FACULTY OF
PAIN MEDICINE
of the Royal College of Anaesthetists

FPM
2007-2017

Newsletter of the Faculty of Pain Medicine

AUTUMN 2017

TRANSMITTER

FACULTY OF
PAIN MEDICINE
of the Royal College of Anaesthetists

Austerity continues, which naturally causes financial reflection. Some do wonder what benefit they get from their annual fee to the Faculty. In this issue of Transmitter, reports from both the Professional Standards Committee and the Training and Assessment Committee contain a wealth of information on the enormous amount of work that is currently occurring, on your behalf, for the furtherance of the goals of Pain Medicine. Curriculum re-writes, guidance on particulate vs non-particulate steroids for neuraxial procedures, guidance on clinic consultation length for new patients, to name but a few. Dip in; there is much more going on.

NRFit (ner-fit). You should know what this is: not Luer! The Dean highlights the current situation. Of course there is delay but, unlike previous attempts to change things, this time the initiative is backed by the International Standards Organisation and so is expected to gradually roll out across all devices. The FAQs on the NRFit website are well worth a read. For example, whilst NRFit will prevent misconnections at the needle / cannula end of things, it will still be possible to spike the wrong bag at the other end. Never room for complacency!

And finally, we have all heard of John J Bonica, but did you know he was a professional wrestler as well as the father of Pain Medicine. Read Thomas Walton's prize winning trainee essay, "The Masked Marvel – a True Medical Superhero", for more interesting facts.

As always, my sincere thanks to both contributors and the Faculty administrative team.

John Goddard

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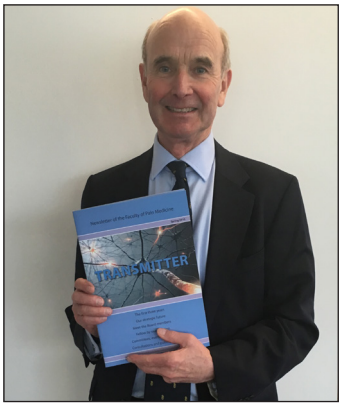

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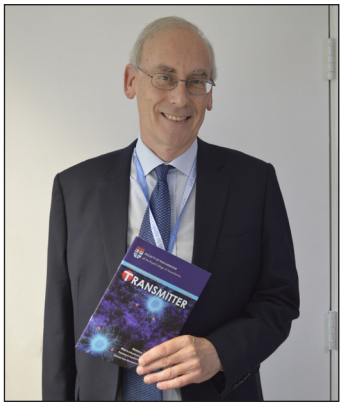

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The Deans and Vice Deans of the Faculty of Pain Medicine 2007 - 2017

Opioids Awareness

Dr Barry Miller

Dean

Opium is the optimism of the people

What was compulsory yesterday, is banned today. Opioids have a long and conflicted place in medicine, from the promise of relief from pain to the scourge of society. This is perhaps pharmacology in its purest biopsychosocial form, and is likely to remain so. Today, we are once again seeing the battlefronts moving.

Over the last year there has been a significant increase in the interest, and concern, around the prescription of opioids and their role in chronic pain problems. In recent times medical concerns over their use relaxed considerably and, in some areas, this has led to improvements in patient care. In others the problems have clearly been very underestimated to significant detriment.

So where do we as a profession stand as the maelstrom circles us? The issue of illegal opioids, bought and sold outside medicine, is a problem that has taxed politicians, law enforcement and addiction services for a long time. Although it borders on our professional remit when the reason for its misuse is an unsupported individual with a complex pain problem, it is mostly outside our direct sphere of influence. Like most issues in medicine there are a number of different factors here, but education, both of professions and patients, is key. It remains the case that the management of pain is haphazard and frequently poor. Throughout the 20th century, pain increasingly became recognised as a symptom to guide diagnosis and solve underlying causes. In consequence, emphasis on actual suffering waned as many became focussed on the certainties of eventual cure.

In this scenario the paucity of pharmacological options becomes stark; Paracetamol, NSAIDs and Opioids are the mainstays. Opioids are often seen as a quick fix, and indeed the immediate effects are often of significant relief. Problems often do not become apparent for 6-12 weeks or more and the development of tolerance and withdrawal, especially pain flares, make assessment and cessation difficult.

These issues (planning for escalation and de-escalation, long term monitoring where appropriate) need discussing from the outset. This is a fundamental for all doctors, especially difficult in our heavily timed-circumscribed interactions with patients. In primary care, can 10 minutes remotely encompass this? Even in our clinics (usually slightly better off) do we have enough time? I note that Jeremy Hunt MP talking to GPs recently finally acknowledged this.

The Opioids Aware initiative with Public Health England is on the Faculty's website, with some detailed guidance on this issue. It is aimed at all who prescribe and the Faculty hopes that it's use and reference will be helpful. It is not a call for abstinence or hasty decisions to the detriment of care, but help in navigating the current views. It is a major programme for the Faculty, with a standing committee dedicated to its review and renewal as needed. It's overall aim is to improve the use of opioids in both short and longterm care.
But a resource is only useful if it is used.

It is a start. And I haven't even mentioned the Gabapentinoids.

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10th Annual Meeting: Core Topics in Pain Medicine

Programme

09.00 - 09.20 Registration & Welcome

9.20 - 11.15 SESSION ONE

Enhanced recovery after surgery: What is 'acceptable pain relief'?: *Dr Mark Rockett, Pain Medicine Consultant, Plymouth*

Biological mechanisms of action of interventional pain techniques in vivo: *Dr Connail McCrory, Dean, FPM Ireland, Dublin*

Developments: Faculty of Pain Medicine: *Dr Barry Miller, Dean FPM*

11.15 - 11.35 Refreshments

11.35 - 13.20 SESSION TWO

Faculty Award Presentation

Patrick Wall Guest Lecture: Cell transplants for the treatment of chronic neuropathic pain and itch: *Professor Allan Basbaum, Chair Department of Anatomy, University of California, San Fransisco*

Consciousness and Pain: *To be confirmed*

13.20 - 14.10 Lunch

14.10 - 16.00 SESSION THREE

Debate: Should MDT aspects of pain management be applied to all chronic pain patients?
- Yes: *Dr Charles Pither, Pain Specialist, London*
- No: *Dr Rajesh Munglani, Pain Medicine Consultant, Cambridge*

Cancer recurrence and regional anaesthesia: *Dr Boyne Bellew, Consultant Anaesthetist, London*

'Body reprogramming' for fibromyalgia: a new paradigm: *Dr Anthony Davies, Consultant in Anaesthesia and Pain Management, Plymouth*

16.00 - 16.30 Discussion & Close

Date and Location

Friday 1st December 2017
9.00 - 16.30
RCoA, 35 Red Lion Square, London
WC1R 4SG

5 CPD points

This day is aimed at all those working within Pain Medicine Services. As well as a useful pain and Faculty updates day, it is an opportunity for pain medicine doctors and nurses to get together with each other and the Faculty Board.

Fees and Registrations

Consultants/SAS doctors: £200
Trainees/Nurses: £140

Register on line by clicking here.
https://www.rcoa.ac.uk/faculty-of-pain-medicine/news-and-events

Programme organised by Dr Shyam Balasubramanian and Dr Manohar Sharma

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The Faculty of Pain Medidince would like thank the partners and organisations who have worked with us us over the past 10 years

British Pain Society	Royal College of Anaesthetists	**Association of Anaesthetists of Great Britain and Ireland**	British Orthopaedic Association	**Chronic Pain Policy Coalition**
Royal College of General Practitioners	**Public Health England**	Royal Pharmaceutical Society	**College of Occupational Therapists**	UK Clinical Pharmacy Association
Chartered Society of Physiotherapy	Pain UK	**Pain Concern**	Physiotherapy Pain Association	**The British Psychological Society**
Royal College of Nursing	**Royal College of Midwives**	Care Quality Commission	**Royal College of Psychiatrists**	Association of Palliative Medicine
Joint Royal College of Physicians Training Board	General Medical Council	**Department for Transport**	National Institute for Health and Clinical Excellence	**And many others**

To mark our 10th Anniversary year, we have put together a series of monthly updates on a wide variety of topics related to the work of the Faculty and the wider Pain Medicine community.

www.faculty-of-pain-medicine/fpm10/fpm10-monthly-updates

FPM10 Essay Prize

Winner: Dr Thomas Walton

Advanced Pain Trainee, North West Deanery

The Masked Marvel: A True Medical Superhero

How John J Bonica Changed the Face of Pain Medicine

" The proper management of pain remains, after all, the most important obligation, the main objective, and the crowning achievement of every physician"[1]

John Joseph Bonica was born 16th February 1917 on Filicudi, Sicily to Antonino, the island's Mayor, and Angela, a nurse and midwife. The family left for America in the mid-1920s for political and educational purposes, unable to transfer funds and having little grasp of the language. When Antonino tragically died, John, aged 15, sold newspapers and shone shoes to keep the children in education[2,3].

In high school, John discovered a flair for wrestling, winning Interscholastic/Intercollegiate Championships and a professional contract. Emma Baldetti came to spectate and, on travelling home together, John proclaimed that he would marry her, which he did following his graduation in 1942[2,3,4,5].

"No medical school has a pain curriculum…"[6]

Bonica graduated from Marquette University Medical School in 1942 into war-expedited training in anesthesiology at St Vincent's hospital, New York. Shortly after, during childbirth under open-drop ether anaesthesia, Emma suffered near-fatal aspiration/hypoxia. John vowed to change obstetric anaesthetic practice and introduced the labour epidural; Emma was an early beneficiary with their second child[2,3,4].

On enrolling in the US Army, Bonica was posted to Madigan Army Hospital, Fort Lewis, as Chief of Anesthesiology. He trained around 150 staff in safe anaesthesia for the thousands of wounded from the war in the Pacific.

"I have declared war on pain"[1]

Recognising the dangers of trauma anaesthesia under thiopentone and ether, along with a desire to improve pain, initiated a self-taught move towards regional anaesthesia in more than 50% of cases.

Meanwhile, Bonica won USA and Canadian Wrestling titles and the Light Heavyweight Championship-of-the-World under an alter ego for discretion: "The Masked Marvel"[2,3,4].

Leaving the army in 1947, Bonica introduced top-class anesthesiology, pain and research services at Tacoma General Hospital, Washington. He published his seminal work 'The Management of Pain' in 1953, a text he felt was long overdue:

"What the hell kind of conclusion can you come to there? The most important thing, from the patient's perspective [pain], they don't talk about."[7]

Tacoma's round-the-clock obstetric anaesthesia service was a world first and the Pain Clinic received international patients where his multidisciplinary, biopsychosocial approach was revolutionary[2,3,4,5]:

"There has emerged a sketch of pain apparatus… applicable to all circumstances. But medicine has overlooked the fact that the activity of this apparatus is subject to the constantly changing influence of the mind."[1]

John became President of the American Society of Anesthesiologists (ASA) in 1965 and of the World Federation of Societies of Anaesthesiologists (WFSA) in 1980, whilst developing Seattle Medical School where he organised an international pain symposium in 1973: the founding of the International Association for the Study of Pain (IASP) [2,3,4].

Whilst continuing to train global anesthesiologists in Pain Medicine and further its research, old wrestling injuries led to medications, nerve-blocks, operations and physiotherapy (swimming in Hawaii/Filicudi) encompassing a typically holistic approach[2,3,4]:

"If I wasn't as busy as I am I would be a completely disabled guy."[7]

John J Bonica died on 15th August 1994 aged 77 of a cerebral haemorrhage, just a month after the death of his beloved wife, Emma. He left an incredible legacy across the clinical, research and training communities of anaesthesia and pain medicine, which prevails in his continually updated publications and the sustained work of IASP [2,3,4].

So here's to John J Bonica: the Masked Marvel, the Founding Father of Modern Pain Management.

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ARIES Talks: Neuropathic Pain in Children

Dr Suellen Walker

Reader and Honorary Consultant in Paediatric Anaesthesia and Pain Medicine

Neuropathic pain affects significant numbers of children, and as with other types of chronic pain, can have a negative impact on quality of life, mood, sleep and family function, and be associated with a significant health and economic burden. However, the presentation, prevalence and causes of neuropathic pain in children differ from adults.

The prevalence of neuropathic pain in children has not been clearly established. The proportion of neuropathic pain presentations at paediatric chronic pain clinics varies with referral patterns and inclusion criteria, with reports of: 11% of new referrals if CRPS is excluded; 15% of children at a paediatric cancer pain service; and over 30% at Great Ormond Street Hospital Pain Clinic, if CRPS is included. Persistent post-surgical pain frequently has a neuropathic component, and is increasingly recognized in children. Up to 20% of adolescents develop persistent pain following major thoracic or chest wall surgery, with pre- and post-surgical pain intensity, child and parental psychosocial factors identified as potential predictors.

Neuropathic pain can be associated with a range of conditions in children, but lack of recognition can delay appropriate treatment. Specific paediatric presentations include episodic burning peripheral pain associated with Fabry's disease or erythromelalgia, and while very rare, these conditions require exclusion as they have treatment and genetic implications. Older children can describe pain as prickling, tingling, shooting, and burning but the screening tools utilised in adults have not yet been validated in children.

Diagnosis continues to be based predominantly on clinical history. Specialist techniques used in adult research, such as quantitative sensory testing, genotyping and phenotyping, and neuroimaging[16] are now also being incorporated into paediatric studies, with the aim to improve evaluation, understanding, and mechanism-based management of neuropathic pain in children.

While it has been suggested that neuropathic pain has an improved outcome in children, with full or partial recovery in 95% in one small series, longer term follow-up in larger samples of children with specific conditions is needed. Multiple factors shape the experience of neuropathic as well as other forms of chronic pain in children, including affective, sociocultural, cognitive, and behavioural responses, resulting in the need for a biopsychosocial formulation and inter-disciplinary management. Pharmacotherapy of neuropathic pain in children may include anti-depressants, anti-epileptics and topical lidocaine, but is currently extrapolated from adult data. Recent Cochrane reviews highlight the need for further controlled trials and evidence-based data for pharmacologic management of chronic non-cancer pain in children and adolescents.

Ongoing clinical evaluations and audits, cohort studies, and sharing of expertise will further improve management of neuropathic pain in children. Paediatric pain teaching and on-line ePain modules, training placements at specialist centres, and inclusion of paediatric competencies in the Faculty of Pain Medicine examination aim to improve understanding and recognition of chronic pain in children. Further research is needed to develop and validate outcome tools for clinical assessment and monitoring, and for controlled trials to improve mechanism- and evidence-based management of paediatric neuropathic pain.

Pain Medicine as part of the RCoA 25th Anniversary programme

Dr Roopa Chatterjee
LPTAG Trainee Representative

Being the trainee representative on the London Pain Training Advisory Group (LPTAG) provided me with an excellent opportunity to see the workings of the training group from close proximity. Pain Medicine training today faces many challenges, especially at this time of austerity and cost cutting. Currently one of the biggest challenges being faced is recruiting more trainees to our interesting and rapidly developing specialty.

When I discovered that the Royal College of Anaesthetists (RCoA) was holding the London Anaesthesia 25th Anniversary Conference in Bloomsbury, I saw this as an available platform to promote our esteemed specialty. I approached the South Thames TPD, Dr Sandesha Kothari, with this idea and she was very supportive and encouraging. Dr Lila Diner, the event organiser was welcoming and promptly allotted a space to showcase Pain Medicine.

On the day, I was a little apprehensive, not having done anything like this before. The administrative staff from the Faculty of Pain Medicine were very helpful in this phase. They had printed FPM posters for me and I also requested for some FPM goodies (pens, diaries, pouches etc) to be delivered to the venue.

The day itself was busy and fruitful. Several novice Anaesthetic trainees and a few medical students enquired with regards to career options and training. Some were oblivious of the existence of our specialty and had many questions. All of them mentioned that the information was useful and a few are even considering taking up Pain Medicine as a career.

The RAs, TPDs and consultants visited the stall. Their queries were quite thought provoking. It was also interesting talking to nurses and ODPs at the event. I was pleasantly surprised and elated that my stall could generate so much curiosity and enquiry. I have realised that the key is to create awareness and I am currently planning to organise a talk on Pain Management for the foundation year trainees. Overall it was an enjoyable and wonderful experience.

NRFIT

Dr Barry Miller
Dean

Over the last few years the MHRA has been working to reduce the risk of inadvertent injection of intravenous medications around neural structures. A variety of systems were introduced a few years ago, but there has been further work to define a single ISO standard and work towards a unified, and more widespread adoption.

This has been developed in the new NRFit (pronounced 'ner fit') system, ISO 80369-6. It is smaller and slightly longer than the standard intravenous Luer system, but similar in design and has both screw and slip fittings. By virtue of its small size it is not cross compatible with the Luer system. Colour is not defined in the standard, but many manufacturers are choosing yellow, as was previously common.

For circumstances where products are commonly used in Anaesthesia, there should be an equal range to current products. The principle list is of intrathecal and epidural needles and syringes. Most will be familiar with the former, but the latter were not widely changed with the previous systems and will be the most obvious change in day-to-day practice.
I understand Solutions for the issue of blood patching are being developed. It is unclear how manufacturers of more highly specialised needles will respond. Some may become available, but some may not. Where the latter is the case, the individual clinicians should be able to continue with their existing needles, although these will need local discussion and recording on the Hospitals' risk register.

It was originally envisioned that this system would be in place by April 2017, but manufacturing issues have delayed this, however, by the time of publication, all hospitals and equipment leads should be in contact with their current suppliers to replace their existing products.

The AAGBI has a more detailed review here: https://www.aagbi.org/safety/non-luer-small-bore-connectors
And the umbrella organisation for NRFit can be found here: http://stayconnected.org/neuraxial-nrfit/

Training and Assessment

Dr Jon McGhie

FPMTAC Chair

On behalf of TAC I would like to thank everyone who has responded to the census; we recognise that this request is an additional burden which is why we try to limit the frequency to five years! The data will be of great help to the FPM in answering workforce related questions. Dr Cole and the FPM admin team have been analysing the results and we hope to bring you finalised numbers in a future Transmitter publication. Some of the initial results are contained in this issue and will form the basis of our workforce arguments at a Parliamentary meeting, where the FPM made representation in October.

There have been some significant changes to case reports and the award of FFPMRCA. Firstly, in preparation for the GMC led update to our curriculum, from August 2017 we have withdrawn the case report as a means of assessing Advanced Pain Trainees; trainees commencing their training year after this date no longer need to complete or submit a case report. All of the other assessments for Advanced Pain Training (APT) are currently unchanged, but may be altered during the curriculum rewrite and we will update you well in advance of future changes. The Board have also approved a change to the award of FFPMRCA. This will now occur following a successful SOE exam pass, independent of completion of APT and will commence with the Autumn 2017 sitting of the exam. This brings the FFPMRCA exam in line with the award of FRCA and other post-graduate medical exams.

It is important to note, that since trainees will no longer need to submit evidence of completion of their APT centrally to the FPM admin team, the Regional Advisor in Pain Medicine (RAPM) will be responsible for the final sign-off stating that the trainee has completed 12 months of training satisfactorily. Therefore while a Local Pain Medicine Educational Supervisor (LPMES) may undertake some of the interim quarterly reviews of progress, the RAPM must have oversight of local training arrangements to ensure that the trainee has achieved and evidenced the core learning outcomes for APT prior to sign-off. The final quarterly review document has been amended slightly to incorporate this change so that the trainee can submit the successful sign-off as evidence to their local ARCP panel. This updated version of the form should be used from now on.

Drs Nick Campkin and Victor Mendis have put together a trainee and trainer guide for Intermediate Pain Training. The trainee version is a Q&A format to encourage trainees at this point in their anaesthetic training to consider Pain Medicine as a future career option. The trainer version includes advice and links to useful documents for LPMESs who have responsibility over Intermediate Pain Training. We hope to extend this work in the future to core training. All suggestions and comments on this and future support documents would be welcomed by the admin team. (fpm@rcoa.ac.uk)

We have submitted a dataset for a future pain logbook to the IT team working with the RCoA to update the e-portfolio, logbook and CPD platforms. It is hoped that this will integrate Acute and Chronic Pain consultations and procedures better than our existing system and we will keep you updated on the progress of this project in the coming year.

Finally, Dr de Gray is leading a curriculum subgroup which will focus TAC resources on the curriculum rewrite which is about to commence for both the FPM and the RCoA. This will be a substantial piece of work necessitating a review of all competencies at all stages of pain training. Hopefully, some of the work will simply be rewording to achieve generic competencies in keeping with the GMC's aim of increased crossover of medical training, but it may also require adjustment to both the timing and nature of assessments that we currently employ. We will keep you informed of the implications that this will have when we have more details.

RAPM Update

Dr Victor Mendis

RAPM Chair

It has been eight months since I took over as Chair of the RAPMs and time is whizzing by.

In March this year we saw the publication of the report from the UK Shape of Training Steering Group (UKSTSG) and welcome the groups main conclusion that the anaesthetic curriculum is already a broad based programme that meets the criteria of training 'generalists' who are able to apply their expertise across the diverse range of hospital services. The College maintains the view that the current arrangements by which trainees gain experience in one special interest area of anaesthetic practice towards the end of training is consistent with the generalist agenda whilst providing an introduction to those who wish to subsequently pursue a career in sub-speciality practice. We now embark on the process of reviewing the Pain curriculum to ensure that this work aligns to the new General Medical Council Generic Professional Capabilities.

Curriculum amendments with regards to Acute Pain Training have been a topic of discussion and Dr Tsang has submitted guidance to the RCoA training committee. Guidance could be provided to trainees via RAPMs to promote more focus on acute pain training at a higher level and I will be writing to all RAPMs on how best we could achieve this.

RAPMs have been actively engaging in the recent worforce census. Dr Sheila Black, our Trainee Representative, conducted a 'patient waiting time audit' which has certainly added value to the workforce data.

Anaesthetic and Pain Medicine trainees have been called upon to take part in a survey about their experience and plans for training in Pain Medicine (acute or chronic) and we hope this information will be helpful to us in designing the best possible training for doctors who wish to work in Pain Medicine and will highlight any areas in need of improvement. All trainees are encouraged to continue to respond to surveys and be confident in approaching their LPMESs or RAPMs or myself at any stage with any concerns pertaining to their training.

The Training and Assessment Committee recommended to the Board, who unanimously agreed, that case reports will be removed from the Pain Medicine curriculum with effect from August 2017. If a trainee doctor is therefore beginning their Advanced Pain Training after the 31st of July they no longer need to complete a case report.

I would like to congratulate our trainees on forming a research group titled PAIN TRAIN that will work closely with the Research and Audit Federation of Trainees (RAFT) to assist trainee led research and to promote communication amongst trainees. I would encourage all trainees to actively participate.

In order to continue to engage with the LPMESs we have planned the next LPMES day due to be held on the 8th of March 2018 . We have taken on board their comments from last year and on this occasion we will allocate more time for general discussion. I am looking forward to welcoming you at this event.

Essential Pain Management
Further Resources

For information about EPM UK and EPM Global, visit: **www.fpm.ac.uk**

Promotional videos are available on the EPM website: **fpm.anzca.edu.au/fellows/essential-pain-management**

Please visit our Facebook page: **@Essential Pain Management**

EPM apps are available for both iPhone and Android. **Search for EPM-Essential Pain Management**

Trainee Update

Dr Sheila Black

Faculty Trainee Representative

As a trainee body, we have had a busy summer, with varioud projects on the go. Many trainees will have completed their APT year, some will have invested their efforts in preparing for the FFPMRCA exam, and others will have joined as Higher or Advanced Pain Trainees in August.

In preparation for the joint FPM10/BPS 50th Parliamentary Reception on 25th October, we attempted to get some datum points that give direct examples of the challenges facing pain services. We put together a simple audit survey which asked four questions of patients to give us data on how long those affected by chronic pain remain outside of, and then in 'the system' before reaching a pain clinic.

We asked patients:

- How long the pain had been present
- When they first visited their GP about their pain
- When their doctor first referred them to a pain clinic

11 trainees and consultants participated; each collected around 10 surveys resulting in 197 surveys in total. This should provide strong data that will be presented at the reception.

A new endeavour this year will be to establish regular pain teaching sessions for trainees in the North of England. Due to the wide geographical area, it can often be difficult for trainees to obtain sufficient study leave time and expenses to travel for teaching. Therefore, we will provide these teaching sessions as a combination of face-to-face and video-link via GoToMeeting. These sessions are supported by the North of England Pain group. Any trainee can attend these sessions; dates will be publicised on the FPM website, and in the trainee newsletter.

Congratulations to Thomas Walton, Advanced Pain Trainee in the North West Deanery, who won the trainee essay competition with this essay on 'The Masked Marvel'. Trainees are also encouraged to submit their abstracts for presentation at the FPM10 Annual Meeting on 1st December. The deadline is 1st November.

Finally, this will be my last article in Transmitter as I step down from my role as Trainee Representative. I have had a great time getting to know many of the pain trainees, and want to thank all the staff at the FPM for their hard work behind the scenes in our Faculty, and all members of the FPM Board and Training and Assessment Committee who have made me feel very welcome and part of the team. The election is underway to find the next Trainee Representative; I wish my successor all the best in this very enjoyable role.

PAIN-TRAIN

The pain trainee research network is now up-and-running, with the launch at GAT in July. Trainees voted on their preferred choice of first project, and chose GABACUTE, a snapshot project looking at the perioperative use of gabapentinoids and anaesthetists' attitudes towards their use. Trainees have rallied and are fully involved in every stage of the project development. The planned start ndate for this project will be the week commencing 27th November 2017.

To participate visit: www.paintrainuk.com
Email: paintrainuk@gmail.com

Spotlight on Anglia

Dr Lorraine de Gray

RAPM for Anglia

Stretching from the Norfolk Broads, across The Wash to Fenland country, down to the historic city of Cambridge and eastwards to Ipswich, bordering on Constable country, East Anglia has for several decades been providing multidisciplinary services for patients with chronic non-malignant and cancer pain.

The East of England School of Anaesthesia has been providing advanced training in pain medicine for the past 17 years. Five centres are recognised for Higher and Advanced Pain Training. These are Norfolk and Norwich University Hospital, Addenbrooke's Hospital, Cambridge, Ipswich Hospital, Peterborough and Stamford Hospitals (North West Anglia NHS Foundation Trust) and The Queen Elizabeth Hospital in King's Lynn. Other hospitals in the region offering Basic and Intermediate Pain Training include West Suffolk Hospital and James Paget Hospital in Yarmouth, Bedford Hospital and Luton & Dunstable Hospital. Papworth Hospital is unique in the region in offering pain management specifically for patients with intractable ischaemic heart disease.

All three counties offer multidisciplinary pain services which include outpatient based pain management programmes. Ipswich was the first to lead the way in 1991, under the auspices of the now retired Dr John Skinner. Dr Skinner was one of the founding members of the INPUT pain management programme in 1989. After moving to Ipswich in 1991, he was instrumental in setting up the first multidisciplinary pain clinic in Anglia which included a Consultant Psychologist. Ipswich was once again a pioneer in setting up the first neuromodulation clinic in Anglia with the first dorsal column stimulator being implanted in 1993. To date Ipswich continues to provide this service, together with the Norfolk and Norwich Hospital and ,more recently, Addenbrooke's Hospital. Pain services are closely interlinked with palliative care services, with hospices and in- and out-patient palliative care units available in Norfolk, Suffolk and Cambridgeshire.

Anglia has two medical schools, the University of Cambridge and University of East Anglia and there is organised teaching in the region for medical students from both universities. Over the past year, I have been in discussion to introduce Essential Pain Management (EPM) UK to students from the University of Cambridge.

Anglia also offers opportunity for research. Professor David Menon heads the research team at the University of Cambridge, Division of Anaesthesia at Addenbrookes' Hospital. Trainees in Anaesthesia including those pursuing a career in Pain Medicine have the opportunity to apply for PhD programmes. Neuroscientists at Cambridge have productive affiliations with a number of world-class institutes based in Cambridge, including the Babraham Institute, the Cambridge Institute for Medical Research, the MRC Cognition and Brain Science Unit, the Hutchinson/MRC Research Centre, the Laboratory of Molecular Biology, the MRC Biostatistics Unit and the Wellcome Trust Sanger Institute.

In the next five years, the map of training in Anglia will change as the East of England School of Anaesthesia will be merging in a phased manner with part of the North London Schools of Anaesthesia to include hospitals in Hertfordshire and Essex.

As with many other regions in the UK, the last two years has seen a drop in the number of advanced pain trainees, although we are now starting to see a reversal of this trend. I am now coming to the end of my six years as Regional Advisor in pain medicine and it is time to hand the reins over. I would like to take this opportunity to thank all of the past and present Local Pain Medical Educational Supervisors and all of the other Consultants in the region; some of whom like me were once upon a time trained in this very region. Thank you for all your support, hard work and dedication.

Paediatric Pain

Dr Paul Rolfe

Paediatric Pain Working Group Chair

There are few subjects more emotive than children suffering in pain. Chronic pain in children is unfortunately relatively common. Although many children may be satisfactorily managed in primary care or in a paediatric secondary care setting, an estimated two thousand children per year will require specialist input to help the child and their family manage their condition. Although some excellent services exist, largely situated in children's hospitals, there is significant geographical variation in the provision of services across the UK. It's fair to say that access and the development of services overall lags significantly behind those for adults. Details surrounding the commissioning of centrally funded specialised paediatric pain services are currently not clear.

Last year I was invited to chair a Paediatric Pain Forum. This focus group met in June 2016 to discuss some of the opportunities and challenges facing paediatric pain medicine as a subspecialty. Topics included training, education and workforce planning. From this the Paediatric Pain Working Party was born. The group consists of representatives from the field of paediatric pain medicine including members who practice in specialist children's hospitals, university teaching hospitals or see children in a district general hospital setting. The group is advisory to the FPM Training and Assessment Committee (FPMTAC) and agreed terms of reference in November 2016 which included the following aims:

- Develop a census of paediatric pain services, identifying workforce and training opportunities
- Quantify the experience and training of higher and advanced pain trainees
- Consider guidance for paediatric pain training

We have made significant progress in identifying services, their workforce and available training opportunities using a range of methods, including analysis of biannual reports. We plan to provide a map of centres offering paediatric pain training on the Faculty website. Questions specifically looking at paediatric pain experience were added to the annual trainee survey in July, allowing us to quantify their overall experience in both inpatient and chronic pain. A similar survey targeting advanced paediatric anaesthetic trainees is also planned.

Current guidance from the Faculty of Pain Medicine exists for those wishing to pursue a career in specialist paediatric pain medicine. It advises that 12 months of advanced paediatric anaesthetic training are required in addition to 12-15 months of Advanced Pain Training, which includes 9 months of adult and 3-6 months of paediatric pain experience. There are very few specialists who have completed this and it is acknowledged that some of this would likely need to be completed post CCT. There are undoubtedly there are benefits to the development of our speciality in setting the bar high but the prospect of completing lengthy training in the face of a relatively small numbers of advanced pain trainees may not provide the necessary workforce. It is likely that an individual would need to gain experience in more than one specialist centre, which by their specialist nature, are often geographically far apart. The creation of paediatric pain training networks or fellowship posts may be a way forward for the few who wish to work in specialised centres.

Training doctors to be specialists in paediatric pain medicine is certainly not the whole story.
The Faculty have published competencies for Paediatric Pain Medicine. The core competencies are expected of all doctors completing their advanced training and form part of the 2010 curriculum. While many pain physicians will not necessarily provide routine pain services for children they may be called upon to offer advice on initial management or be involved in a referral to a specialised service. We are using the anonymised survey data regarding the level of paediatric experience to explore ways of improving access to training that fulfils the needs of training in the core competencies.

Essential Pain Management (EPM)

Dr Helen Makins

On behalf of the EPM Advisory Group

Essential Pain Management has been re-named in the UK. We now use the titles EPM Global and EPM UK to differentiate between the courses taught around the world and in the UK. The course maintains the same 'RAT' format - a structured approach to the Recognition, Assessment and Treatment of pain, using a mixture of short interactive lectures and small group discussions, which are largely case-based.

EPM UK (was EPM Lite)

We have removed the term 'Lite' from the UK course. Despite delivery often being over 2-4 hours, EPM UK has evolved into a 'full-fat' version, rather than a slimmed-down course, with increasing experience showing that the basic structure is very usefully enhanced by highlighting particular areas for deeper exploration. This has provided a great opportunity to facilitate discussions around areas such as the use of opioids in chronic pain, illustrated with challenging case discussions. Each course is adapted by the local teaching team, according to the experience and needs of the course attendees. Over the last year we have expanded our remit to extend teaching of the course to postgraduate and undergraduate medical and allied health professionals.

Medical Schools

EPM has been endorsed by the new RCoA undergraduate curriculum, due to be released in November 2017, recommending EPM UK as a framework for teaching medical students.
In addition, the BMA publication 'Chronic pain: supporting safer prescribing of analgesics', highlights EPM as an effective course for teaching medical undergraduates. Our programme continues to flourish and receive excellent feedback, with at least 14 medical schools incorporating the teaching so far. At a local level, anaesthetic enthusiasts are consolidating EPM effectively by teaching it within their own departments.

Beyond Medical Schools

We recognise that the benefits of teaching medical students a new structure for approaching patients with pain could be short-lived if other more senior clinicians and allied healthcare professionals are not using the same approach. With this in mind, we have extended training to postgraduates and other healthcare workers.

In order to gather momentum we ran our inaugural UK Train the Trainers course in March. This was attended by 20 professionals, which included physiotherapists, nurses, anaesthetists (trainee and consultant) and a psychologist from a variety of Trusts in the UK. The day included familiarisation of course content, personal tips from previous experience and feedback, discussion of teaching techniques, and development of adaptations to ensure relevance for those attending courses. The result was very satisfying, with self-rated confidence to teach the course reaching 88% by the end of the day. Following this a variety of professionals have received EPM training around the country, including student nurses, qualified nurses, physiotherapists, recovery staff and GP trainees, always with excellent feedback reported. In September this year we were delighted to be asked to run a second Train the Trainers event at the National Acute Pain Symposium in Harrogate, ably lead by Dr Sailesh Mishra and his team from Newcastle, and attended by 49 multi-disciplinary delegates. In this way we aspire to expand the number of healthcare professionals using the RAT approach, thereby standardising language with the aim of improving inter-professional communication and patient management.

EPM Global

The UK EPM Global work continues to expand with the UK team running workshops in Benin, Cameroon, Ethiopia, Madagascar, Malawi, Sierra

Leone, South Africa, Tanzania, Uganda, Nigeria and Zambia. We have an on-going partnership with Mercy Ships, who include EPM in their annual Medical Capacity Building Programme.

One of the main aims of each international EPM course is to initiate a sustainable teaching programme. The course is taught to a group of senior clinicians on day one; a selection of whom attend a Train the Trainers course on day two. On the third day these newly trained instructors teach another local group. Barriers to improving pain management and potential ways to overcome theseare explored during each session. For example, a surgeon, having attended an EPM workshop in Benin, wrote and instituted the first pain management protocols in her university teaching hospital, and was able to teach and share her experiences with those attending the course a year later in Cameroon.

The UK EPM Advisory Group continues to work closely with the parent EPM team, the FPM of the Australia and New Zealand College of Anaestethists (ANZCA), led by Roger Goucke and Wayne Morriss, updating and developing teaching materials. Increased collaboration is planned with the World Federation of Societies of Anaesthesiologists (WFSA) to help with the coordination of longer term sustainable projects.

Feedback and Outcome Data

Currently we evaluate EPM by collating a wide range of information, from details of previous pain training received by participants, to MCQ scores and free text feedback. Mike O'Connor has worked very hard to simplify this and the result is a spreadsheet tabulating the pertinent information. The data gathered has been invaluable in developing the course on an on-going basis. In particular we have shown the need for the course, with very few participants stating that they have received previous training, yet overwhelmingly feeling that this would be useful both personally and for their colleagues. We have also demonstrated that misconceptions about the use of opioids are common amongst all groups of healthcare professionals, both in the UK and abroad. In conjunction with the WFSA and ANZCA teams we are planning a more comprehensive evaluation project to assess the long-term impact of EPM to include both quantitative and qualitative data.

Acknowledgements

Doug Justins has stepped down from the EPM Advisory Group in order to embrace retirement more fully. Doug has been one of the stalwarts driving EPM forward and we are going to greatly miss his enthusiasm, common sense and sage advice. We wish him all the best for the future.

We are extremely grateful for the funding from the Royal College of Anaesthetists, the Association of Anaesthetists of Great Britain and Ireland Foundation, and the WFSA. We also owe many thanks to the Medical Capacity Building Team at Mercy Ships for their expertise in facilitating our collaborative annual courses. We are delighted to have started discussions with the World Federation of Societies of Anaesthesiologists and very much look forward to working together in the future.

There are enthusiasts around the UK and abroad, too numerous to mention by name, who continue to promote the EPM message and we thank them all for their on-going work.

I am very grateful to Clare Roques and Mike O'Connor for their contribution to this article.

Pain in Northern Ireland: A current political overview

Dr Pamela Bell

Chair of the Pain Alliance of Northern Ireland

At the time of writing, Northern Ireland is in a state of political limbo with neither a functioning Legislative Assembly nor direct rule from Westminster. This stalemate has significantly hampered progress in reforming services for people with long term pain. Nevertheless, efforts continue to ensure concrete plans are in place to enhance access to treatments across community, primary and secondary care.

Professor Raphael Bengoa's report 'Systems, Not Structures – Changing Health and Social Care' has been widely accepted as providing the blueprint for transformation towards primary and community care, and the Integrated Care Partnerships (ICP) have plans in place which would enhance services to people with pain in primary care. These will initially focus on musculoskeletal pain, fibromyalgia and joint injections. Although funding has not yet been released to roll this out, a pilot service providing Cognitive Behavioural Therapy (CBT) and medication review in primary care in the South Eastern Health and Social Care Trust proved safe and effective, and won an Innovation Award.

A Department of Health Transformation Implementation Group (TIG) has been established and the Health and Social Care Board's (HSCB) Scheduled Care Reform Group has drawn up and submitted extensive plans for service redesign across long term pain, rheumatology and orthopaedics focusing on areas of commonality. The Department has also held a series of Outcome-based Accountability meetings , which are cross-departmental working groups one of which is examining whether Condition Management Programmes (Department of Employment and Learning funded) can be improved to meet the needs of those with long term pain. It is likely that, under further transformation plans, we will see more first-contact physiotherapy in primary care and direct access physiotherapy. Both have been subjected to scrutiny following successful pilot schemes. It is also likely that we will see more Multi-Disciplinary Teams (MDTs) in primary care although the impact of this on our very over-stretched pain clinic MDTs remains to be seen.

The Northern Ireland Pain Forum continues to be active. Jointly hosted by the HSCB and the Public Health Agency (PHA), it represents patients, carers, healthcare professionals across all HSC organisations and charities in co-producing service reform. In the past it has been key to the development of a fibromyalgia pathway, to developing the service specification for ICP-led pain services and in raising awareness of the burden of long term pain.

Currently it has one subgroup working on developing a template of pragmatic outcome measures and evaluation tools that are meaningful to both patients and professionals and which can be used (in the context of busy clinical practice) to compare the efficacy of different interventions. A second subgroup is working on the development of a website and related App. Soon after the Forum was established we identified that it was difficult for patients and carers to find good local web-based information on pain management and services. Funds were insufficient to develop one, but through other work undertaken with the Department of Finance's Innovation Lab, their team recognised the need and through Code4goodNI organised a Hackathon (#Hackthepain). Teams of coders and web designers competed over a twelve-hour day to design a website that was highly influenced by the input of patients, carers and healthcare professionals. Further development of the winning design will be supported by Ulster University Masters students in Photography and Phonography.

One further development, in what is otherwise a rather gloomy picture of rapidly increasing Pain Clinic waiting lists, is the establishment of a joint neurosurgical/pain clinic to deal with complex patients. Further good news must await the resumption of an Administration.

Professional Standards

Dr Paul Wilkinson

FPMPSC Chair

The PSC has been very busy since the last report and I would like to thank all members again for their tireless work. In recent years, the PSC has put many of the necessary standards in Pain Medicine documents in place and these are now under regular review. To ensure that these become living documents we have also concentrated on strategies to support the implementation of best practice.

The work of the PSC can be divided into internal strategy relating to core matters for our own practice and those with wider external ramifications. I start with work relevant to our own practice.

Building on our 'Core Standards for Pain Management Services' document, a **Dashboard of Clinical Standards** has been trialled successfully. This now allows units to undertake an electronic self-assessment matched against existing published standards in Pain Medicine and for the FPM to start collating gap-analysis data. It is expected that this will soon evolve into a pivotal step in improving standards.

Next, following the production of **patient information leaflets for interventional procedures** published on the website, the PSC has been considering the **issue of standards for consent**. Guidance will soon be available specific to our specialty. With the interventional procedures checklist now updated to align with other NatSSIPs publications, we are also finalising a specific **checklist for intrathecal pump refills**. The final document will be placed on the website shortly.

A long running and complex document to produce professional guidance **on the use of particulate vs non-particulate steroids** in neuraxial procedures has been completed. This was a collaborative exercise with the British Pain Society. There were many different views on this and Faculty colleagues' dovetailed this together to inform best practice on this crucial safety issue.

The FPM Board has approved the publication of the PSC analysis summary on **consultation length for new patient consultations;** more information can be found in Rob Searle's article. This analysis is based on a timing of those tasks essential to the accepted standards of consultation. We will now further consider appropriate timing for review appointments.

The guidance document providing patient advice for driving, and covering issues such as opioids and pain related impairments, has been published. A further document to provide **guidance on driving for professionals** is imminent.

In terms of wider external professional significance, the FPM was delighted to be able to help the British Medical Association on a document to enable best pain practice and prevent the misuse of prescription medicines. This was timely given the recent media coverage of prescription medicine misuse. The FPM takes this issue very seriously. In response, a specific subcommittee chaired by Dr Cathy Stannard has been formed to consider the clinical approach to this problem, manage the Opioids Aware online resource and to deal with associated opioid issues.

The FPM has provided advice on a revision of a multispecialty document on **Complex Regional Pain Syndrome** which has been running for several years. This updated version is to be published shortly.

Finally, the Academy of Medical Royal Colleges has raised concerns that colleges are very good at producing guidance but ineffective at delivering translation into practice. In response, the PSC has formed a taskforce to consider its approach to communication and implementation of its work.

Before signing off I would like to reiterate my appreciation for the considerable output of the PSC and hope that this work continues to nurture the professional practice of Faculty Fellows and Members.

New Advice on Patient Consultation Length

Dr Paul Wilkinson

FPMPSC Chair

Dr Tony Davies

FPMPSC Deputy Chair

Introduction

The Faculty of Pain Medicine recommends that a quality new patient consultation for complex chronic pain patients should last 1 hour. This recent advice takes a standards-based approach. The paper is now presented in full together with the atomised task-list which was used to develop this recommendation.

Advice

The Faculty supports high quality patient consultations in pain practice to ensure the best possible care for patients. Patients referred to pain management centres with persistent pain are typically complex. Comprehensive assessment and the management of issues that arise will justifiably take time. Inappropriately shortened or hasty consultations are likely to result in poor clinical decision making and therapeutic care. This could also paradoxically lengthen the patient pathway and increase patient pain and distress.

The professional requirements within the specialist pain consultation have also evolved. There is a greater expectation for shared decision making, undertaking consent according to *Montgomery* principles and the need to promote patient self-management strategies.

The Faculty of Pain Medicine recommends that, for all of the necessary tasks to be completed, a high quality consultation for new patients with complex chronic pain should last for one hour.

In presenting this advice, it is recognised that one size does not fit all and consultants might choose to work differently e.g. dictating at the end of the clinic, using triage or using joint clinics with other members of the interdisciplinary team.

Methodology

To underpin this recommendation for new patient consultations, an atomisation approach was used by the Faculty. Experienced pain specialists were asked to time the key tasks required in a series of consultations; with the tasks shown in the Table below. Their clinical approach is based on the published FPM standards on consultations document: *Conducting Quality Consultations in Pain Medicine*[1]. This document provides the consultation standards and recommendations set by the Faculty and mirrors the GMC document *Good Medical Practice* (2013).

Review of previous notes and referral letter
Review of GP or hospital questionnaires and outcomes of psychometric tests
Patient introduction
Biomedical history
Psychological history
Examination
Investigations (review or request investigations)
Therapeutic explanation
Shared decision-making and treatment plan
Consenting process
Promotion of self-management strategies
Closure
Clinical outcomes recorded
Patient request or electronic follow up outcome
Dictation time
Other unspecified tasks e.g. contact GP or other professionals

This method allowed the required time for a new patient consultation to be accurately quantified. Participants were advised that these should not be 'exhibition consultations' but similarly, the consultation should not be curtailed by perceived time pressures within the clinic.

It is accepted that this methodology will have some limitations. These will include the following:

- There was no independent confirmation that the pain specialists fully met the standards and recommendations set in the document. Thus, the precise time allocation needed could be longer.
- It is difficult to precisely atomise real-time consultations with accepted overlap within components. The subsequent analysis therefore focused on total consultation time.
- Differences in practice will impact on consultation time e.g. whether dictation was undertaken during or after the clinic.
- Prior triaging or use of questionnaires will modify time considerations.
- Only data on adult patients were included in this exercise.
- Some pain specialists will partition assessment (particularly psychosocial components) over both new and subsequent follow-up appointments.

Despite these limitations, the data analysis triangulated to around 60 minutes for consultations for adult patients attending a chronic pain clinic. It is our evaluation that 1 hour is required for a comprehensive biopsychosocial pain assessment of a new patient. This will ensure the timely completion of all necessary tasks, consent process and therapeutic input required to the standard expected from Fellows of the Faculty of Pain Medicine.

Reference:

Conducting Quality Consultations in Pain Medicine. April 2015. Faculty of Pain Medicine.

FPM Census Update

Dr Peter Cole

FPM Workforce Lead

A subgroup of the Training and Assessment Committee met in May and agreed on the final questions for the Workforce 2017 Census. The Census had previously been discussed at the Regional Advisors' (RA) meetings. An explanatory letter with the Census questionnaire was then sent to every RA in the UK. The aim was that the RA would coordinate the completed returns from the Local Pain Medicine Educational Supervisors (LPMES) for each hospital in the region. The RAs and the Faculty also contacted consultants who work in pain clinics where there are no LPMES.

Every RA returned the spreadsheets for their individual region. However the response rate within the region, when compared to data on file from the latest 2017 biannual report, averaged 70% with a range in completed returns of 14% and 100% between regions.

We did a brief analysis of the data and wanted to highlight two areas for this issue; the first is that of the consultants who work in pain clinics or have a regular pain sessions only 1.5% are from non anaesthetic specialties. The second is that 23.5% of the consultants workforce are female, a slight increase from the previous census result of 21.5%.

Faculty administration staff changes have taken place this summer and we thank Jyoti Chand for her work in the early stages and welcome Claire Driver to the team. Claire is currently entering the returns ready for final analysis. We plan to publish in full the results of the 2017 Census for the next edition of Transmitter.

Opiods Aware

Dr G Baranidharan

On behalf of the Opioids Aware Sub-Committee

Opioids play a significant role in the management of acute post-operative and cancer pain. They are also extensively used in non-cancer pain. The Centres for Disease Control and Prevention in the United States declared that they are in the midst of an opioid overdose epidemic. In 2015, 33000 people died due to opioids; nearly 50% due to prescription opioids.

The Faculty of Pain Medicine (FPM) launched an Opioids Aware campaign in 2015. This is an online resource for patients and healthcare professionals to support prescribing of opioids for pain. The Opioids Aware Sub-Committee (OASC) is led by Dr Cathy Stannard and Prof Roger Knaggs with representation from the Professional Standards Committee (Dr Paul Wilkinson and Dr G Baranidharan).

The purpose of the resource is to provide prescribers with the information needed to support clinical decision making on the use of opioids for pain. It also provides supporting information on the potential benefits and harm to the patients, carers and health care team and promotes safe prescribing and on-going care in relation to opioids for pain relief. The website will be constantly monitored and updated with any changes. There will be teaching aids such as power point presentations available for use in the near future. In order to communicate the message clearly we want the presentation to be used in its entirety; taking few slides out of the deck can send false messages. We would also welcome feedback from our members to enable an updated and user friendly web page.

Opioids Aware was developed with contributions from the following organisations:

- British Pain Society
- Care Quality Commission
- Faculty of Addictions, Royal College of Psychiatrists
- Faculty of Pain Medicine
- NHS England
- NICE
- NHS Business Services Authority
- Public Health England

Key Points

Opioids are good analgesics for acute pain and for pain at the end of life. There is little evidence on its use for long term pain

Small proportion of patients may benefit with opioids on the longer term if the dose can be kept low and if they could be used intermittently

Above 120 mgs/day equivalent of morphine, the risk of harm increases substantially without a gain in benefit. This dose could reduce with further information on harm

If a patient is using opioids but still in pain, they are not effective and should be discontinued even if no other treatment available

Pain Clinic Attachments for Trainee GPs

Dr Rob Searle

FPMPSC Member

In 2004, primary care management of patients with chronic pain was estimated to account for 4.6 million GP appointments per year. Chronic pain is more common than chronic obstructive pulmonary disease (COPD) and diabetes, and these patients consult their GP around five times more frequently than those who do not have chronic pain. In spite of these compelling figures, formal GP attachments in Pain Medicine are not commonly part of specialist training schemes in General Practice (STGP).

n 2013 the Pain Clinic at the Royal Cornwall Hospitals NHS Trust became part of the training programme as part of a selection of training rotations. STGP trainees in their second year of specialty training can choose a year of training in Palliative Care and Rehabilitation Medicine (six months) and Pain Management (six months). The scheme is now in it's fourth year and proven to be beneficial and inspiring for both STGP trainees and the Pain Management Department.

The attachment was developed in conjunction with GP trainers and the local Postgraduate Education Department after a joint review of the STGP curriculum. Funding for the post comes from Health Education South West, managed through the local Postgraduate Education Department. Trainees gain experience working alongside consultants, extended scope physiotherapists, psychologists and nurses as part of a multidisciplinary team.

The broad aims of the training are for trainees to gain in-depth knowledge and practice of the subspecialty of pain management in all available settings such as acute pain, persistent and cancer related pain. This includes the biopsychosocial assessment of patients, developing management plans, and contribution to the local pain management course. We also encourage STGP trainees to become involved in quality improvement projects, clinical audit and teaching of medical students. Our trainees provide valuable help on acute pain ward rounds and also see additional new and follow-up patients in the chronic pain clinic, working alongside a consultant.

Although our department often provides placements for anaesthetic trainees and medical students, in recent years we have had few higher specialist trainees in pain. Our STGP trainees have helped us both in service provision but also maintaining our educational and training skills. GP trainees are usually well informed about developments in primary care, and the training programme has helped our pain service to forge closer links with community medicine.

Feedback from STGP trainees has been very positive. They feel better able to manage pain problems in the community, and also develop the skills to provide a holistic approach to complex patient problems. They are able to pass on their knowledge to others in primary care, which we hope will will benefit not only patients, but also the wider health community in the long term.

Audit of Pain Duration

Data collected by trainees and consultants for the Faculty of Pain Medicine

Data analysed by Dr Sheila Black

Introduction

In preparation for the joint FPM10 / BPS 50th Parliamentary Reception on 25th October, we set out to get some key data points that give simple and direct examples of the challenges facing patients within pain services. We asked patients 4 simple questions to give us data on how long those affected by chronic pain remain outside of, and how long they wait in, the 'system' before reaching a pain clinic.

Methods

Pain trainees and consultants distributed the questionnaire to patients attending pain clinics. Data was collected from 197 patients, across 9 hospital sites and audit was registered to local audit departments in each hospital site. Additional data from a pilot audit performed 2 months previously included waiting times from referral by GP until new patient appointment. Data collected by 7 trainees returned 195 data entries.

Discussion

Of the audit of pain duration, 22 entries were in fact 'historical' patients, with first attendance at pain clinics varying from 2001 to 2014. Data from this audit was possibly less reliable as it relied on the patient's understanding of the referral process and recall of specific dates. The previous pilot audit of referral times was possibly more accurate as data was predominantly obtained from computerised referral dates within pain services.

Results

The time from pain onset until referral by GP to a pain clinic was 5.97 years (mean) and varied from 1 month to 35 years. This raised questions regarding why patients wait so long before presenting to their GP and/or requesting referral to a pain clinic and why do GPs wait so long before they consider referring on to a pain clinic.

Questions 1 and 2 gave almost identical results, as 'date of patient realising pain had become chronic' was mostly identical to 'date of consulting a GP for the pain'. Most patients identified chronicity of pain before they consulted their GP, though some patients attended GP for some time before identification of chronicity.

The time from GP referral to first appointment in pain clinic was 23 weeks (mean) varying from 1 week to 2 years 5 months. More focused and objective data from the pilot audit revealed an average waiting time of 15.2 weeks. 147 patients (75%) waited 18 weeks or less.

The time from the onset of pain until first being seen in a pain clinic was 6.2 years (mean), range 1 month to 35 years.

Conclusion

We have shown that patients often wait years suffering chronic pain, before visiting a GP for referral to a pain clinic; the mean wait was 6 years. The mean referral wait time was 15 weeks, with 75% waiting 18 weeks or less for first appointment at a pain clinic.

Faculty Events

Dr Shyam Balasubramanian

Educational Meetings Advisor

Dr Manohar Sharma

Deputy Educational Meetings Advisor

The Faculty promotes excellence in education and strives to meet the needs of its Fellows and Members and others involved in pain management. You will be delighted to note that over the past few years the uptake of our educational activities has been on the rise and events have received very good feedback. We encourage our Fellows to share their expectations and needs during these learning activities so as to design our programme and incorporate learning methods to meet those needs.

The 'Diagnosis and Imaging' study day marked another successful event this year on 14th June 2017. The meeting was well attended by our Fellows and Members. Guest speakers included Dr Nicholas Shenker, a renowned rheumatologist who highlighted the importance of abnormal blood tests as relevant to chronic pain. Dr Alistair Purves presented the role and limitations of neurophysiology study in Pain Medicine. Dr Harun Gupta, consultant radiologist, along with Dr Sanjeeva Gupta, consultant in Pain Medicine, conducted an interesting and interactive session on interpretation of normal and abnormal radiology scans. Afternoon sessions included role of investigations in assessing abdomino-pelvic pain, precision diagnosis of pain of spinal origin and the use of ultrasound guided diagnostic procedures. The whole day turned out to be very interactive, promoting valuable dialogue amongst delegates and the Faculty. The overall feedback from the meeting shows that practical ideas were shared with the hope of creating a positive impact on day-to-day practice in pain management.

The prestigious 10th Anniversary Annual Meeting will be held on Friday 1st December and the various topics include enhanced recover after surgery, biological mechanism of action of interventional pain techniques and the Patrick Wall Guest Lecture on 'Cell transplants for treatment of chronic neuropathic pain and itch' which will be presented by Professor Allan Basbaum, Chair Department of Anatomy, University of California, San Fransisco. Other topics include 'cancer recurrence and regional anaesthesia' as well as a post lunch debate around whether MDT aspects of pain management should be applied to all chronic pain patients. The topics have been carefully chosen to reflect the needs of the delegates on the continuum of post-graduate, specialist training and experts from various disciplines interested in pain management.

Following the success and excellent feedback from Acute Pain Study Days conducted in the past years, we have dedicated the 5th and 6th February 2018 to acute pain. The twenty most frequent topics in acute pain will be presented. To encourage members participation and dissipate good medical practice, our Faculty is considering the inclusion of poster presentations by the delegates in these meetings. We have received several requests from our Fellows to organise a study day on the relevance and importance of psychological interventions in pain medicine. We are sensitive to the needs of our members and are in the process of developing a summer study day on Wednesday 6th June 2018 to reflect this theme.

Our educational meetings are a great opportunity to meet and get updates on the latest developments in Pain Medicine. If you have any new ideas are and interested in contributing to these events, then, please contact either Dr Shyam Balasubramanian (doctorshyam@hotmail.com) or Dr Manohar Sharma (manoharpain@yahoo.co.uk).

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Faculty of Pain Medicine Study Days:
Twenty Topics in Acute Pain - Day 1

Programme

09.00 - 09.20 Registration & Welcome

9.20 - 11.05 CLINICAL PRACTICE

Opioid free anaesthesia
To be confirmed

Paediatric pain management for non-specialists
To be confirmed

A patient with CRPS presenting for surgery
To be confirmed

11.05 - 11.30 Refreshments

11.30 - 13.05 TRAUMA & PAIN

Pain due to broken ribs
Dr Carl Hillerman, Coventry

Inhalation and intranasal analgesia
Lucas Hawkes-Frost, Director of Invesitgation for Healthcare, South East Coast

Pain management in neck of femur fracture
Dr Ben Edwards, Sheffield

13.05 - 14.00 Lunch

14.00 - 16.00 UPDATES IN ACUTE PAIN

Pain trajectory analysis following surgeries
Dr Mark Rockett, Plymouth

Ultrasound and changing perspectives on postoperative pain management
Dr Athmaja Thottungal, Kent and Canterbury

Continuous catheter techniques for post-surgical pain - what next?
Dr Reg Edward, Hull

Post-dural puncture headache - what is new?
Dr Claire Williams, Cambridge

Date and Location

Monday 5th February 2018
9.00 - 16.00
RCoA, 35 Red Lion Square, London
WC1R 4SG

5 CPD points/ 10 CPD points for both days

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

Fees and Registrations

Consultants/SAS doctors: £175
Trainees/Nurses: £140
Book along with the 6th February for a reduced rate of: £330/£255

Register online by clicking here.
https://www.rcoa.ac.uk/faculty-of-pain-medicine/news-and-events

Programme organised by Dr Shyam Balasubramanian, Dr Manohar Sharma, Dr Mark Rockett and Dr Jane Quinlan

FACULTY OF
PAIN MEDICINE
of the Royal College of Anaesthetists

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Faculty of Pain Medicine Study Days:
Twenty Topics in Acute Pain - Day 2

Programme

09.00 - 09.20 Registration & Welcome

9.20 - 11.05 CLINICAL PRACTICE

Opioids and tumour recurrence
To be confirmed

Regional anaesthesia and legal claims
Ms J Midgley, Trust Solicitor, Coventry

Novel analgesia for abdominal surgery
Dr Niraj Gopinath, Leicester

11.05 - 11.30 Refreshments

11.30 - 13.05 APPLIED PHARMACOLOGY

Ketamine for acute pain - when, where and how?
Dr Gillian Chumbley, Nurse Consultant, London

Postoperative pain when on methadone
Dr Jane Quinlan, Oxford

Co-analgesics in acute pain - is there any evidence?
Dr Paul Farquhar-Smith, London

13.05 - 14.00 Lunch

14.00 - 16.00 ACUTE PAIN IN SPECIAL CIRCUMSTANCES

Managing a chornic pain patient in an acute setting
Dr Andy King, Ashford and St Peters

Treating pain in hospitalised cancer patients
Dr Arif Ghazi, London

Pregnant lady with acute back pain
Dr Victoria Tidman, London

Virtual reality technology and burns pain
Dr Charlotte Small, Birmingham

Date and Location

Tuesday 6th February 2018
09.00 - 16.00
RCoA, 35 Red Lion Square, London
WC1R 4SG

5 CPD points/ 10 CPD points for both days

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

Fees and Registrations

Consultants/SAS doctors: £175
Trainees/Nurses: £140
Book along with the 5th February for a reduced rate of: £330/£255

Register online by clicking here.
https://www.rcoa.ac.uk/faculty-of-pain-medicine/news-and-events

Programme organised by Dr Shyam Balasubramanian, Dr Manohar Sharma, Dr Mark Rockett and Dr Jane Quinlan

British Pain Society Calendar of Events

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

THE BRITISH PAIN SOCIETY
EXPERTISE WHERE IT MATTERS

Trainee Study Day

7th February 2018
Churchill House, London

This is an excellent opportunity for those who have an interest in Perioperative Anaesthesia and Management of patients with Chronic Pain. Speakers -experts in their field will cover:

- Neurobiology of the transition of acute on chronic pain
- Perioperative management of the chronic pain patient,
- Management of patients on long-term opioids, and the
- Role of regional anaesthesia

Pain in Military Veterans & Pain in Torture Survivors Study Day

26th February 2018
Churchill House, London

Treating pain in people with post-traumatic stress symptoms: survivors of torture and of war

This day will be run in two halves, and participants are welcome to sign up for either or both. The morning will cover medical, psychological and physiotherapeutic principles and practices of treating chronic pain in military veterans, from an experienced team at the King Edward VII Hospital. The afternoon will cover medical, psychological and physiotherapeutic principles and practices for treating chronic pain in survivors of torture, in a pain clinic, with teaching from clinicians from a variety of settings.

Annual Scientific Meeting

1st & 2nd May 2018
Hotel Brighton Metropole

The British Pain Society would like to invite all healthcare professionals to attend its 2018 Annual Scientific Meeting (ASM), which will be held in Brighton at the Hilton Brighton Metropole.

The Plenary sessions are

- Pain in Mice and Man: Ironic Adventures in Translation
- Chronic pain – what's it like? Patient and Professional perspectives
- A Gut Feeling About Brain Function: Microbiome as a Key Regulator of Visceral Pain
- Leaning on the wind: reducing patient, professional and organizational barriers to pain management through education
- What can sociologists contribute towards the understanding of pain?
- Pain after torture: progress, setbacks, and prospects
- Chronic pain epidemiology: from population health to health policy

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

Faculty Update and Calendar

New Fellows

Dr Ajeeth Baburajan
Dr Fiona Bull
Dr Ranj Khaffaf
Dr Aizad Mohd Yusof
Dr Kavita Poply
Dr Nick Sheppard
Dr Gerard Sinovich

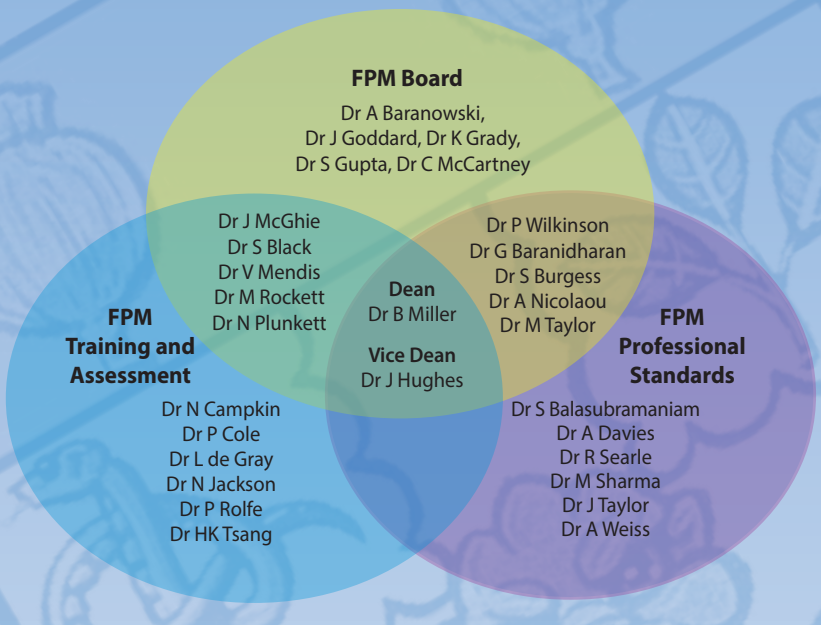
New Diplomate Fellows

Dr Manojit Sinha

New Associate Fellows

Dr Conor Farrell
Dr Stephen Humble

Committee Membership



2017 - 2018 Faculty Calendar

EVENT: FPM 10th Anniversary Meeting	1 December 2017
MEETING: FPM Professional Standards Committee	7 December 2017
MEETING: Board of the FPM	8 December 2017
EVENT: Twenty Topics in Acute Pain	5-6 February 2018
MEETING: FPM Training and Assessment Committee	9 February 2018
EVENT: LPMES Conference	8 March 2018
MEETING: FPM Professional Standards Committee	15 March 2018
MEETING: Board of the FPM	16 March 2018

Please note that all dates may be subject to change

The Faculty of Pain Medicine
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