

Appendix 3: NHS Fife Pain Service Data

Demographics

Age Demographic	Number of Patients	Percentage of Recorded Patients
18-39	435	20.87%
40-59	1052	50.4%
60+	588	28.21%

Pain Site and Duration

Body Part	Number of Patients	Percentage of Patients
Chronic Low Back Pain	831	39.88%
Fibromyalgia	288	13.82%
Neck/Shoulders	216	10.36%
Knees	154	7.39%
Widespread Pain	145	6.96%
Hips	131	6.29%
Ankles/Feet	94	4.51%
Spinal	76	3.65%
Abdominal	67	3.21%
Osteoarthritis	66	3.17%
Pelvic	43	2.06%
Chronic Fatigue	39	1.87%
Head/Facial	32	1.54%
CRPS	27	1.30%
Headaches	27	1.30%



Pain Duration

Pain Duration	Number of Participants	Percentage of Participants
1-2 months	119	5.71%
3-5 months	54	2.59%
6-12 months	102	4.89%
1-2 years	213	10.22%
3-5 years	357	17.13%
6-10 years	172	8.25%
10-20 years	367	17.61%
20-30 years	66	3.17%
30-40 years	16	0.77%
40-50 years	29	1.39%
Unable to Code	6	0.29%
Missing Data	460	22.07%

Referral Pathways

Referral By (Profession)	Number of Patients	Percentage of Recorded Patients
General Practitioner (Referral Management Services)	1413	67.80%
Consultant	310	14.88%
Physiotherapy	148	7.10%
Specialist Registrar/ Staff Grade/ Clinical Fellow/ Non-specified Medic	137	6.57%
Orthopaedic Practitioner	20	0.96%
Clinical Psychology	13	0.62%
Nurse Practitioner	11	0.53%
Non-Specific Referral (Regional Treatment Centres)		
Occupational Therapy		
FY1/2		
Mental Health Services		
Pain Services		
Dietician		
Missing Data		



Secondary Care Department	Number of Patients
General Practice	808
Unknown (Phone Number or Dep refno. only)	355
Orthopaedics	90
Rheumatology	61
Neurology	26
Clinic (Miscellaneous)	22
Physiotherapy	21
Obstetrician & Gynaecology	
Gastroenterologist	
Urology	
General Surgery	
Anaesthesia & Pain	
Vascular Surgery	
Psychology	
Psychiatry	
Renal	
Missing Data	594

Outcome	Number of Patients	Percentage of Recorded Patients
Triaged to Secondary Care	234	11.22%
Triaged to RIVERS	377	18.09%
Attended Consultant's Appointment	214	10.26%
Programme Completed	199	9.55%



Outward Referrals	Number of Patients	Percentage of Patients Recorded
Physio 1-2-1 Referral	124	6.00%
Joint Assessment	21	1.01%
Psychology 1-2-1 Referral	11	0.53%
OT Referral	█	█
Missing Data	0	0%

Physiotherapy Outcome	Number of Patients
Improved	█
Maintained	█
Unknown	█
Missing Data	2079

Outcome Measures

Generalised Anxiety Disorder Questionnaire (GAD-7)		
SCORE	Initial Assessment	Follow-Up Assessment
Mean	9.16	1.46
Minimum	0	0
Maximum	21	21
SD	6.53	3.7
Missing Data	0	3

Visual Analogue Scale (VAS)				
SCORE	Pre-Assessment (Best)	Pre-Assessment (Worst)	Follow-Up (Best)	Follow-Up (Worst)
Mean	3.48	8.75	3.12	7.66
Minimum	0	0	0	0
Maximum	10	10	9	10
SD	1.97	1.47	1.76	1.79
Outliers	5	4	2	1
Missing Data	1230	1227	1647	1647

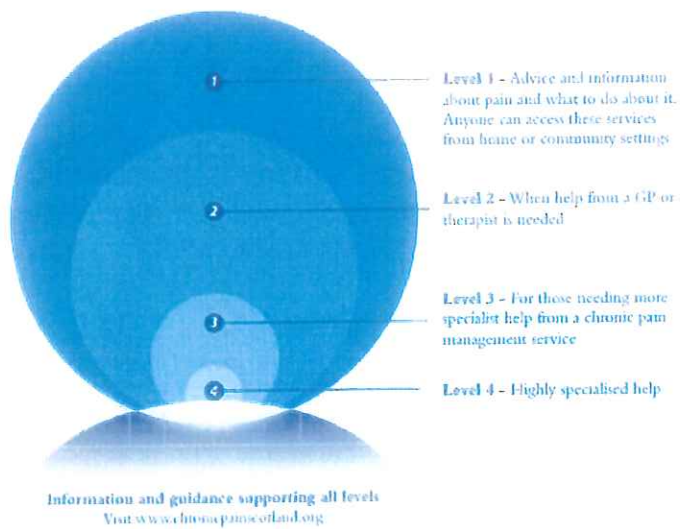
Patient Health Questionnaire (PHQ-9)		
SCORE	Initial Assessment	Follow-Up Assessment
Mean	13.3	1.75
Minimum	0	0
Maximum	31	27
SD	7.15	4.02
Missing Data	1	1

Pain Self-Efficacy Questionnaire (PSEQ)		
SCORE	Initial Assessment	Follow-Up Assessment
Mean	20.3	7.50
Minimum	0	0
Maximum	60	60
SD	12.88	14.91
Outliers	9	2
Missing Data	0	2

Appendix 4: Scottish Service Model for Chronic Pain

Figure 2: Scottish Service Model for Chronic Pain

Most people get back to normal after pain that might come on after an injury or operation or for no apparent reason. Sometimes the pain carries on for longer than 12 weeks despite medication or treatment – this is called chronic or persistent pain.



Appendix 5: Snapshot of PROSPERO Protocol

UNIVERSITY of *York*
Centre for Reviews and Dissemination


National Institute for
Health Research

PROSPERO International prospective register of systematic reviews

A rapid review and meta-analysis of interventions to reduce use of prescribed opioids in patients with chronic non-malignant pain

Lesley Colvin, Blair Smith, Alex Baldacchino, Pauline Adair, Steve Gilbert, Michael Scrpell, Gary Macfarlane, Rebecca Lawrence, Gillian Currie, Cara Richardson, Katherine Berloius

Citation

Lesley Colvin, Blair Smith, Alex Baldacchino, Pauline Adair, Steve Gilbert, Michael Scrpell, Gary Macfarlane, Rebecca Lawrence, Gillian Currie, Cara Richardson, Katherine Berloius. A rapid review and meta-analysis of interventions to reduce use of prescribed opioids in patients with chronic non-malignant pain. PROSPERO 2015, CRD42015017480. Available from http://www.crd.york.ac.uk/PROSPERO/REBRANDINGS/display_record.asp?ID=CRD42015017480

Review question(s)

To assess the recent evidence (since 4th April 2013) for clinical effectiveness of different interventions to reduce or discontinue opioid treatment in patients with chronic, non-malignant pain

Searches

Databases/Information Sources (from 04/04/2015 to current):

- EMBASE
- MEDLINE
- Cochrane Central Register of Controlled Trials (CENTRAL)
- PubMed central
- Web of Knowledge
- CINABL
- PsycINFO

Types of study to be included

Prospective, randomized controlled trials of an intervention compared to either standard care, placebo, or active control, where one of the main outcomes was reduction/cessation of opioids for chronic pain; systematic reviews of prospective studies of interventions to reduce or discontinue opioids.

Condition or domain being studied

Chronic non-malignant pain is common, with up to 20% of the population suffering from significant chronic pain persisting for longer than 3 months. This is a major public health problem, with a huge impact on patients, carers and wider costs to society. Despite a major increase in prescribing of opioids for chronic non-malignant pain over the last 10-15 years, there is no good evidence of long term benefits, and accumulating evidence of harm for some patients. It can be very difficult for patient to reduce or stop strong opioids, even when they are motivated to do so. It is important to understand the evidence for what interventions can help patients to reduce or discontinue strong opioids.

Participants/ population

Inclusion Criteria

Population: Adult patients (>18 years) with chronic non-malignant pain (persisting for at least 3 months); using prescription opioids regularly, for at least three months for pain management

Appendix 6: SPaRC ASM 2017 Programme




This event is approved by the
Royal College of Anaesthetists
for 5 CPD credits

**Scottish Pain Research Community (SPaRC)
7th Annual Scientific Meeting**

**Friday 24th March 2017
West Park Conference Centre, Dundee**

Supported by a grant from Grünenthal Limited

9:00 – 10:00	Registration/coffee/networking – Sidlaw Auditorium Foyer
Chair: Prof Lesley Colvin, Consultant in Anaesthesia & Pain Medicine/ Hon Professor, Universities of Edinburgh and Dundee	
10:00 – 10:05	Welcome and introduction to the Scottish Pain Research Community (SPaRC) 7 th Annual Scientific Meeting <i>Prof Lesley Colvin, Chair of Chronic Pain Research Subgroup</i>
10:05 – 10:15	<i>National Lead Clinician – Brief Update</i> Paul Cameron
10:15 – 10:45	Keynote Presentation 1: Translational Pain Research: From Animals to Chronic Pain Patients Lars-Arendt Nielsen, President Elect, International Association for the Study of Pain
	Session(1): Chaired by Dr Colin Rae, Consultant in Anaesthesia and Pain Management, North Glasgow
10:45 – 11:00	A new national guideline for management of chronic pain in children – an opportunity for consultation Lesley Colvin
11:00 – 11:15	Early Life Stress Affects Morphine Mediated Analgesia and Tolerance Claire Sneddon
11:15 – 11:30	The Scottish National Residential Pain Management Programme: 100 referrals received – Where are we now? Fraser Bell



11:30 – 11:50	Mid-Morning Coffee Break – Sidlaw Auditorium Foyer
	Session(2): Chaired by Professor Blair Smith, National Lead Clinician for Chronic Pain, Scottish Government/ Professor of Population Health Science, University of Dundee
11:50 – 12:05	Using transgenic mice to characterise the spinal circuitry underlying pain and itch Allen Dickie
12:05 – 12:20	Systemic review of validated measurement tools used to assess risk of problematic analgesic use in chronic pain patients Rebecca Lawrence
12:20 - 12:35	Preparing exercise and physical activity as a complex intervention for chronic pain - an audit of patients assessed for pain management with a physiotherapy component, compared to psychological therapy alone Louise Geneen
12:35 – 13:35	Lunch – Main Restaurant
	Session(3): Chaired by Dr Kathryn Martin, Lecturer in Epidemiology at the University of Aberdeen and Professor Tim Hales, Professor/Director of the Division of Neuroscience & the Institute of Academic Anaesthesia, University of Dundee
13:35 – 14.00	Oral poster presentations: Sidlaw Auditorium - Datablitz
14:00 - 14:15	Developing research networks in Scotland Charles Weller, NRS Scotland
	Session (4): Chaired by Dr Mick Serpell, Senior Lecturer & Consultant in Anaesthetics & Pain Management, University of Glasgow/NHS Greater Glasgow & Clyde
14:15 – 14:30	Melatonin as a potential treatment for paclitaxel-induced neuropathic pain Carole Torsney
14:30 – 14:45	What do people think about back pain - and does it matter? A systemic review LaKrista Morton
14:45 – 15:00	DOLORisk Dundee - Development of a Risk Model for (Severe) Neuropathic Pain Harry Hebert
15:00 – 15:30	Poster Viewing and Coffee Break – Sidlaw Auditorium Foyer
	Session(5): Chaired by Professor Gary Macfarlane, Professor of Epidemiology and Deputy Director of Institute of Applied Health Sciences University of Aberdeen
15:35 – 16:05	Keynote Presentation 2: Improving MSK rehabilitation - where do we go next? Jonathan Hill, Keele University
16:05 – 16:20	Discussion and Closing Remarks

Appendix 7: Short Life Working Group Poster (SPaRC 2017)



**'Management of Chronic Pain in Children and Young People:
A National Clinical Guideline'
An opportunity for consultation**

Short-Life Working Group for Paediatric Pain

Lesley Colvin (Chair), Mary Rose (Co-Chair), Pauline Beirne, Katherine Berlouis, Ross Fairgrieve, Peter Fowle, Stephen Gilbert, John Goddard, Heather Harrison, Dawn Houston, James Lemon, Stewart MacLeod, Kevin McCarthy, Erin McGuigan, Pierette Melville, Tony Moore, Cara Richardson, Mandy Sim, Ewan Wallace, Carolyn Wesson, Graeme Wilson, George Youngson and Diane Dempster (Secretariat)

Background

- Chronic pain in children has a prevalence of 15-30%, with 8% of children reported as having severe and frequent pain [1-3].
- The SIGN Guideline on Chronic Pain (SIGN 136) did not include paediatric pain in its remit, as evidence base was limited. Feedback from key stakeholders indicated a need for expert guidance on managing paediatric chronic pain [4].
- While recognising there is limited high quality evidence, this working group combined multidisciplinary expertise to review available evidence and reach consensus. Delivery of good quality, timely care underpinned by the best available evidence is important.

Preliminary Key Recommendations

- ASSESSMENT**
 - A screening tool to identify children at risk of adverse outcomes with chronic pain could be used early to guide intensity and type of intervention.
 - Early biopsychosocial assessment and planning of care may reduce long term disability.
- PHARMACOLOGICAL MANAGEMENT**
 - Long term medication use should be part of a more comprehensive approach, including supported self-management strategies. Regular scheduled review to assess continued benefit and potential adverse effect is essential.
 - Pharmacological treatment should be started after careful assessment. If being used, it should be part of a wider approach utilising supported self-management strategies within the context of a multidisciplinary approach. Treatment should be limited to the shortest possible duration and there should be planned reassessment of ongoing efficacy and side effects. Treatment should only be continued if benefits outweigh risks.
 - Paracetamol and non-steroidal anti-inflammatory drugs should be considered in the treatment of chronic non-malignant pain in children. Use of NSAIDs and/or paracetamol should be limited to the shortest possible duration, such as for use during acute on chronic pain episodes.
 - Antiepileptic drugs could be considered as part of a multi-modal approach in the management of neuropathic pain.
 - Low dose amitriptyline should be considered in the treatment of functional gastrointestinal disorders.
 - Low dose amitriptyline can be considered in the treatment of chronic daily headache, chronic widespread pain and mixed nociceptive/neuropathic back pain.
 - Opioids and compound analgesics containing opioids are rarely indicated for chronic pain because of their adverse effect profile. Be aware of MHRA advice on codeine. Strong opioids should be used with caution and only with specialist advice or assessment
- PHYSICAL THERAPIES**
 - Exercise should be considered as a key component of chronic pain management in children and young people.
 - Expert opinion supports the need for early intervention of movement, physical activity and restoration of function.
- PSYCHOLOGICAL THERAPIES**
 - Psychological interventions should be considered as they can be effective in reducing pain severity and improving function.
 - Online or computerised delivery of Cognitive Behavioural Therapy (CBT) interventions may be considered. Due to geographical limitations in accessing specialist care, consideration should be given to developing online interventions to deliver some components of multidisciplinary care.
- SURGICAL INTERVENTIONS**
 - The benefit of local anaesthetic blockade or other interventions may be considered on an individual patient basis in specialist centres.
- DIETARY THERAPIES**
 - Consider the use of probiotics (Lactobacillus rhamnosus and VSL#3) in children and young people with functional gastro-intestinal disorders.
- COMPLEMENTARY THERAPIES**
 - Expert opinion suggests a potential role for acupuncture in managing chronic back pain or headache, with formal assessment of efficacy.

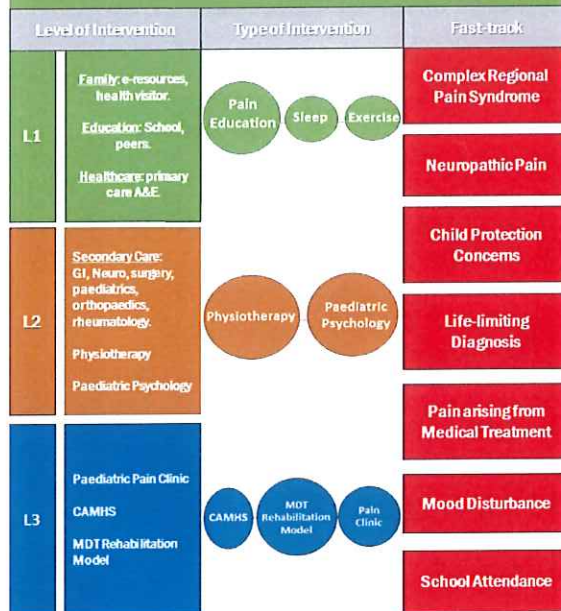
Objective

... of guideline: to provide a useful practical resource, improving quality of life and reducing longer term harms for children with chronic pain.
... of this poster: to seek wider consultation of guideline and to garner feedback. Please send any additional comments to k.berlouis@dundee.ac.uk and c.u.richardson@dundee.ac.uk

Methodology

The key questions for this guideline were developed using the PICO principle (population, intervention, control and outcome). Predefined search strategies were utilised by SIGN researchers. The quality of research was assessed and graded by experts in the respective fields, adhering to accredited SIGN Guideline Methodology [4]. However, most of the recommendations were made based on group consensus opinion, rather than high-grade evidence.

Paediatric Pain Pathway



Conclusion

Currently there is a paucity of high quality studies for paediatric pain interventions. This clinical guideline addresses a previously unmet need: an overview of the current evidence base.

1. Perquin, C.W., et al. Pain, 2000. 87(1): p. 51-8.; 2. Roth-Isigkeit, A., et al. Paediatrics, 2005. 115(2): p. e152-e162.; 3. Stanford, E.A., et al. Pain, 2008. 138(1): p. 11-21.; 4. SIGN 136, Management of Chronic Pain. (www.sign.ac.uk).