Royal National Orthopaedic Hospital

Chronic Pain Centre

Annual Report 2014 - 15

Financial Year 2014 / 2015

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Introduction

The Royal National Orthopaedic Hospital (RNOH) provides comprehensive care for patients with chronic pain (CP) resulting from a wide range of musculoskeletal and neurological problems. Pain management services are provided by experienced specialists ensuring that patients benefit from an inter-disciplinary approach. This approach is fostered by multidisciplinary ward rounds, clinics and meetings as well as combined clinics between specialties within the RNOH.

Key Achievements in 2014 - 15

- Appointment of a third specialist nurse in chronic pain
- Establishment of regular neuro-modulation theatre lists
- Appointment of the first departmental Data Collection and Research Officer
- Commencement of electronic Patient Reported Outcome Measures (PROMs) data collection using the RNOH Patient Outcome Data (POD) system
- Presentation of the service at RNOH Annual General Meeting 2014
- Redecoration of the Chronic Pain Offices
- Interviews set up for the appointment of a fourth substantive consultant in early 2015-16

Current Constraints & Limitations

Adapted from Medicine & Rehabilitation Strategy Document Presented to RNOH Executive Team in January 2015, prepared by Dr Gall, Lead Physician

Changes to the commissioning of services may have a profound impact on future funding for this service. The main risk is that specialist pain services will be defined by comprehensive service provision rather than by separate areas of high expertise and specialisation. The current trend is that demand for the Chronic Pain Service is high and rising. We have had to considerably tighten our criteria for acceptance of referrals in order to meet this demand.

The lack of physical resources including theatre space, clinic rooms, ward space and office space put any expansion plans at risk. Continuing growth and support of IT services will be required. During 2014 there have been intermittent problems with inconsistent administrative and secretarial support services (e.g. typing delays) which has impacted on service delivery.
# Chronic Pain Service Structure

**Service Manager**  
Rob Emmins

**Consultants in CP**  
Roxaneh Zarnegar (Lead Consultant)  
Jonathan Berman  
Tacson Fernandez  
Dan Mihaylov (locum position)  
Liza Tharakan (locum position)

**Consultants in Psychiatry**  
George Ikkos  
Sara McNally

**Clinical Nurse Specialists**  
Julia Sach  
Faustina Aikins  
Michelle Lilley

**Secretarial & Administrative**  
Sarah Jason  
Sonia Brito

**Data Collection & Research**  
Tajinder Manic

**Trainees**

**Advanced Pain Training**  
Danielle Reddi (Feb 14 – Aug 14)  
Maria Stasiowska (Aug 14– Feb 15)  
Ramy Mottaleb (Feb 15 – current)

**Intermediate Pain Training**  
Michael Gilhooley (Higher trainee, Aug 14)  
David Murphy (Higher trainee, Sep 14)

The service is supported by:

- Specialist Physio- and Occupational Therapists in CP and Rehabilitation
- Rehabilitation and Pain Specialist Psychology Service
- Gill Thurlow, Nurse Consultant in Rehabilitation
- RNOH Central Bookings Office particularly Ethal Sangasinha & Kristin Rackwitz
- Pharmacy services particularly Carrie Fung, Acute Pain Specialist Pharmacist
Definitions & Abbreviations

BPI: British Pain Inventory

CP: Chronic Pain

Hospital Episode: The spell a patient has had in hospital for specific condition.

IASP: International Association for the Study of Pain

MDT: Multidisciplinary Team

NPA: National Pain Audit

PMP: Pain Management Programme

Partial Booking: A method for booking follow-up appointments. Clinic follow-up appointments are not made straight away; patients are reminded to make contact nearer their allocated appointment date to be given an exact time and date.

PROMs: Patient Reported Outcome Measures

SCS: Spinal Cord Stimulation
Benchmarking
Against the National Pain Audit 2012

A) Type of clinic:
Multidisciplinary Pain Centre for MSK and Neuropathic Pain

The National Pain Audit (NPA) 2012 defined clinic types according to the International Association for the Study of Pain (IASP) Recommendations for Pain Treatment Services, 2008. The RNOH chronic pain service meets all the standards set for a Multidisciplinary Pain Clinic (Table 1) which also carries out research (Multidisciplinary Pain Centre).

B) Organisational Standards:
Organisational standards figures are reported separately for England and Wales in the NPA 2012. Table 1 shows how we compare against clinics in England who returned data.

The NPA collected data on staffing including:
- Clinical Staffing (clinical psychologist, consultant pain specialist, access to a clinical pharmacist)
- Multidisciplinary Working (combined presence of psychologist, physiotherapist and physician as key personnel)
- Physiotherapy posts
- Administrative staff

Other organisational standards were IT support and wheelchair access.

C) Professional Standards:
Professional standards data collected in the NPA were:
- Carrying out regular clinical audit
- Teaching medical students, therapists or nurses
- Carrying out research

Table 1 demonstrates our position as compared with services in England. Training higher trainees or fellows was not specifically considered by the NPA.
Table 1: RNOH Chronic Pain Centre organisational standards performance against chronic pain services in England

<table>
<thead>
<tr>
<th>NPA Organisational Standards</th>
<th>RNOH 2013</th>
<th>NPA 2012 (England)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychology</td>
<td>Met</td>
<td>48%</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>Met</td>
<td>52%</td>
</tr>
<tr>
<td>Consultant led interventional pain management</td>
<td>Met</td>
<td>72%</td>
</tr>
<tr>
<td>Multidisciplinary working (psychology, physiotherapy &amp; physician)</td>
<td>Met</td>
<td>40%</td>
</tr>
<tr>
<td>Waiting time &gt;18 weeks</td>
<td>Met</td>
<td>80%</td>
</tr>
<tr>
<td>Access to Pharmacist</td>
<td>Met</td>
<td>78%</td>
</tr>
<tr>
<td>Dedicated admin staff</td>
<td>Met</td>
<td>84%</td>
</tr>
<tr>
<td>IT support</td>
<td>Met</td>
<td>57%</td>
</tr>
<tr>
<td>Wheelchair access</td>
<td>Met</td>
<td>100%</td>
</tr>
<tr>
<td>Clinical audit activities</td>
<td>Met</td>
<td>74%</td>
</tr>
<tr>
<td>Teaching activities (any of medical students, therapists, nurses)</td>
<td>Met</td>
<td>66%</td>
</tr>
<tr>
<td>Research</td>
<td>Met</td>
<td>27%</td>
</tr>
</tbody>
</table>
Waiting times

In the 2012 NPA 80% of clinics that returned data in England and 50% in Wales were able to meet the 18-weeks key standard. In England 2.5% explicitly did not meet the standard and the rest did not answer. Please see figures 1.1 & 1.2.

Figure 1.1: Non Admitted Performance (target for RNOH: 95%)

Figure 1.2: Admitted Performance Target for RNOH: 90%
Referral Pathways

Referrals will be considered from:

- RNOH consultants
- Consultants at other secondary or tertiary care centres
- General practitioners both locally and nationally

Referrals from specialist non-medical practitioners will only be accepted if explicitly supported by a named consultant or GP.

Figure 2 outlines the core pathway along which all patients flow. Patients will receive treatments or be referred to other members of the team running alongside this pathway.

Figure 2:
Acceptance Criteria

Information necessary for a comprehensive first consultation including all relevant clinic letters, reports of all imaging and results of relevant laboratory investigations over the previous two years should be included with the referral letter. In case of MRI and CT scans, the referrer should make the necessary arrangements for the actual images to be sent to us including reports prior to a clinic date being given.

Inclusion criteria

- Chronic neuropathic or musculoskeletal pain
- Adult patients (> 18 years) and children over 11 years
- Already reviewed and treated for the chronic pain condition as far as possible either by a service at RNOH or at a secondary care centre
- Referred specifically for a specialist chronic pain service (neuromodulation, residential high intensity pain management rehabilitation programme, paediatric chronic pain, spinal cord injury related pain)

Exclusions

- Patients receiving treatment at other pain clinics or comparable services for the same pain condition will not be offered an appointment unless a direct referral has been made from the other pain clinic / service for a second opinion.

- We do not have multidisciplinary facilities and specialist support to cater for:
  - Chronic headache and orofacial pain as the primary presenting symptom
  - Chronic pelvic pain (except in patients with Spinal Cord Injury)
  - Chronic abdominal pain (except in patients with Spinal Cord Injury)
  - Chronic intractable angina
    (Although advice will be provided for our patients with musculoskeletal pain who have these problems concomitantly.)

Discharge Criteria

Patients will be discharged when one of the following criteria are fulfilled:

- No further interventions planned by the RNOH Pain Centre.
- Only simple titrations of commonly used medication are being offered.
- The treatment options offered to the patient have not been accepted.
- The patient has been accepted for or is receiving treatment at another pain clinic for the same condition.
- The pain service has no treatments to offer that cannot be provided under the care of another specialty that is already treating the patient for the same condition.
Case Load

Case load data 1st April 2014 - 1st April 2015
(Source: RNOH Insight)

A total of 849 patients have attended RNOH Pain clinic as new patients in this year.

Case Load in Adult Pain Clinics
(Excluding neuromodulation clinics)

Table 2: Adult new patient demographics (n = 849)

<table>
<thead>
<tr>
<th>Referral Source</th>
<th>RNOH Pain Centre</th>
<th>NPA</th>
<th>RNOH</th>
<th>GP (Primary Care)</th>
<th>Tertiary Care Centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender Male</td>
<td>292</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender Female</td>
<td>557</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M:F Ratio</td>
<td>1:1.9</td>
<td>1:1.8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Age</td>
<td>52</td>
<td>53.8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral Source</td>
<td>598</td>
<td>201</td>
<td>50</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 3: Patient numbers by age group

![Age Group Diagram](chart.png)
Case Load in Paediatric Pain Clinic (<18 years)
(Source: RNOH Insight)

Seven patients were seen in paediatric pain clinic this year as new patients.

Table 3: New paediatric pain new patient demographics (n = 7)

<table>
<thead>
<tr>
<th>Gender</th>
<th>RNOH Pain Centre</th>
<th>RNOH</th>
<th>GP (Primary Care)</th>
<th>Secondary Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender Male</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender Female</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M:F Ratio</td>
<td>1:2.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Age</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral Source</td>
<td></td>
<td>5</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Admissions for Residential Pain Self-Management Rehabilitation Programs (PMP)

1st April 2014 - 1st April 2015.
This data does not include admissions under rheumatology and rehabilitation services

Number of admissions for chronic pain rehabilitation: 69
Hotel based programme: 24
Rehabilitation ward: 45

Table 4: PMP patient demographics

<table>
<thead>
<tr>
<th>Gender</th>
<th>RNOH Pain Centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender Male</td>
<td>22</td>
</tr>
<tr>
<td>Gender Female</td>
<td>47</td>
</tr>
<tr>
<td>Ratio M:F</td>
<td>1:2.1</td>
</tr>
<tr>
<td>Average Age</td>
<td>51 years</td>
</tr>
</tbody>
</table>
Outcomes Data

1st June 2014 - 1st April 2015 (inclusive)

General information on PROMs data collection
(All clinics)

All adult patients are asked to complete European Quality of Life 5 Dimensions, 5 Levels (EQ5D-5L) and Brief Pain Inventory (BPI) in first and subsequent contact with the pain clinic. They complete Global Impression of Change (GIC) in subsequent visits.

In 2014 – 15, baseline outcome measures were collected from 464 new patients

Home Completion: 131 (28%)
RNOH/Work Completion: 328 (71%)
Other: 5 (1%)

Demographics of those who completed PROMS at home:

Female gender: 87
Male gender: 44
M:F Ratio: 1:1.9
Average age: 50 years

![Age Group Chart](chart.png)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-40</td>
<td>35</td>
</tr>
<tr>
<td>41-65</td>
<td>80</td>
</tr>
<tr>
<td>65+</td>
<td>16</td>
</tr>
</tbody>
</table>

Number of Patients: 35, 80, 16
First visit PROMS Data for Adult Pain Clinics
(Excluding neuromodulation clinics and paediatric patients)

A) EuroQol 5D-5L - Total Patients (441)

Table 5: Data on first visit to RNOH Pain Clinic (n = 441)

<table>
<thead>
<tr>
<th>EQSD-5L health state</th>
<th>Mobility (%)</th>
<th>Self-care (%)</th>
<th>Usual activities (%)</th>
<th>Pain (%)</th>
<th>Anxiety/depression (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No problems (1)</td>
<td>45 (10%)</td>
<td>138 (32%)</td>
<td>11 (2.5%)</td>
<td>8 (1.8%)</td>
<td>127 (29%)</td>
</tr>
<tr>
<td>Some impact (2)</td>
<td>67 (15%)</td>
<td>104 (24%)</td>
<td>57 (13%)</td>
<td>37 (9%)</td>
<td>110 (25%)</td>
</tr>
<tr>
<td>Moderate (3)</td>
<td>102 (23%)</td>
<td>104 (24%)</td>
<td>167 (38%)</td>
<td>180 (41%)</td>
<td>110 (25%)</td>
</tr>
<tr>
<td>Severe impact (4)</td>
<td>193 (44%)</td>
<td>72 (16%)</td>
<td>166 (38%)</td>
<td>192 (44%)</td>
<td>59 (13%)</td>
</tr>
<tr>
<td>Extreme impact/unable to do activity at all (5)</td>
<td>34 (8 %)</td>
<td>23 (5 %)</td>
<td>40 (9 %)</td>
<td>24 (5.4%)</td>
<td>35 (8 %)</td>
</tr>
</tbody>
</table>

It has been possible to compare RNOH first visit figures to those of patients included in the NPA 2012 on entry to the audit but adjustments were made to account for the NPA using EQSD-3L rather than EQSD-5L which has been adopted across all departments at RNOH (Table 6)

In the domain of impairment in usual activities, it has been reasonably assumed that a person who would rate their impairment as ‘severe’ (rather than slight or moderate) would rate themselves as ‘unable’ on EQSD-3L rather than choose the option of ‘some’.

In the domain of ‘pain or discomfort’ it has been reasonably assumed that a person who would rate themselves as having ‘severe’ or ‘extreme’ anxiety or depression in EQSD-5L would rate themselves as having ‘extreme’ pain on EQSD-3L (rather than ‘moderate’ pain)

In the domain ‘anxiety/ depression’ it has been reasonably assumed that person who would rate themselves as being severely or extremely anxious or depressed in EQSD-5L would rate themselves as having ‘extreme’ anxiety/ depression on EQSD-3L (rather than ‘moderate’).

The ‘mobility’ domain was not comparable between the two because the wording ‘confined to bed’ in EQSD-3L has no reasonable equivalent in EQSD-5L.

The adjustments were:

<table>
<thead>
<tr>
<th>EQSD-5L</th>
<th>EQSD-3L</th>
<th>Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘No impairment’</td>
<td>equivalent to</td>
<td>‘No impairment’</td>
</tr>
<tr>
<td>‘Unable’</td>
<td>equivalent to</td>
<td>‘Unable’</td>
</tr>
<tr>
<td>‘Severe impairment’/ ‘Unable’</td>
<td>equivalent to</td>
<td>‘Unable’</td>
</tr>
<tr>
<td>‘Severe’/ ‘Extreme’</td>
<td>equivalent to</td>
<td>‘Extreme’</td>
</tr>
<tr>
<td>‘Severe’/ ‘Extreme’</td>
<td>equivalent to</td>
<td>‘Extreme’</td>
</tr>
</tbody>
</table>
Figure 4: EQ 5D-5L comparative profiles for ‘no impairment’

Figure 5: EQ 5D-5L comparative profiles for ‘severe impairment’/ ‘unable to do’
**Table 7**: EuroQol Index Value of Health Status on first visit to RNOH Pain Clinic & entry to NPA
(Smaller value indicates lower health status)

<table>
<thead>
<tr>
<th></th>
<th>Average (Mean)</th>
<th>Min</th>
<th>Max</th>
<th>Median</th>
<th>1st quartile</th>
<th>3rd quartile</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RNOH, first visit</strong></td>
<td>0.32</td>
<td>-0.594</td>
<td>1</td>
<td>0.318</td>
<td>0.10</td>
<td>0.58</td>
</tr>
<tr>
<td>(n = 441)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NPA, entry to audit</strong></td>
<td>0.404</td>
<td>-0.073</td>
<td>0.845</td>
<td>0.357</td>
<td>0.201</td>
<td>0.596</td>
</tr>
<tr>
<td>(n = 2870)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Table 8**: EuroQol Health VAS Scores on first visit to RNOH Pain Clinic & at entry to the NPA

<table>
<thead>
<tr>
<th></th>
<th>Median</th>
<th>Mean</th>
<th>Interquartile range</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RNOH, first visit</strong></td>
<td>48.5</td>
<td>44.1</td>
<td>35 - 46</td>
</tr>
<tr>
<td>(n = 441)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NPA, entry to audit</strong></td>
<td>50</td>
<td>52.5</td>
<td>35 - 70</td>
</tr>
<tr>
<td>(n = 2870)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

On the whole EQ5D data leads us to conclude that patients seen at RNOH pain clinic are more severely disabled than the general population of patients seen in pain clinics in England (Tables 7 & 8 and Figure 5).
B) Brief pain inventory - Total patients (441)

Table 9: BPI – Pain severity score at first visit to RNOH Pain Clinic (n = 441)

<table>
<thead>
<tr>
<th>Pain ratings</th>
<th>Pain least</th>
<th>Pain worst</th>
<th>Pain average</th>
<th>Pain now</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1st quartile</td>
<td>4</td>
<td>8</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Median</td>
<td>5</td>
<td>8</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Mean</td>
<td>5.2</td>
<td>8.6</td>
<td>6.9</td>
<td>5.6</td>
</tr>
<tr>
<td>3rd quartile</td>
<td>6</td>
<td>9</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Maximum</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>

Table 10: BPI – Pain severity score first visit to RNOH Pain Clinic & at initial entry to NPA

<table>
<thead>
<tr>
<th></th>
<th>Mean average pain severity</th>
<th>Mean worst pain</th>
<th>Mean Pain Now</th>
</tr>
</thead>
<tbody>
<tr>
<td>RNOH, first visit (n = 441)</td>
<td>6.5</td>
<td>4.8</td>
<td>5.9</td>
</tr>
<tr>
<td>NPA, entry to audit (n = 8903 )</td>
<td>7</td>
<td>7.9</td>
<td>6.1</td>
</tr>
</tbody>
</table>

Table 11: BPI – Pain interference profile at first visit to RNOH Pain Clinic

<table>
<thead>
<tr>
<th>Statistic</th>
<th>General activity</th>
<th>Mood</th>
<th>Walking ability</th>
<th>Normal work past 7 days</th>
<th>Relationships with other people</th>
<th>Sleep</th>
<th>Enjoyment of life</th>
<th>BPI interference (mean)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1st quartile</td>
<td>7</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>3</td>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Median</td>
<td>8</td>
<td>7</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>7.35</td>
<td>7.3</td>
</tr>
<tr>
<td>Mean</td>
<td>7.75</td>
<td>6.82</td>
<td>7.12</td>
<td>7.7</td>
<td>5.4</td>
<td>7.35</td>
<td>7.3</td>
<td>7.03</td>
</tr>
<tr>
<td>3rd quartile</td>
<td>10</td>
<td>9</td>
<td>9</td>
<td>10</td>
<td>8</td>
<td>9</td>
<td>9</td>
<td>8.4</td>
</tr>
<tr>
<td>Maximum</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>
### Table 12: BPI – Interference scores first visit to RNOH Pain Clinic & at initial entry to NPA

<table>
<thead>
<tr>
<th></th>
<th>Mean General activity</th>
<th>Mean Mood</th>
<th>Mean Walking ability</th>
<th>Mean Normal work past 7 days</th>
<th>Mean Relationships with other people</th>
<th>Mean Sleep</th>
<th>Mean Enjoyment of life</th>
<th>Mean BPI interference (mean)</th>
</tr>
</thead>
<tbody>
<tr>
<td>RNOH, first visit (n = )</td>
<td>7.75</td>
<td>6.82</td>
<td>7.12</td>
<td>7.7</td>
<td>5.4</td>
<td>7.35</td>
<td>7.3</td>
<td>7.03</td>
</tr>
<tr>
<td>NPA, entry to audit (n = 8903)</td>
<td>7.2</td>
<td>6.6</td>
<td>6.5</td>
<td>7.3</td>
<td>5.3</td>
<td>6.8</td>
<td>7.2</td>
<td>6.7</td>
</tr>
</tbody>
</table>

### Table 13: Direct comparison of entry BPI scores for RNOH Pain Clinic and NPA

<table>
<thead>
<tr>
<th></th>
<th>BPI median average pain first visit</th>
<th>BPI interference (mean)</th>
</tr>
</thead>
<tbody>
<tr>
<td>RNOH, first visit (n = 441)</td>
<td>7.0</td>
<td>7.03</td>
</tr>
<tr>
<td>NPA, entry to audit (n = 8903)</td>
<td>6.5</td>
<td>6.7</td>
</tr>
</tbody>
</table>
Feedback on the CP Patient Portal & PROMS

259 New patients provided feedback on the patient portal & CP PROMS between 1st June 2014 and 1st April 2015. This information is no longer collected by us.

They were asked to rate the system for data collection as a whole on a 10-point Likert Scale from 0 – 10. The mean score was 8.7 (in the “excellent” range).

Figure 6: Pie chart for patient ratings of the POD system

Comments left by patients:

Adding a comment was optional. Of the patients who completed patient feedback, 150 left a comment, 54 (36%) positive, 61 (40%) negative, 14 (10%) had mixed content and 21 (14%) were irrelevant to POD data collection.

Overall the comments followed 4 themes:

Theme 1: Nature of the questions

Although all are validated and widely used questionnaires, patients had many comments about their nature. These included “conflicting questions”, “not all questions are relevant”, “you cannot always give a yes or no answer”, “and the way the questions are phrased does not allow accurate answer”. Most patients wanted more choices, had more to say and wanted free text. Some were offended that the questions attempted to put them in boxes. There were a few positive comments where patients stated they could see how this would assist the doctor.

Theme 2: The time it takes to do the questionnaires

Most these comments were negative: “drawn out”, “took a while”, “used up appointment time”. A small proportion of patients commented that it was “quick” filling them in. Some commented that they thought this was valuable appointment time and said that they would much rather be explain their problems to the doctor.
Theme 3: The technology
Comments about the POD technology were mostly positive and mostly referred to the use of the tablet device when patients used it in clinic with the advocate present. Most of these comments were positive especially re home access technology, ease of use. There were a lot of positive comments about the POD advocates. Some found it difficult, painful and stressful. Many patients admitted to being unfamiliar with the technology and probably would not have been able to complete the forms without an advocate present.

Theme 4: Comments irrelevant to POD
These were comments about problems with access to care or other services.

Conclusions
Although many patients in the Chronic Pain service have a positive experience of using the RNOH POD data collection system, it is evident from the comments that they do not completely understand the purpose of the questionnaires. We have a responsibility to explain this to patients more clearly if we are to continue this type of data collection.

The contribution of POD advocates to this data collection is enormous. Not only do they ensure that we have complete data sets, it is evident from the comments that a significant proportion of patients would not be able to complete the questionnaires at all without them. The patients who would be missed would be the more disabled subset.
Friends and Family Feedback for the Chronic Pain Service
Training

Advanced pain training

Written by M Stasiowska, Advanced Trainee, August 2014 - February 2015

The Chronic Pain Centre provides Advanced Training in Pain Medicine as a one year fellowship. Six-months of this post takes place at UCLH, National Hospital for Neurology & Neurosurgery.

My clinical duties included:

- Interventional lists with direct involvement in the consent process, post procedure management and follow-up arrangements - all were supervised by consultants
- All day Friday clinics under indirect supervision
- Contribution to inpatient reviews
- Administrative duties related to my pain clinic work

I was encouraged to attend clinics in rheumatology, CRPS and shoulder pain as well as multidisciplinary meetings with radiology and spinal surgery. There are weekly educational meetings with a chance to present and discuss clinical cases, research articles or audit/research projects.

At RNOH I have developed confidence in assessing patients with predominantly musculoskeletal pain conditions. I feel able to instigate an initial management plan for patients with complex pathologies, including psychosocial problems and do common procedures such as: lumbar facet injections, caudal epidurals, sacroiliac injections, infusions and capsaicin patch treatment independently.

The department is busy and there isn’t always time to observe other specialists in clinic, theatre and ward rounds. Overall the post offers interesting, clinically relevant and well-rounded training. There is good supervision and senior support and plenty of opportunities to experience a true multidisciplinary approach to chronic pain. I would recommend this post to any pain trainee.

Intermediate Pain Training

Written by David Murphy, Intermediate Trainee, 2014

I completed my Intermediate Pain Medicine module at RNOH in combination with Intermediate Orthopaedics. I spent a dedicated 2 weeks on Pain Management with a well-planned schedule of clinics, procedure lists and MDT meetings. There was a range of interesting cases seen in the clinics.

Consultants took the time to discuss the patients with me and get me involved. The procedure lists showed a good number of different techniques. I was also exposed to less invasive procedures such as lignocaine infusions and capsaicin patch applications where I was able to get more involved. I observed spinal cord stimulator insertion and the follow-up of patients with SCSs. Overall I enjoyed the pain module more than I thought I would. This is down to a combination of the department being friendly and keen to teach and the wide range of pain issues that RNOH manages. I am more confident in assessing chronic pain and have a better idea of the issues facing chronic pain patients presenting for anaesthesia.
Clinical Audit & Quality Improvement

The Chronic Pain Centre (CPC) contributed data towards the 2012 National Pain Audit and participates in all hospital-wide audits relevant to our practice. The full reports of these are available from the Clinical Audit Department. Summaries appear below. We also do clinical audit specific to our own areas of work.

The RNOH Record Keeping Re-Audit 2014

Contributors: J Sach, R Zarnegar

This audit has run annually at RNOH since 2011. Medical records documentation has been examined against national and local standards with 79 question items out of which 52 are directly relevant to record keeping done by CPC staff. When comparing RNOH Chronic Pain centre results against the hospital average, we perform better than average in most of the relevant areas with only three exceptions:

- Correct recording of alterations (single line, dated, timed & signed) – CPC 0%, Trust average 8%
- Recording of the discharge date on discharge summaries – 83%, 90%
- Sending a copy of the last clinic letter to patients – 80%, Trust average 90%

Data from this audit demonstrates that we have improved our performance in documentation of time of the record, printing of our names legibly, recording the consultant name and patient diagnosis on the clerking sheet has improved considerably since the last audit in 2013.

The RNOH Re-Audit of Consent for Surgery and Interventional Treatments 2014

The CPC contributes to the Multi-Site Consent Audit run by the Clinical Audit Department. Individual departmental or consultant data are not available although we have been exposed to the results and changed our practice in line with the general audit findings. The CPC is planning an internal audit of consent for interventional procedures that will also enable us to compare our performance to other clinicians.

The RNOH VTE Risk Assessment Audit

All admissions under the care of a CPC consultant are risk assessed for VTE on admission. The Trust’s performance in this area is steadily improving. The vast majority of our patients who are admitted for day case interventional procedures are not expected to have any reduction in mobility compared to their normal state and therefore do not need any specific prophylactic measures. Rehabilitation admissions usually have greater mobility than usual. Mechanical prophylaxis measures are used for patients who need more extensive procedures such as insertion of neuro-stimulator.
Audit of Medicines Management in the Pain Clinic

M Gilhooley, R Zarnegar

This was a retrospective audit of 38 patients in whom clinical correspondence notes were searched to look for evidence of effective and appropriate analgesia management. Thirty five (92%) of patients had a medicines management plan in the first clinic correspondence. In half of the patients there was at least one medicine reported by the patient to be ineffective. The opportunity to reduce ineffective medicines was taken in half of these (10/38), representing substantial benefits both to cost and potentially to patients’ health status by reducing adverse effects. We already do very well in reducing inappropriate treatments but we can be even more effective in this regard.

Review of Patient Comments on Patient Outcomes Data (POD) Collection

T Manic, R Zarnegar

See page 19.

Clinical Coding for Neuro-modulation

D Mihaylov, T Fernandez

A retrospective audit of the completeness and accuracy of clinical coding for neuro-modulation procedures was performed in collaboration with the RNOH Clinical Coding Department, covering the period January - May 2014. Fourteen n-mod procedures were identified during this period. In all cases, there was evidence of incomplete coding. The clinical activities not coded included multidisciplinary meetings, removal of primary n-mod leads as well as reprogramming of n-mod devices. In all 14 cases, the HRG Specialist Spinal Centre ‘top up’ was not captured. Incorrect OPCS codes were assigned to 3 of the 14 procedures, with no income difference identified following correct code assignment.

As a result of the audit, changes have been made to the way the neuro-modulation service is clinically delivered. Discussions are taking place with RNOH Clinical Coding Department in order to further elucidate and rectify the issues related to completeness of coding.

Policies & Procedures

In 2014, the following CPC policy documents were updated:

- Protocol for the Administration of Lidocaine Intravenous Infusion (R Zarnegar & J Berman)
Research Publications & Conference Abstracts

Improving the value of discharge summaries sent out to general practitioners after a multidisciplinary pain management programme
Gill Thurlow, Thea Claxton, Cara Lovell, Andrew Lucas, Victoria Tidman, Roxaneh Zarnegar. British Journal of Pain 2014, 8 (2) Supplement 1 page 52

“Work is a beautiful thing…” exploring attitudes towards employment in chronic pain (CP) patients attending a pain management programme (PMP)
Parmpreet Kalsi, Wafa Turkistani, Catherine Sykes, Andrew Lucas, Roxaneh Zarnegar. British Journal of Pain 2014, 8 (2) Supplement 1 page 63

Retrospective survey on the use of capsaicin 8% (Qutenza) patch for traumatic peripheral neuropathic pain
D Mihaylov, R Zarnegar, C Fung. Presented at World Congress of Regional Anaesthesia and Pain Therapy (WCRAPT), Cape Town, South Africa, 24th – 28th November 2014

Importance of MRI imaging of spine prior to trial of spinal cord stimulators
T Fernandez, D Mihaylov. Presented at World Congress of Regional Anaesthesia and Pain Therapy (WCRAPT), Cape Town, South Africa, 24th – 28th November 2014