

**NATIONAL ADVISORY COMMITTEE FOR CHRONIC PAIN  
MINUTES OF MEETING**

**Date:** 5 June 2018  
**Time** 14:00 – 15:30  
**Venue** CR09, Victoria Quay, Edinburgh

**Attendees:** Dr Gregor Smith (GS), Scottish Government - Chair  
Prof Blair Smith (BS), National Lead Clinician  
Dr Paul Cameron (PC), National Co-ordinator  
Prof Lesley Colvin (LS), University of Dundee  
Dr Rachel Atherton (RA), Consultant Psychologist SNRPMP  
Sonia Cottom (SC), Pain Association Scotland (3<sup>rd</sup> Sector Rep)  
Gregory Hill o'Connor – (the ALLIANCE) deputising for Irene Oldfather  
Prof Tim Eden (TE), (Patient Rep)  
Magda Laswawska (ML), University of Dundee – observer  
Dr Chris Mackintosh (CM), Medical Director South Lanarkshire  
Phil Mackie (PM), ScotPHN  
Dr Ruth Mellor (RM) , ScotPHN  
Anita Stewart (AS), Scottish Government  
Sharon Robertson (SR), Scottish Government - Secretariat  
Declan Doherty (DD), Scottish Government – observer  
Kerry Russell (KR) (left after item 4)  
Dr Ann Wales (AW) (left after item 5)

**1. Welcome, Introductions and apologies**

Apologies were received from Irene Oldfather; Marianne Hayward, Mike Garden and Cara Richardson. CM dialled into the meeting.

**2. Review of previous actions**

BS asked for the last minutes to be amended regarding an item in Any Other Business to reflect that the Policy Matrix has been produced on behalf of the Scottish Government by the project team developing the core minimum dataset, in collaboration with ScotPHN.

GS noted that it is now agreed that the minutes would be cleared electronically as soon as possible after meetings and published on the NACCP webpage within one month.

GS advised that Miles Briggs MSP, co-convenor of the Cross Party Group (CPG) on Chronic Pain, has written to him again to provide clarification on the matters he raised on behalf of the CPG in March 2018.

The committee reviewed the March action tracker (annex A) and discussed the information provided by ISD, which they felt represented a useful clarification and should be included with this meeting's minutes (Annex C) and uploaded to the NACCP webpage.

GS highlighted the Scottish Government's on-going engagement with NHS Boards about waiting times for pain services, noting that NHS Grampian is embarking on a service re-design and has agreed to be part of the Scottish Access Collaborative (SAC) workshops later this year. GS stressed that this engagement is probing Boards' responses and planned actions to clarify how these changes will improve outcomes for people with chronic pain. LC agreed that it is important to clarify responses, as a Board might list its workforce numbers but the crucial information is how many sessions each member of the team actually provide to the pain service. TE endorsed need to see evidence of progress.

### **3. ScotPHN project – update**

RM and PM gave an update on the ScotPHN project; the recommendations are due to be published this summer. Directors of Public Health have seen a draft of the report and are supportive of the need to take forward actions in a sustainable way. AS highlighted that she will be meeting PM/RM to go through this in detail to ensure information is fed into the Scottish Access Collaborative work. GS agreed that it is important to bring these strands of work together. PM/RM will present an overview to NACCP at the meeting in August. BS noted it would be useful to allow sufficient time for discussion – GS/AS confirmed 20-30 mins has been set aside for this purpose. The report will also be discussed at the routine Scottish Directors of Public Health with the CMO

### **4. Scottish Access Collaborative (SAC)**

KR provided a short overview of SAC and confirmed chronic pain is one of the specialities included this year. The Digital Health Institute (DHI) is facilitating three workshops, which will map existing processes at a high level (the interface between primary and secondary care being critical), explore service demand and opportunities to transform its delivery to better meet the needs of people with chronic pain. CM noted it would be important to identify unmet needs. KR provided SA with clarification about the principle that patients should not be asked to travel unless there is a clear clinical benefit – recognising people should have a choice about how they interact with services – e.g. greater use of virtual clinics. The committee reflected it is great that chronic pain has been included in the SAC work and it is seen as a brilliant opportunity for relevant stakeholders to be engaged in defining a cohesive vision for national transformation that still provides flexibility for local needs and priorities.

### **5. Decision Support Tools (eHealth Digital Strategy)**

AW showed committee members screenshots of the Decision Support Tools being developed for the pilot project in NHS Tayside. These aim to support health care professionals (HCP) communicate options to patients, which include non-medical alternatives such as self-management/social prescribing. The software will also enable patients to access their record ahead of consultations to support shared decision making and virtual clinics.

GS acknowledged that this is a critical development for embedding the Chief Medical Officer's (CMO) "Practising Realistic Medicine" document – especially around co-morbidity considerations and finding out what is important to patients, which assists with conversations about the risk of options. SC obtained clarity about the system offering both medical and non-medical options in tandem (not either/or). PM supported the creation of these tools as a useful resource for GPs' reference. CM felt the person facing aspect is very important and supports the introduction of these tools, however, too many sub menus would be complicated and it would be desirable for as few clicks as possible. CM also questioned how this would interface with the current GP system to avoid too many add-on systems. AW highlighted tools have already been trialled by GPs in NHS Tayside, who were supportive of the approach and patients have been involved via focus groups. AW asked members to reflect on what they had seen and feedback any additional comments by email.

## **6. Workplan themes:**

### **6.1. Workforce/ training - Pain management credential update and Pain specialist survey update**

BS updated the committee about activities undertaken, since its last meeting in March, to explore workforce issues i.e. shortage of pain specialists. BS, AS and PC met Ian Findley (IF), Chair of the Shape of Training Implementation Group Scotland (SIGS) and professional adviser to the Scottish Government on health workforce matters, to discuss credentialing. I F explained the principles of "Shape of Training" is to ensure that the workforce has the appropriate skills, competencies and aptitudes to meet the changing needs of the population, including delivering more care in the community. There is a need for more involvement of generalists, who operate purely in primary and secondary care. This is essential in chronic pain management where the advanced pain training places are unfilled ,and in order to maintain the current ratio of pain specialists, 1.8-2.9 new consultant posts need to be recruited each year over the next 20 years .Alternative solutions to staffing are required.

A framework for credentialing might:

- allow some elements of speciality training to be accessed by other specialists, including GPs, either during training or by a post initial training Certificate of Completion of Training (CCT) in Chronic Pain.
- facilitate a means of access to recognised training for enhanced skills for staff and associate specialist doctors and other health professionals in time.

BS, AS and PC attended a recent workshop about the alignment of general surgical training in Scotland with patient/service needs, which is the first in the UK to be run. BS reflected it was useful to observe (alongside GMC and representatives from other UK governments) how the Shape of Training principles are being taken forward in practice and how data is being used to inform developments. The committee supported the proposal to run a similar workshop for HCPs working within pain services in Scotland, which will be closely aligned with the work completed under SAC. BS confirmed the committee was content for its workforce sub-group to work with relevant policy areas to take this forward, including the collation of data.

The committee reviewed the draft survey that will be used to obtain an up to date picture of whole time equivalent (WTE) HCPs operating in pain specialist services in Scotland compared to two years ago. LC highlighted that it is important to identify if vacant posts left unfilled have resulted in sessions being diverted to other services which TE felt was unacceptable. NHS Boards must have some succession planning to replace specialists leaving the service in future years. CM recommended adding 'GP with a specialism' and 'associate specialist' to the list of HCPs.

The survey will be sent to Medical Directors with a covering letter signed by GS. GS asked CM if he could bring this to the attention of Iain Wallace (Chair of the Scottish Association of Medical Directors (SAMD), with a view to asking Iain to co-sign the letter.

## **6.2. Self-management update**

SC mentioned she is working with AS to consider the NACCP workplan tasks around promoting non-medical approaches. SC and AS recently met the Scottish Government's Chief Pharmaceutical Officer (CPO) who is supportive of us exploring the development of a pharmacy marketing campaign proposal, as a means to raise public and professional awareness of inappropriate or unneeded medication – this supports the aims outlined in the recently published Quality Prescribing for Chronic Pain Strategy and has links to embedding themes from the CMO's Practising Realistic Medicine (building a personalised approach to care, reducing harm and waste and reducing unwarranted variation).

SC advised an update on progress about this NACCP workplan task would be provided ahead of the next meeting in August to enable committee members to inform its development. The committee endorsed the importance of supported self-management being an integral part of pain services provision.

SC also shared the slides she used during her recent presentation to the World Institute of Pain conference in Dublin. SC highlighted while there were over 2,000 conference attendees (44 from the UK), SC was the only person representing self-management.

## **7. Scottish Veterans Commissioner (SVC) report – recommendation**

AS brought the recent report to the attention of the committee and invited discussion on the SVC recommendation relevant to NACCP – that 'the National Advisory Committee for Chronic Pain should consider (UK) veterans specifically as part of their work to improve pain management in Scotland'.

SC agreed veterans are indeed an "at risk group" where there is a huge unmet need in terms of available support. SC reported that the Pain Association has been talking to a Veterans' Clinical Adviser and is applying to the Self-Management Fund, overseen by the Alliance, for funding to deliver self-management support services to veterans in pilot areas. CM wondered whether existing referrals to pain services had indicators to identify veterans.

PC recognised that veterans are an at risk group but highlighted there are also other groups such as all the emergency services. BS agreed but pointed out that veterans are subject to the UK Armed Forces Covenant and Scottish Government 'Our Commitments' (2012) & 'Renewing Our Commitments' (2016), which make provision for 'priority NHS treatment' for both serving personnel and veterans. The SVC is seeking an open debate to provide much clearer understanding of priority treatment, its relevance and an exchange of ideas about how it might be improved. BS stated that while priority treatment is not for this committee to explore, it is helpful to be aware of this wider context.

BS reflected he has first-hand experience of treating service personnel and veterans, and one of the issues is that veterans' medical records are not routinely shared with GPs following their discharge from service and, in BS's experience, it can be challenging to obtain access to records afterwards. PM queried if this has been discussed with the Scottish Government's Military Liaison Officer. AS highlighted that the new Drug and Alcohol Information System (DAISy) database being introduced later this year will gather key demographic and outcome data on people engaging in drug/alcohol treatment services – the database will include a field identifier for veterans. BS agreed to consider whether a field could be added to the core minimum dataset being developed for chronic pain to identify veterans. PC asked if this consideration could be expanded to identify a wider group including emergency personnel.

**8. Next steps and summary of agreed actions (Annex B)**

**9. AOCB**

**10. Date of next meeting / future meetings**

Tuesday 14 August  
Tuesday 6 November



**Action Tracker – 28 March**

Ref.	Actions from meeting on 28 March 2018	Responsible	Status
1	Ratified 19/12/17 minutes to be uploaded onto the website	Secretariat	Completed
2	The committee has asked if ISD can clarify why the publicised data is classed as developmental and what steps could be taken to provide full and complete data. It would also be helpful if ISD could publish narratives provided by Boards alongside the data regarding issues in service provision.	AS	Completed
3	Engage with the Clinical Outcomes and Measures for Quality Improvements (COMQI) group	AS and BS	Completed
4	Officials to continue to liaise between policy areas about workforce developments and to present updates to the committee as appropriate at future meetings.	AS and BS	On-going
5	Establish a sub-group to take forward the pain specialist workforce survey, involving representatives from relevant disciplines such as anaesthetics, primary care, physiotherapy, nursing and pharmacy.	AS and BS	On-going
6	Share NHS Tayside project to implement chronic pain pathways with other NHS Boards	BS	Outstanding – BS advised project not yet at point where it is ready to be shared.
7	SC to provide feedback about the World Institute of Pain conference at the next NACCP meeting	SC	Completed
8	Officials to identify relevant initiatives/ policy work that links to or has implications for chronic pain policy	AS	On-going – but so far has linked SAC work

**Action Tracker – 5 June**

<b>Ref.</b>	<b>Actions from meeting on 5 June 2018</b>	<b>Responsible</b>
1	Update minutes of 28 March meeting to reflect change requested by BS	Secretariat
2	To check with ISD that the information it provided can be included with NACCP minutes (confirmed)	Secretariat
3	AS to meet with ScotPHN to ensure its project findings are fed into SAC work	AS
4	Ensure ScotPHN has 30 minute slot on next NACCP meeting on 14 August	AS/GS
5	Members to provide AW with any additional comments on the shared decision making tools.	All
6	Workforce sub-group to explore credentialing and in conjunction with SAC work – devise workshop for late 2018/early 2019.	BS/AS
7	Workforce survey to be sent to Medical Directors with a covering letter from GS (find out if Iain Wallace will co-sign)	AS
8	Explore pharmaceutical proposal for chronic pain non-medical approaches and define tasks linked to this aspect of NACCP workplan	AS/SC
9	Consideration to be given to whether a field could be added to the core minimum dataset being developed for chronic pain to identify veterans (and other groups)	BS

## Correspondence from ISD

### Can ISD clarify why the published chronic pain waiting times data is classed as experimental and what steps are being taken to progress it to be official statistics?

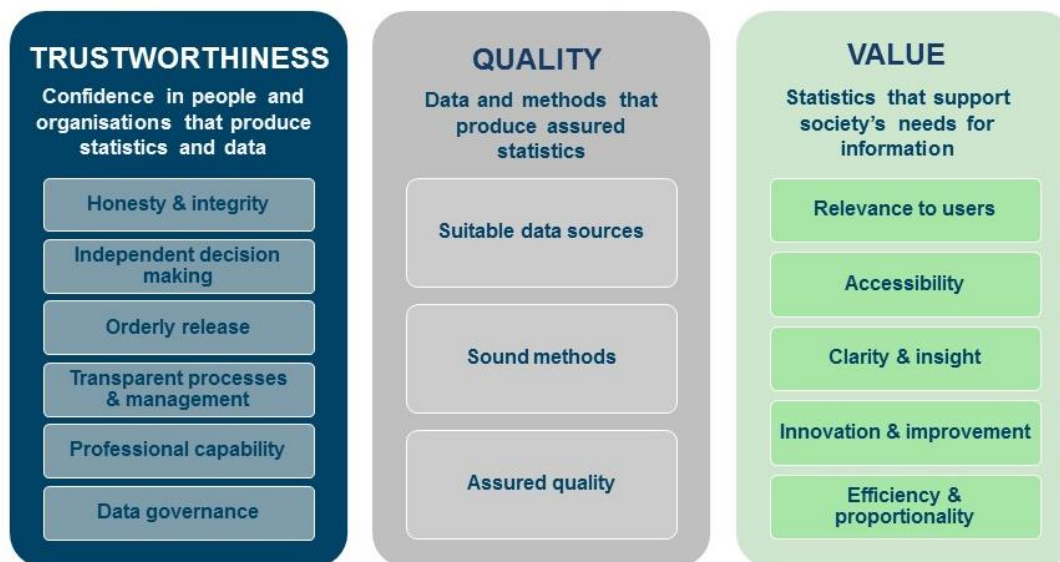
ISD are providers of official statistics and adhere to the Code of Practice for Statistics, regulated by the UK statistics Authority, which was established from the Statistics and Registration Service Act in 2007.

When producing **Official Statistics** you are committing to apply the Code, as set out in The Statistics and Registration Service Act 2007. You should consider the pillars, principles and practices as you produce the statistics.

When producing **National Statistics** you are committing to fully comply with the Code, again under The Statistics and Registration Service Act 2007, and need to continue to comply with the Code.



## The pillars and principles



While Chronic Pain waiting times data is still considered to be experimental, steps are underway to move them to official. The main reason they have remained experimental are the data quality issues and the incomplete data from Pain Psychology Clinics from some health boards (second pillar). The 14 NHS Boards are working with ISD and the Scottish Government to improve the consistency and completeness of the information collected.



At present ISD receives Chronic Pain Waiting Times data via aggregate returns from each NHS Board and so patient-level information is not systematically validated by ISD. ISD carries out quality assurance checks on the data submitted and will query the data with NHS Boards. The derivation of the figures and data accuracy is carried out by individual NHS Boards in collaboration with ISD.

As part of moving the Chronic Pain Waiting Times Publication from developmental status to Experimental Official Statistics, ISD recently carried out a consultation with users. The results have been published on the ISD [website](#). As a result of the consultation ISD have made changes to the summary based on the feedback received. Changes made to the publication summary include more detailed information, which is easier to read and understand, and a link to the excel tables that shows all Chronic Pain publication figures.

The excel file headings have been changed to make them easier to understand and the notes have been improved. The tables now show the number of patients removed from a waiting list for reasons other than being seen (from the NHS boards who are able to provide this data). These changes have been made in order to ensure that the information presented is clear and understandable.

ISD is awaiting advice from its Statistics Governance Team to see if the data can now be classed as 'official'.

### **Can ISD publish the narratives (explaining delays) provided by Boards alongside the data?**

NHS Boards provide data quality and completeness information to ISD each quarter. Some of this information is included in a data quality section of the excel tables that are published on ISD's [website](#). ISD will review whether all of this information can be published.

ISD can use a 'tool' (such as a dashboard) to pull together a variety of different information, an example being the trauma, orthopaedics and ophthalmology specialty information portals that sit within the Discovery suite.

# Pain management - wait from 1<sup>st</sup> appointment to 1<sup>st</sup> return appointment

Experimental data – still work in progress **caution – see notes**

During January to September 2017

•974 people across Scotland had their 1<sup>st</sup> return appointment following their first attendance at a pain management clinic.

•Half the patients were seen within 26 weeks

\*Notes:

there will be more people with return appointments – these figures have not been looked at.

We can't tell how close these patients were to their clinically indicated date of return.

Individuals may have seen other specialist between appointments e.g. Physio.

We don't know if the return appointment was for treatment or follow up – some patients may have had their treatment

