FACULTY OF PAIN MEDICINE
of the Royal College of Anaesthetists

Newsletter of the Faculty of Pain Medicine

SPRING 2013

TRANSMITTER

Shape of Training

Local Commissioning of Specialist Services for Pain

Neuropathic Pain in Patients with Cancer

Pain in Wales

FACULTY OF PAIN MEDICINE

of the Royal College of Anaesthetists

Welcome to the Spring edition of *Transmitter,* although as I write we are deep in the unseasonal snow and struggling to believe in Spring!

This edition reflects the increasing political activity of the Faculty over recent months; changing times have called for responses and statements of the future of Pain Medicine across its various aspects, from commissioning to training, and we have articles summarising our positions and advice in these regards. Thanks go to Dr Beverly Collett for her guiding and inspiring article on aspects of local commissioning of specialist services.

We have the regular updates from the Committees of the Faculty and the representatives of our Trainees, Dr Emma Sherrif and of the Regional Advisors in Pain Medicine, Dr Barry Miller. From Dr Ian Goodall, we also have an update on the e-Learning project, an initiative of the British Pain Society and the Faculty.

We are delighted to hear from Dr Sanjeeva Gupta of the substantial recent activity and successes of the meeting and events group.

Our 'spotlight' article, which gives a superb and enlightening overview of neuropathic pain in cancer sufferers, has been generously contributed by guest authors, Professor Michael Bennett and Dr Matthew Mulvey.

We welcome the detail and clear information in Dr Stephen Ward's article on the National Pain Audit and enjoy the delightful, thought provoking journey through Welsh Pain Medicine brought to us by Dr Sharmila Khot.

As ever, we acknowledge the keen interest and enthusiasm of our readers and would welcome any ideas for, or contributions to *Transmitter*. Happy reading!

DEAN
Professor Dave Rowbotham

VICE-DEAN
Dr Mark Taylor

CLINICAL EDITOR
Dr Kate Grady

MANAGING EDITOR
Mr Daniel Waeland

Sub-Edited by **James Goodwin**

Administered by **Anna Ripley**

© Design and layout by the Faculty of Pain Medicine

Available online at www.fpm.ac.uk

CONTENTS

3 **Shape of Training**
Dr Kate Grady

4 **Message from the Dean**
Prof David Rowbotham

5 **Training and Assessment**
Dr Kate Grady

6 **Professional Standards**
Dr Karen H Simpson

7 - 9 ***Spotlight:* Neuropathic Pain in Patients with Cancer**
Prof M Bennett and Dr M Mulvey

10 **Pain in Wales**
Dr Sharmila Khot

11 **Regional Update**
Dr Barry MIller

11 **FFPMRCA Examination Update**

12 **Trainee Update**
Dr Emma Baird

13 **FPM Trainee Publication Prize**

13 - 16 **Local Commissioning of Specialist Services for Pain**
Dr Beverly Collett

17 **Events**
Dr Sanjeeva Gupta

18 **e-Learning for Pain**
Dr Ian Goodall

19 - 20 **National Pain Audit**
Dr Stephen Ward

20 **New Board Members**

21 **Faculty Updates**

THE FACULTY OF PAIN MEDICINE
of the Royal College of Anaesthetists
Churchill House
35 Red Lion Square
London WC1R 4SG

Registered Charity No 1013887
Registered Charity in Scotland No SC037737
VAT Registration No GB 927 2364 18

Dr Kate Grady

FPMTAC Chair

The Faculty responded to a call for suggestions and evidence for the Shape of Training Review which was set up to consider the future of postgraduate education and training in the UK. It is jointly sponsored by NHS Scotland, NHS Wales, Northern Ireland Department of Health, Social Services and Public Safety, the Academy, the GMC, the Medical Schools Council, CoPMED and HEE. The Faculty responded independently of the Royal College of Anaesthetists. Please find a summary of key points from our response as below:

The FPM has the credentials to give a lead opinion on the Shape of Training in Pain Medicine and on the needs for training in pain management in the non-specialist population of doctors working in primary and community care. Pain Medicine, although a specialist area of anaesthetics, is quite distinct from anaesthetics in its content and through respective patterns of work. Although Pain Medicine training is common to and compulsory for all anaesthetists at Basic and Intermediate level of postgraduate training, specialist training which takes place at Higher and Advanced level is quite distinct and demanding.

In response to how healthcare delivery might change over the next 30 years...

Studies show that more specialist involvement in community care results in better patient outcomes. From the Pain Medicine perspective, it is accepted that more straightforward, simple, every day pain problems can be adequately assessed and managed by non-specialists in primary and community care. Specialist Pain Medicine however is required for patients who have pain which is anything more complex. Those doctors who have successfully completed Pain Medicine training up to and including the Advanced level, as part of their CCT in Anaesthetics, are recognised specialists in Pain Medicine. Skilled pain management requires the input of those qualified in Pain Medicine. Pain management in primary care and the community will need input from qualified specialists in Pain Medicine and Pain Medicine specialists are the obvious leaders of multidisciplinary teams.

The Pain Medicine specialist will continue to deliver enhanced pain management (beyond non-specialist management) to include assessment of complex cases, comprehensive understanding of physiological and pharmacological processes, identification of psychological drivers and the provision of highly skilled interventions for long term or terminal pain problems. Complex pain problems, demanding the skills of the specialist are more common in the elderly and those with chronic disease, both growing populations of patients.

In response to how doctors' training should change in order to meet their patients' needs over the next 30 years...

It is the opinion of the FPM that time in training in specialist postgraduate Pain Medicine, whilst currently of the highest quality, should be extended, broader and adapted to the needs and challenges facing healthcare. It is suggested that the duration of Advanced Pain Medicine training be increased to 2 years. The current length of Pain Medicine training is short compared to other international training programmes.

Increased time in training could be balanced with a service component. Service, given appropriate supervision, feedback and reflection could be of value to both trainee and employer. The Faculty also recognises the value of exposure to other specialties during specialty training. Prolonged training would allow the single level consultant model to be preserved.

As Pain Medicine moves more into the community, training for specialists must include exposure to primary and interface care clinics. The perceived role of the Pain Medicine specialist as team leaders and educators of the non-specialists in primary care and the community, would support the need for more training in teaching and management during the years of specialist Pain Medicine training.

In response to 'What is good in the current system and should not be lost in any changes?'...

The Faculty has had success with positively influencing Pain Medicine training since its inception. There have been evolutionary (curriculum, assessment, minimal standards, portfolio) and revolutionary (examination) mechanisms, and with continued evolution, the standards set and achieved will grow.

Random thoughts of an outgoing Dean

Professor David Rowbotham

Dean

This is the last opportunity I have to contribute to *Transmitter* as Dean of the FPM; a new Dean will be elected in May and take up office in September. Perhaps, it is a good opportunity to reflect briefly on the past three years and look forward to the future.

Much of our attention during my period as Dean has been focused on the development of the FPM Fellowship examination. Introducing a new examination from scratch that complies with modern standards is no mean feat. The team of examiners, led by Kate Grady, has done a magnificent job in delivering this project. Feedback from independent assessors (as well as the candidates!) has been very favourable. We are grateful for the support and advice given by the College's examination department without which it would not have been possible.

> **“Our new Dean will face many challenges, perhaps the most important of which is working with partners to ensure the emergence of safe and effective pain services from the turmoil of the NHS reorganisation”**

Partnerships are important in pain management. We have forged a very close relationship with the BPS and other organisations and this has resulted in several notable achievements. Perhaps the highlight of our joint working was the announcement in the House of Commons that the Department of Health now considers chronic pain as a condition in its own right. Also, we have made great progress in shaping the commissioning of pain services in the new NHS structure. Led by Andrew Baranowski, we have fundamentally influenced service specifications for supra-regional pain centres and are now engaged with the Department of Health in establishing service specifications for locally commissioned specialist pain services. Only a year ago, this seemed an unlikely outcome and I believe that, as long as we continue to work with our partners, we will be able to ensure that pain services will continue to be of the highest standards ensuring safety, cost effectiveness and quality.

The Professional Standards Committee, led by Karen Simpson, has also addressed many issues of importance to our speciality. We receive a constant influx of consultation exercises that need our input, often with very tight deadlines. We have had a significant influence in many of them; I was particularly pleased that, after a period of consultation, NICE announced that they intend to revise their back pain guidelines. Our education programme has been extremely successful and for this we thank Sanjeeva Gupta and his colleagues. The feedback from attendees has been excellent and we are now established as an important source of CME for pain management specialists.

We are witnessing the birth of a new generation of pain specialists in this country. Those who choose specialist Pain Medicine as a career now commit themselves not only to Advanced pain training as part of their CCT but also to an intensive period of study and examination in order to become a Fellow of our Faculty – all this after they have passed the FRCA examination. Only those who are truly committed to Pain Medicine will do this. These new consultants will further improve patient care and enhance our reputation with other specialities, commissioners and the Department of Health.

Our new Dean will face many challenges, perhaps the most important of which is working with partners to ensure the emergence of safe and effective pain services from the turmoil of the NHS reorganisation. In this and other tasks, the Dean and Board will be supported by the Faculty administrative team led by Daniel Waeland. It is impossible to overstate their contribution to the efficient working of the Faculty and we are truly fortunate to have the benefit of their expertise and dedication.

Training and Assessment

Dr Kate Grady

FPMTAC Chair

The Training and Assessment Committee (FPMTAC) has a regular and continuous workload. This article takes an overview of the whole 4 years' activity of the Training and Assessment Committee, this time from the perspective of some of its members.

Dr Mark Taylor, Vice Dean of the Faculty, has had a major role in the design and application of the 2010 curriculum and has a clear overview of its place and its links to other aspects of training. "This curriculum differed conceptually from the previous 2007 curriculum, as it was competency-based with spiral learning. There is a progression of knowledge and skills from Basic to Advanced Pain Training leading to 'mastery,' and each part of the curriculum is linked. This means Higher Pain Training must be completed before starting Advanced, and the 2010 Advanced pain curriculum may appear more conceptual in content than the previous curriculum".

With the start of the FFPMRCA examination trainees and trainers have asked for more detailed information. Dr Roger Okell, member of the Committee and Regional Advisor in Pain Medicine (RAPM) for Mersey has written a supplementary guidance document which describes in more detail the knowledge and skills that must be acquired during Advanced Pain Training.

Dr Roger Okell also represents the FPMTAC on the RCoA Training Committee, which now incorporates the work of the Quality Management of Training Committee. He writes "I negotiate the changes to the CCT curriculum that the FPM considers necessary as Pain Medicine training evolves. I report back to the Faculty on new issues that will affect the delivery of Pain Medicine training, e.g. directives from the GMC. In addition, I have written guidelines for the Faculty on accommodating doctors with disabilities into Pain Medicine training."

Dr Barry Miller is the RAPM for the North West region and Lead RAPM. He wears a number of other hats on behalf of the Committee including Faculty Representative on the RCoA ePortfolio Group and its Workforce Planning Strategy Group.

A new Assessment Working Group which looks to clarify and unify the various strands relating to training and Faculty Fellowship, is led by Dr Miller. The issues identified at their initial meeting in January were: the harmonisation of Higher and Advanced training guidance as discussed above; a review of the WPBA in regards to guidance and their effective use; re-writing the FPM website training pages which currently need updating; the creation of a survey of Pain Medicine training opportunities to include post-CCT fellowships and to post these on the website; a review of the logbook data and a review of the Fellowship application paperwork. Dr Miller has developed the new Case Report scoring system and the external marking scheme and co-developed the logbook for use by trainees in Pain Medicine and Anaesthesia.

Dr Nick Plunkett oversees Out of Programme applications and is also Deputy Chair of the Court of Examiners. "The Faculty, through the FPMTAC, approves Out of Programme training/ experience/research (OOPT/E/R) applications in Pain Medicine. The definitions, and guidance for application, are on the website. It is important that they are discussed with the local Deanery, and RAPM, in good time to process the application. As most regions offer Advanced Pain Training, and this fulfils most trainees' aspirations, numbers are small-in the last 3 years; there have been none for OOPE, one for OOPR, and several a year for OOPT - mostly for training abroad. All have been approved. From 2012, application numbers are down - possible reasons include inter-deanery secondments, and reduced APT applications".

"It is important that OOPT is discussed with the local Deanery and RAPM in good time to process the application"

Professional Standards

Dr Karen Simpson

FPMPSC Chair

The New Year has brought changes in membership and organisation for the PSC, to facilitate future developments and deal with the volume of work that faces us in the coming few years. Doug Justins and Roger Laishley have now demitted; our thanks to them both for all of their hard work. Membership of the PSC is time consuming and we have reviewed our roles and invited some new members to share the load.

As well as Board members we have constituted the committee to include non-Board members to allow us to benefit from the wealth of talent amongst our Fellows. I am pleased to announce that Dr Weiss, Dr Wilkinson, Dr Davies, Dr Searle and Dr Balasubramanian will be joining us. Dr Searle has agreed to take on the role of representing the BFPM at the RCoA Revalidation Committee to support Kate Grady and me as Pain Medicine Revalidation Advisors for the RCoA. Dr Balasubramanian will join the Committee and, as a CEACCP editor, he brings special expertise to support Sanjeeva Gupta and Dr Kothari in their roles as Educational Meetings Advisor and Deputy Advisor respectively for the FPM. The PSC meetings will now all be in person rather than by teleconferencing although some members will be corresponding to limit the need for them to travel.

The Communications Working Party under the leadership of Beverly Collett is functioning well and will ultimately be integrated back into the PSC this year once its strategy is in place. At present there are plans to produce FPM patient information; one of the initial projects will be to support patients' use of medication. This will be done by a small working party with input from lay members and patient representatives and will be the first of many future such projects.

The January FPM meeting on 'Core Competencies in Mental Health for Pain Professionals' was excellent and well received. It was an important meeting that allowed collaboration with the Royal College of Psychiatrists. The January 'Updates in Pain Medicine' meeting was a great success. It goes without saying that Sanjeeva will no doubt provide an equally excellent line up in the planned meeting on opioids later in the year that will include topical issues such as managing those with pain and substance misuse. I thoroughly recommend early booking.

The PSC is asked to respond in detail to ever more consultations; Dr Collett coordinated the FPM response regarding service specifications and clinical policies. This is a particularly important area given national concerns about interfaces between primary, secondary and tertiary pain services.

A particularly challenging area is the situation with regard to the NSPA recommendations on the use of spinal needles. Rest assured that the PSC and the Board have been monitoring the situation and are collaborating with the British Pain Society and the Association of Anaesthetists in responding to this situation. We need to make sure that Pain Medicine specialists' opinions are heard and that the most safe and sensible outcome is ensured for our patients.

2013 Faculty Calendar

Item	Date
MEETING: FPM Training & Assessment Cmte	26 April
MEETING: Board of the FPM	16 May
MEETING: FPM Professional Standards Cmte	17 May
EVENT: FPM Opioids Study Day	**3 June**
EVENT: FFPMRCA Exam Tutorial	**7 June**
MEETING: FPM Training & Assessment Cmte	17 July
MEETING: Board of the FPM	12 Sept
MEETING: FPM Professional Standards Cmte	13 Sept
MEETING: FPM Training & Assessment Cmte	18 Oct

Please note that all dates may be subject to change.

Neuropathic pain in patients with cancer

Professor Michael Bennett
St. Gemma's Professor of Palliative Medicine
Leeds Institute of Health Sciences

Dr Matthew Mulvey
Research Fellow in Palliative Care
Leeds Institute of Health Sciences

Epidemiology of neuropathic pain in cancer

According to Cancer Research UK, more than 300,000 people were diagnosed with cancer in the UK in 2010.[1] Around 50% of these patients will have pain at diagnosis, while up to 75% will experience pain if their cancer becomes advanced and progressive.[2] The pains experienced by cancer patients are heterogeneous and vary depending on pathophysiology and duration of disease, though higher pain intensity is associated with the presence of either breakthrough pain or neuropathic pain.[3] Sadly under-treatment of cancer pain is common.[4]

A recent systematic review of the prevalence and aetiology of neuropathic pain in cancer patients, found that 20% of pains reported by cancer patients are of neuropathic origin.[5] However if the definition of neuropathic pain is widened to include patients with mixed neuropathic-nociceptive pain approximately 40% of cancer patients are affected by neuropathic pain.[5] The aetiology of neuropathic pain in cancer patients is complex, but is conventionally categorised as disease-related, treatment-related, or comorbid.[6] About two-thirds of pains in cancer patients are disease-related (neuropathic cancer pain) but cancer treatments (surgery or chemotherapy in particular) account for about 20% of neuropathic pains, and co-morbid diseases are responsible for a further 10-15%.[5]

Neuropathic pain in cancer patients is associated with increased oncological treatment, greater analgesic requirement (especially strong opioids and adjuvant analgesia), poorer physical, cognitive and social functioning and greater impact on daily living, compared to patients with non-neuropathic cancer pain.[7] Poorer health outcomes and greater disability are also found in non-cancer populations with neuropathic pain suggesting that there is something inherent in this pain mechanism that confers a disadvantage regardless of aetiology.[8] Therefore the effective assessment and diagnosis of neuropathic pain in cancer patients is crucial before improvements in treatment can occur.

Assessment of neuropathic pain in cancer patients

Neuropathic pain is not a single disease but represents a syndrome, which can be thought of as a collection of specific signs and symptoms with multiple underlying aetiologies even in cancer patients. This is further complicated because these signs and symptoms frequently exist as a spectrum and so the clinical question is not 'does my patient have neuropathic pain or not?' but rather 'is this pain of predominantly neuropathic origin?'[9] Therefore, careful assessment is essential to reach a diagnosis.

Despite the existence of a definition for neuropathic pain since 1994,10 there has been no agreement on diagnostic criteria until very recently. Treede et al.[11] revised the definition of neuropathic pain to "pain caused by a lesion or disease of the somatosensory nervous system" and proposed four specific criteria for grading the probability of a diagnosis of neuropathic pain intended to be used for both clinical and research propose. These criteria are:

- **Criterion 1:** the presentation of pain in a neuroanatomically plausible distribution.
- **Criterion 2:** a history of a relevant lesion or disease given the pain distribution.
- **Criterion 3:** confirmatory tests demonstrating presence of negative (hypoesthesia, hypoalgesia) and positive (hyperalgesia, allodynia) sensory

signs confined to innervation territory of the lesioned nervous structure.

- **Criterion 4:** further diagnostic tests confirming lesion or disease entity underlying the neuropathic pain.

Criteria 1 and 2 must be met to instigate a working hypothesis of 'possible' neuropathic pain. Subsequently, criteria 3 or 4 must be met in addition to reach the grade of 'probable' neuropathic pain. Finally, if both criteria 3 and 4 are adequately satisfied the grade of 'definite' neuropathic pain is achieved. Figure 1 illustrates the diagnostic algorithm for neuropathic pain (adapted from Treede et al. 2008).[11]

The neuropathic pain grading system proposed by Treede et al.[11] has been adopted by the European Federation of Neurological Societies (EFNS) and supported by the Neuropathic Pain Special Interest Group (NeuPSIG) of IASP in their recently revised guidelines on assessment of neuropathic pain.[12] According to the IASP guidelines on neuropathic pain assessment,[13] evaluation of somatosensory function should include measurement of touch/vibration, cold, warmth and pain sensibility. Simple, everyday equipment can be used to assess both different types of sensory nerve fibres and their respective central (spinal cord / brain stem) projections to the brain (Table 1).[14] However, while history and bedside examination remain the key assessment criteria, there is no guidance on implementation of the grading system proposed by Treede et al.[11] Specifically, there is lack of guidance on which or how many sensory abnormalities are needed to confirm neuropathic pain (criterion 3). This may account for the poor uptake of the grading system in clinical practice and clinical trials.

In two recent papers that examined the quality of neuropathic pain assessment in cancer patients, a reliable diagnosis of at least probable neuropathic pain was reached in only 8 of 22 prevalence studies and 7 of 9 randomised controlled trials of analgesics reporting on a combined 13,950 patients.[5, 15] In summary then, only 15 of 31 studies of neuropathic pain in cancer patients used a reliable assessment process. There is a clear need for a step-by-step description of the bedside assessment of sensory signs necessary to confirm altered function of the somatosensory nervous system.

Specifically, to standardise the assessment and diagnosis of positive and negative sensory phenomena in cancer patients, several research questions remain:

1. What sensory abnormalities are likely to be present in cancer patients with neuropathic pain and should therefore be examined?
2. How many positive or negative tests are required to adequately demonstrate criterion 3 of the grading system?
3. Is there a role for verbal description or screening tools in the assessment process?
4. Which test or combination of tests are the most efficient for demonstrating sensory abnormalities in (i) clinical practice, and (ii) clinical research?

Geber et al.[16] have recognised that "it might be valuable for future refinements of the grading system to consider combining the number of positive confirmatory tests into a score". The development of a more quantitative scoring system of neuropathic pain signs and symptoms is not a new one. For example the LANSS pain scale and the DN4 questionnaire both include an assessment of verbal description and simple bedside examination.[17, 18] Further work is now needed to reach an international consensus on a standardised assessment process for neuropathic pain in cancer patients. This is likely to improve the recognition and treatment of neuropathic pain in clinical practice but also to ensure more reliable assessment of patients in clinical research and reduce heterogeneity.

Figure 1 *Flow diagram of diagnostic algorithm for neuropathic pain.*

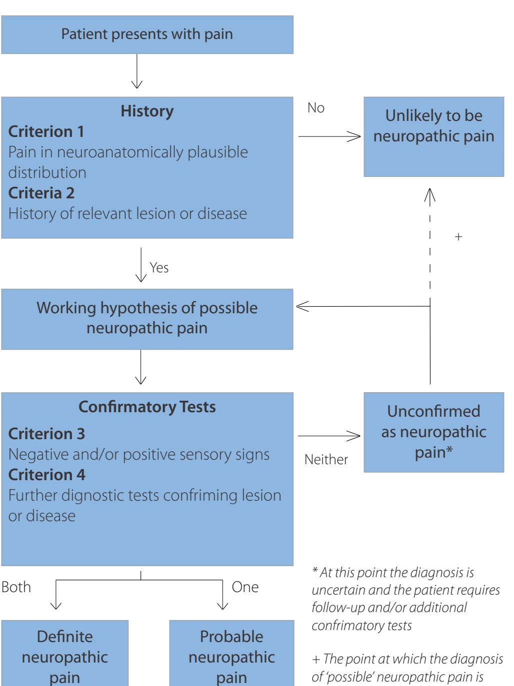


Table 1 *Neuropathic cancer pain*

Putative neuropathic mechanism	Somatosensory findings	Objective clinical evaluation	Experimental evaluation	Sensory sign
Deafferentation	Decreased sensitivity to....	Soft brush	Standardised soft brush	Hypoesthesia
		64Hz tuning fork	64Hz tuning fork	Hypoesthesia
		Toothpick	Weighted punctate needle	Hypoalgesia
		Painfully cold & hot thermo-roller/test-tubes	Peltier thermal sensory stimulator	Hypoalgesia
Central sensitisation	Increased sensitivity to...	Soft brush	Standardised soft brush	Allodynia
		Toothpick	Weighted punctate needle	Hyperalgesia
		Painfully cold thermo-roller/ test-tubes	Peltier thermal sensory stimulator	Hyperalgesia
Peripheral sensitisation	Increased sensitivity to...	Painfully hot thermo-roller/ test-tubes	Peltier thermal sensory stimulator	Hyperalgesia
		Blunt deep pressure (examiner thumb)	Algometer	Hyperalgesia

To confirm the presence of abnormal somatosensory processing, two or more evaluative tests from a mechanistic domain must demonstrate positive or negative sensory signs.

References

1. UK CR. Cancer incidence for all cancers combined. 2012 [cited 2013 25 January 2013]; Available from: http://www.cancerresearchuk.org/cancer-info/cancerstats/incidence/all-cancers-combined/.
2. van den Beuken-van Everdingen MH, de Rijke JM, Kessels AG, Schouten HC, van Kleef M, Patijn J. Prevalence of pain in patients with cancer: a systematic review of the past 40 years. Ann Oncol. [Meta-AnalysisReview]. 2007 Sep;18(9):1437-49.
3. Caraceni A, Portenoy RK. An international survey of cancer pain characteristics and syndromes. IASP Task Force on Cancer Pain. International Association for the Study of Pain. Pain. [Multicenter StudyResearch Support, Non-U.S. Gov't]. 1999 Sep;82(3):263-74.
4. Deandrea S, Montanari M, Moja L, Apolone G. Prevalence of undertreatment in cancer pain. A review of published literature. Ann Oncol2008 Dec;19(12):1985-91.
5. Bennett MI, Rayment C, Hjermstad M, Aass N, Caraceni A, Kaasa S. Prevalence and aetiology of neuropathic pain in cancer patients: a systematic review. Pain2012;153(2):359-65.
6. Piano V, Verhagen S, Schalkwijk A, Burgers J, Kress H, Treede RD, et al. Diagnosing Neuropathic Pain in Patients with Cancer: Comparative Analysis of Recommendations in National Guidelines from European Countries. Pain Pract2012 Dec 19.
7. Rayment C, Hjermstad MJ, Aass N, Kaasa S, Caraceni A, Strasser F, et al. Neuropathic cancer pain: Prevalence, severity, analgesics and impact from the European Palliative Care Research Collaborative-Computerised Symptom Assessment study. Palliat Med2012 Nov 21.
8. Smith BH, Torrance N, Bennett MI, Lee AJ. Health and quality of life associated with chronic pain of predominantly neuropathic origin in the community. Clinical Journal of Pain2007;23(2):143-9.
9. Bennett MI, Smith BH, Torrance N, Lee AJ. Can pain can be more or less neuropathic? Comparison of symptom assessment tools with ratings of certainty by clinicians. Pain2006;122(3):289-94.
10. Merskey H, Bogduk N. Classification of chronic pain: descriptions of chronic pain syndromes and definitions of pain terms. 2nd ed. Seattle: IASP Press; 1994.
11. Treede RD, Jensen TS, Campbell JN, Cruccu G, Dostrovsky JO, Griffin JW, et al. Neuropathic pain: redefinition and a grading system for clinical and research purposes. Neurology2008 Apr 29;70(18):1630-5.
12. Cruccu G, Sommer C, Anand P, Attal N, Baron R, Garcia-Larrea L, et al. EFNS guidelines on neuropathic pain assessment: revised 2009. Eur J Neurol2010 Aug;17(8):1010-8.
13. Haanpaa M, Attal N, Backonja M, Baron R, Bennett M, Bouhassira D, et al. NeuPSIG guidelines on neuropathic pain assessment. Pain2011 Jan;152(1):14-27.
14. Rolke R. Clinical assessment and diagnostic work-up. In: Bennett MI, editor. Neuropathic Pain. 2nd ed. Oxford: Oxford University Press; 2012. p. 25-36.
15. Kurita GP, Ulrich A, Jensen TS, Werner MU, Sjogren P. How is neuropathic cancer pain assessed in randomised controlled trials? Pain2012 Jan;153(1):13-7.
16. Geber C, Baumgartner U, Schwab R, Muller H, Stoeter P, Dieterich M, et al. Revised definition of neuropathic pain and its grading system: an open case series illustrating its use in clinical practice. American Journal of Medicine2009;122(10 Suppl):S3-12.
17. Bennett M. The LANSS Pain Scale: the Leeds assessment of neuropathic symptoms and signs. Pain2001;92(1-2):147-57.
18. Bouhassira D, Lanteri-Minet M, Attal N, Laurent B, Touboul C. Prevalence of chronic pain with neuropathic characteristics in the general population. Pain2008;136(3):380-7.

Pain in Wales

Dr Sharmila Khot
RAPM Wales

Welsh words for pain vary in their meaning contextually. 'Gwynio' is an ache or throb, 'poen' means pain while 'loes' is anguish. Regardless of the context, the suffering associated with each word is much the same. So where are we with regards to Pain in Wales? For the musically inclined, Welsh is well known as the musical nation where the very air we breathe sighs musically, the rhythms of life beat perhaps a bit slower but all the steadier for the slow pace and where there is time, "Time to wait till her mouth can enrich that smile her eyes began"'(WH Davies, *Leisure*).

Pain education, pain research and pain services are the three aspects of Pain Medicine that drives forward our specialty. In Wales we have an opportunity to 'get it right' in all the three areas of Pain Medicine. The new curriculum being developed by the Cardiff Medical School provides an exciting opportunity to introduce and embed Pain Medicine within the grassroots of the undergraduate medical curriculum in Cardiff. Involvement with DFLOG (Discipline Focused Learning Outcomes Group) led to collaborative development of learning outcomes in Pain Medicine for the undergraduate curriculum. There are three all Wales Advanced Pain Training (APT) posts per year, developed collaboratively with supportive and enthusiastic Pain Medicine consultant colleagues throughout Wales and the full support of the Welsh School of Anaesthesia. All past Welsh APTs are now Consultants in Pain Medicine in Wales, England or overseas.

Wales leads the way with the Cardiff University Masters in Pain Management, the first masters level course in the world for pain management study. sPAIN, the first simulation-based pain management course in the UK, supported by a multidisciplinary faculty has also been conceived and developed in Wales.

The geography of Wales dictates division between the North and South Wales. The recent formation of the National Specialist Advisory Group (NSAG) for Pain Medicine under the umbrella of NSAG Anaesthesia working collaboratively with the Welsh Pain Society are attempting to bridge this gap. The Pain Medicine NSAG has two representatives from each Local Health Board (LHB)(similar to PCT) one of these necessarily non-medical. This has led to proportional inclusive representation across Wales of individual pain services and provides opportunity for multidisciplinary representation and academia. This novel group is fully supportive of a collaborative all-Wales approach to pain services, education and research development through a robust systematic all Wales audit process.

Research in Pain Medicine is fraught with difficulties: patient cohort is unstandardised, psychosocial factors are difficult to control for and pain is difficult to measure due to its individual and contextual nature. However large whole population audits, involving patients subject to similar regional variability may adequately support improvement and standardisation of clinical practice nationally and lead to development of all Wales guidelines for Pain Medicine. This will ensure delivery of evidence-based patient care based on best available national evidence for Wales.

The service development and commissioning directives for chronic non-malignant pain, the first in the UK was published in June 2008. Currently varying service provision models are being trialled across different LHB's in Wales. There may eventually evolve an efficient national structure for pain service provision across Wales with in-built flexibility to support regional variations.

My own view is that there is enough music in the souls of the people in Wales to heal all pain. As one drives from Cardiff to the North Wales and the Snowdon peaks or westwards through Pembrokeshire and further west through surely what must be the most beautiful creation of nature; woods, rivers, snow peaks and sunshine one can only ponder on the goodness in the people of Wales that sustains such beauty of creation.

So "Let the sky fall, let it crumble, we will stand tall and face it all together. Let the sky fall!"

Regional Update

Dr Barry Miller

RAPM Chair

"If there is no one to tend the path, soon there will be no path, and then the path will be lost" - *Anon*

We live in uncertain times, and work in an uncertain environment. Every generation claims this, and the world turns. We go to work, attend clinics, theatre lists, and management meetings, and the world turns. But, at the risk of falling into the above error, I suggest that there are real changes taking place, and that they may have a profound effect on Pain Medicine. Throughout England the PCT is being replaced by the CCG. For much of secondary care, the change will have little effect, but at Pain Medicine the 'Eye of Sauron' is being uncomfortably focused. The principle area of change is a new found enthusiasm to expand GP managed and led pain services, and to downgrade, or cease to commission, services run by Faculty regulated doctors.

Training

An important implication of the downgrading of anaesthetist-run services is the potential for an effect on anaesthetic training and hospital on call rotas. Intermediate Pain Training is a requirement of all anaesthetists. The curriculum provides the details, recommending a minimum of 20 sessions in Pain Medicine at Intermediate level, and the Faculty recommends that a minimum of 3/4 of these should be in Chronic Pain, which is the majority of the competencies at that level.

These do not have to be within a classical hospital setting, but they, and the associated WPBAs, can only be with anaesthetic career grade doctors. There is no mechanism for other doctors (e.g. GPs) or Allied Health Professional (Nurses, Physiotherapists) to be involved in, or to sign off, training assessments or assess course competency.

Clearly a hospital without a pain service cannot take trainees for this aspect of training, and a region with no, or very limited, pain services will need to consider how to manage this aspect of the curriculum.

Meetings

Since the inception of the Faculty, the RAPMs have two meetings a year, one linked to the anaesthetic and ICM RAs and one at the BPS. At the last meeting we decided that this would change. In future, although a meeting will still be held at the BPS, this will be more of an updating event, and the two main meetings will now be held at the College.

These will be better co-ordinated with the two RCoA Regional Advisor meetings, so that RAPMs will be able to be involved in general educational business more fully, and specific ICM and anaesthesia material will be held while the RAPM meeting is occurring in parallel. This will be instituted from 2014 (so the meeting at the BPS in Bournemouth is still a full meeting).

Communication

My inbox is slowly receiving requests and information. Keep it coming. I hope I have been able to provide useful guidance, or provide support. Sometimes it is useful for us to know what is going on, at other times we can help direct or support a plan of action. Often it's just useful for another opinion.

FFPMRCA Examination Update

The Faculty owes many people a great debt of gratitude for the work undertaken to make the examination possible, from the FFPMRCA examiners themselves to the FRCA administrators and examiner leads.

The overall success rates were as below:

MCQ 19 Sep 12	SOE 14 Nov 12	Overall Pass Rate
91%	69%	**62.5%**

The pace of work, however, does not slacken but increases as we are coming up to our second Structured Oral Examination.

Trainee Update

Dr Emma Baird

Faculty Trainee Representaive

The new year is shaping up to be an interesting time for Pain Medicine in the UK. The Faculty are striving to improve Pain Medicine training, and thus the quality of patient care. This however was never going to be an easy task. Training throughout the country is improving but there are still many issues to be resolved. One of the main ways the Faculty have of identifying problems is via reports from trainees. This year Daniel Waeland and I are trying and enhance this further having asked you all to take part in a trainee survey. This survey should give us a specific platform to identify short falls in training and ways in which they can be rectified.

I have been impressed by the importance the Faculty have placed on the views of trainees. When I took up the post of Trainee Representative the first sitting of the FFPMRCA exam was looming. Most trainees were requesting a more in-depth syllabus. The Faculty listened to these concerns and a comprehensive 'guide to the syllabus' is in its final draft. This reiterates how strong our trainee voice is. By continuing to voice your concerns and questions via myself or at the British Pain Society Annual Scientific Meeting this April you can help shape the future of Pain Medicine training.

I would like to take this opportunity to thank all the trainees that have taken the time to talk to me on the phone, in person or via email. Without this contact the usefulness of my role would be greatly diminished, plus I would have to fill my segment in the Board meetings with an improvised dance instead of constructive feedback from yourselves.

The Lead Regional Advisor in Pain Medicine, Dr Miller, is in the process of surveying the training opportunities around the UK in Pain Medicine. Hopefully by the end of this process the Faculty should be able to provide us a list of what each region offers trainees in Pain Medicine and can hopefully facilitate those of us that want to sub-specialise in areas not available universally such as paediatric pain.

Pain, like all specialties in medicine is becoming increasingly evidence-based. In order to facilitate this, the Faculty are currently putting together a resource package listing all the systematic reviews available for each of the major areas in Pain Medicine. This will be a great resource not just for the exam but also clinical practice.

The trainee webpage will be undergoing a further revamp. It will contain more information for anaesthetic trainees who are thinking about a career in Pain Medicine. As part of this we will be asking for your 'career stories' the best of which will appear on the Faculty pages. I will be in touch closer to the time but, for those of you who want a head start, it will be along the same lines as the Royal College of Surgeons of England trainees' page.

Don't forget the ASM this year is in Bournemouth in April. The trainees' meeting will be held at lunch time on the Thursday and is a good opportunity to meet fellow trainees and members of the Faculty Board.

2013 Trainee Publication Prize

The 2013 Trainee Publication Prize will go live in early summer, with preceding advertisements on the FPM website.

Fellows and members of the Faculty are requested to please let anyone who may be interested know about the prize.

Publications submitted for the 2013 prize must have been peer-reviewed, published during 2012, be on a topic relevant to Pain Medicine and based on original research or a systematic review which includes metanalysis.

The submitter **must** have been a trainee when the article was published.

All entries should be submitted electronically via **fpm@rcoa.ac.uk**

Local Commissioning of Specialist Services for Pain

Dr Beverly Collett

Board Member

Background

Commissioning for healthcare in the NHS has been steadily changing over the past few years and will alter significantly over the forthcoming months. From April 2013, Clinical Commissioning Groups (CCGs) will take over responsibility for designing local health services in England. CCGs comprise General Practitioners, at least one registered nurse and a doctor who is a secondary care specialist. CCGs should work in partnership with patients, healthcare professionals and local authorities. All GP practices are required to be members of a CCG and the aim is to give GPs and other clinicians the power to influence commissioning decisions for patients. CCGs will be overseen by the national NHS Commissioning Board (NCB). Local offices of the NCB will oversee CCGs and manage primary care commissioning, including holding GP practices' NHS contracts.

Each local authority in England will have a Health and Wellbeing Board (HWB) whose aim is to improve integrated working between local health care, social care, public health and other public service practitioners, so that patients and service users experience joined up care. These boards are responsible for producing a Joint Strategic Needs Assessment (JSNA) to provide local policy makers and commissioners with a profile of the health needs of the population, with the aim of improving commissioning and reducing health inequalities. CCGs have a statutory requirement to consult health and wellbeing boards. These boards can report concerns regarding the CCG to the NQB.

Twelve clinical Senates will be established to help CCGs, HWBs and the NHS CB to make the best decisions about healthcare for the populations they represent by providing advice and leadership at a strategic level. They will comprise a range of clinicians, professionals from health, including public and social care and patients and the public.

A Clinical Reference Group (which includes FPM membership) has been established to decide a commissioning framework for those specialised Pain Management Services which need to be nationally commissioned. It has been estimated that there is a need for 6-10 national centres in England. A draft Specialised Commissioning Framework document has recently been sent out for consultation and the Faculty of Pain Medicine has responded.

The main issue now is what happens in local commissioning groups. The Faculty of Pain Medicine has been alerted to situations whereby little recognition of the specialist management of pain has been taken into account. This belittles the suffering of patients with pain conditions and highlights the difficulty of and the general deficiency in understanding the current pathophysiology of persistent pain states.

Current understanding of pain

Pain is a universal symptom. All of us, unless we have a specific gene deletion, will suffer from pain. Post-operative pain is, most of the time, well-managed in our hospitals. Acute pain is less well managed and, yet, this is what many of our acute pain services are managing. Many patients with chronic pain problems come to the Emergency Department. Many are admitted. Whilst some have their pain investigated and a resolution obtained, many do not have a positive inpatient diagnosis or pathway. Although the aetiology of their pain may be investigated, their management is not properly actioned, other than the use of opioids.

This has to change. We must all have improved awareness of the interface between acute and chronic pain, the financial cost of an admission for pain, and the financial penalties when re-admissions take place for an ongoing pain complaint.

National Pain Audit 2012

The Recent National Pain Audit revealed that patients attending a Pain Management Service had a EQ5D-3L of 0.4- similar to Parkinson's disease - this is really poor quality of life (*see page 20 for more information*). It was also recorded that 16% had multiple previous

GP and ED attendances and that this was reduced after Pain Management Service attendance - reiterating information that was identified by the Audit Commission in 1997 (*Anaesthesia Under Examination* - 1997, Audit Commission). To explore the current situation:

Definition

Chronic pain is recurrent or persistent pain that persists beyond the usual course of an acute disease or trauma, or occurs in conditions that cannot be treated. It can be considered as a condition in its own right or as a component of other long term conditions. Chronic pain encompasses a wide array of conditions, including musculoskeletal, neuropathic, and visceral pain. Cancer pain encompasses any pain in patients with cancer that is caused by the cancer or associated with treatment (e.g. surgery, chemotherapy, radiotherapy) or cancer related debility.

Who should manage chronic/ persistent/ intermittent pain?

The Faculty of Pain Medicine is the professional body responsible for the training, assessment, practice and continuing professional development of specialist medical practitioners in the management of pain in the UK. It supports a multidisciplinary approach to pain management informed by evidence-based practice and research.

Location

Many people with acute, intermittent and chronic pain can be satisfactorily managed by their General Practitioner. However, some patients with persistent pain will need additional assessment and multidisciplinary management either due to the intensity of their pain, significant distress and impact on functioning and substantial co-morbidities.

Specialist or Secondary Care Pain Management Services

Some patients with persistent pain need management by specialist, interdisciplinary, secondary care Pain Management Services based either in local hospitals or the community. These services will be commissioned by CCGs.

Specialised or Tertiary Care Pain Management Services

For a small group of adults and children who have refractory disabling pain, specialised tertiary care services will also be required. These highly specialised services for pain management will be commissioned nationally. It is estimated that there will be 6-10 of these centres in the UK. Referral to tertiary services will be subsequent to assessment and treatment in secondary care Pain Management Services.

Standard setting

The Faculty of Pain Medicine of the Royal College of Anaesthetists is the statutory body setting national standards for Pain Medicine. In 2011, the Faculty produced guidance on the provision of services for management of chronic pain. This highlights that *"Multidisciplinary management of patients with chronic pain alleviates pain and suffering, aids functional restoration and reduces the socioeconomic burden of pain for the individual, health care systems and community."* This document describes the staffing and resources required for a high quality, adequately resourced multi-professional Pain Management Service *"dedicated to (i) the care and support of patients with persistent pain and (ii) the ongoing education and development of staff".* http://www.rcoa.ac.uk/document-store/guidance-the-provision-of-anaesthesia-services-chronic-pain-management-2013

The British Pain Society has produced five pain patient pathway maps using best available evidence for the care of patients with pain in collaboration with Maps of Medicine.

The Pain Summit held in 2011 sets out the key objectives for specialized pain services and pain services nationally. (*A Report of the Pain Summit 2011* - Chronic Pain Policy Coalition, www.painsummit.org.uk).

Since the publication of the Francis Report in February 2013, management of pain in hospitals has been highlighted as an area of concern.

Faculty of Pain Medicine response 2013

The Faculty is involved in all discussions relating to Pain Management Services in the UK. The Faculty is of the view that many patients with pain can be well managed in the primary care setting by the General Practitioner. However, the Faculty is also of the view that the General Practitioner should identify if the patient has signs of problematic pain, i.e. pain that has significantly impacted on functional ability, psychological distress, substance misuse and may need to be managed by specialist intervention by a multidisciplinary team. These are the patients that should be seen in a secondary care Pain Management

Service. If these patients cannot be managed within the local secondary care Pain Management Service, then there should be an ongoing referral to specialised Pain Management Services.

Aims

The aim of a Pain Management Service is to provide patients with persistent disabling pain a timely service that delivers skilled multidisciplinary interventions to reduce or remove the cause(s) of pain and/or to enable patients to manage their pain with psychological and behavioural support that aids functional rehabilitation.

Service objectives:

- Provide a multi-professional patient specific assessment of the patient's pain and put in place an individual management plan.
- Provide appropriate pharmacological management for pain.
- Provide treatment interventions to reduce, eradicate or manage the pain.
- Provide psychological and behavioural interventions that support patients and their carers in managing the pain, enabling patients to lead more normal lives with reduced disability.
- Provide outpatient and inpatient care particularly around the management of pain problems of high medical and psychological complexity, and around the use of controlled drugs.
- Increase social and physical functioning.
- Promote independence and wellbeing for patients through the provision of structured self-management support, with concomitant benefits of fewer inappropriate medical appointments and readmissions.

Pain Management Services are integrated multidisciplinary teams that include specialist doctors, nurses, psychologists, physiotherapists, occupational therapists and pharmacists operating in the community, in local hospitals or in both.

Pain Management Services always involve a Consultant in Pain Medicine. These doctors are usually anaesthetists, who have undertaken specific specialist training and achieved the defined competencies in all aspects of Pain Medicine and who have usually obtained the Fellowship of the Faculty of Pain Medicine of the Royal College of Anaesthetists (FFPMRCA). They offer integrated coordinated holistic management of pain using unique knowledge and skills within the context of the multidisciplinary team to deliver comprehensive patient-centred care. They are the only specialists that are revalidated specifically with respect to complex pain management. For more information on the specialist pain doctor see http://www.rcoa.ac.uk/document-store/what-pain-medicine-doctor.

Pain Medicine specialists work closely with a range of other healthcare professionals who all possess a high level of expertise in different aspects of management of patients with complex pain. Members of the team work closely together through joint working and clinics and interdisciplinary multidisciplinary team meetings and agree management plans with patients and General Practitioners. This multidisciplinary working is a fundamental requirement for effective patient care.

Timely access

Currently, there is a national specification for access to general pain services in primary and secondary care of 18 weeks. Commissioning arrangements should ensure that these are met. The International Association for the Study of Pain (IASP) has investigated waiting times for treatment of persistent pain and formulated recommendations. More rapid access is required for those with severe unremitting pain e.g. trigeminal neuralgia, cancer pain, any pain associated with significant distress and disability.

Location

Pain Management Services can be located either in the community, in the secondary care hospital or both. If partially located in the community, there must be clear liaison and interaction between staff working in the community and those working in secondary care to provide the opportunity for multidisciplinary patient discussion, team education, audit/clinical governance, supervision and support.

Pain Management Clinical Staffing

Staffing should include input from:

- Specialised Consultants in Pain Medicine

  (minimum of two because of the need for peer support and cross cover).
- Consultants from other specialties e.g. gynaecology, psychiatry, paediatrics, palliative care as appropriate.

- Specialist pain management nurses.
- Specialist pain management clinical psychologists providing cognitive and behavioural therapy and other psychological interventions, individually or in a group setting.
- Specialist physiotherapy.
- Specialist occupational therapy.
- Access to dedicated pharmacy.
- Specialist paediatric pain management input from appropriate range of health care professionals as needed.

Minimum standards

- These are defined by the Faculty of Pain Medicine, Royal College of Anaesthetists, the International Association for the Study of Pain (IASP) and the British Pain Society.
- Medical staff must have proven experience and competency in the management of patients with problematic, persistent or recurrent pain. They should be revalidated and appraised with respect to this specialist knowledge and competence.
- Service specific competencies for nursing, psychology and other staff working in the Pain Management Services should be defined and followed as per the recommendations.

Data collection

Activity for pain management is usually recorded under treatment function code 191. This should apply to inpatients, outpatients and pain management programmes and should be used in both secondary and community care settings.

Interdependencies with other services

The strategic vision is for chronic pain services to work within a clinical network across primary, community and secondary care.

Key Service Outcomes

Pain Management Services should be collecting data on patient outcomes., which must be robust and validated and agreed by local commissioners.

Children and Adolescent Services

Child and adolescent Pain Management Services are nationally commissioned. Thus these patients should be immediately referred onto specialised centres.

Conclusion

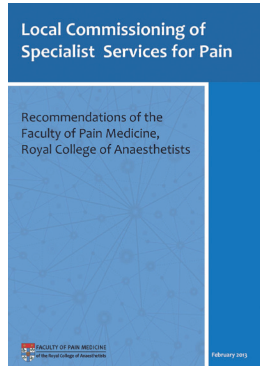
There are now several different bodies that we can influence to promote better use of pain management services. Pain Services have input via Specialised Commissioning, via the CCGs, via the HWBs and via the Senates.

We need to ensure that our voice is heard at several levels. This will need us to be proactive in establishing contacts with these organizations. We need clarification as to what services are CCG commissioned and what services are nationally commissioned. What are the defining points?

We must not forget that the Faculty of Pain Medicine is the statutory body for Pain Management Services and is involved in all discussions and represents the interests of the patient with pain. It is in the patient's best interest that a pathway is followed and that the patient does not stick in primary care without an ongoing positive referral. I see far too many people who have been told that there is nothing more to be done and they just have to live with their pain, when there are obvious strategies that can be employed. Thus, referral onwards to Pain Management Services should be encouraged and not discouraged.

Pain is a problematic area. There is much education that needs undertaking amongst the general public, patients and healthcare professionals. There is evidence that many patients do not have the opportunity of self-management strategies, a Pain Management Service assessment or pain management programmes because of lack of resource, despite evidence of effectiveness.

We need to use the opportunity that this commissioning change in the NHS has given us to improve the care that we offer to patients.



For futher guidance on commissioning for pain services, please see the new FPM document *Local Commissioning of Specialist Services for Pain*, released in February 2013.

Available now online: http://fpm.ac.uk/document-store/fpm-local-commissioning-of-specialist-services-pain

Faculty Events

Dr Sanjeeva Gupta

Educational Meetings Advisor

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

I would like to welcome Dr Sandesha Kothari (London) and Dr Shyam Balasubramanian (Coventry) who have joined me to help organise future meetings of the FPM as Deputy Educational Meetings Advisors to the Faculty of Pain Medicine.

The study day on the 3 June 2013 will be on 'Opioids in Persistent Non-Cancer Pain – The Future?'.

Dr Mark Jackson is organising the FFPMRCA Examination Tutorial day on the 7 June 2013 and a programme can be found on the FPM website.

The Annual meeting of the Faculty will be on the 22 November 2013. If you have any suggestions please contact us via the addresses below:

sgupta6502@aol.com
sandeshakothari@nhs.net
doctorshyam@hotmail.com

Opioids in Persistent Non-Cancer Pain - The Future? Monday 3 June 2013

Approved for 5 CPD points
£160 for consultants
£130 for trainees

Effect of genetic variation on opioid efficacy - pharmacogenetics of opioids
Dr Sophy Gretton, Palliative Medicine Researcher, London

Interface between primary and secondary care in opioid prescribing
Dr Roger Knaggs, Pharmacist, Nottingham

Identifying and managing problem prescription opioid use
Dr Brian Stevenson, Psychiatrist in Substance Misuse, Leicester

Endocrine and immunological effects on opioids
Dr Joan Hester, Pain Consultant, London

Case Based Dicussions:

- High dose opioid use: assessment and management
  Dr Cathy Stannard, Pain Consultant, Bristol
- Practical aspects of prescribing opioid
  Dr Joan Hester, London
- Recognising and managing addiction to opioids
  Dr Beverly Collett, Pain Consultant, Leicester and Dr Brian Stevenson, Leicester

Opioid prescribing: a public health perspective and comparison of prescribing in the US and UK
Dr Cathy Stannard, Bristol

Booking now open: **www.fpm.ac.uk**

Comments from previous events

Updates in Pain Medicine

"Wide range of topics, very useful"
"Very informative; useful in my future practice and as a source of inspiration for my involvement in service configuration"

Core Competencies in Mental Health for Pain Professionals

"Very relevant topics. Presentations and workshops were outstanding"
"Excellent coverage of the subject"
"A good insight into how another specialty can interact with my service"

Managing the Pain Service

"Very useful especially for trainees to prepare for the consultant role"
"Extremely useful array of talks"
"Excellent programme, good speakers and relevant topics"

e-Learning for Pain

Dr Ian Goodall

The first modules and sessions for the Pain component of e-Learning for healthcare are about to be published on the e-learning site and will be available for all healthcare professionals working within the NHS. The format follows closely the eL-A sessions and should be familiar to users of the e-learning for health resource.

The aims of the project are:

- Improving the recognition of unrelieved acute and chronic pain in all patients groups
- Appropriate assessment of pain
- First-class management of pain
- Ensuring patient safety

It is intended that this will become a valuable resource for non-specialist health care workers and will greatly improve their knowledge and understanding of the causes, potential treatment and importantly the suffering of those in pain. The only way to improve quality of care is through education and this will be the tool to dispel the inequality of pain management and provide better patient care. Patient surveys such as those by the Picker Institute highlight the perceived care with regards to inpatient pain care on the wards and demonstrate the variation that occurs in delivery and approach to dealing with patients in pain in hospitals. Other audits have highlighted the lack of awareness of approved treatments for certain pain conditions e.g. spinal cord stimulation. By increasing the education of all clinical NHS workers hopefully we will improve the management of acute pain, chronic pain, and give the right treatment to the right patients regardless of geographical area.

The first module and its sessions focus on the basics of why people get pain, what the principles of treatment are and why pain can become persistent. It is this background knowledge that is vital to have available to anyone treating patients in pain whether it is acute or chronic which will develop more consistent communication with patients and understanding of treatments available and why certain therapies are used. It is also essential that we all understand the ethical and moral responsibilities that we have in helping to manage the pain and suffering of pain patients and this is a key session within the basic sessions. The second module concentrates on basic sciences.

The rest of the modules will focus on key areas such as pain in the older person, paediatrics, post-surgical, neuropathic pain conditions, musculoskeletal conditions etc and will build on the first two modules themes by being more condition-specific. There is a considerable emphasis on the multidisciplinary and interdisciplinary approach to managing pain and the importance of the biopsychosocial model of pain is described throughout from acute to chronic pain management and this will allow greater understanding of how pain has affected an individual.

This is not a secondary care orientated resource, but is designed to cover primary and secondary aspects of care to be utilised by general practitioners as well as practice nurses and community NHS pharmacists etc, and this will complement information provided by the Map of Medicine pathways and NICE guidelines. One of the advantages of having a centralised resource is that it will be able to be updated added to and have useful references to further learning resources that are available elsewhere e.g. IASP, British Pain Society as well as other useful publications.

As pain specialists, trainees and leaders in Pain Medicine it would be ideal to alert our respective Trusts and colleagues to the e-Learning for health resources and hopefully have them adopted as part of each Trust's e-Learning programmes for clinical staff. Treating pain is a quality marker and through better understanding we will improve care. So please take this opportunity to publicise this to your Trust's nursing, pharmacy, physiotherapy post graduate departments as well as establishing a link on the hospital website GP resource.

Please contact the Faculty for further information.

The National Pain Audit

Dr Stephen Ward

National Pain Audit Chair

The National Pain Audit, carried out by the British Pain Society and Dr Foster Intelligence and with the Faculty of Pain Medicine as a principle stakeholder, published its findings in December 2012. This 3 year study was commissioned by the Health Quality Improvement Partnership (HQIP) in September 2009 in response to the Chief Medical Officer's report of 2008: *Pain: Breaking Through the Barrier.*

The audit comprised three phases:

- ***Phase 1:*** pain service registration and completion of a service questionnaire to the registrant based upon key standards. Organisational standards were benchmarked against each other and against national and internationally agreed standards, where they could be ascertained.
- ***Phase 2:*** case mix information from both the provider clinicians and patients. Information from patients about the patient journey to a pain service.
- ***Phase 3:*** outcomes of care from a patient perspective using validated standard questionnaires and questions developed specifically for the audit by both clinicians and patients.

Participation

161 specialist pain clinics returned data for Phase 1 in England and Wales. Detailed information about these clinics using our dedicated search tool can be found at http://www.nationalpainaudit.org/search.aspx. For Phase 2, 91 clinics returned data, giving a response rate of 56%. 9,430 patients were entered on to the case mix tool. For Phase 3, of the patients that had returned PROMS questionnaires, 4,414 returned a final PROMS questionnaire (63%), with 3,192 completed (34%).

Key Findings

Quality of life: the overall mean quality of life score (EQ5D-3L) of 0.4 represents severe impairment, and is lower than many individual conditions. In total 56% of providers reported post-treatment improvement in EQ5D-3L score, and 76% improvement in specifically pain-related quality of life.

Healthcare resource utilisation: 16% of respondents recalled visiting an Emergency Department in the 6 months prior to clinic attendance, seeking additional help, despite having seen their GP. By contrast only 9% of respondents recalled visiting ED in the 6 months after attending their pain clinic for pain-related events.

Variation in availability of services: only 81 out of 204 English pain clinics (40%) were able to fulfill the criteria for a fully multidisciplinary pain service, as defined by the presence of a psychologist, physiotherapist and physician. In Wales, 60% of pain clinics were multidisciplinary.

Key Recommendations

Identification of services: a treatment specialty code (191) is needed to be applied to all specialist pain services regardless of setting, in order to identify them.

Access to services: nationally recognised sources of information on services should ensure that information on local pain services is readily available to patients and timely access is provided.

Staff skills mix: physical therapists, psychologists and senior medical support should be routinely available.

Staffing competencies: specialty interest groups in each profession should provide guidance on which competency and skills are required in order to meet patients' needs.

Service commissioning: commissioners and providers should ensure a health needs assessment is carried out at a local level to determine the level of need for specialist pain services.

Quality of care: quality standards that include integrated and timely working are needed.

Information for patients: providers of pain services need to improve the quality of information given

to patients on managing their pain and ensure non-specialists understand this requirement.

Coding and classification systems: providers should ensure that co-morbidity data should be collected in addition to a pain diagnosis.

Impact on healthcare resource use: research funding bodies such as the National Institute for Health Research should ensure that research on optimal models of care for people with chronic pain include economic modelling.

Treatment information: future audits should capture what treatments patients have actually received and whether these were provided in a timely fashion to patients as determined by peer review.

What Next?

The National Pain Audit has received funding from the Healthcare Quality Improvement Partnership to collect further data from those patients who participated in 2011/2012. We will be collecting additional outcome data, using the EuroQol EQ-5D and Brief Pain Inventory questionnaires, and further metrics on patient experience and satisfaction. In addition to the patient questionnaires we will be updating our organisational database to reflect service changes and reconfigurations of pain services across the country. In this regard we are particularly keen to identify more community-based pain services.

The National Pain Audit findings can be downloaded from http://www.nationalpainaudit.org/media/files/NationalPainAudit-2012.pdf.

New Board Members

Dr John Goddard

John Goddard is a Consultant in Paediatric Anaesthesia and Pain Medicine at Sheffield Children's Hospital and has been in post since 1989. In Sheffield, he leads a comprehensive multidisciplinary Pain Management Service that supports children and young people with acute, procedural and chronic pain problems. He initiated and has continually developed this service since 1991. He has previously been chair of the Pain in Children Special Interest Group of the British Pain Society.

He is committed to the development and recognition of Pain Medicine as a specialty. Currently, he is involved in the National Commissioning process and is a member of the Clinical Reference Group for Adult Specialised Services for Pain Management. Advising the Paediatric Surgery Clinical Reference Group, he has been the main author for the service specification for Highly Specialist Pain Management Services for Children and Young People.

He has been a member of the FPM Professional Standards Committee since 2010. He is also an examiner for the Faculty of Pain Medicine and the current Honorary Treasurer of the British Pain Society.

Dr John Hughes

John Hughes has been a Consultant in anaesthetics and Pain Medicine at the James Cook University Hospital, Middlesbrough, UK since July 1995. Over the years has developed a special interest in chronic pelvic pain whilst maintaining a broad exposure of chronic pain problems. Educationally he has been involved with introducing Pain Medicine to the undergraduate curriculum for phase 1 medical students at Durham University and was the original Regional Advisor in Pain Medicine for the Northern region.

He has been Chair of PUGO (Pain of Urogenital Origin) a SIG of the IASP recently renamed SIG of Abdominal and Pelvic Pain and a member of the IASP Education Working Group. He is a current member of the European Association of Urology Chronic Pelvic Pain Working group and Chair of the British Pain Society/ MoM Chronic Pelvic Pain Patient Pathway Working Group. As well as being a former Regional Advisor in Pain Medicine, he is a past Chair of the RAPMs.

He has an ongoing commitment to the FPM as lead assessor for the Fellowship and CPD Advisor to the RCoA for Pain Medicine.

Faculty Update

New Fellows by Assessment

December 2012
Dmitry YAKUNCHIKOV
Timothy McCORMICK

January 2013
Praburam SELVARAJ

February 2013
Harinda Ashantha GOONESEKERA

March 2013
Michael CLARKE
Benedict HUNTLEY

April 2013
Saowarat SNIDVONGS
Simon LAW
Sumit GULATI
Liza THARAKAN

New Associate Fellows

December 2012
Abdullah NAZAL

April 2013
Bhamini RAMASWAMY
Remigiusz LECYBYL

New Members

April 2013
Muhammad BALOCH

New Committee Membership

The Faculty of Pain Medicine
of The Royal College of Anaesthetists

Churchill House
35 Red Lion Square
London WC1R 4SG

tel: **020 7092 1727** or **020 7092 1746**
email: **fpm@rcoa.ac.uk**

www.fpm.ac.uk