TRANSMITTER

Spring 2020

Exam Ethnicity and Gender Performance Review

Women Working in Pain Medicine

Fast-track Sciatica Service Model

EPM Uganda

FACULTY OF
PAIN MEDICINE
of the Royal College of Anaesthetists

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WELCOME

Dr Manohar Sharma

Clinical Editor

Welcome to Transmitter, Spring 2020 Edition!

These are unprecedented and fast changing times and the situation will have evolved further by the time you read this spring edition. The worldwide spread of COVID-19 has forced our society to lockdown; banning non-essential travel, closing schools and implementing social distancing. All over the world, countries, many that are even more ill-equipped to screen and test patients, are faced with difficult decisions. Whilst colds and influenza are widely known to be seasonal ailments, some epidemiologists fear not only that there will be a regular COVID-19 season but also that we will have to pay heavily in terms of human costs. Despite this I hope that soon, if regulations imposed by the authorities are respected by the public, we will all start to see the curve of infectious disease flattening and allowing time for the development of preventative and therapeutic strategies to control future outbreaks.

Most elective chronic pain clinical activity including pain conferences, events and FPM examinations, are on hold. Most FPM members have been redeployed to the frontline, supporting the anaesthesia and intensive care units in managing the huge surge in COVID-19 cases. The FPM has been active with ongoing work to support members, including guidance on the use of steroid injections in context of COVID-19 and a redefinition of the strategic aims of the Faculty, updated to include "appropriate use of pain therapies, pain education, making pain an attractive and sustainable speciality and guidance on offering best service delivery to pain patients". Other important activities highlighted in this edition include updates on *Surgery and Opioids Best Practice Guidelines*, 2nd *Edition of Core Standards for Pain Management Services in the UK* and *Developing Guidelines and Implementation*.

I would like to take this opportunity to thank Daniel Waeland and offer him our best wishes as he moves to a new job. He has been instrumental in much of the excellent work of the FPM in over the last ten years. He also provided an excellent external perspective on how the FPM developments could fit in with other major pain stakeholders.

These times test our self-discipline and resolve but remind us of what truly matters. I urge you to look after yourself and your families, reach out to support friends, colleagues and vulnerable members of society, and to play your role in coping with this crisis. Only with all our combined efforts and determination, will we be able to put COVID-19 to rest, and emerge from this crisis stronger.

Manohar Sharma

Message from the Dean

Dr John Hughes
Faculty Dean

Since starting to write this update in early February we have been overtaken by the COVID-19 pandemic. It has to be said that the teamwork, coordination and development of not only capacity but guidance has been fantastic. Most pain consultants are also practicing anaesthetists and as such have been appropriately redeployed into front line anaesthetic, ICM and COVID care pathways. The same is true for other members of the pain management team. The nature of pain management and how we work with patients is not sustainable with the current crises and need to maintain social distancing or isolation (many of our patients are in high risk groups). As a result, pain services have been adjusted to cover only the most urgent work; often including inpatient pain services, some outpatient work such as intrathecal pump refill clinics, the small number of very urgent cases often relating to cancer pain and also supporting our palliative care colleagues. It is clear that units have been stepping forward and adapting to the prevailing local circumstances.

You will all be aware we have had to take the decision to cancel not only some meetings but also the exam and we hope to rerun them at a later date when conditions allow. Churchill House is closed but the Faculty is still open for business and our Faculty team are working from home. We remain available and will continue to support our fellows, members and trainees through this difficult time. For trainees concerned about the impact this will all have on pain training a statement has been released which will, I hope, provide some comfort. There is also the online COVID hub accessible via the RCoA web site for the latest information.

Now with the pretense of an available moment to consider more normal times my original musings remain below.

This Spring edition of Transmitter brings some updates on the work that has been ongoing across all our areas of activity. There has been a continued input to the opioids debate as well as elements relating to the role of cannabis in pain management. Core activity around the curriculum and credential continues alongside the roll out of the new RCoA and FPM website. The Professional Standards Committee has responded to several stakeholder engagement exercises related to pain management along with ongoing involvement with guidance documents.

Last September we started an exercise to review the strategic aims of the FPM in light of the growth in the Faculty's activities since its inception twelve years ago. There are four broad strategic areas that remain under development. This will allow a consistent message to be delivered, be it under the umbrella of training, professional standards, research or public, professional and political interaction. One is the appropriate use of pain therapies. The Medicines Advisory Group (MAG) announced in the Autumn falls within this area and includes as one of its functions the maintenance of the Opioids Aware resource. The second is to ensure the specialty is attractive and sustainable. Anaesthesia by its nature is a cornerstone for pain specialist development, be it inpatient pain management or a more outpatients based activity. There is also a role for a much broader access to pain medicine such as with palliative care, rehabilitation medicine and rheumatology. This is being explored with the GMC credentialing programme. A third, linked strategy, is looking at the education of pain to the healthcare system in its broader sense. The current work includes e-Pain, undergraduate and foundation training, patient information, consultation and guideline development. The fourth, fundamental area, is ensuring the best service can be delivered for our patients. That is where the Core Standards for Pain Management Services (currently being updated), Outcome Measures, commissioning support and dialogue with NHSE and other statutory bodies is involved. The Faculty team provides the support to enable these activities to be undertaken and delivered in a timely manner. The details remain to be completed but benefits are already being seen with work across agencies on opioids, developing links with the Centre for Perioperative Care (CPOC) and broadening access to pain medicine.

This strategic review does not alter the structure of the Faculty as all the areas come under the Training and Assessment Committee or the Professional Standards Committee. What it does do is ensure cross committee awareness related to the strategic aims.

With the rapid development of the Faculty, inpatient pain management has been underrepresented. Following the sterling work of Dr Mark Rockett, the development of more formal anaesthetic preassessment clinics and now perioperative medicine, concerns around opioid prescribing and the increasing complexity of patients being admitted to hospital, the Faculty is engaged with supporting the role of inpatient pain management. Inpatient pain management is represented across both main committees and within all the strategic areas of activity. Dr Emma Baird now leads this work and with the new Affiliate Fellowship route we are hoping to increase engagement and understanding of the issues faced by these services.

Before Christmas we met with Professor Chris Whitty, the new Chief Medical Officer for England, and had an open discussion about the impact pain has on the population, what opportunities there are to improve the situation from a broad biopsychosocial perspective and the requirement for a joined up approach. Both opioids and cannabinoids were discussed along with the role, or potential role, they have in clinical practice. The discussion was insightful but realistic about the opportunities of and difficulties in making change.

NICE produced its guidance NG144 on Cannabis based medicinal products in November 2019. The message is clear and the Faculty updated its position statement accordingly. The Faculty supports the development of further research and are pleased to hear that there are trials and potential studies being developed. It is important to understand if there are patient populations that may benefit but also the impact of side effects.

One of the first activities of the Medicines Advisory Group was to call a meeting with all the agencies we were involved with regarding projects related to opioid use. This brought together members from the Faculty, Public Health England, National Institute for Health and Care Excellence, Royal College of General Practitioners, Medicines and Healthcare products Regulatory Agency and the General Medical Council. There was significant agreement of the issues, its complexity and importance of patient management going forward. There is clearly a significant problem regarding opioid use that needs to be addressed and a need for a measured approach to drug optimisation (which includes deprescribing), including patients with long term pain who still need consideration and access to appropriate alternative management strategies. There was also agreement that there are a small number of patients that genuinely benefit on low dose and as such should not be denied medication that improves their quality of life. Links have been made to keep each other aware of changes and to meet again later in the year.

We have had an initial meeting with Professor J Sinclair (Chair of the Faculty of Addiction Psychiatry) and we agreed a number of areas for potential collaboration. There are clearly patients that interact with both pain and addiction medicine services and current practice has scope for improvement. The plan is to look for opportunities to further this collaboration.

The review of all curricula in line with GMC guidance continues. The pain elements of the anaesthetic curriculum, higher and advanced training have all been included. There are ongoing discussions following a GMC review of the submission. Further details will be released as they become available including those around implementation and transition. Running separately, but linked with regard to curricula content, is the credentialing application for pain medicine, again there has been feedback from the GMC and discussions are ongoing.

The Centre for Perioperative Care (CPOC) is a new cross specialty initiative which is being hosted at the RCoA. The Faculty are already involved with the RCoA on one project that links to CPOC on the use of opioids post surgically and there are other areas where pain management will be important. The FPM is developing formal links with CPOC to ensure we can improve patient care going forward and fits well with the inpatient pain work streams.

New Faculty website

The new College and Faculty websites were launched at the end of last year. Please take a look around if you have not already:

https://fpm.ac.uk/

Liverpool Model for Fast track Sciatica Service

Dr Manohar Sharma

Consultant in Pain Medicine, Liverpool

Martin J Wilby

Consultant Spinal Neurosurgeon

We met over five years ago and realised that patients presenting to us with acute sciatica for several months, despite access to the usual care (including simple analgesics and physiotherapy) and imaging within the primary care or in other district general hospitals, were struggling to maintain paid employment which had a huge impact on quality of life. Considering the published literature and our practice of routinely offering surgery for these cases, it was felt that we should collaborate to streamline management of these patients with refractory sciatica. The idea of a joint clinic between the two authors - Manohar Sharma (MS) and Mr Martin Wilby (MW) and follow up by specialist spinal nurses was supported by our NHS Trust. We began to assess potential surgical patients with acute sciatica in the joint clinic. We were able to offer a one-stop service considering patient's expectations and our opinion. Patients were offered transforaminal epidural steroid injection (TFESI) or microdiscectomy surgery, when considered appropriate and necessary. We started to collect clinical outcome data at baseline as well at the follow up after these interventions. In the absence of this joint clinic there was otherwise significant chance that these patients would have been offered surgical microdiscectomy since symptoms generally exceeded three to six months and were disabling.

MW assisted in the analysis of the initial outcomes including pain scores and Oswestry Disability Questionnaire scores. We quickly realised that there was a potential to study the efficacy and safety of these treatments for refractory sciatica in this subset of cases presenting via secondary/tertiary care. We felt genuine clinical equipoise to study TFESI and surgical microdiscectomy in a rigorous/scientific manner with the potential to reduce variation in clinical practice within the NHS.

Further collaboration with the University of Liverpool as well and other academics led to the development of a trial protocol. From an application to a themed call from the Health Technology Assessment/National Institute for Health Research to submit research proposals in the management of refractory sciatica; a randomised controlled trial comparing the clinical and cost effectiveness of surgery to TFESI (NERVES) began. MW was the chief investigator, with MS the lead for developing the TFESI arm of this pragmatic study.

This multicentre trial was successful in recruiting and randomising 162 patients from the NHS in England. The study outcomes have been analysed and are being written up for publication. We learned as part of the multicentre trial that there was a huge variation in management options for refractory sciatica across England.

Following the analysis of this trial; it is highly likely the outcomes will change pre-conceived ideas and influence, in particular the national radicular pain pathway. It was quite an interesting experience from a pain management perspective. I (MS) felt unsure how to describe and explain our clinical equipoise to patients in order to recruit a patient to allow randomisation between epidural injection (a relatively simple procedure) and microdiscectomy surgery (considered more invasive). In practice, it became relatively straightforward to randomise patients in this joint clinic since we expressed our un-biased view on lack of strong evidence of one treatment over

another; so, patients were happy to be recruited. They were offered a choice of crossing over to the other treatment if need be.

In our view, following the outcome of our collaborative approach and NIHR funded trial, we now have significant potential of reducing variation in pain management options for acute sciatica based on high quality evidence in conjunction with cost effectiveness data from multiple centres. We are thus making changes to our clinical pathway for treatment of refractory sciatica. It is reasonable that in future we should be providing a more streamlined management pathway for our patients in chronic pain following spinal surgery. There is a significant potential for further collaboration between surgeons and pain specialists in studying the value of repeat spine surgery vs neuromodulation vs rehabilitation. We believe that there is huge potential to tap in and solve many uncertainties in clinical pathways for pain management by using a collaborative approach to combine knowledge and skill mix between disciplines as shown by our approach.

Surgery and Opioids Best practice guidelines 2020

Dr Devjit Srivastava and Dr Paul Wilkinson on behalf of the joint working party

Prolonged opioid use after surgery is now a significant concern. About 330 million surgeries are performed annually worldwide and 4 million per year in the United Kingdom. It is now recognised that an increasing number of surgical patients continue to use opioids beyond 90 days, which is the time for complete surgical wound healing normally, and thus develop persistent post-operative opioid use (PPOU). For the opioid naive patient reporting for surgery, PPOU is defined as those patients who have received a 60 day supply of opioids between day 90-365 post operatively. For those taking opioids before surgery, PPOU is defined as any increase in opioid use relative to baseline. Recent studies from the USA demonstrate that 0.6-26% of opioid naive patients develop PPOU and the figure is 35-77% for those already taking opioids prior to surgery. Furthermore, data shows that 0.6% of opioid naïve patients who have PPOU develop opioid misuse disorder/addiction. Extrapolation from above estimates would imply that conservatively between 24,000 -104,000 patients in the UK develop PPOU annually and 144-624 patients develop opioid addiction/misuse disorder each year after surgery. Even though we don't have data from the UK, the extrapolated figures imply a significant health care load on the NHS.

Against this background, the Faculty of Pain Medicine and the Royal College of Anaesthetists commissioned a working party to develop a whole system guidance on the best practice relating to opioid use perioperatively. The key aim of this document is to effectively address inappropriate opioid prescribing around the perioperative period without affecting pain control for patients post-surgery. The document titled, 'Surgery and Opioids: best practice guidelines 2020', is a landmark document and represents nearly two years of effort by the working group that included the Royal College of General Practitioners, Royal College of Surgeons and Royal College of Nursing; with corresponding members from the British Pain Society, Royal College of Psychiatry and University of Leicester. This document represents the work of a multi-organisational and multidisciplinary collaboration and sets out the guiding principles in this very important area of opioid stewardship in the perioperative period.

Professional Standards Committee Update

Dr Paul Wilkinson
FPMPSC Chair

The PSC has continued to be highly active and key areas of activity are now highlighted. I thank all members for their huge efforts in managing an enormous activity portfolio.

Palliative Care and Pain:

Dr Matthew Brown and Prof Mike Bennett have continued to look at implementation of the Framework for Provision of Pain Services for Adults Across the UK with Cancer or Life-limiting Disease, released last year. A pilot project to trial implementation of the palliative care framework is underway and the call for pilot centres had been published. The first step will be to select a range of centres and hold meetings with them to determine parameters such as remit and how to measure outcomes. About ten centres have already expressed an interested in participating but the PSC is keen to get all centres involved in some way, even if they are not selected as a pilot centre.

Commissioning: support for members:

Despite delays in shaping this document in a changing landscape, its publication is imminent.

Improving implementation: Guidance risk assessment:

There are several pieces of ongoing work to reinforce our implementation strategies based on our Gap Analysis tool and refinement of our proposed CQC standards.

In addition, the PSC has produced a guide to areas of potential risks that may arise as a result of not following guidelines. These will further help the case for implementation when speaking to managers about resources that are needed. It was agreed that a short paragraph about usage and intended purpose would be included at the start of any Guideline summary. Usefully, this would flag the risks of not acting in line with it. The first risk assessment has been added to the updated epidural injections guidance.

Core Standards for Pain Management:

The second edition is on the home stretch and I thank Dr Weiss, Dr Taylor, Mrs Kato-Clarke and Ms McAnulty for their efforts with this.

Consultation Length:

To manage concerns that the time allowed for follow up consultations may be varied and not evidence based, we are undertaking a survey on this important issue. It has previously been possible to define the time for New Patient Consultations based on the tasks required to be undertaken to the necessary standards. This survey will also capture differing types of administration time.

FPM/RCoA Opioid prescribing project:

The draft guidance is nearly complete and will be shared with privileged stakeholders in the next consultation phase. This document guidance will be aligned with Opioids Aware. A guide to opioid optimisation for members is in process to follow this document.

CPD and Revalidation update:

Consistent with the RCoA, we are striving to move from a CPD matrix to a list of skills. We are considering the action required from the Faculty in reviewing the pain skills and the need to align pain CPD skills with the new curriculum capabilities. I thank Dr Carty for her leadership on this.

Acute/Inpatient Pain:

The PSC is striving to increase activity relating to inpatient and acute pain services. Dr Baird has drafted a business plan guide that will be concise and generic. We are considering what type of data would be persuasive in supporting financial arguments. Work in this area will increase going forward with other projects lined up.

Finally, there are various guideline documents that are undergoing or have completed revision. These can be accessed on the website.

These include:-

- **Best practice in the management of epidural analgesia in the hospital**
- **Guidance on competencies for Spinal Cord Stimulation**
- **Gabapentin and Pregabalin Leaflets**
- **Guidance on competencies for Intrathecal Drug use**
- **Driving and Pain Patient Information Leaflet**
- **Recommendations for good practice in the use of epidural injection for the management of pain of spinal origin in adults**

The Faculty has released updated Guidance on Competencies for Paediatric Pain Medicine.

This document has been endorsed by the Association of Paediatric Anaesthetists of Great Britain and Ireland.

The guidance focuses on the Pain Medicine specialist's contribution to Paediatric Pain Medicine (PPM) and describes two levels of involvement in the practice of PPM:

The first level outlines the core knowledge, skills and attitudes for all anaesthetists specialising in Pain Medicine who may need to be involved with PPM. All Pain Medicine specialists need to have an understanding of this area.

The second level outlines the advanced knowledge, skills and attitudes required of Pain Medicine specialists who work in teams providing a paediatric pain service.

Inpatient Pain Update

Dr Emma Baird

Inpatient Pain Medicine Lead

It is an exciting time to be an inpatient Pain Consultant. The Faculty of Pain Medicine realises the importance of our services and is striving to help improve the provision of in-patient pain nationally. As part of this, inpatient pain will feature more in the new RCoA Anaesthetics Curriculum and clinicians wanting to pursue a career that includes sessions in in-patient pain will be encouraged to complete six months of Advanced Pain Training. Trust leads for inpatient pain will still be expected to have completed the full year of Advanced Pain Training. By improving the training of those delivering inpatient pain we hope to improve the quality of care offered nationally. The additional level 1-3 training in pain all Anaesthetists will have to complete will hopefully improve all Anaesthetists' pain knowledge and thus improve the way they treat pain perioperatively.

Inpatient pain services in the UK form an integral part of many patient's hospital stay. They have been proven to be cost effective and reduce pain and complications post operatively (1-4). The provision of inpatient pain services nationally is very variable (5). When these services are benchmarked against FPM core standards, they often fall short (6). Nationally many teams lack the funding and resources they need to deliver the best possible services.

One way to secure these funds and resources in a time of NHS austerity is through a robust evidence-based business plan. As a new Consultant this is something I never had any experience with as a trainee. We are putting together a guideline document on how to write an inpatient pain business plan with top tips from professionals with more experience. This is being developed and will be published in the coming months.

Linking in with this, Dr Mark Rockett presented the findings of the National CHIPS (Chronic and complex pain workload of inpatient pain services) audit at the most recent FPM inpatient pain study day (7). The purpose of the audit was to reveal the workload of managing in-patients with chronic or complex pain. The full findings of this audit will be published in the near future. The audit found that patients with exacerbations of chronic pain and those with complex pain problems accounted for 15% of the surgical workload. Teams with access to a clinical psychologist had a reduced length of inpatient stay from 10 to 6 days. Mark concluded that adding a psychologist to an inpatient pain service may result in a clinically significant saving of approximately 960 bed days a year per hospital. Potentially, this represents a gross saving of £315,000 per annum. I will be highlighting this in a business plan I am currently writing, asking for psychology time for my inpatient service.

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7)https://www.napsuk.co.uk/archive-2019

Core Standards (CSPMS) UK Update

Dr Anna Weiss

CSPMS Lead

Dr James Taylor

CSPMS Deputy Lead

The 2nd Edition of Core Standards for Pain Management Services (CSPMS) is gradually approaching its completion. Imminently, the 10 Chapters will be undergoing the necessary scrutiny of a privileged stakeholder consultation. The aim is to head for publication by Autumn 2020.

Constructed on the foundations of the first edition, feedback and consultation from readers and contributors, it should become a refined and easily accessible document. The second Edition will maintain the familiar layout of chapters with *Introduction, Standards, Recommendations and Background* sections. You will find most of the chapters leaner, again in an attempt to aid readability and access.

Working on this publication has been a unique opportunity to bring standards and recommendations in line with latest evidence, while having the privilege of collaborating with expert authors and reviewers, who share a deep understanding and contemporary expertise of all aspects of Pain Management in the United Kingdom.

As result of feedback and consultation, further content has been added, including an update on the national framework for pain services in England; chapters reflecting integrated approaches and linking tiers of care; and chapters that address transitional pain management for young people and safeguarding.

The central aim of CSPMS remains the setting of standards and recommendations for good and safe practice. These are to support patients, clinicians and managers in all four home nations and to set benchmarks by which quality of care can be improved from the first GP consultation to intervention in a Highly Specialist Pain Service. These benchmarks are aimed at improving access and continuity of care, championing safety and effectiveness and guiding resources to pathways and therapeutic interventions that offer the best value for money. The unique challenge for the editorial team was to present these in a single, readable and relevant reference document.

CSPMS must remain a collaborative document that highlights our multidisciplinary and patient focused approach to managing all types of pain, in all age groups and across all tiers of healthcare. This is in keeping with the ethos of pain management and the core of professional understanding of the condition. The contributions from respected expert authors and reviewers mirror the patient journey; we are honoured that Patient Representatives, General Practitioners, GPSI, Physiotherapists, Occupational Therapists, Pharmacists, Psychologists, Palliative Care Specialists and Pain Doctors were willing to give their time and effort to help with this publication.

Each chapter is based on best evidence available at the time of writing and was subject to a rigorous review process undertaken by the Professional Standards Committee of the Faculty of Pain Medicine, The Board of the Faculty of Pain Medicine and relevant Professional Bodies.

CSPMS is here to stay as a central project for the Faculty of Pain Medicine and we are grateful that we could contribute on this occasion. We are committed to making its contents as robust and as relevant as possible – for this and future editions. To help the FPM to fulfil this goal in the future, we would like to summon your support and collaboration, be it through feedback, authorship or direct involvement with the Professional Standards Committee for the preparation of future editions.

Guidance Documents: a guide to development, dissemination and review

Dr Sanjeeva Gupta

Consultant in Pain Medicine, Bradford

Dr Matthew Brown

Consultant in Pain Medicine, London

Introduction:

The Royal Colleges, Faculties and Specialist Societies regularly publish a number of documents (i.e. good practice guidelines, frameworks and standards for pain management services, clinical management pathways, patient information leaflets) to promote evidence based practice and improve patient care. A 2016 survey regarding the awareness and usefulness of the guidelines published by the Faculty of Pain Medicine (FPM) and the British Pain Society demonstrated that the awareness among pain physicians of the various published guidelines ranged between 38% and 90% and the survey motivated 89% of the respondents to look at the guidelines(1). The Academy of Medical Royal Colleges has recognised that Medical Royal Colleges and Faculties invest considerable time and resources into the development of clinical guidelines. Therefore, taking steps to improve their ultimate implementation and acceptance is essential(2). We present below an outline of the document produced by the FPM for its use when preparing guidelines which could serve as a pointer to members considering similar projects in their field of practice.

Selection of topics for Guidance Documents:

When developing guidelines, topics should be selected carefully with the following aspects in mind:

- To follow or be aware of existing standards.
- Consider the likely intended service improvement outcome.
- Consider how it fits with the national NHS agenda.
- Consider if the guideline is required at all or could be usefully introduced.

Preparation of Guidance Documents:

When a new document is prepared or an old document is reviewed it is important to consider the following:

- What other stakeholders need to be represented on the writing group?
- Who are the intended users?
- What are the intended outcomes?
- Allow for local clinical judgement where applicable.
- Be clear whether recommendations are based on evidence or clinical consensus.
- Clinical guidelines should incorporate a communication and implementation strategy.

Production and Review of Guidance Documents:

Clinical guidelines should be produced to conform as closely as is appropriate to the following format:

- A clear Executive Summary that highlights how the document fits in with current NHS priorities.
- Clear recommendations or key messages.
- A page considering risks.
- A guide to implementation – a short page indicating what changes would be required to adapt to the recommendations.
- Clear references in agreed format.
- A time-line for review.

Considering risk management:

Risk management is one of the central tenets of clinical governance, a major aim of which is to reduce the risk of harm to patients. This may be through incident reporting, local audit, or compliance with regulations and guidance. Identifying and recording risks associated with non-compliance of pain standards/guidelines may therefore be a way for pain services to bring to the attention of management the need for change, especially if to do so requires additional resources. It is therefore important that new guidelines and their key risks are highlighted to hospital managers.

- A page of a new clinical guideline should highlight the key messages of the guideline as well as the risk management issues to the Health Board / NHS Trust. This will allow managers to decide resource allocation or modification of clinical pathways where needed.

- The following domains of risk assessment/ management of implementing or non-compliance with the document could be included in the document: compliance with patient safety and quality; infection prevention; information governance and impact on workforce; equipment, estate, equity, reputation, finance and public confidence.

Dissemination of and publicity for guidance documents:

To launch, disseminate and assess the success of Guidance Documents it should be (Table 1):

- Interdigitated with available current guidance.
- Launch guidelines on website, publish in newsletters and request guidance partners to publicise.
- Cover guidelines in educational events and include summary in delegate pack.
- Survey in 12 months after publication to raise and assess awareness and monitor uptake and queries.

Table 1: Suggested plan for dissemination of and publicity for FPM guidance documents

INTERDIGITATION WITH CURRENT GUIDANCE	
CSPMS*	Guidance Document to be included in standards or recommendations for next review of Core Standards for Pain Management Services.
Revalidation	Add to revalidation e-resource when this document is updated
LAUNCH	
Release statement	Statement from Guideline Development Lead for the website
News item	News item for website
Hero image	Hero image for the FPM front page
Guideline web-page	Guideline added to the FPM web-page listing all documents
E-Newsletters	Inclusion in the next relevant e-newsletters (all member, RAPM, FT, trainee)
Transmitter	Full page article by Guideline Development Lead for the next Transmitter
Partners	Request partners in the Guidance Document to detail their planned communications plan
EDUCATION	
Events topics	Cover the guideline as part of a programme talk (lecture or debate) on the core topic area
Event materials	A short summary of the guideline to be included in the delegate pack and on any holding slides
Training & Assessment Committee	Request Training and Assessment Committee to consider how the new Guidance Document can be included in trainee education and/or the examination
AWARENESS	
Survey	A short survey to membership 12 months after the release of the guideline to both raise awareness and monitor uptake and queries
British Journal of Pain	Consider publishing a review of the guideline in the British Journal of Pain

*CSPMS: Core Standards for Pain Management Services in the UK.

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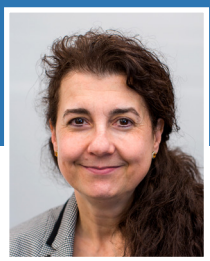
2. *S Gupta, M Sharma. Awareness of the Guidelines Published by the FPM and BPS: A National Survey of Pain Medicine Consultants. British Pain Society Pain News. Pain News, December 2019, Volume 17(4), Page 184-187*
3. *College guidelines: what are the key success factors for their development and implementation. AoMRC; Apr 2017; accessed online Jul 2019: http://www.aomrc.org.uk/reports-guidance/college-guidelines-key-success-factors-development-implementation/*



Training and Assessment Update

Dr Lorraine de Gray

FPMTAC Chair

Membership:
The Training and Assessment Committee welcomes a new co-opted member, Dr Helen Makins, Lead for Essential Pain Management (EPM). The FPM Board in December 2019 encompassed EPM within the remit of TAC and I am delighted to report that under the leadership of Dr Makins, EPM continues to make an invaluable contribution to teaching pain medicine to undergraduates at several medical schools across the UK.

We also welcome a new trainee representative, Dr David Gore, and thank our outgoing trainee representative Dr Helen Laycock for her sterling work over the past two years. I am pleased that she will continue to be involved longer term. Dr Bill Rae has stepped down from the committee due to work commitments.

Ongoing Projects:
The last workforce census highlighted the need to increase recruitment into our speciality. The last years have seen a decreasing number of anaesthetic trainees taking up advanced pain training. With a substantial number of current consultants likely to be retiring in the next ten years, the need for increasing the number of trainees in pain medicine to provide a sustainable workforce has become crucial. TAC has set up a Careers Strategy Subcommittee tasked to set up a recruitment drive both at undergraduate and postgraduate level. Watch out for information which should become available on the new FPM website as well as social media soon. We encourage current trainees and Consultants practising in pain medicine to become ambassadors in this recruitment drive.

"We encourage current trainees and Consultants practising in pain medicine to become ambassadors in this recruitment drive."

In the meantime, the RCoA is considering the initial feedback from the GMC regarding the Curriculum in Anaesthesia submitted for review in Autumn 2019. In tandem, we are having discussions with the GMC regarding the Credential. There are still a lot of discussions to be had before we can clarify how the Credential is going to be rolled out and what it will mean in terms of training in pain medicine.

Quality Assessment and Improvement:
As part of ongoing quality assessment of trainers, TAC has introduced annual appraisal forms for all its trainers including Faculty Tutors (Pain) and Regional Advisors in Pain Medicine. Hospital Review Forms for all regions are finally complete and summarised versions are available on the FPM website to guide trainers and trainees into what each region offers in terms of pain services.

Decommissioning of Pain Services in Secondary Care:
TAC is keeping a very close watch on regions where decommissioning of Pain Services is having an impact on provision of pain training at all levels. We are currently in contact with Heads of Schools and Clinical Commissioning Groups (CCGs) where necessary. CCGs are obliged to work with Health Education England to promote training and education of all doctors. TAC does recognise that the infrastructure of the NHS however has significant regional variations and will be exploring where necessary whether Alternative Providers within the NHS have the sufficient resources and structure to provide training for our doctors.

Women in Pain Medicine

To recognise that it was International Women's Day on 8th March, we have some special feature commentaries from women working in pain medicine. Our Vice Dean, Dr Lorraine de Gray comments on representation of women in Pain Medicine below and a commentary follows from Dr Catherine James about balancing life and work. Dr Rhian Lewis follows this writing about her experience on the FPM Board of Examiners and encouraging more women to apply to join.

Dr Lorraine de Gray

FPM Vice Dean

Up to 55% of medical students in the UK are female. The last RCoA workforce census shows that 32% of anaesthetists are women. However, only 25% of anaesthetists practising in pain medicine are female. The US has similar statistics - 48% female medical students, 35% female anaesthesiologists and only 18% female pain physicians. What is the reason for the current gender gap in our profession?

Several studies have shown that female doctors are more likely to provide patient centred care, preventive health services, follow evidence-based guidelines and spend more time with their patients per consultation. These are attributes that lend themselves very well to a chronic pain sufferer's job spec for a pain doctor: *"a doctor who consistently treats each patient as an individual, listens and understands their needs as well as bringing care and compassion of the highest standard"*

Yes, careers in pain medicine do entail working long hours with patients that, at times, can be very taxing mentally and physically. However, the trade-off is predictable working hours with options of doing limited or no emergency work. Even better, is the experience of going home after a long day's work with the knowledge that you have brought hope and made a difference to someone's quality of life.

The last two decades has seen several women who have made outstanding contributions to pain medicine in the UK, notably Beverly Collett OBE, Kathryn Grady, Karen Simpson and Cathy Stannard. They are my role models. Why not make them yours too?

Dr Catherine James

Consultant in Pain Medicine, Guildford

Doctor, wife, mother, sister, daughter, carer, taxi driver, housekeeper. It's hard to know who I am sometimes. Expectation leads us to believe that we can manage all this in hassle free style and it is no more than we deserve, however, in real life we just have to do the best we can to manage. Juggling all these roles is made possible by a supportive partner, reliable childcare, online shopping and possibly help at home, but these things don't make it easy.

Finding the balance is hard. Everyone's balance is different and the tilt of the scales changes over time. Managing appraisals and assemblies, sports day and service development with clubs and clinics can lead into the trap of thinking you have to be all things to all people, all of the time.

Through my job I am privileged to meet some amazing people to whom life has dealt a raw deal. When I talk with them about self-compassion, celebrating personal success, how some things just need to be accepted, making social connections and taking the time just to breathe, I try to remember that this advice works for all of us.

Female representation on the FPM Board of Examiners: Is 10% Acceptable?

Dr Rhian Lewis
Member of FFPMRCA Board

Much is written about equality and diversity, and we are reminded almost daily (whether by the Cabinet, or industrial boards, or the entertainment industry) of the need to ensure that female/male ratios are improved.

Does it matter? Should we celebrate the first "female" astronaut, etc? Doing so ensures that female achievement is recognised, but it also particularises that achievement, as if women deserve praise for achieving despite being women. Most women don't go around feeling "female" in their interactions at work. They focus on the job rather than their gender. It is interesting, however, that I still get patients (usually older women) saying, "Oh, I didn't expect a lady doctor", though they are often grateful for this, because "it is easier to discuss things with another woman".

A recent BMJ supplement explored some of the sexist comments made to or about female doctors, and also emphasised that these comments are frequently left unchallenged by male doctors in the room. Indeed, some of those male doctors are complicit in the undermining of females in the workplace. As de Beauvoir noted, the patriarchal system is ingrained into all our psyches, including women themselves, from an early age. On a hopeful day I feel that things are improving, but sadly I am often reminded that, although things are much better than during the era of "first wave feminism", there is still a long road to travel.

The number of females in senior NHS roles, for instance, varies greatly, although anaesthesia has always had a greater number than other specialties. However, the current ratio of male to female persistent pain consultants in the UK is approximately 3:1, which leaves something to be desired in terms of gender equality. It will be intriguing to see how these ratios alter over the next decade as the ratio of female graduates alters.

For pain clinicians, the FPM and its examinations set standards for the whole discipline, and it is therefore important that we draw on the full range of talent available to us to help achieve that. In turn, this means ensuring that the full diversity (geographical, gender, class, ethnicity) of FPM membership is reflected on its board of examiners. Yet currently only 2 out of 23 examiners are female, approximately 10%, far below the 25% that would be expected in terms of pain consultants, and of course extremely low compared to the 50% that might be expected in a world where there is equal gender representation!

We would like to see more women join the FPM examining team, not because they are women per se, but because the involvement of women ensures a full range of perspectives from people with diverse backgrounds and experiences, resulting in less danger of "groupthink". It is also worth noting that painful pain states are often more prevalent in females, and some of the problems associated with ongoing pain have psychosocial contributors that are more likely to be part of women's lives. It is not impossible that being female enables greater empathy with this, and that this in turn might better ensure these factors are considered in the reviewing of the written clinical questions.

It has also been shown that female representation and having a role model within a group makes it easier for us to feel "yes I can do that". This may indeed be why many of us are where we are now; I certainly recollect useful advice and support from female anaesthetists in my early years.

Do female candidates feel more comfortable with female examiners? Certainly, knowing that there is space for females is vital in any environment, particularly when there is the stress of an assessment process. A more gender-balanced exam board may also make female candidates feel, even subconsciously, that the environment is balanced and thus may help put candidates at ease so that they can perform at their best.

A diverse board can also aid in disrupting stereotypes and help change the story of medicine as an upper-class male-dominated arena. Mixed gender groups will inevitably be somewhat different to male dominated groups and a greater proportion of women can be valuable. I therefore believe that women should put themselves forward and hopefully be elected to the board.

So, what does being an examiner involve? Apart from the time commitment of writing and reviewing questions, there are two examination sessions per year (a total of 6 days in London).

Becoming an examiner is challenging but perfectly doable. The team includes District General Hospital consultants and academic 'high flyers'; both are needed so that the questions reflect not only the latest scientific knowledge but also ongoing clinical practice. I found writing questions to be demanding at first; because I had to sit down and structure my knowledge for the topics I was assigned. But developing the ability to do that concisely was rewarding. In the examination room itself, I found that pain consultation skills are transferable to, e.g. rephrasing a question so that less able candidates can give their best. The reading and the exam itself is certainly ongoing CPD for the examiners themselves and some of the skills refreshment during the exam preparation and feedback sessions is extremely valuable.

The camaraderie among the examination team is infectious and not only have I made new friends, but I also feel that I am doing something positive for our Faculty and our profession by contributing towards the maintenance and improvement of standards in pain treatment.

I would encourage more women to think of applying, not only to adjust the ratios but to be the role models for the next generation of female pain clinicians. Anyone thinking of applying is welcome to contact one of the two current examiners: rhian.lewis3@wales.nhs.uk or Suellen.walker@ucl.ac.uk.

FFPMRCA Ethnicity and Gender Performance Review

Dr Nick Plunkett

Chair FFPMRCA

Dr Anthony Davies

Vice-Chair FFPMRCA

As part of an ongoing review of the FPM exam's process and outcomes, and following a similar review of FRCA work on the matter, it was decided that our exam was now of sufficient maturity to undertake a routine review of exam outcomes with respect to Differential Attainment (DA).

This explored the pass rate among candidates based on special characteristics including self-report of gender and self-report of ethnicity- BME (Black and Minority Ethnic) and White. It is important to note that there had been no complaints raised, or potentially relevant issues raised in any way, at any time, from candidates, exam staff, examiners or observers. This was undertaken as a proactive exercise to ensure we are acting openly and fairly.

It should be recognised that due to overall small numbers, a significant number of exam diets were reviewed to give sufficient numbers to allow statistically robust data, and its meaningful interpretation.

Process:
This report looks at the FFPMRCA MCQ examination from February 2015 to January 2019, which covers 9 diets, totalling 138 exam sittings and 119 candidates, and the FFPMRCA SOE examination from April 2015 to October 2018, covering 8 diets, totalling 122 exam sittings and 95 candidates.

Demographics:

- Gender: For both the MCQ and SOE excluding previous attempts the proportion of female and male candidates sitting these exams was approximately 32% and 68% respectively. This appears to approximately reflect the overall representation of males to females in APT posts.
- Ethnicity split (SOE): BME-54%, White- 43%, Other- 3%.
- 64% of BME candidates obtained their primary medical qualification (PMQ) outside the UK and Europe, and 75% of White candidates obtained their PMQ from UK or Europe.

Exam attempts:
The number of exam attempts was reviewed with respect to ethnicity. BME candidates on average have very marginally more attempts at the MCQ (1.18 sittings) compared to White candidates (1.16 sittings). BME candidates appear to have less attempts at the SOE (1.25 sittings) than White candidates (1.33 sittings). Assuming failing candidates do re-sit, these are non-significant differences.

MCQ Exam:
For the MCQ exam considering only the candidates' most recent result and initially disregarding the number of exam attempts, BME candidates have a pass rate of 85.25%, which is significantly lower than White candidates at 94.12%.

For candidates on their first attempt, BME pass rate is lower (70.18%) than White candidates (86.27%). When we look at candidates on their second attempt, BME and White candidates pass rate are the same at 80%. This may indicate that BME candidates are initially less familiar with the MCQ exam format and methodology.

There was further scrutiny as to whether there was a difference in first time MCQ success in different components of the MCQ (to determine if any aspect of the MCQ structure, MTF, SBA, or EMQ) was a source of differential attainment. The only difference was for those candidates who failed the MCQ on their first attempt and this difference was only seen in the EMQ component, when comparing BME to white candidates: 75.2 v 78.6% pass rates.

There was no difference in MCQ pass rate over the paper or subsections thereof when comparing performance in the BME group for those whose PMQ was within versus those whose PMQ was outside, the UK & Europe.

MCQ Gender evaluation: The pass rate for male candidates is 4% higher than for female candidates.

SOE Exam:

For the SOE, again looking only at candidates most recent result, BME candidates pass rate is 90.6% and for White candidates it is lower at 85%.

BME candidates SOE pass rate on their first attempt is 75%, which is similar to that of White candidates at 76.2%. As the number of attempts increases the pass rate falls for both BME and White candidates, but BME candidates pass rate is then always higher than White candidates.

We also considered the pass rate of SOE candidates, taking into account the number of attempts they had to achieve the MCQ. The pass rate for the SOE candidates on their first attempt who also achieved their MCQ on their first attempt, was very similar for both BME and White candidates (71.88% & 72.22% respectively). This would suggest that there is no ethnic difference in this performance marker.

The pass rate for male candidates in the SOE was slightly less than for female candidates, by 2.31%. When the pass rate is broken down by ethnicity and gender, BME candidates' success rate is significantly higher than their White counterparts. (BME Female pass rate 100%, White female pass rate 84.21%, BME male pass rate 88.37% and White male pass rate 85.71%).

Female candidates who were successful in their MCQ after 1 or 2 attempts and then went on to pass the SOE at just one attempt, had a success rate higher than male candidates (Females: 1st attempt MCQ 83.33% & 2nd attempt MCQ 75% vs Males: 1st attempt MCQ 70.83% & 2nd attempt MCQ 55.56%).

Summary:

Overall, these results are reassuring and indicate that while some small differences in attainment have been noted, there is no consistent difference in terms of attainment and success in either parts of the FPM examination. Where there are minor differences, these may have a number of explanations. The MCQ is a test of knowledge and some understanding. Its anonymous nature reduces the risk of examiner related unconscious bias. The SOE is a potential source of bias, from the questions, or the questioning style of examiners. It appears that there is no bias inherent in that process from the analysis to date. All examiners undergo face to face and e-learning modules in Equality and Diversity training to further reduce risk of unconscious bias in the question format or questioning style.

With grateful thanks to Samara Branker for her expert assistance in compiling and analysing data used in this report.

Trainee Update

Dr David Gore

Faculty Trainee Representative

At the start of February, I took over from Helen Laycock as your trainee representative. I would like to thank Helen for all the work she has undertaken over the past two years. During her term, trainee membership of the Faculty has been broadened to include all trainees and exam dates have been moved to times more convenient for trainees, away from hospital rotation dates. Furthermore, her redesigned annual survey, which I hope to build upon, started conversations leading to positive change around trainee isolation and access to training.

Originally from Manchester, I am an advanced pain trainee in the Thames Valley deanery working in Oxford and Buckinghamshire. During my training I have worked across the UK including in Manchester, Lancaster and Sheffield. I regularly attend the pain teaching sessions in London and having spoken to many fellow trainees am aware that pain training varies across the UK. I have worked for the GMC assessing curriculum delivery and currently work for the Care Quality Commission. I therefore feel well placed to work for and with you and ensure our views are represented within our Faculty.

I am excited to be involved in the organisation of the annual trainee conference this year on Friday 2nd October (at the RCoA in London) and we will advertise this event soon. Whilst such meetings hold academic value, they importantly represent an opportunity for trainees from across the UK to connect, socialise, support and advise each other. Our conference will be free and open to all trainees who are interested in pain medicine. I would therefore like to ask that we all promote this event, inviting any colleagues/students with an interest in pain medicine to come along.

Since starting this post, I have taken over the administration of our trainee WhatsApp group. Having been a member of this group for a few years it's great to see how well utilised it is. A predictable recurring theme on the group relates to preparing for the FPM examination and it's great to share success stories and take tips from colleagues who have passed. To complement these discussions and to address any uncertainty the Faculty are currently developing a concise pain topics document/curriculum that will be added to the new FPM website. Additionally, expect an updated trainee article about how to prepare for the exam in the near future.

During the coming months I will work to adapt the trainee survey before this is sent out to all registered trainees around June/July. In addition to contacting me directly this is a great way to feedback what is working or not working to the Faculty and also share ideas about the future of our specialty.

Looking forwards, our young Faculty has a busy time ahead and we as trainees have the opportunity to play a key role in its development and maturation. Pain management is increasingly being recognised as an essential healthcare facet where training and awareness can be improved. This is brought home in the 2018/2019 PQIP annual report that notes 1 in 5 patients experience severe pain within 24 hours of surgery (1). This is also reflected in the new incoming anaesthetic curriculum within which it is proposed that higher pain becomes compulsory. As pain education becomes essential within medical curricula and trainees become more involved, we will have the opportunity to both positively improve patient care and attract new and interested trainee colleagues to our Faculty.

Finally, please do contact me with any training or other issues relating to pain medicine. You can email me fpmtraineerep@gmail.com or alternatively contact me via our WhatsApp group. I look forward to hearing from you, meeting you and representing you.

Reference:

1: Perioperative Quality Improvement Programme 2018-19. P.12 (2019). Royal College of Anaesthetists (London. UK). Website: https://rcoa.ac.uk/sites/default/files/documents/2019-09/PQIP%20Annual%20Report%202018-19.pdf (Accessed: 01/02/2020)

Careers Update

Dr HooKee Tsang

Careers Strategy Subcommittee Chair

For most of us working in Pain Medicine, the compassionate care, empathy, and communication we offer are greatly appreciated by our patients, making a career in Pain Medicine an excellent choice. The work we do can be challenging, rewarding, and allows variety in our working week. Unfortunately, misconceptions regarding the work we do and the patients we see still exist among other medical specialties. Studies have identified that negative attitudes towards patients with chronic pain begin early in medical school, with medical students reporting negative perceptions of their encounters with such patients, describing the condition, and its sufferers, most difficult to deal with. (1,2,3)

The Faculty of Pain Medicine has actively promoted pain education in the undergraduate curriculum through EPM UK. This now reaches over 50% of medical schools, providing much needed training and hopefully changing perceptions of our specialty for a new generation of doctors.

2020 opens a new decade with many challenges for Pain Medicine and how it can positively influence a doctor's career choice.

- The 2015 workforce census for the Faculty conducted by Dr Cole and his team highlighted an ageing workforce with 61% over the age of 46 and 58% planning early retirement due to NHS pension changes. At the time of the census, there was an average of 0.8 chronic pain consultants per 100k population with significant regional variation.
- In recent times the siloed approach to the commissioning of Pain Medicine services has led to the decommissioning of specialist services. To address this, the Faculty has put forward a case with NHS Improvement for a special advisor to the Getting It Right First Time initiative to conduct a full review of Specialist Pain Services across England, which may help demonstrate the benefits of these services and the need to ensure not only that they are protected, but that they flourish. Standards and guidance have also been developed to allow commissioners to make informed decisions on commissioning, better preserving effective pain services.
- Pain Medicine does not have specialty recognition with the General Medical Council (GMC) but the Faculty is working with the GMC to develop a Credential in Pain Medicine, which will potentially open up training to more doctors, helping to create a sustainable workforce.
- Often trainees have cited the FFPMRCA as a barrier to pursuing a career in Pain Medicine. The FFPMRCA is well established and has successfully raised the standard of Pain Medicine training. However, the exam is not mandatory.

Reassuringly, during the last decade there has been little variation in the number of pain consultant post advertised per year, with 42 posts advertised in 2018. The Faculty has noticed a concerning trend in that there has been an increase in the number of vacant advanced training posts with significant regional variation. Given the workforce challenge faced by the specialty, a new Careers Strategy Subcommittee has been created to promote our specialty as a career option, which I have been asked to chair.

The committee will help to develop local initiatives aiming to create a national campaign to recruit a new generation of pain specialists. If you would like to get involved please email contact@fpm.ac.uk.

References:

Weinstein SM, Laux LF, Thornby JL, et al. Medical students' attitudes towards pain and the use of opioid analgesics: implications for changing medical school curriculum. South Med J. 2000;93:472-478

1. *Griffith CH 3rd, Wilson JF. The loss of student idealism in 3rd year clinical clerkships. Eval Heal Prof. 2001;24:61-71*
2. *Corrigan C, Desnick L, Marshall S, et al. What we can learn from first year medical students' perception of pain in primary care setting? Pain Med 20011;12:1216-1222*
3. *Faculty of Pain Medicine workforce census 2015*

EPM in Uganda

Dr Clare Roques, Dr Sarah Aturia, Dr Jay Rajan, Dr Patience Atumanya and Dr Andrew Vickers

EPM Project Team Members

Since its creation in 2010, the Essential Pain Management (EPM) teaching programme has been taught in over 55 countries. A key aim of the programme is to create sustainable education by identifying local trainers to continue teaching, after an initial workshop run by overseas trainers. From December 2017 to December 2018 the Faculty of Pain Medicine and the World Federation of Societies of Anaesthesiologists partnered with St Mary's Hospital Lacor and Kumi Hospital in Uganda to extend the provision of EPM in Uganda in a project funded by the Tropical Health Education Trust (THET).

Picture 1. Lacor EPM

St Mary's Hospital Lacor is a charity run, non-profit referral hospital, located near the northern town of Gulu, Uganda, serving over 5 million people from over 20 districts in Uganda, and South Sudan. Kumi Hospital is a private, non-profit organisation, located in the eastern part of Uganda in Kumi town, serving 4 million patients in eastern and northern Uganda and South Sudan.

EPM was first run in Uganda in 2013 and since then a cohort of local instructors has been trained. The aim of this project was to build on this earlier work with instructors from Uganda and the UK working together to significantly upscale the delivery of EPM. In addition, a Ugandan anaesthetist, Patience Atumanya, was recruited as an 'EPM fellow' to help identify local champions at each hospital and coordinate the collection of evaluation data. This included quantitative data in the form of pre and post workshop knowledge tests, and qualitative data to assess practice change and course evaluation.

Over the year, 432 healthcare workers, including doctors, nurses, midwives and students have attended EPM workshops, with 50 staff from 18 hospitals trained as instructors. These numbers were much higher than expected and thought to be partly due to the participation of influential personnel at each hospital. Other potentially, sustainable changes have been seen with participants championing local further educations sessions, and instructors forming a WhatsApp and local EPM training groups. With the help of medical school leadership EPM was incorporated into the curriculum for medical students in the local regions.

Picture 2. Kuni EPM Group Photo

Picture 3. One of the largest groups had to travel by ferry to attend the course

Despite these successes, inevitably there were a number of challenges, most notably having to condense the project into a fixed time period, and having a high turnover of local staff. One of the resulting problems was incomplete data collection.

Nonetheless, the project was notably successful in training many participants and new instructors and in targeting previously underserved populations. Strong connections were made with St Mary's and Kumi Hospitals to spread EPM in key locations across the country and in significantly increasing the cohort of local instructors and champions. The aim for the future is to continue to build on this work by encouraging sustainability through the local delivery of EPM.

Acknowledgements:
We are very grateful for the funding and support provided by the Tropical Health Education Trust.

The project team members: Clare Roques (Clinical Lead, UK), Ocen Davidson (Clinical Lead, Uganda), Martin Ogwang (St Mary's Hospital), Robert Oluput (Kumi Hospital), Peter Kayima (St Mary's Hospital), Patience Atumanya (EPM Fellow, Uganda), Andrew Vickers (UK Instructor), Sarah Aturia (UK Instructor), Jay Rajan (USA Instructor), Daniel Waeland (FPM RCoA), Aaliya Ahmed (WFSA), Claire Driver (FPM RCoA).

Picture 4. New instructor Jonathan relocated to Yumbe District in West nile and delivered the first EPM course in his hospital.

EPM Update

Dr Helen Makins

EPM Clinical Lead

Our Essential Pain Management (EPM) project is gaining endorsement and entry into a number of different training packages at undergraduate and postgraduate level.

Since the Foundation Programme Directors Team agreed to link to an EPM e-Learning package for foundation doctors at the end of last year, we have focused on discussing a similar approach with the Medical Schools Council. I am delighted that our long-awaited meeting with them was fruitful, resulting in an agreement that a medical school EPM e-learning package would be a welcome addition to medical school training.

In addition, we have liaised with the palliative care undergraduate curriculum group and have made some suggestions which we hope will contribute to a consistent approach between the pain and palliative care disciplines.

Work is therefore now starting to create an EPM module within e-PAIN. We anticipate this module including a basic EPM principles session, a session for new EPM trainers, as well as sessions for medical students and foundation doctors. All will be available within e-PAIN and link to the wider e-Learning for Healthcare platform.

We are enormously grateful to Doug Natusch and the e-PAIN team for allocating funding and support to this collaborative project.

Regional Advisors in Pain Medicine - Updates

Dr Peter Cole

RAPM Chair

Leavers and Joiners:

Thank you to those RAPMs who have stepped down as their terms of office have come to an end. Dr Sheila Black replaces Dr Baranidharan in Yorkshire, Dr Naomi Scott replaces Dr Ravi Nagaraja in North Scotland, Dr Joanna Renee replaces Dr Ivan Marples in South East Scotland, Dr Suzanne Carty replaces Dr Anna Weiss in South West Peninsula, Dr Arasu Rayen replaces Dr Shyam Balasubramanian in the West Midlands and Dr Tom Bendinger replaces Dr Tim Vemmer in Sheffield and North Trent. Dr HooKee Tsang (Mersey), currently RAPM Chair Elect, will take over as Chair for 2021/22.

LPMES meeting:

The third LPMES, as they are currently known, meeting took place on 28th November 2019 with the morning lectures on topics including the new curriculum, logbook and e-portfolio. Then followed workshops on training, curriculum, higher learning oucomes and quality assurance. After lunch there were lectures by the Professional Standards Committee Chair and the Faculty Dean. The day closed with a lively question and answer session. Feedback from the events was very positive.

The first three meetings have been attended by a total of 220 delegates and this free event, to which all LPMES are invited, has provided the opportunity to learn more about their role and the Faculty. It will continue on a biennial basis, thank you for all those who helped organise and run the day and for the colleagues that attended. Please look out for the next one in Autumn 2021.

Appraisal forms:

LPMES and RAPM appraisal forms are being sent out. These are both useful for individuals for the evidence of work carried out in their role, and for the Faculty as an objective measure of level of engagement. Following useful feedback , LPMES appraisal forms are now being sent out in a Survey Monkey format, please do take a few minutes to complete this.

Terms of Office: (contact@fpm.ac.uk)

In the last newsletter I appealed to all LPMES to drop the Faculty a quick email with the information of the date they started as LPMES as these records are incomplete. Thank you to those who have done so, if not please do as the term of office of a LPMES is three years and upon mutual agreement with the RAPM can be extended to six years. If you have exceeded or are approaching the end of your second term and if there is a colleague in your department who is keen to take on the role of LPMES then this should be made possible for them. If not, we would be graeful if you could continue, but the information needs to be recorded.

Decommissioning of Services:

The Faculty has written to all Head of Schools of Anaesthesia to clarify if the regional decommissioning of pain services that is sadly becoming more evidence has affected training in pain medicine. This is with particular reference to Intermediate, higher and Advanced levels, where trainees are expecte to attend multidisciplinary pain services in secondary care as part of their training. Consultants, LPMES and RAs may be contacted by the Head of School or assistance in completing this information.

Membership of the Faculty:

Please remeber that with no affiliation with the FPM it will not be possible to be involved in the work of the Faculty, membership of committees or take on the roles of LPMES or RA. So please join, application forms are available on the FPM webpage: https://fpm.ac.uk/about-faculty/join-faculty

Spotlight on Southwest Severn

Dr Gaurav Chhabra

RAPM Southwest Severn

I am delighted to contribute to the spring edition of Transmitter focusing the spotlight on Pain medicine in Severn.

Bristol: The Pain clinic at North Bristol NHS Trust comprises of five Pain consultants collaborating with neurosurgeons, spinal surgeons, neurologists and gynaecologists to provide specialised multidisciplinary assessments and chronic pain management for various conditions such as Craniofacial pain, Spinal and Pelvic pain. The clinic is one of the leading centres in the country for spinal cord stimulation and other neuromodulation techniques managing complex neuropathic pain. A team of neuromodulation nurses also helps with refill of intrathecal pumps for pain and spasticity.

The neuromodulation service has a dedicated research coordinator focusing on various projects, all centred around improving the quality of life of patients with long term pain. In addition, the clinic specialises in various ultrasound guided and fluoroscopic musculoskeletal interventions and organises an advanced pain teaching programme every month which is well received by trainees.

The pain management team run 22 self-management programmes and 7 pain management programmes throughout the year. There is the provision of a highly tailored service and alongside group work, the service can offer Cognitive Behavioural Therapy, Acceptance and Commitment Therapy and Eye Movement Desensitisation and Reprocessing therapy.

The Chronic Pain Management Clinic at University Hospitals Bristol is in the city centre and offers a full range of services for patients living with pain. There are five consultants who run general clinics and MDT for Endometriosis, Complex Cancer Pain and the Pan Bristol Pelvic Floor group. There are links to the Paediatric Chronic Pain service at Bristol Royal Hospital Children and with the Liaison Psychiatry service, with whom shared complex patients are discussed. Two of the consultants also give input to the Adult Acute Pain Service and one has pain clinics in the region's prisons. There are close links with Bristol University with active participation in research trials.

Bath: The Royal United Hospitals (RUH) Pain Clinic at Bath offers assessment of patients within a biopsychosocial framework. The Royal National Hospital for Rheumatic Disease, a part of the RUH Bath, includes the Bath Centre for Pain Services which is a national Specialist Centre treating people of all ages from young children to older adults from across the UK. Treatment is provided by physiotherapists, psychologists, occupational therapists, nurses and doctors and is mainly rehabilitation based, including exercise and coping skills.

The Complex Regional Pain Syndrome Rehabilitation service and the Complex Cancer Late Effects Rehabilitation (CCLERS) are national specialist services now run at the RUH Bath which offer intensive rehabilitation for adults who are living with complex regional pain syndrome or the late effects of cancer treatment. This includes an in-patient rehabilitation programme.

Gloucester & Cheltenham: The busy Gloucestershire pain service covers a wide area including Cirencester, Tewksbury, Stroud and Forest of Dean. It gets approximately 4000 referrals a year and is the integration between different treatment modalities with monthly multidisciplinary team meetings and a close working relationship between consultants and pain management team which offers 16 PMP courses across the year. There are six pain consultants with ample opportunities for trainees to attend clinics and block lists. In addition, there are intrathecal pump clinics for the management of implanted pumps for pain and spasticity.

There is a robust relationship with the Palliative care team to provide externalized ITDD and Pain interventions. Trainees spend time at the local hospice and with the inpatient palliative care team. A member of the consultant team attends weekly Spinal MDT's as well as Pelvic Pain MDT meetings.

Swindon: The Swindon Pain clinic have a team of three consultants offering Higher Pain Training with good access to local IAPT courses. Their Pain management programme runs 2-3 times per year.

I am grateful to Dr C Steeds (LPMES-UHB), Dr N Patel (LPMES-Gloucester), Dr K Howells (LPMES-Bath), Dr L Williams (Pain Lead- Swindon) for their contributions to this article.

Events Update

Dr Manohar Sharma

Educational Meetings Advisor

Dr Devjit Srivastava

Deputy Educational Meetings Advisor

The FPM is committed to continuous improvement of professional development and organises interdisciplinary meetings and annual meetings to benefit its members as well as doctors and nurses from all specialties interested in pain medicine.

The 12th Annual Meeting of the Faculty was held in November 2019 with the theme, "Topical issues in Pain Medicine". Following earlier years' feedback, we included topics on:

- Amputation for CRPS
- Opioids and gabapentinoids co-prescribing: a toxic cocktail
- a debate on current role of cannabinoids in chronic pain management
- Analgesic use for pain in pregnancy, what can be safely prescribed?
- Patrick Wall Lecture: The curate's egg of Evidence Based Medicine: an appraisal was presented by Dr Andrew Moore, Senior Research Fellow, Nuffield Department of Anaesthetics, University of Oxford.

There were plenty of discussions following each presentation and most of them carried significant implications for day to day clinical practice.

Dr John Hughes, Faculty Dean, updated attendees on activities of our Faculty and the measures actively taken to raise the profile of our discipline.

Following the grand success from the past years, the two study days in February were dedicated exclusively for acute/In-hospital pain management. In February 2020, we ran the event 'Hot Topics and updates in Acute Pain' with the support from Dr Emma Baird, FPM acute pain representative. The objective was to move away from lengthy didactic talks to a blend of talks relevant to clinical practice encouraging and prompting interaction with attending delegates on clinically relevant points. Some of the topics included:

- genetics and pain
- neuropathic pain science and management
- update on safety and effectiveness of lidocaine infusion
- perioperative care of CRPS patients undergoing amputation
- tips on de-escalating opioids
- managing pain after emergency laparotomy in post-epidural world
- what we can do about chronic post-surgical pain
- consent for regional anaesthesia and pain procedures
- role of gabapentinoids in acute pain.

These sessions had enough time allocated for discussions with enthusiastic contributions from delegates and the time was well used.

To date we have received several requests to organise an event on managing challenging chronic pain cases. We had planned to conduct 'Interdisciplinary collaboration for chronic pain; when the going gets tough. Integrating evidence with clinical practice' on Wednesday 10th June 2020. We have had to cancel this date due to the COVID-19 situation but will be rescheduling when appropriate. In interactive sessions, pooled expertise of delegates and facilitators will formulate pragmatic clinical management plans. Emphasis will be on importance of pain diagnosis, promotion of evidence-based pain management options and approach for the case utilising interdisciplinary set up and support. The programme will cover presentation of clinical cases, including how a management plan is devised considering evidence and patient orientated approach with input from delegates. Details of the programme are available by clicking here.

Our educational meetings are a great opportunity to network and update knowledge across the horizon of acute and chronic pain, including what might be around the corner and of interest to all. If you have any new ideas or are interested in contributing to these events, then please contact either Dr Devjit Srivastava (dev.srivastava@nhs.net) or Dr Manohar Sharma (manoharpain@yahoo.co.uk).

Faculty Update

New Fellows by Examination and Assessment

Joanna Renee
Shravan Tirunagari
Sachin Krishna Alva
Hadi Bedran
Duncan Lee Hamilton
Rachel irwin
Helen Catherine Laycock
Martin Marinov
Chandni Parikh
Mohammed Qureshi
Vanja Srbljak
Mohamed Ali Eissa Eid

New Affilate Fellows

Dominic Cliff
Russell Goodall
Krisztina Kenesey

2020-2021 Faculty Calendar

MEETING: FPM Professional Standards Committee	21 May 2020
MEETING: Board of the FPM	22 May 2020
MEETING: FPM Training and Assessment Committee	3 July 2020
MEETING: FPM Professional Standards Committee	10 September 2020
MEETING: Board of the FPM	18 September 2020
MEETING: FPM Training and Assessment Committee	2 October 2020
EVENT: Pain in Secure Environments	TBC
EVENT: Multi-disciplinary Study Day	TBC
EVENT: 13th Annual Meeting of the FPM	27 November 2020
MEETING: FPM Professional Standards Committee	3 December 2020
MEETING: Board of the FPM	4 December 2020
MEETING: FPM Training and Assessment Committee	22 January 2021

Please note that all dates may be subject to change

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