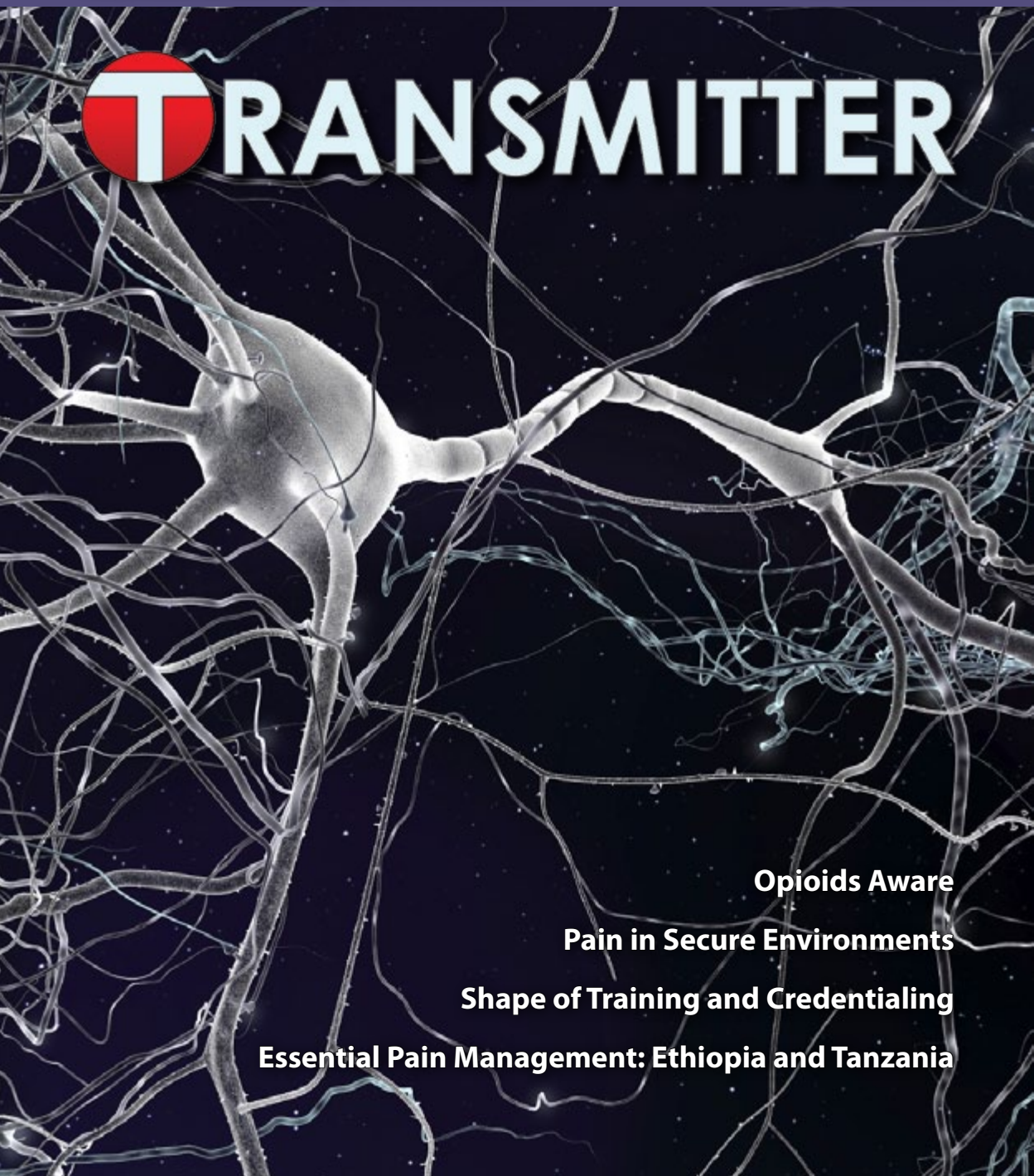
FACULTY OF
PAIN MEDICINE
of the Royal College of Anaesthetists

Newsletter of the Faculty of Pain Medicine AUTUMN 2015

TRANSMITTER



Opioids Aware

Pain in Secure Environments

Shape of Training and Credentialing

Essential Pain Management: Ethiopia and Tanzania

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There is always something surprising and interesting to learn and there are several little facts for me in this issue of Transmitter. I had never heard of Ethiopian Time. The day starts at dawn, not midnight: so, for example, breakfast at 00.30, lunch at 06.00. According to Wikipedia this convention persists because of Ethiopia's pride in its never-colonised status. Initially I couldn't see how this could work, but then realised that, being near the equator, dawn is pretty much the same international time all year round. Still, as Dr Rajan reports on his EPM visit, rather confusing!

Hoo Kee Tsang's article on the history of Pain Medicine in Liverpool was of interest to me, having trained there in paediatric anaesthesia in the mid-80s. I was unaware of one name, John Dundee: I only ever associated him with Belfast.

Training stories feature heavily in this edition. I enjoyed Ruth Whiteman's account of pain training in the Northern region, having myself moved North during training, albeit only as far as South Yorkshire. Beverley Collett's career story highlights the pivotal individuals she encountered during her training, a breadth achieved by the 'old' training structure; much to be commended in my view. Ann-Katrin Fritz expounds the benefits of moving to a different centre in her glowing account of a neuromodulation fellowship at Guy's and St Thomas'.

Once again my thanks to the FPM admin team for production, and to all authors for their time.

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Message from the Dean

Dr Kate Grady

Dean

For the six months since the last Transmitter the Faculty has had the same heavy but gratifyingly successful workload, with our diaries punctuated with important meetings and events. The work of our Professional Standards and Training and Assessment Committees and examinations team continues unceasingly. We hear about each of these further in this edition.

I am delighted to announce that Dr John Hughes, one of our Board Members, has been appointed as the Chair of the Clinical Reference Group for Specialised Pain Services. We congratulate John on this achievement and wish him well in his role. Dr Hughes reported to the most recent meeting of the Board that pain management services have been named as a 'cornerstone' service which means that other specialties have highlighted pain management as an essential service relating to their specialty. We look forward to hearing of further developments within the CRG and know we are in good hands given John's experience and diligence.

Current times are without doubt difficult for Pain Medicine. Some years ago we were hopeful of subspecialist recognition from the General Medical Council. Unfortunately, as you will all know, we received approval from RCoA Council to pursue this status just as a moratorium was introduced on the further development of specialty or subspecialist areas, as all post graduate medical training was to be reviewed. This has taken place in the form of the Shape of Training Review. The overall theme from this is to move postgraduate training to be more generalised although the details for this are yet to be determined. The Faculty have strongly represented Pain Medicine and defended the need for specialised training in Pain Medicine in our senior level discussions with the College who remain supportive. Whilst we strongly aspire to lengthen training at advanced level, the emphasis from Shape remains about shortening or rationalising training: this discussion will be for the future.

So what is the Faculty's current position and plan? The Faculty has its eyes and ears open to current issues and external developments whilst working to ensure our training and standards are meticulous. We are regularly, systematically and formally reviewing the quality of our training and examination, including ensuring it remains fit for purpose in our developing health service. The Faculty has commissioned and led on a huge piece of work on provision standards, Core Standards for Pain Management Services UK. You will read more of this in Dr Collett's article on the work of the Professional Standards Committee. In short however this is the reference for all clinicians of all disciplines across all medical domains and for commissioners and others who are negotiating for pain management provision. Alongside this we are publishing our *Right Patient, Right Professionals, Right Time* initiative which aims to clearly state the role, the position, the place and the need for the Pain Medicine Consultant. We continue to liaise with NICE to encourage the timely development of a Quality Standard for pain.

We are now developing a new strategy for our general communications. This is to bring a greater awareness to the specialty area of Pain Medicine. I am delighted that Fellows of our Faculty are able to take up high profile positions as has Dr Hughes above. It is with great pride too that I am able to congratulate Dr Karen Simpson, Dr Sanjeeva Gupta and Dr Manohar Sharma (all pain medicine consultants and examiners of the Faculty) who, along with Professor Michael Bennett, have won the BMA Medical Book of the Year Award for their textbook, *Practical Management of Complex Cancer Pain*. Achievements such as these reflect well on pain medicine. Congratulations too to Dr Tony Davies who in the furtherance of pain medicine featured on a recent Radio 4 Woman's Hour programme.

We are delighted to report that the James Lind Alliance priority setting workshop determined the top ten priorities for Anaesthesia and Peri-operative care and found that the number one research priority was 'What can we do to stop patients developing chronic pain after surgery'. This is positive news for the Faculty – we are having further discussion on how we will take this ahead.

An Acute Pain Working Party has been set up. Primarily this is to address integration of our acute pain colleagues into the Faculty. In the initial stages the working party have busied themselves with fact finding which resulted in the presentation of two posters at the British Pain Society Annual Scientific Meeting in Glasgow in April. In tandem they are running a Faculty study day in February.

In May, the Royal College of Anaesthetists Diplomates' presentation day was held at the Westminster Hall. This was a momentous and elegant occasion at which nine people were presented with the Fellowship of the Faculty of Pain Medicine of the Royal College of Anaesthetists. Congratulations to you. The hard work and sacrifices made by you and your loved ones are to be commended.

In July I met with the Chair of Council, the Honorary Secretary and the lead for Commissioning of the Royal College of General Practitioners. It was clear from the meeting that the RCGP are keen to continue working in partnership on some joint projects and they are to appoint an ongoing link person.

As an output of the Pain Consortium we have drawn up a series of UK Pain Messages, which offer a number of statistics and facts pertaining to pain management. These are for wide distribution both in public and professional circles. They are to be launched at a Pain Parliamentary meeting to be held on 18 November in the House of Lords. The messages are on the FPM website for those who might wish to make use of them. The House of Lords event will also see the launch of our Core Standards and our 'Opioid Aware' online resource.

Our undergraduate Pain Medicine initiative continues. The course is now well established in Bristol and since my last update we have run courses in Oxford. There are immediate plans for a number of other centres, with the next running in October in Aberdeen. Thanks go to all those involved in this exciting and worthwhile project.

2015-2016 Faculty Calendar

EVENT: FPM Annual Meeting	27 Nov 2015
MEETING: FPM Professional Standards Cmte	10 Dec 2015
MEETING: Board of the FPM	11 Dec 2015
MEETING: FPM Training & Assessment Cmte	22 Jan 2016
EVENT: FPM Acute Pain Study day	8 Feb 2016
EVENT: FPM & NSUKI Study day: Neuropathic pain and neuromodulation	9 Feb 2016
MEETING: FPM Professional Standards Cmte	3 Mar 2016
MEETING: Board of the FPM	4 Mar 2016
EVENT: FPM study day	18 Mar 2016
MEETING: FPM Training & Assessment Cmte	22 Apr 2016

Please note that all dates may be subject to change

EPM Lite: How to set up a programme

An Introduction to EPM Lite: Dr Mike O'Connor: Associate Dean, Severn Deanery

The Essential Pain Management (EPM) Lite programme has been introduced in two separate regions with common themes emerging; we hope this will be of help to others when considering setting up a course. EPM was originally developed in Australia and New Zealand by Roger Goucke and Wayne Morriss as an educational tool for health care workers in low and middle-income countries. EPM Lite is a scaled down version of the full course designed with the additional help of Linda Huggins in New Zealand, to be delivered to medical undergraduates in half a day. The UK Faculty of Pain Medicine supports the introduction of EPM Lite and the first courses were held in Bristol in 2014 and then in Oxford in 2015.

Bristol: Dr Helen Makins: Consultant in Pain Medicine and Anaesthesia

In August 2014, organisation of the inaugural UK EPM Lite course commenced. The concept was embraced by the lead for the Perioperative Care module and a slot found for a central teaching afternoon within the module, for fourth year Bristol medical students. This would be run over an afternoon, four times annually, involving approximately 60 students on each occasion. A team of four consultant and senior trainees in Pain Medicine were recruited to assist with teaching. Practical preparation involved finding a lecture venue, which also allowed splitting into smaller groups of approximately fifteen students for case-based discussion. Course preparation was minimised, as all slides, assessments and cases were kindly provided by Linda Huggins. The sessions have been fun, with the same core group of tutors involved on a long-term basis. Student feedback expressed preference for the case-based discussions over the didactic element and we adjusted the emphasis in response. This year, training structure within Bristol Medical School is changing and there is no longer a central teaching opportunity within the Perioperative Care module. After much negotiation, we have managed to find a slot within a central study day programme, which aims to fill "curriculum gaps". This seems to be a good fit but will involve a different approach again, as the entire year group (260 students) will be taught together. We plan to follow our current model- by using a large hall within the University, which has space to break into ten to twelve small groups for the discussion work. The option of a hub and spoke approach, involving teaching within the Medical School academies has been discussed and may be an option for the future.

Oxford: Dr Peter Cole: RAPM and Consultant in Pain Medicine and Anaesthesia
Dr Tim McCormick: Consultant in Pain Medicine and Anaesthesia

Responding to Kate Grady's article (Bulletin 88 November 2014) and following discussions at the Spring RAPM meeting, two of the Oxford Pain Consultants planned to introduce EPM Lite to Oxford. The first step was to identify space in an already crowded medical student curriculum. It was agreed with the Director of Clinical Studies for the Oxford Clinical Medicine course that EPM Lite could form part of the undergraduate teaching. The next scheduled teaching was the annual "Foundation Year Survival Course", for final year qualified students who have not yet started as FY1 doctors. The first course was run over two afternoons as large group lectures and discussions. Feedback confirmed that smaller groups would have been preferred. The students, about to start on the wards, were more interested in case based discussion approach, with emphasis on actual clinical scenarios. We now use EPM Lite for fourth year medical student teaching, within anaesthesia specialty study modules (SSM). This small group teaching takes place in the Pain Relief Unit seminar room every other week and we have expanded our faculty with two further pain consultants. With only an hour allocated we have reduced the number of slides and changed the order of discussions to start with a case discussion, then introduces the RAT (Recognise Assess Treat) model with teaching of the physiology and pharmacology of pain and end with case based discussions to consolidate application of knowledge. From early feedback, this interactive session has been well received. To generate further interest and roll out the programme to the other hospitals in our region these EPM Lite courses have been presented at the Thames Valley Pain Forum, an educational meeting run biannually for a multidisciplinary audience working in pain management. Establishing these courses was only possible with the help and cooperation of current course organisers and the medical school.

For further information please contact Jyoti Chand (JChand@rcoa.ac.uk).

Essential Pain Management: Tanzania

Dr Phil Lacoux

Consultant in Pain Medicine

This was my first exposure to EPM and I had an experienced EPM Instructor with me who pointed me in the right direction. The organisation in Tanzania was by an interested local Anaesthetist.

The pre course preparation was by the EPM group at the FPM who did an excellent job. The main personal preparation was familiarisation with the course materials which are open source. I updated some immunisations and used four days of Study Leave.

EPM is English language and there is little or no need for taking materials or equipment. This makes it an easy course to travel to other countries with. The course manual is online and I was surprised that participants were accepting of this. The participants were a mixture of medical doctors, Clinical Officers and nurses.

Travel and accommodation were straightforward and there were no security issues. My week involved travelling on a Monday, preparing on a Tuesday, EPM for 30 people on Wednesday, Train the Trainers Thursday and supervise the Trainers teaching 30 new trainees on the Friday, home Friday night.

The structure of EPM is interesting, with the goal of leaving trained trainers in a short time scale. I enjoyed the didactic versus discussion balance on this course. There were the usual moments of clarity and confusion, some animated discussion and some hierarchical influences.

I found having a Pain background myself was important to pitch the course correctly, particularly discussions of opiates and placebo and to be very clear that it is not all about Pharmacology.

I think EPM is useful. I think it puts into context the pain journey we are following in the UK. Tanzania is on its own journey, and hopefully they won't make some of the same mistakes.

In summary, it is good quality, structured, possibly-sustainable training with certificates and was appreciated by those attending in Dar es Salaam, Tanzania. The reports can be read on line on the FPM website: http://www.faculty-of-pain-medicine/essential-pain-management

Essential Pain Management: Ethiopia

Dr Jonthan Rajan

Consultant in Pain Medicine

Ethiopian time starts at dawn rather than midnight. This, along with communication via mobile apps and unexpected government visits were all par for the course on my recent trip to run Essential Pain Medicine (EPM) in Ethiopia!

The ethos of EPM is to provide a simple framework for managing acute, chronic and cancer pain. Having run EPM workshops in Asia, I had the opportunity to take EPM to Gondar, Ethiopia, in March of this year.

We are indebted to the EPM Working Group for their support.

Gondar has a population of 208,000 and is served by the Gondar University Teaching Hospital. Anaesthesia is nurse led. Nurse anaesthetists undergo a BSc programme and have a very limited involvement in pain management out with the theatre suite.

Running EPM in Ethiopia was done with the help of Stephan Wilms, a charming anaesthetist from Germany, with prior links to the Gondar MSc anaesthesia programme. Over the course of three days we ran one instructor workshop and two delegate workshops (one run by five locally trained instructors), training 31 delegates.

There were numerous challenges. Communication with a wide ranging interdisciplinary audience required both English and Amharic and many of the local organisers use Facebook in preference to email (unbeknown to myself.) The use of Ethiopian in preference to western time also proved a surprise! Sadly two physicians had died of opioid overdose in the weeks prior to our visit, increasing the background levels of opiophobia. Furthermore, an unannounced government visit hampered the involvement of a full range of the nursing and pharmacy faculties. Not only were we educating Ethiopia but we were receiving an Ethiopian education of our own!

Despite these hurdles, the course was successful with excellent feedback and improved post course MCQ scores. A number of locally generated recommendations resulted.

The interest in Ethiopia is ongoing. I am delighted to say that Dr Enright, past WFSA President is hoping to visit to Ethiopia in the near future to continue developing Pain Medicine there, using some of our newly trained instructors: we wish her the best of luck.

Key Recommendations:

- Liaise with local Government to develop EPM in local hospitals
- Run 2-3 EPM Workshops in Gondar in the next year
- Form a local EPM steering committee
- Regular EPM training for nurses and medical staff
- Address local pain management barriers

My Career in Pain Medicine

Dr Beverly Collett OBE

Retired Consultant in Pain Medicine

I originally wanted to be a psychiatrist. However, my renal house job introduced me to the excitement of Intensive Care Medicine, so, in 1977, I started anaesthetic training.

I was lucky enough to be mentored by Charles James, one of the original members of the Intractable Pain Society; a great doctor and truly an inspiration. Uncontrolled cancer pain was a significant problem. Intrathecal barbotage of cerebrospinal fluid and coeliac plexus blocks were commonly performed at Kings and at St Christopher's Hospice with no X-ray control (not for the faint-hearted!). As the most junior member of the team, my job was to warm the phenol in glycerol in my pocket in preparation for the performance of lumbar sympathetic blocks, on patients bent forward over their bed tables. But Charles James was a pioneer - a Clinical Psychologist worked with us in the out-patient department; a first step towards a multidisciplinary team.

Pain fascinated me. I spent time at the Walton Hospital in Liverpool with Sam Lipton (Anaesthetist), David Bowsher (Neurologist) and John Miles (Neurosurgeon), learning how to perform cervical cordotomy and trans-sphenoidal hypophysectomy, and about the strengths of the multispecialty team. I was lucky enough to have an attachment to the Oxford Regional Pain Unit to study under John Lloyd, Chris Glynn and Henry McQuay; again seeing the benefit of a team approach to patient management.

I spent a year at the Chinese University of Hong Kong, where we worked on pain assessment tools in a Chinese population (who read right to left and top to bottom) and I achieved my first publication in PAIN.

My first Consultant post was at Whipps Cross Hospital. Roger Baldwin, a gynaecologist, first stimulated my interest in pelvic pain, as he was puzzled by women with pelvic pain yet a normal pelvis, and keen to help them. I pursued my interest in the psychological aspects of pain, working with a psychologist and also a psychiatrist, who used to abreact patients with thiopentone 50mg. Given much of my early experience in pain was in cancer pain management, I became Co-director of the Margaret Centre; a hospice we established within the hospital grounds.

I could not let this opportunity go without saluting the significant educational achievement of PANG (Pain and Nociception Group) organised by Douglas Justins and Peter Evans. The value of PANG, with world-renowned speakers, was remarkable.

Marriage took me to my second Consultant post in Leicester. Here, I had the opportunity to build on the service started by Malcolm Eason and David Brown. The service expanded, became multidisciplinary and we started our own Pain Management Programme. I was lucky to work with enthusiastic colleagues who were keen to jointly develop specialised clinics. We established a Pelvic Pain and Substance Misuse clinic, both of which have proved of benefit to patients, and also excellent educational resources.

I remember clearly how I became involved in paediatric pain. I was asked to see a keen young sportswoman who had injured her knee and was refusing to let anyone touch it. An arthroscopy made the pain worse, a subsequent MRI showed no pathology. At 7.30 pm, after a busy day, I went to see her and her family. I assessed her as I would an adult patient and offered her an Intravenous Guanethidine block under general anaesthestic the next day. That was a disaster! Following this, I decided that I needed to know more about paediatric pain. I set off to an International Association for the Study of Pain (IASP) Special Interest Group meeting on Pain in childhood and returned to establish, after some battling, a fully multidisciplinary service with committed colleagues.

IASP, BPS, EFIC, CPPC and FPM have been key influences and I have been honoured and proud to play a role in all of these organisations. It was a tremendous day when the Royal College of Anaesthetists agreed to the formation of a Faculty, and Pain Medicine could start to develop standards for pain management services and formal education and examination for anaesthetists. Pain is not always thought to be important. Patients may be complex and challenging to understand and help. However, the sensation of pain is a truly fascinating scientific experience and its management an important humanitarian necessity.

Shape of Training and Credentialing

Dr Barry Miller
FPMTAC Chair

"The time has come", the Walrus said, "to talk of many things..." *Lewis Carroll*

Credentialing and other stories

At the end of my last update I mentioned the 'Shape of Training' project and its newly constituted Steering Group. A scoping paper on the development of areas of generic, and cross college, components for future curricula has been circulated, and, a little unexpectedly, the General Medical Council has issued its own consultation document on the future of the credentialing aspect which has the potential to affect us significantly. The GMC had begun its work on this idea before 'Shape of Training'. The Department of Health in 2008 asked PMETB (Postgraduate Medical Education Board) to explore the idea, and, after absorbing PMETB, the GMC developed pilot projects running in 2010, and these fed into Professor Greenaway's review. The new document suggested a number of themes whereby credentials could be used to replace the current system of subspecialties, which have been effectively frozen for around 5 years, with a new and, potentially, more dynamic and flexible system. There are clearly some advantages to the idea, although how this will ultimately feed back into the 'Shape of Training', and whether it will come up with its own proposals is unclear.

The Faculty, along with other bodies has responded to the proposals with caution. There are numerous issues of governance, finance, standards and revalidation, which affect the individual doctor, the hospitals and the Credentialing bodies which are left unclear. These need more discussion and detail, so that their endpoint and effect can be more fully understood.

The GMC has been busy over the summer with another consultation; 'Developing a framework for generic professional capabilities', looking to embed the concepts of its *Good Medical Practice* themes more directly into the curricula of all postgraduate training. It has also published a new document on training; *Promoting excellence: standards for medical education and training* replacing two previous documents, *Tomorrows doctors* and *The Trainee Doctor*. The GMC has a section on its website to find its various discussion documents, and it's worth taking a browse every now and then and consider responding. Many of the issues will affect you as teachers, trainees and the next generation of either.

(Whenever I feel a little jaded by another consultation I think to myself, "How will this affect the doctors treating me in the future" — this usually concentrates my mind!)

Trainee Contracts

There has been considerable concern over indications that the government intends to unilaterally change the Terms, Conditions and Pay of doctors in training. A recent (18th September) letter has been sent to the Health Secretary and we have received comments that although the RCoA and FICM names were put to the letter, the FPM appeared to be missing. The Dean (Dr Grady) was fully involved in the decision, and the FPM Board fully supported the letter and its implications. The letter is signed by the independent members of the Academy of Royal Colleges, and in this group we are represented by the RCoA, as the Faculty is wholly within one college, while the FICM is an intercollegiate body.

Acute Pain — before and after CCT

We have recently begun a review into Acute Pain, chaired by Dr Mark Rockett, with a particular focus on Higher training and Professional activity and support. This is an essential aspect of Pain Medicine, often the first exposure that both patients and other professionals have to the concept of pain as a condition in its own right. The linkage between Acute and Chronic Pain Services is variable, and we are looking to provide additional support, especially for Acute Pain Services that function outside of a mixed environment.

Core Standards for Pain Management Services in the UK

The Faculty of Pain Medicine is proud to present the first edition of Core Standards for Pain Management Services in the UK, also known as CSPMS.

CSPMS is a collaborative multidisciplinary publication providing a robust reference source for the planning and delivery of Pain Management Services in the United Kingdom. It is designed to provide a framework for standard setting in the provision of Pain Management Services for healthcare professionals, commissioners and other stakeholders to optimise the care of our patients. It is a document that will evolve, and cannot be viewed as a frozen moment in time, but it will provide a firm foundation for the future.

CSPMS will be launched at a Parlimentary meeting on 18th November 2015.

FACULTY OF PAIN MEDICINE
of the Royal College of Anaesthetists

October 2015

FFPMRCA Examination

Dr Karen Simpson

Chair of the Court of Examiners

The sixth FFPMRCA examination occurred in October 2015 and the exam has now entered a stable and mature phase. The evolution of the exam has been supported throughout by robust Quality Assurance (QA) and this, of course, remains a top priority for the Court of Examiners and the FPM. All questions are subject to multiple redrafting, refining and peer review. The FPM made a conscious decision to include non-examiners in this process to 'reality check' all questions - some of which are posted on the FPM website as examples of the standard and range of topics covered. Further example questions are planned for release by the end of the year. It is important to recognise the gratitude of the FPM to many colleagues who have assisted with question development. They put in a lot of work in their own time and are the workforce that supports our growing question bank. I am especially grateful to our three new exam question writers Dr Ganesan Baranidharan, Dr Saravana Kanakarajan and Dr Vivek Mehta who have contributed so diligently to this process.

We have recently lost some excellent examiners, some because they have retired from practice. The FFPMRCA exam regulations mirror the FRCA and recommend that examiners who are candidate-facing are no more than 6 months post-retirement. This is right and proper as the 'dictator perpetuo' position, exemplified by Julius Caesar that elevated his dictatorship into the monarchical sphere, has no place in modern examining. However as a classics fan I do have a sneaking admiration for his charisma and audacity. On a more serious note, it is my opinion that 'retired' examiners can still play a vital role in the exam process e.g. audit, QA and representing the FPM at overseas exams. We must value and not lose experienced examiners.

Examiners are chosen on the basis of competitive national application. We will have appointed three new examiners by the end of 2015. I do hope that, in the future, the ever increasing pressures of NHS life do not deter good candidates from applying. We must invest in the FFPMRCA examiners of the future. The RCoA provides excellent training for examiners, not only in the exam process but in other important areas such as equal opportunities and diversity. I was an FRCA examiner for 13 years and I have been deeply involved in the FFPMRCA exam. Examining has been one of the best experiences of my professional life. I would urge colleagues to consider applying for examiner posts when they appear and to support colleagues who wish to become examiners. I will end with Marcus Aurelius who said 'our own worth is measured by what we devote our energy to' - so think about examining in the future it is worth the effort!

As ever I would like to give my personal thanks and those of all the examiners to Graham Clissett and his fantastic team who meet every request for help with calm and pleasant efficiency.

Examination Calendar Nov 2015 - 2016

	FFPMRCA MCQ	FFPMRCA SOE
Applications and fees not accepted before	Monday 2 Nov 2015	Monday 15 Feb 2016
Closing date for FFPMRCA Exam applications	Thursday 17 Dec 2015	Thursday 17 March 2016
Examination Date	**Tuesday 2 February 2016**	**Tuesday 12 April 2016**
Examination Fees	£510	£720

Trainee Update

Dr Lucy Miller

Faculty Trainee representative

Summer is unfortunately over and the dark nights are closing in…winter is coming! The FPMTAC have been busy improving our training experience which was reinforced by the positive responses to the national trainee survey. Importantly, this survey highlighted areas that still need addressing and will provide invaluable information to implement appropriate changes that improve Pain Medicine training in the UK for both higher and advanced trainees.

Thank you to the 35 trainees that completed the national pain training survey 2015. Encouragingly 92% of these respondents agreed that their training equipped them with the knowledge and skill set required to work independently within Pain Medicine. 92% felt optimistic and prepared for a UK consultant post. Clinic and procedural training sessions continue to be well supervised with informal teaching for advanced trainees. On average these trainees attend 3.15 outpatient clinics and 2.3 procedural lists a week. However, in most regions formalised teaching is still minimal. This is something I hope to address in future with web based teaching.

This year, survey responses indicate a marked reduction in the number of trainees being removed from pain training to perform anaesthetic service duties, although 59% of respondents still felt that 'on call' work impacted unduly on their training. Interestingly higher pain trainees reported to commonly administer sedation during procedure lists (86%) although only 21% of those in advanced training positions supported this finding.

In previous years, access to cancer specific training had been an issue but this has improved as only 13% had difficulty attaining the necessary 20 sessions in this field. However, responses highlighted continuing difficulty gaining access to paediatric specialist services or experience in headache, facial and pelvic pain. It should be noted that there are some excellent opportunities across the country in these specialist areas e.g. the Great Ormond Street Hospital two week experience in paediatrics has received excellent feedback from attending trainees. If these services are lacking in your training school region you might find it beneficial to have an early discussion with your RAPM who can assist in organising attendance at a number of alternative centres both in and out of region.

May I congratulate the trainees that passed the most recent FFPMRCA SOE in April, especially the two exceptional candidates who were awarded full marks. The overall pass rate was 60% which is in keeping with previous years. Good luck to all those sitting the September/October examination. To help with exam preparation, please consider the Faculty-run biannual exam tutorials covering a range of topics specifically relevant to the exam syllabus. These also provide an excellent opportunity to meet with peers and to have any exam specific queries answered.

Dr Ramy Mottaleb, London Trainee representative

I had the honour of chairing the recent FPM trainee meeting which gives trainees the opportunity to discuss anything we like with FPMTAC. I think we are privileged to have a platform like this and we, as trainees, should do everything we can to preserve it. Trainees were concerned regarding the time on-call commitments took away from their pain training. The curriculum states that trainees should not be doing more than a 1:8 shift pattern and they should not be taken off daytime pain activities to provide anaesthetic cover except in rare emergency situations. If this is happening then we are advised to escalate this through to our educational supervisors and to the Faculty if necessary. Some trainees were unsure about the amount of specialist sessions they are expected to undertake in areas like paediatrics or spinal cord stimulators. The short answer is there is no number. These are specialists services and trainees are required to have an understanding and not be experts themselves. However, they should try and seek out the best opportunities which may involve visiting other centres or going on courses. Personally, I was reassured that these were the only issues that came up. No one complained about pain departments or bad training. However, if you disagree with me please do make your voice heard!

Post-CCT Fellowship: Neuromodulation

Dr Ann-Katrin Fritz

Consultant in Pain Management and Neuromodulation

Exposure to neuromodulation happened very early in my anaesthetic training when I used to anaesthetise for the neuromodulation lists in Norwich and Ipswich. Everything changed when I attended the 2013 International Neuromodulation Society Congress in Berlin. My eyes were opened! The field of neuromodulation is so vast, overlapping several specialties other than pain; some of the fast growing technologies being presented reminded me of those in science fiction movies. It was truly inspirational and although I did a taster in paediatric pain at Great Ormond Street Children's Hospital in London and eyeballed cancer pain, neuromodulation became my true passion.

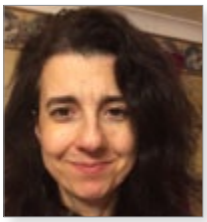
There were few options for decent neuromodulation training within the country. Jobs were advertised sporadically and were in quite different locations. I was happy to get a post CCT fellowship job in pain research and neuromodulation at Guy's and St Thomas', one of the locations recommended to me by friends and consultants. I was an additional fellow post on trial, meaning we were three post CCT fellows instead of the usual two plus the usual APTs and visiting pain trainees from abroad. That may sound like a lot of trainees, but with an abundance of lists and clinics there was always plenty to see, to do, and most importantly, to learn. Typically we would attend two of the three all day neuromodulation lists per week, sometimes all three; in addition to the neuromodulation meeting once a week and check on all booked theatre patients in advance to pick up any possible problems. Some patients needed admission the night before and often we would cast an eye on them the night before. We would consent and check all the patients on the morning of surgery and a list would start at around 08:30. Typically there would be four cases on a whole day neuromodulation list; however we have also done lists with up to six patients. The case load would involve the usual bread and butter cases such as percutaneous trials, tunnelled trials, full implants of spinal cord stimulation, removals and implanted pulse generator (IPG) changes as well as more sophisticated cases such as sacral nerve stimulation via different routes, dorsal root ganglion stimulation, occipital nerve stimulation, challenging revisions. In my first nine months I recorded180 neuromodulation theatre cases in my logbook.

We would review and discharge patients before starting morning clinics or normal pain intervention lists. The scope was vast involving procedures such as epidermolysis, radiofrequency treatments including trigeminal ganglions and epiduroscopy. Within two months I was also able to do my first basic intervention list under distant supervision, which helped build confidence and slow easing into consultant mode. The clinics ranged from the usual, to neuromodulation clinics including a dedicated research and joint urology neuromodulation clinic, pelvic pain, headache including Botox clinic and PENS (peripheral electric nerve stimulation) clinics. We were able to attend the tech day for neuromodulation as well as the full two week pre-implant pain management programme, which I found particularly useful as it's the only one in the world of its kind.

Consultants were keen, knowledgeable and we were well supported; all members of the team were lovely to work with and Dr Al-Kaisy got us involved with research projects, giving talks at international meetings, preparing and taking the FIPP (Fellow of Interventional Pain Practice) exam. International visitors such as neurosurgeon Prof. Rigoard, taught us 'proper' suturing and Prof. Racz passed on his immense knowledge in clinics and specially set up intervention lists.

I also had the invaluable opportunity to get involved in a large service improvement programme. The year was very busy and we always worked very hard, however the knowledge and skills acquired, the contacts made and the fond memories I've collected in that year were priceless, which makes me think that this is probably one of the best neuromodulation fellowships in the world.

RAPM Update



Dr Lorraine Dr Gray
RAPM Chair

Summer has whizzed by and our next meeting for Regional Advisors in Pain Medicine will soon come round. In the interim, the third tranche of the RAPM Bi-annual Reports is currently being collated and the Hospital Review Forms for all the Training Regions should be collated by the end of the year.

Post CCT training in pain medicine

Although the number of trainees in advanced pain training posts remains low, we are seeing an increasing number of post-CCT candidates taking up posts with the intention of undergoing training in pain medicine *de novo*, or alternatively building up on experience and/or expanding the training already received. It is recognised that a number of these posts are being set up without the involvement of the local RAPM. Although strictly speaking the role of the RAPM is to support training in the pre-CCT period, it is important to remember that application to sit the examination leading to the FFPMRCA or DFPMRCA always requires the support and signature of the RAPM.

Rather than face the disappointment of being told at the end of one of these posts that the experience gleaned is not sufficient to allow this support, I strongly advise that anyone employed in such posts who has any intention of sitting the exam contacts their local RAPM or LPMES very early on, and ideally even before applying for such posts in order to ensure that the training received is suitable and will receive the necessary support. This advice also applies to any overseas candidates looking at pursuing training in Pain Medicine in such posts in the UK.

Chair Elect

The Faculty has decided that the term for the Chair of the Regional Advisors in Pain Medicine is to be extended to three years, with a Chair Elect being in post for the third year shadowing the incumbent Chair, ready to take over when their terms ends. In a recent poll amongst the current RAPMs, Dr Victor Mendis, RAPM for North Thames, has been elected as Chair Elect. Congratulations to Dr Mendis — his term as Chair Elect starts from January 2016 and he will take over as Chair as of January 2017.

Outgoing RAPM

Dr Adrian Searle, RAPM for the East Midlands, has just come to the end of his third term as RAPM and I would like to take this opportunity to thank him for his invaluable contribution to training over the past nine years. The Faculty is currently looking at appointing his successor.

Ongoing Challenges for appointing LPMES and RAPMs

It is recognised that within the current financial constraints of the NHS it is becoming increasingly difficult for Consultants involved in training as Educational Supervisors, including Regional Advisors in Pain Medicine and Local Pain Medicine Educational Supervisors to be given the necessary time and support within their job descriptions by their Trusts to fulfil their educational duties. Few Trusts now recognise College "duties" when allocating supporting professional activities. There is no doubt that most of this work is now done in these individuals' own personal time through sheer dedication and love for their role as teachers and trainers. The challenge now and in the future will be to find Consultants to take on these roles and we are aware that the GMC intends to make supporting trainers a key standard when assessing a Trust's suitability to provide training. I believe we should continue to publicly acknowledge the invaluable role that these individuals play.

Spotlight on the Northern Region

Dr Allistair Dodds

RAPM

Dr Ruth Whiteman

Advanced Pain Trainee

It's easy to forget how young the specialty of Pain Medicine is. In the North East our most celebrated champion was Ed Charlton, an avuncular, larger than life character, who tirelessly promoted our Cinderella speciality from his base in the Royal Victoria Infirmary (RVI) in Newcastle upon Tyne. Ed had trained and worked with John Bonica in Seattle for 5 years, co-founded IASP, edited PAIN and would eventually be honoured by the AAGBI and BPS. Perhaps these were his greatest achievements, but the establishment of the RVI pain unit and the inspiration of a generation of anaesthetists to train in our often overlooked speciality, would lead to a thriving community of pain specialists throughout the North East. Today there are two large advanced pain units, based in Newcastle and The James Cook University Hospital (JCUHT) in Middlesbrough. Both offer complete services including paediatric pain, neuromodulation, intra-thecal delivery, cancer pain services and pain management programmes.

Ruth, one of our advanced pain trainees, has provided her thoughts on Training in the North East: During my Advanced Training I've had the opportunity to work at both units in the region. Each offers a very different experience, but they complement each other and both provide exposure to all components of the curriculum. JCUH has a well-developed neuromodulation service, with an innovative approach to multidisciplinary patient assessment and selection. The opportunity to participate in this process, as well as following patients through theatre and after-care was very valuable.

A post-CCT fellowship devoted to neuromodulation is offered for those wishing to sub-specialise.

The department has an active and well-resourced research programme, offering great experience of involvement in large-scale international trials. Attending specialist pelvic pain clinics was one highlight of my time at JCUH. The Acute Pain service has evolved a shared care model for managing patients with acute-on-chronic pain, with specialist nurses to assess and manage patients presenting to the emergency department with complex pain and social problems, with the aim of reducing inpatient episodes.

The RVI Pain Unit has a well-established Pain Management Programme. Trainees are encouraged to attend an entire programme as a participant. It was invaluable experience which cemented my enthusiasm for an interdisciplinary approach. Past participants are invited to attend an annual follow-up conference, which has provided opportunities to get involved in patient education, and pursue my interest in long term follow-up. Trainees are encouraged to participate in regular interdisciplinary team meetings where particularly challenging cases are discussed.

The Great North Children's Hospital is a busy tertiary paediatric surgical unit, with acute and chronic pain services. Palliative care experience is provided in a hospice environment. There is an active and growing regional anaesthesia service, working in close liaison with the Acute Pain Team, with opportunities to learn and practice a variety of blocks and catheter techniques.

I am currently undertaking Advanced Pain Training on a less-than-full-time basis, helped by a supportive RAPM and two very accommodating departments. It is universally perceived to be "grim up North", with higher levels of poverty, unemployment and social deprivation. The truth is our patients are often very easy to work with, undemanding and truly appreciative. Job satisfaction tends to be high and the necessity for private practice attenuated by lower house prices. The North East is a beautiful region, with wonderful beaches, National Parks, and there are hourly trains to London and Edinburgh. You can be in either capital in about two and a half hours. There's room for more, so why not come and join us?

Spotlight on the Mersey Region

Dr Hoo Kee Tsang
RAPM

Merseyside has a distinguished history in Pain Medicine, spanning seven decades. Professor T C Gray, renowned for the early local development of postgraduate anaesthesia training in the late 1940s, also had an interest in pain management. In 1948 Prof. Gray, then Reader in Anaesthesia at Liverpool University, set up the first nerve block clinic at the Liverpool Royal Infirmary, providing some of the first interventional procedures for patients with persistent and cancer pain in Liverpool. In 1952 the nerve block clinic was passed to Dr John Dundee, then Senior Lecturer at the Department of Anaesthesia. He established, contrary to the prevailing opinion of the time, that local analgesia could be effective in providing worthwhile, and occasionally long-term, relief in non-malignant conditions. After Dr Dundee left Liverpool in 1958, Dr J E Riding developed the service further and the clinics were popular with trainees. During the 1950s, intrathecal and regional anaesthesia were not widely used. Regional techniques to block the Gasserian ganglion, the coeliac plexus and the lumbar sympathetic chain were regularly performed in the outpatient clinic, without radiological guidance.

During this early period of Pain Medicine development, clinicians from different specialties collaborated, helping shape the speciality's direction. Whilst the nerve block clinic at the Royal Liverpool Infirmary developed as a unidisciplinary clinic for malignant and non-malignant pain, elsewhere in the city there were further developments. Dr Sam Lipton, a consultant neuroanaesthetist based at Walton Hospital, developed an interest in the management of post-operative and persistent pain. From 1953, Dr Lipton developed what is now recognised as Europe's first clinical service for chronic pain. During the late 50s and early 60s, the NHS struggled to recognise the growing service as there was no precedent, but eventually designated it the Centre for Pain Relief. In 1979, together with Dr David Bowsher and Professor John Miles, Dr Lipton founded the entirely voluntarily funded Pain Relief Foundation in Liverpool.

Through the 1960s the centre developed a multidisciplinary service with physiotherapists, neurologists, neurosurgeons, orofacial specialists, psychologists, and psychiatrists. Clinician interest grew, and the Centre became a focus for training. By the 1970s, formal training courses were introduced, with 'attachments' for visitors from the UK and abroad. Innovation continued and in 1972 the Centre for Pain Relief became the first NHS service to provide acupuncture for pain relief. The 1980s signalled the arrival of new techniques from America, based on behavioural approaches to pain management. Following a visit to Dr Wilbert Fordyce's service in Seattle, consultant neuropsychologist Dr Eric Ghadiali and consultant in Pain Medicine Dr Chris Wells established a Pain Management Programme (PMP) in 1983 at Walton Hospital. This was Europe's first PMP, and is still expanding to provide specialist programmes for sufferers of chronic pelvic pain, facial pain; and for young adults.

In 1996 Dr Austin Leach, consultant in Pain Medicine, helped establish Liverpool's pioneering National Refractory Angina Centre, providing a uniquely collaborative approach to the management of patients with angina refractory to medical and surgical treatment. Now known as the Liverpool Angina Management Programme, it continues to provide a cognitive behavioural approach, significantly reducing the frequency of hospital admissions and length of stay. A specialist pain clinic was established in 2012 at Liverpool's Robert Gregory National Alkaptonuria Centre, offering a "one stop shop" holistic approach for patients with alkaptonuria.

Pain training remains a strong focus and Merseyside has three established Advanced Pain Medicine training posts. Training has moved on from Dr Lipton's era of "see one, assist at one, do one". Advanced trainees have access to specialised services and training in neuromodulation techniques, paediatric pain medicine, and cancer pain training, including advanced techniques such as cordotomies. Research opportunities abound within Merseyside. The Pain Research Institute, now part of Liverpool University's Neurological Science Department, works closely with the Walton Centre pain service. As knowledge and understanding of pain and its impact grow, so will opportunities to train in this fascinating and expanding area of medicine.

I would like to thank Dr J E Riding, Professor J Hunter, Dr A Leach and Mrs B Hall for providing the historical facts for the article.

Professional Standards

Dr Beverly Collett
FPMPSC Chair

The FPM Professional Standards Committee (PSC) exists to encourage and facilitate the establishment, maintenance and improvement of good practice in all aspects of Pain Medicine. At present, proposals for projects come to the Committee mainly from the Board or from committee members.

I am keen to improve links and involvement with our Fellows. I would like to invite Fellows to submit proposals to the committee for projects relating to quality improvement matters, with particular reference to clinical effectiveness, clinical guideline development, delivery of pain management services, CPD, clinical and research governance, audit and the integration of any such areas into the revalidation process. We are keen to receive information about matters that concern you, so that these can be formally debated and a Faculty view obtained.

Core Standards

Over the last year the Faculty has been developing a definitive reference source for how Pain Medicine Services should function in the UK: *Core Standards for Pain Management Services.* This will be published in the autumn and will be a main area of focus at a Parliamentary meeting planned for 18th November. This document contains standards and recommendations for Consultant Doctors in Pain Medicine and the wider multidisciplinary teams involved in acute and chronic Pain Management Services. The document should also serve as a resource for service commissioning bodies and clinical commissioning groups, supporting the earlier *Local Commissioning of Specialist Services for Pain'* publication (FPM 2013) and the work of the Clinical Reference Group for Specialised Pain Services. Core Standards is a dynamic document and we welcome on-going feedback on fpm@rcoa.ac.uk.

I should like to thank everyone who has generously contributed to this document, both in formulating chapters and in providing comment.

Conducting quality consultations in Pain Medicine

I hope that you have found this document essential and thought-provoking reading. The consultation is a key part of practice and directs all individual future patient care. The PSC is keen to use this as an educational tool and is in discussion with RAPMs and the Training and Assessment Committee.

Pain in secure environments

Two training days for Pain in Secure Environments now taken place in London and feedback has been constructive and positive. These courses are run by a course leader and three facilitators (who work with a table of 10 delegates to facilitate informed discussion). It is expected to run these courses regularly and regionally. Therefore, we are developing a group of leaders and facilitators who can shadow existing course runners, with the intention of being able to ultimately lead and facilitate on their own. If you are interested in taking part, please contact fpm@rcoa.ac.uk.

WHO checklist for pain medicine procedures

The PSC has developed an exemplar template WHO Checklist for Pain Medicine procedures. Many hospitals have standardised their approach, but we hope that this will be a useful tool to consider incorporating into your practice.

Opioids Aware

The web-site resource for prescribers and patients to support the safe use of opioids for pain relief is in the final stages of being populated. The formal launch will take place on 18th November at the parliamentary meeting.

Innovations and reflections

I am delighted that the FPM has received one submission from Dr Natasha Curran and the team from University College Hospitals on their Re-Connect model that successfully helps patients and clinicians understand how pain management skills can be adapted to increase confidence in working with particular groups of patients towards intimacy as a pain management goal. Please don't be shy! Seize this opportunity to share your own innovations, and also your reflections on your experiences in Pain Medicine!

Pain in Secure Environments

Mr Kieran Lynch

PHE Criminal Justice Programme Manager

Why develop training on Pain Management in Secure Environments? It is the right of people in custody to have access to evidence based pain management that can be safely delivered to them.

Issues and problems we faced included:

- The prevalence of long term pain in the secure environment population is unknown. A number of risk factors for chronic pain exist in this population, including mental health and substance misuse disorders, physical and emotional trauma.

- Difficulty in distinguishing patients needing medication for pain and those requesting drugs to continue substance misuse or as a commodity for trade.

- Professional isolation and fear of criticism and complaints erode confidence in prescribing decisions.

However, prison offers an opportunity for regular assessment of the effect of analgesic medications on pain and function and an almost unique opportunity to assess the impact of pain medicine and practice.

Chronic non-cancer pain (CNCP) and neuropathic pain (NP) present challenges in terms of understanding their etiology and regarding their pharmacological and non-pharmacological management in prison.

The level of opioid analgesic prescribing in the UK is a cause for concern when one considers that opioids are usually ineffective for CNCP.

The diagnosis and management of NP is particularly challenging, as NP is difficult to diagnose with certainty and many medications used to treat NP have potentially significant side effects.

Their misuse potential may lead people to present with purported symptoms of NP in order to be prescribed these medications (gabapentin and pregabalin in particular). Prescribing rates of pregabalin in prisons are twice those in the community and 47% of prisoners taking pregabalin will also be taking opiate substitute treatment and 49% an opioid analgesic.

Managing CNCP and NP is particularly challenging in prisons for a number of reasons, including the risk of medication being diverted to prisoners for whom it is not being prescribed. There are issues of safety and bullying to consider when prescribing and dispensing medication in prison; prison staff, prescribers especially, may be subjected to threats and intimidation to prescribe medication against their better judgment.

In response to these concerns, it was decided to design and deliver training on Pain Management in Secure Environments to staff working in prisons.

A consultation exercise, involving commissioners, health and social care practitioners, prison governors and other prison staff took place in a number of prisons across England to identify the main issues and concerns relating to the management of pain in secure environments. Following this consultation, it was decided to deliver training on pain management in prisons to staff working in secure environments.

The training comprises a face-to-face training day and is multi-disciplinary, so GPs, pharmacists, nurses, drug workers and other healthcare professionals can attend the course along with non-healthcare staff.

The day introduces the challenges of pain management in secure settings and works through understanding pain, pain management strategies, pain management in addiction or recovery, as well as working through three case studies.

In addition, a formulary for the management of

pain in secure environments has been developed to support better prescribing practice.

As a prelude to the training and to inform its development and design, Pain Clinics were established in three prisons in South Gloucester and the findings from these clinics were used to develop real life case studies.

Despite the assumption underpinning prisoner reasons for acquiring drugs such as pregabalin and gabapentin, an audit of the pain clinics across South Gloucester found that prisoner pain was a real and tangible concern. Most referrals to pain clinics were for long-standing conditions. The findings suggest that prisoner pain is relatively nuanced with 36% of patients seen having medications increased or reintroduced and 26% having their existing prescriptions stopped or reduced. Only 5% of all patients were considered as diverting their medication for illicit use.

This ground breaking training provided by the FPM, the first of its type in the UK, is a systemic and collaborative response to a well-recognised problem and should, over time, be delivered to a large number of practitioners working in secure environments, enabling them to practice and prescribe more effectively.

Opioids Aware - A resource to support safe use of opioids for pain relief

Professor Roger Knaggs

Associate Professor in Clinical Pharmacy Practice

There has been a sharp and sustained rise in prescriptions for strong opioid medicines over the last few years. This trend is largely attributable to use for the treatment of persistent pain despite a lack of evidence that opioids are helpful for this indication and an increasing awareness of substantial harms including misuse, addiction and diversion.

There is a need to promote a culture of appropriate clinical decision making and safe prescribing in relation to opioids. Guidance in the UK and elsewhere has had little if any impact on prescribing trends and may have the unwanted effect of falsely reassuring prescribers and eroding sound patient-centred clinical decision making.

Rather than updating existing guidance the Faculty of Pain Medicine and other stakeholder groups have developed an opioid prescribing resource, based on the evidence, regarding the harms and benefits of opioids which prescribers can then draw on to make a good clinical decision for an individual patient, influenced of course by the individual's clinical presentation, comorbidities and circumstances. This key resource can be drawn on to produce a suite of documents and educational materials in different formats for a variety of audiences including patients.

Key stakeholders were identified by the Faculty and representatives from the following have all contributed to the material contained in the resource: Faculty of Pain Medicine, Royal College of Anaesthetists, Royal College of General Practitioners, Faculty of Addictions, Royal College of Psychiatrists, Royal Pharmaceutical Society, Royal College of Nursing, British Pain Society, Care Quality Commission, NHS England, PHE, DH, Home Office, Medicines Healthcare Regulation Agency, NICE, and Department for Transport.

The resource is not guidance but intends to place opioids in the wider context of pain management. In addition to Information for patients, the three main sections are:

- Best professional practice
- Patient assessment
- Clinical use of opioids

Each section is subdivided further and additional reading and links to relevant documents are provided. Key aspects covered include Opioids and the law, writing prescriptions, reporting harms, the role of pharmacists in safe prescribing, assessing and managing long-term pain, the role of medicines, effectiveness of opioids, side effects and harms, current prescribing trends, problem drug use and special circumstances.

The prescribing resource is co-sponsored and published by Public Health England and NHS England and is hosted on the website of the Faculty of Pain Medicine.

Key messages (Opioid 'Five a day')

- The experience of long-term pain is very complex: a detailed assessment of the many emotional influences on the pain experience is needed for effective treatment planning
- Opioids are effective for treating short-term pain and pain at the end of life but there is little evidence that they are effective for long-term pain
- A small proportion of patients may find opioids useful in the longer-term if doses can be kept low and if use is intermittent
- At opioid doses above oral morphine equivalent 120mg/day harms increase substantially but there is no increased benefit
- If pain persists when the patient is taking opioids, it means the medicine is not working and should be stopped, even if no other treatment is available

The resource will be available in November 2015.

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 Brigitta Brandner, London*
1040-1100	Discussion
1100-1120	Refreshment
1120-1135	**Faculty Commendations**
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 Thanthullu 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

Faculty of Pain Medicine Study Day:

Acute Pain Management in a Complex World

Monday 8th February 2016

9.00 to 9.25	Registration and coffee
9.25 to 9.30	Welcome - *Dr S Gupta and Dr S Balasubramanian*
9.30 to 9.40	Introduction - *Dr M Rockett*
Session one	**Chair - *Dr J Quinlan***
9.40 to 10.10	Acute pain services in the UK, what state are we in? *Dr M Rockett - Pain Medicine Consultant, Plymouth*
10.10 to 10.40	Raising the standard: Developing a pain app. *Dr A Davies - Junior Doctor, London*
10.40 - 11.00	Discussion
11.00 to 11.20	Refreshments
Session two	
11.20 to 11.50	Acute pain management in trauma. *Dr M Wyse - Clinical Lead for Major Trauma, Coventry*
11.50 - 12.20	Managing acute neuropathic pain *Dr M Rockett - Consultant in Anaesthesia and Pain Medicine, Plymouth*
12.20 - 12.40	Discussion
12.40 to 13.30	Lunch
Session three	
13.30 to 14.00	*Discussion session: 2 complex cases* 1 Acute pain management in opioid dependent/abuse patients *Dr J Quinlan - Consultant in Anaesthesia and Pain Medicine, Oxford* 2 Perioperative pain management in patients with chronic pain *Dr S Kapur - Pain Management Consultant, Birmingham*
14.30 to 14.50	Panel Discussion - *Dr Quinlan, Dr Rockett and Dr Kapoor*
14.50 to 15.10	Refreshments
Session four	
15.10 - 15.40	Frequent attenders: the psychiatry of acute pain (re)admissions *Dr I Jordan - Consultant in Psychological Medicine, Oxford*
15.40 to 16.10	Chronic post surgical pain - prediction, prevention, mechanisms. *Dr A Rayen - Pain Management Consultant, Birmingham*
16.10 to 16.40	What happens after hospital discharge? Rapid access clinics *TBC*
16.40 - 17.00	Discussion, Feedback and Close

FACULTY OF PAIN MEDICINE of the Royal College of Anaesthetists

RCoA, London 5 CPD Points. £175, £140 for trainees.
(book along with 3rd February for a reduced rate of: £330, £255 for trainees)
Code: B28

Faculty of Pain Medicine & NSUKI Study Day:

Neuropathic Pain and Neuromodulation

Tuesday 9th February 2016

9.00 to 9.30	Registration and coffee
9.30 to 9.45	Introduction
9.45 to 10.10	Pathophysiology of Neuropathic Pain *Prof. A. Dickenson, London*
10.10 to 10.35	Pharmacotherapy of Neuropathic Pain *Dr A. Bhaskar, Cheshire*
10.35 to 10.45	Discussion
10.45 to 11.15	Refreshments
11.15 to 11.40	CRPS: Pathophysiology and Treatment *Dr S. Thomson, Essex*
11.40 to 12.05	Phantom Pain *Dr A. Bhaskar, Cheshire*
12.05 to 12.30	Chronic post-surgical pain *Dr A. Gulve, Cleveland*
12.30 to 12.45	Discussion
12.45 to 13.30	Lunch
13.30 to 14.00	Failed back surgery syndrome *Prof S. Eldabe, Cleveland*
14.00 to 14.30	Techniques of peripheral and spinal cord stimulation *Dr G. Baranidharan, Leeds*
14.30 to 15.00	Mechanism of action of spinal cord stimulation *Dr S. Thomson, Essex*
15.00 to 15.30	Refreshments
15.30 to 16.00	Who and when to refer spinal cord stimulation: Indications and patient selection *Prof S. Eldabe, Cleveland*
16.00 to 16.30	Complications of spinal cord stimulators *Dr G. Baranidharan, Leeds*
16.30 to 17.00	Anaesthetic management of patients with implantable neurostimulation devices and intrathecal pumps *Dr A. Gulve, Cleveland*
17.00 to 17.15	Discussion & close

FACULTY OF PAIN MEDICINE
of the Royal College of Anaesthetists

nsuki
United Kingdom & Ireland
Neuromodulation
Society
A chapter of the International Neuromodulation Society ins

Programme organised by Dr Sanjeeva Gupta, Dr Shyam Balasubramanian and Dr Ashish Gulve.

Faculty Events

Dr Sanjeeva Gupta

Educational Meetings Advisor

Dr Shyam Balasubramanian

Deputy Educational Meetings Advisor

The FPM conducted yet another successful study day in June '15 on 'Medico-legal issues in pain medicine'. The meeting was aimed at those wishing to embark on medico-legal reporting in pain including understanding what the Court wants. Dr Rajesh Munglani and his team gave scintillating presentations on different aspects of medico-legal practice. The recurrent themes during the day were on consent and communication. In particular, the interactive discussion on limitations of the Bolam test in consent cases was thought provoking. Delegates were informed about the more recent Montgomery ruling and the importance of providing sufficient information so that patients are able to make decisions about management options that could affect them for the rest of their lives.

One of the missions of the Professional Standards Committee is to inform members about the latest pain research and recent advances in the basic science and clinical practice of pain medicine through educational meetings. The forthcoming annual meeting on Friday 27 November is planned with this in mind. Post-amputation pain is a frequent complaint encountered in acute pain rounds and chronic pain clinics. Dr Michael Neil from Dundee will share his practical experience on developing care pathways for managing this challenging condition. The last decade witnessed a rapid surge is opioid prescriptions. Whilst the appropriateness of this practice is still under question, anaesthetists commonly end up caring for surgical patients on high dose opioids. This cohort of patients has unique requirements for optimal postoperative analgesia. Dr Brigitta Brandner will provide recommendations based on current best available evidence. Researchers are identifying several non-analgesic effects of opioids that have important implications on short and long-term use. Dr Shankar Ramaswamy will talk on the controversies about this poorly understood class of drugs, used throughout the history of mankind. Since its inception, the WHO pain ladder has revolutionized and simplified the concept of pain management. However, with better understanding of pain mechanisms and advances in therapeutic options, is this simple 3-step tool still a valuable treatment guide? Prof Sam Ahmedzai will challenge the validity of WHO pain ladder in modern practice and Dr Mahesh Chaudhari will defend its role, in a debate.

Pulsed Radiofrequency was developed as a less destructive alternative to Continuous Radiofrequency in interventional Pain Medicine. Although the technique is widely used in many centers, there is lack of clarity on its precise mechanism and effectiveness. Dr Connail McCrory from Dublin has rich clinical and research experience with Pulsed Radiofrequency and will talk about its application. Managing teenagers going through chronic pain is an art and requires a different approach. This is a dramatically growing problem resulting in hospital admissions and frequent clinic consultations. Dr Thanthullu Vasu from the Leicester paediatric pain service will discuss the practicalities of dealing with pain and associated symptoms in teenagers. Professor Andrew Rice will deliver the prestigious Patrick Wall guest lecture and our Dean Dr Kate Grady will tell us about developments in the Faculty. Members are encouraged to attend this annual meeting which will be a unique opportunity to listen to the presentations of highly regarded speakers, and to get together with other members of the Faculty. The event will take place at the Royal College of Anaesthetists, London. Booking details are available http://www.rcoa.ac.uk/faculty-of-pain-medicine/events/annual-meeting.

The theme for 8th Feb 2016 study day is 'Advances in acute pain management'. A joint meeting is planned on 9th Feb 2016 with the Neuromodulation Society of the UK and Ireland. Bookings are now being taken.

Anaesthesia and Perioperative Care Priority Setting Partnership

James Lind Alliance Priority Setting Partnerships

NIAA National Institute of Academic Anaesthesia

SUMMARY RESULTS

The Anaesthesia and Perioperative Care Priority Setting Partnership (PSP) is an initiative commissioned by the NIAA to identify important topics for future research and help direct the future research agenda.

Why was this PSP needed?

The rationale behind the PSP was simple: research budgets are finite, and research funders need to demonstrate the impact of their research. This entails not only producing academic publications, but also choosing topics for research funding that are important and relevant to clinicians and patients. This PSP's aim was to identify those topics for anaesthesia and perioperative care, and was the largest consultation exercise conducted within the specialty to date.

Who was involved?

We sought input from a broad range of stakeholders – patients, carers, and clinicians. Those who contributed:

- 45 partner organisations (20 patient representation groups; 25 professional societies) affiliated
- 12 Steering group members, all volunteers from partner organisations
- 623 respondents to our first 'ideas-gathering' survey (62% clinicians, 49% patients, 48% carers or relatives of patients)
- 1,718 respondents to our second 'prioritisation' survey (81% clinicians, 28% patients, 36% carers or relatives of patients)
- 23 partner organisations' representatives participated in the Final PSP Workshop

How did the process work?

The PSP was overseen by the **James Lind Alliance,** a body within NIHR that gives a voice to patients, carers and clinicians in identifying and prioritising research topics. The steps involved:

1) Inviting partner organisations
2) 'Ideas-gathering' survey asking respondents to nominate up to 3 research suggestions
3) Classifying and refining those ideas into 'summary' questions, and checking whether any had already been answered by existing research
4) 'Prioritisation' survey asking respondents which of the summary questions they considered the ten most important
5) Final workshop, where partner representatives considered the 25 most popular questions, and used Delphi consensus methods to agree a final 'Top Ten' research priorities

What were the results?

- 1,476 suggestions were received in the first survey
- These were distilled into 92 'summary' questions (none of which had been adequately answered by existing research)
- The 25 questions that received the most votes in the prioritisation survey went through to the final workshop. The final top ten were chosen from these 25.

'Bringing patients, carers and clinicians together to identify and prioritise treatment uncertainties'

James Lind Alliance Priority Setting Partnerships

Anaesthesia and Perioperative Care Priority Setting Partnership

NIAA National Institute of Academic Anaesthesia

THE TOP TEN PRIORITIES FOR ANAESTHESIA AND PERIOPERATIVE CARE RESEARCH

- ***What can we do to stop patients developing chronic pain after surgery?***
- *How can patient care around the time of emergency surgery be improved?*
- *What long-term harm may result from anaesthesia, particularly after repeated anaesthetics?*
- *What outcomes should we use to measure the 'success' of anaesthesia and perioperative care?*
- *How can we improve recovery from surgery for elderly patients?*
- ***For which patients does regional anaesthesia give better outcomes than general anaesthesia?***
- *What are the effects of anaesthesia on the developing brain?*
- *Do enhanced recovery programmes (fast-track surgery to speed up patient recovery) improve short and long-term outcomes?*
- *How can pre-operative exercise or fitness training, including physiotherapy, improve outcomes after surgery?*
- *How can we improve communication between the teams looking after patients throughout their surgical journey?*

(*The questions of particular relevance to Pain medicine are highlighted in bold*)

What other questions not in the Top Ten might also be of interest to the Faculty of Pain Medicine?

The full shortlist of 92 'summary' questions, including the 25 questions ranked highest by the survey respondents, can be viewed on the NIAA website.

Questions of relevance to FPM might include:

- How can we better predict the severity of pain immediately after surgery?
- How can we improve our use of drugs to provide better pain relief before and after surgery?
- How can we use non-drug therapies to provide better pain relief before and after surgery?
- What can we do to reduce the side effects of pain relief medications?
- What are the risk factors for developing chronic pain after surgery?
- How can pain control be improved in patients with longstanding medical conditions?

What happens to the results?

The goal is to maximize the impact of the priorities on the future research agenda. The PSP's success ultimately depends on turning research priorities into tangible research outputs. Strategies include:

- Publications in academic journals to communicate the results to the research community.
- Presentation of results to funding bodies within the NIAA Research council, the RCoA and AAGBI
- External funding bodies, (e.g. NIHR's HTA programme, Medical Research Council, and the Wellcome Trust), will be approached
- All suggestions received will be uploaded to the UK DUETs researchers' database
- All survey respondents who provided an email address will be sent a results summary

Thank you for your involvement in supporting the PSP and please contact us if you want to find out more!

'Bringing patients, carers and clinicians together to identify and prioritise treatment uncertainties'

British Pain Society Calendar of Events

THE BRITISH PAIN SOCIETY

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

2015

Pain the Hidden Epidemic
Patient Liaison Committee Annual Seminar
Thursday 17th December, Churchill House, London

The seminar will include a mixture of lectures about Pain and Neuropathic Pain, as well as an afternoon dedicated to working together to see how we can all make a difference and raise awareness of pain.

2016

Opioid Study Day
Monday 14th March, Churchill House, London

More information will be added to our website when available

Annual Scientific Meeting
Tuesday 10th – Thursday 12th May 2016,
Harrogate

The multidisciplinary nature of the Society's is pivotal to the continuing success of its Annual Scientific Meeting, which has attracted an average of over 600 healthcare professionals to its previous five Meetings. This multidisciplinary nature is reflected throughout the scientific programme, with lecture, workshop and seminar topics chosen specifically to be of interest to all participants, whatever their specialty. Further information can be found on: **https://www.britishpainsociety.org/2016-asm/**

The Power of the Mind in Pain
Philosophy & Ethics SIG Annual Meeting
27th to 30th June 2016,
Rydall Hall, Cumbria

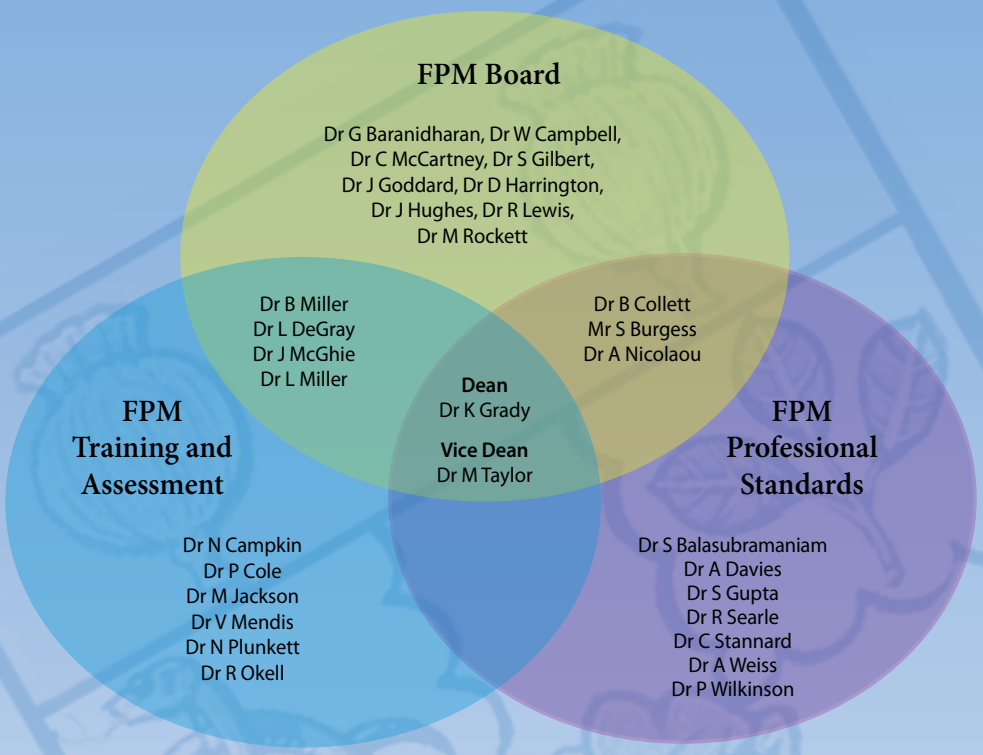
This meeting promises to be a most stimulating conference considering the power of the human mind in pain. There will be a number of speakers looking at a wide range of subjects including spirituality, hypnosis, healing, the placebo effect and other mind-body connections.

It will be held at Rydal Hall near Ambleside in the Lake District and during the conference there will be time to explore the gardens and grounds of the hall as well as the beautiful surrounding lakes and hills.

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

Faculty Update

Committee Membership



New Fellows

Dr Tomasz Grzegorz BENDINGER
Dr Enrique COLLANTES CELADOR
Dr Karthikeyan DHANDAPANI
Dr Parveen Kaur DHILLON
Dr Cherilyn FENECH
Dr Daniel GOVENDEN
Dr Vishal GUPTA
Dr Sleeba Palakattil JACOB
Dr Sabu Kumar JAMES
Dr Nofil Nisar MULLA
Dr Hasankhan Sherkhan PATHAN
Dr Victoria Jane TIDMAN
Dr Evan Matthew WEEKS

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