10) Health-Related Quality of Life[2]

Please circle the number that applies to you.

In general, would you say that your health is:

Excellent	1
Very good	2
Good	3
Fair	4
Poor	5

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[2] SF-36 is reproduced here (in part) with permission from the RAND Corporation. Copyright © the RAND Corporation. RAND's permission to reproduce the survey is not an endorsement of the products, services, or other uses in which the survey appears or is applied.

11)Pain Site (tick any/all that apply)

☐ Head

☐ Facial/Dental

☐ Cervical Spine

☐ Upper Limb: Shoulder/Arm/Wrist/Hand

☐ Chest

☐ Thoracic Spine

☐ Abdomen

☐ Lumbar/Sacral

☐ Pelvis

☐ Lower Limb: Hip/Buttock/Ankle/Foot

☐ Widespread

12)Underlying Diagnosis[2]

Please refer to the ICD 11 classification section

(below) for further details

Please tick all of the options that apply.

☐ Chronic primary pain
☐ Chronic cancer pain
☐ Chronic postsurgical and posttraumatic pain
☐ Chronic neuropathic pain
☐ Chronic headache and orofacial pain
☐ Chronic visceral pain
☐ Chronic musculoskeletal pain

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[2] Proposed ICD-11 classification (Treede et al, 2015)

1. Chronic primary pain is pain in 1 or more anatomic regions that persists or recurs for longer than 3 months and is associated with significant emotional distress or significant functional disability (interference with activities of daily life and participation in social roles) and that cannot be better explained by another chronic pain condition.
2. Chronic cancer pain includes pain caused by the cancer itself (the primary tumour or metastases) and pain that is caused by the cancer treatment (surgical, chemotherapy, radiotherapy, and others).
3. Chronic postsurgical and posttraumatic pain is pain that develops after a surgical procedure or a tissue injury (involving any trauma, including burns) and persists at least 3 months after surgery or tissue trauma.
4. Chronic neuropathic pain is caused by a lesion or disease of the somatosensory nervous system.
5. Chronic headache and chronic orofacial pain is defined as headaches or orofacial pains that occur on at least 50% of the days during at least 3 months.

6. Chronic visceral pain is persistent or recurrent pain that originates from the internal organs of the head and neck region and the thoracic, abdominal, and pelvic cavities.
7. Chronic musculoskeletal pain is defined as persistent or recurrent pain that arises as part of a disease process directly affecting bone(s), joint(s), muscle(s), or related soft tissue(s).

Appendix 3: Quality Performance Indicators (QPIs)[3]

QPI 1 – Pain Education (Levels 1-4)

QPI Title:	Pain Education (Levels 1-4)
Description:	Patients attending an NHS service that provides chronic pain treatment should have access to advice and information about pain. These services include, but are not restricted to, Specialist Pain Services, General Practices, Community Pharmacies and relevant AHP clinics. Pain information should be accessible and might take the format of signposting to relevant services, literature and/or pain education sessions. Clear (legible, audible, understandable) information should include information pertaining to types of pain, coping mechanisms, dealing with sleep and anxiety and the origins of pain. Information should also be provided on exercise and self-management. Where appropriate, this should be provided or signposted in languages other than English.
Rationale and Evidence:	An RCT conducted by Little, Roberts [36] found that providing educational booklets and exercise advice to patients with lower back pain can increase satisfaction and moderately improve functional outcomes. SIGN 136 recommends pain information sessions as safe, low technology, community based and affordable interventions to help patients better manage their condition [37]. Pain education programmes have been found to increase chronic low back pain patients' likelihood of achieving their goals and can result in significant behaviour changes [38, 39]. A decrease in pain can also be found following these programmes as well as physiological improvements [39], though these tend to be short-term improvements [38]. Pain neurophysiology education has been shown to be effective in conjunction with other pain management approaches [40].
Specifications:	**Numerator:** Number of NHS services making information about chronic pain available (including visible signposting relevant to pain education). **Denominator:** Number of NHS services providing chronic pain treatment **Exclusions:** No exclusions.
Target	Each service provides information about chronic pain.

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[3] Version 2 – 16/02/2018

QPI 2 – Outcome Measures (Levels 2-4)

QPI Title:	Outcome Measures (Levels 2-4)
Description:	Patients being treated for chronic pain should be administered relevant outcome measures at the beginning of treatment and at least once after treatment to gauge process (minimum 6 weeks, maximum one year). Health professionals are advised to record the following core minimum data: 1) Age 2) Gender 3) Pain Site(s): List of Body Parts. 4) Pain Duration: Categorised list 5) Pain Severity: Question 1 of the Chronic Pain Grade Questionnaire (CPG) [1]. 6) Underlying Diagnosis: Map to ICD-11 (develop Read code/SNOMED) 7) Emotional Impact: Patient Health Questionnaire-2 (PHQ-2) [2]. 8) Functional Impact: Question 5 of the Chronic Pain Grade Questionnaire (CPG) [1]. No conclusive evidence exists regarding a single self-report physical activity questionnaire [3]. 9) Health-Related Quality of Life: Question 1 of the Short Form Health Survey (SF-36). The same set of measures completed during and after treatment (if possible) allows assessment of progress since treatment began.
Rationale and Evidence:	Repeating relevant measures before and after treatment is a central tenet of patient care, facilitates audit and allows service evaluation and improvement. SIGN 136 states that health professionals should assess a chronic pain patient's history, pain type, severity and functional impact. An examination and biopsychosocial assessment should also be completed in order to inform treatment selection [37].
Specifications:	**Numerator:** Number of patients being treated for chronic pain who have the recommended data recorded at least once. (In Level 3 and 4 services, this means

	all patients; in Level 2 services it is more complex to identify these patients, and this may require specified Read codes, or setting prescribing parameters). **Denominator:** All patients being treated for chronic pain. **Exclusions:** Patients with chronic pain already assessed and who are stable (i.e. accessing the same prescriptions for at least a year), or who decline to complete relevant measures.
Target	90% of patients have at least 50% of the recommended data recorded at least once. 75% have 100% of the recommended data recorded at least once. 50% have at least 50% of the recommended data recorded at least twice in the previous 18 months.

QPI 3 – Pharmacy Review (Level 2-4)

QPI Title:	Pharmacy Review (Levels 2-4)
Description:	Patients prescribed medication for chronic pain should have their medication reviewed at least annually by their GP, Nurse, Pharmacist or Allied Health Professional, or within their specialist pain clinic. This can be face-to-face review, a review of health records or a combination but must include steps 1-7 below..
Rationale and Evidence:	SIGN 136 states that an individual's success in pharmacological treatments is dependent on regular, scheduled re-assessment of pain relief and side effects [37]. It has also been found that if an individual has not responded to treatment after two to four weeks after titration to an adequate dose, then they are unlikely to develop a response thereafter [37]. SIGN 136 recommends several key areas to include in an audit including: - The number of patients using analgesics to manage chronic pain who receive annual review. - The number of patients using strong opioids and gabapentinoids who receive an annual review of their medications. More recently across Scotland, the number of patients on daily morphine equivalent doses of 50mg or above was found to be roughly 6 per 1000 list size [41]. Clinicians should ensure these patients are reviewed at least annually. Key recommendations from the "Quality Prescribing for Chronic Pain: A Guide for Improvement" [41] are: - Clinicians should review effectiveness, tolerability and compliance on an ongoing basis. The burden of medicines should be reduced where possible, in line with Polypharmacy guidance. - Follow a clinically appropriate approach to initiation of analgesia, discussing expectations, risks and benefits and incorporating agreed criteria for stopping/continuing medication. Review of medication must include an assessment of [41]: Step 1: What matters to the patient.

	Step 2: Identify essential drug therapy. Step 3: Does the patient take unnecessary drug therapy? Step 4: Are therapeutic objectives being achieved? Step 5: Is drug therapy cost-effective? Step 6: Is drug therapy cost-effective? Step 7: Is the patient willing and able to take drug therapy as intended?
Specifications:	Key areas to be included in an audit: - 90% of patients using analgesics to manage chronic pain receive an annual review. - 90% of patients using strong opioids and gabapentinoids receive an annual review. - 90% of patients on >180mg/day morphine or equivalent referred for specialist assessment/ advice [37]. More recently [41] suggests that opioids should not be prescribed at higher than 90mg morphine equivalent/day without specialist referral/ advice. Therefore this specification may change.
Target	90% patients who are being prescribed medication to manage their pain should receive an annual medication review. As specified above.

QPI 4 – Service Evaluation and Audit (Levels 3 and 4)

QPI Title:	Service Evaluation and Audit (Levels 3 and 4)
Description:	Pain Services should be evaluated, at a minimum, on an annual basis. Pain Services should be evaluated to determine their effectiveness, use of resources and the extent to which they are fit for purpose.
Rationale and Evidence:	Evaluation of the relevant outcomes in patients attending a Pain Service should be standard practice. This should include the "Core Minimum Dataset". Patients attending Pain Management Programmes should demonstrate significant change in the specified domains of function, psychological well-being, healthcare use, quality of life and work status where relevant [42]. The National Pain Audit Final Report 2010–2012 [43]in England and Wales identified 7 key factors to be included in an audit [43]: - Type of clinic. - Staffing Standards. - Diagnosis and Treatment Coding Standards. - Waiting Times. - Multidisciplinary Care. - Change in Pain and Quality of Life Affected by Pain. - Numbers Receiving Advice and Guidance on Managing Pain. The Faculty of Pain Medicine [44] - Key Pain Management Standards for CQC inspection frameworks: 1. A specialist pain management service will have at least two consultants who have achieved competencies and experience in advanced pain medicine, as defined by the Faculty of Pain Medicine of the Royal College of Anaesthetists, and undergo successful annual appraisal. Where two or more consultants are not available, then cluster working with other regions Pain Services should be identified to ensure cover, peer networking, and support.

	2. No sole practitioner acting in isolation, whatever their profession, can claim to run a pain management clinic or service. 3. Specialist pain management services will involve nursing, physiotherapy, occupational therapy and clinical psychology staff. These specialists will have dedicated sessional time in the pain management service and attend multidisciplinary team (MDTs) meetings. 4. Specialist pain management services must have access to dedicated pharmacy input. 5. Input from other local specialists, e.g. psychiatry, palliative medicine, surgical and medical specialities, gynaecology, paediatrics, neurology and rehabilitation medicine must be available, as needed, to manage the patient case mix.
Specifications:	Areas to be included in an audit: - **Type of clinic** - Services as classified by self-assessment according to the IASP definitions: 1. Modality orientated clinic: clinic carrying out one treatment only. 2. Pain clinic: clinic carrying out more than one treatment but service has single profession. 3. Multidisciplinary pain clinic: service carrying out more than one treatment, with more than one type of healthcare professional. 4. Multidisciplinary pain centre: as per multidisciplinary pain clinic but also carrying out research. - **Staffing Standards** o Minimum staffing levels of a consultant pain specialist, psychologist and physiotherapist [43]. If these standards are not met, cluster working with other regions Pain Services should be identified to ensure cover, peer networking, and support. o A specialist pain management service will have at least two consultants who have achieved competencies and experience in advanced pain medicine [44]. If these standards are not met, cluster working with other regions Pain Services should be identified to ensure cover, peer networking, and support. o Specialist pain management services will involve nursing, physiotherapy, occupational therapy and clinical psychology

	o staff. These specialists will have dedicated sessional time in the pain management service and attend multidisciplinary team (MDTs) meetings [44]. o No sole practitioner acting in isolation, whatever their profession, can claim to run a pain management clinic or service. - **Diagnosis and Treatment Coding Standards** - Use the proposed ICD-11 classifications [45] in accordance with the “Core Minimum Dataset”. - **Waiting Times [46]:** o 18 weeks Referral to Treatment Standard. - **Multidisciplinary Care.** o The minimum standard for multidisciplinary care as defined by the availability of medical, rehabilitation and psychological expertise [43]. - **Change in Pain and Quality of Life Affected by Pain** - The proposed minimum core dataset includes questions on: o Pain Site(s). o Underlying Diagnosis. o Pain Duration. o Pain Severity. o Emotional Impact. o Functional Impact. o Health-Related Quality of Life. - **Numbers Receiving Advice and Guidance on Managing Pain.**
Target	The following areas should be routinely recorded: - Type of clinic. - Staffing Standards. Clinical discipline and WTE* - Diagnosis and Treatment Coding - Waiting Times (average wait to first appointment; percentage waiting >12 weeks). - Multidisciplinary Team meetings. - Change in Pain and Quality of Life Affected by Pain. - Numbers Receiving Advice and Guidance on Managing Pain. *Appropriate standards for these remain to be determined

QPI 5 – Exercise and Activity Therapies (Levels 1-4)

QPI Title:	Exercise and Activity Therapies (Levels 1-4)
Description:	Patients should be provided with advice to increase and/or maintain their physical activity and/or improve their exercise uptake and signposted to a relevant service to improve adherence to exercise, where relevant. Physical exercise is defined as is any bodily activity that enhances or maintains physical fitness and overall health and wellness [47]. Physical activity is defined as any bodily movement produced by skeletal muscles that requires energy expenditure [48]. We cannot make specific recommendation as specific exercise will depend on individual needs. Information regarding the benefits of activity and exercise should be provided by the Pain Service. The following examples are recommended by Scottish Intercollegiate Guidelines Network [37]: 1) Provision of educational material 2) Signposting to online resources (e.g. Couch to 5k) 3) Supervised exercise or activity sessions. 4) Individualised exercises in group settings. 5) Provision of a combined group and home exercise and activity programmes. 6) Referral to external provider (e.g. Live Well) The patient should be provided with support to improve their adherence to the exercise regime.

Rationale and Evidence:	SIGN 136 recommends all forms of exercise and exercise therapy in the treatment of chronic pain patients [37]. It has been found that physical activity and exercise therapy is safe and beneficial in the treatment of chronic pain [49], particularly those with chronic tension-type headaches and migraine [50]. However this needs to be appropriately managed and tailored to the individual with a particular emphasis on managing flare-ups and promoting recovery [50]. Advice to exercise alone, unaccompanied by support, is not sufficient [37].
Specifications:	**Numerator:** Number of patients with chronic pain recorded as being provided with information regarding the importance of activity and exercise, and support to increase this where relevant. **Denominator:** All patients that attend an NHS Service for pain treatment. **Exclusions:** Patients that do not attend an NHS Service for pain treatment. Patients that decline receiving additional information regarding exercise uptake.
Target	90% of patients with chronic pain who were provided with information and support regarding physical activity, exercise and/or exercise therapy

Improving Pain Management across Scotland

Progress Report –June 2018

Current status

Data and Measurement for Chronic Pain Services: A Pilot Study to Inform National Service Improvement

Aims

1. To validate, in three specialist pain services in NHS Scotland, the Core Minimum Dataset (CMD).
2. Based on these, to identify and develop a digital approach to data collection for the CMD, with the facility to add additional measures as required.
3. To develop and implement of a set of agreed Quality Performance Indicators (QPIs).

Objectives

1. Timing dependent on Caldicott application and whether Research Ethics Approval will be required: Validation of the Core Minimum Dataset in Level 3 Pain Services in NHS Tayside, Lothian and Fife.
2. June 2018: Trial run of the Quality Performance Indicators (QPIs) in one Pain Service.

3. June to July 2018 (possibly later, timing dependent on the timing of Step 1 above): Further consultation of the Quality Performance Indicators including Pain Services, Third Sector and service users.
4. August 2018: In light of consultation and pre-pilot feedback, develop the Quality Performance Indicators for wider pilot testing.
5. 2018: Pilot testing of the Quality Performance Indicators (timing to be discussed with the DCMO).
6. 2018-2019: Identification and development of digital approach to data collection for the CMD.
7. 2018-2019: Further development of the Optimum Dataset, incorporating potential suggestions from the consultation and pilot testing.

The consultation for the Quality Performance Indicators (QPIs) and Core Minimum Dataset began on the 27th of October (for 4 weeks). The consultation responses have been analysed carefully and as a result of this consultation, changes have been made to the core minimum dataset. A revised version of the CMD is included in the Appendices section (please see Appendix 1). In light of the responses to this consultation, the QPIs have been refined and the updated version can be found in the Appendices section (see Appendix 2).

We are working with the Caldicott application coordinator to submit an application for Caldicott approval. We are awaiting input from the Head of Information Governance at the University of Dundee before submitting the 5th (and hopefully final) version of this application. Provisional NHS R&D approvals are in place. The validation can commence as soon as national Caldicott approval is complete.