FACULTY OF PAIN MEDICINE
of the Royal College of Anaesthetists

Newsletter of the Faculty of Pain Medicine | Autumn 2012

TRANSMITTER
ONLINE

Major Faculty Updates
Specialist Commissioning for Chronic Pain
Pain Medicine Maps
Paediatric Pain
CPD and Revalidation

FACULTY OF PAIN MEDICINE
of the Royal College of Anaesthetists

I hope you will agree when you reach the back page of this edition of *Transmitter* that it has contained something of particular interest or support for you. We want *Transmitter* to be both 'newsy' and supportive – to navigate unprecedented changes happening around us.

We bring the usual - news from the Dean, accounts of the ongoing work of the Professional Standards and Training and Assessment Committees, updates from our representatives of Regional Advisors in Pain Medicine and the Pain Medicine trainees, details of our fantastic educational meeting programme and the latest on Faculty membership and who's there to represent you at Committee and Board level.

We have the regular article on the FFPMRCA examination, this time with news from the first sitting of the MCQ component.

Our quality guest contributions, we hope, offer something for everybody and resonate with you as being areas of particular challenge, concern or anxiety at the present time.

Dr Andy Nicolaou, who is charged as lead for their implementation, introduces us to the Pain Patient Pathways drawn up by the British Pain Society and published by Maps of Medicine. He describes the arrangements for commissioning and the place of the pathways in engagement with Clinical Commissioning Groups. Dr John Goddard presents us with a very informed and wise view of Specialised Commissioning, which again will affect us, as pain management will also be commissioning specialised services.

We are grateful to Mr Don Liu for his very informed article on revalidation, to help us through yet another of our current challenges.

A challenge for the trainees has been the FFPMRCA examination. We are pleased to report a high pass rate at the MCQ stage and await the outcome of the Structured Oral Examinations; we welcome the extremely insightful article from Dr Julian Scott- Warren.

Finally we hope you enjoy the first of our 'spotlight' articles covering the area of Paediatric Pain Medicine.

Happy reading!

Kate Grady

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Establishing a UK Clinical Research Network for Pain

Professor David Rowbotham

Dean of the Faculty of Pain Medicine

Although the evidence-base supporting the practice of pain management is superior to several other branches of medicine, it is often patchy and arises from a relatively small number of studies utilising, by modern standards, low patient numbers. This has been, and will continue to be, a problem with our relationship with commissioners as they increasingly require treatments to be underpinned by solid evidence of cost-effectiveness. Until recently, when considering clinical trials, most thought was given to study design. Hardly any thought was given to whether a study was feasible, could be completed in a reasonable time with the finances and clinical services available and was sufficiently large enough to ensure that the data gave rise to conclusions that could be accepted with confidence.

In recent decades, the United Kingdom has become one of the worst countries for the delivery of clinical trials, not just in pain but in every specialty. This was partly responsible for the near terminal decline of clinical academia and almost wholly responsible for the mass exodus of the pharmaceutical industry from the UK. The National Institute for Health Research (NIHR) recognised this and has established an imaginative and effective infrastructure to make the UK a reliable deliverer of clinical research, both commercial and non-commercial. The backbone of this strategy was the formation of Comprehensive Local Research Networks (CLRN) and associated speciality networks whose responsibility was the delivery of clinical studies on time and on target. This is making a real difference in many specialties and there are signs that the UK is now becoming recognised as one of the better centres in Europe for this activity. Unfortunately, no substantial network of individuals and centres is available for the delivery of chronic pain studies; consequently, we are unable to take full advantage of these developments.

The CLRNs host a number of specialty interest groups, including the Anaesthesia, Perioperative Medicine and Pain Group. This has made important advances in delivering research and is becoming highly regarded by the NIHR. However, with respect to pain, it urgently needs access to a reliable research network for it to deliver its growing portfolio of pain studies. Therefore, in association with the British Pain Society (BPS), we intend to establish such a network. The first step towards achieving this goal was a meeting held at the RCoA on November 1st 2012 which was attended by 43 delegates.

The meeting explored the background to clinical trials in the UK and heard from others who have made significant progress after establishing networks. Partners in the National Institute of Academic Anaesthesia (NIAA) have awarded around £2m supporting research into anaesthesia and related specialties but only a small proportion of this has been for clinical trials in pain. The Scottish Pain Research Community is well established and has begun to move towards closer co-operation of centres within Scotland to deliver clinical research. The NIAA and BPS have carried out research priority exercises which have resulted in a good understanding of some of the major issues in Pain Medicine which need resolving by large clinical trials; most require a multicentre design. The NIAA Perioperative Research Group has progressed considerably in the last two years by forming a network for the development and delivery research in this area; indeed, it is our unashamed intention to copy what they have done.

The final section of the meeting was given to group work; delegates were asked to answer three questions: should a clinical research network be established; what would such the network look like; and what were the next steps to deliver it? Perhaps it wasn't surprising that all the delegates attending this first meeting thought that the answer to the first question was yes! Also, there was a remarkable consensus on the potential functions of the network. These included: regular national meetings; research training events; ensuring a multidisciplinary approach; developing close relationships with the pharmaceutical industry and MedTech companies; a rapid and reliable census to establish the availability and willingness of clinical centres and individuals to be part of the network; working closely with the CLRN special interest group; identifying and working with a pain friendly clinical trials unit; further developing research priorities; and providing research opportunities for FPM Advanced Pain Trainees and others.

It is likely that the next full meeting of the network group will be in six months' time. However, it is our intention to work hard on this venture utilising the considerable momentum that came from the initial meeting. We will be developing a web presence shortly and formulating an action plan and brief business case. It is also our intention to communicate on a regular basis with those who attended the first meeting. We have made considerable progress in Pain Medicine in recent years particularly education, training and professional standards. However, we need to address issues around the evidence-base underpinning our interventions and treatments. The development of a research network will give confidence that we are taking this seriously and will eventually start to deliver answers to some very important questions. Other specialities have these networks and we need to be one of them.

The network will fail if we do not attract many other members of the pain community, particularly Fellows of the FPM. If you and your colleagues would like to be part of this network please contact the Faculty. Personally, I feel that this is the missing piece of the jigsaw that will elevate Pain Medicine to a level enjoyed by many of our colleagues in other specialties. Please join us – the network will not only serve our patients, the NHS and our profession, it will also give you great personal satisfaction and, I promise you, it will be fun.

Training and Assessment

Dr Kate Grady

Chair, FPM Training & Assessment Committee

The day to day work of the Training and Assessment Committee (TAC) continues to expand. We have had a further change in the membership of the Committee, as Emma Baird joins us as the newly appointed trainee representative. We congratulate Emma on her appointment and welcome her to this Committee. We would like to thank Dr Neeraj Saxena for his work during his time as trainee representative and we wish him well. We also welcome Dr Mark Jackson as a co-opted member. Dr Jackson has been given responsibility for running the twice yearly FFPMRCA examination tutorials, the first of which ran in May and the second of which will run on 17th December.

The Assessment Working Group of the TAC is now live. This group comprises Board and Committee members, and others showing a keen interest in Pain Medicine education and the work of the Faculty. It is the intention that this group will look at assessment across many aspects of the Faculty's activity, such as the RCoA curriculum and its application in the workplace, (at all levels and particularly at advanced level), the examination and entry to Fellowship of the Faculty. It will consider ways in which assessment might be streamlined to suit all these purposes and will review the use of the e-Portfolio and the Pain Medicine logbook.

As described in the Training and Assessment Committee report in the last issue of *Transmitter*, we propose to identify our force of Local Pain Medicine Educational Supervisors (LPMESs) who may be keen to develop their roles within the Faculty and may be potential support for the Regional Advisors in Pain Medicine (RAPMs). We now have a near complete register.

> **"We are very keen to have useful and functional lines of communication with Fellows, Members and trainees"**

The TAC continues to represent the Faculty at RCoA level and beyond. We have close links with the RCoA Training Committee, its Out of Programme Experience system and the Workforce Planning Strategy Group.

We are very keen to have useful and functional lines of communication with Fellows, Associate Fellows, Members and trainees. We hope that the Regional Advisor in Pain Medicine (RAPM) network and representation by the lead RAPM at Board and TAC level fulfils this. We aim that communication with trainees is further ensured by trainees' representation at both levels. We are also happy to hear about issues from any individual directly.

The Faculty is curently undertaking a workforce survey and we have been gathering your responses for the last few months. I would like to make mention of the importance of your responses in our work as a Committee, and as a Board - the engine room of the Faculty. We are keen to work for you and eager to hear from you so we may negotiate on your behalf.

The discussion around time being spent in Advanced Pain Medicine training has been had at Board level. There is clear agreement and advice that Advanced Pain Medicine training should be full time during the working week (allowing for hours off after night time on call commitments). We estimate this is likely to equate to a minimum of six sessions per week. The only duties that might be undertaken outside Pain Medicine training are on-call duties.

We have had a report of a reduction in the number of Advanced Pain Medicine training posts in one region and some reports of reduced take up of existing posts. However, further discussions suggest that this is not a constant pattern, with some regions remaining oversubscribed. We will continue to monitor this and keep our Fellows and Members updated.

The FFPMRCA examination is reported under a separate heading but this report would not be complete without mention of it. The MCQ part of the examination was held on 19th September and the SOEs are to be held in the middle of November. A new examination will always create unknowns, and without a history, the examination presents a challenge to examinees and those involved in the creation of the examination.

We are aware that the examination has generated some anxiety amongst the trainee population proposing to take it, and are working hard to offer as much information and support as is possible. We are delighted to report that 29 of the 32 examinees who sat the MCQ paper have passed and are eligible to apply for the SOE part of the examination. The setting of the pass mark has been rigorous and systematic (following processes used for the same for the FRCA examination); we are very pleased therefore to be bringing news of such a high pass mark.

As ever, we, the TAC remain indebted to and extremely well supported in all our work by the Faculties team of Daniel, James, Anna and Andrea.

Professional Standards

Dr Karen Simpson

Chair, FPM Professional Standards Committee

The summer holidays are over again and it is time for the PSC to consider the areas that it will focus on and develop in the coming year. We need to have a mixture of strategic goals, educational ventures and the capacity to react to changing demands. I have seen the scope and volume of the work of the PSC increase since its inception in 2009. Membership of the committee is a time consuming task and I am grateful to the members who contribute so much, usually in their own time. Our lay representation is particularly important and valued.

I am pleased to announce that a Communications Working Party is being established under the leadership of Beverly Collett that will report to the PSC. It will have many task-based functions, such as promoting the profile of Pain Medicine, ensuring that information is made clear and accessible, establishing communication with central Government and other authorities that have influence over policy, and developing relationships with media. This working party will enable and facilitate dissemination of professional opinion in matters relevant to Pain Medicine.

As ever good practice guidelines continue to be developed: the FPM is working in partnership with the BPS to formulate national guidance on medial branch block and radiofrequency procedures for lumbar spinal pain. In view of recent activity within the insurance sector it is important for the FPM to be involved in the production of clear guidance on clinical practice.

Driving and medication is an issue for our patients and us. It is worth reading the NICE/DVLA guidance for Medical Practitioners '*A Glance Guide to Current Medical Standards of Fitness to Drive*' that was launched in May 2012: http://www.dft.gov.uk/dvla/medical/ataglance.aspx

The FPM has agreed to endorse a consensus statement on addiction to medicines that has the support of a Health Minister. This is particularly important work for which we are very grateful to Cathy Stannard. Evidence to support prescribing is available through the web-based NHS Evidence service managed by NICE: https://www.evidence.nhs.uk

Revalidation is progressing and the FPM has representation on the RCoA Revalidation Specialty Advisory team. Dr Kate Grady and I have been appointed as National Clinical leads in revalidation. We will attend two training days about revalidation and the process of standardisation in 2012 and report back.

Sanjeeva Gupta has again arranged excellent meetings this year and more are planned. An exciting development is the plan for a study day on psychiatry topics in liaison with the Royal College of Psychiatrists. There are many areas of mutual interest and this I hope will be the start of a fruitful collaboration. The work of arranging these meetings is considerable and with this in mind I am pleased to tell you that Dr Sandesha Kothari has accepted the post of FPM Deputy Educational Meetings Advisor to assist Dr Gupta.

The programme for the 22nd November Annual Meeting has the usual excellent mix of international speakers. This day is a good opportunity to learn some new things, catch up with colleagues and check out what is happening elsewhere in the UK! Please do come.

The PSC is increasingly busy and is asked to respond in detail to ever more consultations; it seems to meet the deadlines every time.

Online CPD system

for FPM Fellows and Members

- Set out and maintain a personal development plan
- Search for approved Level 3 Pain Medicine educational events
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- Record your CPD credits, reflective notes and learning outcomes
- Generate a summary report of CPD activities for your annual appraisal

To register for an account go to: **www.cpd.rcoa.ac.uk**

Or contact the RCoA Revalidation and CPD team at cpd@rcoa.ac.uk or 020 7092 1729

Regional Update

Dr Barry Miller

Chair of the RAPMs

“The single biggest problem in communication is the illusion that it has taken place” - *George Bernard Shaw*

The main themes of the last RAPM meeting at the British Pain Society in Liverpool earlier this year could be summed up as ‘Communication and Information’, and, like tiger hunting, can reveal either the joy of what you are looking for, or how worryingly close its teeth are!

The seemingly limited remit of the RAPMs and LPMESs with regards to training, hides the wider responsibilities of these duties, and the core task of co-ordinating local training is sometimes swamped by the variety of political, diplomatic and bureaucratic pressures that come from all directions. We sometimes feel a little lonely in our own regions, when things do not go as planned, or when there doesn’t seem to be any obvious plan at all.

Communications

“Send me a postcard, drop me a line / Stating point of view.”
- *Lennon & McCartney, ‘When I’m Sixty-Four’*

Our parent speciality of Anaesthesia has a good reputation for support. It has always been easy to seek advice, either vertically or horizontally, and it is encouraged at all levels. This applies as much to Faculty work as to clinical. The matters do not have to be weighty or world shattering, but if you want advice – ask.

Send me a postcard, drop me a line, stating point of view.

A new RAPM can sometimes find the breadth of tasks daunting, and may have new ideas to improve local training. How to institute them? Who to liaise with? What are the responsibilities of the Deanery, the School, the local Trusts? Who makes the decision happen?

The answers are not always clear, or uniform across the country, but there will always be someone who can help.

Information

In parallel with ‘Communications’ it is clear that some issues recur, and individuals find they are reinventing the proverbial wheel. To help address this issue I’m looking to expand the FAQ section on the Faculty’s new website. FAQs are intended as a less formal means of circulating common ideas and practices. They are not intended to be prescriptive or proscriptive, but hopefully address frequent issues and give some practical advice on solutions. I’m happy, indeed keen, to receive ideas for this area:
http://www.fpm.ac.uk/faculty-of-pain-medicine/faqs

The RAPM meeting in Spring raised two particular areas, and I’ve added a third, but it is important that all of us are involved in the questions, and potential solutions. What problems have you faced that you think are fairly widespread? What solutions have you tried?

The first area, ‘Succession Planning for the RAPM’ has already resulted in a guidance document which is being circulated in draft form, and it is interesting to hear how various regions have solved this, and the difficulties that have been anticipated, faced and solved.

The second area, and the second intended guidance document, covers the peripheral but often difficult responsibilities of being a RAPM. The third area is a focus on local educational requirements, particularly for Intermediate training. This isn’t going to happen overnight, with a flurry of new documents appearing. It is intended as an ongoing process, and I’m looking for ideas, and solutions.

Send me a postcard, drop me a line, stating point of view.

Fellowship Applictions and Case Reports

This year is an especially stressful one for trainees, and trainers, with the introduction of a new exam, and its requirement for Faculty Fellowship; but it is important to remember that training and Fellowship status go hand in hand, and that completion of the other aspects of the pre-CCT curriculum are just as essential when the portfolio of evidence is being assessed for Fellowship.

A more standardised approach to the Case Reports for Advanced Pain Trainees was rolled out earlier this year and, although the decision on CCT compliance is a local one, for Fellowship it will be expected that a Faculty assessment has been recorded. The new standards of marking and the use of Plagiarism Detection software are both major contributions to this process.

Pain Patient Pathways and Commissioning

Dr Andrew Nicolaou

The Pain Patient Pathways have been a major project since 2010. Led by the British Pain Society (BPS) there has been, and continues to be, significant input and support from the Faculty of Pain Medicine (FPM) and also other partner groups and organisations such as the Royal College of General Practitioners (RCGP) and the Chronic Pain Policy Coalition (CPPC).

The strategy that led to their development followed on from the Chief Medical Officer's report of 2008 which highlighted pain as a clinical priority and for improvement in pain education for all healthcare professionals. There was clear need for a consensus on evidence based best practice. The tumultuous recent changes in healthcare, particularly around the configuration of services and commissioning, and the mounting financial pressures within the NHS has made their importance ever more relevant.

In April 2013 the commissioning landscape will change with the phasing out of Primary Care Trusts (PCTs) and the introduction of Clinical Commissioning Groups (CCGs) . Inherent in the pathways is a design to underpin commissioning and generate educational materials for both professionals and patients. They will also inform other guidance and the new NHS Quality Standard in pain, and complement aspects of the ongoing work of the DH Spinal Taskforce which also has FPM representation.

Considerable effort by over 80 people led to the development of the pathways, with broad and inclusive representation across all stakeholders, Andrew Baranowski being chair of the overall process.

The pathways, with group leads, are:

- **Initial Pain Assessment and Early Treatment**, led by Ann Taylor. This primary pathway leads onto the four specific pathways:
- **Spinal Pain**, led by Sanjeeva Gupta.
- **Musculoskeletal Pain (non-inflammatory)**, led by Benjamin Ellis.
- **Neuropathic Pain**, led by John Lee.
- **Pelvic Pain**, led by John Hughes.

There may well be further pain patient pathways to be developed at a later date such as for neck pain, facial pain and Complex Regional Pain Syndrome (CRPS).

Currently all of the pathways are completed and submitted for publication. The Maps of Medicine (MoM) platform was chosen to publish the pathways. MoM is an interactive, evidence graded platform that can link to other guidance, diseases etc and the pathways are accessible to those with a NHS email and to patients.

As part of the MoM pre-publication process the evidence base for each pathway is being reviewed again by the development groups prior to independent scrutiny. Once this has been achieved sequential publication will follow. With this further evidence review the pain patient pathways will be made more robust. However the timeframe for their release has been unavoidably pushed back. To date the Initial Pain Assessment and Early Treatment and Spinal Pain Pathways are expected for October publication. The FPM website will co-announce the publication dates and link to the pathways when released.

The next phase is their implementation and dissemination. We want the pathways used to inform practice, and with their uptake clinical influence will be achieved. To this end four workstreams for implementation and dissemination have been formed which I chair. Patient input is crucial and embedded in all workstreams at all levels. An informed patient will know what to expect and request from his GP and local pain services. There is understandably overlap between some workstreams, in particular the first two. The workstreams are:

- **Commissioning**, led by Ollie Hart with the RCGP.
- **Primary and Community Care**, led by Martin Johnson with the RCGP.
- **Patients and the Public**, supported by the Patients Liaison Committee of the BPS with help from Ann Taylor, CPPC and Pain UK.
- **BPS membership**, led by Nick Allcock

For the purposes of this article I will concentrate on the first workstream for CCG level commissioning as this is generating much comment and debate and is pertinent to the majority of pain services (and separate to Specialised Commissioning which will be done by a central body, the NHS Commissioning Board, NHSCB. Pain has been recognised as one of the specialities that will be commissioning specialised services. The NHSCB is currently being advised on this by a team led by Dr Baranowski and much of this is work in progress. Dr John Goddard's article has more information on this).

Development of materials to support commissioning is key. Providers will need to speak the language of commissioning to be empowered and be able to negotiate and influence. Clearly an understanding of the processes involved will help all, with service leads or their nominees needing a greater depth of knowledge. A range of materials are being developed and workshops organised, including at the next Annual Scientific Meeting of the BPS.

"Providers will need to speak the language of commissioning to be empowered and be able to negotiate and influence"

Many of us as clinicians may have just a general interest and understanding in what can seem remote to clinical practice and what we were trained for, however the importance of engagement and dialogue with commissioners cannot be underestimated. A review of current service provision and outcomes could be the start of this process, and it is important to ensure that 'upstream' services such as community based pain management or physiotherapy are considered and working well (e.g. good triage will impact favourably on secondary care). The next round of the National Pain Audit will focus on this area. The pain patient pathways can be used to demonstrate evidence based best practice and hence can inform what should be commissioned. Actual examples of commissioning stories from around the country will be posted on the BPS website.

The commissioner's agenda will have different priorities such as staying within budget, equity of services and maximising health gain. Variation in care and referrals rates will be of concern. To support the commissioners, 'value indicators' (defined as outcome/cost) will be added to the pathways with costings applied to the different steps across a variety of settings and for different patient groups and levels of benefit (outcomes). Agreement is needed around benchmarking and what metrics to use in order to compare performance of CCGs and/or providers. Tools and questions are being developed to encourage inclusion of the assessment of chronic pain in a commissioner's local needs assessment.

Commissioners are increasingly considering the care of people with multiple chronic diseases (e.g. diabetes, COPD, depression). Chronic pain is now accepted as one of these longterm conditions. Many patients will have at least three longterm conditions, so it is unusual for people suffering with chronic pain to only have this condition.

In other words we are looking at managing patients with multiple morbidity. Care planning that considers all the patients needs, but especially focuses on risk stratifying patients according to their likelihood of further support will be the ideal. Chronic pain management will need to fit into this new paradigm. We need to work on ways of highlighting people living with pain who could be considered high risk for poor overall physical and mental health.

Strategies to incorporate the pain patient pathways into NHS Evidence, NICE endorsement and further informing the commissioners are other current high priority tasks. Further work in progress stems from 'derivatives'. This is activity generated from and as a result of the pathways. It includes defining 'problematic' pain, agreement on initial valid and reliable assessment tools and work towards including measures of pain in the Quality and Outcomes Framework (QOF).

Some say this is the Holy Grail of getting GPs fully engaged. Many of these are key areas of joint focus between the FPM, BPS, RCGP and CPPC with shared themes and goals between these organisations. The recent in-depth report of the First English Pain Summit, which was launched on July 4th in Parliament, highlighted four key recommendations which encompass much of the aforementioned activity. I am sure collaboration is the way forward with, of course, patient groups on board. There is still much more to be done though and again I would emphasise the need for an early proactive engagement with local stakeholders.

With the development and implementation of the pain patient pathways the aim will be not only to embed the role of pain services but also lead to their improvement for our patients.

Specialist Commissioning for Chronic Pain

Dr John Goddard

One of the key components of the The Health and Social Care Act 2012 is the introduction of clinical commissioning. Most NHS services will be commissioned by Clinical Commissioning Groups, supported by the NHS Commissioning Board (NHSCB). The NHSCB is also responsible for commissioning specialised services directly.

During 2011 the Department of Health established a Clinical Advisory Group (CAG) to review specialised commissioning and advise on future prescribed services. Many of these will, for the first time, be commissioned nationally. Previously many specialised services were commissioned regionally by specialised commissioning groups, which acted on behalf of primary care trusts (PCTs), using Specialised Services National Definition Sets (SSNDSs). There is a SSNDS for specialised pain management services (adult) and paediatric chronic pain is included in specialised paediatric anaesthesia and pain management services, one of 23 parts of the SSNDS for specialised services for children.

The CAG considered the services which are set out in the 34 SSNDSs. All these services were tested against the four 'factors' in the Act to determine whether or not they should be commissioned by the NHSCB:

- the number of individuals who require the provision of the service or facility;
- the cost of providing the service or facility;
- the number of persons able to provide the service or facility;
- the financial implications for clinical commissioning groups if they were required to arrange for the provision of the service or facility

> "Diagnostic and treatment codes in pain are not well developed; seperating specialised from non-specialised activity can be difficult"

CAG made initial recommendations to Ministers in December 2011: whilst many services met the four factors, there was a need for further work on many services to allow for their separate and direct commissioning by the NHSCB. 60 Clinical Reference Groups (CRGs) were established to perform this function. The clinical chairs of the CRGs were recruited by advert from leading clinicians in their fields, with designated support from commissioning and public health colleagues. The other members of each CRG were nominated by the Chair, CAG, commissioners and the patient and public engagement steering group.

Andrew Baranowski is Chair of the adult pain CRG; I am a member, as are the Dean and several other fellows of the Faculty. I had input on paediatric chronic pain to the paediatric surgery CRG by personal communication with the chair, Julian Roberts, and the anaesthetic representative, Kathy Wilkinson.

Following an initial meeting in Bristol in March a large amount of work has been undertaken, with much email communication. Deadlines have been exceptionally tight. The initial requirement was for the CRG to produce a scope of the service that should be commissioned. This is no easy task as diagnostic and treatment codes in pain are not well developed; separating specialised from non-specialised activity can be difficult. Both occur in many centres, and this indeed was the reason for the CRG programme as this problem pertains to many services. In Bristol, a decision was made to describe the service rather than the patients it would manage. Another decision was to include children in the adult scope.

CAG has now published its report which has been accepted in full by Ministers. Adult highly specialised pain management services will include multidisciplinary assessment including out-reach. For specialised interventions, the service will include procedure costs (including devices), follow-up and rehabilitation. Highly specialised paediatric services will include multidisciplinary assessment and specified interventions including intensive in-patient or residential management programmes. Paediatric services remain within the paediatric surgery CRG, but closely cross referenced with the adult service specification.

The full report is available at http://www.dh.gov.uk/health/2012/09/cagreport/

The Secretary of State will now consult with the NHSCB and publish Parliamentary regulations, which are subject to the Parliamentary timetable. Following publication of the regulations, the NHSCB will publish its own understanding of what the regulations cover – as service specifications. The CRGs are currently working on detailed service specifications. Further work will then be needed to determine where services are provided. The NHSCB assumes responsibility for national commissioning from April 2013.

Trainee Update

Dr Emma Baird

Trainee Representative for the Faculty

I'm Emma your new trainee representative. I am an Advanced Pain Medicine Trainee in the North West Deanery, currently at Royal Preston Hospital. I'm a Less Than Full Time trainee balancing work and my small family (husband, two-year old daughter and cat). I intend to sit the FFPMRCA examination in January. After the final FRCA I spent 2009 working as an anaesthetist for Médecins Sans Frontières (MSF). I worked in Sri Lanka during the civil war, Northern Yemen and on the Pakistan Afghan border. I would ideally like to pursue a career that enables me to work both for the NHS as a consultant in anaesthetics and pain medicine and with a Non Government Organisation looking at developing world pain and pain in victims of torture.

The main role of the trainee representative is to facilitate communication between trainees and the Faculty, both so we have a voice within the Faculty, and the Faculty has insight into our views. To get a handle on what my fellow trainees feel about their training I have already spoken to many of you by phone and passed on your views at the recent Faculty Board meeting. Having attended my first Faculty Board meeting this month my overall impression was of how hard the Faculty are working to make our training as good as they can, with very limited time and money.

Having spoken to nearly a third of all the Pain Medicine trainees in the country it has become apparent that we are all worried about the same things... EXAMS and JOBS. The general feeling is that the exam is a good idea, raising the standard of Pain Medicine in the UK and bringing us in line with the Irish and Australian Colleges, but sitting a new exam is always going to be difficult. Well established exams, such as the FRCA, are a known quantity. The new Pain Medicine exam is much more of an unknown. While this will obviously improve with time the Faculty are aiming to publish more sample questions.

Pain Medicine is in a state of flux. Pain departments in my own region are stretched with increasing waiting times and patient numbers. The current climate of limited resources make predicting future posts difficult. We are a 'small community', but one that sticks together. With an increasing need for jobs we will have to see whether the current decrease in some regions of Consultant roles is temporary or part of a longer term trend. The Faculty are engaged with this through their workforce census and their involvement with the RCoA.

During our Advanced year most deaneries seem to be providing us with good training and are keeping the Pain Medicine trainees protected from carrying out non-Pain Medicine duties during office hours. Many of us find it hard to get to London for all the study days/educational meetings. In the future we are hoping that these learning opportunities will be available to download. I am also exploring what each region has arranged in terms of inter-deanery cooperation to facilitate teaching sessions for their Advanced Pain Trainees.

Other important dates for trainee diaries:

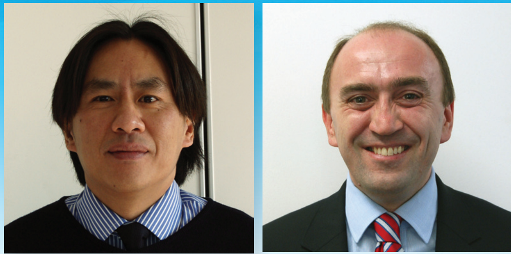
- Annual meeting – Recent advances in Pain Medicine: neurobiology and management 22nd November, RCoA London.
- The next exam tutorial is scheduled for 17th December, RCoA London.
- The British Pain Society Annual Scientific Meeting next year will be held in Bournemouth on 16-19th April.

As part of the BPS Annual Scientific Meeting, the Board of the Faculty of Pain Medicine and myself will hold a meeting to which all pain trainee are invited. This is intended to give you a forum where you can ask questions of the Board and in the past has proven to be very valuable for both sides.

Faculty Calendar 2012 – 2013

Event	Date
EVENT: FPM Annual Meeting	**22 Nov**
MEETING: Board of the FPM	13 Dec
EVENT: Examination Tutorial	**17 Dec**
EVENT: FPM Mental Health Study Day	**29 Jan**
EVENT: FPM Updates Study Day	**30 Jan**
MEETING: FPM Training & Assessment Cmte	1 Feb
MEETING: Board of the FPM	14 Feb
MEETING: FPM Professional Standards Cmte	15 Feb
MEETING: FPM Training & Assessment Cmte	26 April

Please note that all dates may be subject to change.



CPD and Revalidation

Mr Don Liu and **Mr Chris Kennedy**
RCoA Revalidation and CPD Team

With revalidation about to be launched we thought it would be useful to highlight some of the guidance, resources and tools which are available to help Fellows and Members of the Faculty of Pain Medicine to revalidate. In particular, with continuing professional development (CPD) being a key element of revalidation, we wish to draw your attention to the online CPD system which is available to all subscribing members of the Faculty and to introduce the Revalidation Portfolio which is going to be launched soon.

Guidance

Earlier this year we released a key document: Supporting Information for Appraisal and Revalidation: Guidance for Doctors in Anaesthesia, Intensive Care and Pain Medicine. This document is mapped to GMC requirements and includes specialty-specific guidance, so that the appraisal and revalidation process is meaningful and relevant to our doctors. All medical royal colleges were asked to develop a similar guidance document for their specialists, meeting a core framework produced by the Academy of Medical Royal Colleges to ensure there was consistency in what was expected across the medical profession. The draft versions of the specialty documents were tested during the Department of Health's revalidation pilots in 2011 and the finalised versions are now recognised by the GMC and NHS Revalidation Support Team.

The Academy has produced a wide range of information on revalidation including a Return to Practice Guidance document incorporating checklists and action plans identifying issues, potential training and support required by the returning doctor. The RCoA contributes to the Academy's work through participation in various working groups. In 2013 the Academy will be releasing guidance on remediation and revalidation (a working group report with recommendations is already available on the Academy's website) and advice for appraisers in discussing and evaluating a doctor's CPD.

The importance of reflection, in particular documenting your reflection demonstrating your insight, analytical thinking and learning based on your supporting information, is an integral element of appraisal and revalidation. To this end, the Faculty has published *The Good Pain Medicine Speciailist,* to provide a framework in which doctors can reflect on the standards of practice in the subspecialist area. You may also find the new 'Audit Recipe Book' (otherwise known as *Raising the Standard: a Compendium of Audit Recipes*) useful, as it provides an individual performance template for pain medicine anaesthetists to keep track of the supporting information required for revalidation.

Revalidation Specialty Advisors

A Joint (RCoA, Faculty of Pain Medicine and Faculty of Intensive Care Medicine) Revalidation Delivery Committee meets on a quarterly basis, to discuss issues and strategy in supporting Fellows and Members in their CPD and revalidation. We have taken a similar joint approach in establishing a team of Revalidation Specialty Advisors, and setting up a central help desk at the RCoA to manage enquiries received and requests for advice from individual doctors and their appraisers and responsible officers.

The Revalidation Specialty Advisory team includes representatives from all the main sub-specialties in anaesthesia, pain medicine and intensive care medicine, and from the four home nations, and will be able to offer informed advice on revalidation matters relating to our professional work. The team is currently undergoing training organised by the Academy and RCoA, covering an agreed set of principles in providing consistent, reliable and informed advice.

Continuing professional development

In June 2012 the GMC issued new guidance on CPD and we have been mindful of this in enhancing the RCoA online CPD system for our 3,000 currently registered users (including members of the Faculty). Doctors are required to submit a summary of their CPD activities to their annual appraisal as one of the requirements for revalidation. The online CPD system will allow users to record their CPD activities over the course of the year, add their reflective notes and learning outcomes and, for the appraisal, produce a collated summary report in PDF format. There are, in fact, two reporting options. The first produces a report listing CPD credits achieved in all categories of educational activity (e.g. events and meetings, reading, etc), from internal and external, and clinical and non-clinical activities. Option two – the full report – is more detailed and includes the titles and dates of educational activities undertaken, together with any documented reflective notes and learning outcomes. Please note: what you have recorded as your reflections and learning outcomes are what your appraiser will see – so, in preparing for your appraisal, you may want to review and edit what you have recorded over the course of the year before generating the report. The PDF report can be attached to an electronic appraisal form used by your employer or submitted through an organisation's appraisal system.

The RCoA online system is fast becoming the national resource for CPD information in the specialty. Since its launch in December 2011, over 60 events (conferences,

courses, workshops and meetings) with content mapped to Level 3 Pain Medicine of the CPD Matrix have been accredited by the CPD Board (consisting of representatives from the RCoA, Faculties and specialist societies). Events are submitted by organisers for evaluation and if accredited, having met pre-defined educational criteria, are included in the online CPD system's database of events. When searching on the database, filter your search using the Pain Medicine Level 3 code and you will be able to view all forthcoming events, together with links (where available) to booking forms, programme details and the organiser's website.

We encourage all Faculty members to register to use the CPD system. Registration is part of membership and can be done online through the RCoA revalidation and CPD website.

Revalidation Portfolio

We will shortly be launching a Revalidation Portfolio. Again, this is an online resource and will provide a private and secure 'cloud' for managing and storing all your supporting information required for appraisal and revalidation. For example, you will be able to upload your end-of-year CPD activity report together with any supporting information reviewing the quality of your professional work, enter reflective notes and map to the Good Medical Practice Framework domains and attributes. Permission can also be set to allow your appraiser to view your profile (e.g. scope of work and professional details) and portfolio, or alternatively you can export your 'published' supporting information documents into a zip file and attach them to an electronic appraisal form. Once you have completed your appraisal you can store any outcome documents (e.g. statement of appraisal outcomes, agreed personal development plan) in the Appraisal History section of the Revalidation Portfolio, ready to submit to your responsible officer when called to revalidate.

The Revalidation Portfolio has been developed by a cohort of eight medical royal colleges and structured according to the GMC requirements for appraisal and revalidation. We have also included, in places, help-boxes with pointers drawn from the supporting information guidance for doctors in anaesthesia, intensive care and pain medicine. The cohort is expected to make the Revalidation Portfolio available early in the New Year. We will of course let all members of the Faculty know how they can self-register to access this important resource.

Enquiries and advice
RCoA Enquiries and Revalidation team: revalidation@rcoa.ac.uk

Further information and resources
Academy of Medical Royal Colleges – revalidation website: http://www.aomrc.org.uk/revalidation

RCoA Revalidation and CPD website: http://www.rcoa.ac.uk/revalidation-cpd

RCoA online CPD system and registration page: http://www.rcoa.ac.uk/online-cpd-system/register-online-cpd

Supporting Information for Appraisal and Revalidation: Guidance for Doctors in Anaesthesia, Intensive Care and Pain Medicine: http://www.rcoa.ac.uk/node/1951

The Good Pain Medicine Specialist: www.fpm.ac.uk/node/2961

Raising the Standard: a Compendium of Audit Recipes: http://www.rcoa.ac.uk/document-store/audit-recipe-book-3rd-edition-2012

The Royal College of Anaesthetists
Educating, Training and Setting Standards in Anaesthesia, Critical Care and Pain Medicine

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You are logged in as Don Liu. Logout

Subscribe to CPD Approved Events For Category: Adult ICM

Title	Start Date	End Date	Url	Origin	Action (s)
CORE TOPICS by The Association of Anaesthetists of Pakistani origin in the UK and Ireland	14/07/2012 13:00	14/07/2012 17:30	No link available	The Association of Anaesthetists of Pakistani origin in the UK and Ireland	Subscribe

Hints & Tips

Filters

Filter by Event details:
Title:
Keywords:
Origin:

Chronic Paediatric Pain Management

Dr John Goddard

Pain medicine is an evolving specialty. Advanced Pain Training is an optional component of the CCT in Anaesthesia; trainees are expected to spend 12 months in a designated multidisciplinary specialist centre(s). The core competencies are available at http://www.rcoa.ac.uk/CCT/AnnexE. Since the establishment of the Faculty of Pain Medicine of the Royal College of Anaesthetists in 2007 further developments have occurred. All trainees entering Advanced Pain Training since 1st February 2011 are required to have successfully completed the CCT in Anaesthesia and passed the Faculty examination in order to become Fellows of the Faculty by assessment. The first examination is in November 2012.

Paediatric pain medicine as a sub-specialty is evolving too. In 2010 the Faculty published guidance on competencies for paediatric pain medicine, endorsed by the Association of Paediatric Anaesthetists http://www.rcoa.ac.uk/document-store/guidance-competencies-paediatric-pain-medicine. The curriculum consists of two parts: Core competencies for practitioners in Pain Medicine, applicable to all advanced pain trainees and part of the examination; Competencies for practitioners in Pain Medicine who are involved in a paediatric pain service or lead transition of adolescents to adult services.

The latter form the basis for an optional three month component of Advanced Pain Training. Completion of this training and success at the examination will be the first step towards producing specialists in Paediatric Pain Medicine, a major step forward in the development of the sub-specialty. There are currently early discussions in process with Royal College of Paediatrics and Child Health representatives. The situation for other disciplines involved in paediatric pain management is less structured. Impetus to the current situation depends to a large part on establishing larger, coordinated paediatric pain management centres able to provide structured training.

Commissioning

Commissioning of paediatric pain services in the UK is currently very rudimentary. Two or three services have successfully obtained funding through their local specialised commissioning group (SCG) i.e. they are recognised as specialist services. Others have developed and agreed local tariffs with their local primary care trust (PCT) and tend to use these when submitting individual patient requests to other PCTs. The situation is however not coordinated and hampered by a lack of specific diagnostic and treatment codes.

There is, however, some light on the horizon. The Health and Social Care Act (2012) has established the NHS Commissioning Board (NHSCB) which will be commissioning many services previously commissioned regionally by SCGs on a national basis from April 2013. The process for recognition as a prescribed service (nationally commissioned) has been underway since 2011. This process has been by review of previously existing Specialised Services National Definition Sets (SSNDSs), which formed the basis for regional commissioning by SCGs. Paediatric chronic pain is a component of paediatric anaesthesia and pain management, itself a component of the SSNDS for specialised services for children.

Clinical Reference Groups were established in 2012 to produce scopes for their service: the majority of these scopes were recommended as prescribed services in a recently published report http://www.dh.gov.uk/health/2012/09/cagreport.

Highly specialised pain management services for children and young people are now a separate sub-specialty within specialised services for children and will form a service for national commissioning within the Parliamentary approved regulations. The regulations specify that Highly Specialist Pain Management Services for children and young people include services provided by Highly Specialist Paediatric Pain Management Centres. The service includes:

Multi-disciplinary assessment of chronic pain

Certain specified interventions including intensive inpatient or residential management programmes. This includes outreach when delivered as part of a provider network. Significant progress; but a lot more work is to be done until the money begins to flow automatically. Currently the CRG is working on a detailed service specification, which is the document the NHSCB will use to inform exactly what activity will be covered by funding arrangements. Prevalence studies consistently show chronic pain to be present in about 25% of children; clearly national commissioning will not cover all this activity.

Separating specialist from non-specialist pain activity is hampered by poorly developed diagnostic and treatment codes; nonetheless it has been accepted

that this can be done within a reasonable timescale. It will be necessary to make distinctions as non-highly specialist activity will remain commissioned by Clinical Commissioning Groups. When these distinctions have been teased out, and numbers of patients requiring services will be important, further work will be required to determine where highly specialised services will be based and the network arrangements to provide national coverage.

Recent Clinical and Research Developments

Computerised cognitive behavioural therapy (cCBT)
CBT is traditionally delivered by a therapist; recently computerised packages have been developed and evaluated. A review and meta-analysis of (cCBT) for the treatment of pain in children and adolescents has been published. Four studies met the inclusion criteria, all of which indicated beneficial results of using cCBT. Patients with headache, abdominal pain and musculoskeletal pain were involved in packages lasting 4 to 8 weeks, all of which had weekly sessions.

> “Completion of this training and success at the examination will be the first step towards producing specialists in Paediatric Pain Medicine, a major step forward in the development of the sub-specialty”

Importantly, I think, all participants had access to a therapist, mostly by weekly phone calls.Computerised delivery of psychological interventions for pain shows promise in children and young people (CAYP). It remains to be seen how cost-effective this will be as therapist contact appears to remain important.

Multidisciplinary pain services
A very small proportion of (CAYP) with chronic pain develop a complex presentation with severe disability (severe pain, poor physical abilities, minimal school attendance and social isolation). For these CAYP clinical experience and reports from several countries have supported the need for multidisciplinary services. A recent German study reports improvements in pain intensity, pain-related disability, schools absence and pain-related coping at three months following a three week inpatient multimodal treatment; improvement was maintained at 12 months. Response to treatment was similar in children (7-10 years) and adolescents (11-18 years).

Multidisciplinary pain services are expensive to provide and consequently commissioning organisations can be reluctant to fund services. However, the economic costs of chronic pain in adolescence are also high; in 2005 a preliminary study estimated the annual cost-of-illness to be £3840 million in the United Kingdom. The case of need seems clear, but costs-of-illness are spread across many societal areas and healthcare remains reluctant to fund multidisciplinary services for CAYP with chronic pain.

Parents
The research focus in psychology for effective interventions for CAYP with chronic pain appears to be shifting. Initial focus was on the child or young person, this moved on to the family and now attention is turning explicitly to the parents. This topic was recently reviewed. Living with, and caring for, a child with chronic pain is stressful and challenging. First, the review looks at the literature on this topic and second examines research on the effect that parental functioning has on children's adjustment to chronic pain. The review then explores parental adjustments to other chronic medical conditions and finally makes suggestions for future research on parenting the child with chronic pain. A recent qualitative study confirms that mothers feel helpless, acknowledge that being there as a "good parent" is not always helpful and lament the loss of their "normal child".

Research is beginning to show the clinical utility of CBT for parents of children with chronic pain. A randomized controlled trial comparing CBT - modifying responses to illness and wellness behaviours and cognitive restructuring of dysfunctional beliefs regarding pain and function - and education regarding gastrointestinal anatomy and physiology and nutritional advice, has shown CBT to be effective in reducing symptom levels in children with functional gastrointestinal disease.

Goddard JM. 'Chronic pain in children and young people'. *Current Opinion in Supportive and Palliative Care* 2011, 5:158–163

Examination Development

Mr Daniel Waeland

Head of the Faculty

Thirty-two Pain Medicine trainees sat the first ever FFPMRCA MCQ paper on 19th September this year. Hidden within one deceptively thin paper are three years of build up and project management; twenty-one consultants busily writing, rewriting and standard setting questions; and months of administrative beavering away behind the scenes. One week afterwards, the examiners and the standard setting group convened to deliberate about their standard setting results and the MCQ outcomes. Consequently, we had a very positive success rate of 91%.

The first FFPMRCA Tutorial Series was held in May. Forty-one Pain Medicine trainees came to the two days, which featured a series of tutorial stations, each tackling a separate area of the knowledge competencies that would be covered in the exam questions, as well as a few key lectures. The tutorials proved a very helpful way to tackle the exam areas in a way that promoted discussion and questions. The feedback we received both in the informal Q&A sessions at the end of the each day and the formal written feedback will help the Faculty to improve these days for the future. We plan to run this bi-annually, a few months prior to the examination. Dr Mark Jackson has agreed to act as lead for the tutorials, which in future will run for one day and feature a similar mix of tutorials with some lectures. The next will be held on **17th December 2012**.

Naturally, work on the exam continues at the same pace, with the Structured Oral Examination following in November. In the coming months we hope to release a few more example questions onto the website – this will be a continual process as the exam establishes itself and we are availed of a bigger bank of reserve questions.

If you have any comments, concerns or questions about the examination, please get in contact with the Faculty at fpm@rcoa.ac.uk or via the Faculty's Trainee Representative, Dr Emma Baird.

Examination Calendar November 2012 – July 2013

	FFPMRCA MCQ	FFPMRCA SOE	
Applications and fees not accepted before	Monday 5 Nov 2012		Thursday 7 Feb 2013
Closing date for FFPMRCA Exam applications	Thursday 13 Dec 2012		Tuesday 26 Feb 2013
Examination Date	**Wednesday 30 Jan 2013**	**Wednesday 14 Nov 2012**	**Wednesday 10 Apr 2013**
Examination Fees	£475	£675	£675

Examination Calendar August 2013 – July 2014

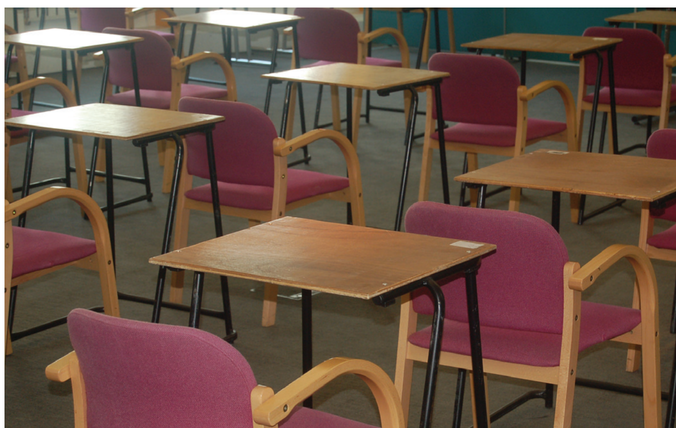
	FFPMRCA MCQ		FFPMRCA SOE	
Applications and fees not accepted before	Monday 24 Jun 2013	Monday 21 Oct 2013	Thursday 12 Sep 2013	Thursday 23 Jan 2014
Closing date for FFPMRCA Exam applications	Thursday 15 Aug 2013	Thursday 5 Dec 2013	Thursday 26 Sep 2013	Tuesday 18 Feb 2014
Examination Date	**Wednesday 4 Sep 2013**	**Wednesday 15 Jan 2014**	**Tuesday 15 Oct 2013**	**Wednesday 2 Apr 2014**
Examination Fees	*TBC*	*TBC*	*TBC*	*TBC*

FFPMRCA: A Candidate's Perspective

Dr Julian Scott-Warren

The FRCA was a difficult experience. The anhedonia of months of involuntary social withdrawal, strained relationships and Parbrook were bad enough the first time, but because both I and my wife went through the Primary and Final separately, it got really tiresome by the fourth round. But we made it through.

Behaviours I now recognise as catastrophising and fear avoidance were evident in both myself and my peers, and just like in the pain clinic were anecdotally associated with poor outcomes. It was with considerable relief that my candidate number was on the notice board at the end of it. No more exams ever again, I concluded, reward centres swimming in dopamine. And had I thought a bit differently and done obstetrics instead, I'd have been right.



Pain Medicine is a growing subspecialty, both in terms of service demand and in complexity. From a prospective Pain Medicine doctor's point of view, it doesn't therefore seem unreasonable that there should be a postgraduate exam in it. Such an exam as the FFPMRCA should serve to safeguard high standards of clinical competence and knowledge in the consultants of the future. Patients will benefit. It's just a shame that it happens to be me that has to sit it.

Exams have many positives, even for the candidate. Without the extra motivational drive provided by a fixed deadline, the studying doesn't get done as much (although my wife and children don't consistently see this bright side), and it's nice as a trainee to feel like your clinical acumen is coming up to scratch.

What really adds to the difficulty this time is being in the first diet. The reason? Exams have rules. Don't break them and you pass. Transgression is, by contrast, suicide. Take the FRCA for example. Turning up to the viva being unable to draw the oxyhaemoglobin dissociation curve is breaking the rules. Can't quote the gas laws or define MAC? See you in six months. But the trouble with doing new exams is that the rules are much less clear. My inability to quote the evidence for Spinal Cord Stimulation in Complex Regional Pain Syndrome might be a rule breaker, or it might not.

This leaves the candidate in a difficult position, because the amount of potential reading material and knowledge that exists in the pain literature is so unimaginably vast that it would take several lifetimes to fully digest. There is of course a reading list on the Faculty website (http://www.fpm.ac.uk/document-store/ffpmrca-examination-guidance); to read and learn everything suggested here might only take one or two.

At the time of writing, the written part of the exam has been done, and the 32 candidates who sat it await their respective verdicts*. Results are due out in a couple of weeks, and in the meantime life returns to a more tranquil normality. I'm contemplating reading a book that doesn't have "Pain" or "Atlas" in the title, and might go somewhere that isn't "home", "hospital" or "the road in between". The exam itself seemed in retrospect rather tricky. It rudely exposed a number of gaps in my knowledge, and to be honest I can't remember whether the conversion of tyrosine to DOPA is the rate limiting step or whether pKa affects volume of distribution. So, biochemistry and pharmacokinetics are the newest additions to the burgeoning things-to-do list.

*29 out of the 32 candidates passed the MCQ paper

FFPMRCA Examination Tutorial

Monday 17th December

£85 for trainees

Approved for 5 CPD credits

The FPM Examination Tutorial Series for trainees includes both tutorials and lectures with opportunities for discussion. These are interactive days covering a wide range of topics. Trainees are expected to pre-prepare for the day to encourage discussion and interactive learning.

Online booking now available

For a full programme and booking information, please visit:
http://www.rcoa.ac.uk/education-and-events/ffpmrca-examination-tutorial-series

FPM Events

Dr Sanjeeva Gupta

Educational Meetings Advisor

On behalf of the Faculty I would like to thank all the speakers who have contributed to the events organised by the FPM. I would also like to thank everyone who has attended the past events.

Dr Douglas Justins and Dr Kate Grady had organised the FFPMRCA examination tutorial series on the 24th and 25th May 2012. Similar tutorials are being organized on 17th December 2012 and 7th June 2013 by Dr Mark Jackson.

The Annual meeting on the 22nd November 2012 will be on 'Recent Advances in Pain Medicine: Neurobiology and Management'. Your attendance will be very much appreciated.

The Faculty has organised a two day meeting on the 29th and 30th January 2013 at the Royal College of Anaesthetists. The theme for the meeting on the 29th January 2013 is 'Core competencies in mental health for pain medicine professionals' The day will comprise of lectures and case based discussions. Topics include: recognising alcohol and drug addiction, understanding treatments for these, signposting sources of support; depression and its treatment including assessment of risk of self-harm and how to manage high risk patients; common personality disorders and how they may present barriers to engagement with pain management; and somatisation disorders. Case-based workshops will be on pain and depression, pain and addiction, pain and personality disorders.

The theme for the 30th January meeting is 'Updates in Pain Medicine' and the topics to be discussed include: updates on psychology in pain medicine; updates on opioids for non-cancer pain management; investigating a patient with pain; updates on the surgical management of spinal pain and radicular pain; updates on self-management in pain medicine; updates in the use of ultrasound in chronic pain management and topics on philosophy and ethics to include: medical ethics overview, ethics of consent and philosophy and ethics of pain and suffering. There will be plenty of opportunity for discussion during the meeting.

There will also be a study day on the 24th May 2013. If you have any suggestions for the day please let me know.

The RCoA has recently introduced an online booking system, so booking onto the FPM events couldn't be easier! Your attendance, contribution, and feedback are essential to the success of all the events.

Further details and full programmes for all our events can be found at
http://www.fpm.ac.uk/faculty-of-pain-medicine/events/events-calendar

Annual Meeting - Neurobiology and Management

22nd November 2012
£180 (£130 for trainees)

- Neural inflamation and pain
- QST and Central Sensitisation
- Pain Pathways
- Patrick Wall Lecture - 'Finding Novel Pain Mediators'
- Faculty Update

Core Competencies in Mental Health for Pain Professionals

29th January 2013
£160 (£130 for trainees)

- Recognising alcohol and drug addiction
- Depression and its treatment
- Common personality disorders
- Somatisation disorders
- Case based discussions

Updates in Pain Medicine

30th January 2013
£160 (£130 for trainees)

- Updates in Psychology in Pain Medicine
- Updates on Opioids for non-cancer pain management
- Investigating a patient with pain
- Updates on self- management in Pain Medicine
- Philosophy and ethics

Faculty Update

Fellows, Members and Committees

New Fellows by Assessment

April 2012
Basil Muhammed Ali ALMAHDI
Jonathan Tsu Chun YEN
Karim Nader SHOUKREY

July 2012
Sonia FLORY
Benjamin Meirion THOMAS
Iordan Roussev MIHAYLOV
Imratpal Singh SOHANPAL
Norman KUFAKWARO
Namita ARORA
Yaser Gamal Mohamed MEHREZ

August 2012
Neeraj SAXENA

October 2012
Lourdes Selvam GASPAR
Joanne RUGEN
Ashish Laxminarayana SHETTY
Atif Razzaq WALI
Devendra Ratnakar TILAK

New Associate Fellows

2012
Sonia Wahan WARTAN
Arif Hussain GHAZI
Henriette Annalie
VAN SCHALKWYK

Board Election Results

An election was held on 26th October 2012 for two new Board Members:

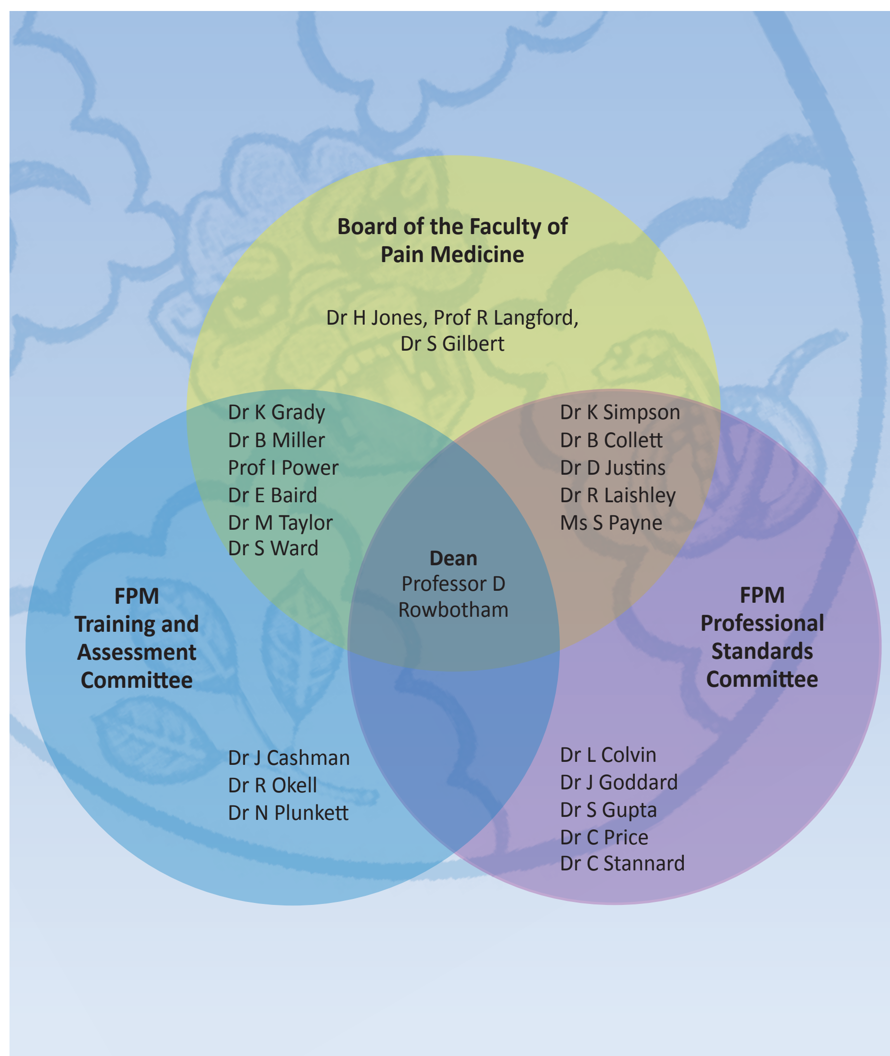
Elected

Candidate	Votes
GODDARD, John	58
HUGHES, John	56

Not Elected

Candidate	Votes
MILLER, Barry	50
LAWSON, Andrew	49
BARANIDHARAN, Ganesan	43
GREENSLADE, Gareth	42
HANU-CERNAT, Dalvina	32
OKELL, Roger	28
IVANOVA, Tzvetanka Marinova	18

The Board thanks all candidates for their participation. Full biographies of the newly elected Board members will follow in the next edition of *Transmitter*.



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