problems exist in some of the other rural areas.

The degree of administrative and secretarial support varied enormously. Most boards relied on the support from the general administrative staff in the anaesthetics departments, a small number had dedicated secretarial support (4 boards) and some relied on outpatient services.

There was considerable interest in the future development of staff and teams within chronic pain. Apart from the Island boards, all boards considered that they needed a substantial increase in all categories of staff if they were to cope with the increasing demands. If as all agreed, patients required 'local' support both for early care and for long-term support, there needed to be a new approach to staffing. While this would normally be thought of as a nurse led component of the service, there was discussion about the possibility of a new generic category of staff who, irrespective of basic training, would cover elements of nursing, physiotherapy, psychology, counselling, etc – indeed as many of the current pain nurses do. Such posts could be key in the more rural areas and the smaller boards.

In all categories of staff there is a combination of extensive experience with many obtaining additional specialist qualifications. Concern was expressed that the new consultant contracts and health services change could make staffing problems worse. Many staff appear to work 50-100% above their contracts – some do it in their free time. While this assists patient care, it can hide the inadequate formal provision and in the long term is not sustainable.

There is only one full-time lead consultant in Scotland. As services expand in the larger boards this would seem to be desirable to have such service led by a full-time consultant. For other staff there could be a mixture of full- and part-time allowing easy links with the other professional services.

Development of pain services, particularly pain management programmes are likely to be hindered by the lack of professional staff, especially psychologists.

Recommendation: 6, 16

THE WORK OF THE PAIN SERVICE

There were fairly similar patterns across Scotland. The majority of patients were referred from general practice (50-90%) and the most common problems were back pain/musculo-skeletal and neuropathic. The referrals for inpatient advice showed a greater clinical range, probably reflecting individual clinician interests and expertise. Referrals did come from the full range of wards with orthopaedics, general surgery and general medicine being the most frequent.

Referral rates showed quite a wide variation (50-500/100,000) but this must be treated with caution due to uncertain data and cross board referrals. Most services saw between 150 and 250/100 000 new patients per year. For new referrals the time allocated for the initial consultation was normally 45 or 60 minutes with 20-30 minutes for return consultations. There was general support for referral protocols, pre attendance questionnaires and triage but these would not necessarily be appropriate in essentially single handed services. Those using these approaches found them useful. There were mixed views about guidelines. A few were keen to develop appropriate guidelines for use in chronic pain, some felt that more research and evaluation was required prior to guideline production, while other considered that there were too many guidelines – many of which were not used.

As it is likely that there are only fairly minor variations in the epidemiology of chronic pain across Scotland, I am presenting some of the data from Lothian to illustrate the pattern.

75% of patients were from primary care. All new referrals are triaged for an initial assessment appointment with either a medical consultant, physiotherapist only or joint psychology and physiotherapy.

Treatment provision

Individual treatment only with single or combined therapists	37%
Individual and subsequent group treatment	26%
Total receiving individual treatment	63%
Group treatment only	16%
Total receiving group treatment	42%

In general, patients fell into two categories – those with relatively recent onset and those with long established chronic pain and these required quite different forms of care.

At the assessment for the Pain Management Programmes it was noted that there were two peaks in the distribution of pain – of up to four years and over ten years. Moderate to severe depression was present in 48% of patients as measured on the Beck Depression Inventory. According to the Sickness Impact Profile, 50% of patients were classified in the medium to high range on a measure of impact of pain on disability. 47.5% of patients reported a significant fear of harm and damage from exercise and activity, and half of the patients rated themselves as having low self-efficacy and sense of control over their life in relation to pain.

The issue of the two main groups of patients was one that dominated all discussions. All these interviewed emphasised the necessity to shift to earlier intervention if there was to be real hope of treatment and rehabilitation – sometimes referred to as moving the bulk of the services “upstream”. By recognising potential problems earlier and dealing with these this could free up resources for others.

For the first group, the urgent emphasis was on treatment, active rehabilitation and, where appropriate, return to work. This, however, could not be achieved when there were long waiting times.

The second group of patients required longer term support to enable them to self-manage their pain and to reduce the impact on their lives, and where appropriate to provide the appropriate treatment and rehabilitation that was not provided at an earlier time.

There is the possibility of making more use of community resources, support groups, voluntary organisations and the expert patient approach.

Both approaches require a range of skills and disciplines with access to a wider range of services than provided directly by the pain service.

It was particularly noted that vocational rehabilitation and advice on employment was difficult to obtain and there were poor links with organisations outside the NHS.

Return appointments varied greatly and this seemed to vary both with the overall approach of the service and the availability of other support. In one fairly recently established service the consultant felt it important to get his patients stabilized on treatment, elsewhere the comment was “ if I do not see them no one else will”. Most services had about the same up to 50% more returns than new but some were seeing four or five times as many returns as new.

As far as the pain clinics themselves were concerned, most considered that they were under such pressure that they could not provide long-term support and repeat attendances. Some consultants, particularly in the smaller services, felt that as there was nowhere else for patients to find continuing support, that they would see them on an annual basis. Others made it easy for patients to refer themselves back to the service. While in some instances referral back was only through the GP, in others if less than six months, patients in could re-refer, while in a few boards direct re-contact by patients with the services was welcome.

There is an opportunity for the NHS, itself a major employer, to promote rehabilitation and return to work in its' own workforce and to encourage links with the occupational health service. Links with other relevant initiatives, either national or local, such as back to work programmes, have considerable potential, but it should be noted that in order to maximize all existing resources there is the need for the board pain service to be adequately staffed.

Recommendation: 4, 8

A COMPREHENSIVE AND INTEGRATED SERVICE

A patient commented “No one takes responsibility for pain”. It is accepted that the vast majority of chronic pain is dealt with by primary care, yet there are no clear guidelines on referral, very variable communication between primary care and the hospital services, lack of awareness of what services are funded by the Board for chronic pain, and little sense of an integrated, seamless system from primary care through hospital pain clinics to specialist interventions and back. Most hospitals reported good informal links within the hospital, between the different clinical specialties.

All services indicated the benefits that would result from better links with primary care particularly through some form of combined approach in the community. As far as specialised interventions were concerned, most consultant anaesthetists considered that they could provide most of the blocks or injections etc that were required. In larger boards, such as Greater Glasgow where individual consultant anaesthetists specialised, there was easy referral between the different hospitals. Generally there was a feeling that the role of the traditional anaesthetics procedures was decreasing.

Specialised neurological and neurosurgical services were available in the four University centres and all boards had access, generally regarded as adequate.

Although the Astley Ainslie (Lothian Chronic Pain Services) receives a substantial number of referrals from other health boards it is not funded as a national referral centre. It was pointed out that this is an extra burden on that service and that by accepting referrals it lets other boards “off the hook”. There was extensive debate about the value of a national referral centre. Currently there are no residential facilities for pain management programmes in Scotland and patients requiring this are referred to centres in England. Some staff and patients felt that a residential centre in Scotland would be desirable, while others felt that if patients had to travel anyway to a single centre in Scotland it was just as easy to travel to the existing and well-recognised centres. One consultant pointed out that he wanted the best

residential facility for his patients wherever it was. At present most boards refer very small numbers of patients to residential centres (generally single figures per year). This would seem to indicate that a Scottish residential centre would not be viable, but if such a centre were to be established in Scotland, there was an indication that more patients might be referred.

As one consultant pointed out “Pain management is a relatively new specialty which has not benefited from historical core funding. Everyone uses our service but no one wishes to fund us”. All boards have uneven services with substantial gaps. In only one board was there a formal published proposal for development (funding still to be identified) within the Board. Chronic pain services are largely unrecognised within the Boards, generally buried within an anaesthetics department. There is a need to integrate new and separate developments within the board wide chronic pain service.

Recommendation: 3,5,10,11

RANGE OF SERVICES – STATUTORY AND VOLUNTARY

Pain management programmes illustrate well the links between statutory and voluntary organisations. Some boards provide their own pain management programmes – some such as Argyll & Clyde in a ‘mini’ format. Other boards link closely with the Pain Association to provide the service, while in others, the Pain Association provides a pain management programme independent of the health board. Thus links vary between close collaboration through referral from NHS to voluntary to no real links.

The Pain Association has many years of experience in Scotland in community based programmes, with self-management and its’ Living with Pain Programme. Through their professional staff they provide training and support as well as producing publications and arranging seminars. Currently there are 22 groups throughout Scotland. Thus they have an effective network, extensive experience and some new arrangements with health board have been established. Inevitably local action is dependent to a large degree on enthusiastic local volunteers and thus local provision can vary from time to time. The value of the support to many patients is clear. As with all voluntary organisational provision, it is important that the health service does not assume that some local provision of pain management programmes absolves the board from ensuring that there is a full and comprehensive service available to all patients within the board.

The role of other patient organisations such as Arthritis Care Pain Concern and Pain Relief Scotland are also increasing. Overall the referral to The Pain Association and other voluntary organisations providing patient support is very limited and it would seem desirable for someone in each pain service to assume the role of co-ordinator.

While this report concentrates on the NHS, the importance of support from a full range of community services is vital to many patients, including – leisure services such as swimming, transport, social services as well as advice on aspects of employment.

Recommendation: 7

RECENT DEVELOPMENTS

A number of boards have pioneered a range of developments and a few illustrative examples are included here. In Tayside, the hospital-based service has been very active in establishing nurse led clinics both for initial contact and support. The Borders have established outreach clinics in a number of health centres, recognising the particular problems of rural communities.

The importance of a close link with primary care is universally recognised – both for early referral and intervention and later long-term support. Current changes in health services in Scotland may offer new opportunities. The possibility of establishing a focus for chronic pain within Local Health Care Co-operatives is being explored and the existence of an identified health professional with a responsibility for chronic pain in an LHCC could assist both with the provision of care locally, access to hospital based services and in addition raise awareness of the service in a wide range of health professionals in the community. Although not necessarily regarded as a formal part of a broad pain service, individual nurses with an interest in pain are providing support in a number of centres. An example of a nurse led clinic has been developed in Cumbernauld and Kilsyth. From an initial pilot in a single practice of 11,000 patients, after an audit it was extended to include all other practices (8 in total) within the L.H.C.C. Acupuncture, hypnotherapy and reflexology are provided by GP's, physiotherapists and nurses. Pain Association Scotland provides support groups in the evenings and Dial-a-Bus transports patients.

A different kind of clinic is found in Dundee in a physio-led clinic held in a community service center of a primary care hospital. There is support from a clinical pharmacologist, clinical pharmacist and therapists.

Another possibility that is being explored, where there are wider changes in hospital services, is additional clinics in diagnostic and ambulatory care centres – again this could assist with the problem of unequal access.

It is generally recognised that back pain is the largest diagnostic category in pain clinics as well as a major cause of attendance at orthopaedic outpatients. Greater Glasgow Health Board has initiated a new back pain service where new referrals go directly to a physiotherapy-based service. The vast majority of referrals are treated within this service, with small numbers being referred for psychological support, medication for pain or orthopaedic assessment. While formal statistics are not yet available, unaudited figures indicate that it is making a substantial impact. It has greatly reduced the number attending orthopaedic outpatients and reduced surgical intervention. Waiting times for orthopaedic outpatients have reduced from 49 weeks in October 2002 to 6 weeks in March 2004. 88% of low back pain was seen within two weeks. Patient satisfaction was high. It can lead to various outcomes – discharge to normal activities but can self refer; refer to pain clinic; surgical referral; enhanced back clinic with psychological support; or, local authority exercise classes.

Up until now there has not been a comprehensive pain management programme in Greater Glasgow Health Board. Currently a major pain management programme for the Board is being established in a Healthy Living Centre. It will be interesting to see the formal evaluation of both the new back pain service and the pain management programme in this different location.

In one board a pharmacist has pioneered a review of medication.

The potential of managed clinical networks for pain is being explored in a number of boards and nationally the wider approach of managed care is receiving considerable support. A managed clinical network would ensure that referral for specialized care would be widely available. This would seem very appropriate for chronic pain services which cover primary, secondary and tertiary provision and which involve a wide range of disciplines and skills.

Some of the personally led initiatives, such as the nurse led clinics, suffer in times of financial constraints in health boards as the service may not be formally funded and staff are required to concentrate on core tasks. It would seem important to encourage enthusiastic individuals both to establish such needed new services and then support them. This will include training and C.P.D. as well as adopting the service once its worth has been shown. A number of staff reported that they had self funded themselves on degree courses and specialized modules. Such initiatives should be seen as part of the board wide plan, but some were not known to the formal board contact for this review.

Recommendation: 13

THE CONTEXT OF A CHRONIC PAIN SERVICE

Most chronic pain services are based within an anaesthetics department and have varying links with acute pain services, cancer pain and palliative care services. With the changing patterns of care within chronic pain – a reduction in anaesthetics-based procedures, and an increasing emphasis on multi-disciplinary pain management – there are suggestions that it might be more appropriate to relocate within “pain medicine”. It is suggested that this would encourage recruitment from a wider professional base. There is some concern expressed about the CPD and revalidation requirements of consultant anaesthetists who practice management in pain.

Generally within an anaesthetics department, separate consultants have responsibility for acute and chronic pain. As there is universal agreement that it is important to seek earlier investigation and treatment of chronic pain, some staff find that closer links between acute and chronic pain services within an overarching pain service would be desirable. It is generally considered that pain services should remain separate from palliative care but that there should be close collaboration.

As health boards give priority to identified services, and chronic pain at present is not labelled as such, it has been suggested that it might be helpful to subsume chronic pain with chronic illness but this could harm the emphasis on early intervention and rehabilitation.

Recommendation: 1,2,6

WAITING

This is of major concern to both patients and professionals. Apart from the islands boards where appointments can be arranged fairly quickly in most boards there is usually a wait of 2-6 months for a first appointment – it can be up to nearly a year. This is usually followed by a further wait for initial treatment. This is very variable from 1-2 weeks to two years, to enter a pain management programme. This would seem to have deteriorated since 1994, although this is mainly associated with increased demand.

In some boards there is some system of prioritisation enabling urgent cases to be seen within one to two weeks. Most inpatient referrals are seen within a few days, but in some boards the inpatient workload is not funded, thus increasing the delay for outpatients. A few boards require the completion of a pre-appointment questionnaire which is deemed to assist with appropriate allocation. In some of the larger services there is separation into nurse led clinics, consultant led clinics or individual or group psychology led provision. Some boards are considering triage systems or initial one-stop clinics.

Many patients referred to chronic pain services have already attended several different outpatients, many have had lengthy investigation and have sometimes spent several years failing to find help and support. It is considered 'important' that these patients are not again subjected to long delay.

The initial aim should be to reduce waiting times for first appointments and for subsequent treatment or access to a pain management programme.

Recommendation: 9

AUDIT AND RESEARCH

Relatively few pain services undertake audit or research with both being concentrated in the Medical School linked departments. As noted earlier there are difficulties in obtaining routine data. The Pain Society has produced recommended data sets and pain scores in different languages but many pain services lack the time and administrative support to undertake audit on a regular basis.

In addition to some research being carried out within the pain services, collaborative studies with other university departments exist in Grampian, Tayside, Lothian and Greater Glasgow. There is also a major focus on pain research in Queen Margaret University College.

As shown in the introduction, good quality epidemiological data for Scotland are now becoming available but there is less on outcome evaluation. Part of this is related to the relatively small numbers in any one service.

Recommendation: 12,13

EDUCATION AND TRAINING

While the current board services have been fortunate in attracting staff with experience and additional qualifications there is some uncertainty about the future. The major problem relates to psychology where recruitment is particularly difficult. Individuals in all disciplines are currently undertaking further clinical and academic studies. Several centres in Scotland contribute to this and there are particular opportunities in Edinburgh and Dundee. There is the possibility of specialised options linked to existing courses such as physiotherapy, nursing and pharmacy. There are also short courses aimed at the primary care team. While some courses are aimed at the under graduate or early professional training, modules can also contribute to continuing professional development. Pain can also be included in higher degrees. The possibility of a Scottish wide collaboration and the development of distance learning would seem well worth following up to try and ensure the future retention of well qualified staff. If as some suggest doctors from disciplines other than anaesthetics should be encouraged, newer opportunities within specialist registrar training programmes will be required and this will require the help of postgraduate deans. The aim should be for an appropriate postgraduate qualification to become the norm for senior staff.

At a less formal level, there was the need for educational programmes for all clinical specialties, to make them aware of what pain services are about and what they can achieve.

As far as early professional training is concerned, it was felt that all needed to be exposed to a formal input on chronic pain, a discussion of professional roles and an opportunity to spend time in a service.

Recommendation: 16

STRENGTHS AND WEAKNESSES OF EXISTING SERVICES

These were well recognised by the staff in the services and there was very close agreement on the main issues.

Strengths

- Enthusiastic and committed staff and a strong sense of teamwork, combining experience and additional qualifications
- Keen to expand services and pilot new developments
- Willingness to change
- Well received by patients and offering a spectrum of care
- Cross service rotation of some professions allows continuity of approach
- Rigorous multi-disciplinary assessment and tailoring of treatment to meet individual needs

Weaknesses

- Under-resourced to meet demands
- Lack of integrated service with single administrative structure
- Inadequate secretarial and administrative support
- Inadequate IT
- Inadequate input from psychology
- Patchy and uneven services across the board
- Lack of out-of-hours cover
- Dependent on goodwill and working to capacity
- Lack of time for staff meeting and continuing education
- Limited time available for education and training of others
- Patients often have to travel a distance
- Sometimes limited support from clinical colleagues and management
- Lack of clear administrative pathway for submission of development bids

A NATIONAL FOCUS

While there are a number of professional or research focussed organisations, there is no national focus for chronic pain services. There was support for a high level national forum that could discuss the many issues relating to the provision of chronic pain services, co-ordinate information, devise appropriate standards and provide advice both to the Scottish Executive and health boards. There would also be the opportunity to assist with multi-centre research and encourage audit. The prime aim of the Forum could be quality improvement and would also provide a focus for discussion of new initiatives.

The existing Scottish Parliamentary Cross-Party Group on Chronic Pain would continue its role with a more political agenda and collaboration between the two national bodies could ensure that chronic pain is accorded a greater profile at public, professional and political levels.

The diversity that currently exist within Scotland, while it reflects the rather ad hoc development of services, does provide an opportunity to learn from the different approaches and within a national framework develop guidelines on high quality care. There is variation in nearly every aspect of the service – referral, first contacts, aims, procedures available, long-term follow up, separation of back pain, links with acute pain, etc. Although it is generally accepted that there should not be a “one size fits all” approach, there is the potential to compare and evaluate different approaches and determine best practice.

Recommendation: 12

CONCLUSION

Chronic pain is a major medical and social problem and a massive drain on national resources. There is good evidence that not only does a comprehensive chronic pain service lead to a saving in NHS resources, but that it leads to a substantial reduction in distress and disability, improvements in quality of life and return to work and a further saving in social security benefits. There is a need to recognise formally chronic pain as an entity in its own right and for each health board to be held accountable for the development and evaluation of an appropriate chronic pain service, either as a separate entity or within an identified pain service. It would be useful for the Pain Service to publish an annual report. There is strong support for a tiered service – local such as co-ordinated at LHCC level with strong links to general practice and the primary care team; a consultant led specialist multidisciplinary service within hospital; and a “regional” specialist referral level including such specialties as neurosciences. The possibility of a national centre with residential facilities for rehabilitation and pain management requires further exploration.

When asked what the key message of this report should be, there was general agreement that this was “formal recognition of chronic pain”. There is a real danger that the existing services will be swamped by increasing demand unless there is action at health board level. At a national level there is a requirement for a strategic approach within NHSiS and for this to be linked with planned co-operation with the voluntary sector – particularly for long term support for patients.

The economic benefits identified in the literature provide support for increased funding for pain services. All services will require additional resources if they are to be brought up to the recommended standards. It is recognised that new funding is likely to be spread over a number of years. Initially this might be directed to reducing inequalities in existing services and to bringing them all up to a reasonable level, providing adequate access to a comprehensive service throughout each board. This should include reduced waiting times for first appointments and for subsequent treatment or access to a pain management programme.

RECOMMENDATIONS

1. All interviewed agreed that there was the need at the national level for formal recognition of chronic pain as an entity in its right. This should be linked to a recognised National Strategy.
2. Each health board should establish either an Integrated Pain Service (including both acute and chronic pain) or a separate Chronic Pain Service. Such a service should have an independent structure. There should be a clear commitment by all Scottish health boards to a high quality Chronic Pain Service and chronic pain should be included in the annual performance assessment framework. It would be helpful for each pain service to produce a short annual report and this should be made available widely.
3. There is an urgent need for each board to review its current service provision against recommended standards. All Health boards should prepare development plans that should include: adequate coverage for patients throughout their area, taking account of the local geography; adequate premises for outpatient, group sessions and pain management programmes; and an administrative base with administrative cover from 9 am to 5 pm. They should identify the budget for chronic pain, ensure the provision of accurate and timely data and review annually their integrated and comprehensive provision for chronic pain.
4. There is a need to recognise the complex case-mix seen in chronic pain (ranging from that of relatively recent origin to long standing established chronic pain) and to ensure that appropriate staff and resources are available to meet the varying needs of these two main categories of patient. This will cover early detection, evaluation and treatment, rehabilitation and long-term support. The importance of early intervention requires greater recognition by those responsible for policy and resource allocation.
5. In some health boards, there was a lack of awareness of all the services that actually existed within the board. As the majority of care is provided in primary care, each health board should ensure that there is improved communication about all its services and that there is seamless care between hospital, primary care and community services.
6. Each mainland health board should consider the appointment of a full time lead clinician for chronic pain and prepare a development plan to ensure all categories of staff in the service are adequate for the board's needs. The possibility of separating from departments of anaesthesia to form a new specialty of pain medicine should be explored and the related wider implications for all staff in the pain service.
7. Each health board should decide what services should be provided by whom and where and the nature of the working relationship or partnership agreed. A member of staff should be identified to coordinate links outwith the NHS. Pain management programmes should be provided within the board to all patients that would be expected to benefit from them.
8. In addition to care provided by a pain service, many patients require a wide range of community services and formal links should be established in each pain service. The need to improve vocational rehabilitation is key. The NHS should set an example with its own workforce.

9. All Scottish health boards should be required to set acceptable waiting times and time to entry to treatment. CSAG recommended that the time between referral and first consultation should not exceed three months.
10. While clearly additional funding will be required to bring chronic pain services to an agreed standard, it should be noted that the evidence from economic evaluations indicates that substantial savings can be achieved.
11. The possibility of a Scottish Referral Service with residential facilities requires further examination.
12. A National Forum should be established with the principal remit of quality improvement. This could be an area that NHS Quality Scotland might explore, but there is also the possibility of professional initiatives from those working in Scotland. While existing published guidelines and service recommendations provide a useful basis, pain services in Scotland should prepare their own recommendations both on service provision and on the basis of outcome evaluation indicate best practice treatment. Collaboration at a national level would provide a real opportunity to build up comparative data.
13. Full evaluation of these new developments is required and for those that are deemed to provide benefit, a dissemination mechanism is required. The various schemes which seek to extend the geographical coverage, devise better links with primary care, and reduce waiting times (such as nurse led clinics) are particular examples. The contribution of specialised programmes such as a dedicated back pain service need to be evaluated and their links with the pain service strengthened. Funds for both health services research and audit will be required. Researchers should be encouraged to submit proposals from cross Scotland teams to the Chief Scientist, Research Councils and charities.
14. With regard to outcome evaluation the contribution of complementary therapy, long-term outcomes, patient functioning and rehabilitation could usefully be included and linked to international research.
15. There is a clear need to be able to produce relevant routine statistics with direct reference to the Chronic Pain Service. There should be a single agreed system within Scotland, such as that identified by the Pain Society.
16. All areas of education and training require formalisation and expansion. This should be co-ordinated on a national basis. The shortage of psychologists is a particular problem and ways of recruiting should be explored. The education, training and employment of a 'generic' pain professional should be examined.

REFERENCES

1. The Management of Patients with Chronic Pain. A report of a Working Group of the National Medical Advisory Committee. **The Scottish Home and Health Department, HMSO** Edinburgh 1994.
2. Services for Patients with Pain. **Clinical Standards Advisory Group, HMSO**. London 2000.
3. SPICE Report for the Scottish Parliament Health Committee 2002.
4. Briefing on Clinical Pain. Scottish Parliamentary Debate. 27 February 2002.
5. Adult Chronic Pain Management Services in the UK. Research Project by Dr Foster in consultation with The Pain Society. Pain Society 2003.
6. Classification of chronic pain. International Association for the Study of Pain. Pain Supplement 3, S1 – S226, 1986.
7. Pain in Europe. A 2003 Report. Janet Fricker in association with Mundipharma International. Cambridge 2003.
8. Pain. McCaffery, M., Pasero, C. **Clinical Management**. 1999. Mosby, St Louis.
9. The Impact of Chronic Pain in the Community. Smith, B. H., Elliott, A. M, Chambers, W A., Smith, W. C., Hannaford, P. C, Penny, K.I. **Family Practice** (2001) 18 (3), 292-299.
10. The Epidemiology of Chronic Pain in the Community. Elliott, A. M., Smith, B. H., Penny, K.I., Smith, W. C., Chambers, W. A. **Lancet** (1999) 354, 1248-52.
11. Chronic pain and the use of conventional and alternative therapy. **Family Practice** Haetzman, M., Elliott, A. M., Smith, B. H., Hannaford, P. C, Chambers, W. A. (2003) 20 (2), 147-54
12. The Course of Chronic Pain in the Community: results of a 4-year follow-up study. Elliott, A. M, Smith, B. H., Hannaford, P. C, Smith, W. C., Chambers, W. A. **Pain** (2002) 99, 299-307.
13. The Glasgow Pain Questionnaire: A new generic measure of pain: development and a testing. Thomas, R., McEwen, J., Asbury, A. J. **International Journal of Epidemiology** (1996) 25, 1060-1067.
14. UK Directory of Pain Management Programmes. Pain Management Programme. Special Interest Group of the Pain Society. 1999.
15. The Expert Patient: A new approach to chronic disease management in the 21st century. (www.doh.gov.uk/healthinequalities/epreport.pdf)
16. Systematic review of outpatient services for chronic pain control. McQuay, H. J., Moore, R. A., Eccleston, C., Morley, S., Williams, A C de C. **Health Technology Assessment** 1997 1 (6).

17. Back pain, its' management and cost to society. Klaber, M.J., Richardson, G., Sheldon, T. A., Maynard, A. **Centre for Health Economics** (1995) Paper 129, York.
18. The economic burden of back pain in the UK. **Pain** Maniadakis, N., Gray, A. (2000) 84, 95-103.
19. Occupational Health: Guidelines for the management of low back pain at work – evidence base. **Faculty of Occupational Medicine** (2000) London.
20. Models of Disability using low back pain as an example. **Royal Society of Medicine Press** (2002) London.
21. The Back Pain Revolution. Waddell, G. (1998) **Churchill Livingstone**, Edinburgh.
22. Vocational Rehabilitation (editorial). **Journal of the Royal Society of Medicine** (2003) 96, 522-3.
23. Desirable characteristics for pain treatment facilities. **International Association for the Study of Pain** No data
24. Anaesthetists and non-acute pain management. **Association of Anaesthetists of Great Britain and Ireland, Royal College of Anaesthetists at the Pain Society** (1993)
25. Guidance for Purchasers. **Royal College of Anaesthetists** (1994) RCA, London.
26. Pain Management Services. Good Practice. **The Royal College of Anaesthetists and the Pain Society** (2003)
27. Chronic Pain: A primary care condition. Smith, B. H. **Rheumatic Disease** (2002) 9.
28. Chronic pain after surgery. Macrae, W. A. **British Journal of Anaesthesia** (2001) 87, 88-98.