FACULTY OF
PAIN MEDICINE
of the Royal College of Anaesthetists

Newsletter of the Faculty of Pain Medicine SPRING 2016

TRANSMITTER

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Training is core business for the Faculty, but service provision has an unfortunate propensity to get in the way. Several of these issues are raised by Lorraine de Gray in her RAPM update. Reluctance of Trusts to fund SPA time and support professional leave for educational supervisors is widespread. However, it is not just the administrative managers who are under pressure: clinical managers still require on-call duties from advanced pain trainees that impact upon training. One area of pleasing development would seem to be co-ordination of formal teaching for advanced trainees across deaneries.

Mark Rockett's report on the work that has been undertaken by the Acute Pain Working Party is an essential read. The Board is very grateful to have more data upon which to deliberate a way forward that will support and maintain the interests of acute pain specialists within the Faculty. Work is ongoing looking at alternative models of training that might meet these needs.

EPM Lite is a real success story. This issue includes two more reports on its successful integration into undergraduate training. Local versions of EPM Lite are now being used in 11 out of 32 UK medical schools.

As always, my thanks to authors and the FPM admin team..

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Message from the Dean: Nearly ten years on...

Dr Kate Grady

Dean

Next year marks the 10th anniversary of the Faculty of Pain Medicine of the Royal College of Anaesthetists and this year is the 10th anniversary of the setting up of the Foundation Board.

In those years, the Faculty has been inducted and developed considerably and next year we will be reflecting on and celebrating its achievements with a programme of anniversary activity.

I met recently with the Centre for Workforce Intelligence (CfWI) and officers of the College. We have been made aware that the CfWI will cease to exist and its function will be taken up by Health Education England (HEE). At the meeting our President gave me the opportunity to present workforce issues peculiar to Pain Medicine. The Faculty have been invited to put these issues specifically to HEE and we have a small group working on this.

Our Core Standards for Pain Management Services (CSPMS) are certainly starting to take root. We have been in close negotiation with the Care Quality Commission (CQC) which we have advised with regard to a standard set for pain management across healthcare. We are delighted to have had this dialogue and to be able to influence not only standards of care through the CSPMS documents but also their implementation through our liaison with the CQC.

We have also recently been approached by the College of Paramedics and are considering including a chapter on paramedic involvement in the management of pain.

The CSPMS primarily address quality and access to care for our patients to whom we have our ultimate responsibility. They also however are supportive and directive for those working in pain services (in all professional groups) and I would urge you all to use the standards to direct your own working practices.

The Acute Pain Working Party led by Mark Rockett is doing a superb job in addressing the issues of how the Faculty can serve our acute pain doctors alongside our chronic pain doctors and in promoting the engagement of acute pain physicians with the Faculty. A highly successful study day on acute pain was held at the College in February.

Our Essential Pain Management (Overseas) course has now been run initially and with follow up (a key to sustainability) in Malawi and Uganda and for the first time in Tanzania and Ethiopia, with a follow up planned to Ethiopia. There are plans to take the course to Madagascar (through our links with the Mercy Ships group) and to Nigeria in the near future. We offer our thanks to the Association of Anaesthetists of Great Britain and Ireland and the Royal College of Anaesthetists for their generous further funding and to all who have taken part in this high impact global initiative.

The Essential Pain Management Lite (undergraduate) course is shortly to have become established in eleven medical schools. This represents a significant proportion of the UK medical schools. We are proud of this achievement and grateful for all those who have committed to this project.

Our Pain in Secure Environments courses continue. You will recall this is a course to develop pain awareness and management skills in personnel working in the 149 secure environments in England and Wales which we run with support from Public Health England. We have run four courses, three on site and one off site in Taunton with further courses planned in Staffordshire and London.

Thanks to those who replied to our survey on the need for a buddying / mentoring system which could be run out of the Faculty. The survey revealed there is a clear appetite for such a system and we are set to work on this.

Our 'Opioids Aware' resource is being very well received! We have had a meeting with the Care Quality Commission and Public Health England at which implementation, dissemination and measuring of outcomes were discussed. It is felt that the resource would be of particular use to other medical specialties, pharmacists and medical safety officers and this will be pursued. Other educational modalities are being considered e.g WebEx meetings. Our President has promoted this resource through the Academy of Royal Medical Colleges, thereby accessing all Royal Medical Colleges.

The Board will be having an 'away afternoon' on 8 May (at the RCoA!). It is four years since our last event of this type and we have put into action the ideas which were generated then. We feel we now have some headroom and capacity to take on further work or address new areas. We would be keen to hear from you if you feel there are any areas which are not being addressed, if there is anything which might be coming to us that we have failed to see, or if there is anything we could turn out hand to which we are missing at the moment. Please email fpm@rcoa.ac.uk.

Ongoing Faculty Projects

Opioids Aware, an online resource to support prescribers and dispensers in making good decisions on initiating, maintaining and monitoring patients on opioid therapy for pain, has received nearly 14,000 hits since its launch in December 2015. It informs all prescribers about recognition and prevention of opioid therapy hazards, and includes information for patients and carers to support their choices on medications for pain. The resource can be accessed from the Faculty website.

The Faculty has produced a **Safety Checklist for Interventional Pain Procedures** under local anaesthetic or sedation, which is adapted from the WHO surgical safety checklist. This is available to download and print from the Faculty website.

The **'Innovations and Reflections'** section of the website contains examples of innovative practice submitted by Fellows and pain management teams. These can be illustrations of exceptional practice or reflections of difficulties faced and how these were overcome (or not). It is hoped that by sharing ideas, people will be encouraged to consider what they could do to improve their local service and how to go about this. The Faculty welcomes current and relevant submissions for inclusion.

The Faculty has created **ASK2QUESTIONS,** a pre-screening tool developed to help identify complex and problematic pain. The tool is quick and simple to use and can help with decisions about whether further screening and assessment (including possible referrals) is necessary and guide early management. If you would be interested in piloting ASK2QUESTIONS and helping to develop this tool further, please contact us at fpm@rcoa.ac.uk Further information is available on the website.

The Faculty has produced **Patient Information Leaflets** on medications commonly used to treat persistent pain. The leaflets were created with the help of multi-professionals as well as patient representatives and are intended to be handed out to patients when they are prescribed these medications. The leaflets can be used within a variety of clinical settings including Pain Management Services, GP practice, community pharmacies and physiotherapy clinics. The Faculty is currently developing information leaflets on interventions.

E-Pain is a multidisciplinary e-learning programme in pain that responds to the need for improved knowledge, skills and attitudes of all staff in the NHS who deal with patients who have acute or chronic pain. The development of this programme is a joint initiative undertaken by the Faculty of Pain Medicine and the British Pain Society.

Further details on all Faculty projects are available at **www.fpm.ac.uk** or email **fpm@rcoa.ac.uk**

Specialised Pain Services and Commissioning

Dr John Hughes

Chair NHS England for Specialised Pain Services

There have been a number of questions around the commissioning of specialised pain services (SPS) and the role of the Clinical Reference Group (CRG). There have certainly been changes over time, and reorganisations, but some of the principles remain. Here is an outline of where the CRG fits in the scheme of things and some of what it has done.

First the terms for levels of care have changed with specialist services being similar to those previously known as secondary care and specialised as tertiary care. The principal difference is that the focus has moved away from an institution or set of buildings to the individuals with the skills, aptitudes and knowledge who deliver the care. Specialised care may involve specific equipment or requirements to be delivered from a given institution, but it may be the individuals with a specialised set of skills (e.g. pelvic pain, headache) who work closely as a team in that area of practice.

There are 65 CRGs, one for each specialised service. They are divided into Programme of Care Boards (PoC) with Pain Medicine being in the Trauma PoC. Over the last 18 months or so NHSE has been undergoing an internal review and restructuring. Currently there is a stakeholder consultation on the CRGs with a proposal to reduce the number to about 42 and alter the composition to fit better with the national model: it is proposed there will be a chair (now with one PA of remuneration), four regional members instead of the 14 senate members, two public/patient voice members (down from four, but now with some remuneration) and up to four affiliated members (Faculties, Societies etc.). The option to use sub groups and working groups will remain in order to have the relevant expertise available.

The broad outline is:
CRGs advises NHSE on the strategic delivery of specialised services, one element of which is developing a service specification; (D08)[1] for specialised pain services.

The service specification sets out the parameters that are required of a commissioned specialised service. It is not prescriptive in how those requirements are delivered, which allows each region/senate to develop its own model of delivery depending on their circumstances. It could be a single centre operating from a single site but could equally be a network or hub and spoke system or some type of consortium.

Specialised services are commissioned by the Regional Teams, which are completely independent of the CRG. It is anticipated that the Regional Teams will involve the regional CRG member, as they will have specific knowledge of the dynamics and potential services that can be delivered, but that role will be advisory. It is likely that the Regional Team will commission a single unit for specialised services but expect them to develop and deliver a structure that aligns their region to the service specification. That will often mean new contractual arrangements between providers in order for it to work. This is a change in practice requiring a degree of lateral thinking in order to deliver the care appropriately. It may also be the case that specialised centres will need to work together as not all centres will be able to provide all services. This will be particularly true for interventions where there are very small numbers of patients involved.

To date there have been very few centres commissioned for specialised pain services within this context, and I think some of the older arrangements have not been wound up in order

to ensure care continues to be delivered in this transition period. There are discussions ongoing in some regions/senates but in others there is, to all intents and purpose, radio silence. To be fair, the Regional Teams have all the specialised services to commission, have been learning on the job themselves, and I do not think Pain Medicine has been at the forefront of their agenda. Delivery of the specifications has been a difficulty but is not lost on NHSE and is an area that is being addressed. There is nothing to stop individuals, trusts or other institutions asking the Regional Teams what is happening. It would also be reasonable if a region has a proposal to go and discuss it with the Regional Team.

The CRG also undertakes a key role in prioritising and developing specialised service commissioning policies. These are evidence based documents specifying the situation for commissioning or not commissioning a specific intervention. For example the 'commissioning of intrathecal pumps for severe cancer pain' will be commissioned and 'commissioning of deep brain stimulation (DBS) for chronic neuropathic pain' will not normally be commissioned. All these policies go through a variety of stages in development, including external scrutiny and public consultation. Within limits of time and funding, only so many can be undertaken each year and as such is an area of work in progress. With the recent internal reviews, the policy development process has been streamlined with external evidence reviews being developed from the start. There are various reviews and consultation stages involved and the policies are finally approved, or not, by the Clinical Priorities Advisory Group (CPAG). There is inevitably an element of competition as the financial pot is limited. The process is developing, has certainly improved; feedback from the reviews is helpful and the additional support given to develop them essential. That said, there is room for further improvement. The SPS CRG, at the time of writing, has four policies within the system.

"The objective remains the same; providing high quality care to the correct patient in a timely manner by the appropriate professionals"

Other roles for the CRG include advising on quality measures as specified in the service specification along with their development and refinement. Increasingly, there is work across CRGs where there is shared interest (e.g. deep brain stimulation involves the Neurosurgery CRG).

The other area that is often asked about is that of Individual Funding Requests (IFRs)[2] and Critically Clinically Urgent Funding Requests. These continue and are aimed at patients who are exceptional and where there is no commissioning policy. The assessment of these has been reviewed and a greater degree of consistence is expected as time moves forward. They are all recorded and counted and as such can be a trigger for the NHSE to review and assess if a policy should be developed. At that point the CRG may become involved to comment or develop a policy proposition. They are therefore important at an individual level but also in a broader sense to flag up an area that requires attention.

With the difficult times that healthcare finds itself in and the relatively short time CRGs have been in existence, their role continues to evolve. The workings of NHSE are likewise developing with the effect that rules change and goalposts move with remarkable regularity. The objective remains the same; providing high quality care to the correct patient in a timely manner by the appropriate professionals.

References:

1. Service specification D08 http://www.england.nhs.uk/commissioning/spec-services/npc-crg/group-d/d08/

2. IFR request page https://www.england.nhs.uk/commissioning?s=IFR&site=

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.

This collaborative multidisciplinary publication provides 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.

http://www.fpm.ac.uk/document-store/core-standards-pain-management-services-the-uk

The Faculty has been working with the Care Quality Commission (CQC) to identify key standards for inclusion in their inspection framework over eight areas:

- Urgent and Emergency Care
- Medical Care
- Surgery
- Critical Care
- Maternity and Gynaecology
- Services for children and young people, neonates and transition
- Outpatients and diagnostics
- End of Life Care

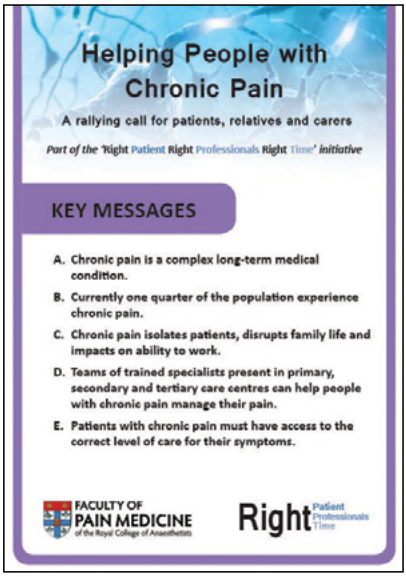
These key standards can be found on the CSPMS webpage.

The Royal College of Anaesthetists' *Guidelines for the Provision of Anaesthetic Services* (GPAS) 2016 contains an Acute Pain chapter. This can be found at http://www.rcoa.ac.uk/gpas2016

‘Right Patient Right Professionals Right Time’

This Faculty of Pain Medicine initiative has produced two documents, one aimed at national stakeholders & commissioners and one aimed at patients & advocacy groups. These were launched in parliament in November 2015.

You can help by forwarding the briefing document to your local commissioning groups and providing the patient document for your patients.



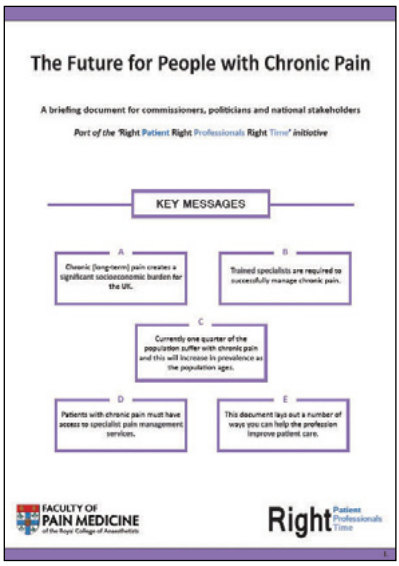
Helping People with Chronic Pain: A rallying call for patients, relatives and carers

This is available in a standard A4 document or as a printable leaflet version that makes an A5 folded leaflet when printed out double sided on A4 paper.

Access this leaflet at:
http://www.fpm.ac.uk/node/21141

The Future for People with Chronic Pain: A briefing document for commissioners, politicians and national stakeholders

Access this document at:
http://www.fpm.ac.uk/node/21142



Right Patient Professionals Time

EPM Lite

Dr Sailesh Misra

Consultant in Anaesthesia & Pain Medicine

Implementing Essential Pain Management Lite , the Newcastle experience: A survey of undergraduate pain curricula for healthcare professionals in 2009 highlighted the poor education in pain management to medical students. EPM Lite has been a positive step aimed at bridging this gap. At Newcastle University, we have piloted EPM Lite to the Tyne Base Unit students in the 2015-16 academic year.

Following my conversation with Dr Mike O'Connor, the EPM-Lite UK project lead, I approached the University with a timetable to fit in their final year undergraduate curriculum. It comprised of a one hour introductory lecture, followed by small group workshops to the final year students in their clinical placement period. The EPM Lite manual was sent out to the students a week before the workshop. The workshop included a combination of presentations and case based discussions.

The introductory lecture outlined the basic concepts of pain management and introduced the Recognise, Assess and Treat (RAT) approach. The next step was to build a core team of instructors who would deliver the course in workshop format to small groups. of students. Luckily, my obstetric anaesthetic colleague, Dr Julia Morch-Siddal was already an EPM instructor, having delivered the course in Europe and Africa. We identified eight anaesthetic consultants and acute pain specialist nurses who formed the core teaching faculty and completed an accelerated EPM instructor course with Julia before running the workshops.

We have carried out four workshops, constantly modifying our content delivery. The students have consistently prefered more case based discussions in their feedback, which has been increasingly positive. We invited Mike to a workshop to ensure standardisation, quality and to share his experience.

The Newcastle story of EPM Lite has been one of motivation, commitment and opportunity to improve pain education from a team of like-minded educators. I am thankful to my colleagues at Newcastle University for recognising the local need and their whole hearted support.

Dr Saravana Kanakarajan

Consultant in Anaesthesia and Pain Medicine

In Aberdeen, EPM Lite was introduced for undergraduate medical students in the current academic year 2015/16. In discussion with the medical school, it was decided that EPM Lite, a workshop teaching systematic approach to pain management, would be best delivered to the final year students where they prepare for a safe, effective and competent practice. Our aim is to complement the ongoing didactic lectures of pain physiology, assessment and treatment in their second and fourth year. The course is delivered as a half day workshop for medical students during their surgical block. Thus, four such workshops were planned for this academic year and all have now been carried out successfully. A team of consultant anaesthetists and pain fellows deliver the workshop locally. We had the external expertise from Dr. Mike O'Connor for our first workshop in October 2015.

On average, 24 students participate per workshop. A soft copy of pre-course material including manual and clinical scenarios are sent well in advance. In addition, students are encouraged to bring a case for discussion. On the day of the workshop, they get an hour of didactic lectures and then are divided into four groups enabling the small group discussions to be more effective, focused and interactive. The majority of the students readily engage with the systematic approach to pain management which is reflected in the feedback. Based on the feedback, the didactic element of the workshop has been reduced; elements of

prescribing have been introduced and the manual has been adapted to the needs of the final year students. To streamline the concept, the lecture on pain assessment and treatment has been adapted for the Recognise, Assess and Treat (RAT) model. There are efforts to roll out the programme in other hospitals of the region. Apprehension about using this model during OSCE examinations has been raised and is being addressed with the examination board of the University. Overall, the introduction of EPM Lite has been welcomed both by students and the medical school. We are grateful to the local curriculum co-ordinators who understood the concept and readily embraced it for the benefit of the students.

Overall how useful was this workshop in helping you understand pain management?

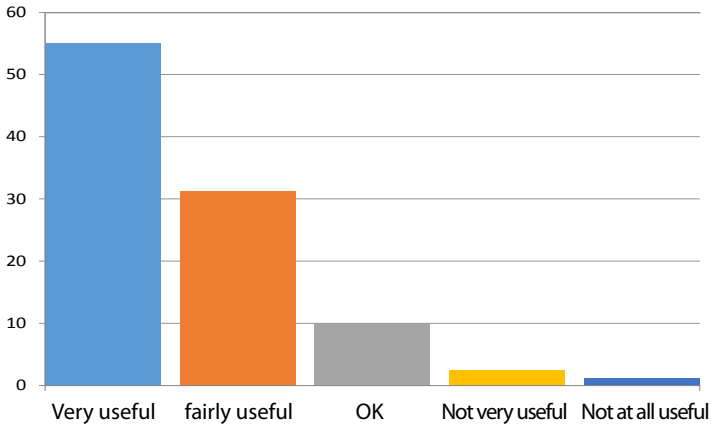


Figure 1: Student feedback from Aberdeen EPM Lite course (%)

Obituary for Dr Mike Gregory

Dr Kevin O'Sullivan

Consultant in Anaesthesia and Pain Medicine

Mike Gregory Consultant in Anaesthesia and Pain Management died suddenly on November 23rd 2015.

Having qualified in Medicine from Barts, Mike chose to pursue his career in the North West. He was appointed as a Consultant to the Royal Oldham Hospital specialising in Pain Management where he established the first patient controlled analgesia based Acute Pain Service in the region.

Mike was an enthusiastic early adopter of novel treatments, co-authoring a seminal paper on total intravenous anaesthesia for Caesarian Section whilst working at the Prince of Wales Hospital in Hong Kong and subsequently participating in numerous pharmaceutical trials.

He eventually devoted himself full time to Chronic Pain management and developed a large and hugely popular multidisciplinary clinic. He had boundless energy and enthusiasm in the service of his patients. His Monday intervention list had over thirty scheduled procedures; as he said, "this still left room for emergencies!"

Mike willingly took on leadership and managerial roles throughout his career. He was dedicated to the ideal of optimising resources within the NHS.

He was devoted to his family and was a loyal friend and an esteemed colleague. He was unfailingly generous in sharing his knowledge and expertise and in offering advice and guidance.

In his spare time Mike loved the outdoors. He was a keen skier and cyclist, taking part in the Ride London 100 mile charity cycle last August. He loved to holiday every year in the West of Ireland with his family.

Mike will be remembered by his colleagues, his friends and his family and also by his patients for his enthusiastic and generous approach to all and for his dedication to the Pennine pain service.

Professional Standards

Dr Beverly Collett OBE

FPMPSC Chair

This is my last update as Chair of the Professional Standards Committee. I would like to thank all the Committee's members who have been innovative, hard working, and most importantly, enthusiastic in volunteering to take on projects. Collectively, the PSC has accomplished a great deal over the past couple of years on behalf of the Faculty and this is due to the diligence of the committee members.

I am delighted that Tony Davies will become Chair after the PSC meeting in May. He is an astute, thoughtful man and I have every confidence that he will be most successful in this vital role. He will be very ably supported by Paul Wilkinson as Deputy. Paul has an eclectic background and range of professional interests. I expect that the next few years will be a fruitful time for this important committee.

I am very pleased that Anna Weiss has been appointed as future CSPMS Lead. Formal review will be undertaken in two years.

We will welcome a new member, James Taylor, in May. James is one of the trainers for the Pain in Secure Environments courses that have been successfully held both in and outside London over the past year. Sanjeeva Gupta will come to the end of his term of office as Educational Meetings Advisor in February 2017 and Shyam Balasubramian has been appointed as his successor. Sanjeeva has designed excellent varied educational meetings which have been a credit to the Faculty.

We met with Claire Lane from the Care Quality Commission. It was agreed that key standards from the CSPMS could be included in the CQC inspection framework across several clinical service areas. The standards agreed are detailed in this issue. The GP branch of the CQC has also been alerted to the document and we hope to have discussions regarding standards which could apply to out of hospital and primary care services.

Mark Taylor is now representing the Faculty in discussion with Andreas Goebel, Chair of the CRPS Guidelines Development Group, on additional guidance and the next edition of *CRPS in adults* guidance. I hope that this will result in Faculty endorsement of additional guidance and the next version of this important document.

Many of you will be aware of the NHS England publication *National Safety Standards for Invasive Procedures* (NatSSIPs), published in September 2015. This document sets out clear responsibilities for all those involved in any invasive procedures from the individual healthcare professional, through management, Medical Director and Chief Nurse and onto the Trust Board and Commissioners. The Chair, William Harrop-Griffiths was most interested in our safety checklist for Interventional Pain Procedures under local anaesthesia or sedation, which has just been formally ratified. We have sent him a copy as an exemplar of what the FPM considers to be good practice. Many thanks to Tony Davies and Paul Wilkinson for their hard work on this.

The FPM registers as a stakeholder to many NICE consultations and responds to DH publications on your behalf. If you see a consultation document that you feel strongly about, please let us know, so that we may incorporate your views. We are reviewing some of our current publications that are close to their date limitation. If you would like to be involved in any re-write, then please let us know.

I have received superb support from Daniel, Anna, Laura and Jyoti who are a font of knowledge on the workings of the Faculty, the Royal College of Anaesthetists and other associated organisations and who have been unstinting in their hard work and effort for this committee. My personal thanks are extended to the committee for their industry and meticulous attention to detail.

Lay Perspective of the Board & PSC

Dr Stuart Burgess

FPM Board & PSC Lay Representative

As a lay person I am delighted to have this opportunity to contribute to *Transmitter*. It is a privilege for me to 'sit in' on the meetings of the Faculty of Pain Medicine.

I have been asked to introduce myself and share some of my journey. For over 20 years I have worked in two Universities as a Chaplain – the University of Nottingham (at the time of the establishment of the medical school) and the University of Birmingham, where I worked closely with the Medical School giving seminars to medical students on ethics.

For 15 years I was a Church leader for the Methodist Church in Yorkshire and was part of the 'thinking group' around the setting up of the medical school based at the Universities of York and Hull. For almost a decade I worked as the Rural Advocate to the Prime Minister, serving three Prime Ministers, Tony Blair, Gordon Brown and David Cameron and chaired two Non Departmental Public Bodies, the Countryside Agency and the Commission for Rural Communities. Presently I Chair a National Housing Association, serve on the board of Transport Focus and Chair the Directors of The Wesley, the first ethical hotel in the UK, based in Euston.

I have always been interested in health issues having cofounded the Nottinghamshire Hospice. For me one of the most creative pieces of work was founding St Andrews House in Birmingham for the mentally ill, in conjunction with the Mental Health Department of the University of Birmingham and the local authority and a housing association. I was the first Co-Chair for the Patient Liaison Group for the British Medical Association.

The Board considers numerous topics and I have been impressed by the level of debate and openness to listening to each other, which is not always the case in other organisations in which I am involved. I was particularly impressed by the discussion and production of the 'Core Standards for Pain Management.' This is an excellent piece of work and I was able to give a lay perspective throughout. The work on a Buddying/Mentoring system for the Faculty, in my opinion, covers an important area. Mentoring relationships can benefit many people, including the employee, the employer and the individual. In any organisation where there are increasing demands and pressures, both internal and external, the value of mentoring is of growing significance. The promotion of the ten Pain Messages created through the Pain Consortium which included patient input helps the patient to understand more fully the work of the Faculty and the wider pain community.

I was delighted to attend the meeting in the House of Lords last November which highlighted the current state of Pain Medicine, the Core Standards document and Opioids Aware. Following on from this I brokered a meeting between the Dean and the Bishop of Carlisle, the spokesperson on health issues in the House of Lords for the Church. Hopefully this will raise the profile of the Faculty through a question being asked in the House and this could be followed by arranging a mini debate.

Perhaps the Faculty should look more closely into raising public awareness of its work.

I thoroughly enjoy my involvement (not that I understand all the issues!) but hopefully through listening and occasionally making comments I can in some small way make a contribution.

Epidural Steroid Injections: Development of a British position statement

Dr Neil Collighan

Chair of FPM/BPS Axial Steroids Consensus Group

On the 23rd April 2014 the United States' Food and Drug Administration (FDA) released a Drug Safety Communication with regard to a warning that injection of corticosteroids into the epidural space of the spine may result in rare but serious adverse events, including loss of vision, stroke, paralysis, and death. It also stated that Corticosteroids are not approved by FDA for injection into the epidural space of the spine.

To raise awareness of the risks of epidural corticosteroid injections (ESIs) in the medical community, FDA's Safe Use Initiative convened a panel of experts, including pain management experts, to help define the techniques for such injections which would reduce preventable harm.

These actions raised concerns within the American pain organisations and, in November 2014, responses were published on behalf of multiple pain stakeholder groups. Specifically they were concerned that the FDA *Warning* failed to differentiate between the risks and benefits of transforaminal and interlaminar routes of administration, and particulate and non-particulate formulations of steroids.

An extract from this strongly worded rebuttal includes: 'We believe that the 17 references selected by the FDA to support the Warning do not address or in any way support a safety concern related to epidural steroid injections when administered by the interlaminar or caudal approach and underscore the need for the FDA to retract and revise the Warning. We strongly support providing patients with accurate information so they can make informed decisions about their treatment. Because of the omissions outlined above, we believe that the FDA's Warning has led many physicians and patients to incorrectly conclude that all epidural steroid injections carry grave risks. When epidural injections are performed correctly (correct technique, correct medications, and correct setting) for appropriate indications, they are safe and can provide improved quality of life and function. Removal or curtailing these procedures would lead to more patients seeking surgical or unsafe medical therapies with potentially (much) greater risks.'

A collaboration was undertaken between the U.S. Food and Drug Administration Safe Use Initiative, an expert multidisciplinary working group, and 13 specialty stakeholder societies. They reviewed the existing evidence regarding neurologic complications associated with epidural corticosteroid injections and produced consensus procedural clinical considerations aimed at enhancing the safety of these injections. It concluded that adherence to 17 specific recommended clinical considerations when performing epidural corticosteroid injections should lead to a reduction in the incidence of neurologic injuries. This was published in May 2015[1].

The FDA published its formal response in October 2015 in the New England Journal of Medicine[2]. They have chosen not to modify the current warning with regards to neurological injuries. They have however declined to publish a specific contraindication to the injection of glucocorticoids into the epidural space. On the grounds of insufficient evidence they did not differentiate between particulate and non-particulate steroids, nor the route of injection.

Predictably this chain of events caused concern outwith the United States. The uncertainty that it caused with regards to the future of epidural steroids was discussed at the highest levels within the Faculty of Pain Medicine and the British Pain Society. This led in June 2015 to the decision to create a working group to create a position statement that will help British pain services make decisions around this difficult area. I was approached to Chair the group and representatives of varying stakeholders were co-opted. As with all documents it has grown from a simple statement to a much larger document. We hope to publish very soon a British Consensus Position Statement, to help both clinicians and patients in delivering a safe and clinically effective procedure.

References:

1. Safeguards to Prevent Neurologic Complications after Epidural Steroid Injections: Consensus Opinions from a Multidisciplinary Working Group and National Organizations Anesthesiology 5 2015, Vol.122, 974-984.
2. http://www.nejm.org/doi/pdf/10.1056/NEJMp1511754

Neuromodulation Database

Dr Ganesan Baranidharan

Consultant in Anaesthesia and Pain Management

Neuromodulation is a rapidly expanding field in Medicine. It is currently used to treat neuropathic pain, epilepsy, movement disorders and urinary and fecal incontinence. There is a surge of interest from start-up companies looking at newer indications and newer innovations. Technical advancement is also being made in the areas where we lacked efficacy

Spinal Cord Stimulation (SCS), Peripheral Nerve Stimulation (PNS), Deep Brain Stimulation (DBS), Sacral Nerve Stimulation (SNS), and Vagal Nerve Stimulation (VNS) encompass the main modalities for neuromodulation. Chemical modulation of the central nervous system (CNS) is achieved by direct drug delivery to the CNS via an Intrathecal Drug Delivery System (ITDD) used to treat pain and spasticity. This is used mostly in long term and diverse conditions.

The National Institute for Health and Care Excellence appraised SCS in 2008 and a guideline was published (TA 159). There are approximately 40 centres in the United Kingdom currently offering neuromodulation. Various specialists such as Pain Medicine doctors, Neurosurgeons, Colorectal and Uro-Gynaecological surgeons currently perform these techniques with assessment by multi-disciplinary teams comprising of psychologists, neurologists, neurophysiologists, physiotherapists and specialist nurses. In the UK there are approximately 1000 SCS, 1200 SNS, 500 ITDD and 600 DBS procedures performed per year.

The Neuromodulation Society of the United Kingdom and Ireland (NSUKI) is the UK chapter of the International Neuromodulation Society (INS). The objective of this professional society is to expand and educate specialists on the role of Neuromodulation. In 2010, we raised a small grant to initiate our National Neuromodulation Registry (NNR).

Why do we need a NNR?

The field of neuromodulation has seen a surge in Randomised Controlled studies (RCT) such as SENZA, ACCURATE, RASCAL, and SUNBURST adding to the available literature. The NNR will be an effective tool to look at the data of these techniques in the UK. The database is owned by NSUKI and was developed in collaboration with The National Institute for Cardiac Outcome Research (NICOR). NNR is not an electronic record of patients. Its main function is a device registry linking with clinical outcomes which will allow for benchmarking, search facility, MHRA reporting and GP letters. The current data fields include:

- Demography
- GP Post code
- Diagnosis
- Base line scores such as BPI, EQ5D, MIDAS, Ashworth score
- Implanted device serial numbers
- Follow up data
- Drug dosage for ITDD
- Re-operation data

SCS and PNS for pain, Occipital Nerve Stimulation (ONS) for headache, and ITDD for spasticity and pain are currently available. This will be expanded in the near future to include other modalities such as SNS, DBS, and Gastric stimulation.

NSUKI has raised funds for the first two years of the database with an unrestricted educational grant from the device industry. A pilot phase was setup and six centers have taken part. This has allowed us to develop and adapt an initial data set. We currently have a Database Management Group to make sure we get appropriate, useful data. Clinical governance framework is a key factor and this board consists of members from NSUKI, NICOR, the Faculty of Pain Medicine, Association of British Healthcare Industries (ABHI), GP commissioning board, NICE, Medicines and Healthcare Products Regulatory Authority (MHRA) and the Society of British Neurological Surgeons (SBNS).

A national launch is the next phase. All centres will be expected to take part in the data collection. The results will be presented at every NSUKI Annual Scientific Meeting. A Research Board will be established to utilise and analyse the data for the benefit of prospective and retrospective studies.

Acute Pain Medicine Update

Dr Mark Rockett

Acute Pain Medicine Lead

Introduction

In the Autumn 2014 edition of *Transmitter,* I outlined what was known about the state of Acute Pain Medicine in the UK and how it was changing. Early in 2015 the FPM formed an Acute Pain Working Party (APWP) to look into Acute Pain Medicine in the UK in its broadest terms. The work of this group overlaps with that of the Training and Assessment Committee (TAC) and the Professional Standards Committee (PSC). The makeup of the APWP was intended to reflect this broad remit. A number of work streams were developed to address unanswered questions about training in, and delivery of, acute pain medicine in the UK.

Standards

Much of the standard setting work for Acute Pain Medicine suggested in 2014 has been completed. The FPM document, *Core Standards for Pain Management Services in the UK* is now available on the website. This document includes a chapter on standards for acute pain services, written by a multidisciplinary author group. The RCoA Guidelines for the Provision of Anaesthetic Services (GPAS) 2016 is also complete and has a chapter on Acute Pain service. It is hoped that these documents will enable acute pain leads to secure the resources they require to provide an adequate service for their patients.

Workforce

The FPM Acute Pain service census was sent to all identified Acute Pain leads. The first dataset included 117 replies, giving a 37.5% response rate from all UK acute hospitals. Consultant input into Acute Pain Services (APS) was limited, with 79% of hospitals providing two or fewer clinical sessions per week and 50% one or fewer sessions. In most cases only one or two consultants were involved (88/110). Nursing support was limited to two or fewer whole time equivalents in 42% of hospitals. The majority of APSs do not provide an out of hours service (89/109 - 82%). Working with chronic pain colleagues was limited in a significant proportion, with 59% (66/111) having no specialist expertise within the team despite 98% of teams reviewing patients with chronic pain. The majority reviewed medical patients with pain (87/110 - 79%). In two thirds of trusts, at least 20% of the workload was non-surgical. The findings of the census are in preparation for publication.

Trainee involvement in the development of Acute Pain Medicine training is crucial. The APWP is liaising with our Trainee Representative prior to gathering trainees' opinions on training and working in Acute Pain Medicine. One clear determinant of training choices is the availability of relevant consultant posts. With this in mind the APWP reviewed the last 12 months' job adverts in the British Medical Journal. Of 291 relevant job adverts, acute pain management alone was mentioned in three, acute and chronic pain in three. Chronic pain or 'pain management' was mentioned in a further 26 adverts. In this sample, it would seem that specific reference to acute pain specialists is limited, but about 10% of job adverts reference pain medicine overall.

Education and training

It is clear that acute pain doctors manage complex pain problems, often with limited resources. Ideally, all doctors practicing acute or chronic Pain Medicine would complete advanced pain training. However, the commitment to acute pain is frequently limited to less than one session per week. It is therefore understandable that trainees might not be willing to complete advanced training to provide this role. CSPMS UK states that Higher Pain Training is an appropriate level of training for a clinician working in acute Pain Medicine. However, the current stipulation of 20 sessions, often interrupted by on call commitment, may not be sufficient to provide training in all the technical and non-technical skills needed to manage complex pain and run a multidisciplinary service. The APWP is in the process of investigating new models of training which might meet these needs.

The recent FPM study day, 'Acute Pain Management in a Complex World' proved popular, with more than 90 attendees. I was pleased to see a mixture of acute and chronic pain practitioners, anaesthetic trainees and

acute pain nursing staff in the audience. I am grateful for support from Drs S. Gupta and S. Balasubramanian as Education Meetings Advisors and Jane Quinlan, who shared her expertise in her usual engaging manner. The outstanding organisational skills of Laura Owen, Faculties Coordinator, allowed the day to run without a hitch. There appears to be an appetite for further acute pain meetings and we are keen to make this a regular event.

Research

I have reflected on the lack of investment in non-commercial research in Pain Medicine in the UK and mentioned the National Institute of Academic Anaesthesia/James Lind Alliance priority setting exercise. The number one research priority selected by the combined patient and professional panel was: 'What can we do to stop patients developing chronic pain after surgery?' Clearly, this question is of great clinical importance and emphasises the overlap in research opportunities between acute and chronic pain. Hopefully this will translate into more of our colleagues putting forward their research ideas. The top-ten research priorities can be accessed at: http://www.niaa.org.uk/JLA-NIAA-Priority-Setting-Partnership-Final-Results.

Summary

This article outlines some of the FPM activity related to Acute Pain Medicine. I believe this marks a strong start to developing stronger links between the Faculty and acute pain doctors in the UK.

Revalidation Update

Dr Rob Searle

Consultant in Anaesthesia and Pain Medicine

There are currently over 220,000 doctors in the UK that are subject to revalidation. Between December 2012 and January 2016, the GMC has approved recommendations to revalidate just over 141,000 doctors. A small proportion of doctors (just over 31,000) had their submission dates deferred, mainly because of insufficient available evidence. During this time, around 2,600 licences have been withdrawn from doctors who have failed to engage with revalidation.

This year, the GMC commissioned an independent research project to evaluate the impact of revalidation on doctors, patients and the public. Many doctors will have been asked to participate in a survey connected to this project in 2015, with further surveys planned in the future. The study is due to report in 2018, and will cover the first five years since the introduction of revalidation, with the aim of helping to shape revalidation in the future.

Appraisal is a key component of the revalidation process; the College and Faculty have published guidelines to aid this process. Most recently, the Core Standards for Pain Management Services in the UK (2015) gives standards for appraisal and revalidation.

Many fellows will be familiar with some of the online tools designed to aid the appraisal process. By the autumn of last year, over 7500 users had registered for the CPD online diary provided by the Royal College of Anaesthetists. The CPD web app is a mobile enhanced version of the of the main CPD diary, and can be used even when devices are not connected to the internet (with entries later synchronised to the full version of the CPD online diary once internet connection is restored). In the first year since its launch, the web app has received in excess of 17,000 'visits'. Other CPD diaries are available, with the GMC launching their own version in 2015.

Another key component of the revalidation process is patient and colleague feedback. For those Faculty fellows who also practise anaesthesia, the College has developed a patient feedback questionnaire specifically for anaesthetists. It has been piloted in the UK and approved by the GMC for use by anaesthetists for revalidation purposes.

The College also continues to provide a revalidation helpdesk, with the majority of enquiries relating to CPD, returning to practice after a period of absence and scope of practice. Senior clinicians from the Faculty of Pain Medicine act as Revalidation Specialty Advisors and are available via the helpdesk for Pain Medicine specific revalidation advice if it is required.

Pain Medicine: looking forward

Dr Barry Miller

Vice-Dean

"What's past is prologue",
William Shakespeare, 'The Tempest'.

We are a curious specialty. Our stated aim of reducing pain and suffering is no different from that of all other doctors, but we take a much broader view, applying our skills to the aims without the need for diagnostic clarity.

Modern medical practice has evolved only in the last 200 years, from the ideas of vaccination in the late eighteenth century to the development of Anaesthesia in the mid-nineteenth, but it is not until the twentieth century that treatments began to be developed for the numerous recognised diseases. Antibiotics, Steroids, Antidepressants, Anticancer drugs etc. A burst of pharmacological and medical advancement from the 1920s to the 1960s and, to a certain extent, mainly refinement of those principle players since then.

As a profession, one of our main areas of focus has been for pain to be recognised as a condition which needs primary consideration when any doctor is presented with any condition. This is a significant change in modern medical thinking, which has evolved, mainly in the last 100 years, to view all symptoms and signs as guides to what is actually wrong. The appropriate treatment is then modelled around disease eradication, modification or stability. Those of us in Pain Medicine, the audience I'm speaking to, and I hope for, recognise that 'modern' medicine has profound limitations that doctors and patients often have difficulty in facing. This is the simple recognition that our ability to diagnose, to treat, to cure, has many gaps; known unknowns and unknown unknowns. The arguments over the best treatments for back pain; the failure of medications to help many cancer survivors with intractable post-herpetic neuralgia. The large NNTs which leave many with a poor existence.

So how do we change perceptions? What are our goals?

In the narrowest definitions the Faculty provides a framework for education, training and standards for Anaesthetists practising in the sphere, but we need to look to influence those outside our existing borders, and maybe widen them.

The management of pain is core to medical practice, but knowledge of the tools available, whether the myriad of drugs or the concepts of Pain Medicine, is patchy. From undergraduate education, to those in poorly resourced Acute services, to doctors from other colleges practising various facets of Pain Medicine with limited recognition.

In last month's *Transmitter* we saw how the Essential Pain Management (EPM) programme was being used not just to export good practice outside the UK, but, in the EPM Lite form, to Medical Schools in the UK. Dr Kate Grady and Dr Mike O'Connor have been active in reaching out to Medical Schools and the GMC. Just a few hours in a big curriculum, but the same core teaching materials gradually being rolled out and replicated across the UK. A single message with simple principles. To begin to influence how new doctors will view the patient in pain. To begin.....

In other areas the Faculty is looking to redefine our involvement with Acute Pain services, and in this issue Dr Mark Rockett outlines the areas being developed, around training, continuing education and an enhanced place within the Faculty.

But Pain Medicine clearly isn't the unique preserve of Anaesthetists, so we are looking to colleagues practising essentially the same work, but from different college, faculty or societal backgrounds with a view to developing new relationships and thinking.

Next year we will have our 10th Anniversary. There is still a lot to do.

Training and Assessment

Dr Jon McGhie

TAC Chair

Firstly, as I am sure you are aware, Dr Barry Miller is now the FPM Vice Dean and I would like to congratulate him on this appointment. I know he will excel in his new role and I wish him all the best. His political awareness and in-depth knowledge of the curriculum and examination regulations has been a huge asset to the Training and Assessment Committee (TAC) and I am sure his experience will continue to be put to good use by the FPM Board. I am fortunate that he has handed over a smooth running group of enthusiastic individuals to continue the work of TAC!

Since the last Transmitter article there have been a few other personnel changes and role switches:

• Dr Lorraine de Gray is now Deputy Chair. Lorraine has worked tirelessly in recent times to develop the RAPM feedback system and to gather and respond to trainee and service questionnaires. I am sure she will continue to be an asset to the group and I look forward to working alongside her.

• Dr Victor Mendis, who has been working with the Quality Assurance side of TAC, will take over the role of Lead RAPM from Lorraine de Gray later in the year. Victor has been involved in redeveloping the Hospital Review paperwork, but will now primarily represent the RAPMs on TAC.

• Dr Peter Cole has joined the TAC group and has kindly agreed to be the workforce planning lead. This will involve planning the next FPM census and liaising with the RCoA, who have a parallel work-stream, to ensure we have adequate specialists in place to meet the needs of the changing population.

• Finally, welcome to Dr Sheila Black our new trainee representative. We look forward to working with you! I'd like to thank Dr Lucy Miller, our outgoing trainee representative, for her efforts over the last 18 months, particularly in developing the trainee survey and being a friendly and informative liaison between TAC and the trainee body.

"Every generation needs a new revolution."
—Thomas Jefferson

The TAC group is seven years old this year! So while still relatively young in the grand scheme of College committees, in this short space of time it has helped to shape the progress of the FPM towards the FFPMRCA exam, informed pain curricula at all levels of anaesthetic training and has developed quality assurance processes with regard to fellowship of the FPM.

None of these achievements will remain static and I look forward to their evolution and to the revolution of ideas that will undoubtedly occur.

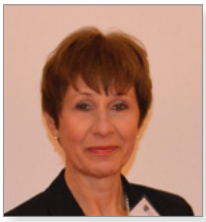
The TAC group exists as a bridge between the RAPMs, LPMES, trainees and the FPM Board in matters to relating to training and the examination; I have always found it to be a friendly group that is receptive to new ideas, so please get in touch via the FPM admin team if you have thoughts or concerns relating to pain training that you would like us to consider. I would like to ensure that the good work achieved to date is consolidated; good lines of communication between pain clinicians and the FPM are essential to achieve this.

Recent TAC work-streams have updated the examination eligibility (the amendments are on the website) and there are groups currently reviewing acute pain and paediatric pain guidance. Workforce planning remains high on the political agenda and we are grateful for the feedback that the RAPMs provide in their six monthly updates. There are huge uncertainties on the horizon relating to junior doctor contracts, GMC regulations and the EU referendum. Any and all of these may bring tidal waves of change to the NHS and how training is delivered. While there will be a decision made on the EU issue by the next TAC update in the Autumn, the current government attitude and disenfranchisement felt by junior doctors is unlikely to resolve quickly and we will keep a watchful and supportive eye to ensure that pain training opportunities are not undermined by what is to come.

FFPMRCA Examination

Dr Nick Plunkett

Deputy Chair of the Court of Examiners



Dr Karen Simpson

Chair of the Court of Examiners

As we go to press we are in the midst of the 8th sitting of the FFPMRCA Examination. A total of 20 candidates sat the MCQ part of the exam on 2 February 2016; the successful candidates have been notified and will be expected to be preparing for the SOE Examination on 12 April. The pass mark was 69.92%: 13 out of 20 candidates passed giving a pass rate of 65%, slightly lower than the average pass rate of 77% calculated from the proceeding 7 MCQ sittings.

The previously very well described and highly rigorous approach to quality assurance of every aspect of the examination was adhered to, as on all occasions. The MCQ Angoff group, which is now mature as well as expert, utilised validated methodology to determine the pass mark, as on previous occasions.

The previous (7th sitting) of the examination took place in September and October of last year. Fourteen candidates presented to the SOE Examination, with 10 achieving the pass mark of 31/40 (reached through a combination of statistical analysis and expert judgment) giving a pass rate of 71% which is slightly higher than SOE average. No candidate scored maximum marks in the SOE and therefore no candidate met the criteria for a commendation letter at this sitting.

Of the fourteen candidates who sat the exam, ten were on their first attempt, two on their second attempt, and two on their third attempt.

FFPMRCA Examination Calendar August 2016 - July 2017

	FFPMRCA MCQ		FFPMRCA SOE	
Applications and fees **not** accepted before	Mon 20 Jun 2016	Mon 1 Nov 2016	Mon 29 Aug 2016	Mon 6 Feb 2017
Closing date for FFPMRCA Exam applications	Thurs 4 Aug 2016	Thurs 15 Dec 2016	Thurs 22 Sep 2016	Thurs 9 Mar 2017
Examination Date	**Wed 31 Aug 2016**	**Wed 1 Feb 2017**	**Tues 18 Oct 2016** (backup day 19 Oct)	**Tues 4 Apr 2017** (backup day 5 Apr)
Examination Fees	£510	£510	£720	£720

All four candidates on multiple attempts passed the examination. As well as being professionally and personally rewarding for the candidates involved, this is reassuring for all (Court and Candidates alike) that the examination is fit for purpose as a quality standard universally recognised in UK Pain Medicine as worth attaining. It also illustrates to candidates who are unsuccessful on their first attempt that they should, according to the adage, "try, try again!".

The examination was well attended by most of the Court of Examiners, all of whom gained specific training in equality and diversity. The Court of Examiners was delighted to welcome three new examiners who doubtless will enrich the current cohort with specific expertise and drive: Drs Vivek Mehta, Ganesan Baranidharan and Saravanakumar Kanakarajan. New question writers, Drs Mark Jackson and Glyn Williams, and examiners also attended a training half day specific to their needs, attended also by Lay Representatives, who gave very positive feedback about content and process. In addition, new examiners had further specific training including mock examination practice.

The majority of examiners were again audited in real time as to their performance; feedback was given, with no significant issues identified. All new examiners and question writers attended a brief ceremony to mark their induction into their new roles, congratulated by the Court members.

Special thanks go to question writers, and all examiners for the time and effort taken to deliver every aspect of this exam to meet and surpass its high standards. We also acknowledge the work that goes on throughout the year to maintain question banks and quality assurance activities such as Angoff and Ebel quality assurance work. The time and effort involved in an increasingly adverse climate with respect to employer recognition of these vital roles is acknowledged, as is the fact that much of this activity goes on in free time.

Special thanks also and as ever, to the inexhaustible enthusiasm, professionalism, diligence and calm of the RCoA Examinations Department, especially Graham Clisset, Neil Wiseman and Beth Doyle for making every aspect of the exam run as smoothly as it does.

FFPMRCA Exam Tutorials

FFPMRCA Exam Tutorials are held biannually.

The next tutorial will be taking place on:

Friday 9th SEPTEMBER 2016

Location: The Royal College of Anaesthetists

Fee: £95.00

For more details and to book please visit **www.fpm.ac.uk** or email: **fpm@rcoa.ac.uk**

RAPM Update

Dr Lorraine de Gray

RAPM Chair

The beginning of the New Year has seen two newcomers added to our group of Regional Advisors in Pain Medicine (RAPM). I would like to extend a warm welcome to Dr Yehia Kamel, RAPM for Lincolnshire and Leicestershire, whilst Dr Praburam Ibrahim Selvaraj has taken over as RAPM in Derbyshire and Nottinghamshire. Appointing individual Consultants to take over these posts is becoming increasingly difficult. As I wrote in the Autumn edition of *Transmitter*, growing demands on an already overstretched NHS are leading to challenges in terms of providing both clinical and educational supervision. We have recently conducted an electronic survey looking at the allowance of Supporting Professional Activities (SPA) in job plans for all Regional Advisors and Local Pain Medical Educational Supervisors (LPMES). This survey was aimed at finding out whether Trusts are allowing for additional SPA time in recognition of the time needed to provide clinical training as well as formal teaching, assessments and annual appraisals for trainees. The results are currently being evaluated but a preliminary overview shows that, in spite of national guidance to support training roles, the majority of RAPM and LPMES have no allocated SPA time in their job plan specifically for College related duties; in a similar vein, taking professional leave to attend meetings in relation to these duties was difficult and in the majority of cases had to be paid back as part of an annualised job plan. A full evaluation of the data will be published in due course and will comprise part of the annual submission on upcoming educational issues to the GMC.

Other training related issues were discussed at the last RAPM forum held at the end of last year. In particular, formal teaching for advanced pain trainees was reviewed and the plan is for neighbouring regions to offer formal teaching to each other's trainees. This has been successfully piloted in London. The Faculty of Pain Medicine continues to provide exam tutorials twice a year. These are an excellent way of preparing for the FFPMRCA examination and I would encourage everyone sitting for the examination to attend one of these tutorials.

Case reports continue to be an aspect of advanced pain training which attracts a lot of discussion among both trainers and trainees. Writing a case report is a learning process. It is important that trainees are encouraged to plan writing this report so as to allow time to discuss and review the article which should be, at the end of the day, of a publishable standard. It is essential that correct referencing is used and that material is not unintentionally or otherwise plagiarised. We encourage trainees to have their case report written and in its last stages of revision by the ninth month of advanced training in Pain Medicine.

The impact of on-call rotas on higher and advanced training in pain medicine is also under review by all RAPMs. Although the curriculum is competency based and not measured in the absolute total number of sessions or procedures performed, it is nonetheless recognised that competency can only be achieved if there is sufficient exposure to teaching and experience achieved on a regular basis. RAPMs have a duty to ensure that trainees have their training time fully protected – such trainees are only expected to cover general anaesthetic duties during this time to cover night and weekend emergency work. Moreover, we are exploring which on call rotas lend themselves to the least impact on day time training hours.

In an ever changing NHS, financial constraints and the impact of political agendas pose challenges for the year ahead. We will not be deterred from continuing to fully support our trainees and nurture more anaesthetic trainees to consider a career in Pain Medicine.

Spotlight on Oxford

Dr Peter Cole

RAPM for Oxford

Recently, when looking for a set of patient notes, I noticed several faded books. Taking a closer look, I discovered hand written notes of procedures carried out in the Oxford Regional Pain Relief Unit, beginning in the 1960s; they made for a fascinating read. These records supplement Jennifer Beinart's 'A History of the Nuffield Department of Anaesthetics 1937-1987'.

Anaesthetist Richie Russell, having published in the Lancet in 1936 on spinal injection of alcohol for intractable pain for terminal cases of cancer, later developed treatments for ex-servicemen with pain relating to injuries sustained during the Second World War. This work inspired anaesthetist John Lloyd, who started a pain clinic in 1962. Lloyd was treating cancer patients so effectively with neurolytic nerve blocks that many were able to resume life at home. When the local health authority agreed to fund a standalone unit the proposed name was challenged in a letter by John Lloyd "I very much doubt it should be the 'Terminal Care Unit", and the name 'Oxford Regional Pain Relief Unit' (PRU) was agreed, remaining until recently.

Over subsequent years the pattern of referrals changed; many more patients with chronic non cancer pain were referred, whilst cancer pain was still managed. The unit continued to thrive in the hands of Chris Glynn, joined by Henry McQuay and later Tim Jack, and moved to its current site at the Churchill Hospital in 1989. A new wing was built from over £1 million of charitable funds raised by the Oxford Pain Relief Trust, mainly through the enthusiasm of Chris Glynn. The importance of pain was recognised by Henry McQuay being made Professor of Pain Relief, and the PRU thrived as a centre of excellence, teaching many of todays leading pain specialists. Evidence based pain medicine was made accessible to all by the development of the Bandolier website created by Andrew Moore and Henry McQuay, followed by the Cochrane Pain and Palliative Care Review Group (PAPAS) with Phil Wiffen as the original coordinating editor, followed by Chris Ecclestone. Many methodological developments and products in evidence and pain have seen their origins in the unit. On the nearby John Radcliffe site the Nuffield Professor of Anaesthetics, Irene Tracey, heads a large team with an international reputation for functional MRI imaging and pain research.

More than 120 patients per week are now seen in the clinic and over 100 treatments performed each month. However the PRU is only one of several areas within the Trust managing patient with persistent pain; others include neurosurgery neuromodulation, pain rehabilitation programs at the Nuffield Orthopaedic Centre and separate pelvic, paediatric, and palliative care clinics.

Whilst we have developed expertise in our unit by running joint neuromodulation, neuropathic and CRPS, headache and opioid reduction clinics, the majority of referrals to the Pain Relief Unit are for chronic non cancer pain and often for musculoskeletal conditions. As these patients have usually had pain for many years; pain reduction and self-management are more realistic targets than pain relief. As the nature of the work has changed therefore so has the name, to The Oxford Pain Management Centre. As resources struggle to meet demands, we work with the CCG to provide support for the management of patients in primary care.

The faded records contain impressive reports of pain relief, albeit sometimes for short periods, for pain associated with trauma and terminal cancer. Whilst many treatments have been discontinued (e.g. electrical percussor for hitting painful spots in amputation stumps) there was clear documentation that many of these treatments provided tremendous benefit. A few years later there were details of the first radiofrequency denervations (1972) and spinal cord stimulators (1973). These pioneers laid the foundations for future practice, evidence based reviews, scientific research and for the reputation of excellence in Pain Medicine in Oxford.

Trainee Update

Dr Lucy Miller

Faculty Trainee Representative

This will be my last article as trainee representative for the Faculty of Pain Medicine and I would like to congratulate my successor Sheila Black on accepting this highly rewarding position. It has been a privilege to work alongside such a dynamic Faculty as they strive for both improved training in Pain Medicine and high standards for pain services throughout the UK. Change in working conditions for junior doctors has never been more prominent and the Faculty are very aware and supportive of these issues.

Recently fourteen candidates sat the FFPMRCA examinations with 60% passing on their first attempt and 100% pass rate for those on subsequent sittings. Congratulations to all successful trainees. New examples of exam questions are to be added to the RCoA Faculty of Pain Medicine website shortly. In addition, the last exam tutorial took place on 18th March.

One interesting change in training relates to the intended benefit of the case report. It will soon be a requirement that this is completed by the ninth month of APT to allow greater opportunity for discussion and learning with the LPMES. The best of these will also be selected annually to receive the 'Case Report Prize', which will be included on the FPM website and mentioned in *Transmitter.* In addition the author will receive a complimentary invitation to the Annual Meeting.

The impact of 'on calls' during APT is an important issue raised at the trainee annual meeting and also highlighted in the biannual report by the RAPMs. It appears to vary in effect throughout regions and the Faculty have recently issued a survey to fully assess the problem. Please could I ask you, firstly, to complete this survey, but furthermore feedback any pertinent discussion points to Sheila (the new trainee representative).

May I draw your attention to the FPM website which is continually evolving and acts as a great resource for trainees. It has sections relating to careers, training, education and research. It's also a great 'go to' for quick access to recent guidelines, publications and leaflets. The APT document is currently being addressed and updated in line with 'Core Standards' and will shortly also be added to this website. The new addition of the fantastic Trainee Newsletter now further maintains up to date communication between the Faculty and trainees in an easy to read format. Please take the time to whizz through it!

Finally, may I thank you for your input and support in changing the shape of pain training over the last two years. I do hope to meet many of you at the BPS meeting in Harrogate; I wish you well with your completion of training and as future consultants in Pain Medicine.

Dr Sheila Black

Faculty Trainee Representative

I am an Advanced Pain Trainee in Leeds/Bradford. As of February, I am the Faculty Trainee Representative. Currently in my last year of anaesthetic training, I have worked in a number of regions in the UK and abroad. I graduated from the University of Aberdeen, and completed my SHO training in Aberdeen. I moved to France for 18 months working in cardiac anaesthesia before returning to the UK where I worked in Glasgow in PICU (Yorkhill Hospital) and adult anaesthesia. I continued my registrar training in anaesthesia in 2010 in Yorkshire and commenced my APT year in August 2015. This varied experience of working in different regions and countries has given me great insight into the challenges of training and service provision, especially in Pain Medicine. On taking on this role, I am delighted at the chance to influence training in Pain Medicine over the next two years on behalf of Trainees.

Academic Research Fellowship: Barts Health NHS Trust & the London Clinic

Dr Shankar Ramaswamy

Post-CCT Research Fellow

Anaesthetic trainees often dream of a research job, which is well paid, but also enables excellent 'hands-on' clinical experience. I would like to share my experience as a research fellow at Barts Health, in collaboration with the critical care unit (CCU) at the London clinic. This post involves doing six 24 hour shifts a month as a CCU fellow at the London clinic, one of central London's prominent CCUs, led by Dr John Goldstone. With a pay package equivalent to a senior registrar, excellent on-call accommodation and food, this job gives you a flavour of how the private sector works. I had the remaining days of the month to achieve my goals at the Pain and Anaesthesia Research Centre (PARC) at Barts Health.

In the late 1990s, a consortium of co-located private hospitals in London perceived the need to provide high quality 24/7 resident cover for their critical care or deteriorating patients. This led to the mutually beneficial concept of on-call duties in the private sector, which could support anaesthetic research fellow posts in the NHS or university, and subsequently, as the number and complexity of such patients increased, individual rotas were arranged in each hospital. This model, originally developed by Professor Richard Langford at the Pain and Anaesthesia Research Centre (PARC) at Barts Health, now benefits most of the central London training schemes, with an impressive accrual of research fellowships, publications and higher degrees.

PARC has a fantastic team of doctors, principal scientist Dr Theresa Wodehouse and research assistants. You are also well supported in doing appropriate courses and getting study leave. The pain department is led by Dr Jayne Gallagher, ably supported by other consultants, including Dr Vivek Mehta who is also now the Director of PARC.

A number of fellows in the past have utilised this position in a variety of ways such as working towards their MD/PhD and even getting 50% of their time recognised towards their Advanced Pain Training. They have subsequently secured consultant positions in prominent teaching hospitals.

This post can cater to the needs of the trainee at different stages of their career. For instance, in my case, as a post-CCT fellow, the post was tailored to achieve my research goals including publications, experience with various stages of research cycles and also working towards a research degree. I also achieved excellent hands-on experience in neuromodulation and was employed to provide regular sessions as an ad-hoc consultant in Pain Medicine and Anaesthesia.

Dr S. Snidvongs is a newer consultant at Barts, and an ex-London clinic fellow. She also gained substantial research experience and publications during her time, which paved the way for her consultant position.

In summary, this job is indeed unique as it can be tailored to your needs, as it was to mine. I have no hesitation in recommending this opportunity to my junior colleagues who want to get substantial academic experience but without the need to apply for an independent grant to secure your mortgage.

2016 Trainee Case Report Prize

The previous Trainee Publication Prize has now been replaced with a Trainee Case Report Prize. This 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.

The Prize winner will be invited to the Annual Meeting, have their report added to the website and will be mentioned in *Transmitter* **and the BJA publication.**

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

The Faculty would like to emphasise that Trainees must have their case reports completed by the ninth month of their training programme and that ARCPs can not be signed off until a satisfactory case report has been submitted.

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 doctors and nurses from all medical disciplines interested in Pain Medicine.

The 8th Annual Meeting held in November 2015 with the theme 'Clinical Updates in Pain Medicine', was yet another successful education event organised by the Faculty. Experts from different areas made the day informative by sharing their knowledge and clinical expertise. Dr Michael Neil presented his impressive experience in managing pain following amputation. Discussion on atypical analgesia such as calcitonin and memantine was interesting. Professor Andrew Rice delivered the prestigious Patrick Wall lecture on pre-clinical pain research; this included critical analysis of animal studies. Dr Connail McCrory, Dean of the Faculty of Pain Medicine (Ireland) presented the results of his pulsed radiofrequency (pRF) research. It was interesting to learn that the biological effect of pRF on dorsal root ganglion (DRG) is neuroimmune mediated and may be superior to epidural steroids. It was equally fascinating to learn that pRF of DRG has limited effect in Failed Back Surgery Syndrome. Dr Thanthullu Vasu described the different approaches used in Leicester Paediatric Pain Service to manage persistent pain in teenagers. Despite its use over the last three decades, debates are ongoing on the strengths and limitations of WHO pain ladder. Prof Sam Ahmedzai and Dr Mahesh Chaudhari eloquently presented their perspectives about its validity in the modern medical practice. Drs Brigitta Brandner and Shankar Ramaswamy discussed perioperative care of opioid dependent patients and non-analgesic effects of opioids respectively. Dr Grady, our Dean, presented achievements of the FPM and the recent developments in setting standards in clinical practice.

The study days in February 2016 attracted excellent positive feedback. On 8th February, Dr Jane Quinlan and Dr Mark Rockett steered the 'Acute Pain Management in a Complex World' event. The fact that as many as 60% of patients still experience significant pain in the postoperative period indicates the need for development of acute pain services. Dr Amelia Davies, trainee doctor, has developed a new pain application for smart phone users to provide guidance on pain management and to recognise complications. Dr Matthew Wyse described his experience in managing pain following major trauma in the pre-hospital and emergency environment. Techniques such as intranasal fentanyl and judicious use of regional blocks like serratus anterior plane block for chest wall injury were attention-grabbing. Dr Asius Rayen, the Editor of Pain News, summarised the facts on persistent post-surgical pain. Dr Chandran Jepegnanam talked through his interesting experience in setting up a novel 'rapid access clinic' for patients with pain discharged back to community. The highlight of the day was the interactive interesting case discussions facilitated by Drs Quinlan and Rockett. Enthusiastic participation from the delegates during the case discussions raised the educational value of the event.

On 9th February, in association with the Neuromodulation Society of the United Kingdom and Ireland (NSUKI), the FPM held a 'Neuropathic Pain & Neuromodulation' study day. The event was organised by Dr Ashish Gulve and started with an eloquent presentation from Prof Tony Dickinson on pathophysiology of neuropathic pain which

included fascinating facts on the different types of sodium channels and their roles in pain generation. This was followed by Dr Arun Bhaskar's talk on neuropathic pain medications. Most medications used have an unfavourable number need to treat (NNT) and the search for an ideal drug is still continuing. Different clinical conditions including CRPS, phantom pain and persistent post-surgical pain were discussed. Dr Simon Thomson explained the mechanism behind neuromodulation. The focus of the afternoon session was on the technical aspects of spinal and peripheral neuromodulation. Dr Ganesan Baranidharan's presentation with illustrative videos was well received by enthusiasts interested in learning the basics of this innovation.

The February study days received excellent feedback with comments such as "Fantastic. Exactly what I needed", "Contemporary agenda covering clinical relevant subjects. Good mixture of subjects", "Very good conference lots of audience participation and chances to ask questions and share", "Good value for money. Learnt a lot" and "very informative, well-structured and presented".

Although newer technologies have revolutionised medical practice, the importance of history and clinical examination in the pain clinic cannot be over-emphasised. Following earlier success in 2014, Dr Meera Tewani is once again organising a 'Musculoskeletal system examination for diagnosing pain problems' study day. The event is already advertised and will make an important contribution to your CPD. More detail on event registration is available at: www.fpm.ac.uk.

The Committee welcomes suggestions to enhance the usefulness of our educational meetings. If you have any 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).

Faculty of Pain Medicine Study Day:

Musculoskeletal System Examination for Diagnosing Pain Problems

FACULTY OF PAIN MEDICINE
of the Royal College of Anaesthetists

Wednesday 15th June 2016

08.50 – 09.20	Registration
09.20 – 09.30	Introduction - *Dr M Tewani and Dr S Balasubramanian*
09.30 – 09.50	The role of clinical examination *Dr M Tewani - Pain Medicine Consultant,*
10.00 – 12.50	**Three workshops of 50 minutes:**
10.50 – 11.10	Refreshments
	Examination of the Lumbar Spine and Pelvis *Dr J Tanner - Orthopaedic and sports medicine specialist, London* *Dr V Ketkar - Musculoskeletal Physician, Birmingham*
	Examination of the Hips and Knees *Dr P Gregory - General Practitioner, Warwick* *Dr D Ravindran - Pain Medicine Consultant, Reading*
	Examination of the Ankles and Feet *To be confirmed*
12.50 – 13.40	Lunch
13.40 – 16.30	**Three workshops of 50 minutes:**
15.20 – 15.40	Refreshments
	Examination of the Cervical and Thoracic Spine *Dr J Tanner* *Dr D Ravindran*
	Examination of the Wrists, Hands and Elbows *Dr P Gregory*
	Examination of the Shoulders *Dr V Ketkar*
16.30 – 16.50	Discussion
16.50 - 17.00	Feedback and close

RCoA, London
5 CPD Points
£175, £140 trainees.
Code: C83

Programme organised by Dr M Tewani, Dr S Gupta and Dr S Balasubramanian

British Pain Society Calendar of Events

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

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.

Pain in Children Study Day
13th July 2016
Churchill House, London

Interventional Pain Medicines SIG Annual Meeting
16th September 2016
Manchester Airport

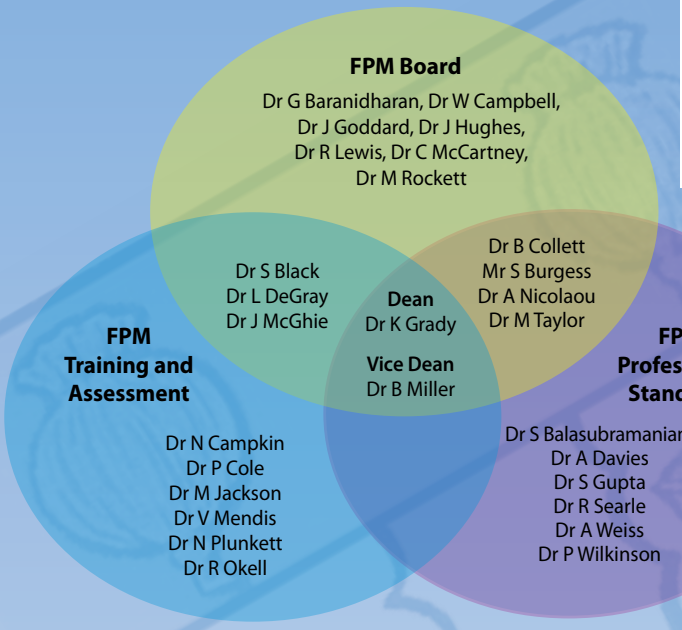
Patient Liaison Committee Annual Seminar
3rd November 2016
Churchill House, London

Headache SIG Annual Meeting
16th November 2016
Churchill House, London

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

Faculty Update and Calendar

Committee Membership



New Fellows

Dr Ravi SRINIVASAGOPALAN
Dr Rajesh Kumar AGGARWAL
Dr Naomi Grace SCOTT
DrTipu Zahed AZIZ
Dr Alan FAYAZ

2016 Faculty Calendar

MEETING: FPM Professional Standards Committee	12 May
MEETING: Board of the FPM	13 May
EVENT: FPM Musculoskeletal system examination for diagnosing pain problems study day	15 June
MEETING: FPM Training and Assessment Committee	8 July
EVENT: FFPMRCA Exam Tutorial	9 Sep
MEETING: FPM Professional Standards Committee	15 Sep
MEETING: Board of the FPM	16 Sep
MEETING: FPM Training and Assessment Committee	7 Oct
EVENT: FPM 9th Annual Meeting: Core Topics in Pain Medicine	2 Dec
MEETING: FPM Professional Standards Committee	8 Dec
MEETING: Board of the FPM	9 Dec

Please note that all dates may be subject to change

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