2010 Judith Meppem NSW Nursing and Midwifery Overseas Travel Scholarship Report

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“Chronic Pain is like a toxic spill, with damage that eventually spreads far beyond the original site. Neglect one local disaster—a back injury, a twisted knee—and it can metastasize into more pain. More pain poisons the joy and the vitality of one individual, whose suffering then seeps into the lives of family members. Pain can destroy a wide radius of lives in the same way that clear cutting erases the history of a forest.”

Marni Jackson (2002), author and chronic pain sufferer

Acknowledgements:

I would like to take this opportunity to thank the NSW Nursing and Midwifery Office for this unique opportunity for me to travel overseas and visit these pain centres as without this scholarship, my incredible journey would not have been possible. Also for the Hunter Integrated Pain Service (HIPS) and the support they have given me over this time.

A huge thank you to all my close family and friends for the support they gave my family whilst I was away overseas for nearly two months. For my husband and children, a huge big thank you all for your ongoing love, support and mostly patience that has allowed me the opportunity to complete this report as I know how much time this has taken away from some family commitments. I love you all very much.

Fiona Hodson
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      • Site 3: Wellington Hospital (Julie Barton)
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3. Canada
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        (Margarite Paul)
      • Site Visit 9: OASIS Program: West Vancouver Community Health Centre
        (Margarite Paul)
      • Site Visit 10: OASIS Program Richmond Clinic Health Science Building
      • Site Visit: 11 Royal Columbian Hospital (Brenda Poulton)
      • Site Visit: 12 St Paul’s Hospital (Dr Brenda Lau)

   3.2 Calagary: Alberta (3 Days)
      • Site visit: 13 The Alberta Health Region Chronic Pain Centre
        (Dr Chris Spanswick)
      • Site visit:14 Primary Care Network Calgary Foothills
        (Yolanda Martens-VanHilst)
      • Site Visit: 15 Rockyview General Hospital (Dina Sotiropoulos)
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3.4 Resources and Links

4. United Kingdom (4 days)
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   - Site Visit: 17 Pain Association Scotland Head Office (David Falconer)
   - Site Visit: 18 Tayside Pain Service (Dr Johnathon Bannister)
   - Site Visit: 19 Edinburgh, Pain Association Scotland (Phil Sizer)
   - Site Visit: 20 Glasgow, NHS Lanarkshire (Janette Barrie)

4.2 Southampton, England (6 days)
   - Site visit: 21 Southampton University’s NHS Trust (Dr Cathy Price)
   - Site Visit: 23 Stoneham Centre, Mooregreen Hospital (Barbara Sharp)
   - Site Visit: 22: NHS Eastern and Coastal Kent Community (Val Conway)
   - Site Visit: 24 Southampton City Centre, Clinical Reference group (Dr Cathy Price)
   - Site Visit: 25 Adelaide Health Centre (Southampton), Western Community Hospital (Lorraine Favaretto)
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1. Executive Summary

As a result of the Inaugural 2010 Judith Meppem New South Wales (NSW) Nursing and Midwifery Overseas Travel Scholarship, I attended various Acute Pain Services and Chronic Pain outpatient centres in the Canada, Scotland, England and New Zealand. I was very interested in reviewing the various Models of Care for Pain Management, clinical services, resources and the possible transferability of these models to the Australian setting. I was also very interested in the diversity of various roles that nurses can provide in the acute care, outpatient setting, community and primary care in regards to Pain Management.

I have endeavoured to make the format of this report informative and interactive to enable direct links to source documents via the web where relative to the site visit overview and contact details of key people. As a summary at the end of each country I have also collated some extra links and resources to access. For those resources that I have been given in hardcopy or electronically that I mention at the end of site visit, I am happy for people to contact me via email with a request and I can forward to them.

1.1 Key Objectives

- Identification and review of nursing roles (Advanced Nursing Roles and Nurse Practitioner) in pain management for community, outpatient and acute care setting.
- Review of various pain management resources and community pain self management programs and outcomes in other pain centres.
- To identify pain management resources and guidelines for Primary Care sector eg) GP’s and Community Health to Acute Care
  - Assessment tools
  - Stratifying complexity
  - Referral guidelines
  - Treatment guidelines
  - Primary care management (individual and group, care plans, programs)
- Review Triage strategy and service delivery model that utilizes non-medical members of the pain management team that enables timely access to levels of care to determine a stratified approach to the patient’s level of need and thus a much
• Identification of potential partnership/collaboration opportunities.

1.2 Sites Visited

New Zealand
Auckland (7 days)
• Site 1: Waikato Hospital (Sue King)
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• Site Visit: 27 Waterbrook Medical Practice (Dr Mark Saville)
1.3 Background to Study Tour

I am a Pain Management Clinical Nurse Consultant with the Hunter Integrated Pain Service (HIPS) NSW, Australia [www.hnehealth.nsw.gov.au/pain](http://www.hnehealth.nsw.gov.au/pain). I have worked in all aspects of pain service delivery including inpatient, outpatient, procedural, research, aged care, community, health promotion, education, strategic planning, redesign and management. My key areas of interest at present are, Pain in the Emergency room for frequent presenters with pain, Pain in the older person, End of Life issues and Chronic Disease management. I have recently been involved in working as a project offer for Hunter New England Local Health District (HNELD) on developing an Integrated Persistent Pain Model (IPPM). This project is inclusive of the rural and remote areas, taking a lifespan approach from the community to tertiary sector.

I am a member on the Executive for the Agency for Clinical Innovation (ACI), NSW Pain Management Network and working parties to develop a NSW Pain Model of Care, NSW Pain Ministerial Taskforce, NSW State Director for the Australian Pain Society and Board member of Chronic Pain Australia, a consumer advocacy organisation for people with chronic pain.

After being awarded the Judith Meppem overseas travel scholarship, my goal was to travel overseas to New Zealand, Canada and the United Kingdom to look at some of the innovative work that was already being done in these various pain services. Of particular interest to me was the work these pain services and individuals had accomplished in various acute and community settings. I also wanted to focus on the contribution that nurses could have towards better pain management in clinical practice. The pain services and contacts I chose to visit were known for their innovation and redesign around pain services and were not the most internationally renowned centres. The other consideration was to look at countries that had a similar model of funding for health to Australia. I felt this would be more appropriate to consider the transferability aspects of these models of care to my pain unit at HIPS or other centres in NSW who had similar staffing, resources, demographics and geographic challenges.

1.4 Update on Pain

Pain is defined by the International Association for the Study of Pain (IASP 1994) as ‘an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage’. Pain that persists beyond the normal healing time of about 3 months and may even have no identifiable cause is known as chronic pain. Pain that is persistent with no clear explanation for its existence has the potential to affect all domains of an individual’s life. It can impact on their physical health, ability to mobilise, perform functions of daily living, psychological well-being where they may suffer from anxiety or depression, and the human factor with the impact this has on their family, friends and community.

Pain is one of the biggest health issues in Australia today and is as big a problem in health and costs as cancer, AIDS and coronary heart disease. Data compiled by Access Economics
(2007), quantified the cost of persistent pain in the Australian community to be $34.3 billion with productivity costs such as impacting on work performance and employment and burden of disease (cost of loss of well-being) being the largest components as both 34%, followed by health system costs at 20%. 3.2 Million Australians were estimated to have persistent pain 5. International research is now showing that the prevalence of pain has increased from 1 in 5 Australians to now 1 in 3 people as confirmed in Europe and the US in 2011 3,5,6,7.

Pain continues to be a significant public health issue both in Australia and internationally. It is predicted to be an even bigger problem over the next 25 years because of the ageing population and the associated increasing burden of painful pathology eg) Osteoarthritis and chronic conditions. Chronic pain and the impact it has on individuals is poorly understood by the general community and many health professionals despite much better education and research in this area over the last decade 3. It is very difficult for people with chronic pain to access effective evidence based pain management or community support for their chronic pain and this is compounded even more for those living in regional, rural and remote areas in Australia. With Australia being such a multicultural nation, there is even less understanding or research into pain management for the various ethnic groups or indigenous population. To address these issues, an inaugural Australian National Pain Summit was held in March 2010, to elevate awareness of the prevalence and economic cost of persistent pain to the community through the development of a National Pain Strategy. This strategy will be aligned with the Federal Government’s proposals for health reform to make more effective, cost-effective and accessible healthcare solutions available to all Australians.

People with chronic pain continue to present to various health care providers across the health care continuum. Their health care needs will are varied and often further complicated by multiple factors such as age, co-morbidities, poly-pharmacy and psychosocial issues. Treatment over the last 30 years has shifted from pure medical interventions to a bio psychosocial model. The Access Economics report in 2007 reports that, ‘a coordinated multidisciplinary approach is not only the most effective way of helping patients to manage their chronic pain, but it can also be the most cost-effective for more disabled chronic pain patients’ 5.

Part of effective management of patients with chronic pain involves developing the concept of pain as a chronic disease and need for interdisciplinary care at all levels 4. There needs to be strong coordination between Pain Management specialists working alongside GPs and other health professionals to initiate and support integrated primary care for patients with pain issues. This includes educating general practitioners and other community based healthcare providers in evidenced based pain management strategies utilizing a whole person approach. Patients also need to play an active role in their ongoing pain management. This can be achieved with support by various health professionals in the community and if applicable, participation in self-management programs with a cognitive behavioural (CBT) and preventative healthcare approach that can also include carer’s partners or family members. Implementation of these and other management strategies for
chronic pain patients, would most likely result in reduced health care costs, eg) repeated surgery, duplication of diagnostics, overuse of analgesic medications, excessive hospitalisations, multiple visits to varied allied health professionals and an improved quality of life for the individual and their family.

In countries such as New Zealand, Canada and the United Kingdom, chronic pain is recognised as a major health problem that has considerable impact individually, socially and economically 5,7,8,9,10. It is viewed as meeting the criteria to be a condition in its own right, rather than a symptom of other conditions 4. This is now also being heavily promoted both in Australia and abroad.

Internationally there has been great momentum in highlighting the importance of pain management as a ‘human right’ and to create guidelines for national strategies to help implement improved pain management worldwide and lobby governments to adequately fund and support pain management services. An inaugural International Pain Summit was held in September, 2010, in Montréal, Canada. It was an advocacy event with more than 260 pain specialists from 62 countries attending along with consumer, healthcare and government representatives. As a result of this event the ‘Declaration of Montréal, that Access to Pain Management Is a Fundamental Human Right was developed 11. This remains an ongoing declaration for people to sign up and support on the IASP website, http://www.iaspppain.org/Content/NavigationMenu/Advocacy/DeclarationofMontr233al/default.htm. It hopes to send a strong message for governments to recognise and support national pain initiatives and policy in various countries.

Post this summit and declaration, many countries such as Canada have initiated Province wide strategies eg) PainBC 9. Australia has the National Pain Strategy 3, and now in America they have recently released the Institute of Medicine (2011), Relieving Pain in America: A blueprint for transforming prevention, care, education and research 5. If these initiatives continue to be repeated in numerous other countries, then at last there is “Hope” for those who now “suffer” in silence.

1.5 Dissemination of Information

Sites chosen were pain services I knew well for their innovation and redesign around pain services. Many of the directors or leaders of these services were known as innovators in their practice. There may be some limitations to aspects of the services that I visited for review eg) timing of the year and weather (snow), availability of staff and days I attended clinics. Findings, conclusions and recommendations are therefore made on the information, resources and research available to me during these site visits and the personnel that I was able to speak with at the time. Therefore, in some instances there may be some bias in report to this regard but I have tried to remain as objective as possible as an observer to these sites. This scholarship allowed me to:

- Further review and consider other international Models of Care for Pain that initiate early assessment and treatment of pain in the community and acute care
setting to prevent chronicity for the NSW Pain Management Model and HIPS.

- Review of other diverse pain programs, referral pathways, processes, collaborations and partnerships with Non-government Organisations (NGO)’s to see if any aspects of overseas models are transferrable to NSW Pain Model or HIPS.
- Ongoing development and review of pain management resources for the Primary Care Sector eg) Triage Criteria, GP resources and pathways, treatment and practice guidelines, lifestyle and chronic condition self management programs and other various pain management related patient resources.
- Review and consideration of Nurse Practitioner and Advance Nurse Practice roles in Pain Management for HNELHD.
- Establishment of key collaborations with other pain centres with regards to future pain related research opportunities and resources.
- Dissemination of information of study tour via presentations, submissions for pain related projects/research or publications, has helped raise awareness of pain issues in the community and the nursing profile and opportunities in pain management.
- Report submitted to Chief Nurse and NSW Health for review and consideration re: Promotion of opportunities for nursing staff in the pain specialty, standardisation of pain management practice and research collaborations between Australian and other International Multidisciplinary Pain Centres and Services.
  


- Speaker as requested at various Pain, nursing or other healthcare conferences.

- Submission of an article to various clinical newsletters eg) NSW Nurses pain Interest Group, Australian Pain Society and Chronic Pain Australia e bulletin [http://www.chronicpainaustralia.org.au/](http://www.chronicpainaustralia.org.au/)

### 1.6 Findings

- Pain is not considered to be a very well supported speciality within many healthcare organisations and systems overseas, as is the case in Australia.

- Many pain nurses, especially in the Acute Pain Services (APS) were feeling very overwhelmed with the extra demand on their service and expertise due to the increasing workload in the acute care setting with regards to complex pain patients. Many felt very isolated from their colleagues in the chronic pain services as there were no formal pathways for them to access expert advice and support. All of these services were anaesthetic led and often the registrars on the round did not feel they had the knowledge or expertise to deal with these difficult pain patients and thus it
was usually left up to the nurse to coordinate care and management with other specialist teams. This process was very time consuming and led to some of these patients having extended periods of time in hospital.

- There is an aging workforce in the pain speciality both here and overseas.
- Lack of a career pathway and recognition for nurses in pain management. All senior nurses expressed how difficult it was get new nurses interested in the speciality and committed to do pain related activities in their “own time”.
- Whilst on my visits with senior nursing staff, we ended up having an informal ‘clinical support’ discussion with each other, of which we both did find some solace and validation. Many did not feel ‘valued’ by their organisation for their tireless efforts in developing pain services with limited resources over many years.
- Patient care journey is enhanced by the coordinating skills of nurses on the pain management team. Nurses provide unique skills and knowledge and assist patients in pain education and management strategies eg) appropriate use of opioids, self-management and non pharmacological strategies for pain.
- In all sites, nursing staff provided strong leadership and communication skills with patients and multidisciplinary team members.
- All Chronic pain services visited supported an interdisciplinary team approach with collaborative decision making amongst all team members with client centred goals as the focus and promotion of self management.
- Many assessments and treatments in chronic pain services are not delivered by one professional at a time eg) joint session of a physiotherapist and medical officer for patient assessment. This reduces duplication, re-telling of patient story/history, freeing up of clinicians time and increase throughput in clinic and thus reduce waiting lists for access to service.
- Limited capability of research and data collection in pain management and consensus on outcome measurements for pain services and interventions.
- Collaboration with Chronic Disease services and utilization of existing resources especially in primary and community care.
- There was validation that the model of care that has been developed in HIPS is very transferrable to other regions. Much of the findings overseas will allow further development of this current model.

1.7 Conclusion and Recommendations

- Development of support network for nurses within NSW in the pain specialty such as “Clinical Supervision” which could be financially supported and recognised by NSW health. This would encourage nurses to feel “valued” and well supported to continue their difficult practice in pain management and also prevent “burnout” and recruitment and retention issues.
- Inclusion of more pain management education in undergraduate and postgraduate nursing education and other healthcare disciplines.
- Encourage better networks and links for nurses working in acute pain or inpatient
services to access chronic and complex pain advice through chronic pain clinics in new model of care for NSW.

- Promote and support pain education/research for APS medical and nursing staff regarding complex and chronic pain assessment and management. This could be facilitated by mentorship with chronic pain specialists on acute rounds on a regular basis or availability of a consultative service eg) Phone advice line.
- Promotion of future career opportunities for nurses in general practice as a professional development pathways for pain management eg) Practice nurse roles with pain as sub specialty and development of pain competencies
- Promotion of more nursing roles at all stages of patient continuum of care for pain management including in chronic disease management and pathways eg) Early intervention and education in general practice, assessment and management
- Promotion of innovation in pain practice that is recognised and supported through various healthcare forums. This will promote dissemination of information, encourage collaboration, sharing of resources and stop people having to “re-invent the wheel” eg) ARCHI [http://www.archi.net.au/home](http://www.archi.net.au/home)
- Confirmed need for an Interdisciplinary team model of care in pain management services rather than a Multidisciplinary model where nurses play a pivotal role in the care coordination of the patient journey.
- To support other healthcare professionals, Multidisciplinary Pain Centres need to take on an expert consultative and educational role to support the primary and community sector for pain management issues.
- Collaboration with Chronic Disease services and utilization of existing resources especially in primary care and community.
- Pain Model of Care for NSW must have a framework of integration between primary and tertiary care that is comprehensive and coordinated with regards to pain management service delivery and incorporates a lifespan approach eg) Paediatrics, Elderly and other specialty groups. This would include early assessment and management of acute pain that is evidenced based to prevent progression to chronic pain and ongoing disability.
- Review of current pathways in multidisciplinary pain services eg) Early pain education, dual patient assessments and non medical triage eg) nurse and physiotherapists depending on resources.
- Standardised pain outcome measures for patient interventions for pain management across the care continuum. This will enable further comprehensive research into best practice for pain management.
- Multi-centred trials and collaborations for Pain in ED project
- Review of clinical and community pharmacists role in pain clinics and acute care
- Allocation of resources to support data collection and data management to inform future developments in pain practice eg)evaluation, research and funding
- Priority of recurrent funding into consumer focus and clinical research in pain and its management that is supported by government and community.
1.8 References:

- Stollznow Research for Pfizer Australia; Pfizer health report issue 46, Chronic Pain April 2010, Sydney.
- Institute of Medicine (2011) Relieving Pain in America: A blueprint for transforming prevention, care, education and research, the National Academies Press, Washington, D.C.
- NHS Quality Improvement Scotland (2006), Best Practice Statement: Management of chronic pain in adults
SITES VISITED NEW ZEALAND (1st August-10th August 2010)

- Hamilton Hospital (Sue King NP Acute Pain: 2/8/10)
- Palmerston North Hospital (Judy Leader NP Pain Management: 3/4/5/ 8/10)
- Wellington Hospital (Julie Barton CNS Acute Pain & Kathy Clarke: 6/8/10)
- Auckland Hospital (Kate McCallum CNS TARPS: 9/8/10)

Site 1: Waikato Hospital, Hamilton, New Zealand
Date: Monday 2nd August, 2010
Facility: Waikato Hospital, NZ
Address: Pembroke Street HAMILTON 3240
Phone: (07) 839 8899
Contact: Sue King, Nurse Practitioner Pain Management Inpatient Pain Services
Email: sue.king@waikatodhb.health.nz

Figure 1: Waikato Hospital, Hamilton

Waikato Hospital (Figure 1) is a major 600 bed regional hospital and is the main trauma facility for the area in Hamilton, New Zealand. It is the single largest health care provider in the District health Board (DHB). It provides specialised and emergency healthcare for the Midlands and Waikato area and covers eight percent of New Zealand. Waikato DHB covers a regional population of more than 860,000.

Waikato District Health Board has a larger proportion of people living in high deprivation. The Maori population is estimated to be 21.4% and of this, Pacific island people are 2.4% and growing. Both groups tend to have a high representation in adverse health conditions especially diabetes and cardiovascular disease. Furthermore, the Waikato population is getting proportionately older with people 65 years and older, projected to increase by more than 78 per cent by 2026. With this increase in the older age group and the consequent increase in chronic and complex health conditions seems to define many of the strategies Waikato DHB is putting in place to meet future health needs.

http://www.waikatodhb.govt.nz/

Staff Contact during visit:
- Sue King Nurse Practitioner Inpatient Pain Service (IPS)
- Dr Chris Jephcott, Anaesthetist and Director (IPS)
- Bronnie Pester, CNS (IPS)
- Jeannette Shennan, Clinical Psychologist Chronic Pain Clinic
I met and stayed with Sue King in her home near Hamilton. Sue was the first pain nurse practitioner in New Zealand (NZ) who is also able to prescribe medication on her own to patients experiencing pain problems in the Waikato Hospital. Sue has been nursing for over 33 years and in the acute pain service since its inception in 1995. She is passionate about pain management and nursing professional development.

As in Australia and overseas, Nurse Practitioners (NP), are expert nurses who work within a specific area of practice incorporating advanced knowledge and skills. They practice both independently and in collaboration with other health care professionals to promote health, prevent disease, diagnose, assess and manage people’s health needs. In order for Sue to have been certified as an NP, she needed advanced understanding and skills in Pain Management and Pharmacology. NP candidates in NZ must submit a portfolio of evidence (Sue’s portfolio was 272 pages) of their clinical practice and complete six competencies related to their specialty. This presentation is to a panel of a doctor and nurse in the pain field, nurse educator, nurse manager and a representative from the nursing council.

Sue attends the daily Acute Inpatient Pain Rounds (IPS) with medical officers but is able to prescribe some medications on her own if necessary. There are some limitations though as she can only prescribe anti-emetics, laxatives and some analgesics used to relieve pain eg) List of authorized medications for practice. The junior doctors and anaesthetic registrars rotated through IPS, will also seek her advice or recommendations for pain management prescribing so this is a training and education bonus to the hospital.

**Acute Pain management (IPS)**

Early in 2010 the Waikato Hospital Anaesthetic Department re-branded the Acute Pain Service (APS,) the Inpatient Pain Service (IPS). An anaesthetist only led Paediatric Pain Service contributes to the inpatient acute pain management requirements of children and one of the sub-specialty obstetric anaesthetists provides a consultative service for women with pain related to pregnancy. It provides the following; multimodal analgesia eg)PCA, epidurals,ketamine infusions, neuraxial and peripheral nerve sheath blockade.it also offers assistance with sedation related to painful burns and VAC dressings.
The medical staffing is a Specialist Pain Anaesthetist Monday to Friday with general anaesthetic roster cover Saturday and Sunday. An Anaesthetic Registrar is rostered for the morning pain round. There is also a 1.0fte Nurse Practitioner (Sue King) and a Clinical Nurse Consultant 0.4fte. Average numbers of patients per day is 20-25 ranging in complexity.

**Current challenges in the acute care setting:**
- Increased numbers of referrals, changes in demographic with older patients and co-morbidities and complexity.
- Increase in care and length of time on service needed for complex patients with limited input from chronic pain team.
- Chronic pain adult inpatients are often complex in terms of their co-morbidities, including age, concurrent disease processes, multiple drugs therapies and physiological impairments. As well, their complexity they may have underlying psychology, challenges with pain diagnosis, treatment, drug related dependency issues and high utilisation of health care resources in both the community and hospital setting.
- Frequent emergency department presentations and prolonged transit times lack of integrated assessment and coordination of care, multiple teams unnecessary investigations and interventions and difficulties discharging patients once admitted to acute care setting.
- Acute and Chronic Pain service but **not** integrated
- At present areas poorly served include persistent pain management in children, adolescents, and pain in the elderly person.

**Procedural Pain Management**
- One session a fortnight is available for interventional pain management eg) diagnostic interventions/blocks, epidural steroid injections and implantation and refills of intrathecal pumps.
- Cancer procedures eg) coeliac plexus block, insertion of epidural or intrathecal catheters for the management of intractable cancer pain.

**Chronic Pain Service Outpatients**
The chronic pain service (CPS) sees outpatients and holds contracts for interventional pain management and for psychological services by the ACC (Accident and the Compensation Corporation). The ACC is a unique body providing comprehensive no- fault personal injury cover for all New Zealand residents and visitors to New Zealand including all accidents including those occurring at work, whilst traveling and at home. [http://www.acc.co.nz/](http://www.acc.co.nz/)
Approximately 50% of the chronic pain work is for ACC claimants and is compensable. There are some services offered in the community but these remain somewhat fragmented and there is scope for the DHB to better coordinate ACC funded pain services. For non-ACC patients in the Midland Region access to pain services or education for self-management of their pain is more difficult and the current service is very under resourced. Ultimately
inadequate chronic pain management results in unnecessary acute episodes, increased consultations and admissions to hospital with possible longer hospital stays. Approximately 250 new outpatients are seen per year, with over 50% being referred from General Practitioners. When I was visiting there was at least a 6 month waiting list to be seen and in all likelihood, many patients would be unable to access the service at all.

Current Staff:
Physician 0.6FTE
Psychologist 1.0FTE (shared by 2 Clinical Psychologists 0.8)
Clerical 0.8FTE
Physiotherapist 0.3FTE (general physiotherapy budget)
Nursing (No dedicated nursing FTE, NP role coordinate between services)

Current challenges in Chronic Pain Outpatient setting:
- Inadequate staffing resources for service demand
- Facilities limited eg) outpatient clinic and program, meeting space
- Long waiting list for pain program

Sue is very active and involved in many pain related project and clinical research and has generously discussed these projects in detail and provided me with electronic copies and templates of this work where possible.

- **Risk Assessment Quality Improvement Project**: To determine if a risk assessment tool could identify those patients at risk of severe postoperative pain who then went on to develop chronic post-surgical pain.
- **Hospital Discharge communication**: Development of better communication strategy with patient’s pain management plan post hospitalisation to patient and GPs in the primary healthcare sector.
- **Staff pain management education and certification**: Redeveloped into E-learning format and workshops for pain management
- **Pain Catastrophising study**: Prediction of severity of postoperative pain, analgesic use and transition from acute to chronic post-surgical pain. This is a large study proposed over multiple sites.
- **Growing case management for complex pain patients**: NP role has allowed more comprehensive care coordination and development of management plans for complex pain inpatients which is undergoing review process.
- **IPS referral form**: Enables better communication and data collection for service.

Challenges for NP Pain Management:
NP position was made out of existing Clinical Nurse Specialist (CNS) funding and thus no real increase in nursing resource. Sue has had to continue to juggle the CNS role responsibilities alongside the newly created NP role responsibilities and growing demands of the inpatient pain service. There is undoubtedly a certain amount of overlap between the NP and CNS roles. This creates challenges for the service in terms of succession planning and moving
forward with service delivery and innovation. Sue outlined further the issues for her as an NP in Pain Management.

**Positives:**
- Being able to prescribe: A challenge because you actually appreciate the complexities associated with making decisions about therapeutics.
- Growing case management: Rewarding aspect of her role and is accompanied by ability to work independently to co-ordinate the most appropriate management. It usually occurs in a collaborative way, however key to success is the negotiation and critical liaison between other healthcare professionals and specialist teams.

**Negatives:**
- Lack of sufficient nursing resource in pain that are unwilling or unable to fully contribute to picking up more responsibilities for the service.
- Lack of recognition/value, work overload and expectations of the NP role as a senior nursing leadership position.

**Key Outcomes and Benefits:**
Sue Visited HIPS earlier this year: Post visit Collaborations:

- Pain in the ED “Frequent Presenters” project. I shared all of this information and resources with Sue. She is now trying to implement this model in Waikato Hospital ED for the complex pain patients. (Appendix 2: Pain in the ED Poster) [http://www.archi.net.au/documents/our-services/innovations/pain-in-ed.pdf](http://www.archi.net.au/documents/our-services/innovations/pain-in-ed.pdf)
- Persistent Pain Flags Doc (HIPS Document)
- National Knowledge and Skills Framework for Pain Management Nursing. This template has enabled modification in HIPS workplace for pain nurses. (HIPS Document)
- Sue and I continue to email each with latest information, resources and pain project opportunities.

**Resources Received:**

- Inpatient Pain Service- A Discussion Paper Waikato Hospital May 2011
- Consultation document: Specialty Standards Endorsement: National Nursing Consortium
- Medicines (Designated Prescriber: Nurse Practitioners) Regulations2005 (SR 2005/266)
- Sue King NP “List of ‘P’ drugs for prescribing” document
- The National Knowledge and Skills Framework for Pain Management Nursing: Draft Document from New Zealand (Figure 4)
Proposal for a Nurse Practitioner in Pain Management at Waikato Hospital June/July 2007
- NP in Pain Management Statement of duties
- CNS Pain Management Statement of duties
- Templates and electronic information for IPS

National Knowledge and Skills Framework for Pain Management Nursing

Figure 4: Pain Management Draft National Knowledge framework for Pain Management Draft (March 2010)
Site 2: Palmerston North Hospital, New Zealand
Date: Tuesday 3rd, Wed 4th, Thursday 5th August, 2010
Facility: Palmerston North Hospital, NZ
Address: 50 Ruahine Street, Palmerston North 4414 NZ
Contact: Judy Leader, Nurse Practitioner Pain Management
Phone: 64 63569169 Pager 142
Email: judy.leader@midcentral.co.nz
http://www.midcentraldhb.govt.nz

Figure 5: Palmerston North Hospital

The base regional hospital in Palmerston North (Figure 5,) has a dedicated Intensive Care, Coronary Care and Neonatal Unit along with other specialist services. It provides one of the largest trauma centres in New Zealand (NZ). Population is approximately 158,838 with a median age of 34.6 years. Of this, 15% are Maori, 2% Pacific, 3% Asian, and 76% European and 4% other ethnicities. MidCentral District health Board (DHB) stretches across the North Island of New Zealand from the west to the east coast.

In NZ there is marked socioeconomic disadvantage and greater health needs for the Maori and Pacific ethnic groups. These groups have consistently poorer health outcomes in comparison with the rest of the population. This is similar to Australia’s indigenous population. Therefore many actions to improve Māori health is supported by better health programs in MidCentral DHB eg) Māori Health Action Plan.
http://www.midcentraldhb.govt.nz

Staff Contact during visit:

- Judy Leader Nurse Practitioner Pain Management
- Community and Primary Care team for Chronic Illness
- Acute Pain Service Staff
- Emergency department specialist staff
- Senior Nursing Management (Chiquita Hansen and Sue Woods)
**Judy Leader** is a Nurse Practitioner Pain Management in MidCentral DHB, Palmerston North. Her daily practice involves working with individuals experiencing pain in multiple settings from the acute post-operative hospital ward, primary health care, outpatient clinics, residential care setting, hospice or will visit the patient in their home if necessary. Judy performs a comprehensive nursing assessment and is responsible for the identification and coordination of appropriate multidisciplinary team members in order to develop a management plan for the patient in pain. This may include a balance of both pharmacological and non-pharmacological interventions. Her care coordination role is to monitor progress, evaluate efficacy of interventions and to further collaborate with identified team members as required, reviewing and amending the individual’s pain management care plan as required.

Judy did not apply for prescribing rights as an NP but although not prescribing, reduction and rationalisation of analgesia is a key component of her practice. Whilst working alongside prescribers she takes every opportunity to educate others, share resources and encourage contemporary evidence based pain management practice. Judy is the Immediate Past President of the New Zealand Pain Society and continues to take every opportunity to promote pain management nursing opportunities.

My relationship with Judy evolved from us meeting at international Pain Conferences. I had spoken to Judy and was very interested in the diversity of the Pain NP role in NZ and how this could relate to the current practice in NSW and other states in Australia. MidCentral DHB was known for being innovative, especially around nursing leadership and had great frameworks for skills and knowledge in various disciplines. It was from here that the idea and planning to visit NZ pain centres/ sites and meet with other pain nurses in various clinic settings began. Judy was instrumental in giving me the NZ pain nurse contacts to correspond with and organise some of the site visits for my scholarship. She also generously opened her home to me and I stayed with her and her family for my visit.

Part of my visit to MidCentral DHB included meeting with district nurses (known in NSW as Community Nurses), Emergency Department (ED) staff, visiting the diabetes lifestyle centre and Primary Health Organisation management centre and team. I also had the opportunity
to deliver a presentation to Senior Nurse Management (Sue Woods) in the acute hospital setting and sit in on a divisional nurse management meeting.

In her NP role, Judy practices across the health care continuum in MidCentral DHB. Figure 8 outlines her practice across the care continuum for pain management. In NZ, their health services are funded by the Ministry of Health (MOH). There is unique funding to acute and primary care. In order to appreciate Judy’s practice, here is an overview of how Primary Care Organisations (PHO) operates within health system.

Figure 8: Nurse Practitioner Pain Management across Care Continuum

Primary Health Organisations (PHO)’s are not-for-profit bodies funded by DHBs for the provision of a set of essential primary health care services. They include General Practice (GP) which covers a broad range of health and preventative services including health education, counselling, disease prevention and screening or local health clinics around the needs of a defined group of people. GP services need to be well linked with other primary health services eg) Allied Health to ensure continuity of care. DHBs work through PHO’s who manage and deliver services in the community. www.moh.govt.nz/primaryhealthcare

The PHO key roles are:

- Work with local communities and enrolled populations
- Identify and remove health inequalities
- Access to comprehensive services to improve, maintain and restore people’s health
Co-ordinate care across service areas and care continuum

Central PHO’s are responsible for a range of other specialised services such as diabetes specialist nursing, chronic care teams, local health promotion and services to improve access.

Figure 9: Logo for Primary Health Organisation (PHO)

Chiquita Hansen was the Director of Nursing (DON) Primary Health Care (PHC), MidCentral DHB. She was the lead on the PHC Nursing Development Team and involved in all the activities of the PHC Nursing Clinical Governance Council. She is very committed to the development of PHC nursing professional practice and plays a pivotal role in assisting primary health care nurses to maximise their unique contribution to the health outcomes of individuals, families, Maori and ethnic group population.

I was very inspired and spent a few hours going over many of her Community and Nursing programs and strategic health planning documents for MidCentral DHB and the PHO. Some of these are noted in the resource section later and the sharing and collaborative culture is fostered in this DHB as noted by their logo above (Figure 9). Chiquita’s management responsibility covers the Nursing Clinical Governance Council (CGC) which covers 14 areas of nursing practice across the community from practice nurses to public health (Figure 10) eg) cardiology, pain, diabetes, wound, primary care and elder health. This Professional Development pathway has been heavily invested in the work of the PHO and CGC and organised within the following PHC Nursing Professional Practice Model made up of three components:

- Education And Research
- Clinical Practice
- Nursing Leadership And Collaborative Practice

Contact: Debbie Davis RN Nurse Coordinator Practice and Health Care Development
Email: debbie.davies@midcentraldhb.govt.nz
**Helen Snell** is a Nurse Practitioner in Diabetes and related conditions across the Lifespan that I met. She was instrumental in the National Diabetes Nursing Knowledge and Skills Framework (NDNKSF) (Figure 11). It was specifically developed to assist all registered nurses to demonstrate that they are adequately prepared to provide the required care and education for the person with diabetes and related comorbidities, whatever their practice setting. It is linked with other national guidelines, standards of practice and the Nursing Council of New Zealand’s competencies for registration. In New Zealand Registered Nurses are required to demonstrate their competence within the requirements of their practising certificate. The Pain Nurses in NZ have drafted a similar one for Pain Management nurses (Figure 4). The HIPS nursing team have modified this document for the Australian nursing context and current nursing pain practice within HIPS with their permission and idea to standardise Pain Nursing practice between NZ and Australia and further collaboration. This framework document can be sourced from HIPS on request.

Contact: Helen Snell NP Diabetes Lifestyle Centre Email: helen.snell@midcentral.co.nz
Another of my site visits was to the Emergency Department, Palmerston North Hospital. Here I met Dina Cole (Figure 12), Clinical Nurse Specialist Intellectual Disability & Restraint Coordinator.

Internationally the assessment of pain in people with intellectual disability has been identified as a very difficult area leading to major health disparities for this pain cohort. Dina works closely with people with intellectual disabilities, family, carers and healthcare professionals. She has developed a fabulous resource Figure 13: Pain Assessment in People With Intellectual Disability charts which she has given me as a resource. She also discussed the issues and difficulties that are frequently experienced by health professionals and the education, processes and systems that are currently being implemented at MidCentral DHB in an attempt to minimise some barriers. She plays a pivotal role in pre-operative education and in the Emergency Department.

Contact: Email: dina.cole@midcentral.co.nz

I also met with the Emergency Department (ED), staff and was presented with two examples of District Nurse Led approaches to care. First one was the Post Emergency...
Department Assessment and Liaison (PEDAL) Team which is related to an Avoidable Admissions Project. It is managed by MidCentral Health (MCH) District Nursing Service (DNS). It is an assessment and liaison service provided by a dedicated Social Worker and Community Registered Nurse within the Palmerston North Hospital ED with anyone over the age of 16 years. Goal is to improve health outcomes for ‘at risk’ people attending the ED by supporting them to safely and effectively recover at home after discharge by:

- Facilitated holistic and comprehensive multidisciplinary team assessment
- Highlighting patients requiring additional assessment and/or management
- Providing advice re options and planning for community care or advocating for admission if necessary
- Collaborate with the patient’s PHC and secondary care team in order to develop and implement a support package that will enable them to both recover, and remain well within the community and as independent as possible
- Remaining available for 24-48 post discharge with a home visit as required

The PEDAL team gave me access to all their reports, presentations and outcomes of this project. I was able extrapolate some of this information to help inform the model of care for the Pain in the ED project at John Hunter Emergency Department (appendix 2)

Another interesting project in this ED was the General Practitioner Assessment and Liaison (GPAL) program which was an extension of the PEDAL program. This was a new and innovative approach with General Practice Teams (GPTs).

Goals of team:
- Reduce acute demand on ED and Hospital services
- Provide GPTs with access to a rapidly responsive and home based health recovery package for their ‘at risk’ patients, without need to refer patient to ED eg) Frail elderly with pneumonia or gastroenteritis
- 24 /7 advanced district nursing assessment and monitoring of the patient’s health states and level of recovery
- Avoid a hospital admission as it poses significant risk for the frail elderly eg) Falls

Contact Denise White, Clinical Nurse Specialist Community Midcentral Health: denise.white@midcentral.co.nz

Acute Pain Service (APS)
I did not actually go on an Acute pain round but met the nursing staff and discussed issues. Acute Pain Service (APS) is an anaesthetist led service with CNS nurse support. It provides multimodal analgesia eg) PCA, epidurals ketamine infusions, peripheral nerve infusions etc. Staffing and challenges are very similar to other APS service at Waikato, Wellington and Auckland Hospitals (Site Visit 1, 3, 5). I met with some of the Clinical Nurse Specialists who perform the daily pain rounds. APS rounds can average 25-30 patients a day. Again there are an increase number of complex patients for which Judy as the NP will be called in to
assist the staff with the pain plan for this patient.

There was also an issue about after hours APS support for post-operative pain patients. Medical staff were usually caught up in theatres and unable to meet demand for pain issues on the ward in a timely way. An ‘APS Needs Survey’ was developed and disseminated to the wards and clinical staff. It provided the evidence required to build a business case for hospital management to approve changes and stagger APS shifts during the day. There is now at least an hour handover time for APS staff to perform education, follow up reviews from morning round and provide APS cover to the hospital till at least 8pm. This has been very successful and the ward staff now feel well supported and everyone is happy with these changes including APS staff. Judy provided me with this survey and information around this process.

Shared Resources and Collaborations:

- Set up a ‘Sister’ type relationship with (HIPS) to utilise an opportunity for developing a network for colleagues eg) Information sharing/research thus a signed Memorandum of Understanding between MidCentral DHB and Hunter Integrated Pain Service (HIPS)
- Explore NP’s models of practice and how we link in NSW
- Maori Assessment tools (Figure 14)
- Acute Services, Palliative/Hospice, Older Person and Primary Care.
- Collaborations with NZ Pain Society and Australian Pain Nurses
- Articles awaiting publication Hayes C, Hodson FJ. A whole person model of care for persistent pain: from conceptual framework to integrated application. Accepted 2011 to Pain Medicine
- Retrospective 13 year study on our Intrathecal patients at HIPS: Hayes C, Jordan, M. & Hodson FJ. "Ceasing established intrathecal therapy in persistent non-cancer pain: a review of 13 years experience with implanted drug delivery systems" (For submitted to Pain Medicine)
Resources Received:

- **Nursing Clinical Governance Council (CGC) Annual Report 23 June 2010.**
  This collective report provides an overview of the diversity and breadth of work being undertaken in the primary health care (PHC) nursing field, demonstrating how nurses support and improve health across the continuum of wellbeing. It also discusses the links between Occupational Health and Public Health and future project work. It outlines the partnership on CGC between General Practice and Maori Health created opportunities for further information sharing and understanding of programs.

- **NDPD (Nursing Practice Development Program) Health Promotion Module** aimed at practice nurses, disease state management nurses, occupational health nurses.

- **Consultation on the registered nurse scope of practice under the Health Practitioners Competence Assurance Act (2003) (Expanded practice)**

- **Newspaper media Australian Clinical Nurse Consultant Inspired by Palmerston North Hospital (Judy leader and Fiona Hodson article)**

- **The Use of Intermediary Care for Managing Acute Demand. Examples of Two District Nursing Led Approaches Post Emergency Department Assessment and Liaison (Pedal) and General Practitioner Assessment and Liaison (GPAL) September 2009.** Denise White, Clinical Nurse Specialist Community, MidCentral Health

- **The Interventional Pain Management (IPM) guidance:** Evidence based recommendations on a wide range of procedures to help practitioners and patients make informed decisions. [http://www.acc.co.nz/for-providers/clinical-best-practice/interventional-pain-management/index.htm](http://www.acc.co.nz/for-providers/clinical-best-practice/interventional-pain-management/index.htm) Judy Leader was on working party for their development.

- **Powerpoint presentations:** Judy Leader NP: House Clinicians APS, Pain in the Elderly, Multidisciplinary Community Pain Clinic Proposal 2004, NP in NZ, Pain, Suffering & Primary Health Care - What we can do, Caring for people with pain over time; Maximising resources, Long Term Conditions Wellness Model (Community Model), Clinical Reasoning Process:

- **Resources for Intelectually disabled Assessment Tool:** Dina Cole

- **Study:** To determine Carbon dioxide (CO$_2$), instead of air, insufflated during colonoscopy reduces pain experienced by patients post colonoscopy: Anne Cleland 2009, MidCentral Health.

- **APS Needs Survey, Outcomes and briefing document**

- **NP in Pain Management Statement of duties**

- **CNS Pain Management Statement of duties**

- **Templates and electronic information related to service and pain**
Site 3: Wellington Hospital, New Zealand
Date: Friday 6th August, 2010
Facility: Wellington Hospital
Address: Riddiford Street WELLINGTON SOUTH 6021
Contact: Julie Barton (APS CNS) and Kathy Clarke Clinical Nurse (Chronic Pain CNS)
Tel (04) 385 5999 Ext 6026
Email: Julie.Barton@ccdhb.org.nz
http://www.ccdhb.org.nz/

Wellington Regional Hospital (Figure 15) is the largest facility operated by Capital & Coast C&C District Health Board (DHB). It is one of five major tertiary hospitals in New Zealand. This hospital provides a comprehensive range of specialist secondary and regional tertiary services for a population of about 900,000 people. Tertiary services include cardiology, neurosurgery, vascular surgery, renal medicine and transplants, oncology, paediatric surgery, obstetrics and rehabilitation. It also has the region’s main emergency and only trauma service with a rooftop helipad for specialist surgical, intensive care, neonatal intensive care. Wellington Hospital is also the tertiary referral centre for the lower half of the North Island and the upper half of the South Island. In addition to hospital-based services, multi-disciplinary services are provided in the community. These include general and specialist district nursing, specialist multi-disciplinary rehabilitation services, occupational therapy, speech language therapy, physiotherapy, dietetics, social work and home support services. Mental health, alcohol and drug services are also provided in the community: http://www.ccdhb.org.nz/

Staff Contact during visit:

- Julie Barton: CNS Acute Pain Service
- Dr Paul Hardy: Chronic Pain Medical Director
Kathy Clarke: Clinical Nurse Specialist Chronic Pain
Maria Polaczuk: Occupational Therapist: Chronic Pain

Acute Pain Service (APS)

I did not actually go on an Acute pain round but met the staff and discussed issues. Acute Pain Service (APS) is an anaesthetist led service with CNS nurses support. It provides multimodal analgesia eg) PCA (Figure 16), epidurals, ketamine infusions etc. Staffing and challenges are very similar to the IPS service at other Acute NZ hospitals eg) Visit 1,2 & 5. I met with Julie Barton who is the Clinical Nurse Specialist and Manager of this service (Figure 17). Average numbers of patients per day is approximately 30-40 patients, of which probably 5, would be defined as having complex pain and/or health issues. Many acute post-operative patients also have a chronic pain history and this may certainly complicate their pain management. There has been a significant increase in patient numbers, complexity and Pain frequent presenters to ED. Continuing pain education and audits are usually performed in the afternoon by nursing staff on a regular basis.

Current challenges in the acute care setting:

- A lot of resources have recently gone into educating medical and nursing teams on the wards to manage basic pain more effectively, confidently and autonomously. The APS team has been actively encouraging clinical staff to ‘take over’ care of their own patients, especially those with a PCA pump (Figure 17) who are stable post operatively. (Source: PCA http://www.smiths-medical.com/catalog/ambulatory-pumps-sets/cadd-ambulatory-infusion-pumps/cadd-solis/cadd-solis-ambulatory-infusion.html)
- Education and support has been very time consuming for nursing staff but the development of an algorithm for discontinuing PCA and asking staff to prescribe analgesia or other alternatives has been difficult. Many still continue to call the APS team despite the investment in this area. Work is currently underway for the updating of an on line Preferred Medicines List for the two DHBs in Wellington. This also will have information on acute, chronic and palliative pain management.
- Data and audit collection has been ongoing to try and enhance their chronic pain cover eg) Proposal for weekend anaesthetic cover for APS to cover complex pain patients and ensure appropriate follow up care is performed.
- Acute and Chronic Pain service on same hospital site but there is limited integration between clinical staff in each team, mostly due to workload and resources.
- Julie is also the clinical nurse and also does management for the APS as well. At times this can take her away from the clinical needs of the service. This role is required though to ensure that data collection and QA is performed and organisational lines of responsibility for the organisation are adhered too.
Chronic Pain Service  Outpatients

Wellington Regional Pain Evaluation and Rehabilitation, Services Level K Wards Support Block, Riddiford St, Newtown, Riddiford Street WELLINGTON SOUTH 6021
Phone (04) 385 5344 Ext 6026
Contact: Dr Paul Hardy (Director) & Kathy Clarke Clinical Nurse (Chronic Pain CNS)
Email: paul.hardy@ccdhb.org.nz

The Wellington Region Pain Management service provides a comprehensive evaluation and rehabilitation service. Access to the service is via a referral from a specialist, GP or health professional. The goal is pain management rather than medical cure. This hopefully achieved through patient education of effective coping strategies, appropriate use of medication, facilitation of physical and emotional well-being that will enable patients to return to a healthy and functional role in the community where possible.

Multidisciplinary team members includes:

- Clinical Psychologist
- Doctors
- Occupational Therapists
- Physiotherapists
- Specialist Nurses

Dr Paul Hardy is the Clinical Leader for Pain (Acute and Chronic Pain) at Wellington Hospital. The Chronic Pain Service has been working more closely with primary care regarding pain management and referrals. They were very interested in the HIPS Screening Questionnaire, available at: [www.hnehealth.nsw.gov.au/pain](http://www.hnehealth.nsw.gov.au/pain)  They would like to work more closely with other pain clinics in NZ and Australia to standardise outcome measurements for pain clinics.
I met with Clinical Nurse Specialist Pain, Kathy Clarke who has subsequently left this service and is working in primary care. Kathy still has a keen interest in pain management but did express at the time of the visit that she had little support from hospital management regarding the needs of the service and resources. She also felt that it was hard to get legitimacy as the Nurse Manager and Clinical Nurse in an already established service. The fact that she was the only nurse in the Chronic Pain Service as well contributed to her feeling of isolation. Unfortunately the Acute Pain staff did not seem to show a lot of interest in chronic pain and were happy to delegate difficult chronic pain patients to her whenever possible. This was becoming an overwhelming task on top of her already full workload and responsibilities. She and other staff also outlined the issues around long waiting lists for assessment and programs and the ongoing frustrations for patients and staff.

Some interesting ideas in this clinic were the “Arts and Pain” program which was run by the Occupational Therapist Maria Polaczuk in the clinic. She is very happy for people to contact her regarding the program she runs in Wellington.

Areas of interest and Collaboration:

- Dr Paul Hardy has expressed an interest in visiting the HIPS service in the future with some nursing and other pain staff
- Interest in outcomes, Questionnaire, Primary care, Education
- HIPS Model of Care and resources. (Appendix 1: HIPS Model of Care)  
- Julie Barton, ongoing email exchange of resources
- Pain in the ED Frequent Presenters (Appendix: 2 Pain in the ED Poster)  
The Auckland Regional Pain Service (TARPS), is located in Building 7 of the Greenlane Clinical complex (Figure 18), which has outpatient services and day stay surgery in the Centre. It is part of the Auckland District Health Board (ADHB). TARPS clinic has been located here since 1996 and is a short distance from the main Auckland Acute Hospital site. There is a dedicated free bus service traveling from the centre of Auckland to all 3 hospitals and linked buses.

TARPS were established in 1990 and have grown enormously since then to the multidisciplinary pain services and programs it provides today. It is a specialist tertiary regional hospital based multidisciplinary service that provides acute and chronic pain management to the people of Auckland and the surrounding regions of Mankau and Waitemata. TARPS consist of an outpatient services that includes clinical assessment and management of acute and chronic pain by utilising a multidisciplinary approach to pain management. The TARPS team includes medical specialists from Anaesthetics, Rheumatology and Postgraduate Trainees (Registrars) in Rheumatology and Pain Fellows, Psychiatry, Otolaryngologist, Clinical Nurse Specialist and Allied Health staff, Occupational Therapist, Social Worker, Physiotherapists, Psychologists. [http://www.adhb.govt.nz/](http://www.adhb.govt.nz/)

TARPS have developed clear referral, review and discharge criteria for patients with chronic pain to their service. It is also expected that all specialist consultation and medical work up
has been completed in primary care prior to referral to TARPS. Once a referral is received to TARPS service, it will be assessed to determine its urgency and then the administration staff will send the patient a screening questionnaire for completion. Only when both referral letter and screening questionnaire is received will the medical team perform a second triage to ensure the patient is referred to the most appropriate clinical discipline or team members to address their pain issues and their appointment for assessment is made. This could be a single appointment for example a medical only if assessment for a possible procedural intervention or the need for a more comprehensive multidisciplinary approach which could include a psychosocial and physical assessment with a physiotherapist and psychologist. Assessments and subsequent treatment will be determined at the multidisciplinary team at lunchtime meeting. TARPS will then work collaboratively with the referring general practitioner or specialist team and the patient.

TARPS holds contracts with Accident and the Compensation Corporation (ACC) [http://www.acc.co.nz/](http://www.acc.co.nz/). The ACC is a unique body providing comprehensive no-fault personal injury cover for all New Zealand residents and visitors to New Zealand. It includes all accidents including those occurring at work, whilst traveling and at home. All referrals from ACC are managed within 3 weeks and TARPS receives its funding relatively equally through ACC and the ADHB (Auckland District Health Board).

TARPS is an adult based service and the main conditions treated are:

- Musculoskeletal pain disorders e.g. chronic back pain, neck, shoulder pain,
- Neuropathic pain
- Complex Regional Pain Syndrome (CRPS)
- Fibromyalgia
- Headache
- Phantom limb pain
- Facial pain
- Post-herpetic neuralgia
- Atypical chest pain(s)
- Abdominal pain with or without Irritable Bowel Syndrome (IBS)
- Pelvic pain/endometriosis
Procedures and Treatments Provided by TARPS:

- **Comprehensive pain assessment and treatment plans:** A client centered biopsychosocial multidisciplinary team approach is taken for assessment. This model is well established with a predominant Cognitive Behavioural Therapy (CBT) psychological focus. This might entail an individual, joint or a triple assessment for a review and physical capacity evaluation with various pain specialists for the management of complex chronic pain patients. Required specialty input will be determined on triage and on the individual assessment process.

- **Medication management:** Identification of appropriate pharmacological agents for possible short or long term maintenance of chronic pain or other related issues eg) Depression and anxiety, sleep disorders or neuropathic pain.

- **Outpatient Interventional Clinic:** Delivery of a range of interventional pain procedures eg) nerve blocks, joint injections, intrathecal medication infusion pumps, and spinal cord stimulators.

- **Outpatient Physiotherapy:** A comprehensive musculoskeletal assessment and or a physical capacity evaluation. Physiotherapy input could be part of an individualised program or group work.

- **Outpatient Occupational Therapy:** Assessment for home aids or modifications and Assessment of Motor and Process Skills

- **Non Pharmacological Pain Management:** Either individually or in groups to explore and refine a range of non-pharmacological strategies for pain management eg) Relaxation training, Cognitive coping skills training eg) Mood management and Hypnosis for pain control

- **Psychotherapy:** This can be individual, couples and family.

- **Comprehensive 3-week Pain Management Program:** This is a structured 3-week course (Monday to Friday – 8.15am to 3.00pm) for patients with chronic non-malignant pain. Also a **12 week Activity Focused Program**


**Staff Contact during visit:**

- Doctor Kieran Davies Chronic Pain Medical Director
- Brigitte Gertoberens Anaesthetics
- Kate McCallum Clinical Nurse Specialist Chronic Pain
- Dr Michael Butler Rheumatology
- Debbie Bean & Julian Reeves Health Psychologist
- Murray Hames & Brett Donaldson. Physiotherapist
- Yvonne Middleton Team Support
- Bex Cornwall Occupational Therapist
In terms of TARPS dedicated staffing, FTE breakdown is as follows. This was provided to me and is as accurate as I can tell for 2010:

Nursing: 1.0
Occupational Therapist: 1.0
Psychology: 1.0 + 1.0 + 0.4 + 0.1 + 0.8 + (intern) 0.5
Health Psychologist: 1.0+ 0.1
Psychiatry: 0.8 + 0.4
Rheumatology: 0.5
Physiotherapy: 0.5 (External)
Anaesthetics: 1.0 + 1.0 + 1.0 + 0.4 + 0.4 + 0.5 (Pain Fellow) + 0.2 + 0.4
Team support: 0.5
Transcription: 1.0
DHB referral coordinator and Pain Management Programme coordinator: 1.0
ACC referral coordinator: 0.5
Scheduler: 1.0

Kate McCallum Clinical Nurse Specialist Chronic Pain (Figure 19). Kate has been the sole nurse working in TARPS since 2004. She has previous experience as the Nurse Co-ordinator (locum 12 months) ADAPT Pain Management Program in 2003 at the Pain Management and Research Centre, Royal North Shore Hospital, Sydney Australia. She is very interested in Pain and Hypnosis and is a member of the NZ Pain Society NZ Society of Hypnosis. She is also an active member and participant on the NZ Pain Society and involved in many pain nursing issues and professional development. I also stayed with Kate in her home for visit.

As part of her current duties in TARPS she:
- Manages an individual caseload of 10 clients per month.
- Assesses patient needs, discusses and implements individual management plans.
- Educates and counsels patients about pain management strategies and other areas as needed e.g. Hypnosis and pain sessions.
- Participates and helps run the 3-week Comprehensive Pain Management Program.
- Individual, couple and family therapy undertaken co-jointly and/or under supervision.
of Senior Clinical Psychologist

- Assists in team-driven efforts for building relationships with other healthcare providers, insurance companies and hospital management.
- Contribute to ongoing pain management education both locally and nationally.
- Provide clinical mentorship for students and registered nurses
- Plays a significant management role in service

**Participation: (1 and ½ days with TARPS team)**

I sat in on a half a day in the morning of the 3 week Pain Management Program. This was very interesting to see the different types of patients and issues that are brought up in the group and the disparity between ACC funded patients and other TARPS chronic pain patients. The ACC funded system does appear to favour some pain patients enrolled, for example, ACC can cover the full costs of transport, hotel and pain program, whilst ADHB patients are only funded at approximately 1/3 the level of ACC patients. There does also appear to be some issues for the ACC pain patient as there are certain processes and pathways they must adhere to in order to receive the support and funding for their injury. According to the program, there is a mix of didactic lectures, power point presentations, structured exercises and activities which warranted the group going upstairs in the centre to the Physiotherapy department and gym space. With the format of the pain programs it appears that each discipline and presentation is varied which is a good breakdown for the sessions throughout the day and the group was very engaged.

I met with various medical, nursing and allied health staff individually and as part of TARPS case management session. I was also very fortunate to sit in as an observer for a patient assessment. This was a joint medical and psychosocial assessment with a physiotherapist. This was great to see how this process works because at HIPS our team is currently still doing a 3 hour Multidisciplinary assessment on similarly triaged patients. This will likely change in 2012 to this format after completion of a research project. I can see major benefits of this process, less duplication of a physical and functional assessment, patient not repeating their story and medical history and time saved for clinicians as completed in half the time if performed by individual disciplines.

Speaking with the anaesthetic staff it appears that they are tending to be moving away from the less evidenced based pain procedures like HIPS, for more non pharmacological approaches to pain management e.g) Self management focus and pain programs with functional activities for patients. Another interesting area was what Kate does with her Pain and Hypnosis sessions. She very generously gave me numerous articles and information on this area and is hoping more pain nurses will get actively involved and qualified in this area for chronic pain patients. This and the arts in pain management program was well supported in the TARPS team with much of the artwork from the patients placed around the facility from the previous group programs e.g) Collage work and paintings.
Positives:

- Interdisciplinary approach rather than multidisciplinary approach was well evident in TARPS team
- In case discussion and decision making, recommendations involved all team in a collaborative way
- TARPS team very generously provided me with much written material, assessment protocols, templates, data and various other patient and clinic related handouts

Negatives:

- Lack of public awareness and also in primary care sector in NZ with regards to chronic pain and its management
- Kate felt very isolated from her colleagues over at the Auckland Hospital site in the Acute Pain Service. This also supported other Senior Chronic Pain nurses in NZ and the need for ongoing clinical supervision and support
- There was also some issues related to the legitimacy and profile of her as a chronic pain nurse. At times her clinical skills were unable to be used as she ended up with much of the operational and management load of the service to ensure it was sustainability as medical director does not work full time.
- Major funding and billing issues with ACC contracts for TARPS. ACC has different reporting and billing requirements than ADHB system and a considerable amount of ongoing negotiation with ACC is a time-consuming factor.
- This ongoing issue with the two funding bodies in health system does create some inequity for chronic pain patients and a two tiered health system in NZ.

Resources Received:

- Assessments and Outcome Measures
- New Patient Pre-assessment Pain Questionnaire and Review 6 months, 12 months post group program.
- The Auckland Regional Pain Service 2009 Stats
- Numerous articles on Hypnosis and Pain
Auckland City Hospital (Figure 20), serves a population of around 444,100 seeing almost two million patients annually. It is a teaching hospital and Auckland District Health Board (ADHB) is the largest trainer of doctors in the country. It has over 570 beds, with services ranging as follows: Cardiothoracic Surgery and Intensive Care Unit, Trauma Service, Emergency Department, Neurosurgery with Neuro High Dependency Unit, Children’s Intensive Care Unit, Neonatal Intensive Care, Heart Lung Liver and Renal Transplant Service, Obstetrics, largest Oncology Unit in NZ, Women’s health, Surgical Services, Orthopaedics, ENT, Urology, Vascular, Neurosurgery, Paediatrics, Radiology, Psychiatry, General Medicine and Subspecialties: Cardiology, Renal, Haematology, Gastro, Geriatrics, Respiratory. 

http://www.adhb.govt.nz/

**Acute Pain Service (APS)**

I did not actually go on an Acute Pain but spent ½ a day with Kate and the APS team. But I met with some nursing staff. The Acute Pain Service (APS) is similar in operation, staffing and challenges as the other NZ hospitals I visited eg) Site 1,2 & 5. An interesting person I met though was **Francesca Storr** who is a Pain Nurse for Woman’s Health issues. Along with daily ward rounds she also runs an outpatient clinic along side the Anaesthetic team, specifically for women with pain issues. They dealt with a lot of recurrent pelvic and abdominal chronic pain issues and women that had history of physical, psychological, sexual abuse and now have chronic pain issues.
She was very interested in our Pain in the ED Project (Appendix 1), in which our team developed a Model of Care and “Flags for Persistent Pain patients in ED (Appendix 2), of which was a cohort of the frequently presenting women with abdominal pain to the ED. We will continue to share information around this issue.

There were also some issues of difficulties and integration between the Chronic and Acute Pain Services for this group as well. Most acute pain nursing staff did not have much to do with the TARPS service and it was up to the medical staff to refer patients. Education and support from nursing and medical staff was difficult for Kate to access as most of this was in the acute care sector in Auckland Hospital. A feeling of isolation between the Acute and Chronic Pain services was further compounded by TARPS being located on another healthcare site in Auckland about a 10 minute drive away.

Francesca and Kate are also both involved in developing and lecturing in the under and post graduate nursing pain programs at with the University of Auckland. An area of mutual interest was around Pain in the Older Person and we both shared some resources on this topic and continue to do so.

Ongoing Collaborations

HIPS had a visit recently from Clinical Nurse Specialist Nurse Jane Suckling from the Auckland Hospital. She works with Francesca in the Women’s Pain Clinic. Jane stayed with my family and I for her 2 day visit to HIPS. Auckland were especially interested in the HIPS “Understanding Pain” and “Lifestyle and Pain Programs” that could potentially be modified for Women in Pain group www.hnehealth.nsw.gov.au/pain (Review under pain programs and see Appendix 1 HIPS Model)

Sharing of Resources:

- HIPS Model of Care and Pain Program resources. (Appendix 1: HIPS Model of Care) www.hnehealth.nsw.gov.au/pain
- Pain in the ED “Frequent Presenters” project. I shared all of this information and resources with Sue. She is now trying to implement this model in Waikato Hospital ED for the complex pain patients. (Appendix 2: Pain in the ED Poster) http://www.archi.net.au/documents/our-services/innovations/pain-in-ed.pdf
- Persistent Pain Flags Doc (HIPS Document) and all project related information
New Zealand Pain Society is an incorporated Chapter of the International Association for the Study of Pain (IASP) and New Zealand's largest society for people interested in pain management and the study of pain. The NZPS offers a range of resources for pain sufferers and pain professionals, including advice, education, training, pain assessment techniques and information on pain research. http://www.nzps.org.nz/

Accident Compensation Corporation: Amanda Bowens, Research Advisor, ACC
http://www.acc.co.nz

The Interventional Pain Management (IPM): Evidence based recommendations on a wide range of procedures to help practitioners and patients make informed decisions.

http://www.moh.govt.nz/moh.nsf
SITES VISITED CANADA: (8th November - 12th November 2010)

- Surrey Memorial Hospital (8/11/10)
- Vancouver General Hospital (VGH) - Gordon and Leslie Diamond Health Care Centre-OASIS Program (9/11/10 & 12/11/10)
- Royal Columbian Hospital (10/11/10)
- Richmond Clinic- OASIS Program Health Science Building (12/11/10)
- St Paul’s Hospital (12/11/10)

Vancouver, British Columbia, Canada

Site Visit: 6 Surrey Memorial Hospital  
Date: Monday 8th November 2010  
Facility: Surrey Memorial Hospital Pain Management Clinic (Surrey Outpatient Care and Surgery Centre)  
Address; 13750 96TH Avenue, Surrey BC, V3V 3H5  
Contact: Ruth Ringland Nurse Practitioner, Fraser Health, B.C  
Phone: (604) 585-5666 Ext 772493  
E-mail:ruth.ringland@fraserhealth.ca  
www.fraserhealth.ca

Surrey Memorial Hospital (SMH) (Figure 21), is a publicly funded hospital in the city of Surrey, British Columbia, Canada. It is one of 12 hospitals in the Fraser Health Authority, which is the fastest growing health region in Canada. Patient population is approximately 1.5 million of which 37% is living with multiple chronic conditions. It is the second largest hospital in British Columbia and has the busiest emergency department.

The hospital offers general medical services and emergency services, as well as an area and regional referral centre for specialized paediatrics, maternity care, Agency for Cancer Services and hospice care. [http://www.fraserhealth.ca/](http://www.fraserhealth.ca/)

There is an Acute Pain Service which is funded from the Anaesthetic department and includes an Anaesthetic registrar and clinical nurse. The Chronic Pain Management service is located in the Surrey Outpatient Care and Surgery Centre (SOCSC) first Floor, F Building on
the hospital grounds. Patients are assessed, pain programs run and and some day only pain procedures eg) Trigger point injections and nerve blocks

The Surrey Memorial Hospital tertiary Pain Clinic is the largest publicly funded pain clinic operating within the Fraser Health Authority as the regional pain centre hub. It has adopted an interdisciplinary, holistic approach that aims to treat more than the physical sensation of pain. The clinic now has four physicians, a nurse practitioner, physiotherapist, occupational therapist and support staff. It plans to gain more funding and include psychology, social work and additional physician specialists when funding is available.

The pain clinic’s scheduling system, resources and outpatient program is accessible and integrated with other on site programs of chronic disease care including, enhanced family practice, cardiac, renal, neurology, diabetes and geriatrics. Common elements of self-management program resources, education and mental health support can therefore be shared between specialist services. Case coordination for complex patients requiring multiple services can be organised through this system. This model is a new way of delivering care and services to persons living with chronic conditions, including people with chronic pain. The Pain clinic sees approximately 50 to 60 patients a week, all referred by doctors and the wait lists are running about 12 -15 months at present.

Team Members:

- Dr Brenda Lau: Medical Director Surrey Memorial Hospital Pain Management
- Ruth Ringland: Nurse Practitioner (Family Practice) RN, MN, NP
- Rajni Dhiman, Occupational Therapist
- Roly Fletcher, Physiotherapist

Chronic Pain Self Management Class held in the clinic.

There was no program on the day I attended but I was able to have some discussions with Ruth Ringland NP, Rajni Dhiman OT and Roly Fletcher Physiotherapist who run the program together as outlined below.

**COHORT A** (education only): 6 week, Thursdays 10:30-12:00, pain clinic education room

**COHORT B** (full program, includes education, exercise, and relaxation): 6 week, Thursdays 1:00-4:00, pain clinic education room

- Education 1:00-2:30 pm
- Exercise 2:30-3:00 pm (4th floor, B building, cardiac gym)
- Relaxation 3:30-3:30pm (4th floor, B building, cardiac gym)

**FOLLOW-UP:** Patients invited back for a follow-up session, 7 weeks after completion class.
I spent a day visiting Surrey Memorial hospital. I spent the morning meeting and discussing issues with Sarah Denman form the Acute Pain Nurse. In the afternoon I met Ruth Ringland who is a Nurse Practitioner (Family Practice) in the Surrey Memorial Chronic Pain clinic, some administration staff, Pain Proceduralist’s and Rajini Dhiman the Occupational Therapist for the Chronic Pain Self Management Programs. I did not meet Dr Brenda Lau (Medical Director) this day but later in the week at St Paul’s Hospital in Vancouver.

Ruth Ringland (Figure 22), has been working in the field of Pain Management for over 20 years. Like most pain nurses she was involved in Acute Pain Services and then moved into the Chronic Pain area. She has been involved in both undergraduate and post graduate nursing education and curriculum development in Canada. She has particular interest and expertise in Fibromyalgia. During my visit I was fortunate to attend one of her lectures on the topic to other healthcare staff as it was ‘National Pain Week in Canada. I was very interested to hear about the process she had to go through to become a NP to practice in pain management in Canada BC.

Like in many countries Nurse Practitioners (NPs) work autonomously and collaboratively with other healthcare professionals to provide health care services that contribute to the health and wellbeing of patients across the lifespan. In addition to health care services, NPs conduct research and are often active in patient advocacy activities. All Nurse Practitioners are Registered Nurses who have completed extensive additional education, training, and have a dramatically expanded scope of practice over the traditional RN role. In Canada BC, to obtain a license and practice, Nurse Practitioners need to choose an area of specialty eg) family, women's health, paediatrics, adult, acute care. There is also the Masters in Nursing Science: Family Nurse Practitioner at Tertiary facilities in BC to complete.
Ruth chose to practice as a Family Nurse Practitioners in her Chronic pain role. This enables her very large scope in her current pain practice. She undertakes comprehensive history taking, physical exams, diagnoses, prescribes, orders diagnostic tests manages diseases and conditions within a professionally regulated scope of practice. She works in close collaboration with health care professionals and service providers within her health service. This is evident when she is doing Trigger Point injections and other pain related procedures and the close relationship she has with the anaesthetists in her service.

In Canada, NPs are licensed by the province or territory in which they practice. The Registered Nurses Association of British Columbia (RNABC) is responsible for the regulation of Family Nurse Practitioners through approval of education programs and registration processes. [https://www.crnbc.ca/](https://www.crnbc.ca/). This includes examinations and ongoing quality assurance program for renewal of registration, including the establishment of standards, limits, and conditions on the scope of practice for each person. The government is responsible for developing Family Nurse Practitioner legislation and funding employment, compensation issues in BC and salary is through Ministry of health. There is a similar process for NP endorsement in Australia which is now regulated by the Australian Health Practitioner Regulation Agency (AHPRA) [http://www.ahpra.gov.au/](http://www.ahpra.gov.au/). The Australian professional organisation is the Australian College of Nurse Practitioners. (ACNP) [http://www.acnp.org.au/](http://www.acnp.org.au/)

This was very interesting to spend an afternoon with Ruth as she was very autonomous in her clinical practice. I was very interested in her ‘Trigger Point’ and ‘Pain Procedure’ clinic. She stated that she had to do more qualifications to perform these procedures which were overseen by her Anaesthetic colleagues. This would certainly have an impact on pain procedural times for patients if NP’s were qualified to perform these in NSW. Unfortunately there would be funding issues also associated with this as well at present.

**Acute Pain Service (APS)**

I did not actually go on an Acute pain round but met the staff and discussed issues. I met with Sarah Denman who is the Clinical Nurse Specialist for the Acute Pain Service. This Acute Pain Service (APS) is an anaesthetist led service with CNS nurse support. Like many of the services I have already visited it provides multimodal analgesia eg) PCA, epidurals, ketamine infusions etc. Interesting though when questioned on APS issues she mentioned similar staffing and challenges as the APS service in NZ hospitals.

Average numbers of patients per day is approximately 15-20 but the rounds were very busy with an increases in complex pain patients. Sarah and Ruth do support each other on this site but there are still issues with formal integration between Acute and Chronic pain Services and medical staff. They also had an increase in ED Frequent Presenters to Emergency Department with Persistent Pain and ongoing management issues. I gave them all the resources and info related to this project for them to review. (Appendix 2 Pain in ED)
At Surry, over the last 2 years the Pain Nurses have developed a very successful “Pain Champions” Program. The APS have recruited over 14 nurses on their busiest surgical wards who are now a core group of pain management champion nurses that network and generate enthusiasm, educate and resolve pain issues in their own units. This program included education and ongoing support for the nurses involved from the APS. It was largely extensive volunteer time given by these pain champions. The Pain Champions were also very conscious to network and share their results with their colleagues within the hospital which has now also got the attention of senior management to support the program for other nurses in work hours.

I have previously tried this “Pain Champions” concept in the acute care setting with limited success at two sites. Sarah has subsequently sent me all the information regarding this program eg) curriculum, data and outcomes etc. I intend to review this material and see what is new and different from the previous programs I had implemented. If I can see merit in using some of this program in my practice at HIPS, it will be done in collaboration and acknowledgement of their work.

**Positives to services:**
- Template and central referral system for Chronic pain service
- Autonomy of clinical practice for NP
- Sharing of Chronic condition programs and resources with a Centralised system for scheduling in outpatient setting
- Good nursing support between Acute and Chronic Pain service
- Succession planning and APS support with Pain Champions Program

**Negatives to services:**
- Limited staff, resources and funding for Chronic pain to meet current and future demands
- Cramped facility in outpatient setting
- Limited access to medical staff on some days and in program
- Lack of succession planning and issues with sustainability and burnout for staff in Chronic Pain service

**Information and Resources Shared with Surrey:**
- HIPS Nursing Triage document
- ACC link NZ for Procedural pain management
- Various pain related articles and links
Resources and Links Received:

- All information related to self management programs
- All Pain clinic forms and templates (electronic files in relation to Chronic Pain clinic eg) Templates for Self Management Pain Program, Intake form, assessment forms, Procedural info etc)
- http://www.fmnetnews.com/basics-symptoms.php - Fibromyalgia information and network
- http://www.pace-canada.org/about/en/index.php PACE Canada is a comprehensive guide to counselling for healthy active living designed to assist health care providers in effectively increasing their patients’ physical activity levels and improving their eating habits. Tool Kit and Counselling Guide
- Provincial wide database of healthcare providers- public/private, medical/non medical Self management Provincial Pain program

Other Contacts:
Sarah Denman: APS Nurse Surrey Hospital-Sarah.Denman@frasehealth.ca
Rajini Dhiman: OT Chronic Pain Service-Rajni.Dhiman@frasehealth.ca
The Osteoarthritis Service Integration System (OASIS) is an assessment and referral program that primary mission is to enable individuals with hip and knee osteoarthritis to self-manage their condition and access support services at any stage of the disease. Its program provides Multi-disciplinary assessments for individuals in the early stages through to the more advanced stages of osteoarthritis, Personalized action plans, variety of education sessions on topics such as exercise, nutrition, and pain management and a comprehensive listing of available Community Services. Figure 24. It is a very innovative model and they encourage continuous improvement, and sharing knowledge with other organisation. This was very evident by the amount of material they gave me to bring home from my visit.

The OASIS Team (Figure 23) spans the continuum of care to support people with osteoarthritis at every stage of the disease whether in Primary Health Care Network, the Community Care Network or the Acute Care Network. OASIS is involved in all of these different areas, the in order to help individuals navigate the health care system and access the range of services and treatments they need to live well with osteoarthritis.
Regional Office:

This office coordinates all the clinics and works collaboratively with all the other partners involved in the OASIS Program. It has administrative staff that monitors and evaluates programs in order to improve service delivery and patient outcomes. There are a number of Education specialists who develop and run the numerous education sessions within the OASIS Program. My main contact for visit was with Margarite Paul RN who does the Pain Management education sessions for OASIS programs.

Louise McLeod OT, Educator, OASIS
Margarite Paul RN, Educator, OASIS
Arlaina Waisman, RD, Educator, OASIS
Wendy Watson PT, Educator, OASIS
Brandon Wong, Business Support Coordinator

Figure 24: OASIS Program
Sourced: www.vch.ca/oasis
OASIS: Multiple Stakeholders

- Clients and caregivers
- Primary Care Physicians (PCPs)
- Allied health professionals
- Orthopaedic surgeons
- Rheumatologists
- Community organization
- Education partners

Key Values of OASIS:

- Fair and equitable access to services.
- Client empowerment
- Partnering with others
- Responsive to needs of diverse cultural groups
- Build a shared learning environment.
- Teamwork and sharing of knowledge and expertise
- Education across continuum of care.
- Informed lifestyle and treatment choices.
- Evidence-based best practices and the
- Quality improvement through regular performance measurement

Resources Received from OASIS:

- OASIS Pathways
- Complete OASIS Program packages that they provide to patients and healthcare professionals
- Patient Booklets for Surgery: Hip and knee replacement
- Templates of OASIS Assessment Tools, Personalized Action Plans, Referral forms
- Education Sessions
- Numerous OASIS Resources and booklets
Vancouver General Hospital (VGH) (Figure 25), is a medical facility located in Vancouver, British Columbia. VGH is the second largest hospital in Canada, after The Ottawa Hospital. Vancouver Coastal Health (VCH) is responsible for the operations of the hospital. VGH is the largest hospital in British Columbia, offering specialized and tertiary services to residents in Vancouver. The hospital accepts patients referred from other parts of the province requiring highly specialized services. Approximately 40% of the hospital’s cases come from outside the Vancouver region. http://www.vch.ca/

The OASIS Multidisciplinary Team have their outpatient clinic at Vancouver General Hospital (VGH) Gordon and Leslie Diamond Health Care Centre (Figure 26). I was introduced to the OASIS team for multidisciplinary assessments. Which includes being seen by two or more clinicians which eg) nurse clinicians, physiotherapists, occupational therapists, and dieticians. I was able to follow a patient through the entire process on the morning attended the clinic and this included an OT and Nurse assessment.

This initial assessment by the team is hoped to be a “one stop shop” assessment for people with osteoarthritis and the appointment can take up to 2 or 2 ½ hours. Staff assess the patient, identify issues related to their overall health and wellness, ability to mobilise and perform ADL’s and ask them about their goals for their health. A comprehensive functional and physical assessment is conducted. Patient X rays and scans will also be discussed with
the patient in detail and opportunity for any questions to be asked at that time. This is a very good time for the patient to ask and clarify any issues related to their condition. Once this assessment is done by various team members then there is a team meeting to discuss and plan each patients care to ensure that the patient has timely access to appropriate referral eg) GP, surgeon, or rheumatologist.

As part of this initial assessment a ‘Personalized Action Plan’ is developed. It will outline all the recommendations for treatment, follow up, personal self-management goals, and referrals to support services and community programs. OASIS will then work in collaboration with the patient or GP to facilitate the recommendation outlined in the Personalised Action Plan.

**OASIS Multidisciplinary Team Roles:**

**OASIS Nurse**
- Review patient health history and medications taken for pain
- Discussion of goals for self-managing osteoarthritis
- Work in partnership with GP for health issues and refer to support services
- Encourage attendance at an OASIS education session led by a nurse clinician educator on Pain Management which explores ways to manage pain through medications and alternative methods

**Occupational Therapists**
- Identify and address daily activities that cause you pain or unable to live independently
- May suggest helping aids eg) long handled reacher’s or bathtub benches
- They may also suggest attendance at an OASIS education class led by an occupational therapist educator eg) Osteoarthritis Basics & Beyond.

**Physiotherapists**
- Address problems with function, moving and using your joints and muscles.
- Suggest exercises that can help strengthen muscles and improve movement.
- Recommendation of aids eg) cane or walker to reduce the force put on painful joint.
- They may also suggest an OASIS education class led by a physiotherapist educator eg) Osteoarthritis & Exercise.

**Dietitians**
- They are experts in the science of food and human nutrition.
- Develops and leads education sessions about nutrition and osteoarthritis.
- Suggest attendance at an OASIS education session led by a dietitian education eg) Nutrition & Supplements or Weight Control.
All of the above Multidisciplinary OASIS team members will liaise or refer patients onto the relevant healthcare providers in the community to continue management of the patient if necessary. Figure 27 outlines the patient journey through the OASIS Program in more detail.

After morning assessment clinic, I also sat in on the OT session: **Osteoarthritis Basics & Beyond**. It was very informative as she was discussing the use of aids in improving pain issues and osteoarthritis but some of the content was generic enough to translate to other painful conditions.

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**OASIS: Patient Journey**

- Client presents to Physician with hip or knee pain
- Physician assesses clients for OA and appropriateness for referral to OASIS
- Client contacted and scheduled for assessment appointment
- OASIS multidisciplinary team assesses client needs:
  - Weight management
  - Pain management
  - Nutrition
  - Mobility/exercise
  - Home support
  - ADL to daily living
  - Social services
  - Need for surgery
- Client triaged into appropriate care stream
  - Candidate for surgery in next 6 mos.
  - Client requiring medical management and other non-surgical support
- Preparation and communication of personalized action plans
  - Discussed with client
  - Copy to referring physician
  - Copy to surgeon (surgical candidates)
- Surgical candidates referred on to surgeon for surgery consultation
- Client participates in OASIS classes for optimization for surgery

**Figure 27: OASIS patient Journey**
Site Visit 9: OASIS Program: West Vancouver Community Health Centre  
Date: Tuesday 9th November 2010  
Facility: OASIS Program: West Vancouver Community Health Centre  
Address: 241-2121 Marine Drive Vancouver, BC V7V 4Y2 Canada  
Phone: 604-904-6177  
Contact: Delores Langford: Registered Physiotherapist  
Email: delores.langford@vch.ca  
www.vch.ca/oasis

The West Vancouver Community Health Centre (Figure 28 & 29) was built for fitness, recreational activities and community programs. Its facilities include a gymnasium, gymnastics studio, yoga and dance studios, art rooms, martial arts facilities and meeting rooms. This is where Vancouver Coastal Health OASIS and other healthcare programs are run. There is also access to a hydrotherapy pool across the road from this centre for patients of the OASIS program to access. There are other sites available in the Vancouver region for OASIS to run their programs self management programs. Getting access to facilities can be a challenge with many competing interest for community space that has good disabled and community transport access.

I did not get the opportunity to review any programs running in this facility but I did have the opportunity to speak with an OASIS physiotherapist who outlined her role in the OASIS Program in a little more detail than previously mentioned. (See Site Visit 8)
On the morning of Friday 12th November, I attended the OASIS Pain Management OASIS Education session delivered by Margarite Paul at the Richmond Clinic Health Science Building (Figure 30). This facility is located across the road from the Richmond Hospital (Figure 31). This is one of the free sessions that OASIS offers to enable patients to self-manage their osteoarthritis at all stages of the disease. The following are the free Primary Education Sessions:

- Understanding Osteoarthritis
- Osteoarthritis & Exercise
- Nutrition and Supplements
- Mindful Eating for Weight Control
- Pain Management

Usually 10 to 12 people are booked into each education session. They are offered regularly in multiple locations on the North Shore Vancouver, Richmond and are led by health professionals, including physiotherapists, occupational therapists, nurse clinicians, and dieticians. The classes are interactive sessions aimed at giving osteoarthritis patients and carer’s practical tools and tips to make everyday activities easier for those affected. There is a chance to ask questions of the educators and also share health and osteoarthritis history with others attending the group. The sessions are usually 2 hours long with a break during the session and bringing along a support person or family member is encouraged.

**Pain Management: Margarite Paul: Educator Registered Nurse**

- Why does pain happen?
- What can make pain worse?
Who can help me deal with my pain?
How can I manage a flare up?
What are some non-medication strategies I can use to deal with my chronic pain?

Part of my objective for reviewing this program was to see how pain management could be included in other self management lifestyle and chronic condition programs eg) Diabetes, Cardiac programs. As evidenced in the OT session at site visit 8, pain comes up as an issue for many attending in the group and much of the information is generic enough for other pain related conditions. I spoke with some of the attendees of the OASIS program and education session and they were very satisfied with the services provided to them by the OASIS team.

Other Education Sessions OASIS offered but did not attend related to surgical candidates with Osteoarthritis for better patient outcomes: [http://oasis.vch.ca/](http://oasis.vch.ca/)

**Pre-Hab Education Sessions**

- People who have been identified as a surgical candidate
- Hour multidisciplinary education session that provides clients with tools and information needed to prepare for surgery
- Goal setting, nutrition, exercise, pain management, joint protection and planning for home modification if required
- Class attendance 2 to 12 months prior to surgery is optimal.

**Pre-Op Education Sessions**

- People with confirmed surgery date (8 weeks before surgery)
- Explains what patient needs to do to prepare themselves and home before their intended surgery
- Information about hip and knee surgery and what they can expect in hospital
- Organisation of equipment that would need to be purchased or rented prior to surgery for use in hospital or home on discharge

**OASIS: Benefits**

- Equitable access to services based on need rather than entry into referral queue
- Centralised referral intake system for efficiency of resources
- Access to first available surgeon
- Up to date inventory of public and private sector services
- Standardized referral forms and assessment tool
- Personalized action plan for all clients
- Alignment with other Chronic Disease Management initiatives
- Reduction in surgery and complications post operatively
- Very patient centred approach to chronic condition management
Royal Columbian Hospital (RCH) (Figure 32), has 402 acute care beds and is a major tertiary care facility. It is the trauma centre for Fraser Health Authority. Others specialities include neurosurgery and specialist open-heart surgery. RCH has a helipad that receives air ambulances operated by the BC Ambulance Service. [http://www.fraserhealth.ca/](http://www.fraserhealth.ca/)

The Acute Pain Service is an Anaesthetically funded Interdisciplinary delivery of multimodal analgesia in acute care setting. There is an Anaesthetic Registrar, Pain Consultant, Clinical Nurse Consultant and Brenda Poulton as the Acute Care Nurse Practitioner, providing pain management to patients and a consultation service to staff at the Royal Columbian Hospital. The service sees approximately 30 patients each day on the APS round and a significant portion of this is related to trauma as the hospital is a specialist trauma centre. There is also a significant problem with illicit drugs. As an NP, Brenda can’t prescribe opioids but she is able to titrate then and is able to order NSAID and adjuvants used for pain management. Like Ruth in Surrey she is paid for by the Ministry of Health (MOH) in BC and is referred to as “Shadow Billing”. There is some uncertainty each year for services that this funding will remain recurrent.

There seems to be a current theme with the APS services I have previously visited in NZ and Canada. All of the senior acute pain nursing staff I have met thus far have stated that they are struggling with the increase in pain patient complexity in the acute care setting. They are also getting many “Chronic Complex Pain” referrals from the Acute Pain Service anaesthetic registrars and nurses who are unsure how to manage them due their inexperience or lack of education in this area. This is also a problem expressed my nursing
pain specialist colleagues working in acute pain services in NSW hospitals.

Pain Brenda Poulton: RN, MN Acute Care Nurse Practitioner, has been working in the specialty of pain management for a long period of time. She is a strong advocate for the professional development of nurses in the specialty of pain. Her current practice at Royal Columbian hospital is in the acute care setting. She also has strong linkages with the University of British Columbia (UBC) and is involved in the development of the UBC Interdisciplinary On-line Modules for Health Sciences on Pain Management. She also is an active member of the Canadian Pain Society and nurses pain interest group.

Her current pain focus is with Pain BC [http://www.painbc.ca/], which is a not for profit organisation that is aiming to reduce the burden of pain on individuals, families, communities and society. Lobbying is occurring to get Chronic Pain recognised as a chronic condition by the BC government and hopefully get pain better resourced. Pain BC hope to achieve this by:

- Engagement of people living with pain, health care providers, and community, government, and academic partners
- Education of people living with pain, health care providers and the general public
- Advocacy with decision-makers in health care and other systems supporting people living with pain
- Knowledge translation to bring evidence and research into practice

Source: [http://www.painbc.ca/content/mission](http://www.painbc.ca/content/mission)


Resources Received:

- Community engagement report eg) surveys for patients and providers prior to Pain BC Society (2 year survey about Pain problems)
- Info and article on all day pain education for Interdisciplinary staff involved in education and the development of on-line pain modules.
- BC Undergraduate health Science Program Interdisciplinary vs Multidisciplinary. Modules: Total lived experience” 5 cases and a Journey through Healthcare system (online) Pharmacy, Medical, Allied Health and Nursing.
- Article by Judy Watt-Watson on education in University Health Sciences programs.
- Acute Pain chart review study outcomes and tools used for review of 9 Acute Care Hospital chart review (325) done in collaboration with Jan Muir (Awaiting publication)
"Rapid Recovery" RCH post op pathways eg) GI and or tho (joints) operations

Nurse Initiated Pain policy for ED

Information and Resources Shared with Brenda:

- HIPS GP Pain Management Action Plan
- Brian Broome (Mind Body connection, Patient s tory and Pain) http://www.mindbody.org.nz
- HIPS Nursing Triage document
- ACC link NZ for Procedural pain management
- Various pain related articles and links
- Continue to remain in contact via email and send each other pain related resources
St. Paul's Hospital (Figure 33&35), is an acute care, academic and research hospital located in downtown Vancouver. Its downtown location brings many of Vancouver’s tourists and visitors to its doors and a longstanding history of providing care to disadvantaged populations. It is part of Providence Health Care (PHC) which is an organization comprised of two acute care hospitals, St. Paul’s Hospital (SPH) and Mount Saint Joseph (MSJ) Hospital, located in Vancouver, British Columbia. SPH is an acute care, tertiary, academic and research hospital with over 500 acute care beds while MSJ is a community hospital with 108 acute care beds and has a multicultural approach to service delivery and clinical programs.

http://www.providencehealthcare.org/

Dr Brenda Lau (Figure 34) is the Regional Division Head, Pain Management Services, Fraser Health and a Pain Specialist at St Paul’s Hospital. Brenda is a Canadian anesthetist and interventional pain specialist. She completed her fellowship in Pain Medicine with Professor Michael Cousins in Sydney, Australia in 2006. In 2007 she completed her Master of Medicine degree in Pain Management with a focus on the impact of health system reforms on Multidisciplinary Pain Centers. She is a Clinical Assistant Professor with the University of British Columbia, the Director of the Surrey Memorial Hospital Pain management clinic, National Taskforce member on establishing the Specialty and a board member of the Pain BC Society.
Key contact: Dr Brenda Lau

As the Regional Division Head, Pain Management Services, Fraser Health, Brenda has been involved in the development and enhancement of chronic pain management and services within Fraser health and British Columbia. The BC Pain Society was formed to facilitate the development of a province wide program. See: Provincial Pain Summit 2011 Final Report from the June summit 2011 [http://www.painbc.ca/](http://www.painbc.ca/). There are 3 key committees:
- Specialist Services Committee (SSC)
- GP services committee (GPSC GP)
- Shared Care Committee (SCC)

The BC Strategy for Pain Services is a: (Figure 36)
- Stepped Care Model
- Regional Pain Services System
  - Tertiary Pain Center hubs
  - Satellite/Community Pain Centers
  - Community-based Self-management programs
  - Integration with community-based services (e.g. Chronic Disease)
- Regional Referral and Triage System
- Navigation of services: PainBC Website, CHARD (Community Healthcare and Resources Directory)
- Alternative Funding Models

The BC Regional Pain Service model will need to integrate well with primary care networks and chronic disease management services within BC. The OASIS Program for osteoarthritis patients would be a perfect example of a collaborative partnership. Identification and utilisation of existing resources and services to facilitate access to better pain management for the population of BC. It could mean enhancing some of established services to ensure they could deal with the increase in patients who might benefit from access to their service.

Vancouver Coastal Health (2007) also developed a regional strategy for optimal pain management and sustainability. Much of which has now been incorporated into the 2011 BC Pain Strategy. [http://www.painbc.ca/content/strategy](http://www.painbc.ca/content/strategy)
System Changes Concepts for BC Pain Strategy: (Figure 37)

- Early comprehensive pain assessments in the community
- Early access to self-management and interdisciplinary teams as required
- Early identification of complex patients and access to advanced services
- Improved Specialist support for community
- Simplification of existing ministry supported online and physical resources
- Centralized navigation of resources
- Improved case coordination when transitioning from tertiary to community

Optimize Current Resources within Tertiary Pain Clinics (Figure 38)

Navigation of resources:
- Case coordination within a clinic
- Central regional triage intake
- Websites, resources and e technology
  - BC Pain Society [www.painbc.ca](http://www.painbc.ca)
  - CHARD (Community Healthcare and Resources Directory)
  - HealthlinkBC: 8-1-1
  - Provider Support
- Dedicated teleconference time
- PSP-Specialist (MD/NP) Pain Champions
Figure 37: BC Community Based Pain Clinic Services
Source: Brenda Lau Presentation

Figure 38: BC Tertiary Pain Centre Services
Source: Brenda Lau Presentation
I only was able to spend half a day with Brenda Lau. I shadowed her for this time and was able to ask her questions as the day went along. This included being an observer to a subacute pain procedures clinic which was performed on dedicated 4 bedded ward space, New patient assessment clinic and some more pain procedures in the afternoon in theatres. At the same time as the procedures were occurring the clinical nurses were doing intrathecal pump refills. Unfortunately I did not get to meet Jan Muir the APS CNS who has been heavily involved in the BC Pain Strategy along with Brenda Lau and Brenda Poulton. I was able to meet and discuss some issues with Rachel Dwosh who is the Clinical leader running the Chronic Day Program which is a comprehensive multidisciplinary outpatient group self management program. Again they have a long waiting list and limited resources to meet the current demands of this service.

Information and Resources Shared with Brenda:

- Brenda and I continue to remain in regular email contact. Either one of us will be sending something current around Pain Management information, resources or links. Brenda is keeping me well appraised of the BC Pain Strategy and this has been invaluable as some of it is very relevant to the committee’s I am involved on with developing a statewide Model of Care for Pain with the NSW Pain Network Agency for Clinical Innovation (ACI) and NSW Pain Ministerial Taskforce.
- HIPS Model of Care and resources. (Appendix 1: HIPS Model of Care) www.hnehealth.nsw.gov.au/pain
- Pain in the ED “Frequent Presenters” project. I shared all of this information and resources with Sue. She is now trying to implement this model in Waikato Hospital ED for the complex pain patients. (Appendix 2: Pain in the ED Poster) http://www.archi.net.au/documents/our-services/innovations/pain-in-ed.pdf
- Persistent Pain Flags Doc (HIPS Document)
- Articles awaiting publication Hayes C, Hodson FJ. A whole person model of care for persistent pain: from conceptual framework to integrated application. Accepted 2011 to Pain Medicine
- Retrospective 13 year study on our Intrathecal patients at HIPS: Hayes C, Jordan, M. & Hodson FJ. "Ceasing established intrathecal therapy in persistent non-cancer pain: a review of 13 years experience with implanted drug delivery systems" (For submitted to Pain Medicine)

Reference:

Calgary, Alberta, Canada

Site visit: 13 The Alberta Health Region Chronic Pain Centre
Date: 15th November 2010 to Wednesday 17th November 2010
Facility: Holy Cross and Ambulatory Care Centre, Chronic Pain Centre, Calgary (CPC)
Address: The Alberta Health Region Chronic Pain Centre (AHRCPC), Holy Cross Centre
Main Entrance off of 2nd Street, 2202 2nd Street SW, Calgary, Alberta T2S 3C1
Phone: 403-943-9900
Contact: Dr Chris Spanswick
Email: chris.spanswick@albertahealthservices.ca
http://www.albertahealthservices.ca/

Figure 39: Holy Cross and Ambulatory Care Centre and Alberta Health Region Chronic Pain Centre

Key contacts:
Chris Spanswick MB ChB FRCA FFPMRCA, Medical Leader, Calgary Pain Program
Lori Montgomery MD CCFP, Interim Medical Director, Chronic Pain Centre
Suzanne Basiuk RN MN CNN(C), Manager, Chronic Pain Centre
Sara Pereira RN MN ACNP, Manager, Calgary Pain Program
Administrative Coordinator: Karen Bannister
Chronic Pain Centre Manager: Marg Sorge
Occupational Therapist & Rehabilitation Lead: Martha Butler

The Alberta Health Region Chronic Pain Centre (AHRCPC) is located within the Holy Cross
and Ambulatory Care centre in Calgary (Figure 39). It operates within a comprehensive
Regional Pain Program throughout Alberta Health, Canada. It includes adult and paediatric
acute and chronic Inpatient and Outpatient Pain Management services. As of April 1, 2009,
the Calgary Health Region and 11 other provincial health Authorities joined together to
form Alberta Health Services (AHS). The Alberta Health Region Chronic Pain Centre
(AHRCPC) provides services aimed at managing pain by an interprofessional team who have
received special training in pain management. Goal of program offered by pain team is to
focus on self-management techniques. Patients are expected to participate in their
treatment program, including attending education sessions, goal setting, and exercising as
prescribed. Chronic pain management programs focus on musculoskeletal, neuropathic,
pelvic and headache pain. Patients with other types of pain will be considered.

The service also offers community based group education and skill development in small
group and lecture formats, in collaboration with the Living Well program.
Services Offered

- Medical management including nerve blocks and implantable devices
- Physiotherapy, acupuncture
- Individual and group therapy
- Family therapy
- Patient education and support
- Self Management Programs
- Telephone consultations with family doctor

The Interprofessional Team at AHRCPC

Anaesthetists, Family Physicians, Gynaecologists, Kinesiologists, Neurologists, Nutritionists, Occupational Therapists, Pharmacists, Physiotherapists, Psychiatrists, Clinical Psychologists, Clinical Nurse Specialist, Registered Nurses, Rehab assistant, Social Workers and Secretary and administration staff.

Referral to service is usually by the family physician via the Central Access and Triage. Referrals average approximately about a 100 a month. All referrals will be assessed on a case by case basis. Patients forwarded Pre-assessment Form which last year was 36 pages (See link http://www.albertahealthservices.ca/). There was some discussion of reducing this down to less than half this size. The team was very interested in the HIPS Screening Questionnaire (www.hnehealth.nsw.gov.au). The triage questionnaire allows baseline measurements and post service outcomes (See Questionnaire for specific measures) to be reviewed at regular intervals 3,6,12 months post discharge. The screening Questionnaire is then scanned into a database, which flags potential triage into 3 streams within the centre:
  - Neuromusculoskeletal Pain (NMSK) 14 teams (includes pain from nerves and/or muscles) Pain Specialists and interdisciplinary staff
  - Pelvic Pain (3 Teams) gynaecologist and interdisciplinary staff.
  - Headache (4 teams) neurologist and interdisciplinary staff.

Patient flow has been reconstructed so that patients do not always see a physician first and that they must be willing to engage in self management is a prerequisite for entry into service. There is a clear care pathways for the AHRCPC. (Figure 40). Clients are expected to attend the following sessions prior to an individual assessment: (Figure 41). About 50% of patients do not return their orientation package and of those who do so, go onto attend next session, the do not attend (DNA) rate is very low. In each of these groups there is about 8-10 people.
  - Orientation session
  - Explain pain educational session
  - Goals session

While on the waitlist patients are expected to attend the chronic pain Living Well classes and/or the other Living Well classes that would benefit people with chronic pain as they may have to wait up to 10-12 months for a multidisciplinary team assessment.
Figure 40: Pathway Through AHRCPC
## Groups Pathway

### Orientation: First contact for client at the centre

**When:** One 2 hour session

**Taught by:** Dietician, Nurse, Kinesiologist, Occupational Therapist, Physical Therapist, Physician Psychologist or Social Worker

**Content Goals:**
- Provide an overview of the centre, programs and staff
- Clarify who could benefit from our services and describe the responsibilities of the clients and staff
- Provide information about chronic pain, its impact and the strategies we teach for managing pain
- Describe pathways to graduation

### Explaining Pain: Must be completed before all other groups

**When:** One 2 hour session

**Taught by:** Dietician, Nurse, Kinesiologist, Occupational Therapist, Physical Therapist, Physician Psychologist or Social Worker

**Content Goals:**
- Improve understanding of the neurobiology of pain
- Provide current knowledge about the causes of chronic or persistent pain
- Increase client's awareness of the adaptability of our nervous system
- Provide a brief review of strategies that improve their ability to influence the pain experience

### Goals Group: Explaining Pain must be completed first

**When:** Weekly for two 1.5 hour sessions

**Taught by:** Dietician, Nurse, Kinesiologist, Occupational Therapist, Physical Therapist, Physician Psychologist or Social Worker

**Content Goals:**
- Develop goal setting and problem solving skills
- Identify sabotages and barriers for goal attainment
- Identify one to two goals which will initially guide CPC program
- Options for setting further goals as participate

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Figure 41: Group Programs Pathway AHRCPC
### Monday, November 15

<table>
<thead>
<tr>
<th>TIME</th>
<th>DISCIPLINE/TOPIC</th>
<th>WHO/WHERE</th>
</tr>
</thead>
<tbody>
<tr>
<td>0800 – 1100 h</td>
<td>Procedures</td>
<td>Michelle Chahor</td>
</tr>
<tr>
<td>1100 – 1200 h</td>
<td>Welcome/Centre Tour</td>
<td>Karen Bannister</td>
</tr>
<tr>
<td>1200 – 1300 h</td>
<td>LUNCH</td>
<td></td>
</tr>
<tr>
<td>1300 – 1400 h</td>
<td>Medical Director, Chronic Pain Centre</td>
<td>Dr. Lori Montgomery</td>
</tr>
<tr>
<td>1400 – 1500 h</td>
<td>Calgary Pain Program Orientation and Strategic Directions, etc.</td>
<td>Sara Pereira, Program Manager &amp; Suzanne Basiuk, Care Manager</td>
</tr>
<tr>
<td>1500 – 1630 h</td>
<td>Living Well/Community Liaison</td>
<td>Penny Barnes, RN</td>
</tr>
</tbody>
</table>

### Tuesday, November 16

<table>
<thead>
<tr>
<th>TIME</th>
<th>DISCIPLINE/TOPIC</th>
<th>WHO</th>
</tr>
</thead>
<tbody>
<tr>
<td>0800 – 1200 h</td>
<td>Primary Care Network—Crowfoot Centre #201, 60 Crowfoot Cres NW; Phone: (403) 374-0244</td>
<td>Yolanda Martens-VanHilst &amp; Team</td>
</tr>
<tr>
<td>1200 – 1300 h</td>
<td>LUNCH</td>
<td></td>
</tr>
<tr>
<td>1300 – 1400 h</td>
<td>Pharmacist Role in Chronic Pain</td>
<td>Don McIntosh, Pharmacist</td>
</tr>
<tr>
<td>1400 – 1500 h</td>
<td>Psychology Role in Chronic Pain</td>
<td>Diane Fox, PhD</td>
</tr>
<tr>
<td>1500 – 1615 h</td>
<td>Triage/Nurse Clinician Scope of Practice</td>
<td>Diane McNamara, RN</td>
</tr>
</tbody>
</table>
As outlined in my program visit above, I attended multiple interviews with allied health, medical, nursing and management staff on numerous sites within Alberta. I was also fortunate to observe pain procedures, patient consultations, group sessions and staff case meetings.

**Roles and responsibilities within AHRCP team**

- Physicians assist the patient to understand their medical condition, offer medication management and may offer a limited variety of interventions. Physicians may include Physiatrists (physical medicine + rehabilitation), neurologists, obstetrician, gynaecologists, palliative care specialists and anaesthetists
- Psychiatrists work with clients with mental health issues requiring medication
- Nurses organise client programs, provide support, advice and may manage medication changes
- Pharmacist provide information about medications and side-effects and works with the medical staff to develop medication plans.
- Occupational therapists measures ability, activity goals and skills and assist in a return to productive life activity
- Physical Therapists assess movement patterns, help develop treatment plans
- Psychologists assess understanding of pain, impact on life and assist clients to develop skills to reduce the effect of pain on thoughts, feelings and actions
- Social Worker assists clients to reduce barriers to participation in the program (e.g. finances or transportation) and facilitates client access of community resources
- Kinesiologists provide exercise programs for clients
- Dietician deals with nutrition, food sensitivities or digestion issues related to pain or medication
- Administration and secretarial roles, support service by collection of data, support clinical staff where possible and liaise with patients where required

[http://www.albertahealthservices.ca/](http://www.albertahealthservices.ca/)
I met with Dr Christopher Spanswick who is currently the Medical Leader and Consultant Pain Physician of the Calgary Pain Program and Assistant Professor, Department of Anaesthesia, Faculty of Medicine, University of Calgary. Chris began his consultant career in Pain Management and Anaesthesia at Hope Hospital, Manchester, UK 1984. Here he led the Chronic Pain Centre in the United Kingdom from 1988 to 2004. Moved to Calgary to take a position within Alberta Health Services at the Chronic Pain Centre, 2004. Has published articles and a major textbook on pain management. He is currently developing inter-professional community based pain management teams.

Dr Lori Montgomery is the Alberta Health Services Calgary Pain Program Chronic Pain Centre Interim Medical Director. She is responsible for maintaining clinical standards and developing program capacity; management of a multidisciplinary group of 26 physicians and more than 70 allied health professionals, Clinic physicians, Multidisciplinary neuromusculoskeletal pain and headache clinics, Chronic Pain Consult Service Working with nurse specialists in adult acute care hospitals to assess and make recommendations regarding the care of inpatients with complex or chronic pain problems. She also has special skills training in the fields of neuromusculoskeletal, pelvic and headache pain, as well as problem drug use. She is also involved in the inpatient consult service at Rockyview General Hospital, and clinical teaching of residents and medical students.

After discussion with both of these clinicians they were very interested with the HIPS Model of Care http://www.hnehealth.nsw.gov.au/pain and what was happening with the Australian National Pain Strategy. http://www.painaustralia.org.au/strategy/

Information and Resources Shared with Chris and Lori:

- HIPS Model of Care, Triage criteria, Screening Questionnaire, Lifestyle and Pain Program, Understanding Pain program. Source: www.hnehealth.nsw.gov.au/pain
- HIPS GP Pain Management Action Plan
- Pain in ED Project (Appendix 2)
- HIPS Nursing Triage document
- Queensland Persistant Pain Strategy Document
- Free Psychology website with pain component
- Various pain related articles and links

Data Management Outcomes, Evaluation and Research:
This is a priority area within service. They have dedicated a 1 FTE position (computer programmer) to collate data from the 36 page Questionnaire which is scanned and other data that creates various reports for the service. I met briefly with Dr Paul Taenzer (Psychologist) who is the principal contact person re data analyses and research project for the service. He did outline the integral role that the data collection played towards the successful enhancements process and ongoing development of the AHRCP service. He provided me with background data and information on the service and its development.
AHRCPC partners with Chronic Disease Management (CDM) who provides community based accessible education classes, exercise and self-management classes supporting those living with chronic conditions including chronic pain. There is further collaboration to provide educational programs in the community through Living Well with Addiction Services and this has also enabled better linkages and resources for Inpatient Chronic Pain and Acute Pain Services in various settings throughout Alberta.

Information on the Programs and AHRCPC is provided on the website with other useful links for rural and remote patients:
http://www.calgaryhealthregion.ca/programs/rpp/resources/lectures.htm

It is also possible for people to attend these sessions face to face or via the web. In the Living Well with a Chronic Condition Program (Figure 43). The sessions are taught by Occupational Therapists and Physiotherapists as well as clinical psychologists. They are run in 4 locations in Calgary and are offered during mornings, afternoons, evenings and weekends. No referral is necessary, but clients must call the Chronic Pain Centre at least two days before the lecture to reserve a seat for the lecture.

Program provides:

- Information and tools for patients & families, the public and health care providers
- The Calgary Pain Program and Living Well have an ongoing partnership to provide education & support program for people with chronic pain
- Living Well also provides education & support for people with diabetes, high blood pressure, heart disease, arthritis, chronic lung disease and other long term illnesses (see the living well website for more information)
- Open to the public and is offered throughout the city & in rural locations
- Offered in a culturally sensitive manner to certain ethnic populations who may have cultural barriers to the mainstream Living Well program
- There are 3 Components to the Living Well Chronic Pain Program
- Pain Self Management classes (free)
- Explaining Pain education classes (free)
This series of lectures offers information about the nature of pain and the ways that the body’s systems are affected by pain. The lectures aim to provide a strong informational base so that other components of the AHRCP program may be better understood and better incorporated.

**Topics include:**
- Understanding Pain
- This Is Your Body
- Pacing In Chronic Pain
- Sleep
- Understanding Medications
- Nutrition & Pain Management: How Are They Related?
- Navigating The Health Care System And Understanding Investigations
- Role Of Exercise In Pain Management
- Attention and Memory Anxiety
- Depression And Chronic Pain

Although I did not get to access any of the Paediatric component of the AHRCP it does provide this service:  
**Pediatric Complex Pain: Children & Adolescents**
- Strategically aligned with the Regional Pain Program, the Pediatric & Adolescent Complex Pain Service cares for children who experience chronic, complex pain.
- Goal of this service is to care for children who experience chronic, difficult to manage pain
- Pain must be the primary reason for the referral
- Transition services to the Chronic Pain Centre is available if required.

**Paediatric Acute Pain Inpatient Services**
- Offered at Alberta Children's Hospital 24/7.
- Services follow children with complex acute pain problems and children who have undergone operations requiring specialised pain management post operatively.
- Team consists of Clinical Nurse Specialists, Nurse Practitioners and Anesthetists.

**Recent Information from: AHRCP**
- Chronic Pain in Alberta has now officially become recognized as the 4th chronic disease in the province.
- Accredited pain course “Chronic Pain Management for the Family Physician” runs three times per year. The course is designed to begin with a full day of broad spectrum, small group pain teaching tailored to the needs of the participants. Each participant then has the opportunity to schedule 3-5 days with any of the multidisciplinary staff of the Calgary Chronic Pain Centre who act as preceptors.
- University of Calgary, Faculty of Medicine, Department of Continuing Medical Education: [www.cme.ucalgary.ca](http://www.cme.ucalgary.ca).
Resources Received:

- AHRCPC Triage/Referral document
- Group Programs Pathway AHRCPC
- Clinical Pathway AHRCPC
- AHRCPC Screening Questionnaire
- AHRCPC Self Management handbook
- Outcome Measurements and data
- AHRCPC 2009 Year in review
- AHRCPC templates
- Job Descriptions for OT and Nursing Positions
- Links for Web based Pain Programs (Charles Pither: Pathways to Pain- since return this web based program has been reviewed and summarized by HIPS team and is available on request)
- Ambassador Program information.

Resources Shared with Chris Spanswick:

- Chris and I maintain email contact for continued sharing of information
- HIPS GP Pain Management Action Plan
- HIPS Nursing Triage document
- ACC link NZ for Procedural pain management
- Various pain related articles and links
Site visit: Primary Care Network Calgary Foothills
Date: Tuesday 16th November, 2010
Facility: Primary Care Network Calgary Foothills
Address: 1716-16th Avenue NW, Suite 500, Calgary, Alberta T2S 3C1;
Phone: 403-284-3726
Contact: Yolanda Martens-Van Hilst Primary Care Network Foothills Chronic Pain Lead
Email: martens-vanhilst@cfpcn.ca
http://www.albertahealthservices.ca/

Figure 44: Calgary Foothills Primary Care Centre

Key Contacts:
- Yolanda Martens Van Hilst Chronic Pain Lead Calgary Foothills Primary Care
- Dr June Bergman in Clinic-Director CFPCN Physician: bergman@ucalgary
- David Croker Director of Clinical Services: crocker@cfpcn.ca
- Observe David Wollman Behavioral Health Consultant

Calgary Foothills Primary Care Network
This network is a group of family physicians in Northwest Calgary and Cochrane collaborating with Alberta Health Services to deliver the best possible primary care. Calgary Foothills Primary Care network (PCN) brings together physicians and other primary health care providers to achieve efficiencies, assess and meet patient needs and cooperate on special programs that serve the Calgary Foothills PCN catchment area. Chronic Disease is a very high priority for care. Chronic pain also fits under this umbrella as well as similar resources required for their management. There are approximately 265 general practitioners in the Calgary Foothill area comprising a primary care network (PCN) and 85% of these are enrolled in the programs for the network in this area.

Chronic Pain Management Group
In partnership with Calgary Chronic Pain Centre, the Calgary Foothills PCN (Figure 44) Pain Management Clinic provides increased access for patients with non-complex neuro-musculoskeletal chronic pain while offering direct support for member physicians and other health care providers in the community. The Pain Management Group consists of a multidisciplinary group of physicians, nurse practitioners, dieticians, pharmacists, chronic disease nurses, kinesiologists, physiotherapists, and chronic pain nurses. The Group utilizes
multidisciplinary care for chronic pain patients and decreases the number of non-complex patients waiting for assessment at the Chronic Pain Centre. Physicians refer patients to the Pain Management Group for assessment and self-management treatment. 

http://www.albertahealthservices.ca/

Tele-chronic Pain

Member physicians may also consult a Chronic Pain specialist through the Tele-chronic pain service, where physicians can discuss patient medications, diagnosis and difficult/persistent health related issues over the phone. Each 15 minute telephone session can cover up to two issues and there is now reimbursement for this time. There is a template for this telepain consult.

Patient Benefits

- Access to chronic and complex disease services closer to home
- Improved continuity of care and communication between chronic disease healthcare professionals and physicians
- Increased support for self management for patients
- Access to primary care and a family practice physician (unattached patients)
- Better patient health outcomes
- Timely access to services

Physician Benefits

- Implementation support to ensure multidisciplinary providers are well integrated into the physician’s office
- Reimbursement for participation
- Decreased workload through multidisciplinary teams providing assessment, education and monitoring support for their patients with chronic disease
- Pain Lunch-and-learn sessions for family physicians in their primary care network. Allows them access to pain management education without taking time out of their clinic. This is funded and provided by Dr Chris Spanswick or Dr Lori Montgomery from the AHRCPC.

I had discussions with Dr June Bergman in Clinic-Director CFPCN Physician, David Croker Director of Clinical Services and sat in as an observer with a patient with David Wollman Behavioural Health Consultant.

The majority of my visit was spent with Yolanda Martens-VanHilst the Chronic Pain Lead Calgary Foothills Primary Care (CFPC). Yolanda has many roles and responsibilities at CFPC: Currently chronic pain session runs for one full day per week with educational activities in the morning and appointments in the afternoon and this is a Tuesday. Most of the patients seen should not be too complex but if required after assessment they can be referred onto AHRCPC.
Pathway for Chronic Pain patient.

- Yolanda (Nurse) does patient triaging for pain patients
- Inputs patient history on a computer template
- Patient to attend Pain Orientation session, Explain Pain program and Goal Setting program at CFPCN or AHRCPC prior to appointment at CFPCN
- At this stage the patient is required to complete various instruments such as the Patient Self Efficacy Questionnaire (PSEQ), Patient Specific Functional Scale (PSFS) and DUKE Health Questionnaire assessment tools
- Nurse does initial “meet and greet” for ‘initial consult’ with various team defined at triage and some of these may be a joint assessment.
- At the team meeting input is provided to initiate appropriate decisions about the patients management and a pain management plan is developed
- Care coordination for the patient is performed by Yolanda as the nursing role as well as Nurse follow up appointments when required
- Whilst patients are awaiting other appointments they are encouraged to attend Self management, programs eg) ‘Living Well’ program either via web or in person
- If patient needs eg) ‘Smart Moves’ program (Physical function based) or ‘Letting Go Moving Forward’ a Grief Group program th nurse will coordinate this for them to attend as part of the management plan
- An alert in the computer system will come up every 1-2 months for a patient to ensure their care is progressing.
- A time limit is set on the amount of time a patient will spend in the centre and this varies from 2-6 months. If they are too complex or require CBT or interventions they will be referred to AHRCPC

Issues:
- Funding at present is good for Chronic conditions and telehealth
- Sustainability and succession planning for all disciplines but especially nursing as only Yolanda is only nurse involve in the service
- Increase demand for chronic pain services and need to add another day to clinic

Resources Received:
- Letting Go Moving Forward program
- Templates and assessment tools for clinic
- “Telepain” template

Information and Resources Shared with Yolanda:
- HIPS Model of Care, Triage criteria, Screening Questionaire, Lifestyle and Pain Program, Understanding Pain program. Source: www.hnehealth.nsw.gov.au/pain
- HIPS GP Pain Management Action Plan
- HIPS Nursing Triage document
The Rockyview General Hospital (Figure 45 & 46) has acute care beds. The facility offers a full-range of adult-focused, inpatient and outpatient services. The AHRCPC offer chronic pain consultative services for the 3 adult acute care hospitals in the Calgary region Monday to Friday for patients with complex acute post surgery, trauma or chronic pain related issues. They also provide continuing pain education session for healthcare providers. This service may only be available via phone but the team try and do a round at least once one day a week at each of the hospitals. The team consists of a 2 x Nurse Practitioner, 1 x Clinical Nurse Specialist, Nurse Clinician, Chronic Pain Physician and some admin support with access to Addiction Specialist, Pain Psychologist and Pharmacist. (Not all of these people are on each site at any one time)

**Acute Inpatient Pain Service**

I met Dina Sotiropoulos, Nurse Practitioner (Family Practice) at 8am in the Acute Pain Service Office at Rockyview Hospital one very cold snowing/blizzard morning in Calgary, (I actual beat her to work on this day). I was to shadow her on one of her daily rounds in the hospital. As the NP she works as part of the AHRCPC consultative services for patients in the hospital with primarily complex acute pain issues. These patients are either referred by the APS or other teams for her to review. She also provides ongoing pain education for health care providers and patients on acute and chronic pain management. Dina like Ruth Ringland at Surrey is a NP in Family Practice. She is unable to prescribe opioids but she can recommend them and if the consulting team orders then she is able to titrate and order adjuvants such as NSAIDs. Once requested to see a patient she will perform a very comprehensive assessment on them. There is a template provided in the hospital electronic
record. This will include a review of their past history, procedures, tests and medications. Many times she has found that some issues with patients are that they are on contraindicated medications for their conditions or some pathology needs to be actioned upon. She will then contact the team and document in the notes her recommendations for the patient.

Dina will contact the AHRCPC once she has assessed the patient and discuss with them her management strategies for advice and approval. She referred to this process as contacting the “mothership”. A formal round with the Pain Consultant, Dr Spanswick or others will be on a Thursday. Generally she said she felt supported but at times a little isolated in her practice but it was good to know that there was someone there to ask for advice and support. Currently she is struggling with the increase in her workload with the numbers of Complex Acute Pain patients and the reluctance of the formal Acute Pains Service staff in the hospital to deal with them effectively.

Another interesting point that Dina discussed with me was the lack of support she felt regarding financial support to become an NP in Canada. She stated it took her 2 years to complete her program at university in which she had to financially support herself with no guarantees that on completion she would be provided a job as an NP. The other issue is that as the Ministry of Health funds these NP positions, if there is a change in government will this funding and positions remain? Nobody knows the answer to this.
The Pain Management Unit (PMU) at the QE II Health Sciences Centre (HSC) in Halifax (Figure 47) is a university-affiliated tertiary care clinic administered by the Department of Anaesthesia. It is also part of the Capital District Health Authority (CDHA). The PMU team includes health professionals from many disciplines, all of whom are committed to supporting people to manage acute and chronic pain (e.g., anaesthesia, psychiatry, psychology, physiotherapy, occupational therapy, and nursing). With chronic pain, we aim to reduce the pain where possible and provide additional strategies that support people to live with the pain and pursue a healthy lifestyle.

Key Contacts:

John Clark MD, FRCPC: Medical Director, Pain Services, CDHA
Mary Lynch, MD, FRCPC Psychiatrist: Medical Director, PMU, QE II HSC
Darlene Davis RN, BScN, MN, NP Health Services Manager, Pain Services, CDHA
Lynn Langille: Acute Pain Nurse, Victoria General Site (GGS)
Douglas Cane: Psychology Pain Programs, PMU, HSC
I had a detailed discussion with Dr John Clarke, Medical Director and Darlene Davies who is an NP but is currently working as a Health Service Manager for the Province wide pain service. Both are involved in the ongoing Implementation and evaluation of the Nova Scotia Pain Service.

In 2004, the Nova Scotia government was receiving numerous complaints from GP, Specialists and patients regarding the waiting times to access pain clinics. It was noted that some people were waiting up to 4 or 5 years to access a pain management services. Much work went into developing, “An Plan plan for the organization and delivery of Chronic Pain Services in Nova Scotia”’ (2006) Sourced at: http://www.painaustralia.org.au/images/painaustralia/research/NSActionPlanPostSLTJuly192006.pdf for the organisation and delivery of Chronic Pain Services in Nova Scotia. This plan included funding existing pain centres to ensure they could meet the demands and responsibilities of education and training required for pain management now and into the future. There were also identified significant gaps in service provision at the community and primary care level for the population regarding access to services. Funding was required to establish new multidisciplinary pain centres throughout the province as well as to ensure that pain management resources at a primary care level were well linked to secondary and tertiary care pain centres for support and advice. This plan included funding and developing a GP mentorship program where GP’s to rotate through Pain Centres and have a formal network attachment to one Pain Specialist. Much of this work is being done by Peter McDougal who is one of 7 physicians involved in the program.

There are 9 health regions in Nova Scotia and it has developed a very impressive provincial pain management strategy. Enhancing pain management resources and educational activities at a primary care level, with linkage to secondary and tertiary care pain centres. The PMU team has now increased its capacity to see patients and has implemented a new Centralised triage form (Figure 48) and system. There is a fulltime data person employed and there is also better access to the GP details for patients. These initiatives help to ensure those who need the services the most will have access to it as soon as possible. Although some patients may be seen quickly if they meet the urgent or fast-track criteria, others may wait two years or more for chronic pain services. Currently they triage about 80 referrals a month and the waiting list is between 1-2 years. This is much improved on waiting list previously but fluctuates due to the anaesthetic shortage in Nova Scotia in the Pain speciality.

This province wide strategy is continually under review and evaluation but it has significantly enabled patient’s better access to better pain service closer to their homes and in a more timely way. There is still more work to occur on the strategy but much of the work done in Nova Scotia could be transferrable to the NSW of Australian Model of Care for Pain. There is also scheduled to be a National Pain Summit in Ottowa, Canada in 2012 that will endorse Chronic Pain as a National Priority. This would be a significant shift in the right direction for Chronic Pain and funding.
Chronic Pain Services at PMU:

- Chronic pain treatment and management could be through medication, ranging from antidepressants to opioids which may be effective in managing chronic pain.
- Management strategies might range from procedural interventions eg) nerve blocks, acupuncture, trigger point injections or use of transcutaneous electrical nerve stimulation (TENS), and self-management techniques.
- **Chronic Pain Self-Management Program**: This is a group program of up to 16 people who learn ways to feel better, live healthier and learn to cope with their chronic pain. The program uses principles from psychology, physiotherapy and occupational therapy.
- Approximately 50% of patients self refer to the Pain Program which will require staff to interview them for suitability for the group. They can also do the group again later if they wish. The wait list is about 8 months.
- The PMU staff also encourages patients to attend the Your Way to Wellness free program that helps those with chronic conditions overcome some of the daily challenges that they face, of which chronic pain could be included. It also
- **Way to Wellness**: It is a six-week program (2.5hrs each) to learn how to manage your condition better, develop new skills, and use proven tools to help you maintain an active, fulfilling life and family members, friends, and caregivers of someone with a chronic condition are also encouraged to attend.

http://www.cdha.nshealth.ca/pain-management-services/

I had the opportunity also to speak with Dr Mary Lynch (Figure 49), Professor of Psychiatry, Anesthesia and Pharmacology at Dalhousie University. She is Director of the Pain Management Unit, Queen Elizabeth II Health Sciences Centre and Capital District Health Authority, Halifax, Nova Scotia. I had seen her speak at the Australian Pain Summit in 2010. Dr Lynch has over 20 years experience as a clinician assisting patients with chronic pain and has been instrumental in Nova Scotia and Canada to get Chronic Pain recognized and funded appropriately from government. She chaired the Canadian Pain Society (CPS) Wait
Times Task Force and has gone on to Co-chair the CPS Task Force on Service Delivery, The International Association for the Study of Pain Task Force on Wait times and serves as President of the Canadian Pain Society. Her research interests are on development of new agents for the treatment of neuropathic pain, integrative care in chronic pain management and she also has a special interest in inviting artists who live with pain to participate in a project called the Inspirational Artists Project. This interest in Arts and Pain was also very evident on the site visit by all the artwork adorning the research unit at the QE11 PMU.

![Figure 49: Dr Mary Lynch Director](image)

**Acute Pain Services**

Aim is to support people to manage acute pain resulting from surgery or trauma and to achieve as much pain relief as possible, allowing patients to recover and regain normal function more quickly. Again I was unable due to time restraints to go on the daily APS round but did meet with Lynn Langille who is the Clinical Nurse Specialist for the Acute Pain Service at the Victoria General Hospital site. This APS service is an anaesthetist led service with CNS and nurse support. It provides multimodal analgesia eg) PCA, epidurals, ketamine infusions etc. Average numbers of patients per day is approximately 20-25 patients per day. The rounds can be very busy especially if there are many complex pain patients.

There does appear to be good consultative support between the Acute and Chronic Pain Service for nursing and medical staff due to its close proximity to the PMU at QE11 on the same grounds. Lynn works a little differently from the practice in my acute hospital and APS as when the patient comes out of their operation, the Anaesthetist will page her to do an post op pain assessment and recommend a PCA or other modality which will then be initiated in the recovery room. This does seem a little foreign to me but seems to work for her service.

We discussed audit issues and analysing data issues and systems and have subsequently shared some resources and articles. Lynn also does a lot of the pain inservice and education on the wards which can be very time consuming and at times needs more nursing resource to cover the hospital.
Contact Details:

Dr John Clark: john.clark@cdha.nshealth.ca
Darlene Davis: Darlene.davies@cdha.nshealth.ca
Lynn Langille: lynn.langille@cdha.nshealth.ca
Douglas Cane: douglas.cane@cdha.nshealth.ca

Resources Received:
- Templates and assessment tools for clinic
- Triage form
- Nova Scotia Pain Plan
- Pain Program brochures and Information
- Patient Pamphlets http://www.cdha.nshealth.ca/pain-management-services/pamphlets-resources

Canada Links

NATIONAL CANADIAN INITIATIVE
Websites for information about Canadian initiatives:

- Canadian Pain Society  www.canadianpainsociety.ca
- Canadian Pain Coalition  www.canadianpaincoalition.ca
- Chronic Pain Canada  www.chronicpaincanada.org
- Pain explained Canada  www.painexplained.ca
- Headache Network  www.headachenetwork.ca
- Pelvic pain  www.pelvicpain.org
- Useful Links  www.aapainmanage.org/links
Other Resources and Links:

- [http://communitypainnetwork.com](http://communitypainnetwork.com) This provides an opportunity for family physicians to increase their understanding on how best to manage chronic pain for their patients. Critical for success has been a partnership with government and involvement of stakeholders.


- [https://www.crnbc.ca/crnbc/documents/324.pdf](https://www.crnbc.ca/crnbc/documents/324.pdf) - Health Professions Act, Nurses (Registered) And Nurse Practitioners Regulation, Crnbc Bylaw.


- [http://www.painbc.ca](http://www.painbc.ca) Pain BC, individuals, researchers and clinicians who share our interest in reducing pain.


- Community Management of Chronic Pain [http://cme.medicine.dal.ca/files/PMU.htm](http://cme.medicine.dal.ca/files/PMU.htm) Physicians interested in a clinical traineeship in the management of chronic pain should be aware of this preceptorship program presented by the Capital Health Pain Management Unit.

- [http://www.cdha.nshealth.ca/](http://www.cdha.nshealth.ca/)

- [http://www.cdha.nshealth.ca/pain-management-services](http://www.cdha.nshealth.ca/pain-management-services)

- [http://www.cdha.nshealth.ca/primary-health-care/your-way-wellness](http://www.cdha.nshealth.ca/primary-health-care/your-way-wellness)
SITES VISITED UNITED KINGDOM (25th November - 7th December 2010)

- Pain Association Scotland (David Falconer 25/11 & 26/11/10)
- Edinburgh, Pain Association Scotland (Phil Slizer 26/11/10)
- Glasgow, NHS Lanarkshire (Janette Barrie 29/11/10)
- Southampton University's NHS Trust (Dr Cathy Price 1/12/10)
- Stoneham Centre, Mooregreen Hospital (1/12/11/10)
- NHS Eastern and Coastal Kent Community (Val Conway 2/12/10)
- Southampton City Centre, Clinical Reference group (Dr Cathy Price 3/12/10)
- Adelaide Health Centre (Southampton), Western Community Hospital (6/12/10)
- Richard Hotham Unit Bognor Regis War Memorial (Dr Simon Dolan 7/12/10)
- Waterbrook Medical Practice (Dr Mark Saville 8/12/10)

Perth, Scotland, United Kingdom

Site Visit: 17 Pain Association Scotland Head Office  
Date: Thursday 25th & 26th November 2010  
Facility: Pain Association Scotland Head Office  
Address: Suite D, Moncrieffe Business Centre, Friarton Road, Perth, PH2 8DG  
Phone: 01738 629503 or Freephone: 0800 783 6059  
Contact: David Falconer, CEO of the Pain Association of Scotland  
Email: info@painassociation.com  

Key Contact:
David Falconer: Director, Pain Association of Scotland

David Falconer (Figure 50) has been the National Director of Pain Association Scotland (PAS) for almost 21 years. He has been instrumental in the development and delivery of its service.
which has now become the approved and preferred provider by the Scottish Government's Chronic Pain Steering Group. The association delivers self-management programs in collaboration with the NHS chronic pain services and a “rolling maintenance program” is delivered through a network of 32 local groups on a monthly basis for people burdened with chronic pain. PAS has been part of the Pain Collaboration and Exchange (PACE) initiative [www.paceconnect.org.uk](http://www.paceconnect.org.uk) which was started in 2004, in Northern Ireland, Scotland, Wales, North and South of England to improve pain management in the UK. The head office of PAS has recently located to Perth, Scotland (Figure 51).

**Pain Association Scotland (PAS)**

PAS has pioneered the development and delivery of the self-management training approach to chronic pain throughout Scotland for the last 21 years. It delivers staff-led pain management programs in a variety of urban and rural settings, Hospitals, Community Centres and Health Clinics. Their aim is to improve the quality of life, health and wellbeing for chronic pain sufferers, their families, carers and colleagues, through the delivery of self-management techniques. PAS is specifically designed to target those in the community who are affected by Long Term (Chronic Painful) Conditions.

PAS has tried various models over 15 years for pain self management program delivery eg) Expert Patient Program [http://www.expertpatients.co.uk/](http://www.expertpatients.co.uk/), Volunteer peer facilitators (trained, supported & supervised). It has taken the de-medicalization and Bio-Psycho-Social approach to management whilst encouraging patients to work collaboratively with healthcare professionals for their pain management.

**PAS currently deliver staff-led training in 32 locations throughout Scotland**

- self-management programs style is interactive
- Engagement is flexible delivery for programme.
- 8 week program, held once a week in local communities
- Wait for a new program to begin is only 1 month
- “Rolling program” of monthly meetings in the same local communities, where participants can discuss anything

All activities in the program focus on following self management principles related to pain management. Each session has a specific focus and a number of topics that are inter-related. The sessions are informal, interactive and friendly, consisting of teaching, discussion, sharing and practical sessions. Experienced staff member can facilitate and guide the pace and needs of the group at each session.

**Program Topics:**

- The Pain Stress Cycle
- Breathing skills
- Gentle movement
- Relaxation and distraction
- Acceptance
- Stress management
- Pacing and energy level awareness
- Dealing with anxiety and fear
- Guilt & embarrassment
- Goal setting & getting back to activity
- Communication with family and doctor
- Improving sleep
- Confidence and self esteem
- Holistic principles
- Dealing with negative thinking


PAS provides Intensive Self-Management Programs for the NHS in collaboration with Specialist Pain Services, ensuring that their local service has a high-end exit strategy. Others may have no local multi-disciplinary pain management program and use PAS service to fill essential gap in their provision. See Figure 52: Scottish Model for Chronic Pain

**Collaborative projects with the NHS are characterised by:**

- Specialist interactive approach to chronic pain developed for Scottish client group
- Open/speedy access to training input
- Continuity - Rolling programme is delivered throughout the year
- Flexibility - Projects respond to local needs
- High standards with good outcomes for clients
- Cost effective with good utilisation of resources
Figure 52: Scottish Model for Chronic Pain

Pain Association Australian Pain Summit Presentation

Collaboration with specialty teams in NHS and PAS

- Self Management Programs with the NHS Northumberland & Lanarkshire Chronic Pain Services in East England (Phil Sizer PAS)
- Self-management programs by the Scottish lead clinician for chronic pain services in Scotland Dr Pete MacKenzie.
- Janette Barrie (Nurse Consultant), NHS Lanarkshire Chronic Pain Service and author of the "Best Practice Statement" & involved in Government GRIPS Report on pain.
- Glasgow Back Pain Model*: Mick McMenemy (Lead physiotherapist).
- Rural services: Dr John McLeod (Consultant Anaesthetist) who runs his services the Inverness Program for the whole Highland area.
Resources Received:

- Program content and information
- Links to Community Pain Resources
- NHS Reports
- Chronic Disease reports and resources
- Scotland ‘Long Term Conditions Collaborative Improving Complex Care’, 2009

Resources sent and Collaborations with PAS:

- Partnership with HIPS and Chronic Pain Australia on Supporting Knowledgeable and Empowered Communities in the Hunter Pain Project (SKECH).
- We are possibly going to pilot PAS “Rolling Program” in our Local Medicare Local in the Hunter as part of this SKECH pain project
- David and I continue to liaise, Skype and email resources to each other around consumer pain issues and strategic documents relevant for enhancing pain awareness and funding.
Site Visit: 18 Tayside Pain Service  
Date: Thursday 25th November 2010  
Facility: Tayside Pain Service, Ninewells Hospital, Dundee DD1 9SY  
Address: Contact: Dr Johnathon Bannister  
Email:j.bannister@dundee.ac.uk  
Phone: 013 8242 5612  
http://www.nhstayside.scot.nhs.uk/  

Key Contacts:  
Dr Jonathan Bannister: Consultant in Anaesthesia and Pain Medicine, NHS Tayside  
Judith Rafferty: Lead Specialist Pain Nurse, NHS Tayside  
Dr Bill Macrae: Consultant Anaesthetist, in the department of Clinical Neurosciences  
Chronic Pain Service, the Acute Pain Team and the Hospice, NHS Tayside  

Ninewells Hospital (Figure 53) is located in Dundee. As part of the hospital there is a teaching section that includes the medical school and nursing school of University of Dundee. As such it was the second purpose built medical school in UK.  

The Pain Service provides Chronic Pain clinics throughout the Tayside Pain Service which is based on three sites, that is Ninewells Hospital, Dundee, Perth Royal Infirmary and Stracathro Hospital, Brechin. At Ninewells there is a Multidisciplinary Pain Service which is to set up to oversee the management of acute pain throughout Dundee Teaching Hospitals. Currently the team consists of Consultant Anaesthetists, a specifically appointed nursing sister and "link nurses" within some postoperative wards in Ninewells Hospital. There is also regular liaison with the Clinical pharmacists. They manage acute post-operative and complex pain issues in the acute inpatient setting. I did not get access to this team on my brief afternoon visit.  

I discussed the Pain Service with Johnathon Bannister in a little more detail and he outlined the staffing at Ninewells as the following: 4 Pain Consultants with dedicated Nursing and Secretarial support providing a comprehensive service. There are good links with Psychology, Physiotherapy and Occupational Therapy. There is centralised triaging to service and the GP’s have an e-template. He was also familiar with HIPS model and work.
This is usually triaged by the physiotherapist or pain nurse. Referrals will be accepted by either GP or Allied Health Professional. There is a good relationship with GP’s and Pain education. They are supported by government one afternoon a month to have education and many take Tayside Pain Service up and attend their Pain education program. This has reduced need for patients to be referred to the Pain clinic unless requiring specialist treatment eg) Pain intervention.

Pain Association also provide a Partnership with Tayside for their Intensive Self Management Pain Programs. They run them with staff from PAS and Tayside.

- Programme delivered in a flexible way to suit local needs, resources and interest
- Referrals from clinicians
- Programmes may involve clinical input or support from ESP Physiotherapists or Specialist Pain Nurses
- Aim is to improve well-being and self-efficacy by taking participants on a journey from a clinical model of care towards active self-management model
- Model provides substantial benefits including self-management skills
- Improved Outcomes include: self-efficacy, reduced stress and anxiety, increased activity and improvement in patient well-being

I had the opportunity to meet Judith Rafferty who is the Lead Nurse at Tayside Pain Service. and some other Pain Management Nurses who are involved in Consultant/Nurse Led Clinics Eg) New and Review Patients, TENS and Acupuncture. It was interesting to hear about the triage and assessment clinics and how the nursing role works with the PAS Pain program. Many thought this was great utilisation of resources. They could still case manage patients involved in groups but did not need to be in attendance as the PAS program leader would feedback to the Pain Team on any patient issues

**Information and Resources Shared with Tayside:**
- Pain ED Frequent Presenters work (Appendix 2)
- HIPS Nursing Triage document
- ACC link NZ for Procedural pain management
- Various pain related articles and links
- Continue to remain in contact via email and send each other pain related resources

**Contact:**

Judith Rafferty Lead Nurse Ninewells Hospital Dundee [jrafferty@nhs.net](mailto:jrafferty@nhs.net)
Unfortunately my plans to visit other pain services with PAS in Innverness and Falkirk did not eventuate due to mother nature. The United Kingdom was snowbound and I was stuck for 4 days in Edinburgh, Scotland (Figure 54). I was fortunate that David Falconer from PAS was to still arrange for a few of their staff and contacts to meet with me during this time.

I met again with Phil Sizer (Figure 55) who is the lead Trainer from Pain Association Scotland. I had sat in on a group program the day before which he delivered. He has significant experience delivering training in self-management, often in partnership with specialist pain clinics and other health professionals. He has also recently been involved in a large project in collaboration with Tayside Pain Service. Phil has a background in Philosophy which means discussions are a critical and often a stimulating part of workshops.

We discussed what was different about the PAS program. He stated that they had tried the Expert Patient program and also Nurse and Psych led programs and they had not seemed to have worked for their Scottish clients. ‘Expert Patient’ program was too costly, structured and rigid. Healthcare professionals tended to medicalize issues too much in the program even without meaning too. He explained it was different from other self-management programs because of style of interactive engagement with the groups and the non-linear way in which we work through the programs. Interaction is a key element to getting the best from and for the group. It is therefore vital that people delivering it are confident with
the Ideas and have outstanding group-work skills.

In terms of style PAS group leaders favour a more ‘human’ level of interaction with a serious focus but a great deal of room for humour as some of the issues can be very serious. This is potentially different from the more clinical approaches where ‘distance’ may be required. It is also very different from more ‘out of a book’ programs where ‘content has to be got through’ in a fixed way eg) Expert Patient Program.

In basic terms it means PAS team work in a way that is appropriate to the group. Usually all topics are covered (and if they’re not spoken about a hand out is given at the end of session. He finds that as the session unfolds, different groups need to focus on different topics. For example, I sat in on one of his groups (Planned for my visit as a maintenance group session) and the topic was to discuss PACING issues but as the session progressed, other people in the group wanted to discuss some medication and health issues. The session was facilitated by Phil but by the end we still did get around to discussing pacing issues and everyone felt heard and informed.

He stated, “Different people have different needs, but there does appear to be a common strand that runs through all the work and that in my mind is getting people to adapt positively to change using pacing, stress management, changing thinking and questioning habits. We recognise that the group is central to normalising people’s experiences, however we do not dwell (in fact I mostly avoid) discussion about individual diagnoses”. From what I experienced I believe this to be true.

There was much positivity from the group after the session. Many patients stated that they used the program session as a social outlet and for support to keep them managing their pain as best they can. They are not allowed to “Bitch and Moan” about things but present things in a constructive way to the group. If they wish to socialise this is to happen outside of the program and some do with their partners.

Ideal group numbers for group sessions is 8-10 people. Costs to run 8 week program eg) Venue, travel and speaker are approximately $4,000. This is partially funded with NHS contracts and donations to PAS. With regards to the groups it does not matter what order you attend the sessions. No referral is necessary and the only information collected for outcome review purposes is demographics, PSEQ other information is currently being decided upon eg) Opioid reduction and healthcare utilisation. A new self evaluation (spider web) tool (Figure 56) is available on the PAS website http://www.painassociation.com/ for patients to with chronic pain and links to other resources. It is in early phase of development.

Outline of 8 Session Program for PAS:

- Introduction: Defining self management, defining chronic pain, bio-psycho-social model, pain stress cycle, over-activity rest cycle
- Evaluation and focus on goals, understanding Chronic Pain acute vs chronic,
mechanisms, management options, relaxation 1
- Pacing 1 over activity-rest cycle, drainers, fillers, baselines, relaxation 2
- Pacing 2: thoughts and feelings, understanding resistance, changing habits, anxiety relaxation 3
- Stress, Anxiety, Pain-Stress Cycle, Mapping stress, Negative thinking relaxation 4
- Negative thinking, self-esteem, confidence relaxation 5
- Dealing with others, communication, management plans, flare-ups, next steps, goals for review relaxation 6 evaluation, feedback
- Review

The program starts off looking at what pain is, what mal-adaptations develop, how to break those behaviours, understanding issues that prevent adaptation, building understanding in self, changing habits and building confidence. It moves from pain management to self-management; moving increasingly toward dealing with psychological issues as a way to get unstuck and move on.

Some comments above from: Phil Sizer

Figure 56: Self Evaluation Tool on PAS website
Glasgow, Scotland, United Kingdom

Site visit: 20 Strathclyde Hospital, NHS Lanarkshire
Date: Monday 29th November 2010
Facility: Glasgow, Scotland
Address: Strathclyde Hospital, NHS Lanarkshire, Motherwell
Contact: Janette Barrie Nurse Consultant for Long Term Conditions NHS Lanarkshire
Phone: 01698 858293
Email: Janette.Barrie@lanarkshire.scot.nhs.uk

(Figure 57) Glasgow City

Contact:
Janette Barrie: Pain Management Clinical Nurse, Nurse Consultant for Long-Term Conditions at Strathclyde Hospital, NHS Lanarkshire, Motherwell

Due to snow I was unable to get to Strathclyde Hospital, NHS Lanarkshire, Motherwell Chronic Pain Service where Janette Barrie works so I caught a train to Glasgow (Figure 57) and we meet for lunch and chatted for a few hours. I am thankful to David Falconer from PAS for organising this form me. I found that after only speaking with her for a few hours that we had known each other for ages. She said the same the same of me and I think it had a lot to do with where we are both now in our pain careers and taking on more of a strategic and planning role. I have certainly stayed in touch with her post visit as she is a great resource and it seems that Scotland and the NHS are that much further advanced with their Model of Care for Pain than we are in NSW.

I think it is good to know the background to Janette as you will then appreciate how instrumental she has been in getting Chronic Pain funding and resources in the UK. Since qualifying as a Registered Nurse she has had a variety of clinical experience. She became a Clinical Nurse Specialist in Pain Management for NHS Lanarkshire and graduated from the University of Wales College of Medicine with an MSc in Pain Management. She has formed strong links between NHS Lanarkshire and Pain Association. With the synergies that chronic condition and chronic pain have, she was seconded to NHS Lanarkshire Board as Project Manager for ‘Life Long Illness’ and is the author of ‘Lanarkshire’s Outline Strategy for Life
Long Conditions’ and ‘Best Practice Statement’ Janette was then further seconded to the North Lanarkshire Partnership to project manage the local community planning pilot on ‘Chronic Disease Management’. She then joined the Practice Development team in August 2004 to take forward the development of a ‘Best Practice Statement for the management of chronic pain in adults NHS Quality Improvement Scotland’ : Practice Development March 2006, www.nhshealthquality.org. Other work she has been involved in with the Scottish Government for Older Persons is the ‘Long Term Conditions Collaborative Improving Complex Care’, 2009 http://www.scotland.gov.uk/Resource/Doc/263175/0078713.pdf Janette is also reviewing the Practice and District Nurses clinical pathways and education in primary care with regards to Chronic Pain and Chronic Conditions.

Another important government document is the ‘GRIPS report which outlines relevant information on Pain Services in Scotland for long term conditions. It is a similar body of work that the NSW Pain ACI is doing with Tertiary Pain surveys and visits to existing Pain facilities. Janette noted that she alto of resistance to her gathering of this information from the medical directors as they were unsure of the government’s initial motives but can now see it was to allow a plan for all of Scotland and review current resources out thee for Chronic Conditions and Self Management. A great resource Janette sent me was from the Long Term Conditions Alliance Scotland 2008, “Gaun Yersl “:The self management strategy for long term conditions in Scotland, , Scottish Government, Edinburgh

This strategy was unique as it was commissioned by the Scottish government but developed by the Long Term Conditions Alliance Scotland (LTCAS). The intention was to learn from people’s own experience when it comes to living with a chronic condition and allow them to inform health policy. It shows a great partnership with NHS Scotland and the alliance to allow a systematic way that self management can be embedded across the entire country.

Janette continues to represent Chronic Pain and is on numerous working parties and committees at a Local and National level to continue to get Chronic Pain recognised as a condition in its own right.

Information and Resources Shared with Janette::

- NZ ACC website for Pain Procedures www.acc.co.nz
- Queensland Persistent Pain Strategy Document
- Various pain related articles and links

Resources Received from Janette:
- Duty Statements for her Project Officer Roles
- NHS QOF website and Links
- GRIPS report and information
- Best Practice Statement; s as above and Chronic Condition,Self management policy
Key Contacts:

Dr Cathy Price: Pain Medicine Consultant Southampton  NHS (Figure 59)

**Dr Cathy Price** (Figure 58), MB BCH, DCH, FRCA, FFPMRCA is a consultant in Pain Medicine at Southampton University Hospitals Trust in the UK since 1999. In 2003 in response to significant pressures on the services, the local health community took the innovative step of shifting specialist pain management care out of hospital and adopting a whole systems approach to management of pain.

In 2000 as the Clinical Lead, she developed the first community based Pain Management Program in the UK and then in 2002, Community based Pain Triage Teams. These strategies helped eliminated long waiting times and has developed innovative ways of helping patients with complex pain problems and was transferrable to other sites in the NHS.

Cathy is an elected Member of the British Pain Society and is an executive membership of the UK Chronic Pain Policy Coalition. She has assisted government in the UK on with production of various reports on pain. Cathy continues to play a key role in in developing education and pain competencies for Practitioners with a special interest in pain.
Southampton Region:

In the Southampton area, there were prolonged waiting times in excess of one year for patients to be seen in specialist pain centres and often inappropriate referrals were made. At times it became impossible to manage and was necessary to close referrals into the service for a period of time. The end result in 2004 was the redesign of the service and development of primary care pain services, whilst retaining the option of a specialised hospital based pain services for complex pain patients. This was done in close consultation with the National Health Service (NHS) Trust.

The process required:
- Developing referral pathways for general practitioners
- Provision of treatment guidelines for different treatment options.
- Utilisation of non-medical staff to triage where possible eg) Physiotherapist, Nurse who are specially trained
- Stratified approach to patient’s need and earlier assessment and treatment.
- Health practitioners working closely with NHS managers to negotiate resources
- Detailed patient pathway (Figure 60) 16-18 weeks, 4 weeks to first Chronic Pain Service (CPS) team assessment, 4 weeks further for diagnostics and a 4 week wait for treatment or treatments if required. This was the plan!
- Triage by chronic pain service and refer to either musculoskeletal or rheumatology team and if required CPS team assessment as early as possible or proceed to treatment which can range across pain management programs, procedures, medication or the services of an external provider such as mental health
- GPs trainees are now regularly rotating through the assessment process.

In the United Kingdom, the NHS funds health and states that it “purchases health care” but does not directly provide it. Therefore, it is up to local regions and even private providers to make application to the NHS to provide funding for a service within a region and or specific site. Primary Care Trusts (PCTs), work with local authorities and other agencies that provide health and social care locally to make sure that the local community’s needs are being met. They have the ability to purchase healthcare in a region on behalf of the NHS providers and private practitioners at NHS rates, which then made significant savings in this pathway of care. It enabled a comprehensive interdisciplinary approach to chronic pain management at a ‘community’ and primary care level in Southampton.
Chronic Pain Management Service in Southampton

After redesign of services in 2004, Chronic Pain Service (CPS) team’s pain moved from a consultant-based approach to a multidisciplinary team, with consultant supervision. The teams are involved in primary care based assessments and treatment, as well as in the secondary care for those with highly complex needs.

The most specialised part of the service is based at the Royal South Hants hospital where the service manages about 450 patients a year. Less complex patients are managed by the community teams at Stoneham (SCPCT) and Hythe (HPCT). A variety of treatment options are also available as an outpatient. On request the chronic pain team will work with the inpatient acute pain service and other specialist teams at acute hospitals to help manage chronic pain conditions affecting inpatients.
Resources Received:
- A copy of the triage questionnaire
- Template for General Assessment
- Epidemiology data for pain brief and enhancements in Southampton
- GP Survey for Pain issues
- Summary sheet for team key decision points
- Summary sheet for patient to GP
- Reports on Outcomes [http://www.bathcentreforpainservices.nhs.uk/]
- Maps of Medicine information [http://www.mapofmedicine.com/]
- National Pain Audit 2009 - BPS/Dr Foster [www.nationalpainaudit.org]

I was generously hosted by Dr Cathy Price in her beautiful home (Figure 61) for a week and she had arranged numerous visits for me in the Southampton area. Unfortunately as you can see by (Figure 63), this was the snow scene outside my bedroom window the day after I arrived. We were unable to even get out of the driveway. A new experience for me to help shovel the driveway. Unfortunately all the roads were closed and my visit planned for this day to meet Neil Berry, Consultant Psychologist and clinical lead of the community pain service covering Southwest Hampshire, based in the Hythe Community Hospital was cancelled. I was also unable to meet Dr Jane Hazelgrove, Pain Medicine Specialist who is the clinical lead for the Southampton Pain Service.
As I was still stranded at her home, Cathy organised for me to speak via phone with Val Conway (Figure 63), who is the Clinical Lead-Consultant Nurse Community Chronic Pain Service, NHS Eastern and Coastal Kent. I spoke at length with her for over an hour and was able to gain some interesting information from her regarding the community based Integrated Clinical Assessment and Treatment Service (ICATS) for chronic pain in NHS.

Val Conway has been working as a Consultant Nurse in Chronic Pain since 2003 and now has over 15 years’ experience working with chronic pain patients. She is also a qualified acupuncturist. Val has been actively involved with the local Primary Care Trust (PCT) in Kent to redesign and develop a multi-disciplinary chronic pain service in East Kent. She is also Chair for a recently launched Primary Care Special Interest Group within the British Pain Society and hopes to be able to improve and develop pain management in primary care nationally.

Eastern and Coastal Kent and other aspects of her clinical practice in pain management. NHS Eastern and Coastal Kent is the largest NHS Community Health provider in England, serving a population of approximately 1.4 million people. It provides care across east and west Kent via a range of settings eg) private and nursing homes, health clinics, Community Hospitals, Minor Injury Units a Walk-in Centre and mobile units. As from 1 April 2011 they will be operating as an NHS Trust across the whole of Kent (excluding Medway) and its new name will be Kent Community Health NHS Trust. [www.eckcommunityservices.nhs.uk/](http://www.eckcommunityservices.nhs.uk/)
The Pain Clinic

The (ICATS) for chronic pain has been set up to provide a community based service tailored to the needs of chronic pain patients. It is staffed by a team of specialists in pain eg) medical, nurses, psychologists, physiotherapists and various supportive therapists. Their aim is to involve patients as much as possible in managing their own pain and improve their quality of life and function.

After much discussion on the phone and note taking, Val shared information on a few of her projects around Pain in the community. Here are the key areas I noted of interest and applicable to the work in Australia and NSW ACI around Models of Care for Pain. She has also given me a few links and resources to other interesting research in pain.

- There are 8 prisons in her health region. It is part of her role to go into prison and do assessments, rationalize medications and offer support and education to prisoners.
- Justice health issues in pain like NSW. Limited resources and recognition and staff wanting patients off all opioids and other meds are expensive, many patient’s judged as addicts without cause.
- Diverse population with many refugees from various backgrounds.
- There are 3 hospitals in her trust and they have a centralized triage system.
- GP’s with special interest in pain thus ,60-65% of pain management for patients is done in primary care and 35 & in Specialist Chronic Pain service.
- There are many nurse led clinics for less complex patients triaged and the nurse will help develop a management plan with the patient. This has been running for 4 years and is very unique (To send data and information)
- There are community pain programs available for patients eg) “Stitch and Bitch” group and some research states it does help reduce stress and distracts patients from pain and good social outlet for some (Articles on knitting and pain relief).
- Clinical leadership Audit in UK
- Older person and Pain issues and presentation.
Key Contact:

Dr Cathy Price: Pain Consultant
Barbara Sharp: Musculoskeletal Services Manager (Physiotherapist)

Moorgreen Hospital (Figure 64) is a community hospital in West End, near Southampton. Although it is within the geographical boundaries of Hampshire Primary Care Trust, the services and administration are primarily delivered by Southampton City Primary Care Trust.

Pain Assessment and Treatment

The primary aim of this service is to provide community and primary care practitioners with an accessible, chronic pain specialist multidisciplinary team. There is a centralised referral systems and initial appointment is with the ‘Pain Assessment Team’ (PATT). Patients primarily should have been fully assessed and preferably all other interventional treatment options ruled out prior to referral to other services.

The team provides confirmation and explanation of diagnosis and negotiates a suitable treatment plan which may be organised through secondary care, the GP, other services or continued within the team. The team can further explain investigation results and deal with the impact the long term condition may be having on the individual. Patients are provided with self help information when appropriate. Patients requiring further management may be transferred to physiotherapy, Pain Management Program or Pain Clinic. Links with liaison Psychiatry and mental health teams are available if required.
I went on an assessment with a patient and an ‘Extended Scope Practitioners’ (ESPs) who was a physiotherapist. ESPs are highly qualified expert therapists who work in an extended role and provide a range of interventions which include treatment, education and advice. In this practice they acted as the first point of contact in assessing the patients instead of a medical officer. They are able to order some diagnostics and use their advanced clinical reasoning and assessment skills to ensure that the patients are directed onto the correct treatment pathway. She was part of the ‘Orthopaedic Choice’ program which enabled patients who were previously waiting to see an orthopaedic surgeon to initially be seen by ESP for their initial assessment. She worked as part of an interdisciplinary team, with access to specialist clinicians including orthopaedic Surgeons, Radiologists and Pain Medicine Specialists. This assessment process has reduced patient waiting times, appropriate treatment much closer to home, reduced referrals to acute secondary care and reduced surgical procedures.

The Physiotherapist used the Physiotherapy Spinal Assessments template (I was given a hard copy of this tool. After the assessment she also referred queries to the Practitioner with a Special interest in Pain Management (PwSiS), known also as Gypsies for further advice and support regarding ongoing management for the patient. In the UK there is a Guidance and Competencies for the provision of services, using Practitioners with special interests (PwSiS) endorsed by the Royal College of GPs, Royal Pharmacological Society of Great Britain, NHS and Department of Health (Figure 65).

http://www.db.gov.uk/en/publicationsandstatistics/publicationpolicyandguidance/DH080956
Another very helpful document in primary care is, the 2009 Persistent Pain Guidelines for the pharmacological management of pain in primary care/non-specialist centres and referral to non-specialist secondary care services (Figure 66).


This spinal assessment was very comprehensive and all was documented in the patient notes. The patient and their partner were able to ask as many questions to the ESP as they wanted and their scans and X rays were put up and explained in great detail. Any miss information was corrected and after it was explained and the patient was offered some non-surgical alternatives and GP follow up, he was very happy with this approach. This whole process took over an hour.
Key Contact: Dr Cathy Price

In the afternoon Cathy took me to a District Health Service ‘Map of Medicine’ (MOM) Clinical Reference group in Southampton City centre. Map of Medicine pathways (Figure 67) represent a starting point for clinically-led service improvement, design and redesign activities. They are comprehensive, incorporating evidence-based information, expert knowledge and national policy. Implementing the Map locally allows multi-disciplinary teams from across organisations to come together to adapt a pathway to meet local challenges, ensuring that patients remain at the centre of all decision making on care design and delivery. http://www.mapofmedicine.com/

The group were discussing a shared back pain pathway in primary care. There were representatives from the acute hospital, GP’s community care and orthopaedic specialist and surgeons with a vested interest in the pathway. It was a very interesting processes but appeared to be successful with other previous Maps developed eg) Diabetes MOM. Cathy was obviously representing the pain management side of this process. I have had some limited review of MOM in my area health service but have never developed one with a group for pain or otherwise.
Figure 67: Map of Medicine example
I attended an Adult Outpatient Physiotherapy Musculoskeletal Clinic with Cathy Price at the Adelaide Health Centre (Figure 68) which is a new health centre based in the centre of the Millbrook community. Solent Healthcare provides most of the community-based services at the building including: eg) Physiotherapy, Musculoskeletal clinics, treatment for long term conditions.

The primary aim of this service is to provide community and primary care practitioners with an accessible, musculoskeletal diagnostic and physical treatment service for adults 16 years and over. This is an alternative service to direct secondary care provision. Treatment, following a full subjective history and objective examination, will be negotiated with the patient and will include elements of self-management, exercise, manual therapy, acupuncture, class work, gym, information provision and motivational techniques. Follow up appointments are made dependent on the individual needs of the client.

Patients who do not respond to physiotherapy here or require further diagnostic input will be transferred to an appropriate MSK or Rheumatology team. If they require further multidisciplinary input they will be transferred to the Chronic-Pain Assessment team (PATT).

Cathy did a lot of triaging in this clinic. She went through the process and the issues with regards to referrals that are incomplete and the need to contact the GP for more information. It was also interesting how easy it really was to triage the patients into the
appropriate clinical pathway from the information provided in the triage form. Even if they were triaged to the wrong team initially, due to the care coordination and case discussions process they would soon be referred onto the appropriate specialist for their care.

I also met with Paula Williams who was the NHS Program and Project Team around Pain Management Services and Long Term Conditions and Delivery Support teams for South Central NHS. She provided me with a document from a national conference in the UK (2009) commissioned by the Department of health; ‘Whose Pain is it anyway? Innovation in Commissioning for Chronic Pain management and selfcare.’ It explored how effective commissioning can improve the experiences and care of people living with chronic pain with a particular emphasis on self management.

This is a useful document with some interesting examples from NHS Kirkless PCT, NHS West Sussex and NHS Somerset regarding redesign, development and implementation of pain management services in these areas.
Site Visit: 26 Richard Hotham Unit Bognor Regis War Memorial
Date: Tuesday 7th December 2010
Facility: Richard Hotham Unit Bognor Regis War Memorial Hospital
Address: Shripney Road, Bognor Regis, West Sussex PO22 9PP, United Kingdom
Contact: Dr Simon Dolan Consultant Pain Management
Phone: 44 1243 865418
Email: simondolin@aol.com

Key Contacts:
Dr. Simon Dolin
Tina Hamilton - Sharpe CNS Lead Nurse

**Dr Simon Dolin, FRCA, PhD (Neuropharmacology)** (Figure 69), is the lead medical consultant in the West Sussex wide chronic pain management community services, Bognor Regis Hospital & Nuffield Hospital Chichester with 15 years consultant experience, the last 10 years have been full-time in Pain Management. He has extensive experience in wide range of interventional pain procedures.

![Figure 69: Simon Dolan](image1.png)

I had a morning visit at the Richard Hotham Unit at the Bognor Regis Chronic Pain Centre (Figure 70) where I was able to follow a couple of patients through the clinic with the nurses and physiotherapists and then have a discussion with Dr Simon Dolan. Dr Dolan is the lead clinician for the multidisciplinary team of nursing, physiotherapy and clinical psychology, rheumatology and liaison psychiatry.

The Chronic Pain Service provides a comprehensive multi-disciplinary assessment by the Pain Assessment Triage Team (PATT) who works closely with the Muscular-skeletal, Physiotherapy and Rheumatology departments. Patients need to be referred by a GP, consultant, allied health professional or cancer service and triage is centralized and done by specially trained nurses and physiotherapists and no longer is the responsibility of the limited medical staff. This has allowed more valuable clinic time for medical staff.
Treatment options may include, Medication review and rationalisation, TENS service, specialised physiotherapy services, myofascial pain techniques, acupuncture or interventional pain relief techniques for selected patients.

Patients are encouraged to self-manage their conditions, and are given their patient held record and provided with educational support to assist in their choices of treatment and lifestyle adaptation. This is done through educational workshops, group drop-in sessions and pain management program.

In the patient review that I was able to shadow staff member Tina Hamilton -Sharpe on, the patient was back for repeat trigger point injections and thus the comprehensive history taken from the patient on a template was completed along with the patients questionnaire previously in the clinic. The patient was very happy with this service and was also attending some education programs in the community. There is usually a follow up phone call made by the staff after treatment in the clinic.

This clinic had also recently piloted the Western Australian STEPS Pain program 1, with Dr Stephanie Davies but it was not all that successful. One possibility that staff noted was that it was too intense for their patient demographic as it was two days in a row, 8 hours in total. Perhaps if it was offered over a longer period of time and less intense for patients.

Resources Received:

- A copy of the triage questionnaire
- Template for Bognor Regis General Assessment
- Summary sheet for team key decision points
- Summary sheet for patient to GP

Reference:

1. Davies SJ, Quinter JL, Parsons R et al. Pre-clinic group education sessions reduce waiting times and costs at public pain medicine units. Pain Med 2011;12
Site Visit: 27 Waterbrook Medical Practice  
Date: Wednesday 8th December, 2010  
Facility: Waterbrook Medical Practice  
Address: Dryden Close, Waterlooville, PO7 6AJ, UK  
Contact: Dr Mark Saville (GP)  
Phone: 023 9225 7321  
http://www.waterbrookmedicalpractice.co.uk/index.aspx

Figure 71: Mark Saville, Cathy Price and Fiona Hodson

Key Contacts:  
Dr Mark Saville: GP  
Joy Lowe: Long term Illness Nurse  
Chad Chadha: Pharmacist

Waterbrook Medical practice was established in 1972 and is now a training practice of for doctors. The practice is supported by a team of district nurses, midwives, community psychiatric nurses and counsellors.

Dr Mark Saville MB BCh (Wales 1987) DRCOG MRCGP, Full-time partner and registered GP trainer. Joined the practice in 1991 and his particular interest is Diabetes and Long Term Conditions Clinic in GP Practice.

Long Term Illness Clinic  
A Long-term illness clinic takes place in this practice on Wednesdays and is nurse-led. The clinic reviews all stable patients with hypertension, ischaemic heart disease, diabetes and a past history of CVA/strokes every six months. It seems that pain is a big issue in this clinic for most patients as well.

Whilst in the Southampton area meeting Dr Cathy Price (Pain Specialist) and her facilities in December 2010, I met her husband Dr Mark Saville who is one of the General Practitioner’s at the Waterbrook Medical Centre. As I was very interested in the management of Chronic and Complex conditions in general practice, which very often can have a complicating pain component, he offered me the opportunity to visit and sit in on a Long Term Conditions (LTC) clinic to see how this team works within his practice.

I visited this clinic on Tuesday 7th December 2010 till lunchtime. I was introduced to some of the team by Mark and followed a few patients through this clinic with Joy Lowe (Nurse) and...
Chad Chadha (Pharmacist). I was very impressed with the comprehensive way these two team members worked together to facilitate a better health outcome for each patient and the way they worked together to also involve other family members/carers in attendance.

Initially Joy would do the required health checks, pathology and physical assessments as a template on a computer program along with informal discussions to find out any other issues relevant that might impact on their current health and chronic condition status. This holistic approach to patient care also identified some social and financial issues that these patients face each day which might complicate their long term condition management eg) Diabetes and increasing costs associated with healthy food choices. Both staff displayed a very skilled and subtle way of engaging the patient and their carer about healthy lifestyle choices, medications, diet and disease management strategies. There could also be a trans-generational impact on health status of future patients seen in your practice. These costs in the future may be hard to quantify but would be significant for each individual, their family and National Healthcare System (NHS) budgets. This LTC clinic also significantly compliments the medical management provided by GP’s in the practice who are the care co-ordinators responsible for each patient.

Issues around clinical and pharmacological management were then handed over to Chad (Pharmacist) to discuss and review with the patient. There was consistency of “health messages” to the patient and family/carer regarding their long term condition by both members, re-enforcing management strategies for the patient. Chad would then review the patients’ progress and discuss any health concerns with them in more detail if needed. A large part of his role was also regarding pharmacological rationalisation and management. Pain medications and management was addressed with each of the patients I saw in the clinic. Chad discussed with the patient to have his medication reviewed as they had been on an antidepressant for many years. The patient then expressed their desire to try and stop using this medication as it appeared not to be needed anymore and due to time constraints at last GP visit, did not bring the topic up for discussion. A plan of action was then put in place for their next visit. This reduction in medications could reduce polypharmacy and side effect issues for the patient and have a financial impact on the practice and patient.

I was very impressed with this LTC clinic and could see the major economic and health benefits it can have to a medical practice and the patient. It was complimentary to what the GP’s could do in their time limited medical consultations, usually related to more acute health episodes. I believe it also plays a significant preventative role for many patients regarding their health status due to comprehensive ongoing review and management processes in place. The LTC clinic, although taking more time for throughput, was able to address multiple issues and make a comprehensive healthcare management plans for each patient that were very patient and at times carer/family centred. I think this model would also work well in Nursing Homes and Residential Care facilities where there are many elderly people with multiple co-morbidities and long term health conditions, of which pain is usually of significance. I would recommend this model to Primary Care in NSW.
United Kingdom NHS, Scotland and England Links

National Institute for Health and Clinical Excellence

- National Institute for health and Clinical Excellence (NICE) is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. [http://www.nice.org.uk/Guidance/CG96](http://www.nice.org.uk/Guidance/CG96)

PACE (PAin: Collaboration and Exchange)

- PACE (PAin: Collaboration and Exchange) sets out to support the development of primary care chronic pain management by: 1. Facilitating the multi-disciplinary sharing of knowledge and best practice. 2. Raising awareness of the need for more effective pain management provision in the UK
- National Prescribing Centre (NPC) NPC Rapid Review: Quick and succinct commentary on a recent newsworthy health issue related to prescribing and/or medicines. [http://www.npc.nhs.uk/rapidreview/?p=1465](http://www.npc.nhs.uk/rapidreview/?p=1465)
An Executive Committee has been formed of senior representatives from a broad range of stakeholders who share a concern for improved pain management services in the UK in a mission to develop an improved strategy for the prevention, treatment and management of chronic pain and its associated conditions. [http://www.policyconnect.org.uk/cppc](http://www.policyconnect.org.uk/cppc)

Guidance and Competencies for the provision of services, using Practitioners with special interests (PwS). Pain Management which are endorsed by Royal College of GPs, Royal Pharmacological Society of Great Britain, NHS – Primary Care Contracting, Department of Health [http://www.db.gov.uk/en/publicationsandstatistics/publicationpolicyandguidance/DH080956](http://www.db.gov.uk/en/publicationsandstatistics/publicationpolicyandguidance/DH080956)


BMJ Evidence Centre: Clinical Evidence is one of the world's most authoritative medical resources for informing treatment decisions and improving patient care. [http://clinicalevidence.bmj.com/ceweb/index.jsp](http://clinicalevidence.bmj.com/ceweb/index.jsp)


UK Royal College of nursing [http://www.rcn.org.uk/](http://www.rcn.org.uk/) Representing nurses and nursing, promoting excellence in practice and shaping health policies


Bath Pain Program: Bath Centre for Pain Services (BCPS), part of the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust. They are a centre of excellence for the provision of intensive rehabilitation services for adults, young adults and adolescents with chronic pain. [http://www.bathcentreforpainservices.nhs.uk/Index.aspx](http://www.bathcentreforpainservices.nhs.uk/Index.aspx)

• “The Pain Toolkit” via petemoore2@yahoo  [www.painconcern.org.uk/...]

• “Walking for Health”:  [www.whi.org.uk]

• Expert Patients Programme:  [www.expertpatients.co.uk]

• Southampton Based Chronic Pain Support Group:  [www.keepingpace.co.uk]

• Care closer to home Pilots:  
Appendix: 1 HIPS Model of Care

A Whole Person Model of Care for Persistent Pain in Hunter New England Health
Fiona Hodson and Dr Chris Hayee
Hunter Integrated Pain Service HNEN Health

Background
The Hunter Integrated Pain Service (HIPS) is a multidisciplinary team based at John Hunter Hospital. HIPS manages acute, persistent and cancer pain with an emphasis on health promotion and active self management.

In 2004, HIPS began a process of service redesign to improve access for patients from a wide geographical area, where travel rates consistently exceeded service capacity and waiting lists were excessive.

The model (Figure 1) that has evolved is consistent with WHO’s Health for All strategy and -- 2004 & 2007 NSW State Health Plans --- and 2006 World Health Organization health priorities. The model balances community, primary and tertiary interventions and also non-medical treatment with active self management. Progress was achieved without increasing resources, by rethinking in holistic practices and redirecting in new evidence-based approaches.

The inaugural National Pain Summit March 2010 Canberra acknowledged the HIPS model as one of Australia’s 5 best practice models. It was also noted as a leading model against those from United States, Canada and United Kingdom.

Figure 1 HIPS Model of Care

Key strategies in the redesign process:
- New referrral priorities & waiting time targets
- Modification to clinical services, referral and coding procedures, outcome measures and individualised care planning
- Websites for pain management resources, lists for healthcare professionals & community www.hnennh.gov.au/pain
- Early discharge policy linking with general practitioner
- Telephone support for patients & health providers
- Personalised Pain Management Action Plans (PPMAs)
- 80 hour group program replaced by shorter group tailored to individual needs: Working with Pain, Living with Pain, Stress Group, Neuropathic Pain Group
- Pre-assessment: Understanding Pain education
- Research activities eg benchmarking, utilisation of outcomes with other specialty pain units around Australia

Figure 2 HIPS Redesign Strategy

Figure 3 HIPS Whole Person Model of Care

5 year evaluation of service improvement and patient access following implementation of a new model of care for persistent pain in HNEN Health.

Method
Evaluation of HIPS model included qualitative data such as staff, patient and referral feedback and quantitative analysis of waitlists and clinical outcomes.

A series of key changes were initiated from late 2004. At a systems level, the decommissioned a stratified and integrated model which aimed to improve access and patient care. The approach (Figure 2) included a greater focus on community and primary resources, group interventions and more active and efficient use of specialist services at tertiary level.

At the level of the individual patient, therapeutic behaviour shifted away from more traditional biomedical treatments and high intensity cognitive behavioural (CBT) programs towards a more patient centered approach. Early exposure to more optimal management around neuroplasticity, mindfulness and lifestyle interventions has encouraged uptake of this management for a much larger cohort of patients.

Figure 4 HIPS Patient Ability

Overall reduction in waiting time for clinical assessment across all intake categories A,B,C (Figure 5) despite a reduction in medical FTE over last 4 years.

Understanding Pain = new model of care
Reduced impact of non-attendance

Future Scope
The model has proven to be successful in the Hunter New England region. Currently the Agency for Clinical Innovation (ACI) is investigating transferability of this and other models across NSW consistent with the National Pain Strategy. Future directions will involve delivery of key public health messages; continued partnerships with primary care including education; development of resource lists, compliance/external affairs; delivery of short group interventions in the community.

References

Figure 5 HIPS Patient Ability