TRANSMITTER

Autumn 2019

Faculty Mentoring/Buddying Scheme

Our new Medicines Advisory Group

Welcome to our new Dean

Research in Pain Medicine

FACULTY OF
PAIN MEDICINE
of the Royal College of Anaesthetists

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WELCOME

Dr Manohar Sharma

Clinical Editor

Welcome to the Autumn 2019 edition of Transmitter!

There has been significant press coverage, interest and concern about the use of opioids, gabapentinoids and antidepressants for chronic pain management. Cannabinoids need careful consideration and are part of a current NICE clinical guideline development project in which the Faculty is a stakeholder. Public Health England published a comprehensive document in September 2019 on "Dependence and Withdrawal associated with some prescribed medicines". The Faculty has fully engaged with 'prescription painkiller' related issues with Public Health England, NICE, NHS England and the Medicines and Healthcare products Regualtory Agency (MHRA) and recently published a position statement. The Faculty is further devoted to educating the public and healthcare professionals on appropriate use of these medicines. The Faculty has also set up the Medicines Advisory Group, led by Dr Barry Miller, to coordinate medication related activities and the Faculty continues to provide considered opinion on research and media engagement in this fast evolving field.

Another major development covered in this edition is the Credential in Pain Medicine. This would potentially allow doctors from closely related specialties such as rheumatology, neurology, palliative care and rehabilitation medicine to achieve a credential in Pain Medicine, post-CCT or pre-CCT. Our new Vice Dean, Dr Lorraine de Gray, is actively leading this with the General Medical Council.

Pain Medicine as a specialty is facing significant challenges, as presented by the article on pain services within West Midlands region. It highlights reduction in provision of neuromodulation and psychosocial aspects of services for pain management; some of these outsourced with a significant impact on advanced pain training as well as multi-disciplinary input for complex chronic pain sufferers. The Faculty is developing a guide for its members on commissioning related issues to mitigate these threats to our specialty.

Practicing Pain Medicine often means working in smaller departments with little peer/senior support. It is challenging at best and has the potential for a significant impact on mental health of healthcare professionals. The article on the Faculty's buddying and mentorship scheme is helpful not only for new consultants but also for those who have been in their post for some time.

I welcome you to register for the 12th Annual Meeting on the 29th November in London and look forward to your support and ideas for next year's Annual Meeting.

Manohar Sharma

Message from the Dean

Dr John Hughes
Faculty Dean

This is my first report as Dean and I am honoured to have been elected and look forward to the work ahead. We have a strong team with a broad set of experiences and interests across the Board and committees. There is excellent support from the Faculty team to inform, discuss, organise, remind, cajole and ensure delivery of the various activities we are engaged with. The Faculty has come a long way over the last 12 years from its inception and continues to develop across the training, educational and professional standard domains. As you will see there are important opportunities going forward that show promise for the specialty and our patients. There is a growing awareness of the burden pain has on society and as such the role for pain medicine and management. The Faculty, along with the BPS, CPPC and other likeminded organisations, have a responsibility to engage and help shape high quality pain management going forward.

Let me first look back and thank Dr Barry Miller for doing sterling work over the last three years as Dean. It has been a busy time with ever increasing demands on the Faculty. Some of the highlights include: broadening access to membership, developing a credential for consideration by the GMC, publication of the multi-organisational framework for pain service provisions for adults in the UK who have cancer or life-limiting diseases, completion of the outcomes project with the BPS and his significant engagement with the discussions regarding opioids and cannabinoids. I thank him for his diligence and hard work. I am also delighted that he will be continuing to serve the Faculty going forward as a member of the Board and in other capacities.

It is also a pleasure to welcome Dr Lorraine de Gray as the new Vice Dean and thank the other Board members that stood. Lorraine brings a wealth of experience as Chair of the Training and Assessment Committee as well as leading the work on credentialing and the curricula review.

With the increase in work for the Faculty across both of the main committees, the Board is reviewing the structure and core values to ensure it remains fit for purpose and to build in quality assurance, prioritise projects against our core roles and to ensure deliverability.

The GMC has set new standards requiring all Colleges to review their curriculum and the RCoA is no exception. The Faculty is integrated into this and has ensured pain medicine remains a fundamental part of anaesthetic training at all levels. Alongside this, the GMC has been looking at credentialing and the FPM application is one of the first credentials being progressed by the GMC. This is being developed in parallel with the curriculum to ensure consistency.

There have been several new Affiliate Fellowship applications and there is ongoing work looking at strengthening the links with inpatient/acute pain services led by Dr Emma Baird. This will build on the significant work undertaken by Dr Mark Rockett over recent years, who we thank for his insight, delivery and devotion to the task. The Faculty is here to support pain medicine in its broadest sense which includes the inpatient environment. There is ongoing interaction with the RCoA's perioperative medicine projects along with other initiatives to provide patients with equitable high quality pain management. This includes the Get It Right First Time (GIRFT) project for Anaesthesia and Perioperative Medicine, led by the NHSI.

Following feedback from the membership, the Faculty introduced a buddying system in 2017 for the support of fellows and members working in pain medicine. Now, two years on, there is an update on this initiative including the personal experience of a mentee (pages 8-9).

There have been increasing calls from external organisations for the Faculty to be involved with projects they are developing. These will continue and require focused and reasoned responses. The Professional Standards Committee (PSC) should be congratulated on its turnaround and balanced responses in what are often short time frames.

There has been significant discussion and press coverage around opioids, cannabinoids and other medications over the last year or two. The Faculty has been fully engaged with the discussions

(notably with PHE, NICE, NHSE, MHRA) and will continue to be. In order to facilitate this, the Board has approved a Medicines Advisory Group (reporting to PSC) which will incorporate Opioids Aware within this broader remit including other medications, research and media engagement. I am delighted that Dr Barry Miller will chair this group and has already demonstrated an understanding, interest and experience in this area.

The 'Core Standards for Pain Medicine Services' review continues apace with the chapters being reviewed and edited. This has broad endorsement and is an important document if we are to ensure pain management is practiced to a high standard for the benefit of patients. The content and layout is being modified following feedback from users, and we thank all involved for their continuing efforts.

Faculty of Pain Medicine 12th Annual Meeting

Topical Issues in Pain Medicine

Friday 29th November 2019

09.00 - 09.20 REGISTRATION AND REFRESHMENTS

CRPS and limb amputation - update for practice
Dr Andreas Goebel, Consultant in Pain Medicine, Liverpool

Opioid and gabapentinoid co-prescribing for chronic pain: a toxic cocktail?
Dr Sailesh Mishra, Consultant in Pain Medicine, Newcastle upon Tyne

10.50 - 11.20 REFRESHMENTS

Faculty Developments
Dr John Hughes, Faculty Dean

Patrick Wall Lecture: The curate's egg of Evidence Based Medicine: An appraisal
Dr Andrew Moore, Senior Research Fellow, Nuffield Department of Anaesthetics, University of Oxford

13.00 - 14.00 LUNCH

Debate: Cannabinoids should now be prescribed for chronic pain
Dr Paul Farquhar Smith, Consultant in Pain Management, London
Dr Dalvina Hanu-Cernat, Consultant in Pain Management and Anaesthesia, Birmingham

Acute pain services - future direction and value
Prof Richard Langford, Consultant in Pain Medicine and Anaethesia, London

Analgesic use for pain in pregnancy - what can be safely prescribed?
Dr Surabhi Nanda, Consultant in Maternal Fetal Medicine

16.00 - 16.30 DISCUSSION AND CLOSE

RCoA, London
5 CPD Points
Consultants and SAS Grades: £205
Trainees/nurses: £150
Code: B08

Please note that the programme and timings are subject to change.

FACULTY OF PAIN MEDICINE
of the Royal College of Anaesthetists

Programme organised by Dr Shyam Balasubramanian and Dr Manohar Sharma

Professional Standards Committee Update

Dr Paul Wilkinson

FPMPSC Chair

The FPMPSC has been working hard on a variety of projects and we would like to invite you, our Fellows and Members, to help us with these by considering the following questions across six of our main developments.

1. **Guideline engagement:** we have strengthened our internal procedures referencing the Academy of Medical Royal Colleges (AoMRC) document on implementation that was the trigger for our own piece of work. The AoMRC have highlighted the need to provide more focus on implementation to maximise the yield on work undertaken by professional bodies such as the FPM. This published work is our response.

Q1. Do you have a rolling assessment of your team practice benchmarked against FPM guidance documents considered at your Governance meetings?

2. **Commissioning support guidance** will be published in the next month.

Q2. Is your local area following best practice?

3. **Palliative Care and Pain:** our recent publication is being actively used as a platform to improve standards of care. Examples of implementation locally and alignment to key areas of the document are becoming evident.

Q3. Is your unit aligned to this document?

4. **Refinement of Gap Analysis:** Dr Srivastava is to review the core outcome set and extended outcomes set of Core Standards for Pain Management Services. We encourage all units to engage with the survey.

Q4. Have you done a gap analysis for your own unit?

5. **Opioids issues:** Public and medical concern continues over opioid prescribing. The Faculty has underpinned this effort with four key streams of work:
   - Opioids Aware, our online information source.
   - A briefing statement to health professionals on the management of opioid medications.
   - FPM/RCoA Opioid Prescribing Project: an initiative to reduce the opioid load into the community after surgery and enable timely reduction.
   - A resource to enable best practice in opioid reduction.

Q5. Have you considered the briefing statement on the Faculty website and how to put that into action locally?

6. **Guidance risk assessment:** Dr Searle is exploring how using risk would be useful in helping with implementation of guidelines. This would help highlight to departments the clinical risk of not engaging with guidelines and also assist in communication over the clinical resources that are needed. Future revisions or new documents should soon include information on risk.

Q6. Can you look out for this work and consider putting safety first and communicating risk issues that arise from non-compliance?

Positive change is in hands of the reader!

Now is the time for action!

Other current work includes revision of Core Standards for Pain Management Services. All redrafted chapters have been submitted and Dr Weiss and Dr Taylor are undertaking cross editing.

The Events programme continues to thrive and the recent Pain in Secure Environments training in Aberdeenshire was a great success. Dr Balasubramanian confirmed he would be stepping down from his role as Education Meetings Advisor after the annual meeting with Dr Sharma taking over and Dr Srivastava appointed as Deputy Education Meeting Advisor. On behalf of the PSC, I would like to thank Shyam for all his hard work.

A number of publications are currently under review. 'Recommendations for good practice in the use of epidural injection for the management of pain of spinal origin in adults', 'Guidance on competencies for Spinal Cord Stimulation' and 'Standards of good practice for medial branch block injections' and 'Radiofrequency denervation for low back pain'. These will be out in due course.

Once again, I thank all members of the FPMPSC for their continuing hard work.

Medicines Advisory Group (MAG)

Dr Barry Miller

Chair of Medicines Advisory Group

"You can check out any time you like,
but you can never leave"

Hotel California, Eagles

Over the last few years the issue of analgesics in long-term pain states has moved from a niche subject to one of increasing national, international, legal and political concern. It is barely possible to open a newspaper and not read of the "opioid crisis" or the various degrees of legalisation of cannabis, both in the UK and abroad. As clinicians on the forefront of these clinical issues it is important that these complex issues are addressed, not by the simple binary forces of prohibition and relaxation, but by informed debate on their proper place in medical practice, the associated risks and benefits, how these should best be managed to help the individual and to recognise public health concerns.

The Faculty, with Public Health England, created the 'Opioids Aware' resource in 2015, which is now the most commonly accessed area of the Faculty's website, and was produced in advance of similar guidance in the USA and Australia. More recently we have set out a position statement on Cannabinoids and the need for proper regulation, licensing and assessment of potential benefits and risks. Earlier this year, the scheduling for Gabapentinoids was changed, and, most recently, increasing concern is being focused on Antidepressants.

In all these areas, it is essential that a professional voice for pain is heard, on both the risks and the benefits.

Human stories of the stresses both for and against a medication make for powerful journalism, but rarely reflect complex issues which are the bread and butter of everyday pain medicine practice. Further, increasing numbers of anecdotal reports on the inappropriate reduction, change or cessation of medication leading to significant distress and morbidity, combined with the frequent failure to properly assess pain problems and offer suitable options, are a matter of deep concern. This aligns with concerns over the increasing use of non-primary care provision of services with no medical input as part of the assessment or management.

The use of analgesia within medicine has always been an underrated and poorly taught subject. Often going unmentioned in textbooks, papers and curricula – or given lip-service: The Merck Manual 20th edition (2018) on Acute Herpes Zoster "Wet compresses are soothing, but systemic analgesics may be necessary". And this is just published!

With such a paucity of guidance, and regulatory pressures targeting medications, there is not a risk of future over and under medication: it is the norm now.

There remain major challenges within the research environment in relation to long-term studies of established (out-of-patent) medications and promotion of newer products as they come to the market (e.g. Vioxx, Oxycontin). Ongoing economic challenges have always placed pressures on long-term symptom management, and the NHS and our specialty are bellwethers of this.

In response to this environment, the Faculty has setup a dedicated group to co-ordinate all the medication-related activities. The 'Medicines Advisory Group' will liaise with the various groups within the Faculty and College, and without (e.g MHRA, PHE, Government, etc) to help develop professional guidance, and guide policy which takes account of the, sometimes perceived, asynchronous needs of the individual in pain, and the wider society.

Buddying/Mentoring scheme

Dr Carol McCartney

Board Member

Three years ago a survey was conducted regarding the potential for a buddying and mentorship scheme within the FPM. The response was positive and a scheme was established to improve support available to members.

The survey highlighted a need for a support network as pain doctors often work in small departments where they may be the only doctor in the service. As trainees, we often have good professional development support with named educational supervisors and the opportunity to reflect and plan development through the ARCP system. It can therefore be a sudden shift as a new consultant to find these options are no longer open. Although appraisal as a consultant has a role to play, it is guided by GMC principles and is often conducted for most consultants by an appraiser independent of the anaesthesia or pain medicine department, which does not fulfill the role of mentorship.

What is mentoring? Mentoring is defined as 'off-line help by one person to another in making significant transitions in knowledge, work or thinking' (Clutterbuck and Megginson, 1995). It is to support and encourage innovation and creativity through an external sounding board, and encourage and support people to manage their own learning so that they may maximize their potential, develop their skills, improve their performance and become the person they want to be (Eric Parsloe 1992 The Oxford School of Coaching and Mentorship). Mentorship differs from coaching as the relationships usually continue over a long period of time. Mentors are usually more experienced than their mentees and can pass on knowledge and experience, and potentially open doors and opportunities.

Although there are some established schemes, and additional support for struggling doctors, the FPM wanted to offer a tailored service for our members, particularly in light of the GMC recommendation that all new consultants should be mentored. Although this may happen in some localities, it was not universally available and not of the specific nature which would be most helpful to our young specialty.

We wanted to develop a system of mentorship which offers this type of support and counselling on an informal voluntary basis to those who want to be mentored and to those who want to be mentors.

It is hoped that it will lead the mentee to greater job satisfaction, be a platform to empower them for their future direction and improve self-esteem and self-efficacy. There is some evidence that mentorship can prevent occupational burn out which pain medicine specialists may be prone to, as they often work in small departments or in isolated areas with often challenging patients. By tapping into the experience of mentors, the mentee may be able to understand organisational politics and use resources available in a tactical way, such as learning of outside schemes not advertised locally, to enable research and development.

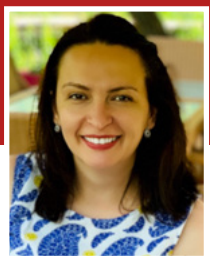
How the scheme is run: The Faculty holds a database of mentees and mentors. When approached, mentors are suggested based on requirements specified by individuals, such as areas of work they want support in. Both sides are allowed to choose whether to enter the mentorship, as this is a voluntary scheme. Meetings can be held in person, if geographically possible and the participants choose to do this, or via Skype (or equivalent). Meeting frequency should be flexible, however a 3-6 monthly frequency is recommended with more regularity if working on specific projects. Meeting should last less than an hour and either party should be able to terminate the relationship if not happy, or if they feel that they have achieved their initial goals, as discussed at the first meeting.

Although the meeting content is confidential, an outcome form is completed and audited by the FPM to ensure the system is viable and successful.

Mentors should be Faculty members who have ideally completed a formal mentorship course. They need to show a proven record of accomplishment as mentors. Mentees will also be members of the Faculty.

Since going live with the scheme we have successfully introduced four partnerships. All have been satisfied with their meetings and found the scheme useful.

As a Faculty, we want to promote the scheme and expand opportunities to participate so if you are interested then please sign up as a mentor or mentee, or both! The scheme is not just for new consultants, indeed all need support or help with ideas and taking these forward.



Experience of the Mentoring scheme

Dr Sabina Bachtold

ST7 Anaesthesia/Pain Medicine

Back in 2017 I received an email from the FPM advising that a mentoring/buddying scheme had been launched for the members. I was finding myself halfway through my maternity leave, having completed part of my advanced pain training, the written part of my exam and questioning everything from choice of career to professional and family future. I was fortunate enough to be a trainee in London where I had contact with plenty other pain trainees but still felt that I was not figuring out the bigger picture of my life as an anaesthetist/pain physician whilst having a very young family.

I decided very quickly that the scheme was just what I needed. I enrolled as "New parent of twins. Towards the end of my training. Looking for mentoring regarding career development and progression and how to juggle a career in anaesthetics with pain medicine."

I was very quickly offered a choice of two consultants and thankfully the one I expressed an interest towards kindly also accepted to mentor me. We met in person very soon after over breakfast in IKEA! The terms of our mentoring interaction were quickly established and out of the way: everything was going to be very informal and this put me at ease significantly. I was fascinated to listen to the story of their amazing career and humbling account of all their professional and personal achievements but also of the difficulties they had encountered over their decades in the profession. I felt I was in a non-judgemental environment where I could express my doubts and anxieties about my professional future in a way that would have been difficult for me to do with my peers, supervising consultants or immediate family. I left our meeting feeling so much more courage about anything that life and the profession would throw in my direction. We have continued our mentoring relationship thereafter both by meeting in person or via telephone and I feel privileged to be in contact with a mentor of such amazing experience.

I cannot recommend this scheme highly enough to my colleagues in this specialty where we can be very geographically isolated and might lack the (informal) contact we need in order to preserve our wellbeing. This scheme might also be one of the answers to attracting more colleagues into the specialty at a time of low recruitment numbers particularly as the scheme is open to intermediate/higher pain trainees. As a previous LPTAG trainee representative I know that having access to mentors and role models is something extremely valuable in attracting and keeping colleagues in the world of Pain Medicine.

Faculty Mentoring/Buddying scheme

If you would like to be a mentor, mentee or buddy to another Pain Medicine doctor please email **contact@fpm.ac.uk** to register your interest and we will send you further information and an application form.

Training and Assessment Update

Dr Lorraine de Gray

Vice-Dean and FPMTAC Chair

New appointments:
Since my last update in the Spring, the Training and Assessment Committee has welcomed a number of new appointees. In June 2019, Dr Victor Mendis was appointed Vice Chair of the committee. Dr Mendis has a wealth of experience in training, having been Regional Advisor in Pain Medicine for North Thames for six years. During most of that time he was a very active member of this committee and also Chair of the RAPMs between 2016 and 2018. We also welcome two new committee members - Dr William Rea and Dr Ashish Gulve. Dr Rea was Regional Advisor in Pain Medicine for West Midlands from 2016 to 2019. Dr Gulve has been the RAPM in post for the Northern Region since March 2019. Dr Paul Rolfe, RAPM for East of England, has been appointed for a second term to the committee and continues to be the Lead for Paediatric Training in Pain Medicine.

The new Anaesthetic Curriculum:
A major focus of TAC at present is on the forthcoming new Curriculum for CCT in Anaesthetics due for publication in 2020. We continue to work collaboratively with Dr Nigel Penfold, the RCoA Lead on the new curriculum rewrite.

In June 2019, during a council meeting, the General Medical Council approved the framework for GMC-regulated credentials. Proposals are now in place for a phased introduction by working with a limited number of early adopters.

Pain Medicine Credential:
I am delighted to report that Pain medicine has been chosen as one of the first five GMC regulated credentials to be considered. The GMC Curriculum Oversight Group will start to review proposals for the credential in October 2019. Task and Finish Groups are being set up by the GMC to help review the submissions. The Faculty will continue to work very closely with the GMC in this landmark event for our specialty.

In the meantime, the new Curriculum for Anaesthetics now describes three Levels of Training in Pain Medicine to achieve the Higher Learning Outcome of "Managing pain".

Level 1 occurs within the first three years (Core Training Year 1- 3). Level 2 occurs in Specialist Training Year 4 or 5, whilst Level 3 will occur in Specialist Training Year 6 or 7.

Training in Pain Medicine will be compulsory at all three levels for all doctors undertaking a CCT in Anaesthetics. However, Level 3 will have three different sub-tiers of Training in Pain Medicine as follows:

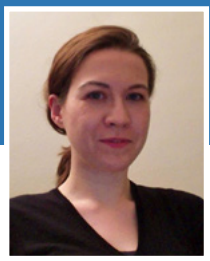
A. Pain Medicine training for the General Anaesthetist: this will build up on skills/ knowledge acquired at Level 1 and Level 2.

B. Pain Medicine training for Anaesthetists who wish to become Lead Clinicians or have a significant role in managing Acute In-patient pain. This is anticipated to require up to six months of training- "Higher Learning Outcomes for Managing Pain for the Acute Pain Specialist"

C. Pain Medicine training for Anaesthetists who wish to become Specialists in Pain medicine – this will take 12 months and should ultimately lead to a Credential in pain medicine, assuming that the Credential process continues as currently indicated. The Curriculum in Anaesthesia will list the Specialist Key Capabilities in the Credential in Pain medicine Curriculum and will cross reference to it for greater detail.

The Credential in Pain Medicine will also be an option to pursue post CCT in Anaesthetics if preferred.

The Credential in Pain Medicine will allow not only CCT doctors in Anaesthetics to become pain specialists, but will also open the door to other closely related specialties including Rheumatology, Neurology, Palliative Care and Rehabilitation Medicine to achieve a credential in Pain Medicine at post-CCT or pre-CCT (as Out Of Programme training).



Trainee Update

Dr Helen Laycock

Faculty Trainee Representative

In Spring 2020 I will end my term as your trainee representative. I have been in post for nearly two years and it has been a privilege to represent you on the Faculty Board and TAC. During this time I have seen the Faculty seek out, value and respect the trainee voice, with issues raised being discussed and acted upon. This has ranged from enabling trainees to become Faculty members at any stage of training to ensuring exam dates fall outside hospital induction periods. This position is a fantastic opportunity to both represent your colleagues and see the inner workings of the Faculty and I wish the new rep all the best.

This time has led me to reflect on the issues we face as pain trainees and what challenges and opportunities these present to the next trainee representative.

The first issue is recruitment. In some regions Advanced Pain Trainee (APT) posts are unfilled, and whilst under-recruitment is not isolated to pain medicine, it is important to consider how we enthuse our colleagues of the future. Last year's trainee survey highlighted that working with inspirational clinicians during core and intermediate training led trainees to develop an interest in pain. A similar theme is emerging from this year's survey, alongside trainees being enthused by the diverse clinical work pain medicine offers. At the AAGBI trainee conference this year, a Faculty Board member took part in a 'dragons den' type event giving a five-minute pitch outlining the benefits of a career in pain medicine. Events like this are excellent, promoting pain to trainees who have limited exposure early in their career. We can also contribute by simply discussing our career choices with other trainees at trainee events, on-call or in the anaesthetic coffee room. There are many approaches to improving recruitment and developing these is a real opportunity for the next trainee representative.

The second issue is communication, both outfacing and internal. We need to ensure our voice continues to be heard, not just within the Faculty, but in other committees, groups and boards at a regional and national level. The more pain trainees are visible to our peers, trainers and the wider medical community, the more our views, training needs and role will be considered. For internal communication we face the challenges of being a small group of trainees, spread out across the UK. Our trainee WhatsApp group and emails from the Faculty represent useful methods to receive information about our training and gain support and advice from our peers. As a London APT, I was fortunate to gain peer support by attending training days and having informal chats over coffee. This is not an opportunity many have and hopefully the national training day open to any trainee interested in pain, offers a possible solution. This years' trainee survey highlighted barriers to attending including issues gaining study leave and funding. Next year's meeting will be advertised on the Faculty website and please get in contact if you face difficulties in attending.

The third issue is the challenges APTs face during their training year. It can be isolating being the only trainee in a region and opportunity for peer support is limited. I am currently revising for the FFPMRCA SOE and am back in anaesthetic training having finished my APT. Via the trainee WhatsApp group, I have organised viva practice with a colleague in a different region of the UK. These viva sessions have been invaluable in exam preparation (thanks to my brilliant viva partner), but highlight how important support during training is. We have to figure out how to balance learning a new specialty with honing our clinical skills and learning new technical skills. This is alongside anaesthetic out-of-hours commitments, completing workplace based assessments, ensuring sufficient case numbers and mix, developing competence and independence in pain medicine, revising for an exam and completing the obligatory audit, research, management and QI aspects required for both APT and future job applications. We are a cohort of trainees that face unique challenges, however the general move towards ensuring wellbeing of doctors represents a great opportunity to support our colleagues through this rewarding but demanding training year.

Finally, Pain Medicine itself is undergoing changes that include how we manage chronic pain, recommissioning of local services and GMC credentialing. These overarching themes impact on us planning our future roles and ensuring our specialty continues to recruit. However, these are exciting times, with each issue presenting great opportunity. I look forward to seeing how these evolve to shape pain training and our specialty in the future.

Regional Advisors in Pain Medicine - Updates

Dr Peter Cole

RAPM Chair

Leavers and joiners:
Thank you to the work of those RAPMs who have stepped down as their terms of office have ended. Dr Ashish Gulve replaced Dr Dodds (Northern) in March. Dr Selvaraj (Nottingham and Mid Trent) has had to step down and temporarily Dr Kamel (Leicester and South Trent) is covering this region. Dr Manchanda (West of Scotland) was replaced by Dr Paisley in July. Applications for Dr Baranidharan's replacement in Yorkshire are now closed and the Faculty is pleased to announce that Dr Sheila Black will be taking over as RAPM. Congratulations to Dr Tsang (Mersey) on his appointment as RAPM Chair Elect from January 2020 and Chair for 2021/22.

Appraisal forms:
We have developed LPMES and RAPM appraisal forms which are intended to be useful tools for LPMESs as evidence of work carried out in their role, for appraisal, revalidation and job planning. For the Faculty the forms will provide an objective measure of level of engagement and failure to return the form will not reflect well. The RAPMs have now completed and returned their forms and their feedback has been positive. The appraisal forms for the LPMESs will be sent out in the autumn to be returned by the end of 2019. If for some reason you have not received the form, you can download it from the Faculty website.

Membership of the Faculty:
From the Workforce Census 2017 and other sources, we know there are consultant/specialists working in pain medicine in the UK with no affiliation with the FPM. These colleagues therefore miss opportunities to be involved in work of the Faculty, membership of committees or taking on educational roles of LPMES or RAPM. Earlier this year membership categories were reviewed and developed. An additional two categories were created; Affiliate and Affiliate Fellow. Application forms are available on the FPM membership website. Since creation, 17 Affiliate Fellows and 6 Affiliates have become members of the FPM and I encourage all non-members to apply.

LPMES conference:
The third Faculty LPMES Conference will take place on 28 November 2019 and promises to be a very interesting day. There will be lectures on curriculum, logbook and e-portfolio, a Professional Standards Committee update and an FPM update from the Dean of the Faculty. Workshops will be on training, curriculum and higher learning outcomes and quality assurance including WPBAs and ARCP. The day will close with a question and answer session, which has always been well recieved.

Terms of Office:
Faculty records for terms of office are incomplete for the majority of our LPMESs. Thank you to those RAPMs and LPMESs who have contacted the Faculty (contact@fpm.ac.uk) providing information on start dates and hospitals for new LPMESs. Local RAPMs are now completing missing records and this information is now being kept centrally. **Please could I ask all LPMESs to contact the Faculty with a very short email stating the hospital you work in and your start date as an LPMES.** Terms of office of LPMES are three years and upon mutual agreement with RAPMs, can be extended to six. 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 the LPMES, then this should be made possible for them.

Spotlight on West Midlands

Dr Shyam Balasubramanian

RAPM, West Midlands

Schools of Anaesthesia: The West Midlands region covers a wide geographical area and comprises three schools of Anaesthesia – Birmingham, Stoke and Warwickshire. Birmingham School has eight hospitals, four of which are accredited for advanced pain training (APT). Two of ten hospitals are accredited in Stoke, while Warwickshire School has three of seven hospitals accredited.

Trainees: We currently have three advanced pain trainees, one within each School of Anaesthesia. Ten Local Pain Medicine Educational Supervisors (LPMESs) in the region oversee pain training from Intermediate to Advanced levels. At any given time, there are more than 100 trainees undergoing intermediate pain training within our schools.

Communication: LPMES and trainees use email for formal training issues. In addition to this, WhatsApp has revolutionised communication the world over and the Midlands Pain Circle is no exception. There are 35 pain clinicians within our WhatsApp group and discussions include clinical and service issues, relevant scientific articles and adverts for educational courses.

Continuing Medical Education: Dr Rayen, Pain Consultant in Birmingham, arranges the West Midlands Pain Forum every three months. These evening meetings attended by clinicians and trainees across the region provide an effective platform for networking and exchanging ideas. Dr Tameem, Pain Consultant in Dudley, organises the annual West Midlands Pain Society meeting which is a multidisciplinary event covering recent updates in our discipline. Both events are approved for CPD credits by the Royal College of Anaesthetists.

Workforce: Since taking over the RAPM role in October 2018, I have approved ten job descriptions for Pain Medicine consultant posts across the region. There were some successful appointments however many posts were re-advertised due to a lack of suitable candidates. The Faculty of Pain Medicine has already conducted a workforce review identifying a growing shortage of Pain Medicine specialists in healthcare regions within the country, West Midlands not being an exception.

Two consultant anaesthetists in the region have expressed interest in retraining in pain and have been directed to guidance provided by the FPM. However, this will need enormous support from the employers in terms of time and resources especially if 'off site' attendance is required to gain the necessary competencies. 'In-house' training can only be undertaken within a hospital recognised for APT.

Some centres are looking at innovative ways to meet the ever-increasing demands for pain services including using Physician Associates to provide selective treatments.

Opportunities: There are numerous projects available for those interested in research. Pain Medicine related studies are being conducted at Birmingham, Keele and Warwick Universities. One recent example is the IWOTCH (Improving the Wellbeing of People with Opioid Treated Chronic Pain), a multicentre study by the University of Warwick.

Challenges: Hospitals in West Midlands were centres of excellence for specialised pain procedures such as neuromodulation. However, changes in commissioning models have led to cessation of these interventions in nearly all the pain services in the region.

Comprehensive multidisciplinary teams have been another casualty of adverse commissioning. Although some hospitals still have them, CCGs elsewhere have 'outsourced' the 'psycho-social' aspects of care to private healthcare providers within the community leaving hospital-based pain services to solely address the 'biological' aspects.

These changes have not only affected patient care but have to some extent also compromised delivery of higher pain training as set in the FPM curriculum.

Despite the challenges, there are rays of hope. We already have three advanced pain trainees and two more anaesthesia registrars within the Schools have expressed an interest in training in pain. This could be a sign of a reversal of fortunes for Pain Medicine and set a trend that will encourage even more trainees into our rewarding specialty.

Research in Pain Medicine

Dr Andreas Goebel

Reader and Honorary Consultant in Pain Medicine

We are a small specialty tackling a humungous unmet need in the UK population. We can do our best by educating and informing our patients and by relating techniques equipping them to better live with their chronic pain conditions.

In contrast unfortunately, with few exceptions in small subgroups of patient, our analgesic tools are still from the Stone Age. Unsurprisingly, our patients would like to see 21st Century solutions. In order to move forward into today's age we need research.

To establish good pain research, we need you, the reader of this article. Pain clinicians are the yeast in the research-cake! There is no one else from a healthcare perspective who understands the clinical situation as well as we do. In addition to this expertise, many of us share a sense of the often enormous suffering in our patients and the urgency behind the need to find new solutions. We may also be motivated by the apparent unfairness that those who are poorest, most distressed, perhaps with the most past trauma are at the highest risk to additionally develop chronic pain, as if these other factors were not enough. How can we break this cycle?

Our clinical expertise will support us to ask the right questions, and to design the right studies both where we ourselves initiate such studies, or where we collaborate with others. Scientists in the pharmaceutical industry, the excellent academic basic pain researchers of which the UK has so many, as well as colleagues in related healthcare disciplines, generally start from a position of little understanding (trust me on this) about chronic pain presentations in humans and their enormous diversity. Having our input should avoid another 25 years of often rather useless drug-research efforts, as frustrating to these colleagues as to us.

Many of us may feel that they are ill equipped for research and that their research efforts will not matter. We may be right about the former but are definitely wrong about the latter. How can we best equip ourselves for fruitful research, initiated either by us or others? Pain specialists' interests in research take many shapes. Some of us may never wish to have any involvement in research. Some may want to support colleagues in their respective projects.

Others wish to engage in laboratory work, or research in humans including, but not limited to, clinical trials. A few will pursue an academic career, more may want to gain an academic degree, and regularly people might simply see research as a potentially interesting addition to their working lives with the nice bonus of seeing their names on a published paper.

A good starting point for pain specialists wishing to learn more about pain-research may be to shadow a colleague in a clinical trials unit or a laboratory. For those who engage in a clinical research project I suggest that you consider additionally arranging some time with a basic science researcher, and vice versa. Having held a pipette for a number of days or having attended a monitoring session in a trials unit, we appreciate just how slow, meticulous and exciting these respective fields of research are, and in the process we enjoy becoming more effective members of the overall UK pain research network.

When I started to work in pain medicine in the UK, there was no registry of pain-research active clinicians, industry, basic scientists, and there still is not one; we have been starting to assemble such a list and endeavour to make this available next summer via various pain-related websites, as a resource for interested clinicians.

In funding terms, times for research are actually good, as research-funders have woken up to the huge unmet population needs. Charities, including Versus Arthritis and the Pain Relief Foundation have driven much development in this area, drawing in large UK research institutes and councils. On the other hand, given that it might be necessary to have time off work to conduct research, NHS employer support can be a challenge for many of us; we need novel solutions that will facilitate this area, so that clinician involvement, including in smaller clinical research projects can be supported.

With their current work on credentialing in mind, any support the Faculty of Pain Medicine can lend to allow non-anaesthetic specialists to gain qualifications and then work in pain medicine can only enhance and enrich what pain specialists can contribute to pain research. Ultimately, any movements towards sub-speciality or even speciality status for pain medicine will streamline training and create further room for trainees to become involved in this field.

Trainee perspective: Research. Who would do it?

Dr Richard Berwick
ST5 Anaesthetic Registrar

As the swirling nebula of ice crystals sublimate, the stacks of cryco-vials appear in the industrial super-freezer. Each time, I am surprised at how few there are. Thirty seven does not seem like nearly enough. These vials of frozen serum represent years of work: 18 months of planning and eight months of recruitment. Countless hours of computer formatting and patient questions, innumerable appointments, report forms stacked waist-high.

Research: Who would do it?

Fibromyalgia is not everyone's passion. To be fair, I probably would not have pictured myself embroiled in this line of research back at medical school. However, quite serendipitously, I am hooked. Our project, 'Autoimmunity-informed Phenotyping In patients with Fibromyalgia Syndrome', looks to characterise an immune component of fibromyalgia that confers temperature sensitivity in the mouse model of fibromyalgia. Following an exciting set of pilot experiments with collaborators at King's College London, this project at the University of Liverpool was set up by Professor Goebel.

> "Research has really helped me to sympathise with my patients.

Research has really helped me to sympathise with my patients. I have spent hours learning about patients' experience of the disease. Seeing the personal struggles they face has been both an edifying and humbling experience. I have seen such a variety of patients, each one completely different, but united by their suffering. This wealth of experience has given me understanding of the personal burden of disease that equips me to serve these patients so much better in clinic.

Fibromyalgia is complex and poorly understood. It is also, often rather simplistically, reduced to no more than a disease of central sensitisation. I have realised that there is much more to understand: from the neuro-chemical to the neuro-anatomical, from the physiological to the psychological. This knowledge is not only important to validate the disease but also to defend it against those who might suggest it is merely a disorder of resilience. The suffering these patients experience is very real and they have often felt dismissed by doctors.

Rather more than occasionally, I receive a look of consternation from my colleagues when I explain that I wish to do pain medicine. At a time when recruitment to chronic pain is at an uncomfortable nidus, my research has equipped me with a 'motivating' sword and shield. Doing my best not to be belligerent, I fight misconceptions and hope to champion pain medicine. Knowing a little of the research is, perhaps, the first step towards changing the recruitment quandary.

Research is not always easy: sometimes it is difficult to arrange, sometimes stressful and, without fail, a lot of work. But, the reward is worth it. It helps in understanding your patients, not to mention their disease, and it confers scientific credibility on our specialty. Even putting these things aside, it is a fascinating process and, some would say, a medical duty to develop our collective knowledge and our treatment paradigms. Seeing my project grow and mature, even over the short space of time that I have been involved in it, has been superbly rewarding.

Research: Who would do it? Me.

For more information:

1. *bioRxiv 713495; doi: https://doi.org/10.1101/713495*
2. *http://www.isrctn.com/ISRCTN18414398?q=&filters=&sort=&offset=38&totalResults=18006&page=1&pageSize=100&searchType=basic-search*

Treating Complex Patients with Painful Diabetic Polyneuropathies:

15 Years of Experience from Specialised Diabetic Polyneuropathy Pain Clinic in Newport, Wales

Dr Tzvetanka Ivanova-Stoilova

Consultant in Anaesthesia and Pain Medicine

Professor Peter John Evans

Consultant in Endocrinology ad Diabetes

Diabetic neuropathies are the most frequent metabolic neuropathies and are one of the microvascular complications of diabetes. They present a serious clinical challenge due to the diversity of the neuropathic clusters, concomitant morbidities and the progression of the neuropathic disease. WHO Global Burden of Disease survey 2013 identified that diabetes is 7th cause of Years Lived with Disability, irrespective of the advances in management of diabetes[1].

> **"We reduced the doses of strong opioids by 40% and gabapentinoids by at least 30%**

In 2004 we founded a specialised Diabetic Polyneuropathy Pain clinic in Newport, in conjunction with the Secondary Diabetes Service and Wound Healing Institute, for patients who failed to respond to pharmacological treatment in primary and secondary care according to NICE and local guidelines[2].

As a service model we initially organised MDT clinics with Physiotherapy, Occupational Therapy and Clinical Psychology. We do the clinic once a month with 45 minutes for initial patient assessment and 30 minutes for follow-up. The aims were:

- To comprehensively assess the pain-types of patients with diabetic neuropathies and intractable pain
- To objectively measure motor function
- To follow the trajectories of symptom progression/ regression of the neuropathic disease
- To analyse treatment failures
- To provide urgent treatment for patients with acute diabetic polyneuropathy
- To provide individualised comprehensive treatment program for each patient
- To improve patients' adherence to medication and lifestyle advice by education, behavioural change and emotional support
- To improve coherence of the multidisciplinary teams and patients
- To reduce ulceration and amputation incidence of 15% in each calendar year

To assess patients we used the validated questionnaires for pain severity (Brief Pain Inventory (BPI)), neuropathic symptoms and signs (Leeds Assessment of Neuropathic Symptoms and Signs (LANSS)), and anxiety/depression (Hospital Anxiety and Depression Scale (HADS)). We did phenotyping of the neuropathic symptoms and signs: hyperalgesic type of pain which was widespread in acute polyneuropathy or localised in feet and legs; musculo-skeletal pain on walking affecting the calf muscles; hypoalgesic type with profound numbness; distorted body image of feet perceived as burning hot when they were ice cold. We diagnosed other neuropathies such as tarsal tunnel compression, truncal neuropathies, proximal amyotrophy and iliopsoas syndrome in intractable abdominal pain. We assessed signs of nerve dysfunction: sensation to cold (small fibre function, vibration and proprioception (axonal function). We mapped this on a body dermatome diagram and showed it to our patients. On follow-up appointment we documented and compared the sensory map changes. We use Timed Get-up-and-Go Test (GUGO) as objective measure of motor function and balance and we diagnosed concomitant pain conditions such as musculo-skeletal disorders, peripheral vascular disease, autoimmune disease, central post stroke pain[3].

Comprehensive treatment:
We optimised medication according to the pain phenotype. We used duloxetine for hyperalgesic nocturnal pain, reduced gabapentinoids on peripheral

Patients and families with health professionals on an annual diabetic polyneuropathy seminar

oedema, giddiness and loss of balance. We stopped quick release opioids, did an opioid rotation or used Tapentadol. We treated focal hyperaesthetic pain with intradermal botulinum toxin or 5% lidocaine plaster. We performed various interventional treatments for the secondary pain syndromes under image guidance or in ambulatory settings[4]. Patients were taught exercises for improving balance, co-ordination, ankle torque and core stability. Individual psychology was needed to help cope with advancing condition. We organise annual educational seminars for patients and teams from pain medicine, diabetes, podiatry, psychology, physiotherapy, dietetics. Patients' experiences, questions and answers and art exhibition were included[7].

Results:

- 22-40 new patients are referred annually. 402 new patients were treated with mean age 56 years (24-75), male: female ratio: 2,5:1;BMI 43 (20-60); timed GUGO test 26 sec (norm 10 sec). All patient had autonomic neuropathies; 4 of them had hypocorticism
- Musculo-skeletal secondary pain has been diagnosed in 83% of them[4]
- There was no correlation between severity of neuropathy and ambulation
- We found that large fibre dysfunction +/- hypoalgesia, clinically co-related with poor balance, reduced ankle torque and injurious falls
- Small sensory fibre dysfunction + hyperalgesia clinically co-related with severe pain requiring urgent treatment
- We treated urgently acute diabetic polyneuropathy with intravenous lidocaine infusions[5]
- We diagnosed hypogonadism in male patients on long term opioids and clinical deterioration[6]
- Our sensory mapping during initial consultation and follow-ups were tracking the changes of patient's perception of cold and vibration. Reversal of sensory losses coincided with clinical improvement
- All patients (100%) were satisfied with our seminars and will attend again, 96% indicated that they could better manage their condition. We registered 15% improvement in mobility by GUGO test
- We reduced the doses of strong opioids by 40% and gabapentinoids by at least 30% to maximum dose of 1800mg/day
- We annually discharge 11% of our patients with >50% improvement or reversal of symptoms. 9 patients died from systemic diseases
- The amputation rate fell from 15% to 2.54%

We hope our clinical expertise detailed above will be useful in setting up other UK centres.

References:

1. Rice A. et al- Global burden of disease survey 2013, Pain 2016;157:491-496

2. Ivanova-Stoilova T. Neuropathic pain , p.82-102 in White R and Harding K . Trauma and Pain in wound care, Vol 11, Mölnlycke HealthCare,2009

3. Ivanova-Stoilova T, Donne P, Jones L, Wilson E., Wartan S. Persisting pain in Patients with diabetes. new diagnostic and therapeutic approaches from our new Diabetic Polyneuropathy Pain Clinic – Poster, 12th Congress of IASP, Glasgow, 2008

4. Ivanova-Stoilova, Wartan S.- The role of local anaesthetic blocks in improving clinical outcome for patients with diabetic neuropathies and intractable pain- Poster, 12th World Congress of IASP, Glasgow, 2008

5.Ivanova-Stoilova T. Obuobie K.- Managing the complex patient with co-morbidities: Multimodal treatment of acute diabetic polyneuropathy in patient with Type I diabetes, anorexia and major depressive illness-Poster, 4th International Congress on Neuropathic Pain, Toronto, 2013

6. Ivanova-Stoilova, Evans P.- Endocrine dysfunction in male patients with painful diabetic polyneuropathy on long-term strong opioids- Pain News 2013;11,188-189

7. Ivanova-Stoilova, Jones L., King R., Hibbert-Jones E., Biswas M., Evans P, Obuobie K., Wilson E.- Multi Professional Educational Seminars as part of comprehensive management of painful diabetic neuropathies (our 13 years' experience from specialized Diabetic Polyneuropathy Pain Clinic, Newport, UK) Poster, 16th World Congress of IASP, Boston 2018.

FFPMRCA Examination Update

Dr Nick Plunkett

Chair, FFPMRCA Examinations

Dr Anthony Davies

Vice-Chair, FFPMRCA Examinations

The 14th sitting of the FPM SOE examination took place on 2nd April 2019, prior to which the Court of Examiners carried out a paper checking exercise to assess the relevance and difficulty of the questions in line with other exams and the examiners' expectations. This examination was found to be of an acceptable level of difficulty and relevance, similar overall to previous examinations. 13 candidates presented for examination, and following diligent application of rigorous standard setting methodologies, 9/13 candidates passed, giving a 69% pass rate which is in the normal range for this examination.

As part of the standard setting process, borderline regression and Hofstee calculations were plotted against the exam data after the exam. The statistical analysis was discussed by the Court of the FPM Examiners and the data obtained was used as a starting point in agreeing the pass mark. The final pass mark of 32/40 was reached through a combination of statistical analysis and expert judgment and this is in line with pass marks set for previous exams. The range of candidate scores were 24 - 40, one candidate scored 32, one candidate scored 31 and three scored 33. The performance of all borderline candidates was discussed at length by the Court of Examiners and it was agreed that their results should stand and the pass mark remain at 32. Eleven candidates were on their first attempt. Two candidates were on their second attempt and both passed at this sitting.

Examiners were audited during the exam through video observation undertaken by Dr Mike O'Connor and Dr Karen Simpson, of the audit and feedback team. Feedback on performance was given using the video footage collected. Examiner practice was found to be of a uniformly high standard, with advice gvien to further improvement.

One visitor attended on the day, Professor Connail McCrory, ex-Dean of the Faculty of Pain Medicine of the College of Anaesthetists of Ireland. Professor McCrory felt the standard was set appropriately and gave positive feedback.

In the academic year 2018-2019, two candidates met the criteria from the October 2018 and April 2019 sitting of the exam and were considered as possible prize winners. After due consideration, the Court of Examiners agreed that Dr Sangram Patil and Dr Hoi Wong both achieved the highest level of distinction. Both candidates were ranked first in their respective MCQ sittings achieving similar scores and both attained a score of 40/40 in the SOE at their first attempts. Therefore, a recommendation was made to the Board that they be awarded the FFPMRCA Prize for academic year 2018-2019. It was a distinct pleasure to commend them, and Dr Mahesh Kodivalasa (a previous winner) to Dr Barry Millller, in one of his last official roles as Dean, for the awards at the Diplomates Day held in London on 6 September at the Central Hall, Westminster. It was also wonderful to see many successful candidates from the previous FPM examinations receive their certificates, to the applause and support of all diplomates and dignitaries, and most especially family members to whom, it is acknowledged, so much is owed.

As ever, we would like to thank Graham Clissett and the examinations team for a polished and professional examination. We would like to take this opportunity to especially wish a fond farewell to Graham, who has been a constant support to us all in our roles as examiners since the very first foundation of the Court to construct a high quality, valid and reliable examination from scratch. The fact that the examination has been an undoubted success in achieving its aims is due in no small measure to the advice and guidance from Graham over the years. In recognition of Graham's pivotal

role within the RCoA family, Graham was awarded the President's Commendation at the Diplomates Day. For now, Graham, a keen horticulturist, is moving on to (quite literally) pastures new!

We would also like to welcome Fiona Daniels, RCoA Head of Examinations, who in her role replacing Graham, comes with huge and relevant expertise in high stakes assessments and with whom we look forward to a continuing, close and fruitful relationship.

Finally, friend and colleague Dr Manohar Sharma has taken the decision to demit his role as examiner, to focus on the numerous other roles within Pain Medicine, which benefit from his efforts. A foundation examiner from the outset, Manohar has given great service as an examiner, question writer, and Court member with contributions both honest and wise.

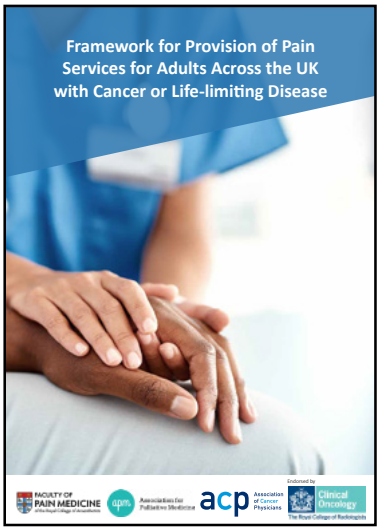
FFPMRCA Examination Calendar February - October 2020

	FFPMRCA MCQ		FFPMRCA SOE	
Applications and fees **not** accepted before	Mon 28 Oct 2019	Mon 15 June 2020	Mon 3 Feb 2020	Mon 10 Aug 2020
Closing date for FFPMRCA Exam applications	Thurs 12 Dec 2019	Tues 21 July 2020	Thurs 5 Mar 2020	Tues 15 Sept 2020
Examination Date	**Thurs 6 Feb 2020**	**Wed 26 Aug 2020**	**Tues 31 Mar 2020**	**Tues 13 Oct 2020**
Examination Fees	£530	£tbc	£740	£tbc

New Faculty website

Work has been underway to develop new College and Faculty websites.

The new websites are launching in November and an announcement will be made when they are live.



The Faculty, along with the Association for Palliative Medicine, Association of Cancer Physicians and the Royal College of Radiologists (Faculty of Clinical Oncology), has written a framework for pain service provisions for adults in the UK who have cancer or life-limiting diseases.

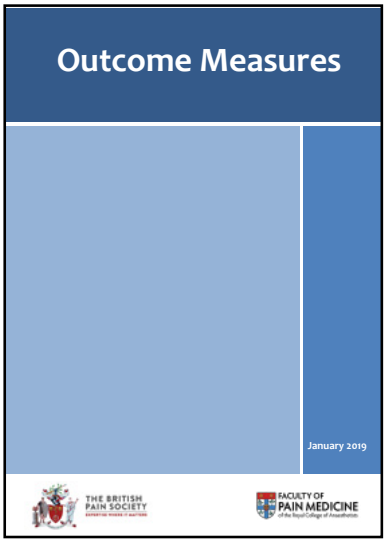
The guidance aims to improve pain services for adults across the UK with cancer or life-limiting disease with closer integration of pain management, oncology and palliative care services.

The full guidance is available at: https://www.rcoa.ac.uk/system/files/FPM-Framework-pain-services-cancer-and-life-limiting-disease-2019_1.pdf

The Faculty of Pain Medicine has produced a guidance document on standards for Revalidation of specialists in pain medicine.

This document should be read in conjunction with relevant GMC Guidance.

The full guidance is available at: https://www.rcoa.ac.uk/system/files/FPM-Good-Pain-Specialist-2014-v2.pdf



The Faculty and the British Pain Society (BPS) have jointly developed a practical guidance document of outcome scales which are appropriate to pain management.

These measures will improve patient care and allow benchmarking against other services and against targets, helping to bring uniformity locally and nationally.

Each scale is presented with a brief description, the advantages and disadvantages, information on use and copyright.

The full guidance is available at: https://www.rcoa.ac.uk/system/files/FPM-outcome-measures-2019.pdf

Events Update

Dr Shyam Balasubramanian

Educational Meetings Advisor

Dr Manohar Sharma

Deputy Educational Meetings Advisor

An investment in knowledge pays the best interest. Our Faculty helps pain clinicians maintain competence and learn about new and developing areas in the field of pain medicine. Apart from guidelines, publications and online resources, the Faculty runs live educational events at the RCoA that cover different aspects of clinical practice. The study days in February are mostly dedicated to acute pain; the June event is run in the format of an interactive skills workshop and the objective of the winter annual meeting is to update on the developments in basic science and clinical medicine.

From January 2020 onwards, Dr Manohar Sharma will be the lead Education Meetings Advisor and Dr Devjit Srivastava, with a special interest in acute pain, has been appointed as Deputy Education Meetings Advisor.

Based on the feedback from the previous events, we have developed an informative programme for the forthcoming 12th Annual Meeting, which will take place on Friday 29th November 2019. The Patrick Wall Lecture 'The curate's egg of Evidence Based Medicine: an appraisal', will be delivered by Dr Andrew Moore. Other topics include CRPS and amputation, opioid and gabapentinoid co-prescribing for chronic pain, analgesic use for pain in pregnancy, acute pain services, future direction and value, and a debate on whether cannabinoids should now be prescribed for chronic pain. Bookings are now open and further detail is available on the website.

Clinicians involved with perioperative medicine will agree that the complexity of managing acute pain in the in-patient setting is increasing because of a combination of patient, surgical and medication factors. The February 2020 study days are aimed at acute pain enthusiasts involved in managing challenging in-patient pain conditions. Details of the programmes follow on pages 22-23 and are available on the website. Please share the details of the event with the members of your hospital acute pain team!

Although there are advances in the technology, a big proportion of pain practice relies on eliciting focused history and meticulous examination skills. In June this year, following requests from our members, we ran the musculoskeletal examination skills workshop. Dr Meera Tewani and her team organised stations for examining the spine as well as upper and lower limbs. Speakers included experts from other disciplines such as orthopaedics, rheumatology and sports medicine. Delegates were divided to small groups and each session comprised of a brief presentation followed by demonstration of the examination on a volunteer. As in the past, the event attracted excellent feedback.

The Faculty educational events form a platform for networking and exchanging ideas. The event organisers listen to the feedback from our members and constantly change the content and delivery style to enhance the learning experience. We urge the fellows with novel ideas to come forward and contribute to our courses.

Our Faculty needs you!

FACULTY OF PAIN MEDICINE
of the Royal College of Anaesthetists

www.fpm.ac.uk
email: contact@fpm.ac.uk
@FacultyPainMed
tel: 020 7092 1747

Faculty of Pain Medicine Study Days: Acute/In-hospital Pain Management - Hot Topics and Updates. Day 1

Programme

09.00 - 09.20 Registration and welcome

9.20 - 11.20 Basic Science

Have the genetics of Painless Jo opened up a novel analgesic discovery pathway?
Dr Devjit Srivastava, Deputy Educational Meetings Advisor, FPM

Neuropathic pain - science, diagnosis and management
Dr Harriet Kemp, NIHR Clinical Lecturer & Advanced Pain Trainee, London

Opioid tolerance and OIH - science, diagnosis and management
Prof Lesley Colvin, Professor in Pain Medicine, Dundee

11.20 - 11.40 Refreshments

11.40 - 13.10 Clinical Practice

Lidocaine infusions - how to run them safely in hospital
Prof Andrew Smith, Director of Lancaster Patient Safety Research Unit

Perioperative care of CRPS patients
Dr Emma Baird, Consultant Anaesthetist, Preston

13.00 - 14.00 Lunch

14.00 - 16.30 Quality Improvement/Training/Education

Patient perspective - how getting off opioids changed my life
Ms Louise Reid, Acute Pain Nurse Specialist; and Justine, Inverness

De-escalating opioids - some practical tips
Dr Sailesh Mishra, Consultant in Pain Management & Anaesthesia, Newcastle

Chronic pain and inpatient pain services - preliminary findings of the CHIP national audit
Dr Mark Rockett, Consultant in Anaesthetisa & Pain Management, Plymouth

Top 10 pain CPD/research articles of 2019
Ms Felicia Cox, Lead Nurse Specialist, London

16.30 Close of meeting

Date and Location

Monday 3rd February 2020
9.00 - 16.30
RCoA, 35 Red Lion Square, London
WC1R 4SG

5 CPD points/ 10 CPD points for both days

This day is aimed at all those working within Services that involve Acute Pain Management. An informative day of updates, it is also an opportunity for networking.

Fees and Registrations

Consultants/SAS doctors: £180
Trainees/Nurses: £144
Book along with the 4th February for a reduced rate of: £335/£260

Register online:
https://www.eventsforce.net/rcoa/82/register

Programme organised by Dr Devjit Srivastava and Dr Manohar Sharma

Please note that the programme and timings are subject to change.

FACULTY OF PAIN MEDICINE
of the Royal College of Anaesthetists

www.fpm.ac.uk
email: contact@fpm.ac.uk
@FacultyPainMed
tel: 020 7092 1747

Programme

09.00 - 09.20 Registration and welcome

9.20 - 10.50 Clinical Practice

Managing pain after emergency laparotomy in a post epidural world
Dr Benjamin Fox, Consultant Anaesthetist, Norfolk

Chronic post surgical pain - what can we do about it?
Dr Sibtain Anwar, Consultant in Anaesthesia, Pain Medicine and ICM, London

10.50 - 11.20 Refreshments

11.20 - 13.00 NHS/Legal Issues

Consent for regional anaesthesia and pain procedures
Ms Norma Shippin, Director of CLO and Legal Advisor, Scottish Government

Learning from medication errors - lessons for acute pain mangement
Dr Rinesh Parmar, Vice-Chair and Treasurer, Doctors Association UK (DAUK)

13.00 - 14.00 Lunch

14.00 - 16.00 Research/Acute Pain in Special Circumstances

The POEM Study - National audit of A&E pain management
Dr James Sheehan, Specialty Registrar in Anaesthetics and ICM, Cambridge

Current role of gabapentinoids in acute pain
Prof Roger Knaggs, Chair of UK Clinical Pharmacy Assocation pain management group, Nottingham

Pain assessment in the sedated and mechanically ventilated ICU patient - a quality improvement approach
Ms Mairi Mascarenhas, Clinical Educator, Inverness

16.00- 16.15 Feedback and Close of meeting

Please note that the programme and timings are subject to change.

Date and Location

Tuesday 4th February 2020
9.00 - 16.30
RCoA, 35 Red Lion Square, London
WC1R 4SG

5 CPD points/ 10 CPD points for both days

This day is aimed at all those working within Services that involve Acute Pain Management. An informative day of updates, it is also an opportunity for networking.

Fees and Registrations

Consultants/SAS doctors: £180
Trainees/Nurses: £144
Book along with the 3rd February for a reduced rate of: £335/£260

Register online at:
https://www.eventsforce.net/rcoa/82/register

Programme organised by Dr Devjit Srivastava and Dr Manohar Sharma

e-PAIN

e-Learning for Pain Management

e-PAIN is free for all NHS staff, OpenAthens account holders and students

For more information and to register for free access, please visit www.e-pain.org.uk

FACULTY OF PAIN MEDICINE of the Royal College of Anaesthetists

e-LfH e-Learning for Healthcare

NHS Health Education England

THE BRITISH PAIN SOCIETY EXPERTISE WHERE IT MATTERS

Public Health England

FACULTY OF PAIN MEDICINE of the Royal College of Anaesthetists

PAIN IN SECURE ENVIRONMENTS

A training day on Pain Management designed to educate professionals working in secure environments

Friday 1 May 2020 Royal College of Anaesthetists, Holborn, London

Delegate Fee: £255

For further details and to register, please visit www.fpm.ac.uk
or email contact@fpm.ac.uk

British Pain Society Calendar of Events

Understanding Pain in a Complex World
12th November 2019
Churchill House, London, WC1R 4SG

We are delighted to be sharing the interests of our Philosophy & Ethics Special Interest Group with a wider audience through our first Philosophy & Ethics themed Study Day on the topic of 'Understanding Pain in a Complex World'.

Discussions will include topics such as; Pain after surgery- the role of developmental trauma, Complex pain- a philosophical challenge and Integrating the art of healing with the science of curing.

For booking and to view the full programme please visit**:**
https://www.britishpainsociety.org/mediacentre/events/understanding-pain-in-a-complex-world-12th-november-2019/

53rd Annual Scientific Meeting
31st March – 2nd April 2020
London (Venue TBC)

Put the dates in your diary now for the 53rd Annual Scientific Meeting of the BPS.
We are putting together an exciting and stimulating programme and will be announcing plenary speakers 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

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

Faculty Update

New Fellows by Examination and Assessment

Siti Nurul Farrah Ayob
Imran Azher
Sudhindra Dharmavaram
Alexander John Doyle
Robert Lyons
Craig Daniel Montgomery
Nathan Desmond Joseph Oliver
Mohamed Sobhi Ahmed Abdelmeged Rabie
Hoi Wang ivan Wong
Madan Thirugnanam

New Affilate Fellows

Andrea Vroemen-Cermakova
Sujesh Bansal
Sibtain Anwar
Webster Rushesha
Christos Angelis
Velliyottilim Parameswaran
Ricky Nagpaul
Catherine Hill

2019-2020 Faculty Calendar

EVENT: LPMES day	28 November 2019
EVENT: 12th Annual Meeting: Topical Issues in Pain	29 November 2019
MEETING: FPM Professional Standards Committee	5 December 2019
MEETING: Board of the FPM	6 December 2019
MEETING: FPM Training and Assessment Committee	24 January 2020
EVENT: Acute Pain Study days	3- 4 February 2020
MEETING: FPM Professional Standards Committee	27 February 2020
MEETING: Board of the FPM	6 March 2020
MEETING: FPM Training and Assessment Committee	24 April 2020
EVENT: Pain in Secure Environments	1 May 2020
MEETING: FPM Professional Standards Committee	14 May 2020
EVENT: Multi-disciplinary Study Day	10 June 2020

Please note that all dates may be subject to change

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