FACULTY OF PAIN MEDICINE
of the Royal College of Anaesthetists

FPM 2007-2017

Newsletter of the Faculty of Pain Medicine SPRING 2017

TRANSMITTER

Pain and Driving

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Management of Patients with Cancer Related Pain

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PAIN MEDICINE
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Welcome to this bumper edition of Transmitter, celebrating the 10th anniversary of the establishment of your Faculty. Contributions from our three past-Deans highlight three seminal, but overlapping, phases of our development: Inception, launch and establishment of internal committees; development of external partnerships, alliances and the exam; a focus on quality assurance and training in pain for all health professionals. All this effort and activity has been fully supported by our parent College which, serendipitously, celebrates its 25th anniversary this year.

"Changes, they are a coming"; so says our current Dean in this issue. Of several work-streams he details, to me the most important is a review of our membership criteria; detail on this is reported by John Hughes, Vice Dean and chair of the working party. In order to represent and influence all aspects of Pain Medicine, the Faculty must include interested parties. We need to embrace non-anaesthetic doctors with interest and practice in Pain Medicine and Acute Pain doctors.

Finally, Bill Rea reports on the implementation of EPM Lite in Birmingham. Unlike other medical schools, which have developed a workshop based approach, this was successfully delivered by formal lectures along with e-learning initiatives. There is more than one way to skin a cat!

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Message from the Dean

Dr Barry Miller

Dean

Our tenth anniversary year is upon us and *"changes, they are a coming".* We are reviewing ourselves, and the support we provide, in a rapidly changing NHS, and UK in general.

We have embarked upon projects to reach out and, hopefully, become more involved with those practising Acute Pain, those who practice Pain Medicine, but who are not anaesthetists (see the article by John Hughes) and to the many SAS doctors who work in hard pressed services, and have limited professional support.

Mentoring

We have recently developed a mentoring or 'buddying' scheme to help new consultants in the early years of their career. This is a critical time, and in a specialty where an individual may only have one or two established colleagues, it is easy to feel out of depth in the transition from trainee to independent practitioner. We hope to faciliate safe space for discussions with an individual not directly involved in their day to day or Trust wide environment.

We are keen to hear from those who wish to consider being mentors and those who feel they would gain value from such a service (see page ## for more information).

Outcome Measures

Outcome measures from Pain Services are a difficult topic, there are many tools available, none perfect, and most services use one or more to some extent. Increasingly CCGs are including in their Service Level Agreements (SLAs) a requirement for patient and professional feedback on the service, comparisons between services (often very different in structure and function) are being made, and at national level the specialty often struggles to get its message across because of the lack of comparable data.

The Faculty of Pain Medicine and the British Pain Society have set up a working party to look at the various measures available and see if it possible to provide some guidance on their use in different parts of a service.

Existential Threats – Decommissioning

There is no doubt that there is considerable anxiety within the profession about its future. There is widespread concern that services are being seen by predatory CCGs as a soft target for saving money. The evidence to support this is often anecdotal. A survey[1] by Lorraine de Gray (Deputy Chair of the Training and Assessment Committee) indicated that most CCGs intended to continue to support secondary care services.

It is essential that Consultants make contact with their local CCGs. Many are unfamiliar with these bodies, but there will be named individuals whose task is to contract Pain Services and who will be involved in negotiating SLAs; these are a mixture of clinical and corporate contracts. The Business Manager within the Anaesthetic or allied directorate will also be involved, but problems are likely to occur unless you are proactive with both the CCG and the Trust. Knowing what the CCG thinks it wants, negotiating some areas, and if need be redesigning some aspect of a service is essential to long term survival. Early conversations will alert you to perceived issues that the CCG may have flagged, will give you an idea of whether tendering is likely to occur, and give you the tools to support your service with national guidance (e.g NICE, the FPMs Core Standards for Pain Medicine Services in the UK document[1][2], "Key Pain Management Standards for CQC inspection frameworks"[3] etc).

The world has changed, and we must engage with the purchasers, and competitors, in ways we have never had to before.

[1] Forthcoming poster at British Pain Society ASM 2017
[2] http://www.rcoa.ac.uk/faculty-of-pain-medicine/standards/core-standards
[3] https://www.rcoa.ac.uk/system/files/FPM CQC key standards.pdf

New Faculty Initiative: Mentoring/Buddying Scheme

The FPM Mentoring/Buddying scheme was launched at the start of March 2017. If you would like to be a mentor, mentee or buddy to another Pain Medicine doctor please email **fpm@rcoa.ac.uk** to register your interest and we will send you further information and an application form.

Mentoring and Buddying relationships are often mutually beneficial with both parties having the potential to learn, increase confidence and support and enhance their practice. Individuals may want support over one particular area, or several e.g. clinical practice, research, clinical governance issues, managing a service, service development, professional work/life balance etc.

A **mentor** is usually more experienced/qualified than the mentee. This can be a long term ongoing relationship that can be quite informal, with a broad focus and meetings taking place as required.

Buddying relationships are usually informal and between two similarly experienced/qualified doctors who can offer support to each other, acting as confidential sounding boards.

The above relationships are often mutually beneficial with both parties having the potential to learn, increase confidence and support and enhance their practice.

Within the Faculty scheme you can choose to act as a mentor, mentee, buddy or you have the option to act in more than one role.

Faculty Heritage and Development: Doug Justins

Dr Doug Justins

Faculty Dean 2007 - 2010

The Royal College of Anaesthetists (RCoA) established a Pain Management Committee in 1992 and, with the aid of Council members such as Keith Budd, pain management gained a higher profile including introduction of pain topics to the curriculum for training in anaesthesia by 1995. As early as 1992 it had been acknowledged that pain management deserved "sub-specialty" status and there were frequent discussions of a separate diploma and additional training. All this occurred at a time of big changes to postgraduate training in the UK during the 1990s. Things were complicated, changing regularly and often, ultimately frustrating.

In 1995 I was elected to College Council and became Chairman of the Pain Management Committee for the next eight years. Step by step improvements were made to training in pain management and in 2003 serious work began to establish a Faculty of Pain Medicine within the RCoA. College President Peter Hutton and Vice President Graham Smith provided great support and encouragement. This was a big step for College Council and the proposals were debated at length and many times before approval was gained.

The Faculty of Pain Medicine of the Australian and New Zealand College of Anaesthetists (ANZCA) had been established in 2003. Professor Michael Cousins from Sydney was generous in sharing information about their process of development.

The title Pain Medicine was chosen for the Faculty in preference to pain management. A definition was produced: Pain Medicine describes the work of specialist medical practitioners who undertake the comprehensive management of patients with acute, chronic and cancer pain using physical, pharmacological, interventional and psychological techniques in a multidisciplinary setting. The Faculty was aimed at specialists in Pain Medicine, not general anaesthetists.

In 2005 Council appointed a Founding Board of the Faculty that was tasked with devising the structure of the Faculty. This included defining eligibility for membership of the Faculty and establishing how the Faculty would be administered. The Regulations for the Faculty were adapted from the existing Regulations of the RCoA. Once again College Council examined all the proposals in considerable detail. The President at that time, Peter Simpson, Vice President John Curran and College Chief Executive Kevin Storey helped to shape the Regulations into an acceptable form.

ANZCA had established an intercollegiate faculty. The UK Faculty was not intercollegiate but resided solely within the RCoA. It was feared that involving the numerous Medical Royal Colleges and Faculties in the UK might have delayed the development of the Faculty. Approval was sought from all the relevant Colleges and none expressed any concerns. It was recognised that there are a number of non-anaesthetists (e.g. neurologists, neurosurgeons and palliative care physicians) who have a strong interest in Pain Medicine but in fact the vast majority of practising pain physicians trained as anaesthetists. A route was established so that non-anaesthetists could join the Faculty.

On 2nd April 2007 the Faculty was launched. I was elected Dean and Karen Simpson became the first Vice Dean. Probably the biggest initial task was vetting over 500 applications for Foundation Fellowship. Inevitably some applicants were disappointed but overall the Faculty grew and prospered. Other routes of entry were opened up in due course.

Other big challenges were to develop the programme for higher and advanced training in Pain Medicine, to construct a robust system of assessment, including an examination and to define professional standards including requirements for revalidation.

During my three years as Dean of the Faculty hard work by members of the Board and many others produced an organisation with a secure foundation and an exciting future. Thanks are due to everyone who contributed to the successful outcome of this enterprise.

Faculty Heritage and Development: Dave Rowbotham

Prof Dave Rowbotham

Faculty Dean 2010 - 2013

A priority for the Faculty of Pain Medicine (FPM) during the period of my Deanship was developing effective working partnerships and alliances including the Royal College of Anaesthetists (RCoA), British Pain Society (BPS), Chronic Pain Policy Coalition (CPPC), General Medical Council and several sections of the Department of Health. This was essential in order to emphasise nationally our new responsibility for training and standards for Pain Medicine. A good example of this partnership working was our role in the first UK National Pain Summit: a collaboration of the FPM, BPS, Royal College of General Practitioners and CPPC (alliance of patients, professionals and parliamentarians). At this time, the Minister of State for Cares Services stated that the Department of Health recognised chronic pain as a long-term condition in its own right. From our perspective, it was gratifying to see in the widely read and cited report of the meeting that: *Chronic pain education for most health care professionals is weak at both undergraduate and postgraduate levels with the exception of pain medicine training in anaesthesia.*

This period witnessed the birth of a new generation of pain specialists in the UK. They began to commit themselves, not only to advanced pain training, but also to the new FPM examination. The first examination was held in September 2012 and it was gratifying to read the comments of the external auditor who stated that the examination was of a very high standard. Developing an examination from scratch was a major piece of work by a dedicated team of board members, fellows and FPM/RCoA staff – this cannot be overstated. We also enhanced our contact with trainees by meeting them at national meetings and ensuring effective representation at the FPM Board. The latter was very enlightening and gave us a real insight into the new challenges faced by our trainees.

The Faculty expanded its educational programme including study days, an annual meeting and examination focussed events. The quality and feedback from attendees was excellent and we became established as a leading source of CME for pain medicine specialists. Pain touches the professional lives of most people working in the NHS. Collaborating with the Department of Health and BPS, the Faculty led on the development and introduction of the e-Learning for Pain programme. This was designed for all healthcare professionals who may deal with patients in pain, thus providing an opportunity to influence pain management standards and safety throughout the NHS.

As well as responding to a growing number of requests for guidance and formal consultation exercises, the Faculty took the lead in a number of professional matters including concern over the inappropriate use of high-dose opioids in chronic pain. We published an influential position statement on the roles and responsibilities of fellows of the FPM with respect to this. At this time, the largest ever reorganisation of the NHS was taking place, associated with escalating financial problems. Many pain services were under threat and we spent considerable time helping and advising our fellows who mostly had little experience of the new commissioning arrangements. We published guidance which helped them to negotiate locally. We also intervened in a dispute emanating from a private healthcare provider who had stated that some pain relieving procedures could only be performed after agreement from other specialists. The Faculty does not often get involved with private practice but this had implications with respect to the reputation of our training and revalidation programmes. After meeting with them, the provider withdrew its statement completely and recognised fellows of the FPM as experts who were more than capable of assessing the need for such procedures.

Finally, the progress that we made during this time was made possible by the dedication and expertise of the FPM staff and we are extremely grateful for this.

Faculty Heritage and Development: Kate Grady

Dr Kate Grady

Faculty Dean 2013 - 2016

I took office as Dean in September 2013. At that time the work of our two committees was established and systematic, and this allowed some time and energy to consider the position and work of the Faculty. We turned our attention to quality assurance with a review of the outputs and direction of the committees, from which a quality nexus was developed for training and assessment and the concept of our Core Standards for Pain Management Services was born.

Changes in the way pain services were to be delivered were underway; a shift of delivery of services to the community made if apparent that the Faculty and its Fellows were likely to be progressively more engaged with community settings and in collaborative working in the community and primary care. With this in mind, we set up the UK Pain Consortium which is a bringing together of the British Pain Society, the Chronic Pain Policy Coalition (a group concerned with patients, physicians and parliamentarians), the Royal College of General Practitioners, the Clinical Reference Group for pain services and the Faculty. Meetings are held three times a year to discuss collaboration and to present a united front for pain.

The Core Standards were written by a multiprofessional team with input from all the major organisations and professions delivering pain management in the UK. They addressed the changing face of the delivery of pain management. Universal standards and aspirations were agreed for all areas of pain management and across all domains of service delivery from the community through to the most complex of care. The standards were launched at a reception at the House of Lords in November 2015. Standards were lifted from the publication to inform the Care Quality Commission. Our 'Right patient, Right Professionals, Right Time' campaign was begun to promote timely access to the best management for our persistent pain sufferers.

Essential Pain Management (EPM) and Essential Pain Management Lite (EPM Lite) were introduced during my years as Dean. EPM is a course delivered out of the Australian and New Zealand College of Anaesthetists to the developing world which runs over three days, the fundamental principle of which is its sustainability in local hands once visiting Faculty depart. EPM lite is a short version of EPM which is delivered to undergraduates throughout the developed and developing world. The UK FPM was invited to introduce the EPM course to Africa and to date we have run courses across six countries. Fellows have also taught on courses in nine other overseas countries.

Before tackling EPM lite for our UK medical undergraduates, we presented our proposal to the General Medical Council. To date EPM Lite has been piloted in 13 UK medical schools with plans underway to introduce it to a further five.

From its very founding the intention was that the Faculty would welcome all practitioners of Pain Medicine from acute to chronic. To this end, we co-opted a Board member with a specific interest in acute pain and an acute pain working party was set up to represent the interest of the acute pain fraternity. Our acute pain representative was also able to represent us on the RCoA peri-operative medicine project.

The FFPMRCA examination which was introduced in April 2012 continues to run successfully as a discriminator of admission to Fellowship of the Faculty. FPM fellowship is awarded to successful candidates at the RCoA Diplomates' day, a splendid and momentous day and this continues on an annual basis.

Further outputs of the Faculty have been the 'Opioids Aware' project, an educational resource addressing current issues in opioid prescribing, and the introduction of the Pain in Special Environments course to those working in the secure institutions in England and Wales.

In 2016 work began on a mentoring / buddying system for our Fellows – this continues.

Faculty of Pain Medicine 10th Annual Meeting:

Core Topics in Pain Medicine

Friday 1st December 2017

09.00 - 09.30	Registration & Welcome
09.30 - 09.40	Introduction *Dr Shyam Balasubramanian, Educational meetings Advisor, FPM*
Session One	**Chair: Dr Barry Miller, Dean, FPM**
09.40 - 10.10	**Enhanced recovery after surgery: What is 'acceptable pain relief'?** *To be confirmed*
10.10 - 10.40	**Biological mechanisms of action of interventional pain techniques in vivo.** *Dr Connail McCrory, Dean, FPM Ireland, Dublin*
10.40 - 11.00	**Discussion**
11.00 - 11.25	**Developments: Faculty of Pain Medicine.** *Dr Barry Miller*
11.25 - 11.45	Refreshments
Session Two	**Chair: Dr John Hughes, Vice-Dean, FPM**
11.45 - 12.00	**Faculty Award Presentation**
12.00 - 12.50	**Patrick Wall Guest Lecture:** **Cell transplants for the treatment of chronic neuropathic pain and itch.** *Professor Allan Basbaum, Chair Department of Anatomy, University of California, San Fransisco*
12.50 - 13.20	**Consciousness and Pain** *Baroness Professor Susan Greenfield CBE, Oxford*
13.20 - 13.30	Discussion
13.30 - 14.20	Lunch
Session Three	**Chair: Dr Shyam Balasubramanian**
14.20 - 15.10	**Debate: Should MDT aspects of pain management be applied to all chronic pain patients?** - Yes: *Dr Charles Pither, Pain Specialist, London* - No: *Dr Rajesh Munglani, Consultant in Pain Medicine, Cambridge*
15.10 - 15.40	**Cancer recurrence and regional anaesthesia** *Dr William Harrop-Griffiths, Consultant Anaesthetist, London*
15.40 - 16.10	**'Body reprogramming' for fibromyaliga: a new paradigm** *Dr Anthony Davies, Consultant in Anaesthesia and Pain Management, Plymouth*
16.10 - 16.40	Discussion & Close

RCoA, London
5 CPD Points
£200 for Consultants, £140 for trainees/nurses
Code: B08

FACULTY OF PAIN MEDICINE of the Royal College of Anaesthetists

FPM 2007-2017

Programme organised by Dr Shyam Balasubramanian and Dr Manohar Sharma

New Membership Working Party

Dr John Hughes
Vice-Dean

The Faculty has constituted a working group to investigate two new routes of entry to the FPM. One is the potential for non-anaesthetist physicians. This has developed with the support of the RCoA and with interest having been expressed by non-anaesthetists working in or in conjunction with pain units. The second was to investigate a potential route for anaesthetic colleagues who practice acute/inpatient pain medicine.

The terms of reference were agreed in December 2016 and included:

- Develop a route for fellowship for non-anaesthetic secondary care physicians
- Look at training routes and credentialing
- Assess the role of the exam in such a move
- Develop a grandfathering route for consultants already in post
- Produce an options paper for an affiliate membership to allow consultant anaesthetists with acute/inpatient pain responsibilities to be associated with the FPM
- Produce an options paper for anaesthetic trainees to gain affiliate membership if they are planning to undertake acute/inpatient roles as consultants

There has been a set of briefing papers and a meeting to develop a broad outline as to the options and feasibility for the project.

Non-Anaesthetic Fellowship

There was agreement that this was an opportunity to improve liaison with colleagues working in the field that currently we are unable to support. There are several potential hospital physicians that may be interested. With this being a complex change to the regulations and membership it was felt that initially one specialty be considered with the anticipation of further roll out over time.

The training should be the same as for anaesthetists. The current system was felt to be appropriate and has some potential to absorb further advanced pain trainees (as the numbers are likely to be small). The curriculum is already in place, as is the managerial structure and the exam. The exam is fit for propose and non-anaesthetists should have a similar chance of success to anaesthetic based trainees.

There is sufficient scope within the current curriculum to accommodate non-anaesthetists and allow them to develop within their own specialty area whilst gaining a broad pain exposure. Indeed there is scope for anaesthetic trainees to develop areas of interest within pain medicine.

Grandfathering would be required and specific criteria will need to be developed along the lines of the original grandfathering process, demonstrating clinical activity, CPD, appraisal etc. This would be a time limited fellowship route for non-anaesthetist consultants.

Acute/Inpatient Affiliate membership

There has been a strand of work looking at acute pain within the FPM with a very successful educational day earlier this year. There has also been discussion from this group of colleagues to have a closer association with the FPM.

There are two strands to this. The first being the current established consultant with acute pain sessions and commitment, and the second being trainees developing that interest and aspiration.

Other strands of work within the FPM and RCoA also considered this an important avenue to explore. It will entail the production of a new membership route that will need to cover established consultants as well as trainees. As part of this there may be an opportunity to access a path to full fellowship but this has implications on entry rules to the exam.

Now the concept is agreed the next step is to produce a more detailed document for each of the groups.

There will be discussion with potential non-anaesthetic specialty groups and their training programme committees to explore a way forward.

Improving the management of patients with cancer-related pain

Prof Mike Bennett

St Gemma's Professor of Palliative Medicine

The Faculty of Pain Medicine aims to develop guidance in 2017 for provision of integrated pain management, palliative care and oncology services to improve access to pain management for patients with cancer-related pain.

Each year 350,000 patients in the UK are diagnosed with cancer and 160,000 people die from this disease, which is expected to rise to 193,000 deaths by 2030. Pain from cancer or cancer treatment is common. Following chemotherapy, 60% of patients will experience peripheral neuropathic pain 3 months after treatment, (30% persisting at 6 months). Evidence suggests that 45-56% of patients with advanced cancer (72,000 to 89,600 each year in the UK) experience moderate to severe pain intensity before they die, often for many months.

Under-treatment of cancer pain persists; around one third of patients don't receive analgesia proportionate to their pain severity. Even in the UK, less than half of cancer patients receive a strong opioid before they die. For patients that do receive a strong opioid, median treatment duration is only around 9 weeks. In addition, median referral time to palliative care services before death for nearly 4000 cancer patients was only 37 days. The National Survey of Bereaved People (VOICES) evaluates perceptions of the care given to recently deceased persons. In 2015, only 18% reported that pain was controlled 'completely, all the time' at home compared with 38% in hospital and 63% in hospice. Not surprisingly, uncontrolled pain is the most frequent reason for community based cancer patients to contact out-of-hours primary care services.

These data suggest that a significant number of UK patients with cancer pain are not well managed, and particularly for those with advancing disease, there is currently little time to co-ordinate specialised pain management interventions. Earlier pain assessment leading to tailored drug management, support for self-management and more specialist interventions might lead to improved outcomes for all patients. Closer integration of pain management, palliative care and oncology services is needed to improve access to pain management for patients with cancer-related pain.

A recent review has summarised the current evidence regarding integration of pain management and palliative care services in the UK. Evidence from surveys of pain management and palliative care professionals suggests that except for a very few centres, these services remain poorly integrated. There are no reported surveys of oncologists on this topic.

Existing guidance describes the need for multi-disciplinary and integrated services to support patients with cancer pain, and describes the patient outcomes expected of such integrated services. However, there is no unifying guidance on how such an integrated service might be configured (which includes oncology representation), how it might be commissioned, and what activities it should undertake. The proposed new guidance from the Faculty of Pain Medicine could address these issues by collating existing guidance on competencies, standards and outcomes into a cancer pain service specification, drawing it to the attention of clinical and commissioning communities. This would also support NHS organisations in meeting the newly introduced Care Quality Commission (CQC) standards for cancer pain.

Closer integration of the two services can result in more comprehensive pain assessment and a wider range of management options for patients comprising pharmacological, interventional, rehabilitative and psychological. The scope for collaboration on clinical, research and teaching initiatives is enormous and remains seriously under-developed. Key priorities in pain management strategies for patients with cancer-related pain should be to help them achieve a balance between pain and adverse effects of analgesia to optimise physical function, and support for self-management. In this context, greater collaboration between pain management, palliative care and oncology services could prompt earlier access to pain management and improve outcomes.

Professional Standards

Dr Paul Wilkinson
FPMPSC Chair

It is a great privilege to Chair this very active committee and I thank all members for their hard work and support. Updates in key areas of activity now follow.

Gap analysis from Core Standards in Pain Medicine Services (CSPMS)
The establishment of CSPMS, supported by various professional and patient organisations, has been an enormous step forward for pain services and covers both primary and secondary care services. There is now a pressing need to map the current provision of pain care to CSPMS to support quality improvement. Led by Anna Weiss and James Taylor, the PSC has translated CSPMS into a series of questions linked to benchmarking criteria. Please see the next article for further detail.

Patient Information
The patient information leaflets for interventional procedures have been completed and are reported on by Andrew Nicolau in this issue of Transmitter. We will be actively seeking feedback for change as they are used. We are also reviewing the pain medications leaflets as well as exploring patient resources relating to medicine reduction; in particular opioid reduction.

DVLA and Fitness to Drive
Wyn Parry, Chief Medical Officer at the DVLA, attended a recent PSC meeting to discuss drug and driving legislation. Sleepy drivers create a very significant risk to the public. Pain medicines may lead to somnolence but similarly, poor sleep patterns may be helped by good pain relief. The first step was to provide the most robust patient advice and also to advise of increased professional responsibilities under new legislation. I am pleased to announce that the first document will shortly be published on the FPM website under the leadership of Rob Searle. The next step is to provide guidance to practitioners for this complex problem.

Intrathecal Refill checklist
A checklist to improve safety during intrathecal refills has been produced which is being piloted currently. It is anticipated that this will be available on the website very soon.

Pain in Palliative Care
Exploratory work on cross-specialty standards in Pain Medicine and Palliative Care has begun led by Professor Michael Bennett. This incorporates a partnership with both Oncology and Palliative Care. It is recognised that this cannot be done by one professional group alone, as standards for one specialty must be a matter for that specialty. This is a complex piece of work but has the potential to be a significant step forward for cancer pain services.

Consultation Length
Readers may recollect that we have worked to address the challenge of providing advice on new patient consultation length. The approach included evaluating the time required to perform the itemised tasks of a consultation using the published PSC consultation standards document as a framework. Seven consultants from different centres provided data for the analysis. We will provide further guidance on consultation length, taking into account impact factors such as prior triage and patient complexity.

Epidural Steroid Safety Guidelines
This has proven to be a complex process due to the professional breadth of opinion, modest evidence base and significant ramifications for the speciality. It has reached an advanced stage of development and should be published soon.

Summary
The FPM Professional Standards Committee strives to improve standards of practice in pain and I hope that the far-reaching work of the PSC continues to support members in their daily practice.

Core Standards for Pain Management Services (CSPMS)

Dr Anna Weiss
CSPMS Lead

Dr James Taylor
FPMPSC Member

15 months since launching CSPMS[1] it seems timely to take stock and consider the next step in its evolution. CSPMS was designed to provide a framework for standard setting in the provision of Pain Management Services for healthcare professionals, commissioners and other stakeholders. The aim was to provide a comprehensive list of benchmarks for pain management services. Since its launch, key standards within CSPMS have been identified for inclusion within the CQC's inspection framework.

The Faculty recognises that CSPMS must evolve to remain credible and relevant for pain services operating in diverse clinical contexts. Developments must respond to feedback from fellows striving to meet these standards, under increasing workloads and within a fluid commissioning environment.

Queries and comments - Since launching CSPMS the Faculty has received a handful of queries and comments in relation to the published standards and their application in professional practice. This modest number may reflect awareness of the standards or represent an indirect comment on the somewhat expansive layout of the document. Could we improve communication and accessibility for the 2nd Edition?

The two main areas of enquiry were:
Training and qualifications - Consultant colleagues enquired regarding the emphasis on FFPMRCA as a qualification for acute pain management and sought reassurance regarding their qualifications for the delivery of acute pain services.

Future training for acute/in-hospital pain medicine leads has been debated by the FPM with guidance to be issued imminently[2]. The FPM acknowledges that the majority of acute pain services are led by experienced and highly qualified colleagues devoted to continuous professional development that enables provision of safe, high quality services. Current qualifications need to be considered individually in the context of the environment colleagues work in and relevant CPD they acquire.

Disparity of Core standards within specialist practice - It was highlighted that the assessment of pain during labour does not fit criteria applied in other clinical settings (including pain assessment pre- and post-partum). We are approaching the Association of Obstetric Anaesthetists for advice as to whether specific standards for labour pain assessment and management should be agreed and if so, through which body. This may include guidance on specific assessment tools. Establishing standards for labour analgesia is currently outside of the remit of the CSPMS.

CQC Key Core standards - In January 2016 the FPM and the CQC agreed to a set of Key Core Standards, ratified for use during CQC inspections[2]. Currently these are the **only** pain related standards applicable for CQC inspections.

Gap Analysis Questionnaire - As the CSPMS UK contains many statements of intent and aspiration, the FPM has recently developed a "Yes/No" Google questionnaire for assessment of Core Standards felt achievable, realistic and easily measurable. Its purpose is to provide a benchmarking instrument to inform the Faculty of the current national baseline and inspire service development. Look out for the questionnaire and please take a few moments to answer it.

The future? - The multidisciplinary approach applied in the construction of the first document will be maintained as we develop the 2nd Edition. Feedback from you and your colleagues within your multidisciplinary team will be invaluable. There is scope for affiliated documents - the development of a Standards Document for Palliative Care, proposed by Professor Mike Bennett, is one of the projects the Faculty will be collaborating on.

1. http://www.rcoa.ac.uk/system/files/FPM-CSPMS-UK2015.pdf
2. http://www.rcoa.ac.uk/system/files/FPM-CQC-KEY-STDS_0.pdf

Acute Pain Update

Dr Mark Rockett

Acute Pain Medicine Lead

In addtion to the Faculty and RCoA anniversaries this is also the IASP Global Year Against Pain After Surgery. Writing the Pain Medicine lecture for the College Anniversary celebrations has given me cause to reflect on how far we have come and how far there is still to go to reach our goal of 'pain free surgery for all'. Reading the literature, it has become clear to me that the most significant improvements in post-operative care have arisen not from new drugs or techniques but from organisational, educational and attitudinal change.

In the early 1990s, acute pain services (APS) were introduced into UK hospitals following publication of the Report of the Joint Working Party of the Royal College of Surgeons and (then) College of Anaesthetists[1]. This seminal document recommendeds that an APS should include not only specialist pain nurses and doctors but also clinical psychologists, pharmacists and physiotherapists – how many of our pain services meet these standards today?

In today's cash-strapped NHS, Quality Improvement is a recent ubiquitous phenomenon, but we pain clinicians were well ahead of the game. In the early 1990s, simple QI measures implemented by an APS demonstrated significant improvements in post-operative care (at least a 30% reduction in median pain scores)[2]. There is a risk that we may lose focus on getting the basics right, in favour of the latest innovations, recent research from Germany has revealed that more than half of the APSs do not meet basic quality standards, and in Denmark APSs have all but vanished outside teaching hospitals[3,4]. These worrying developments must not be allowed to occur in the UK; APSs should support important innovations such as enhanced recovery programmes, and cannot be replaced by a guideline[5].

Quality Improvement - One way to support and encourage QI in pain services is to set standards and share data, both about organisational factors and patient-level outcome data. Such acute pain registries have revealed surprising new findings about pain after surgery[6]. Establishing a nationwide registry is a step too far at present, but the benchmarking of individual services against their peers, based on organisational data, is a more practical proposal and one which we are working towards with the Faculty. Improvement in the quality of care has been demonstrated in Germany using such benchmarking tools, suggesting this would be a worthwhile development in the UK[7].

Education and training - Other FPM acute pain projects are also in progress with the overall aim of supporting APSs in providing high quality care. We recently held another highly successful acute pain study day entitled 'Acute Pain: Challenges and Complexities', which included insights into the management of patients with complex pain problems including the psychology of pain and managing acute pain in patients with chronic pain. The Training and Assessment Committee of the Faculty have begun work on reviewing acute pain training and our recent survey of the experience of acute pain training among our trainees is in preparation for publication.

Research and audit - Although UK pain research is world class in the basic sciences, clinical pain research, particularly in acute pain, has been very limited. The advanced pain training year is busy enough without expecting our trainees to develop a research interest. We therefore need to engage our trainees at an early stage in their careers. Discussions with research-active trainees have begun to investigate the feasibility of forming a trainee-led pain research network affiliated to the highly successful national RAFT group.

1. Commission on the provision of surgical services *Report of the Working Party on Pain after Surgery* RCS and College of Anaesthetists 1990
2. Gould TH et al *Policy for controlling pain after surgery: effect of sequential changes in management,* BMJ, 1992 305(6863) p1187-93
3. Erlenwein, J et al. *A follow up on Acute Pain Services in Germany compared to international survey data* EUR J Pain 2016 20(6) p874-83
4. Neilson PR et al, *Post-op pain treatment in Denmark 2000-2009: a nationwide sequential survey* Acta Anaesth Scand. 20102 56(6) p686-94
5. Romunstad L and H Breivik *Accelerated recovery programmes should complement, not replace the APSs.* Acta Anaes Scand, 2012 26(6) p672-4
6. Gerbershagen HJ et al, *Pain intensity on the first day after surgery: a prospective cohort study.* Anaesthesiology 2013 119(4) p934-44
7. Meissner W et al. *Quality improvement in postoperative pain management* Dtsch Arztebl Int, 2008 105(50) p865-70

Coffee evening for patients awaiting Spinal Cord Stimulation

Dr Ganesan Baranidharan

FPM Board Member

Spinal Column Stimulation (SCS) is an evidence based therapy currently available for patients with intractable neuropathic pain (NICE TAG 0159). At Leeds Teaching Hospitals, as part of the care pathway for provision of SCS, an information session is provided prior to offering patients a place on the neuromodulation waiting list. This session enables the Clinical Nurse Specialists (CNSs) to discuss the principles of SCS, the benefits and risks of this therapy, the surgical procedure and resulting after care. It also enables a demonstration of the equipment involved and offers an opportunity for patients to discuss the information and their concerns.

A recent patient satisfaction survey, undertaken by the CNSs, revealed that although patients found the information session most useful, they would also have liked an exchange with patients who have experience of this therapy. The challenge for the team was to establish an appropriate forum that would enable these discussions to take place. It was not deemed appropriate to provide direct contact telephone numbers; equally, evidence from social media network sites clearly demonstrates the need for more controlled patient information and direct exchange amongst patients on this subject.

The aim of our initiative was to provide articulate, appropriate communication on matters of SCS in a safe and time-limited environment. A coffee evening format was chosen to allow patients and volunteers to meet on safe and neutral territory to talk in an informal meeting over a cup of coffee. All patients who are currently on the waiting list for an SCS trial or a full implant are invited to attend.

The volunteers for the coffee evenings have been selected from the pool of current Leeds SCS patients. These volunteers have been chosen as they are easy to talk with, articulate in their ability to describe their experiences and willing to freely give up some of their time to meet our new patients. Currently the service has over 20 excellent volunteers who between them have the experience of the full range of implants that Leeds Pain Management Services provide.

The Coffee Evenings are currently held on site at Seacroft hospital from 7-8 pm on a Thursday. The format is to introduce the volunteers and inform the guest patients that they have only one hour to mingle with the volunteers and ask as many questions as they would like to. At the end of the hour, the meeting is closed. Limiting the meeting to one hour only has helped the volunteers to plan their time and has helped to focus patients' questions.

The first six coffee evenings proved a great success with both the patients and volunteers alike. The meetings have spurred a working group with patient and pain team members enabling a number of service improvements. The group has made a patient information video about chronic pain and withdrawal from opiates, developed a patient information leaflet for opioid withdrawal and has been part of developing our research patient information leaflets. Several of the volunteers have been selected to speak about their experiences at local and national seminars.

It was also observed that the coffee evenings have spurred a wider need for social interaction. Patients expressed the desire to meet again, potentially at regular intervals throughout the year, for a coffee and a general chat. Chronic pain can be socially isolating and it appears that both patients and carers enjoy support from others who have shared similar experiences.

For further detail about this project, please contact Mrs Carol Bourke (carol.bourke@nhs.net), Specialist Nurse or Dr G Baranidharan (g.baranidharan@nhs.net), Consultant in Pain Medicine, Leeds Teaching Hospitals NHS Trust.

Workforce Update

Dr Peter Cole

RAPM for Oxford

The results of the 2012 pain census were published by Drs McGhie and Mendis in the autumn 2013 and spring 2014 editions of *Transmitter*. This census revealed 461 consultants working in Chronic Pain; almost half aged 41-50, with the majority of the workforce over 46. 22% were female. There was a range of 0.5-1.5 pain consultants per 100,000 population, with significant regional variation.

Since the original work was undertaken, NHS pension changes and tax reforms have altered some specialist's planned retirement dates. The FPM is also conscious that recruitment and retention problems in some areas have left pain management positions unfilled. To quantify these workforce changes, we plan to run another pain census in 2017.

The core questions for the census are being finalised by a subgroup of the Training and Assessment Committee. We hope that the majority of the data will be collected through the next biannual report (which will be sent out in May). This is completed by the Regional Advisors, with help from Local Pain Medicine Educational Supervisors; however, there may also be some questions that can only be answered by individual consultants. Accurate information is important to inform future planning of our workforce, so we are grateful in anticipation of your support with this process.

We are aiming for the information to be analysed for presentation to the Faculty, BPS and Chronic Pain Policy Coalition reception in October.

Patient Information Leaflet Update

Dr Andrew Nicolaou

FPM Board Member

Patient information leaflets for pain procedures have been produced by the Faculty and are now available as a downloadable resource on the website.

Initially produced to cover the commonest procedures such as epidural injections, facet injections and so forth, the project was broadened to include patient information leaflets for 16 procedures.

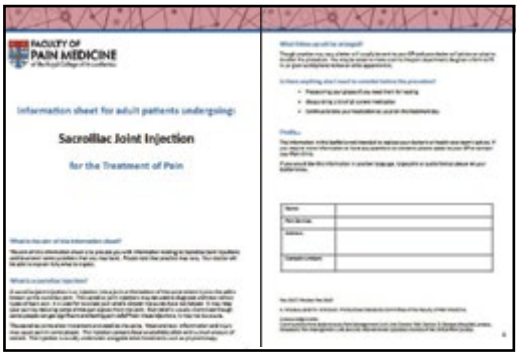
Right from the start lay and public input was central to their development and underpins this resource.

A range of opinion was also sought from clinicians coming from a variety of backgrounds and workplaces in producing these patient leaflets. It was also recognised at the beginning that variation of practice does exist, often reflecting local available resources, and there may not be one particular way to do things.

The patient information leaflets aim to reflect this - they are not intended to outline a prescriptive formula or directive on how exactly to perform a block or on whom, nor do they judge evidence or in any way act as a substitute for consent, but instead act as a general guide to what a patient may expect when having certain pain procedures.

We hope they help to support and inform the patient further following discussions with their clinical team and in the context of shared decision making, having considered other options.

These leaflets are a start and cover a range of the procedures currently performed in interventional practice in the U.K. For the next stage in this projects' development we seek feedback from their use in practice to update and further refine this material, and later hope to include further procedures.


FACULTY OF PAIN MEDICINE

Information sheet for adult patients undergoing:

Sacroiliac Joint Injection

for the Treatment of Pain

Pain and Driving

Dr Rob Searle

FPM PSC Member

Over 180,000 people are injured in traffic accidents every year in the UK, and the problem remains a significant public health concern. Although road deaths peaked in 1966 and have steadily declined since, around 1800 people a year still die on British roads, a figure that has not changed significantly since 2010.

Driving is a complex task that requires co-ordinated responses from many body systems including vision and hearing, attention and concentration, insight and judgement and muscle power/control. It follows that many of these processes may be functionally impaired in patients who suffer from pain. Impairment may result from the underlying condition causing pain (such as nervous system or musculoskeletal problems), or may be due to the effects of pain itself, which we know can cause cognitive impairment. Some pain related co-morbid conditions such as anxiety, depression and insomnia are also associated with cognitive complaints such as memory and concentration problems. Indeed, fatigue and tiredness have been implicated in up to 20% of all road traffic accidents, and there is a strong link between fatal accidents and driving at night. The DVLA have ruled that patients who suffer from excessive sleepiness (as a result of any condition or medication) must not drive, and if driving a bus or lorry must inform the DVLA.

Many pain medications may cause impairment of driving abilities by interfering with the visual, cognitive or motor abilities needed to drive safely. The recreational use of illegal and prescription medications (such as opioids and benzodiazepines) and the association between this and road traffic accidents led to the introduction of drug driving legislation in England and Wales in 2015. In the year following the introduction of these legal changes, nearly 8000 people were arrested by police. People can be tested by the roadside (for drugs such as cannabis or cocaine) or by blood/urine samples. If test results are above certain limits, illegal drug users are assumed to be impaired and are prosecuted. Although patients who are prescribed these medications and take them in line with medical advice will not be prosecuted if they are over the legal blood limit, they should be reminded that it is illegal to drive under the influence of any drug if it is causes impaired driving ability.

The Faculty is concerned about the effects of pain and pain treatments on driving ability and plans to introduce guidance for pain doctors and their patients on this topic. In the meantime, Faculty members should counsel their patients that their driving may be impaired by pain, associated pain conditions or medications and that it is illegal to drive if their condition causes excessive sleepiness or their medication causes impairment. It remains the responsibility of the patient to decide if they are impaired, but if their doctor tells them not to drive they will be breaking the law if they continue to do so.

National Neuromodulation Registry Update

Dr Ganesan Baranidharan

Honorary Secretary, NSUKI

Neuromodulation is an ever-expanding field and we are currently in an era of electroceuticals. NICE has recognised this as a cost-effective therapy for neuropathic pain in their guidance (TAG 0159). The technology is expanding with newer anatomic targets such as dorsal root ganglion and newer wave forms such as high frequency, burst, high density, whisper etc.

The Neuromodulation Society of UK and Ireland (NSUKI) is an organisation working towards education and development of Neuromodulation. NSUKI in partnership with Northgate PS (who administer the National Joint registry) are launching the National Neuromodulation Registry.

The aim of the database in the first phase is to collect patient demographics including: postcode for access to therapy information, NHS number, an implant device registration, length of refractory pain, occupational status, global perceived effect, quality of life data using EQ5D 5L, trial to permanent implants, complications and revisions. This will be for all SCS, Peripheral Nerve Stimulators and Intrathecal Drug Delivery systems. The clinical governance group includes NSUKI, NICE, Medicines and Healthcare Products Regulatory Agency (MHRA), the Faculty of Pain Medicine, Industry Partners, Lay Representation and Commissioning.

The British Pain Society 50th Anniversary

Dr Arun Bhaskar
Chair, Communications Committee,
British Pain Society

Pain is probably one of the most common symptoms, but it was only during the latter half of the last century that medical professionals started paying closer attention to the science and psychology of pain rather than treating it just as a symptom. Following the Second World War, pain clinics were set up in London, Plymouth and Liverpool by 1947 and, by the mid-1960s, there were about 29 practicing clinicians in the UK. The Intractable Pain Society of Great Britain and Ireland (IPSGBI) was formed in 1967, making it probably the oldest Pain Society in the world (IASP was founded in 1973). 17 of these clinicians met in Manchester at the invitation of Dr Mark Swerdlow who was appointed as the first chairman of the Intractable Pain Society with the following office-bearers; Prof William Mushin (President), Dr Mark Churcher (Secretary) and Dr John Challenger (Treasurer). The society was established to attempt to treat and prevent the development of persistent pain, mainly in cancer patients. The Society was initially a consultantonly body (mainly anaesthetists); over time the membership of the society changed to become a multidisciplinary society. The Intractable Pain Society became the Pain Society of Great Britain and Ireland in 1988 and became a Chapter of IASP. The Irish Pain Society formed in 2001 and the Pain Society of Great Britain and Ireland adopted the current name of The British Pain Society in 2004.

Several prominent figures contributed to the development of pain medicine in the UK. Dr Tim Nash started the Newsletter of the Intractable Pain Society and also served as President of the Society. Dr Ed Charlton, another President, oversaw the transition to the multidisciplinary Pain Society; he was instrumental in developing the IASP Curriculum and, along with Dr Chris Wells, started the Neuropathic Pain SIG. Prof Sir Michael Bond played a key role in the founding the Pain Society and was President of the Society in 2009 as well as President of IASP. The IASP definition of pain and the importance of the psychological aspects of pain medicine were some of his important contributions and he was knighted in 1995 for services to medicine.

Dr Doug Justins, another former President of the Pain Society, served on the Council of the Royal College of Anaesthetists and was the Chair of the Pain Management Committee. He was the first Dean of the Faculty of Pain Medicine, serving in all roles with distinction. Dr Beverly Collett OBE, who after serving as President of the British Pain Society was elected to the Council of IASP and served as Hon Treasurer to IASP as well as Hon Secretary of European Pain Federation (EFIC). Dr Collett actively campaigned for raising the profile of Pain Medicine in the UK Parliament through the Chronic Pain Policy Coalition and was awarded the OBE in 2015 for her services to Pain Medicine. The British Pain Society grew from strength to strength as the foremost multidisciplinary body in Pain Management in the UK under subsequent Presidents, Dr Joan Hester, Prof Richard Langford and Dr William Campbell.

The BPS has well over a 1200 members from various disciplines and has 14 Special Interest Groups (SIGs) that impart education to medical professionals and patients. The BPS is one of the largest IASP chapters and has contributed office-bearers to both IASP and the EFIC. The Patient Liaison Committee actively contributes to the work of the BPS and ensures that goals and work streams are patient focused. The British Journal of Pain is the indexed journal of the Society; Pain News isthe Society's quarterly newsletter. Pain News is bringing out a special edition commemorating the 50th Anniversary and I would like to thank all the former Presidents who took their time to share their memories and experiences. A Wikipedia page is also being created and will be kept updated for the benefit of the public as well as new members who are joining the Society. https://en.wikipedia.org/wiki/British_Pain_Society

The 50th anniversary Annual Scientific Meeting is being held on 3-5th May 2017, Birmingham UK and offers a diverse and exciting programme, which boasts a wide array of subjects and experts from all over the globe. Following the theme of IASP's Global Year Against Pain After Surgery, The Acute Pain SIG have organised a pre-ASM study day on 2nd May 2017 on persistent pain after surgery. Dr Andrew Baranowski, President, the Council Members and the Scientific Committee extend a warm welcome to join the ASM in Birmingham commemorating the golden jubilee celebrations of The British Pain Society.

Acknowledgements

Dr Tim Nash - Notes and Documents on the early days of the Pain Society

Dr William Campbell – Immediate Past President for his words of wisdom and support

Dr Arasu Rayen, Jenny Nicholas, Dina Almuli for their valuable support & assistance

Dr Stephen Humble, Dr Asako Shida, Dr Alice Costello – research into the history of the British Pain Society

Resources

The British Pain Society
https://www.britishpainsociety.org

The British Pain Society 50th Anniversary ASM
https://www.britishpainsociety.org/2017-asm-birmingham/

The History of the Intractable Pain Society of Great Britain and Ireland
Dr Mark Mehta *PAIN* 8 (1980) 121-22, Elsevier North-Holland Biomedical Press

2017 is the
Throughout the year we will be celebrating the achiev
The timeline below highlights t

RCoA Council approves the foundation regulations of the FPM. On 6 Dec, the Founding Board of the Faculty meets for the first time and begins its two-year journey to forming the Initial Board of the Faculty.

2005

The initial Board forms with **Doug Justins as its first elected Dean**. Foundation Fellowship opens and hundreds join.

2007

The **Training & Assessment Committee** (FPMTAC) and the **Professional Standards Committee** (FPMPSC), meet for the first time. An embryonic version of the **FPM webpage** is launched. Dave Rowbotham becomes the second Vice Dean. Our membership routes expand.

2009

Transmitter launches. Our first Education Meetings Advisor is appointed and oversees an overhaul of the Pain Medicine events programme. Much work is taken forward by FPMTAC, including creating the first trainee logbook. Guidance on specialist area competencies are produced. After three years and helping to birth the Faculty, Doug Justins stands down and **Dave Rowbotham becomes Dean**.

2010

FFPMRCA Court of Examiners is formed and begins the difficult tasks of populating a question bank and ensuring a fair and responsive standard setting process for the exam. The first guideline is produced by the FPMPSC with many more to follow in coming years. Kate Grady becomes the third Vice Dean.

2011

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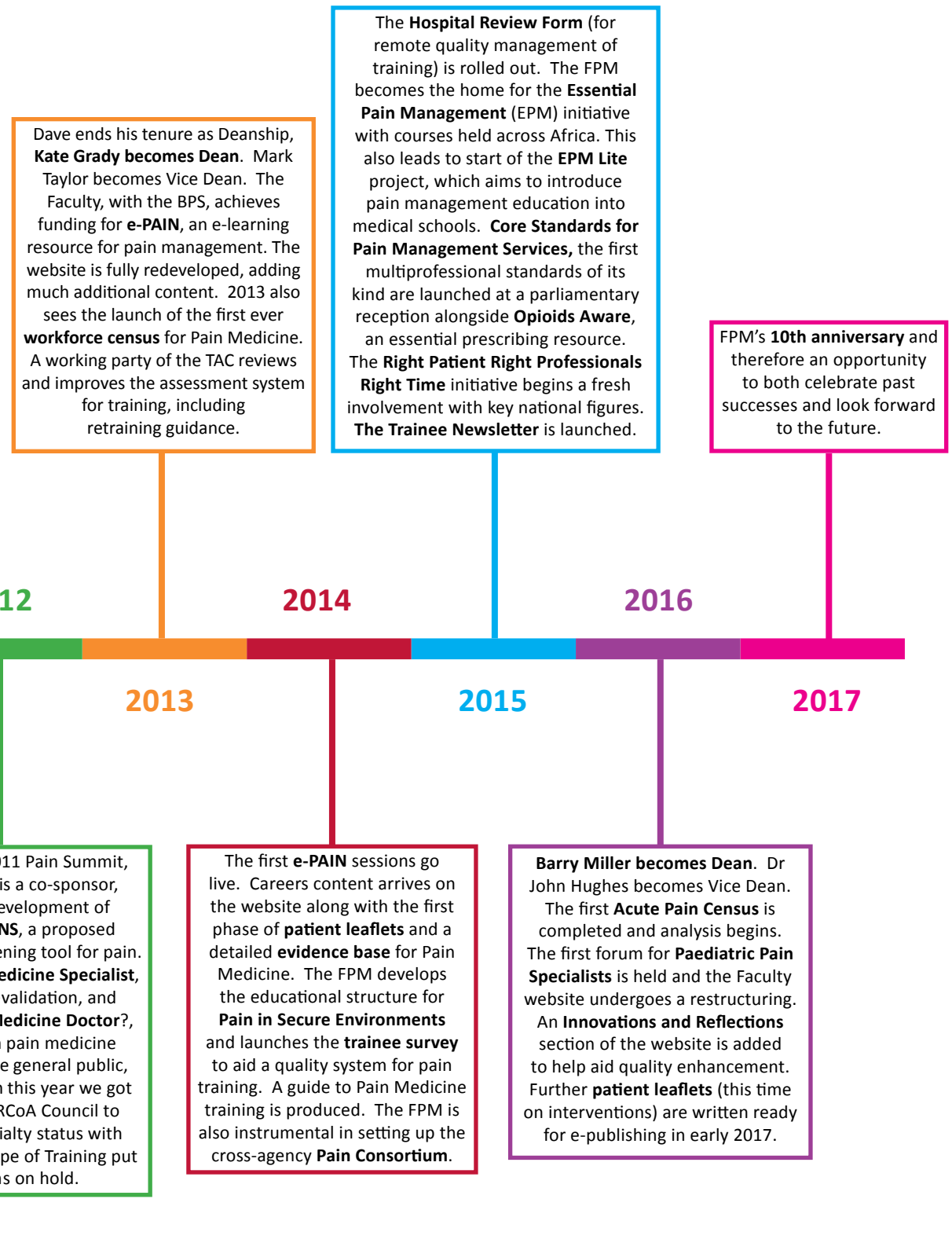


e-PAIN

Dr Douglas Natusch

Clinical Lead, e-PAIN

Dr Rhian Lewis

Deputy Clinical Lead, e-PAIN

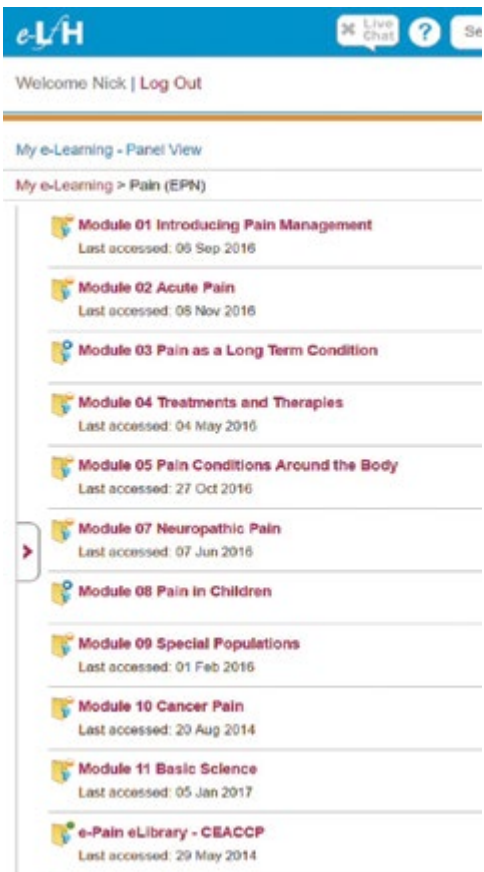
Who can use e-PAIN?
Anyone, anywhere in the UK, at any time! You just need an NHS email address and a desire to learn about pain management.

Starting a career in Pain Medicine a generation ago, some of us may recall feeling less experienced in the field compared to the level of proficiency we had achieved in Anaesthetics. In the operating theatre we could deal with major cases comfortably, and felt proficient and well-read. This feeling was underpinned by structured anaesthetic training and the FRCA exam. 'Pain' seemed to be quite a different animal. There were fewer consultants to speak to, few entry-level textbooks, and limited information to support learning. Moving on a generation, how things have changed! There is a Faculty of Pain Medicine of the Royal College of Anaesthetists (FPMRCA), detailed training at all levels, and the FPMRCA fellowship exam is now an embedded part of advanced training.

Many of us involved in NHS pain services now deliver training for doctors at different stages in their careers and we are also involved with the training and career development of other staff within the pain clinic. It can often seem difficult to advise newcomers to the subject about where to start their studies. There are textbooks, journals, and a huge number of resources on the internet, but newcomers need something accessible, high-quality, and located under one roof.

We suggest below that this gap has now been filled by e-PAIN, which is useful to any individual interested in learning about pain management in the UK.

What is e-PAIN?
e-PAIN is a unique e-learning program hosted on the e-Learning for Healthcare website at http://portal.e-lfh.org.uk. Once you log in, you can choose the "Pain (EPN)" package to put on your "My e-Learning" shelf, giving you access to 11 modules written by leading multi-disciplinary UK professionals, and following the International Association for the Study of Pain's curriculum. Each module contains five sessions on average, each taking around 30 minutes to complete.



e-PAIN was established as a multi-disciplinary project between The Faculty of Pain Medicine, The British Pain Society and e-Learning for Healthcare on behalf of the NHS, and was commissioned under the expert guidance of a group led by Dr Doug Justins, former Dean of the Faculty of Pain Medicine and President of the British Pain Society.

What does e-PAIN offer?

The knowledge base of e-PAIN reflects the knowledge base found in a multi-disciplinary pain team – yet it is available to anyone from any specialty interested in learning about pain. Doctors in training can therefore benefit not only from the expertise of senior doctors in Pain Medicine, but learn about clinical psychology from psychologists, medicines from pharmacists, musculoskeletal problems from physiotherapists, and work on pain in the elderly by clinical nurse specialists. e-PAIN modules vary in focus from information about core subjects like acute pain, through to specialist modules such as pain in children. Anyone accessing e-PAIN has the opportunity to learn more about pain management, in their own time, at their own pace, and to the level they are interested in. Each one of the e-PAIN modules can be completed stand-alone, and users can then print out a certificate for CPD, allowing learners to focus CPD on their own interests and requirements.

Who uses e-PAIN?

User statistics suggest that e-PAIN is used by all disciplines, and indeed some of the most frequent users are paramedics, indicating a wide interest in providing good pain management. However, the same statistics also revealed that few doctors in training are currently using e-PAIN.

We suggest that e-PAIN is not only useful for consultant CPD, but is also valuable for anaesthetic trainees who want to read beyond the basic anaesthetic curriculum. Advanced trainees undertaking the FPMRCA exam should definitely turn to e-PAIN to learn about specialist areas of practice in the UK. Many of the specialist modules (e.g. cancer pain, pain in children, addiction) are unique to e-PAIN.

Future plans?

All online packages need to be updated to maintain currency, and last year the Faculty recruited the authors to take the venture forward by supervising module completion, and reviewing and refreshing the program.

The final sessions to complete the package are currently being written, and modules have been re-arranged to form a more coherent structure. We are also looking at the difficult area of how to assess module difficulty and relevance against the needs of our users in different professions. In this we are being assisted by six NHS pain team members from different disciplines, who undertook to read sessions, and comment on the appropriateness of each module for someone from their training scheme starting out in pain management. Based on this work, two modules will be updated shortly, and a rolling program of appraisal and update for all the modules will be maintained. We are also restructuring the e-PAIN library, which currently holds the articles from BJA Education but has the potential to be a platform for useful free online resources in future.

There are many people to thank for the development of this amazing resource, not all of whom we can mention here. However, Dr Doug Justins, Dr William Campbell and Professor Richard Langford deserve special mention. So too do Daniel Waeland and Jyoti Chand at the Faculty of Pain Medicine, and Nick Clearey at e-Learning for Healthcare, all of whom do huge amounts of work for the project behind the scenes.

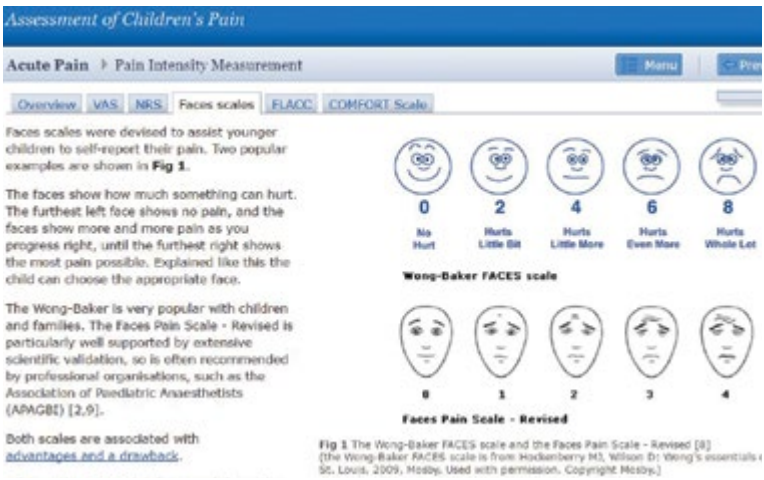


Fig 1 The Wong-Baker FACES scale and the Faces Pain Scale - Revised [8] (the Wong-Baker FACES scale is from Hockenberry MJ, Wilson D: Wong's essentials of St. Louis, 2009, Mosby. Used with permission. Copyright Mosby.)

We recommend you take a look at e-PAIN and tell others about it. We are always happy to receive feedback or suggestions which we can take on board over the coming months.

Essential Pain Management (EPM), Mercy Ships, Benin

Dr Jane Mills
ST7 Anaesthesia and Advance Pain Trainee

Dr Samantha Jayaweera
ST3 Anaesthesia Trainee

Dr Helen Makins
Deputy EPM (UK) Project Lead

The Faculty of Pain Medicine is committed to providing EPM courses in Africa. In November 2016 three of us, all UK based anaesthetists, taught EPM in Benin for the first time alongside Mercy Ships.

Benin is a French speaking West African country, with a population of over 10 million, the majority of whom live along the Southern coastline. Life expectancy is 59 years, literacy rates are low (43%) and infant mortality high (64 deaths/1000 live births).

Mercy Ships is an international Christian charity delivering healthcare from a converted Norwegian ferry, currently docked in Cotonou, Benin's largest city. The world's biggest non-Governmental hospital ship, the Africa Mercy is a modern complex of operating theatres, wards and a small Intensive Care Unit, while the upper decks provide living accommodation for the volunteer workers.

Alongside a comprehensive elective surgical programme they offer a wide range of medical teaching for local health care providers. In order to provide a sustainable teaching programme beyond the Mercy Ship input, local teachers are identified and trained as trainers for each course, and follow-up contact is provided to encourage and monitor ongoing teaching programmes.

We taught the one-day EPM course to 83 professionals in French, using translators when necessary. Participants were invited using existing contacts within local hospitals, and included midwives and nurses, along with doctors and surgeons.

The course explains the pathophysiology of pain and gives a basic structure for the recognition, assessment and treatment of pain (RAT approach), which is appropriate for any health care professional. A large number of experienced practitioners contributed to lively debate.

There was much discussion about the differences between addiction, tolerance and dependency. Clinical conundrums posed by the delegates included one of unexplained generalised body pain. Whilst we might call this fibromyalgia, it was not a concept or a problem they had ever encountered before.

There were some interesting ethical dilemmas. Discussion around placebo effect evolved into a debate; as there are many people in Benin who cannot afford or do not have access to active medications, if you were in rural Benin with a patient in pain and no possibility of an active medication, would you prescribe a placebo?

Nurses and midwives were more reserved when expressing their opinions, explaining that they felt powerless to institute change. In our 'overcoming barriers' session they appreciated that small differences in attitude amongst their peers would be potentially powerful. For midwives in particular, an understanding of the emotional aspects of pain perception seemed useful – reassurance is freely available in the absence of entonox and epidurals.

Doctors were particularly vocal. A Palliative Care doctor was scorned by his Anaesthetic colleagues for using 5mg of oral morphine for pain management in the community, as this was considered extremely dangerous. Interestingly, Palliative care is a small specialism in Benin and his practise had been learnt from time spent abroad. An enthusiastic Plastic Surgeon addressed the group, imploring them to take responsibility themselves for instituting change and improvement. She has since run a further EPM course and we were encouraged by her potential to inspire others.

We are grateful to the Faculty of Pain Medicine and Mercy Ships for facilitating this trip. The organisation provided by the Mercy Ships team, including the identification of appropriate delegates and follow up support will maximise the chance of long-term change in the management of pain in Benin.

For more information please visit:
www.mercyships.org.uk
and www.fpm.ac.uk

EPM - Lite, West Midlands

Dr William Rea

RAPM West Midlands

The West Midlands Deanery comprises three Schools of anaesthesia: Birmingham, Coventry & Warwick and Stoke. Each School is associated with a University offering Medicine, those universities being Birmingham, Warwick and Keele respectively. So far EPM-Lite has been piloted in Birmingham and discussions are underway at the other two universities with a plan for the near future.

Following my conversation with Dr Mike O'Connor and Dr Helen Makins, the EPM-Lite project leads, I approached the Birmingham Medical School about possible openings in the curriculum for pain education. Some subjects relevant to pain are delivered during the basic sciences teaching in Years 1 & 2.

It was felt that Pain Management training might fit best with the main Internal Medicine module which occupies half of the year 4 curriculum at Birmingham. As there were already time pressures on the year 4 training programme, the medical school offered a plenary session during which teaching is delivered for complimentary modules which don't fit comfortably into any particular specialty block.

Prior to the first course, I attended a course in Bristol to observe and experience EPM-Lite first hand. I presented some of the lecture material and also facilitated a small group discussion. This was an excellent experience and one I would recommend to anyone responsible for EPM-Lite in their own School.

Following this, I met again with the Year 4 and Medical leads at Birmingham University's medical school. For largely logistical reasons (Birmingham has nearly 400 undergraduates in its 4th year), we decided to deliver the first course entirely as lectures. This format actually worked surprisingly well. The teaching material comprises pre- and post-course MCQs for evaluation, an electronic voting system (Turning Point) was embedded into the PowerPoint presentation by the University's IT team to make evaluation easier.

As well as the face-to-face component of the course, the Student Handbook and a video recording of the lectures were uploaded to the University's virtual learning platform for revision purposes. Students at Birmingham also have access to e-Pain through e-Learning for Health and these resources are signposted to them during the course.

Feedback from the first course has been extremely encouraging. At Birmingham, we have asked students to attend sessions either in acute or chronic pain during their medicine modules; next year, we are planning to incorporate a mini-CEX evaluation of the RAT pain assessment model into the student learning diary so we can get some objective evidence that they are putting the learning into practice.

Worthy of a mention is that our students in Birmingham are increasingly involved in clinical audit (participation in clinical audit is compulsory in Year 4 at Birmingham with presentation of audit projects at an end of year prize competition); EPM-Lite has been a good opportunity to advertise our audit projects to a large group of willing volunteers which should further help to raise interest in Pain Management. Since starting EPM-Lite we have also fielded requests from a few students to do their Special Clinical Experience module in Pain Management in Year 5. We hope that supporting education in Pain Management in these ways at undergraduate level will lead to greater numbers of graduates considering careers involving a pain management component.

Training and Assessment

Dr Jon McGhie

TAC Chair

Since my last update, the Training and Assessment Committee has taken on some new members. Dr HooKee Tsang has taken over from Roger Okell and is our liaison with the RCoA Training Committee. Dr Paul Rolfe joins the committee to look at issues which relate to paediatric pain training. Finally, Dr Mark Rockett has come on board to assist with training issues relevant to acute pain training and research.

The broadening of the group reflects the need to support and develop pain training across all stages of professional practice. The evolution of the FPM curriculum from the original RCoA curriculum was initially focussed on getting advanced pain training right. However, with fellowship routes and the exam well established, we have started to direct our focus towards other stages of training. Our current work streams include:

Intermediate pain training — Victor Mendis is leading a sub-group from the TAC to develop an information handbook for this stage of training. We hope that this will help to inform trainees about career options in pain medicine and regional training opportunities.

Paediatric Pain Training — Paul Rolfe will lead a working party of TAC to develop strategies and recommendations with regard to training, assessment and workforce concerns in Paediatric Pain Medicine.

Acute Pain — Dr Rockett is the Acute Pain lead for the FPM and has been heavily involved in workforce issues and professional core standards in this area. As a natural progression of this work, he will advise the TAC group on training issues and opportunities relevant to acute pain. Future amendments to the higher pain training curriculum to make it more relevant for trainees who wish to pursue an acute rather than chronic pain career is one aspect of this work.

Research — Sheila Black, our trainee representative, is working with Dr Rockett to develop opportunities for advanced pain trainees to engage with existing research frameworks. There are several successful regional trainee groups primarily researching in anaesthetics. It is hoped we will be able to guide interested higher and advanced pain trainees across the UK to develop similar networks.

Logbook — Dr de Gray is leading a small group to redesign the pain logbook that we currently ask trainees to complete to support their advanced pain training experience. We hope to simplify the data that is logged to make it easier for trainees to complete. As a secondary aim, we hope to get better quality and standardised data that we can aggregate and use to guide future pain training.

Workforce — Dr Cole is leading on this area with a planned census scheduled to occur before the end of 2017. It is hoped that a high return of information from clinicians and RAPMs will give good quality information on workforce changes. Further information on the census will be emailed out to fellows and members later in the year.

Quality assurance — Dr Tsang has taken an amendment on anaesthetic on-calls during pain training to the RCoA training committee. This addressed concerns fed back to the FPM that on-call and daytime anaesthetic sessions were eroding pain training opportunities in some regions. The RCoA were supportive of our concerns and information on the statement can be found on the website. We are continuing to assess the hospital review forms with a plan to consolidate the information on our website to provide a nationwide listing of pain training opportunities.

On the horizon are two developments that will influence any future pain curriculum. The first is the GMC's generic professional capabilities (GPCs) document, which seeks to embed good medical practice competencies within future curricula. This is currently out for consultation, but will be integrated and launched alongside new standards for postgraduate curricula and credentialing (SCAR) later this year. We will keep you updated on the impact of these developments in future Transmitter articles.

Trainee Update

Dr Sheila Black

Faculty Trainee Representative

Over the last couple of months, we have made progress with an exciting development involving the creation of PAIN-TRAIN, a UK network of trainees who are interested in research into pain, to accomplish research/audit projects across the country.

There has been a desire for this form of co-operation in pain research for some time now, from the Faculty of Pain Medicine and trainees alike. After a couple of false starts involving attempts at projects, mainly due to lack of infrastructure, we decided to create a trainee network to perform nation-wide projects, which will provide much more useful data than a sole investigator working alone. This network will form a branch of RAFT (which is a larger network of anaesthetic trainees involved in research) in the same manner as groups like AARMY, SWARM, etc. From this alliance, we will benefit from the experience and infrastructure of more academically minded colleagues in RAFT.

The group will comprise trainees from all grades of training who have an interest in pain research, both from an anaesthetic background, and Pain trainees. We are especially keen to encourage anaesthetic trainees, to highlight the interesting aspects of our specialty and encourage trainees to enter pain training.

The plan will be initially to run small national pain audits or surveys within the trainee network, utilising trainees in each region. Once we have demonstrated small projects to be successful within our group, we can then utilise the manpower/infrastructure within RAFT to carry out bigger projects.

Membership of the trainee research group will be on opt-in basis, not automatically conferred, but actively encouraged. Trainees can join at any stage in training. Trainees will need to be International Council for Harmonisation Good Clinical Practice (ICH GCP) trained, and will receive a certificate of participation for all audits/data collections they complete. Ideally, once established, this will require a trainee research network lead, a non-funded role, prepared to take the lead on small projects and recruit trainee data collectors.

The ultimate responsibility for this group will lie with the FPM Training and Assessment Committee, which will be responsible for deciding which projects to undertake. However, the emphasis will certainly be that this network is run *by* trainees and *for* trainees. The projects chosen, and direction in which the network moves, will result from the input of trainee members.

Some projects may require local approval and registration of audit process in each site across the country, but should not require ethical approval or submission to REC. Each site needs a trainee lead, and a consultant to assist with the local audit office, R&D, etc.

We plan to 'launch' this group at the GAT ASM in Cardiff in July in collaboration with RAFT, so are keen to get as many trainees signed up as possible, prior to starting our first project. Any interested trainees are encouraged to contact me on *Sheila.black3@nhs.net* along with ideas and suggestions about future network projects.

Sri Lanka

Post CCT Fellowships in Pain Medicine and Anaesthesia

Opportunities are available for the above fellowships in Sri Lanka either on a short term or long term (upto 1 year) basis.
No formal payments are made by the Sri Lankan Government, but for those who want to consider a long term post there may be opportunities for locum shifts.

For further information please contact Dr Victor Mendis. victor.mendis@meht.nhs.uk

RAPM Update

Dr Victor Mendis

RAPM Chair

In January 2017, I took over as Chair of the Regional Advisors in Pain Medicine from Dr Lorraine de Gray. I would like to take this opportunity to thank Lorraine for her hard work and dedication and wish her all the very best in her future endeavours. In her first update in 2014, Lorraine committed to engaging with Local Pain Medicine Educational Supervisors (LPMES), and has been successful in getting the first such meeting underway. We will continue engaging with LPMESs regularly and will rely on your ideas and feedback. I enjoyed welcoming the LPMES for the first such meeting in March this year, which gave us the opportunity to discuss important issues. Over the past 12 months the College has undertaken a review of the role of Regional Advisers and recognized that RAs are the College's senior local representatives who work with Postgraduate Deans, employers and fellow consultants on all matters relating to training, professional standards and continuing professional development. There has also been a significant undertaking with the aim of better aligning the role to the respective responsibilities of stakeholders such as Health Education England (HEE).

This year the Faculty is celebrating its tenth anniversary. Not only is it a time for celebration, but also an opportunity for us to reflect on training issues, especially in the light of the changes affecting the NHS and provision of pain services across the country. With this in mind we will continue to gather further information from the RAPM Bi-Annual reports. Whilst we will endeavour to minimise the number of surveys, I am sure you appreciate the importance of this exercise. Data from previous surveys could be used as part of the HEE submissions and surveying CCGs and GPs about patient waiting times. Referrals to pain services may also be an area that we will explore for workforce planning and quality assurance. The hospital review forms reflect the work load, training and modules offered in each Advanced Training Centre and are very valuable for prospective and current trainees.

The trainee surveys continue to show ongoing on-call issues and difficulties for trainees to access certain modules like cancer and paediatric pain. We plan to design a map of specialised training centre locations across the UK which will be published on the Faculty website. With advanced planning it is anticipated that trainees across the UK could make use of these specialist modules. Regional teaching continues and it is hoped that this will be more formalised and advertised to all trainees. In January, London piloted the first video conferencing during the teaching day which was well received by those who joined us from across the UK. The Faculty continues to run exam tutorials twice yearly and trainees are encouraged to participate. Trainee feedback is vital to further improve training standards, and I would like to assure all trainees that such feedback is carefully considered and acted upon. I would like to take this opportunity to thank Dr Nick Campkin (West Essex) and Saravana Kanakarajan (Scotland) who have completed their terms, having done an exceptional job and welcome Dr Dominic Aldington (Wessex), Dr Kothari (South Thames) and Ravi Nagaraja (North Scotland) into their new roles as RAPMs. At a time of increasing demands and overstretched NHS services, we are grateful that we have been able to appoint to these roles.

As Chair, I aim to focus on improving the profile of Pain Medicine, which I am sure will continue to attract trainees of the highest calibre. The specialty continues to develop as we learn more about the complexities of pain. An in-depth knowledge of the physiology of pain, the ability to evaluate patients with complicated pain problems, understanding of specialised tests for diagnosing painful conditions and appropriate prescribing of medications for varying pain problems, along with skills to perform procedures and more importantly to play a role in coordinating additional care such as physical therapy, psychological therapy, and rehabilitation programs in order to offer patients a comprehensive treatment plan should make this a very attractive

Spotlight on West Scotland

Dr Lisa Manchanda

RAPM for West Scotland

Over the last few years the NHS in the West of Scotland has seen many changes including the opening of the Queen Elizabeth University Hospital in Glasgow during the summer of 2015. It is one of the largest acute hospitals in the UK and sits alongside both the Royal Children's Hospital and the Institute of Neurological Sciences. The hospital has excellent teaching facilities within the Teaching and Learning Centre which we are utilising for our annual Pain Fellowship Exam Preparation course this March.

The Chronic Pain Service remains at two main sites, one in the North (Stobhill ACH) and one in the South (New Victoria Hospital). It takes over 4000 referrals from both primary and secondary care. Both sites have well established large multidisciplinary teams who meet weekly and are fully involved in training.

The Glasgow Pain Management Programme has been running since 2008 and in 2015 the Scottish National Residential Pain Management Programme commenced in Glasgow. Indeed, Glasgow is hosting the 17th National Conference of the BPS Pain Management Programmes SIG in September 2017.

The Spinal Cord Stimulator Service is based at the QEUH and has been running as an MDT service since 2009. They take referrals out-with the local area and provide training for the advanced pain trainee.

The Beatson West of Scotland Cancer Centre hosts the Interventional Cancer Pain Service (ICPS) for the West of Scotland. This service started in 2007 as a joint venture between palliative medicine and chronic pain and has developed considerably over 10 years. Currently the service is able to provide a comprehensive joint assessment from chronic pain, palliative medicine, physiotherapy and psychology and, where appropriate, a range of interventions for the management of complex cancer pain.

The ICPS is able to support patients by offering range of invasive procedures for cancer related pain, e.g. intrathecal drug delivery, coeliac plexus blocks and neurolytic blocks. The ICPS will start offering percutaneous cordotomy, where appropriate, from March of this year.

Within Greater Glasgow and Clyde work by the Managed Clinical Network has been ongoing since 2008 following the publication of the GRIPs report (Getting Reliable Information on Pain Services). The network has many subgroups including one on Education. Their work includes primary care pain education and the production of patient information both written and audiovisual. There are also plans for a joint chronic pain and addiction service in the future.

As trainers we provide guidance and support to our trainees to enable them to develop and gain new skills in Pain Medicine. We need to ensure they train in a positive environment despite the obvious pressures on our service.

My own personal aims include enhancing links with other subspecialties. We have provided pain training for palliative care and rehabilitation medicine doctors with reciprocal arrangements for our own Advanced Pain trainees. We also have links with many other specialist clinics which has enabled our trainees to access the entire FPM Pain Medicine curriculum.

Training is a team effort and we have the good fortune to have many dedicated enthusiastic individuals in the Pain Service who go above and beyond to facilitate training in the West of Scotland. We have also enjoyed training many individuals who themselves are now actively involved with pain training in the extended area. We often meet at local pain meetings in Glasgow or in Edinburgh at the biannual North British Pain Association meeting or indeed socially given any excuse!

I would like to thank my colleagues including Lars Williams, Andy Crockett, Alison Mitchell and Colin Rae for their assistance with this update.

LPMES Conference

Dr Ashish Shetty

LPMES, UCH, London

Amidst financial constraints, staffing shortages and European Working Time Directive guidelines, Educational Supervisors are facing an ever increasing workload from both a clinical and administrative point of view. The first ever LPMES meeting was held on 9th March and it was heartening to see the progress we have made as a group as we commemorate our 10th anniversary.

Dr Barry Miller gave an excellent update on the FPM activities and ongoing projects. He discussed the need for better collaboration with various organisations like NICE and GMC. The Essential Pain Management Lite project aims to introduce pain medicine to undergraduates. The FPM is collaborating with the BPS on outcome measures, with the intention of forming standardised measures that can be used by Clinical Commission Groups and Clinical Reference Group for allocation of resources.

Deputy Chair of FPMTAC, Dr Lorraine de Gray, discussed the training structure and the assessments. There is a stress on reflection where the assessments should give a broader picture of assessment and overall standards of performance. The current training continues to be competency based with a suggested minimum of 16 sessions in cancer pain and 200 sessions in total to be attended during Advanced Pain Training. However, the GMC is considering a change in all curricula, which aims to move from 'competency' to outcome as arbiters of completion of training. The LPMES day recognised the role of the trainers as ambassadors of the specialty, nurturing pain physicians for the future.

Dr Nick Plunkett highlighted that the FFPMRCA exam is designed and conducted in accordance with the highest standards, to further raise the standards of Pain Medicine in UK: It is now a mature exam in all aspects.

Dr Miller opening the LPMES meeting

Over the last 10 years training has become more streamlined. The FPM website is a valuable resource for both trainers and trainees alike. Well-trained doctors who have a holistic approach to pain management have become a valuable asset to hospital team and have emerged as flag bearers of pain medicine as a specialty. Continuous improvement in the FFPMRCA pass rates may partly reflect the improvement in training standards and the commitment of pain trainees. The FPM has provided guidance with certain training issues, such as on call commitments for the APT, by providing clear statements.

In 2012, a Census reported 461 Consultants in England and Wales amounting to less than 1 full time equivalent Pain Consultant per 100,000. The current training capacity is 50-60 APTs, however the fill rate is currently only at 50%.

There are 90 hospitals in the UK, within 21 regions, providing intermediate, higher and advanced training. With 31 APTs currently in training and the relentless work done under the leadership of FPM, the future of Pain Medicine looks secure for now. However, recognition, recruitment and resources remain the main challenges that we clearly face for the future.

Royal College of Anaesthetists Career Day 2017 Pain Medicine lecture

100 sixth form students attended the careers day organised by the RCoA and for the first time, a talk on Pain Medicine was included in the agenda which was very well received by the students. The talk focused on the basic aspects of pain management and gave the students an insight about the type of patients seen in pain clinics, modalities of treatment and the opportunities available in this fast developing specialty.

FFPMRCA Examination

Dr Nick Plunkett

Deputy Chair of the Court of Examiners

Dr Karen Simpson

Chair of the Court of Examiners

Since the last Transmitter FFPMRCA Examination update report in autumn, we are now in the midst of the 10th FFPMRCA examination, an event which resonates with the FPM's 10th birthday!

In the autumn 2016 diet of the exam 19 candidates sat the MCQ with 15 passing; a 79% pass rate. The pass mark was determined by the Court of Examiners using rigorous quality control methodologies as described previously. Thereafter 14 candidates presented for the SOE; determination of the pass mark occurred by the usual quality control measures employing a combination of statistical analysis and expert judgement. Eight candidates were deemed to have reached the appropriate standard to be granted the FFPMRCA. This gave a pass rate of 57% that was identical to the previous SOE sitting. Both autumn pass rates were close to previous averages for these exams. The latest February 2017 MCQ results showed 10 of the 12 candidates who presented for the exam passing; an 83% pass rate.

Overall the average pass rate for the 10 MCQ sittings to date is 77%; for the SOE sittings it is 64%. This range of values is within reasonable tolerances, given small candidate numbers and has been stable over time apart from a particularly low MCQ pass rate in autumn 2013. The Court of Examiners scrupulously assessed the autumn 2013 result and was content that it was valid. Although there is a small difference between the average pass rates for the two parts of the examination, this is considered acceptable in specialist examinations such as the FFPMRCA.

FFPMRCA Examination Calendar August 2017 - July 2018

	FFPMRCA MCQ		FFPMRCA SOE	
Applications and fees **not** accepted before	Mon 19 Jun 2017	Mon 30 Oct 2017	Mon 28 Aug 2017	Mon 5 Feb 2018
Closing date for FFPMRCA Exam applications	Thu 3 Aug 2017	Thu 14 Dec 2017	Thu 21 Sep 2017	Thurs 8 Mar 2018
Examination Date	**Wed 30 Aug 2017**	**Tue 21 Jan 2018**	**Tue 17 Oct 2017**	**Tue 17 Apr 2018**
Examination Fees	£510	£510	£720	£720

It is worth noting that the 1st time MCQ pass rate is 68.5% and this should act as encouragement to all potential candidates. Also reassuring, and particularly encouraging to those candidates who approach the SOE examination with some trepidation, is that everyone who re-sat the SOE examination has passed it eventually. In fact the pass rate for resit candidates increases through serial sittings, to 100% for those very small numbers of candidates who had required four SOE attempts. This shows that those who resit eventually do perform well enough to pass. This is likely to be due to a combination of exam experience coupled with further requisite study and clinical experience. It is particularly worth noting that no candidate who has presented to date to resit the SOE has failed the exam completely.

The number of candidates presenting for the FFPMRCA examination has remained fairly stable. There are approximately 30 applicants each academic year for MCQs and SOEs; this reflects the current number of Pain Medicine trainees across the UK.

The examiners were audited whilst conducting the SOE examination, as is our usual practice since the inception of the exam. There are further planned improvements to our audit tools and processes, under the direction of Dr Mike O'Connor, FPMRCA Examination audit lead. He has also noted that continuous improvements have resulted in the conduct of the SOE resembling a professional clinical conversation predicated on demonstrating high levels of knowledge and understanding. This examination standard therefore befits the stated aim: "The examination will be designed and conducted in accordance with the highest standards and further raise standards of Pain Medicine in the UK."

We had two visitors attending the October 2016 SOE examination. Both enjoyed the day and felt that the examination was a fair test of knowledge and understanding, and that it was conducted in a manner befitting its importance as a high stakes examination.

As before, special thanks to all examiners and question writers who commit much time and effort to the examinations all year round. They are a dedicated group who actively commit to the important work of constructing questions and quality assuring them. Finally, many thanks to the RCoA examinations department, especially Graham Clissett, Beth Doyle and Samara Branker, for their expertise in ensuring that the exams and all related activity run so very smoothly.

Faculty Events

Dr Shyam Balasubramanian

Educational Meetings Advisor

Dr Manohar Sharma

Deputy Educational Meetings Advisor

'An investment in knowledge pays the best interest' - Benjamin Franklin.

The Faculty promotes excellence in education across the continuum of undergraduate, specialist training and continuing education. We are delighted to note that over the past few years the number of delegates enrolled in our educational events is on the rise. We encourage our Fellows to share their expectations and needs during each learning initiative. We then design our programme and incorporate learning methods so we are able to meet everyone's needs.

Our 9th Annual Meeting in December 2016 marked another milestone. The Patrick Wall Lecture, delivered by Professor David Bennett, threw light on a better understanding of neuropathic pain and how it can potentially translate to better patient care. We had the privilege of hearing Dr Stephen Ward's experience with developing NICE back pain guidelines. The debate on the usefulness of epidural analgesia for abdominal surgery was interesting and informative. With advances in surgery and anaesthesia technologies, there is a rising trend to move away from neuraxial procedures towards peripheral interventions. 'The great aim of education is not knowledge, but action'. The second half of the meeting focussed on clinical subjects such as transforaminal steroid injections, paravertebral blocks and myofascial trigger points, which generated enormous interest amongst delegates during discussions.

Recently, in February 2017, we conducted two study days with the themes 'Acute Pain: Challenges and Complexity' and 'The Science and Art of Pain Management'. Dr Mark Rockett and Dr Jane Quinlan shared their vast experience with perioperative pain management. A debate on intravenous lidocaine infusions critically appraised the current evidence for this novel intervention. The Faculty was pleased to witness the successful introduction of a 'Problem Based Learning Environment'. On the second day, in the afternoon, the sessions were delegate-centred. Three common clinical scenarios were used as trigger materials and the participants actively engaged in solving the problems thereby enhancing everyone's learning experience.

Clinical diagnosis depends on the fundamental principles - history, examination and investigation. We received several requests from our fellows to organise a day on 'Diagnosis and Imaging in Pain Medicine'. We are sensitive to the needs of our members and have developed a summer study day on 14 June 2017. In the light of the recent NICE back pain guidelines, one of the sessions is on 'precision diagnostic techniques for neck and back pain'. Other relevant topics are bloods tests, role of neurophysiology studies, point of care model with ultrasound, and investigating abdomino-pelvic pain. There is an interactive practical session on interpreting MRI scans. Delegates can email interesting test results, radiology pictures etc. to be included in the discussion.

Dr Sanjeeva Gupta has completed his tenure as Educational Meetings Advisor. We are grateful for his tireless contribution in preparing dynamic programmes.

Faculty members with innovative ideas and interests in contributing to these events can contact Dr Shyam Balasubramanian (doctorshyam@hotmail.com) or Dr Manohar Sharma (manoharpain@yahoo.co.uk).

Faculty of Pain Medicine Study Day:

Diagnosis and Imaging in Pain Medicine

Wednesday 14 June 2017

9.00 - 9.25	Registration and coffee
9.25 - 9.30	Welcome and Introduction *Dr Shyam Balasubramanian, Consultant in Pain Management and Anaesthesia, Coventry*
9.30 - 10.00	Abnormal blood tests and their relevance in pain *Dr Nicholas Shenker, Consultant Rheumatologist, Cambridge*
10.00 - 10.30	Neurophysiology in Pain Medicine *Dr Alistair Purves, Consultant Neurophysiologist, London*
10.30 - 10.50	Discussion
10.50 - 11.15	Refreshments
11.15 - 11.30	Imaging in Pain Medicine - What is relevant? *Dr Harun Gupta, Consultant MSK Radiologist, Leeds & Dr Sanjeeva Gupta*
11.30 - 12.00	Identifying normal structures on a MRI scan *Dr Sanjeeva Gupta, Consultant in Pain Management and Anaesthesia, Bradford & Dr Harun Gupta*
12.00 - 12.30	Identifying pathologies on a MRI scan *Dr Harun Gupta & Dr Sanjeeva Gupta*
12.30 - 13.00	Radiology case discussion
13.00 - 13.50	Lunch
13.50 - 14.20	Investigating abdomino-pelvic pain *Dr Ashish Shetty, Consultant in Pain Management and Anaesthesia, London*
14.20 - 14.50	Fluoroscopic guided precision diagnostic techniques for neck and low back pain *Dr Manohar Sharma, Consultant in Pain Management and Anaesthesia, Liverpool*
14.50 - 15.20	Ultrasound guided diagnostic interventions in pain medicine *Dr Shyam Balasubramanian*
15.20 - 16.00	Interesting case discussions - interactive session (Delegates to email cases in advance) *Dr Sanjeeva Gupta*
16.00 - 16.30	Discussion & Close

RCoA, London
5 CPD Points Code: CB1
£175, £140 for trainees/nurses

FACULTY OF PAIN MEDICINE of the Royal College of Anaesthetists

FPM 2007-2017

Programme organised by Dr S Gupta, Dr M Sharma and Dr S Balasubramanian

2016 FPM Fellowship by Election Awards

Presented at the 9th Annual Meeting on 2nd December 2016

The award of our Fellowship by Election is the highest acolade possible. It is considered for practitioners across the world who have made sustained and significant contributions to the practice of Pain Medicine. This may be either to the UK or their own country's health services.

Professor Sam Ahmedzai

Professor Sam Ahmedzai is Emeritus Professor at the Medical School at the University of Sheffield with 30 years experience of being a Consultant Physician in Palliative Medicine. In 1985 he established the first UK palliative care research programme. Sam chaired the 2015 UK NICE guideline for care of the dying adult (NG31). He led the EORTC Quality of Life Group which produced the EORTC QLQ-C30- the worlds leading tool for measuring quality of life in cancer. Sam has been a leading figure in palliative medicine during which he has particularly championed evidence based practice and the search for ways of improving pain management in cancer appreciating the multispecialty approach. Due to Sam's extensive academic work in palliative medicine, the Faculty of Pain Medicine is very pleased to award Fellowship by election.

Professor Roger Knaggs

Professor Roger Knaggs is being presented with Fellowship by Election for his extensive work on the Faculty patient information leaflets, the Opioids Aware resource and general support of many other Faculty initiatives where we have benefitted from his clarity of thinking and highly informed understanding and approach to pain management. Roger is currently Associate Professor in Clinical Pharmacy Practice at the University of Nottingham and an Advanced Pharmacy Practitioner - Pain Management for the Nottingham University Hospitals NHS Trust. Roger is at the cutting edge of clinical opioid research and has produced seminal material that has helped illuminate the patterns of opioid use in the UK and elsewhere. Roger frequently appears in the media to (very clearly) explain pain and opioid use to the public and is tireless in his pursuit of knowledge to improve the management of patients with pain.

Professor Blair Smith

Professor Blair Smith is a world recognised authority on the epidemiology of pain, particularly in the field of neuropathic pain, with multiple high impact publications, invited plenary lectures and international research collaborations. He is vice chair of the Neuropathic Pain Special Interest Group of the International Association for the Study of Pain. He is Lead Clinician for Pain in Scotland and is working with the Scottish Government to shape the clinical service for chronic pain in NHS Scotland. He chaired the Scottish Pain Research subgroup of the National Chronic Pain Steering Group from 2009-2015. He also contributed to the SIGN Guideline 136: Management of Chronic Pain, launched Dec, 2013. He is an honorary consultant in Tayside Pain Service, having previously practised as a GP, so has experience of managing chronic pain in both primary and secondary care settings. We have awarded Blair's Fellowship for his notable inter-specialty links and academic epidemiology work.

Dr Suellen Walker

Dr Suellen Walker is one of the foremost researchers in the developmental neuroscience of pain, and a leader in both research and education at a National and International level. Suellen took up a post in 2005 as Consultant Anaesthetist at Great Ormond Street Hospital with a joint appointment at the UCL Institute of Child Heath to lead the paediatric pain research programme. Suellen has received numerous research awards and accolades including 2 young investigator awards, the prestigious IASP John J. Bonica Fellowship award, and recently the RCOA Mackintosh Professorship. Suellen publishes extensively in high impact journals, is in great demand as a teacher and lecturer all over the world, sits on numerous scientific, academic and editorial boards and is deeply committed to, and involved in, many aspects of UK training in pain medicine. Suellen was a Foundation Diplomate and Initial Board Member of the Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists, and has played a leading role in the development of education and practice in Paediatric Pain both in her home country and here in the UK .

British Pain Society Calendar of Events

THE BRITISH PAIN SOCIETY
EXPERTISE WHERE IT MATTERS

To attend any of the below events, simply book online at:
www.britishpainsociety.org/mediacentre/events/

50th Anniversary Annual Scientific Meeting
Wednesday 3rd – Friday 5th May 2017
Birmingham

Put the dates in your diary now for this flagship event – the 50th Anniversary Annual Scientific Meeting of the BPS. We are putting together an exciting and stimulating programme and will be announcing plenary speakers and parallel session topics in the near future. The ASM is a great opportunity to:

- Network with colleagues
- Keep up to date with the latest cutting edge research and developments relevant to pain
- Raise questions, partake in debates and discuss outcome
- Meet with poster exhibitors and discuss their research

For regular updates please visit: https://**www.britishpainsociety.org/2017-asm-birmingham/**

Living Well Right to the End
Philosophy & Ethics SIG Annual Meeting
26th to 29th June 2017
Rydall Hall, Cumbria

How to live well at all can prove elusive and has been much debated for thousands of years.

Is it to do with physical health or pleasure or a general sense of wellbeing or happiness or fulfilment or meaning or is it merely the absence of suffering?

Can we somehow enable those we care for to achieve a level of wellbeing even as they become ill and perhaps face death?

Can we achieve a measure of wellbeing in our own lives?

Our meeting this year takes place in the beautiful surroundings of Rydal Hall amongst the lakes and fells of Cumbria where we will be considering all of these issues.

Gonnae no dae that! – exploring patient and clinician fears
Pain Management Programmes SIG Biennial Conference
14th & 15th September 2017
Glasgow Caledonian University, Scotland

Speakers including: Amanda C-de-C Williams, Tamar Pincus, David Gillanders and Johanns Vlaeyen.

Social events:

- Wednesday evening: drinks reception in the iconic Glasgow City Chambers.
- Thursday evening: Scottish gin and real ale tasting, plus the chance to play the bagpipes at the National Piping Centre!

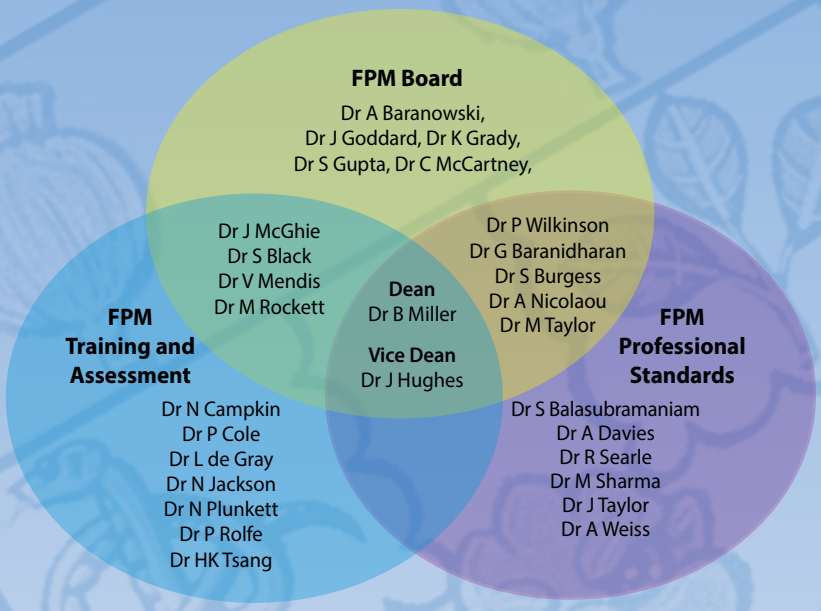
Further details for all our meetings can be found on our events listing page:
www.britishpainsociety.org/mediacentre/events/

Faculty Update and Calendar

New Fellows

Dr Husham Sami Mahdi AL-SHATHER
Dr Sheila Anne BLACK
Dr David Alex CRABTREE
Dr Michael Alexander Clement JONES
Dr Suneet Pravinkumar NAYEE
Dr Mowafak ABDELGHANI
Dr Gaurav CHHABRA
Dr Valentina Jasmijn Antonia JANSEN
Dr Lori Ann LINDSAY

Committee Membership



2017 Faculty Calendar

MEETING: FPM Professional Standards Committee	18 May
MEETING: Board of the FPM	19 May
EVENT: FPM Diagnosis and Imaging in Pain Medicine	14 June
MEETING: FPM Training and Assessment Committee	7 July
EVENT: FFPMRCA Exam Tutorial	1 Sep
MEETING: FPM Professional Standards Committee	7 Sep
MEETING: Board of the FPM	8 Sep
MEETING: FPM Training and Assessment Committee	3 Nov

Please note that all dates may be subject to change

The Faculty of Pain Medicine
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