Consultation response

Question 1: We would like to know in what context you are responding. Please choose one of the following:

I am responding as:

a) an individual who experiences chronic pain ☐

b) a family member or carer of someone who experiences chronic pain ☐

c) a health professional ☐

d) an organisation representing people who experience chronic pain ☐

e) other stakeholder (please tell us in the comments box below) ☒

Collective response as an organisation – collated responses within NHS Tayside (including GPs, AHPs, Clinical Health Psychologists, Chronic Pain Specialists, Primary Care Management and LTC Lead)

Question 2: Please choose your preferred option (Chapter 2 provides details).

Option 1 – a centre of excellence in a single location ☒

Option 2 – a service delivered by local chronic pain clinicians ☐
(supported by other clinical advisors in another part of the country)

Option 3 – a service delivered in different locations ☐
(by a team of chronic pain specialists – an outreach or roving service)

Please tell us why this is your preferred option in the comments box below. The factors listed in Chapter 2 of the consultation paper may help you.

Of the three options, Option 1 appears to be the most appropriate option for current need and is perceived by healthcare professionals as providing the best 'value for money'. Options 2 and 3 raise a number of issues in relation to funding and operational delivery that is perceived to be difficult to implement.

NHS Tayside has established a Service Improvement Group to facilitate the redesign of local pain services to be aligned with the Scottish Pain Service Model. The objectives for the project include the implementation of chronic pain pathways that are aligned with the Scottish Chronic Pain Service Model through a transformational change programme that will consist of a series of successive and interlinked improvements, to develop a service that delivers upon the six elements of quality. As this improvement programme is progressed it is recognised that the current need and referral trends may change and the service scope and service requirement may change overtime. As an example there is a perception that ensuring supported self management, based on the fact that the bio-psychosocial model is available from the time of diagnosis and throughout the journey of chronic

pain them there may not be the same requirement for a residential programme or of a residential programme.

Taking cognisance of this ongoing improvement work, some respondents raised concern that it may be more prudent to re-evaluate need for a residential course following achievement of the pain improvement programme outcomes.

The majority of respondents, however, also believed that if there is a general acceptance that such residential courses should be available, Option 1 remains the preferred choice, as it is perceived that there are a number of challenges are associated with the other options presented as an alternative to a national centre.

Development and sustainability of suitable residential settings in each Board area would be questionable given the small numbers of patients accessing a resource of this type in each area.

MDT Chronic Pain Day Clinics rather than appointments within each board area may prove a more effective way of providing access to assessment and education by the MDT team, perhaps delivered in a locality setting outwith acute hospitals to help de-medicalise Chronic Pain management as far as possible.

The general consensus was that neither a peripatetic nor a remote access clinic is a viable option.

There is some concern form some respondents that investment in a residential pain management programme has the potential to reduce investment in local pain services. Clear guidance needs to be given from the Scottish Executive to local Health Boards emphasising that this is not an alternative to local pain management programmes or adequately resourced pain services if this level of funding is provided to develop level 4 of the National Chronic Pain Model for Scotland. I

It was viewed as critical by respondents that levels 1,2 and 3 within the Pain Model are resourced and developed locally to support a residential programme if that is the preferred option.

Question 3: Are there any of the options you disagree with? (If No, move straight to Question 4.)

If yes, please tell us which one(s) in the comments box, and why?

Option 3 as co-ordination of this would be very challenging and there was concern from respondents that this does not represent a feasible proposal.

Question 4: If you have other ideas that have not been covered, please tell us about these in the comments box below. You may want to include the advantages and disadvantages of each.

Ongoing work through local Board Improvement Groups or MCN's to redesign pain pathways may influence future assessment of the ongoing need for residential pain programmes and how they could be delivered.

Question 5: What do you think the barriers are to accessing a residential pain management service? (For example, distance away from family, work or family commitments, upfront travel costs.)

Please list as many as you wish in the comments box below and include any others that are important to you.

Need to balance optimal patient experience and minimise travel time with access to expert specialist facilities that due to cost cannot be duplicated over multiple sites without potentially reducing service quality.

A Scottish residential programme does not eliminate travel difficulties. For someone with chronic pain, travelling three hours for an assessment is only slightly less overwhelming than travelling seven hours.

Family accompanying patients may find an alternative location in Scotland as unfamiliar as the Bath location.

Patients with family, employment and caring responsibilities often refuse a referral to Bath because of financial implications. Investment in local services for Pain Management Programmes and multi-disciplinary pain services would provide a greater benefit for the majority of patients.

A perceived fundamental challenge with residential Pain Management Programmes is that lessons and skills learned in an idealised setting, away from the stresses and pressures of everyday life, are not easily transferred when the patients return to their homes. Our experience of the Bath Programme reflects this, with frequent re-referrals for the same problems. For this reason, referral to residential services is considered as a final option in situations whereby local services are not available. Local Pain Management Programmes avoid most of these difficulties. Travel costs are generally lower with no accommodation costs. Patients are not removed from their families and support networks. Patients have the opportunity to try out suggested strategies in their everyday lives, report back any difficulties, and work with staff in resolving these.

Some respondents raised concern that a residential Pain Management Programme may hinder implementation of the Scottish Service Model, as it may be interpreted that patient's needs are seen as being met, thus, the introduction of a residential programme may be detrimental to Scotland's pain patients in the short and medium term. Other respondents perceived a residential programme to be a positive adjunct to services delivered locally, and thought that in the absence of a local Pain Management Programme, a residential Pain Management Programme would be inadequate.

Question 6: Please choose from the list below which aspects of residential pain management services should be included in a Scottish service.

(choose as many as apply)

A chronic pain assessment ☒

Supported one to one sessions to teach coping skills ☒

Group sessions ☒

Residential accommodation ☒

Opportunity for immediate carer/support provider to accompany patient ☒

Peer support ☒

Tailored exercise programme ☒

Medication assessment ☒

Other (please tell us in the comments box below) ☒

Follow-up should be a routine part of the programme offered by a Specialist Pain team.

Care input should be tailored – some aspects must be discussed individually with the patient away from carers (behavioural issues).

Question 7: Irrespective of the final service model selected, should access to the current service provided in Bath (or elsewhere in the UK) be retained for occasional use?

Yes ☐ No ☐ Don't Know ☒ - *Why would we need this, our services should replace the need for this?*

Question 8: Have you previously attended, or supported someone attending a residential service outside Scotland?

Yes ☐ (please answer Question 9)

No ☒ (please move straight to Question 10)

Question 9: If you have attended, or supported someone attending a residential service outside Scotland, please tell us about any advantages and disadvantages of the experience.

N/A

Question 10: If you, or someone close to you, has been offered but declined a residential service outside Scotland what were the reasons for this?

N/A

Question 11: If you wish to add any further comments on issues raised in the consultation paper or current chronic pain services in Scotland, please use the comments box below.