We are planning to conduct a shadow QPI assessment exercise on the level 4 pain services and we have developed the data collection form (see Appendix 3). This exercise will allow us to test the QPIs, the data collection form and responses to it. It also allows services to familiarize themselves with the questions that they are likely to be asked.

We are also liaising with eHealth regarding imbedding the CMD within TRAKcare. As identified in the pilot phase of the project, there are a number of health boards currently using or moving on to TRAKcare which would allow for wider implementation of the CMD. Electronic input of questionnaire data allows for more efficient presentation and analysis of data within the Pain Services. This will be also be useful for data collection in relation to the QPIs. The Project Team (BHS, PC, ML, CR) also met with representatives from ISD on the 27th of April in St Andrews House regarding the collection and dissemination of the CMD and QPI data using digital tools. They are currently awaiting a paper from [redacted] of ISD, to stimulate further discussion of methods to support this.

[1] See Appendix 5 for a Gant chart of progress

Appendices

Appendix 1 – Core Minimum Dataset (CMD)

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

Core Minimum Dataset

Demographics

1) Today's date

____

2) CHI Number

____

3) Age

☐ 18 - 24 years old

☐ 25 - 34 years old

☐ 35 - 44 years old

☐ 45 - 54 years old

☐ 55 - 64 years old

☐ 65-74 years old

☐ 75 years or older

4) Gender

☐ Female

☐ Male

☐ Non-binary/ third gender

☐ Prefer to self-describe

____

☐ Prefer not to say

5) Postcode

____

6) Pain Duration

☐ Less than 3 months

☐ More than 3 but less than 6 months

☐ More than 6 but less than 12 months

☐ More than 1 but less than 3 years

☐ More than 3 but less than 6 years

☐ More than 6 but less than 10 years

☐ More than 10 years

7) Pain Severity

In the past six months, on average, how intense was your pain rated on a 0-10 grade scale where 0 is "no pain" and 10 is "pain as bad as it could be".

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
No Pain										Pain as bad as it could be.

8) Emotional Impact

Please circle the option that applies to you.

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At All	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

9) Functional Impact

In the past six months, how much has this pain interfered with your daily activities rated on a 0-10 scale where 0 is "no interference" and 10 is "unable to carry on activities"

☐ 0 No interference ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Unable to carry on activities

10) Health-Related Quality of Life[1]

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

---

[1] 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

---

[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).

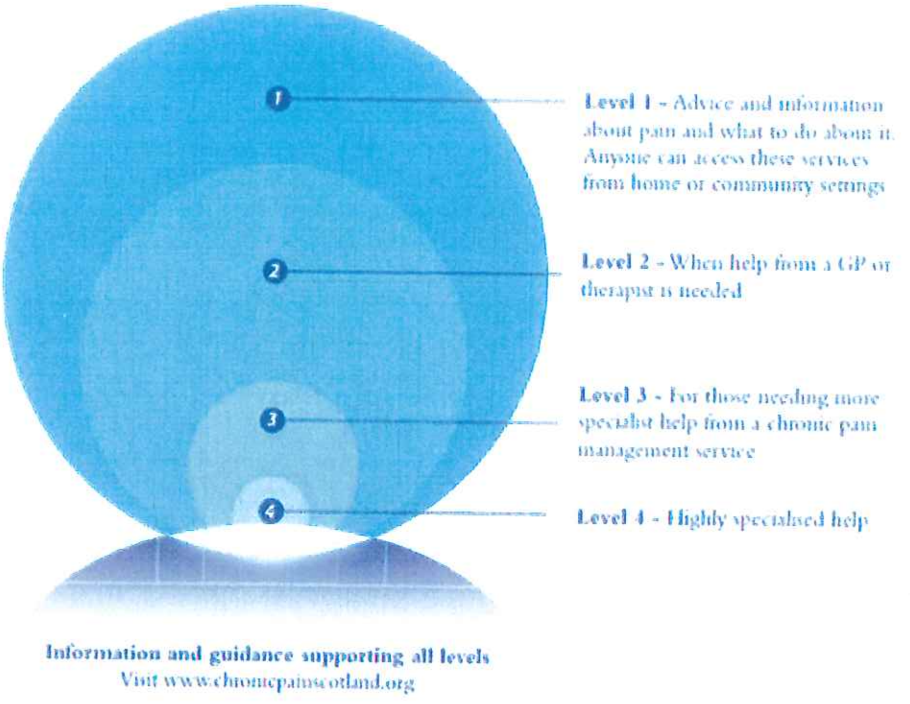
Appendix 2 – Draft Quality Performance Indicators (QPIs)

In accordance with the objectives of the original proposal, collated information from research across the country and a literature review was used to develop recommendations for service improvement. The QPIs have been modelled against the four levels of the Scottish Service Model (Figure 1).

Quality Performance Indicators (QPIs) are a set of standards used to measure and monitor chronic pain data in Scotland. The aim of QPIs is to drive continuous quality improvement in the care of patients with chronic pain. QPIs are designed to be clear and measurable, based on sound clinical evidence whilst also taking into account other recognised standards and guidelines. The main source of evidence for these QPIs is SIGN 136 and the National Prescribing Strategy (which is in its final stages).

The QPIs will undergo a formal and rigorous consultation process with feedback welcome on all areas, specifically attainable and realistic targets for each indicator.

Figure 1: Scottish Service Model for Chronic Pain



QPI 1 – Educational information about pain (Levels 1-4)

QPI Title:	Educational information about pain (Levels 1-4)
Description:	Patients attending an NHS service that provides chronic pain treatment should have access to educational information about pain. These services include, but are not restricted to, Specialist Pain Services, General Practices, Community Pharmacies and relevant AHP clinics. Educational information about pain 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 [1] 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 [2]. 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 [3, 4]. A decrease in pain can also be found following these programmes as well as physiological improvements [4], though these tend to be short-term improvements [3]. Pain neurophysiology education has been shown to be effective in conjunction with other pain management approaches [5].

Specifications:	**Numerator:** Number of NHS services providing educational information about chronic pain (including visible signposting relevant to pain education). **Denominator:** Number of NHS services in health board providing chronic pain treatment **Exclusions:** No exclusions.
Target	100% Each service provides educational information about chronic pain.

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). Patients should have information recorded relating to 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) [6]. 6) Underlying Diagnosis: Map to ICD-11 (develop Read code/SNOMED) 7) Emotional Impact: Patient Health Questionnaire-2 (PHQ-2) [7]. 8) Functional Impact: Question 5 of the Chronic Pain Grade Questionnaire (CPG) [6]. No conclusive evidence exists regarding a single self-report physical activity questionnaire [8]. 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 [2].
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 attending the Pain Service for management of 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 partially completed questionnaires. 75% of patients have fully completed questionnaires.

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 [2]. 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 [2]. 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 [9]. Clinicians should ensure these patients are reviewed at least annually. Key recommendations from the "Quality Prescribing for Chronic Pain: A Guide for Improvement" [9] 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 [9]: 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 7: Is the patient willing and able to take drug therapy as prescribed? Adverse effects should also be assessed.
Specifications:	**Denominator:** All patients who received an annual (or more frequent) review of their medication. **Numerator:** (1) All patients receiving three prescriptions or more for analgesics within the reporting period, (2) All patients receiving three prescriptions for strong opioids and/or gabapentinoids during reporting period, (3) All patients who receive at least one prescription for >90mg/day morphine equivalent during the reporting period. Key areas to be included in an audit: - 90% of patients using analgesics to manage chronic pain receive at least 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 [2]. More recently [9] 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 at least 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 [10]. The National Pain Audit Final Report 2010–2012 [11]in England and Wales identified 7 key factors to be included in an audit [11]: - 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 [12] - 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 [11]. 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 [12]. 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 staff. These specialists will have dedicated sessional time in the pain management service and attend multidisciplinary team (MDTs) meetings [12]. 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 [13] in accordance with the “Core Minimum Dataset”. - **Waiting Times [14]:** o 18 weeks Referral to Treatment Standard. - **Occurrence of Multidisciplinary Team meetings.** o The minimum standard for multidisciplinary care as defined by the availability of medical, rehabilitation and psychological expertise [11].