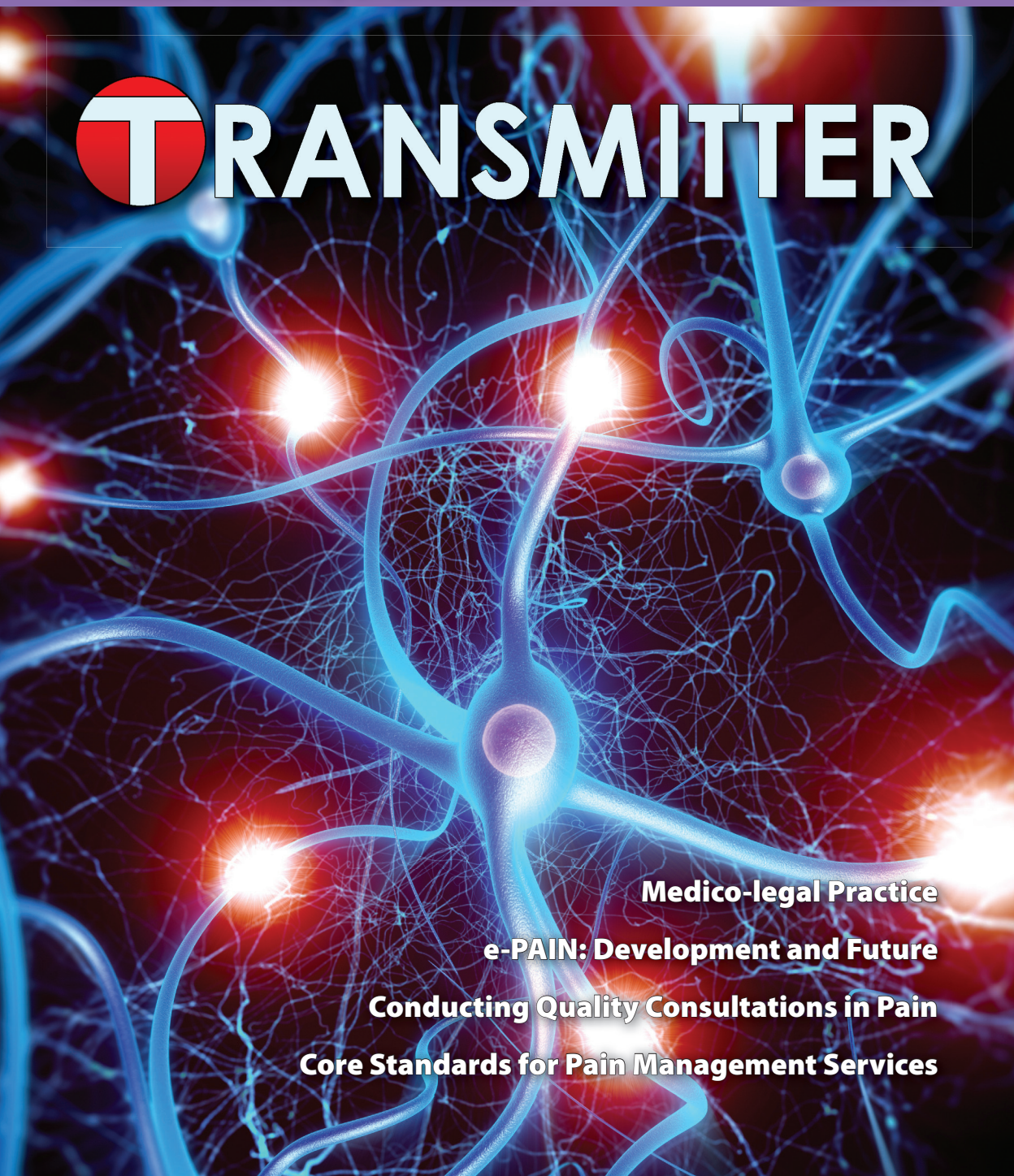
FACULTY OF
PAIN MEDICINE
of the Royal College of Anaesthetists

Newsletter of the Faculty of Pain Medicine SPRING 2015

TRANSMITTER



Medico-legal Practice

e-PAIN: Development and Future

Conducting Quality Consultations in Pain

Core Standards for Pain Management Services

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Work and politics seem to follow one everywhere. As I write this sitting abroad, there is the different perspective one gets from BBC World; no mention of the forthcoming UK general election! What effect the outcome of May's voting will have on the NHS is not clear to me at present, but the strain on the service and its employees will no doubt continue.

This edition of *Transmitter* focuses heavily on the 'core' business of the Faculty, teaching, training and standards, in many diverse areas. Articles on e-PAIN by Doug Justins and Julian Scott-Warren, Essential Pain Medicine (EPM) from Doug Justins and Claire Roques, and Advanced Pain Training in the TAC report, to highlight a few: the Faculty is busy. Also updates on two standard documents the Faculty is currently working on: *Core Standards for Pain Management Services* from Anna Weiss and *Conducting Quality Consultations in Pain Medicine* by Tony Davies and Paul Wilkinson.

I, too, wish to congratulate Beverly Collett, Chair of the FPM Professional Standards Committee, on receiving her OBE. She is proud that it is in recognition of services to pain management: I am pleased that it reflects her immense personal contribution to raising the profile of pain, particularly with parliamentarians. Politics again!

As always, my thanks to Daniel, James and Anna for their production. And special thanks to all authors, particularly for contributing in a timely manner.

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Message from the Dean

Dr Kate Grady

Dean

As I open this report I am delighted to congratulate and welcome our new elected Board members Dr Ganesan Baranidharan, Dr Carol McCartney and Dr Barry Miller. I look forward to working with them and together taking the Faculty forward. We also welcome Dr Rhian Lewis as a co-opted member of the Board to provide liaison with Pain Medicine in Wales, as well as Dr Jon McGhie as a newly appointed Board member.

Congratulations also go to Dr Beverly Collett on the award of an OBE for her services to pain management. This is richly deserved, a huge accolade to Beverly personally and to Pain Medicine and goes a considerable way to the advancement of our specialist area.

The months since our autumn edition of *Transmitter* have been eventful; in mid November we had our Annual Meeting and were delighted to award Professor Sue Fleetwood Walker with the Patrick Wall Medal for the delivery of the eponymous lecture.

Later in November our ASK2QUESTIONS work (formerly known as the Complex Pain project) was presented in the House of Lords along with the work streams of the British Pain Society, Royal College of General Practitioners and the Chronic Pain Policy Coalition, as outcomes of the Pain Summit of 2011. ASK2QUESTIONS identifies two simple, sensitive and specific questions for healthcare professionals to ask at the initial pain consultation which might identify potential long term pain problems and chronicity, allowing this to be addressed early and proactively. The work is being piloted in primary care in various areas of the country.

In December two of our long serving and highly respected Board members, Professor David Rowbotham and Dr Karen Simpson demitted. We will value ongoing contact and thank them for all their work for the Faculty since its inception.

January saw a stakeholder engagement event for the Perioperative Medicine Project, hosted by the Royal College of Anaesthetists. This is to reduce risk to 250,000 higher risk patients undergoing anaesthesia and surgery each year. The RCoA, as the largest single hospital specialty is well placed to lead the development of Perioperative Medicine and Pain Medicine has its place and is represented in this work.

The work of our Training & Assessment and Professional Standards Committees, and events team continues and you can read more of this in this edition of *Transmitter*. The FFPMRCA examination continues to build a quality profile.

Our undergraduate Pain Medicine initiative 'Essential Pain Management Lite' goes for strength to strength. We have had responses from a number of you linked with medical schools or involved in undergraduate teaching to which we are responding and the course has now been piloted in Bristol and the Peninsula medical schools.

The overseas Essential Pain Management courses which are delivered as a joint project of the Faculty and the British Pain Society, supported by the RCoA, The Association of Anaesthetists of Great Britain and Ireland and the Australian and New Zealand College of Anaesthetists have now run in Uganda, Malawi, Tanzania, Ethiopia and Sierra Leone, with good educational outcomes. More information on these projects can be found elsewhere in this issue.

We are keen to hear from our Fellows, Associate Fellows, Members and trainees as to how you would like to Faculty to address your educational and professional needs or if you would like to become more involved in the work of the Faculty. Please email me at fpm@rcoa.ac.uk.

New Board Members

Dr Ganesan Baranidharan

Ganesan Baranidharan is a consultant in Anaesthesia and Pain Medicine at the Leeds Teaching Hospitals NHS trust and Honorary Associate Clinical Professor at the University of Leeds. He completed his UG from Madras Medical College and his anaesthesia and pain training from Yorkshire Deanery and McMaster University, Canada. He is active in research and teaching. Most of his research activities are on neuropathic pain and neuromodulation.

He has a special interest in managing pain of visceral origin. As a secretary to Neuromodulation Society of UK and Ireland, he has had a significant contribution in developing a National Neuromodulation Database. He is currently the Regional Advisor for Pain Medicine in Yorkshire and also teaches in various courses nationally and internationally. He has successfully run his annual cadaver workshop in Leeds for the last 8 years. He enjoys cycling, cricket and badminton in his spare time.

Dr Carol Anne McCartney

Carol McCartney qualified from St George's Hospital at the University of London in the summer of 1984 and went on to do House Jobs at St George's and Epsom Hospitals. Her interest in pain started whilst doing a Radiotherapy & Surgical job at the Royal Marsden in Sutton and she started anaesthetic training at Redhill and at Greenwich Hospital and then at St Bartholomew's Hospital London where she held both Registrar and Senior Registrar posts.

Dr McCartney trained in Pain Medicine under the tutorage of Jane Gallagher and Charles Gaucci on the North-East Thames rotation and was one of Professor Langford's first Pain Research Fellows. Dr McCartney became a consultant at the Mid-Essex Hospital in Chelmsford (Broomfield) a District General Hospital in Essex in 1996. The Department has now developed and grown with five consultants, six nurses, three physiotherapists, two psychologists and supporting administrative staff. They have their own unit performing interventional techniques and out-patient consultations and seeing 7500 patient episodes per year.

Dr Barry Miller

Barry Miller is a consultant in Pain Medicine & Anaesthesia at the Royal Bolton Hospital, appointed in 2000. He has a specialist interest in the interventional aspects of palliative care, and been closely involved medical education, being the first RAPM (Regional Advisor in Pain Medicine) appointed under the Faculty, joining the newly formed TAC (Training & Assessment Committee) and later taking on national roles as Chair of the RAPMs, and, currently, Chair of the TAC.

He is an expert member on the Greater Manchester (West) Research and Ethics Committee and a peer-reviewer for the *BJA*. He is a council member for the Manchester Medical Society and has been Medical Staff Committee Chair, and Chair of the local BMA.

Essential Pain Management

Dr Clare Roques

Chair EPM UK Working Group

Essential Pain Management (EPM) is an educational package for all healthcare workers, designed to improve the management of all types of pain. Working on the premise that pain is an issue that affects individuals all over the world and is often inadequately treated, the stated aims of the project are: to improve pain knowledge; to implement a simple framework for managing pain; and to address pain management barriers. It was written by Roger Goucke, a pain specialist from Australia, and Wayne Morriss, an anaesthetist from New Zealand, with the support of the Faculty of Pain Medicine of the Australian and New Zealand College of Anaesthetists (ANZCA).

The programme is run as a series of workshops, usually over three days, incorporating a 'train the trainer' session, which facilitates early handover to local teams. EPM is an 'off the shelf' package with all the necessary educational resources incorporated, such as manuals, slideshows, feedback forms and certificates. Since the first pilot workshops were held in Papua New Guinea in 2010, EPM has been run in over 30 countries, translated into several languages, and been supported by many organisations including the International Association for the Study of Pain, the World Federation of Societies of Anaesthesiologists, the British Pain Society, the Association of Anaesthetists of Great Britain and Ireland (AAGBI) Foundation and the Royal College of Anaesthetists (RCoA).

The growth of EPM in recent years has led to a dedicated EPM sub-committee of the ANZCA and to the formation of the EPM UK Working Group. The UK Working Group's remit is to coordinate EPM workshops, primarily across Africa, with faculty from the UK. To date the group has run workshops in Uganda, Malawi and Tanzania, with more projects planned including in Ethiopia. Generous support for these workshops has been donated in the form of funding from the AAGBI Foundation and the RCoA, and administration from the Faculty of Pain Medicine.

In September 2014, I travelled to Uganda with Andrew Vickers (an anaesthetist and pain specialist from Lancaster) to run a set of EPM workshops as an initiative of the UK Working Group. The workshops took place at St Mary's Hospital, Lacor, a not-for-profit Catholic hospital with a 482 bed capacity serving a population of over 5 million people in the north of the country.

Of course on arriving in Uganda we had many questions. Would the course materials and our teaching style be locally relevant? Would participants engage with and enjoy the workshops? Would the venue be suitable? Would the course materials be printed correctly? Would the caterers arrive on time? We need not have worried, however, as anaesthetist and local EPM coordinator Dr Ocen Davidson had organised the project incredibly well and had clearly invested many hours in ensuring the smooth running of the workshops.

Over three days we taught a total of 57 participants and eight new trainers. In order to maximise the effectiveness of teaching during the workshops and the long-term sustainability of the project, faculty was largely made up of local trainers. Several had attended a set of EPM workshops I had run in 2013 in Kampala, the capital city of Uganda, and all had considerable teaching experience. We were also very fortunate to have participants attending the workshops from a large number of hospital departments including medicine, surgery, paediatrics, palliative care, pharmacy and physiotherapy. Another key to the success and popularity of the workshops was the very strong public support from senior clinical managers in the hospital.

Despite the initial anxieties and hard work involved, the whole project was incredibly enjoyable and we received very positive feedback for the work. We could not have been made to feel more welcome by the staff at St Mary's Hospital and I am already looking forward to making plans to return to facilitate further EPM workshops.

Essential Pain Management in Malawi

Dr Douglas Justins

Member EPM UK Working Group

The UK Essential Pain Management (EPM) Working Group had planned EPM courses to be held in Uganda, Malawi, Tanzania and Ethiopia in late 2014 and early 2015. In November 2014 we ran two one-day EPM Workshops and a half-day Instructor Workshop at Queen Elizabeth Central Hospital, Blantyre, Malawi.

Malawi has a population of 14 million and Blantyre is the largest city in Malawi with a population of around 1 million. Queen Elizabeth Central Hospital (QECH) is the main hospital in Blantyre and it has over 1,000 beds. It is one of the largest hospitals in Central Africa and offers almost every surgical specialty. Often bed occupancy is greater than 100%. Kamuzu Central Hospital in Lilongwe has upwards of 1,000 beds.

The Instructors from the UK were Douglas Justins (St Thomas' Hospital, London) and Karen Gilmore (Torbay Hospital, Torquay). We benefited from the enthusiastic help and expert organisational skills of Cyril Goddia (Chief Anaesthetic Clinical Officer and Head of Anaesthesia Training, QECH, Blantyre). Sarah Clark (Anaesthesiology Resident, Stanford Hospital, California, USA) who was completing her time as Educational Fellow at QECH, Blantye, also helped with the teaching.

There had never been teaching courses on pain management in Malawi before these EPM workshops. Health workers to whom we spoke in Malawi identified pain management as a major deficiency in local healthcare provision. Medically qualified anaesthetists are scarce throughout Malawi and clinical officers administer anaesthesia. Responsibility for post-operative pain management often rests with the surgeons. Pethidine is the most commonly used opioid.

Identification of local barriers to the delivery of effective pain management (and of potential remedies) is an important part of each EPM workshop. Workshop participants identified significant barriers in Malawi that included:

- Lack of awareness and education of healthcare workers about pain management.
- Cultural issues for staff and patients when suffering from or dealing with pain.
- Failure to recognise and assess pain.
- Problems with the procurement of appropriate medication including morphine.
- Failure to administer appropriate treatment because of lack of staff and administrative issues.

For the workshop on day one there were 27 participants (2 doctors, 10 clinical officers, 15 nurses). For the Instructor course on day two we had 8 participants (1 doctor, 2 clinical officers, 5 nurses). For the workshop on day three there were 25 participants (2 doctors, 12 clinical officers, 11 nurses). The day three workshop was run by the new Instructors from day two. Workshop participants came from Blantyre, Lilongwe and the Malamulo College of Health Sciences.

Based on feedback and other comments the workshops were judged to be very successful. Course participants completed a 24-question test at the beginning and the end of each workshop to assess learning during the day. Gratifyingly there was a significant improvement in scores after the workshops.

A fundamental teaching idea for EPM is the use of the RAT model – RAT stands for Recognise, Assess, Treat – applied to pain. It was agreed that the RAT approach provided a simple framework for managing a variety of pain problems and that it could be utilised in the local hospitals. Participants observed that the EPM teaching was pitched at the right level and that it was relevant to Malawi.

The two one-day EPM workshops trained 52 healthcare workers (4 doctors, 26 nurses and 22 clinical officers). The Instructor workshop trained 8 healthcare workers. Hopefully these new Instructors can cascade the EPM message to other healthcare workers in Malawi.

The Development of e-PAIN

Dr Douglas Justins

e-Learning for Pain (e-PAIN) is a multiprofessional e-learning programme designed to improve the knowledge, skills and attitudes of all staff in the NHS who deal with patients who have acute or chronic pain.

The widespread incidence of unrelieved pain and the shortcomings in its management had been highlighted in various reports (children, older people, sickle etc.) published between 2007 and 2009. The CMO's report in 2009 called for improved education about pain for all health professionals who deal with patients (*150 Years of the Annual Report of the Chief Medical Officer: On the State of Public Health 2008*).

An invitation to propose development of e-learning content was published by e-Learning for Healthcare (e-LfH) with a submission deadline 25 September 2009. e-LfH is funded by the Department of Health. The FPM agreed to submit a joint application with the British Pain Society (BPS). Our target audience was all healthcare professionals who deal with patients. The application emphasised that e-PAIN would utilise the knowledge and skills of the team at the Royal College of Anaesthetists who successfully delivered the e-Learning Anaesthesia (e-LA) programme. e-LA had won a prestigious gold award for 'Best Online or Distance Learning Project' in 2009. The BPS's Educational Special Interest Group provided experience in multiprofessional educational initiatives.

The bid was successful and the team set to work to create 200 hours of online learning presented in 30-minute sessions. One of the biggest challenges was pitching the material at the right level for the multidisciplinary audience. Nick Cleary became Project Manager for e-PAIN bringing his extensive experience from e-LA. Overall editorial responsibility rested with three clinical leads: Richard Langford, Douglas Justins and David Rowbotham. The initial lead editor Ian Goodall assembled the first group of session authors who got the project underway.

The Future of e-PAIN

Dr Julian Scott-Warren

The e-PAIN project continues to build and expand upon its already extensive library of learning sessions and modules. There is still work to do in certain areas to ensure that it provides a comprehensive, easy to understand and multidisciplinary overview of our specialty, but the sterling efforts of the e-PAIN Executive Committee, module editors, session authors and structural designers ensure that the future is looking bright. Once all the scheduled sessions are completed, the work of keeping e-PAIN up-to-date will begin in earnest, and this huge task is likely to be somewhat reminiscent of the painting of the Forth Bridge!

By the time you read this, a new sleeker, faster web portal will have been implemented across the entire e-LfH initiative, and users of e-PAIN will have begun to benefit from a simplified interface and effective search facility. It also means that we can tailor and tweak how sessions and modules are presented at the front-end, to allow us to, for example, highlight new and updated sessions. The Faculty of Pain Medicine is keen to improve pain management and education in developing countries. On the horizon is the design and manufacture of an educational DVD, which, it is proposed, will contain the basic and essential e-PAIN sessions required to educate and address the problem of pain under treatment in poorer parts of the world. We envisage the targeted distribution of this material within existing educational initiatives.

On the subject of overseas work, there may be an opportunity to collaborate with partners from sister organisations around the world to greatly expand the educational material available and become a truly international resource – watch this space!

Training and Assessment

Dr Barry Miller

FPMTAC Chair

Minimum Numbers

The question of 'How many is just enough?' is a repeated query that is asked of the TAC, and probably almost all other educational bodies. The answers given are invariably vague, and to those in training seem to be avoiding the question. So let's be clear and honest: there isn't an answer, and nor is there ever likely to be one. Okay, having said that, it is fair to give a reason why this is the case. The first is simply that the GMC, (and before April 2010, PMETB) decided that the most useful phrase to describe the aims of medical training is 'competency based'. This is a succinct expression without being didactic, and we should probably be grateful for the leeway that it affords.

All of us are different. Some 'get the hang of it' quicker than others, some take longer to recognise potential difficulties. In some places there may be an enthusiasm, or specialist service, providing a high frequency of something, and in others it may be comparatively less frequent. The minimum number that any one individual needs is unknown, and largely, unknowable. That said, the old adage of 'see one, do one, teach one' is no longer an approach to be recommended, so it is unlikely that one will ever be enough and, if at the end of training opportunities, the trainee is still having difficulties it may be time to review the trainee, the training and the trainers.

The trainee should have achieved competence. The ability to know when to do, what to do, how to do it, and be seen to perform the procedure safely. It is both that simple and that complicated. Ever was it so.

Case Reports

The case reports have been an important aspect of the entry criteria for Fellowship and Diplomate Fellowship status within the Faculty since it took over the regulation of Pain Training in the UK. Before the exam there was a requirement for four case studies; this was reduced to two when the exam was instituted. We receive all the reports of those applying for Fellowship, cross mark them within the Faculty as a quality assurance measure, and receive feedback from the RAPMs and trainees. After review we have decided to reduce the number required to one. The Faculty recognise the increasing burden of work and expectation within the Advanced Pain Training (competency based) year and recognise that the reports are an aid to learning and should not become an all consuming distraction. Feedback has indicated that a change would be welcomed.

Case reports in the training and post-training environment have an important value, but there is perhaps some confusion as to their differences as well as their similarities. Essentially – and I apologise if I'm stating the obvious – it is the use of a single case to examine some part of it in detail. This may be in presentation, pathology, diagnosis or management. Published cases usually look at something rare or new, acting as a lesson and a guide. For the trainee it is unlikely that they will be presented with such an opportunity and therefore common everyday situations are more often written up. The format remains the same. It is important to define the aim clearly, describe the clinical aspects succinctly, with additional detail in the part to be focused on, and then discuss this aspect, with references to research, analysis and existing guidelines, that have informed current practice and the care of this individual.

Shape of Training

Since the final report in March 2014, there has been much talk, but no clear movement in relation to the potentially revolutionary changes in Professor Greenaway's report. From our perspective, the issue of reduced time in the overall specialist training scheme to produce more 'generalists', with specialised training moving to a post-CST (the proposed CCT acronym replacement) locally run credentialing system, poses significant challenges. Over the year a number of bodies have raised issues, and it is heartening to see that the Steering Group has widened its membership to include these voices.

FFPMRCA Examination: Quality Assurance

Dr Nick Plunkett

Deputy Chair of the Court of Examiners

Dr Karen Simpson

Chair of the Court of Examiners

It is timely, following the conclusion of the fifth diet of the FFPMRCA examination in October 2014, with over 75 successful candidates to date, to present a review of the quality assurance that underpins the integrity of the examination. The stated aim of this examination is to improve the quality of Pain Medicine training and practice for the benefit of patients. Successful candidates are awarded the right to use the post-nominals FFPMRCA; these indicate that they have achieved a world class qualification from a Faculty of a Royal College. Not including those who were not successful at the most recent exam (who will be coming back for their second attempt soon), 93% of those who have applied to take the exam have gone on to pass.

Quality assurance (QA) was at the forefront in the 4 years of planning that went into this exam prior to the first sitting in Autumn 2012. QA has remained a top priority at each and every examination in its individual planning and execution. In general terms, the purpose of the entire process is to define a pass mark that is considered, on the basis of all the QA measures, to be the standard at which a 'just passing' candidate would be acceptable for interview for a consultant post with a Pain Medicine component. The methods of the QA programme have been reviewed and supported by the GMC. QA is integral to every aspect of the examination, i.e. the questions, the examiners, and the examination itself. By controlling all of these variables we are highly confident that, in the examination itself, the only significantly unknown variable is the standard of knowledge and understanding possessed by the candidate, the assessment of which is, of course, the express purpose of the examination.

All questions are drafted to FRCA standard in terms of structure. All MCQ and SOE questions are written by trained and experienced examiners and question writers. They are subject to multiple redrafting and peer review. Every question is tested by the group in terms of its applicability to the safe and effective practice of Pain Medicine. Each question is rigorously and specifically tested for relevance and difficulty.

Examiners are chosen on the basis of competitive application. The exam cohort is fortunate in having a significant number of examiners with wide experience in the FRCA examination. Many examiners have attained Fellowship by examination in internationally recognised examinations such as Fellowship of the Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists (FFPMANZCA) and Fellow of Interventional Pain Practice (FIPP). All examiners have had specific training for the FPM examination in technique and marking consistency. Examiner performance within the examination has consistently been audited in a programme designed and led by the senior FRCA Examiner Audit Lead, Dr Jane Pateman.

New FFPMRCA examiners and question writers 2014: (l-r) Dr G Baranidharan, Dr V Mehta, Dr S Kanakarajan, Dr K Simpson (Chair), Dr R Sawyer, Dr J Weinbren, Dr V Mendis

Each MCQ and SOE paper is chosen to test the depth and breadth of Pain Medicine knowledge and understanding in all areas of practice in the published curriculum.

Each paper is carefully reviewed for overall balance. Following the MCQ examination the pass mark is set by an expert Anghoff reference group that includes senior pain clinician representation from outwith the Court of Examiners. The group reviews every single leaf of each MCQ for its ability to discriminate between strong and weak candidates. This provides an internal measure of reliability.

> **"All MCQ and SOE questions are written by trained and experienced examiners and question writers... each question is rigourously and specifically tested for relevance and difficulty"**

The SOE paper is reviewed in detail by the examiners on the day before the examination. This is to standardise the process of administering questions and define an agreed level of knowledge required to pass. This enhanced QA process is unique to our Faculty. After every examination there is detailed group discussion on the pass mark. A range of validated measures are used to help define the pass mark for both papers, including Anghoff, Ebel and Hofstee methods; this is supported by multiple regression analysis of examiner scale judgement. Whilst these methods are not sufficient in themselves to define a pass mark, they add quality and validity to the ultimate decision made by the Court of Examiners.

After the examination any borderline candidates are discussed in detail by the whole group of examiners who then agree the final pass mark.

The Faculty has developed a highly valid examination with the most robust QA processes possible to ensure that it successfully identifies candidates who have demonstrated the knowledge and understanding needed to attain a qualification indicative of the highest standards of Pain Medicine training and to act as a guarantor of the highest quality of Pain Medicine practice.

The QA process was developed and refined by Jeremy Cashman without whose skills we would not have been able to progress so fast and so far. The QA has now been handed to Tony Davis who has already shown that we can be confident that the stringent QA process that has been put in place will continue and evolve.

In addition we rely completely on the support of our excellent examinations team under the guidance of Graham Clissett and we offer them our thanks for their unfailing support. We would like to give special thanks to Neil Wiseman whose knowledge and skills in quality assurance have been invaluable.

FFPMRCA Examination Calendar August 2015 – July 2016

	FFPMRCA MCQ		FFPMRCA SOE	
Applications and fees **not** accepted before	Mon 22 Jun 2015	Mon 2 Nov 2015	Mon 31 Aug 2015	Mon 15 Feb 2016
Closing date for FFPMRCA Exam applications	Thurs 13 Aug 2015	Thurs 17 Dec 2015	Thurs 24 Sep 2015	Thurs 17 Mar 2016
Examination Date	**Wed 2 Sep 2015**	**Tues 2 Feb 2016**	**Tues 20 Oct 2015** (backup day 21 Oct)	**Tues 12 Apr 2016** (backup day 13 Apr)
Examination Fees	*TBC*	*TBC*	*TBC*	*TBC*

Trainee Update

Dr Lucy Miller

Faculty Trainee Representative

I would like to draw your attention to a number of improvements that have occurred during the dark nights of winter. As I'm sure you have noticed the Faulty of Pain Medicine website has been substantially updated and there is yet more to follow. It now offers five career stories which illustrate the diversity of Pain Medicine as a consultant and the routes to achieving this. It also includes a comprehensive step by step guide as to what is expected during the Advanced Pain Training year. This can be found under the subtitle of 'Training and Assessment'. It details training requirements at each three month interval and acts as a fantastic aide memoir: http://www.fpm.ac.uk/faculty-of-pain-medicine/a-career-in-pain-medicine.

Another exceptionally useful addition to the website can be found under the heading 'Evidence Base'. This resource collates national and international guidelines and Cochrane reviews subdivided into ten headings that relate to Pain Medicine: http://www.fpm.ac.uk/faculty-of-pain-medicine/evidence-base.

May I congratulate all those that have recently passed the FFPMRCA. On average 73% of candidates pass the MCQ and 67% pass the SOE. The recent recruitment of new examiners and question writers will continue to maintain the high quality of this examination. It is also intended that with a larger bank of questions the Faculty will be able to release more MCQ and SOE examples as requested in the Trainee Survey.

One change to training that commenced in January of this year was the reduction in case report requirements to one. This should still be of publishable quality and is intended to be a learning exercise with involvement of RAPMs or Educational Supervisors prior to final marking and submission to the Faculty. The guidelines, marking criteria and examples with scorings can now be found on the Faculty of Pain Medicine website: http://www.rcoa.ac.uk/faculty-of-pain-medicine/training-examination-and-assessment/case-reports.

There continues to be a slight fall in the number of Advanced Pain Trainees this last year with unfilled positions now available across the country. Articles have recently been submitted to *Pain News* (Dr E. Baird) and the RCoA *Bulletin* (Dr DeGray and I) which are aimed at increasing awareness amongst anaesthetic trainees of both what Advanced Pain Training entails and highlighting the advantages of a career in Pain Medicine. This fall in applicants has been previously attributed to the speculative uncertain future of Pain Medicine in the UK. However, please be assured that pain is very much on the agenda nationally and the number of available consultant positions each year remains consistent. In fact the Faculty's contribution to Health Education England's Call For Evidence stated "This expanding, elderly population with significant co-morbidities is likely to increase demand for chronic pain services".

Two trainees have kindly volunteered to assist in developing a web-based platform for recording and sharing formalised teaching sessions between trainees. In the interim the London Pain Training Advisory Group has kindly invited trainees from the rest of the UK to attend their training days. Dates are available on the Faculty website. The first few 'open' London days have been a great success. Please feel free to utilise this resource and to network in the process.

Finally, following a poll of attendance of pain trainees at the BPS meeting in April it has been decided to hold the next annual meeting in the autumn at the Royal College of Anaesthetists. It is also hoped that you will join me for a social gathering nearby afterwards. It would be lovely to meet as many of you as possible.

Becoming a Consultant in Pain Medicine

Dr Graham Simpson

Consultant in Anaesthesia and Pain Medicine

I have recently been asked, "What is it like becoming a consultant in Pain Medicine?"

Firstly I have to admit that I have been fortunate in many ways. I negotiated a weekly pain session during a large part of my ST7 year, which meant that I wasn't away from doing clinics or procedures for too long. I also work in the unit where I spent the latter part of my training, which meant that I was already familiar with most aspects of the job when I started. In many ways, this has eased the transition for me, but becoming a consultant is still an exciting and frightening prospect.

Overall, I will confess to really enjoying it so far. I really enjoy the new challenge of being an independent practitioner, and have to say my stress levels are overall (at the moment) a lot lower than they were throughout my training.

My initial angst related to an underlying concern of not having enough knowledge, skills or experience, after a relatively short apprenticeship compared to that of a general anaesthetist. I'm not complaining! I feel that on one hand Pain Medicine has really enhanced my anaesthetic practice, and on the other I have worked hard, and feel that I have attained the core skills to do the job.

I had always presumed that the person ranked above me at various times of life (student, SHO, SpR, consultant), was the font of all knowledge. Now that I have reached the end of the junior doctor conveyer belt, I realise that this was a naive assumption. Yes, I do have more knowledge and experience, but there remains a lot of uncharted territory to be explored.

My initial impression is that as a consultant the learning curve accelerates rapidly. By and large, business will continue as normal. I will to go to courses (probably more often than before), write a PDP, read journals, discuss cases with colleagues, broaden my experience, and continue to learn.

There are many positives to becoming a consultant (not all discussed). Firstly, I am no longer on the trainee rota! I really enjoyed my training, but I didn't realise how tough it was until I stopped doing it. I'm not saying being a consultant is easy, it's just different. I now have a job plan which gives an orderly pattern to my working life for the first time since University term times. I can now plan my life outside of work because the rota is written well in advance. I know when my clinics are, and I have the opportunity to plan well ahead and see my family and friends a lot more. Secondly I have supportive colleagues who are always there for advice, and to allow me to share my dilemmas with them.

One of the most difficult aspects of the job is the mountain of administration and the time needed to complete it. Clinics create a huge amount of letters, referrals, phone calls and emails and although we have marvellous secretaries who are the engine room of the department, it can be a real pain trying to keep on top of it all. Effective time management is the key. Clinic over-runs spilling into the afternoon procedure list does nothing for my popularity with the nurses.

Finally, before starting, I was given some expert advice, which I hope I have interpreted correctly. Learn to say no, and be careful not to take on huge responsibilities initially (even for a couple of years) to allow yourself to grow into your new role. Secondly be wary of doing work that is not in your job plan, and make sure (note to self), that your clinic workload is manageable. It will quickly become the norm, and what is expected of you. Keep a diary of activities to demonstrate how hard you work!

Overall, becoming a consultant is well worth the hard work, sacrifices and struggles, and I am enjoying it immensely. What we know for certain is that there is always another challenge around the corner.

First Steps in Paediatric Pain

Dr Jonathan Rajan

ST7 Pain Medicine and Anaesthesia

During the final two weeks of my Advanced Pain Training (APT) year, I was fortunate enough to be given the opportunity to dip my toes into the unknown waters of paediatric pain. A two week placement at Great Ormond Street Hospital (GOSH) would help shed light on the complexities faced by parents, children and a wide range of healthcare professionals. The experience would help bring personal insight into this emerging subspecialty, whilst shining a light on the opportunities for use of transferable skills in the adult pain world.

Pain affecting children is commonplace but its treatment has long been the bastion of a few selected specialist centres. During the last few years the Faculty of Pain Medicine has championed both revolutionary and evolutionary changes in pain training. This raising of the bar has been set against the backdrop of a changing landscape in commissioning of specialist pain services. The growing success of paediatric pain has implications for adult practice. Whatever the future political landscape may hold in store, it is likely that patient centred care will mean that pain specialists in the adult sector will need a greater appreciation of paediatric pain, as a greater number of these patients transition to adult services.

Advanced competencies in paediatric pain involves two key parts. Namely, core competencies in both adult and paediatric patients as well as competencies specific for transitional services and specialist paediatric pain services. Advanced training in paediatric pain requires 12-15 months of APT of which 3-6 months should be in paediatric pain, in contrast to the standard year of Advanced adult pain training. The dearth of specialist centres means that paediatric pain training is often neglected with little experience gained.

However, my two week placement allowed me to see first-hand the inner workings of daily practice in a specialist pain centre and reflect on in its impact on the wider field of chronic pain. During my placement, I was fortunate to observe chronic pain interdisciplinary clinics, complex regional pain syndrome, headache, rheumatology, musculoskeletal and genetic (erythromelagia) clinics. I also undertook acute ward rounds and partook in palliative care meetings focused on a variety of patients, including a patient with cholangiocarcinoma.

Other than clinical activities I was able to attend a journal club at Dr Walker's laboratory with a range of PhD students. I was able to see first-hand the anaesthetic circuits used for mouse models, (warming blankets included), modern quantitative sensory testing equipment and develop a more realistic perspective of the scientific and academic aspects of Pain Medicine.

I gained fascinating insights into how neonatal pain can potentially influence brain development and how translational medicine in biological models can provide interesting avenues for cross speciality and patient education on the biological nature of pain. The ethos of cross speciality discussion and the pivotal role of allied health professionals underpin all work in paediatric pain – teamwork makes the dream work!

On reflection, even if one is not intending to practice paediatric Pain Medicine as an adult pain specialist, there are many transferable skills. An understanding of the interplay between specialists and how they can impact on the improved quality of care and patient safety can be something that is transferred to a greater degree to adult practice.

Furthermore, with ever more children making their way through transitional services in the future, more former paediatric pain patients will become patients in the adult chronic pain setting. Knowledge and understanding of translational services, paediatric pain syndromes and the nature of the patient provider interface in paediatric pain can only help the adult specialists in dealing with this challenging group of patients as they grow older.

RAPM Update

Dr Lorraine De Gray

RAPM Chair

The end of last year saw the return of the first tranche of RAPM Bi-Annual Reports from 19 out of 21 regions. The reports have been analysed and the data have been very useful in highlighting the excellent resources and training available to our trainees. They also highlight areas within training which can be improved such as ensuring that on-call commitments do not encroach on day time training particularly at Higher and Advanced level, and the need for completion of quarterly assessments and case reports in a timely fashion.

The data also allow us to map which regions offer formal teaching and whether this is available to trainees from other regions. These data are to be published to provide trainees with the opportunity to access this formal teaching. Several regions are now opening their doors to trainees from neighbouring regions for formal teaching.

> **“Several regions are now opening their doors to trainees from neighbouring regions for formal teaching”**

The data also allow us to map out which regions provide training in subspecialist modules, that is, cancer pain, paediatric pain, spinal cord stimulation, and intrathecal drug delivery. The data will help trainees in choosing where they may wish to pursue Advanced Pain Training. The reports also highlight that there are currently several unfilled training posts in Advanced and Higher Pain Medicine and I cannot once again emphasise enough the importance of targeting specialist registrars doing basic and intermediate training in Pain Medicine. If we deliver enthusiastic well-structured teaching and training at the basic and intermediate levels, it is very likely that this will have a positive impact on the current recruitment of trainees.

The Hospital Review Form was also rolled out late last year, with four regions having already submitted their data. Another four regions will be submitting their data in the next few weeks and it is projected that by the end of this year, the Faculty will have a complete set of data from all regions. I look forward to sharing these data once we have been able to review them in detail.

The new year has also brought about some new changes and newcomers to our ranks of Regional Advisors. Dr Adrian Searle now also has responsibility for the newly merged East Midlands region. This brings the total number of regions overseeing Pain Medicine training across the UK to 20 in total, each overseen by a Regional Advisor. Dr Nick Hacking has taken over from Dr Barry Miller for the North West Region and Dr Sonia Pierce has taken over from Dr Sharmila Khot for Wales. I would like to take this opportunity to welcome the newcomers and to thank Dr Khot and Dr Miller for all their dedication and hard work over the last few years. I would also like to congratulate Dr Miller and Dr Baranidharan (RAPM Yorkshire) on their election to the Faculty Board.

Lastly I would like to bring to your attention a document published by the Royal College of Anaesthetists in December 2014, *Regional and Deputy Regional Advisor Guidance for College approval of job descriptions, job plans and person specifications*, which apart from general advice also includes useful information for the approval of consultant posts which have a part or full time component in acute and/or chronic Pain Medicine. This complements and should be read in conjunction with the document *Guidance for Advisory Appointments Committees (AAC) Assessors* published in November 2014.

I look forward to meeting all the Regional Advisors at our spring meeting, and also look forward to meeting all trainees attending the British Pain Society Annual Scientific Meeting in April. Do come and introduce yourselves to me.

The Changing Landscape of Pain Training in Wessex

Dr Nick Campkin

RAPM for Wessex

What are the challenges facing training in Pain Medicine in 2015? I have seen a lot of changes in Wessex over the last 20 years, since I came here as a Senior Registrar in 1993. Fresh from Westminster and enthused by the Pain and Nociception Group (PANG) meetings, I was interested in chronic pain management. Back then there was no formal pain training programme; I made my own, using study time when necessary, and was lucky to find excellent mentors who were interested in teaching. There was an active regional pain forum, the Wessex Pain Group led by Tim Nash in Basingstoke. It was a great place to develop an interest in chronic pain, with plenty going on and senior clinicians who encouraged me to spend time with them and at other centres of excellence outside Wessex.

I started as a consultant in Portsmouth in 1995. We achieved College recognition as the regional advanced training centre and I soon found myself involved in education and developing the pain training in Portsmouth and Wessex. I was Associate Specialist Training Committee (now the Pain Training Advisory Group) Chair from 2001 and became Regional Advisor in Pain Medicine in 2010. Over this time we have seen reconfiguration of many chronic pain services across the country, with Wessex being no exception. In Portsmouth we have experienced disinvestment in the hospital multi-professional Pain Clinic and commissioning of a community persistent pain team without direct medical input. Last year the Dorset pain service contract was awarded to a primary care provider, with medical input contracted from local consultant pain physicians.

Disinvestment in hospital Pain Medicine and commissioning of other providers of pain services has led to concerns about providing training.

To maintain the quality of Advanced training we have developed a regional rotation across Wessex. At intermediate level, Pain Medicine, including chronic, cancer and acute pain is a core element of the anaesthesia curriculum. A pain module as an intermediate trainee improves recognition of more complex pain problems with an understanding of the biopsychosocial model enhancing the biomedical approach. Trainees see a range of modalities useful in managing persisting pain and learn the value of good communication, the limitations of drugs and injections, and when and how to ask for help. Such knowledge and skills are beneficial to all anaesthetists, for whom managing pain is a core skill. The curriculum demands supervision and assessment by anaesthesia trainers, and there has been concern that if pain services are divorced from acute hospitals and anaesthetists, providing and assessing training will become difficult.

What lessons have we learned in Wessex? Dealing with such changes has reinforced the importance of maintaining good relations and links with new providers of pain services, and recognising responsibility for anaesthesia training when discussing service reconfiguration with commissioning groups. Service specifications and job descriptions should ideally include this element explicitly. There is guidance available at http://www.rcoa.ac.uk/faculty-of-pain-medicine/guidelines which may be helpful. It is vital to engage medical pain clinicians and Local Pain Medicine Educational Supervisors and recognise and reward clinical and educational supervision in job plans. Some elements of chronic pain services remain in acute hospitals (inpatients, support to acute pain services, cancer pain, for example) and afford training opportunities. Trainees need to take ownership, and plan and organise their pain module actively with clear expectations in terms of session numbers and mix, assessments and logbook, reflecting the curriculum. To maintain standards the unit of training is reviewed and signed off by the LPMES: the ePortfolio makes this easy to do online.

Training can be delivered against a changing landscape of service provision with imagination, flexible use of resources, and most importantly the goodwill of interested trainers.

Medico-legal Update

Dr Jon Valentine

Consultant in Pain Medicine

Chronic pain claims commonly fall into the 'catastrophic injuries' category. The claims are often high value and complex with medical opinion being sought from several other disciplines, often including orthopaedic surgery and psychiatry or clinical psychology.

Sixteen years ago, I received my first letter of instruction from solicitors seeking the expert opinion of a pain specialist. I had no knowledge about writing medical reports or what it meant to be an expert witness. The intellectual challenge looked interesting and the remuneration welcome so I chose to learn the ropes. I would say I continue to learn those ropes, but one undoubtedly amasses considerable knowledge and experience in 16 years of reviewing expert evidence, watching covert surveillance, discussing cases with lawyers, attending conferences with counsel, listening to experts giving oral evidence in court, and reading judgements after trials.

As a reader of this article, you might be considering working as an expert witness or looking to expand your current medico-legal practice. My aim is to provide some useful guidance and advice based on my knowledge of the business and my personal experience over the years. It is very important to understand the commitment involved. Your duty is categorically to the court, not the claimant or instructing party. You must be aware that failing in this duty can result in serious professional consequences. Preparing evidence in complex cases is time consuming and often takes much longer than expected. There will be inconvenient deadlines, meetings and case conferences. Court hearings will threaten your long awaited and much needed holiday!

Your office must respond promptly to correspondence; provide estimates of your total fees for each case; establish terms of engagement; manage confidential documents; ensure deadlines are met. You need reliable typing and proofreading services. You also need to be very well organised to ensure payment is received in accordance with your terms.

In terms of learning, *Writing Medico-Legal Reports in Civil Claims – An Essential Guide* by Giles Eyre & Lynden Alexander is an excellent place to start. Sound knowledge of the Civil Procedures Rules is essential, and Bond Solon Training provides an established online learning course. There are numerous courses for experts to attend, ranging from basic report writing to courtroom skills. There is no easy way of establishing a good flow of instructions beyond doing the job well each time the opportunity arises. Always communicate well; provide timely responses; ensure your report is well written and presented; address the issues raised in your letter of instruction.

It is of course important to impress the solicitor that instructs you, as he/she might then instruct you again and recommend you to his/her colleagues. However, barristers and senior claims technicians also read your evidence and hear of your performance at conference and in court. Their numbers are much smaller and consequently word gets around fast. Their opinions about the quality of your work can have very important influence on the instructions you receive.

For most, it is probably important to register with medical reporting agencies to attract the instructions, but do chose the agencies carefully. My advice is only use members of the Association of Medical Reporting Organisations (AMRO), but if tempted to use other services, do check out the company by using an online service such as DueDil.

Finally, remember that advice from colleagues with experience can be invaluable when it comes to understanding the business and avoiding the common mistakes that many of us have made along the way. These colleagues often have tremendous enthusiasm for the work and will be only too happy to offer their advice along with an account of their personal experiences.

***The Faculty is running a study day on 'Medico-legal Issues in Pain Medicine' on 5th June 2015* (see pg.27).**

Professional Standards

Dr Beverly Collett

FPMPSC Chair

The Professional Standards Committee has been busy. This is reflected in the number of articles written by committee members in this edition of *Transmitter* as we wanted to inform you about many of these important items in more detail than my routine report allows.

Core Standards

Anna Weiss has been tremendous in collating and helping co-edit chapters for the *Core Standards for Pain Management Services*. This document will be sent out for consultation and comment in late spring and should be available on the Faculty website in the autumn. It is a dynamic document that will be subject to ongoing updates as the work of pain management services develops. It will be a significant and important resource for all healthcare professionals working in pain management services, as it defines recommendations and standards which these services should aspire to and achieve. May I personally thank the individuals who have been involved in writing chapters and their parent organisations and colleges for fully supporting this project.

Conducting Quality Consultations in Pain

Tony Davies and Paul Wilkinson have produced an exceptional document defining the standards required to optimise specialist pain consultations. This is an excellent, thought-provoking treatise on the quality consultation, discussing both the theory and the practical aspects of the consultation, linking to GMC standards. I am sure that you will find this an excellent tool and we thank Tony, Paul and their expert colleagues for this outstanding document. This is now available on the Faculty website.

Patient Information Leaflets

Andy Nicolau and Paul Wilkinson have produced a template for patient information leaflets for injection interventions. This has been ratified and work is underway now to produce information leaflets for a variety of procedures. These will be available to download from the Faculty of Pain Medicine website by this summer and we hope you will find these useful to supplement your routine consent process. The medication leaflets on pregabalin and gabapentin are being updated to reflect the recent Public Health England/NHS England advice.

Pain in Secure Environments

Cathy Stannard continues to work with Public Health England on a pain management educational package for prison staff and the first pilot training day is being planned. Once established, it is hoped that the audience for this course could be widened and it could be made available to other groups of staff, such as staff working in nursing homes and residential care.

Opioids Aware

This is the name of the opioids resource that Cathy Stannard and Roger Knaggs are developing. It will be formatted as an organic web resource hosted via the Faculty of Pain Medicine website. Learn more about this at the British Pain Society Annual Scientific Meeting.

ASK2QUESTIONS

Andy Nicolaou, Professor Ann Taylor and Dr Chris Barker have highlighted this important work: that is to identify early the patient with acute pain who may run the risk of developing chronicity. This is of vital importance to patients, General Practitioners and to consultants in Pain Medicine and could lead to better strategies to get these patients fast-tracked into appropriate treatment. You can find the ASK2QUESTIONS webpages via the Faculty website.

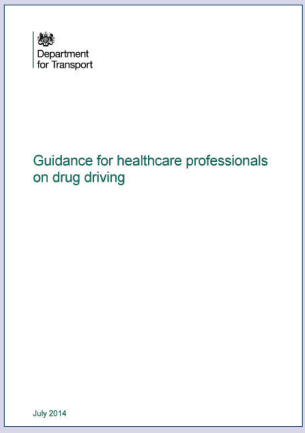
WHO Checklist for Pain Medicine Procedures

Safety is an important aspect of the work of this committee. Many of us use a WHO Checklist when we undertake procedures, but these are not totally ideal for pain interventions. Paul Wilkinson has taken on the task of developing a WHO Checklist for Pain Medicine procedures and will update on this in the autumn.

Examples of Exceptional Practice

The Faculty is very aware that many pain management services have instigated areas of innovative practice, excellent patient services, new links, or exceptional training, research and education facilities. Yet, there is little opportunity to tell others about these areas of excellence in current journals. In addition, most healthcare professionals are self-effacing and are not prone to advertising what they do. Sometimes, people may not be aware of how innovative or exceptional their practices are.

The Faculty would like to establish a website forum where you can share these examples of exceptional practice. If you wish to participate, please submit a paragraph (300 words) telling us about any aspect of your service that is successful, new, different or exciting to fpm@rcoa.ac.uk.



Drugs and Driving

The government's previously announced primary legislation to create a new offence of driving with a specified drug in the body above the accepted limit for that drug came into force in March 2015. The legislation includes a 'zero tolerance' approach to a group of drugs associated with illegal use and certain drugs associated with medical uses. The 'zero tolerance' group includes:

- Cannabis (THC)
- MDMA (Ecstasy)
- Ketamine
- Methylamphetamine
- Cocaine (and a cocaine metabolite, BZE)
- Lysergic Acid Diethylamide (LSD)
- Heroin/diamorphine metabolite (6-MAM)

Amphetamine was not included in the initial regulations to go before Parliament in 2014 but is expected to be included later in 2015 once a limit has been agreed. Some benzodiazepines (including Clonazepam and Diazepam), Methadone and Morphine are included in the medical drug category, and have blood limits set at a higher level than the 'zero tolerance' group. The higher limits are generally above the normal therapeutic range, however those on high doses could test above the specified limit for that drug.

For patients who are prescribed drugs in either category, the government has included a statutory medical defence. If the police are satisfied that a driver is taking the relevant medicine on the advice of a healthcare professional and in accordance with written instructions they will not be prosecuted. It may be helpful for patients to keep suitable evidence with them when they are driving.

The statutory medical defence will not apply if the patients driving is impaired due to drugs, and patients should still be warned not to drive if this is the case. Although it is the responsibility of the driver to consider whether their driving is, or might be impaired on any given occasion, it is the responsibility of prescribers to give suitable clinical advice to patients regarding the risks of their medicines. This advice should include not to drive if symptoms or signs develop suggesting their driving may be impaired (such as sleepiness, poor coordination, impaired or slow thinking, dizziness or visual problems); not to drive at times when the risk may be temporarily increased (for example when first starting or when increasing or reducing the dose of a medication that may impair driving); and to take care in circumstances that may increase the risk of their driving being impaired. For a list of examples of such circumstances please refer to the full FPM guidance at http://www.rcoa.ac.uk/system/files/FPM-Response-to-Changes-to-Drug-Driving-Law_0.pdf.

It is also strongly recommended that clinicians read the detailed guidance for healthcare professionals that is available on the Department for Transport website: https://www.gov.uk/government/publications/drug-driving-and-medicine-advice-for-healthcare-professionals.

Core Standards for Pain Management Services

Dr Anna Weiss

Co-Editor, Core Standards

Background

In autumn 2013 the Faculty of Pain Medicine Board declared the need for a comprehensive document which would prepare for the development of future standards for Pain Management Services in the United Kingdom. This was preceded by the publication of the *Guidelines for the Provision of Anaesthetics Services* (GPAS) 2013 document, which encompassed relevant guidelines for anaesthesia-delivered acute and chronic pain management services. The *Core Standards* document refers to the GPAS document plus other relevant publications.

Role of the FPM in securing Core Standards

The Faculty of Pain Medicine is committed to securing professional standards for all pain specialists who are Fellows of the RCoA and those in training. There is interest from bodies external to the RCoA for the FPM to become instrumental in advancing standards for professional groups other than anaesthetists involved in the delivery of such services. The prevailing consensus was that setting standards for professionals other than those affiliated to the RCoA must not become the primary role of the FPM. However there is appreciation of the principles underpinning pain management that care is based on multidisciplinary practice. To prepare a *Core Standards* document fit for purpose the FPM pursued collaboration with other professional bodies. This is well represented in a variety of chapters of the publication.

Why is it needed?

The ongoing changes to the NHS make this a timely undertaking. Variations to commissioning structures across the UK invite the need for a set of rules for clinicians and commissioning bodies to ensure equity of care across the NHS and amongst affiliated care providers. This document aims at supporting clinicians, commissioners and health managers to ascertain good service provision. It will also address the professional components that underpin good medical and wider professional practice. The most important aim of this document is to support the principles of safe, equitable and quality care for patients.

Process of Core Standards development

The publications of the BPS, FPM, RCoA (GPAS 2013/2014) and GMC were consulted. The National Pain Audit and the Map of Medicine Pain Pathways were considered. Commissioning documentation and *National Guidance on Pain Service Provision* was included. Where no national guidance or standard was available, we referred to IASP or other recognised sources. A scoping meeting in July 2014 defined more precisely aims and direction of the document. First draft chapters were returned by August 2014. Debate and clarification have resulted in most chapters being either written or in end draft by now.

Main features of the document

Chapters have a brief introduction and a concluding background section and distinguish between **Recommendations** – aspirational or desirable features that may become standards for future versions; and **Standards** – items already imbedded in practice or of overriding necessity for good care.

Content covered

1. Commissioning of Services across the UK
2. Description of Services
3. Physical Facilities (for delivery of pain services)
4. Pain Management Services Team
5. Patient Pathways
6. Pain Interventions
7. Education, Appraisal and Revalidation
8. Service improvement and Clinical Governance

Forty-five authors have contributed, representing a broad base of experience, either through involvement in organisations campaigning for patients with pain conditions or clinical, research or management expertise.

Where are we headed?

The first version of *Core Standards for Pain Management Services* is planned to be presented for public consultation soon. We expect much debate and hope that all of it will be ultimately of service to our patients and the progress of pain management across the UK.

Conducting Quality Consultations in Pain Medicine

Dr Tony Davies

FPMPSC Deputy Chair

Last year the FPMSC Chair, Beverly Collett, asked the Professional Standards Committee to reflect on important quality issues that should be considered within its remit. It was suggested that, whilst the Committee has concentrated appropriately on many diverse aspects of Pain Medicine, there has been little focus on optimising the fundamental building block of our practice: namely the clinical consultation.

The clinical consultation is the bedrock of our professional practice in pain. Pendleton, a pioneer in clinical communication skills, described the consultation as the central act of medicine. Despite considerable medical and technological advances, this statement holds as true today as it did back in 1984. Most research work in this area has been undertaken from a primary care perspective. Whilst these generic consultation skills are important for all medical practitioners, it is well recognised that the specialist pain consultation is typically a complex interaction. Indeed, colleagues frequently comment on their respect for pain clinicians as they navigate the challenge of busy clinics with high patient distress and suffering.

Many pain clinicians gravitate toward this specialist area because of the maturity of their communication skills. Considerable skill is required in aligning these professional attributes with patients' needs and belief systems. Pain practitioners will also inevitably have developed a personalised approach to the consultation largely based on their experiential learning. In medical education there is however a well-accepted adage that 'Experience is not always the best teacher'. There is the risk that we fall into the trap of thinking 'But this is the way I've always done it'. In clinical situations this may impede the evolutionary development of more creative strategies and solutions. This is particularly important at present with the increasing focus on patient centred care and shared decision making.

Routinely evaluating our clinical performance during consultations may help us maintain our professional development. This new document *Conducting Quality Consultations in Pain Medicine* will facilitate this strategy. The consultation guidelines have been built from the General Medical Council standards and our own Faculty document *The Good Pain Medicine Specialist*. Myself and my co-author, Dr Paul Wilkinson, have been keen however, to ensure that the document goes beyond minimum standard setting with an aspiration to ensure that the highest quality consultations are delivered. It is acknowledged that all components will not necessarily be achieved within a single consultation but may require delivery via a series of consultations. In a multidisciplinary team, some aspects of the assessment and management may be undertaken by other suitably trained members within the team. A key focus of the document is to signpost well-recognised difficulties that may arise during consultations with a view to managing them effectively.

As well as the obvious quality considerations inherent in a document of this type there may also be potential practical ramifications. For those working within the National Health Service we are regularly being asked to justify our clinic profiles. This document should facilitate managerial discussions where quality is firmly on the agenda. The clearly defined biopsychosocial framework required will by definition require a more comprehensive assessment.

To promote professional development of the skills required in consultations, we have provided referenced supplementary information in the appendices. Evidence has been drawn from acknowledged clinical consultation models and other relevant research. Guidance has also been forthcoming from respected clinical communication skill experts.

We hope that colleagues will find this document a useful resource which will facilitate clinical excellence in this core practice as well as provide the tools to foster further practitioner development.

ASK2QUESTIONS

Dr Chris Barker

Clinical Director,
Community Pain Service

Dr Andrew Nicolaou

FPM Board Member

Mrs Ann Taylor

Reader,
Cardiff University

Background

The first English Pain Summit took place in Central Hall, Westminster in November 2011. It was a landmark meeting of parliamentarians, healthcare professionals, commissioners and patient groups, with the Faculty of Pain Medicine well represented. Other groups present included the British Pain Society, the Chronic Pain Policy Coalition and the Royal College of General Practitioners.

Important issues around chronic pain and the current status of pain services in the United Kingdom were considered and discussed. The outcomes of this summit included four key recommendations to be led and delivered by the stakeholder groups involved with pain.

The first of these recommendations – "Clear standards and criteria must be agreed and implemented nationally for the identification, assessment, and initial management of problematic pain" was led by the Faculty of Pain Medicine Delivery of this key recommendation from the Pain Summit would draw upon the lead the Faculty has taken on shaping and developing educational standards on pain.

Given that the remit was the identification and assessment coupled with the initial management of problematic pain, it was also clear that strengths and expertise should be drawn from other collaborating groups, such as in particular primary care.

Much around this recommendation would fall to General Practitioners, physiotherapists, practice nurses and others in primary and community care and 'upstream' of secondary and tertiary pain centres. The Faculty was pleased therefore to involve Ann Taylor from Cardiff University as lead on this recommendation, and Dr Chris Barker, both of whom have contributed an enormous amount to furthering pain management from their respective backgrounds of nursing and general practice. In a similar fashion to the multidisciplinary environment we strive to promote for our patients, and with the right patient being seen by the right person in the right place, they have been the right people for this task and key to the delivery of this recommendation.

A culmination of lots of hard work over many months, with robust stakeholder engagement, defining complex/problematic pain, consideration of specific assessment tools and the development of further tools led us back to Westminster in November 2014.

The group was pleased to be part of this final presentation on behalf of the Faculty and led by Kate Grady. We outlined the progress and delivery on 'our' recommendation, and this was well received by all.

There is still work to do, not just with developing further themes from the original task given, but also derivatives from it. For example piloting the ASK2QUESTIONS pre-screening tool as widely as possible will be important and further work to support grant applications around problematic and complex pain.

Our view is that work around risk stratification and the identification of patients in need and distress, and then diverting resources accordingly and in a timely fashion, will become increasingly more relevant and important – especially in the current climate of increasing financial pressures in the NHS.

What it is?

ASK2QUESTIONS is a very short pre-screening tool to help clinicians decide when they need to take careful notice of a person presenting with pain. It's designed particularly for diagnostic clinicians working in primary care, such as GPs and physiotherapists, but its utility isn't limited to these groups. We see it as a tool that can be used quickly by many other groups such as district nurses, community matrons, Accident and Emergency Department staff, and so on.

What are we trying to identify?

Complex pain. This is a fairly new classification for pain as it doesn't reflect a temporal or aetiological way of looking at it. It is patient centered and relies mainly on the intrusiveness of pain. We all know that 'Yellow Flags' are predictive of chronicity; there are other non-psychological factors such as duration, pain intensity and number of pain sites that have also been shown to predict chronicity. Classifying pain as complex means we need to take more notice of those presenting with it. Addressing factors associated with complexity early, and treating appropriately, is a good thing all round – if the pain is early in presentation we may prevent chronicity, if it's already chronic then we can reduce morbidity and help to prevent 'revolving door' scenarios.

What is pre-screening?

This is a type of screening that helps the clinician decide who to formally screen for a particular condition. A good example is in depression. If the clinician suspects depression may be a problem he or she uses the two question yes/no tool. If there are two 'yes' responses, the person is formally screened with a depression diagnostic tool such as PHQ-9 (Patient Health Questionnaire) or HADS (Hospital Anxiety & Depression Scale). This approach avoids formally screening lots of people unnecessarily, is quick, easy to remember and doesn't alter the flow of the consultation too much. Pre-screening tools need high sensitivity, but the specificity is less important, as this will be ironed out in the formal tool.

How did this work start?

By seeing patients in non-specialist settings like GP surgeries, and recognising a need to help frontline clinicians make good decisions with their pain patients. We looked critically at the evidence for predicting and preventing chronicity, and also helping those with chronic pain manage in the most constructive ways. These predictive factors were combined, distilled and formulated into the following questions:

Q1. Over the past 2 weeks has pain been bad enough to interfere with your day-to-day activities?

Q2. Over the past 2 weeks have you felt worried or low in mood because of this pain?

How did we get here?

The concept of complex pain (previously 'problematic pain') was presented at the 2011 English Pain Summit Meeting. It was felt this needed more understanding conceptually. The Faculty of Pain Medicine was requested to lead on this recommendation. A small group took this work stream on and, with the support of the FPM and assistance from the Royal College of General Practitioners, developed it.

We ran a national stakeholder meeting and compiled a summary document. We also surveyed GPs nationally for feedback on both the concept of complex pain and the two screening questions. Recently we presented our 3-year work stream summary to the House of Lords as part of the Pain Summit meeting update on progress towards their recommendations, where it was positively received.

Plans for the future

We are now piloting ASK2QUESTIONS across the UK. We have started to identify sites for this and have interested GPs and pharmacists involved. The plan is to gather data regarding diagnostic utility, acceptability in short consultations, shared decision-making etc. from GPs, and use this to inform a HTA application for formal multi-site study.

Additionally, we aim to provide a toolkit to help the clinician gain the most from using the tool. This will involve utilising existing resources e.g. Map of Medicine pathways, online treatment packages, and local protocols. If you would like to help with the audit please contact us (fpm@rcoa.ac.uk).

Faculty Events

Dr Sanjeeva Gupta

Educational Meetings Advisor

Dr Shyam Balasubramanian

Deputy Educational Meetings Advisor

The Faculty of Pain Medicine is committed to continuous improvement of professional development and organises study days, joint meetings and annual meetings to benefit consultants and trainees. Following a survey conducted by Dr Paul Wilkinson to determine the educational requirements of Faculty members, the content and format of our meetings have been modified. The feedback from the delegates has been very positive and encouraging.

Recently, the Faculty conducted two successful study days. The theme of the first day was 'All you need to know about Complex Regional Pain Syndrome'. Dr Andreas Goebel and his team shared their rich experience in managing CRPS as well as setting up an efficient service. The morning session had interesting lectures followed by interactive workshops in the afternoon. Although newer technologies have revolutionised medical practice, the importance of history and clinical examination in the pain clinic cannot be overemphasised. The second day was led by Dr Meera Tewani with the focus on 'Musculoskeletal system examination for diagnosing pain problems'. The event was fully booked and the day was made up of six examination stations. Eminent clinicians from different disciplines demonstrated different clinical examination techniques.

Medico-legal principles underpin our clinical practice. With an ever-growing expectation from society, doctors have a professional obligation to practice medicine that is legally and ethically correct. Dr Rajesh Munglani is organising an important meeting to be held at Churchill House on 5th June 2015 to discuss 'Medico-legal issues in Pain Medicine'. This event has already attracted enormous interest amongst the Fellows of the Faculty. Discussion topics will include issues around consent, case studies, medico-legal assessment of patients and report writing.

The Professional Standards Committee has started planning for the prestigious Annual Meeting which is due to take place on 27th November 2015. Do pencil this date in your diary. Apart from the Annual Patrick Wall Lecture, the programme will include interesting presentations on acute pain, interventional procedures, controversies around opioids, and an interesting debate on the usefulness of the WHO pain ladder in modern practice.

The Committee welcomes innovative suggestions to enhance the usefulness of our educational meetings. If you have novel ideas and would like to contribute to the events, please contact Dr Sanjeeva Gupta (sgupta6502@aol.com) or Dr Shyam Balasubramanian (doctorshyam@hotmail.com).

These events make an important contribution to your CPD. More details on event registration is available at http://www.rcoa.ac.uk/faculty-of-pain-medicine/news-and-events.

2015 Trainee Publication Prize

The 2015 Trainee Publication Prize will go live in early summer. Fellows and members of the Faculty are requested to please let anyone who may be interested know about the prize.

Publications submitted for the 2015 prize must have been peer-reviewed, published during 2014, be on a topic relevant to Pain Medicine and based on original research or a systematic review which includes meta-analysis.

The submitter **must** have been a trainee when the article was published. All entries should be submitted electronically via **fpm@rcoa.ac.uk**

Consultation Responses

RCGP Inquiry into Patient Centred Care in the 21st Century – Call for Evidence

July 2014

Purchaser–provider split and managed competition are still in place in the UK making it difficult to 'break the boundaries'. Whilst market mechanisms might suit well in commissioning services for acute medical and surgical care, the same formula is not entirely appropriate in organising care for patients with chronic pain who require complex interventions over an extended period of time involving coordinated inputs from a wide range of healthcare providers from community, primary and secondary care. The present purchaser–provider split, time-based targets, and centralised control are barriers to integrate the chronic pain services.

The introduction of care pathways by itself will not translate into high-quality care. Training of professionals and project team members working with care pathways is equally important. Healthcare leaders should have the knowledge on how to implement changes and be able to support the professionals in using the care pathways.

Secondary care can support care planning. Pain is a significant part of long term conditions and safe effective pain management that focuses on a biopsychosocial model rather than pain relief can contribute significant to the care planning process as well as add timely interventions that maintain patient function and reduce harm. By working alongside practices much more can be achieved.

The GP threshold to refer patients with chronic pain to the hospitals is low and discharging the patients back to the community is also difficult, resulting in a revolving door phenomenon. In spite of pain being the most common reason for a patient to consult their doctors, education about the assessment, identification and management of pain is very basic in the university-based teaching for healthcare professionals. Inter-professional education is also rare. To obtain competency in care for managing long-term conditions, we require a training system designed to ensure that 'education and training commissioning' is aligned locally and nationally with the 'commissioning of patient care'.

NICE – Care of the Dying Adult

August 2014

A key criticism of the Liverpool Care Pathway (LCP), perhaps unfairly, was how clinicians recognise when someone is in the last days of life. This is inherently a difficult challenge but one that requires greater clarity. One approach is to lower the 'risk' associated with this decision. In other words, staff may currently feel that they have to be certain before they can commence an end of life care pathway, or that this decision is irreversible.

A more flexible approach (and the LCP always advocated regular review) is to adopt the concept currently used for the Amber care bundle. The eligibility for this is an uncertain prognosis, i.e. may recover or may deteriorate. If an end of life care pathway embraced a similar concept ("a high chance of death in next few days but with possibility of the patient rallying for a little longer") this might reframe the purpose of a pathway and allow burdensome interventions to be withheld or withdrawn, but still making provision for basic comfort care including food and fluid, medications for basic symptom control. Staff and families may perceive this more positively as "expecting the worst but hoping for the best" rather than an approach which is designed to facilitate death.

Patients vary greatly in their sensitivity and response to medication (particularly when frail and old) and so a specific dose of a medication may cause unconsciousness in one patient but have no effect in another; the principle issue is titration to effect, based on some measurable end point (the patient stops fitting, or ceases to be agitated – though the latter is not easy to agree).

Staff and families also vary greatly in their perception of effect. For some families, only deep sedation to unconsciousness for their loved one's agitation is perceived as effective management and respecting the patient's dignity. For other families, any hint of tiredness or drowsiness brought about by medication for distress is perceived as medical error and a clear indication of clinicians hastening the patient's death.

GMC and NMC Openness and Honesty: The Professional Duty of Candour

December 2014

- The guidance could be more helpful if it covered all HCPs e.g. physiotherapy, occupational therapy, clinical psychology and pathology technicians etc. One presumes that the governing bodies of these organisations will be considering similar guidance, but it would be sensible if it could all be incorporated into one.
- Would also be helpful for more detail about the coroner and the police and what can be said to relatives when the coroner or police are involved. This may be further into a judicial process than this document is aimed at, but sometimes police are called in quite early.

Do you have any ideas about how we could illustrate how the guidance works in practice (e.g. case studies or decision tools)?

- Examples would help, vignettes are important.
- Suggested asking hospital Quality and Safety teams for ideas – they will have examples. As will Royal Society of Medicine, Patient Safety Section.

Do you think there is anything else that doctors, nurses and midwives should consider when apologising to patients or those close to them?

- Often the error is in systems and not only in individuals. It is important for the team not to make one person shoulder all of the blame. Sometimes, it appears that one person is the major focus of blame, but it turns out not to be the case when the error is appropriately investigated.

To what extent do you agree that patients should always be told about near misses?

- Very difficult to answer, but not always. It should be a serious incident to disclose and discretion applied with the Trust oversight. There may be issues of public confidence by burdening patients with near misses; a system's approach to near misses is more important. There is also a potential for this to take so much time that clinical care is affected.
- Patients do respond to apologies, but some see it as an admission of guilt and may lose confidence in their medical practitioners.

GMC Confidentiality Guidance Review

December 2014

- This document is comprehensive and very good, reads easily and is most informative.
- Many queries about confidentiality will be about issues that are subject to separate guidance, for example advice to DVLA, regarding guns and knife crimes etc. There is a real need for all these guidance documents to be clearly signposted and easily accessible so that practitioner has ready access to all materials. Searching through several documents to find what one wants is not useful. In addition, these documents do need to be published at the same time as a package if possible.
- Should be more guidance on the use of images – smartphones are ubiquitous and we often see photos being taken to show colleagues etc. Similarly the discussion of cases on internet forums is now common – some case studies might help.
- There is a need for some basic information that the doctor can access easily – without necessarily recourse to hospital's legal team regarding common problems.
- For example, child of divorced parents is in hospital, normally cared for by mother and new husband. Child's father and new wife comes in wanting information. What should happen? Lady with dementia has two children – if one is recorded a next of kin, do both have equal access to information?
- Would welcome stronger emphasis on describing the most common risk of breaching confidentiality, which is by discussing/ exchanging patient information on busy wards and clinics.
- The document could help doctors further by identifying some correct procedures as opposed to incorrect, possibly linking to other policy documents such as whistleblowing.
- Possibly more guidance under 'public interest' section of what is ethical practice relating to the duty of disclosure (vs. duty of confidentiality) concerning organisational failing – case studies could help.
- Also could give some examples of difficult confidentiality issues or some Frequently Asked Questions.
- Perhaps include a quick reference guide.

Faculty of Pain Medicine Study Day:

Medico-legal Issues in Pain Medicine

Friday 5th June 2015

FACULTY OF PAIN MEDICINE of the Royal College of Anaesthetists

Programme organised by Dr Rajesh Munglani and Dr Sanjeeva Gupta

0900-0930	Registration and coffee
0930-0940	Introduction: *Dr Rajesh Munglani and Dr S Gupta*
Session One: 0940-1010	Chair: Dr Rajesh Munglani **Medico-legal work an introduction and general principles: what does the Court want?** *Marcus Grant, Barrister, Temple Garden Chambers, London*
1010-1040	**Issues around Consent, guidelines and judging standards of Clinical Practice** *Philip Turton, Barrister, Ropewalk Chambers, Nottingham*
1040-1100	Discussion/ Questions
1100-1120	Refreshments
Session Two: 1120-1145	Chair: Dr Shyam Balasubramanian **The Medico-legal assessment of a patient in pain** *Dr Jon Valentine, Pain Medicine consultant, Norwich*
1145-1210	**The Medico-legal assessment of a patient in pain: talk by a psychiatrist** *Dr Michael Spencer, Consultant Psychiatrist, Cambridge*
1210-1240	**Determinants of chronic pain in the long term: advising the Court** *Dr Rajesh Munglani, Pain Medicine consultant, Cambridge*
1240-1300	Discussion / Questions
1300-1400	Lunch
Session Three: 1400-1435	Chair: Dr Sanjeeva Gupta **Medico-legal pitfalls of clinical pain practice** *Dr Nicholas Padfield, Pain Medicine Consultant, London*
1435-1510	**How not to get sued** *Dr Helen Hartley, Medico-legal Advisor, Medical Protection Society, London*
1510-1530	Discussion / Questions
1530-1550	Refreshments
Session Four: 1550-1620	Chair: Dr Rajesh Munglani **A Masterclass in Medico-legal report writing** *Giles Eyre, Barrister, 9 Gough Square, London*
1620-1650	**Jumping into a blackhole: horror stories from Expert Witness work** *Stuart McKechnie, Barrister, 9 Gough Square, London*
1650-1715	Discussion /Feedback/ Close of meeting

RCoA, London
5 CPD Points
£170, £140 for trainees.
Code: C83
Bookings now open:
www.rcoa.ac.uk

ROPEWALK CHAMBERS — 9 GOUGH SQUARE — MPS — tgc temple garden chambers

Faculty of Pain Medicine 8th Annual Meeting:

Clinical Updates in Pain Medicine

Friday 27th November 2015

0900-0930	Registration & Welcome
0930-0940	Introduction
0940-1010	**Pain following amputation** *Dr Michael Neil, Dundee*
1010-1040	**Perioperative management of patients on opioid maintenance therapy** *Dr Scott-Warren, Manchester*
1040-1100	Discussion
1100-1120	Refreshment
1120-1135	**Trainee Publication Prize**
1135-1200	**Developments: FPM** *Dr Kate Grady, Dean, FPM*
1200-1250	**Patrick Wall Guest Lecture** - *Professor Andrew Rice*
1250-1340	Lunch
1340-1430	**Debate: 'WHO pain ladder for cancer pain'** - is not valid in modern practice: *Prof Sam Ahmedzai, Sheffield* - is still valid: *Dr Mahesh Chaudhari, Worcester*
1430-1500	**Pulsed Radiofrequency: where are we now?** *Dr Connail McCrory, Dublin* *Vice-Dean of Faculty of Pain Medicine (Ireland) and editor, CeACCP.*
1500-1515	Discussion
1515-1530	Refreshment
1530-1600	**Chronic Pain and Teenagers** *Dr Vasu, Leicester*
1600-1630	**Non-analgesic effects of opioids** *Dr Shankar Ramaswamy, London*
1630-1700	Discussion & Close

RCoA, London
5 CPD Points
£195 for Consultants, £140 for trainees.
Code: B08

FACULTY OF PAIN MEDICINE
of the Royal College of Anaesthetists

The British Pain Society
Calendar of Events 2015-16

2015

The Tyranny of Diagnosis
Philosophy & Ethics Special Interest Group Annual Meeting
Monday 29th June – Thursday 2nd July
Launde Abbey, Leicestershire

Pain Management Programmes 15th National Conference
Pain Management Programmes Special Interest Group
Thursday 17th & Friday 18th September
Manchester

Study Day – Topic TBC
Monday 23rd November
Churchill House, London

Headache Special Interest Group Inaugural Meeting
Wednesday 25th November
Churchill House, London

Patient Liaison Committee
Annual Seminar
Thursday 17th December
Churchill House, London

2016

Opioid Study Day
Monday 14th March
Churchill House, London

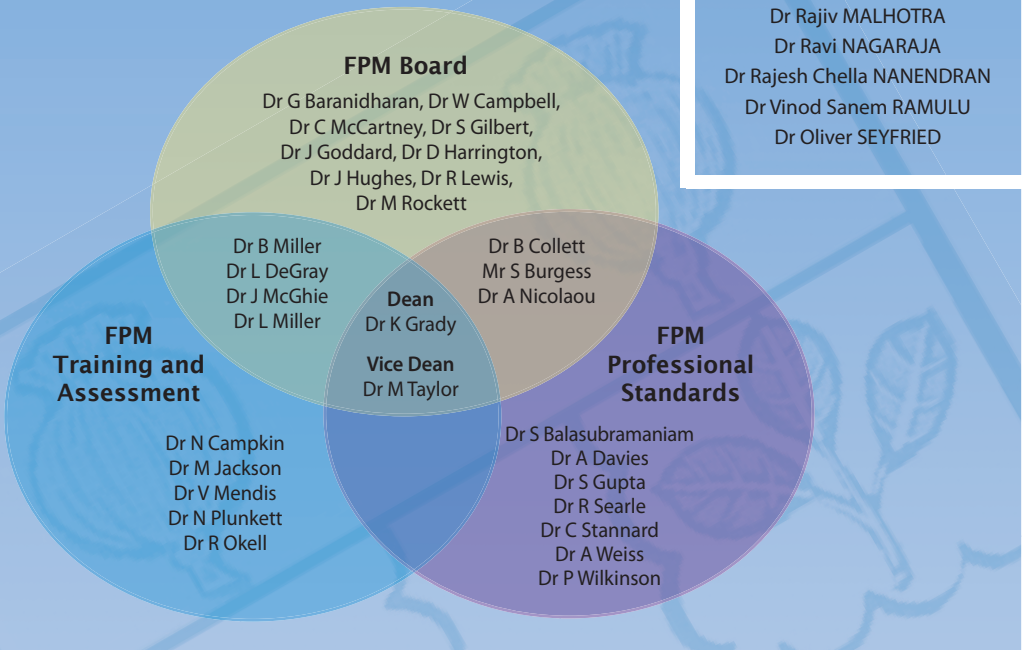
Annual Scientific Meeting
Tuesday 21st April – Thursday 23rd April
Glasgow

More information can be found on our website
https://www.britishpainsociety.org/mediacentre/events/
Or email meetings@britishpainsociety.org

THE BRITISH PAIN SOCIETY

Faculty Update and Calendar

Committee Membership



New Fellows

Dr Rajiv MALHOTRA
Dr Ravi NAGARAJA
Dr Rajesh Chella NANENDRAN
Dr Vinod Sanem RAMULU
Dr Oliver SEYFRIED

2015 Faculty Calendar

MEETING: FPM Training and Assessment Committee	1 May
EVENT: FFPMRCA Exam Tutorial	**13 May**
MEETING: FPM Professional Standards Committee	14 May
MEETING: Board of the FPM	15 May
EVENT: FPM Medico-legal study day	**5 June**
MEETING: FPM Training and Assessment Committee	17 July
EVENT: FFPMRCA Exam Tutorial	**11 Sep**
MEETING: FPM Professional Standards Committee	17 Sep
MEETING: Board of the FPM	18 Sep
MEETING: FPM Training and Assessment Committee	9 Oct
EVENT: FPM Annual Meeting: Clinical Update in Pain Medicine	**27 Nov**

Please note that all dates may be subject to change

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