TRANSMITTER

Autumn 2020

Spotlight on: UCLH Complex Pain Team

Pain Services and COVID

FFPMRCA Trainee Perspective

Medicines Advisory Group Update

FACULTY OF
PAIN MEDICINE
of the Royal College of Anaesthetists

CONTENTS

This and back issues available online at www.fpm.ac.uk

WELCOME

Dr Manohar Sharma

Clinical Editor

Welcome to Transmitter - Autumn 2020 Edition! We are unfortunately witnessing a rapidly evolving and deteriorating situation with a second wave of COVID-19 upon us. There is now high likelihood of a very tough winter ahead. We must adapt and evolve to find new ways to live and progress until the development of better preventative and therapeutic strategies to control this virus. There are now challenges ahead with unpredictability of future demand of FPM members and pain trainees to be redeployed to the frontline, supporting the anaesthesia and intensive care units in managing the anticipated huge surge in COVID-19 cases. Most elective chronic pain clinical activity is resuming in some form or other with most being conducted on remote virtual platforms with some face to face interaction, and variable access to inpatient and theatre-based pain interventions and online PMP. This approach may not be satisfactory or accessible by all (staff and patients alike) for clinical purposes but with no end in sight for the pandemic, there is little choice in this matter.

The Court of FPM examiners are monitoring the new models and outcomes of exam delivery very closely. Who would have imagined the SOE exam via remote video link, but such initiative is the key to continue some normality to offer opportunities for the next generation of Pain Medicine doctors. The GMC have reopened discussions regarding Pain Medicine credentialing and we hope to progress and keep you updated. FPM members and trainees have risen to the enormous challenges to continue provision of access to pain services and pain education as best as possible by new initiatives to facilitate these, as noted in several articles. The FPM, in response to significant request and support from trainees and trainers alike is introducing FPMLearning, a remote source of learning accessible to trainees and trainers. Further details are in the 'New FPMLearning Website' article by Dr Lorraine de Gray.

Those of us who regularly conduct inpatient pain rounds will recognise the challenge posed by complex pain – repeated, prolonged inpatient stays, and extreme levels of pain and distress regardless of the analgesic doses or combination of drugs administered. A new award-winning model of a complex pain team is truly an example of turning a challenge in to an opportunity, made possible only by a well-functioning inter and multidisciplinary team, as shown in article by the complex pain team from University College London Hospital.

I am delighted to welcome James Goodwin who replaces Daniel Waeland as Associate Director of Faculties across both the FPM and FICM. He brings valuable experience and connections within the RCoA that is already proving beneficial in these unusual times. We need to remember to talk to and support each other and ensure time for rest and recuperation. Only then will we be able to come out stronger at the other side of this pandemic.

Manohar Sharma

Message from the Dean

Dr John Hughes
Faculty Dean

Since the last edition of Transmitter there has been a significant workload taken on by members of the Professional Standards and the Training and Assessment Committees, both in supporting Fellows and Members during the COVID pandemic but also, when possible, to ensure forward movement of our core business. This is on the background of remote working and changes within the secretariat.

As the COVID pandemic continues, we will remain vigilant and provide updates going forward. It is clear that many pain management units are, to varying degrees, up and running again but with limitations on what services can be provided. This will clearly continue to change but I hope that with the introduction of better remote consulting opportunities, services will be able to keep some activity even if the situation worsens again. My understanding is that face-to-face contact is starting to increase within the constraints of, social distancing, national guidance, clinical need and individual risk. We also need to remember to support each other and ensure time for rest and recuperation.

Trainees have been doing sterling work on the front line and I am pleased to see training has restarted and mitigation plans put in place to minimise the impact on overall training. Trainees have clearly used their own initiative to ensure other training opportunities are utilised when pain clinics and lists are reduced. The exams are back and the number of candidates is encouraging. The court of examiners are monitoring the new models of exam delivery and the outcomes very closely, as this is clearly new to us all. They have requested feedback from candidates, which is vital in understanding the benefits and difficulties with running such exams.

Still on the educational front, the GMC have reopened discussions regarding credentialing and we hope to be able to progress that over the coming months. The Faculty is also reviewing all its educational components to bring them under one roof in order to ensure consistency, improve access and make best use of resources.

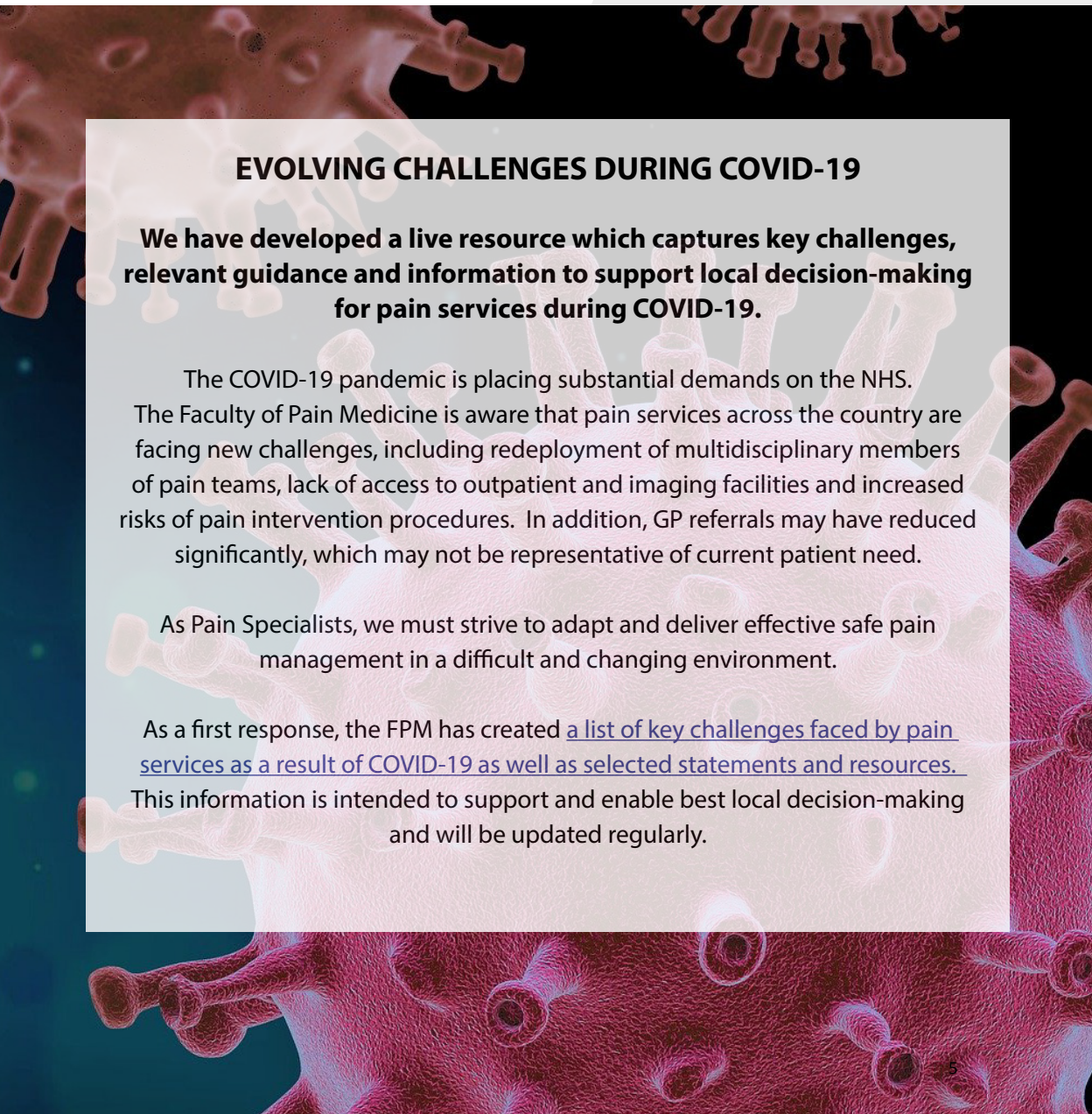
With regard to our core business, there have been several updated guidance documents and others nearing completion. The review of the Core Standards for Pain Management Services (CSPMS) is progressing and has been through a stakeholder review. This will be an important document going forward as pain services change in response to the evolving health care environment.

Looking at our inpatient services, NICE have published guidance for perioperative care (NG180) which encompasses part of the perioperative pathway and provides useful guidance. The Centre for Perioperative Care (CPOC) is developing and the FPM is now part of their advisory group so able to have more direct contact looking at areas where advice or guidance may be needed. There is ongoing collaboration with CPOC on postoperative opioids which is reaching a conclusion. This will support our inpatient colleagues to develop their teams to provide advice and care across the whole of the perioperative period.

Having mentioned NICE it is impossible not to include the consultation on Chronic Pain: assessment and management. This has caused a lot of concern amongst both patients and professionals as well as from overseas. There are undoubtedly positives within the document but also significant confusion, lack of clarity and the potential for a variety of differing interpretations and implementation strategies to be developed that would not be in the best interest of patients. The Faculty has submitted a robust response via the stakeholder process. We are aware that others have done the same.

Finally I would like to take the opportunity to thank Daniel Waeland (Head of Faculty) for his significant contribution to the Faculty over the

last 10 years. Those that have worked with him will be well aware of the influence he has had in developing the Faculty to where is it today. He moved on to pastures new in the summer and we would like to wish him well in the future. Virtual interviews with strong candidates were undertaken and I am delighted to welcome James Goodwin who replaces Daniel Waeland with the new title of Associate Director of Faculties, which better describes his role across both the FPM and FICM. He is well known to some of us when he was Faculty Manager before becoming Head of Research at the RCoA in 2015. He brings back valuable experience and connections within the College that is already proving beneficial. Caitlin McAnulty has been providing maternity cover this year and has unquestionably proved invaluable keeping us up to date, managing staff changes, developing the COVID site and ensuring even distribution of work across the secretariat to ensure delivery. She is about to leave us and return home to Australia and we wish her well in the future. That means that Emmy Kato-Clarke is returning and we welcome her back to the team. I would also like to thank other Fellows and Members who have, and continue to, contribute and support the work streams both now and over recent months.



EVOLVING CHALLENGES DURING COVID-19

We have developed a live resource which captures key challenges, relevant guidance and information to support local decision-making for pain services during COVID-19.

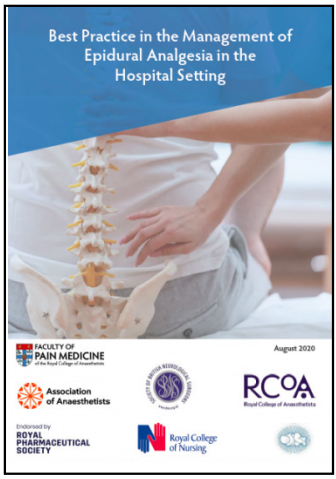
The COVID-19 pandemic is placing substantial demands on the NHS. The Faculty of Pain Medicine is aware that pain services across the country are facing new challenges, including redeployment of multidisciplinary members of pain teams, lack of access to outpatient and imaging facilities and increased risks of pain intervention procedures. In addition, GP referrals may have reduced significantly, which may not be representative of current patient need.

As Pain Specialists, we must strive to adapt and deliver effective safe pain management in a difficult and changing environment.

As a first response, the FPM has created a list of key challenges faced by pain services as a result of COVID-19 as well as selected statements and resources. This information is intended to support and enable best local decision-making and will be updated regularly.

FPM Guidelines and Publications

Three of our most recent Clincial Guidelines are highlighted below and all other FPM Guidelines and Publications are available by clicking here.
Look out for the Surgery and Opioids Best Practice Guidelines 2020, which is due soon!



The Best Practice in the Management of Epidural Analgesia in the Hospital Setting guidance has recently been published and is endorsed by the Royal College of Anaesthetists, Association of Anaesthetists, Royal College of Nursing, Royal Pharmaceutical Society, Association of Paediatric Anaesthetists of Great Britain and Ireland and Society of British Neurological Surgeons.

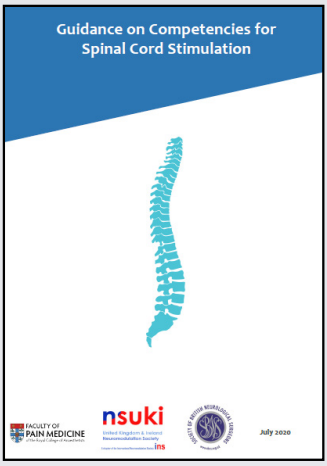
Epidural analgesia provides excellent pain relief with high patient satisfaction when compared with other methods of analgesia and may avoid side effects associated with systemic therapy. However, safe and effective epidural management requires a co-ordinated multidisciplinary approach.

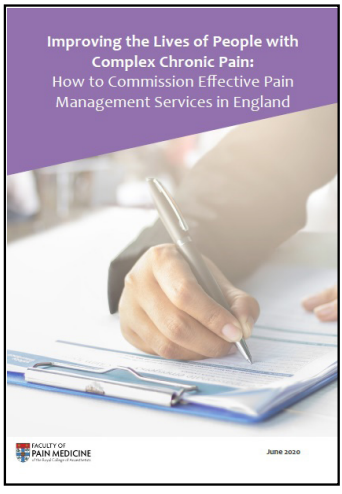
The full guidance is available by clicking here.

Guidance on Competencies for Spinal Cord Stimulation was published over the summer and is endorsed by the Neuromodulation Society of the United Kingdom and Ireland (NSUKI) and the Society of British Neurological Surgeons.

The document sets out the competencies at a core level as well as the advanced level for those directly involved in providing SCS services, including the MDT assessment.

The full guidance is available by clicking here.





Improving the Lives of People with Complex Chronic Pain: How to Commission Effective Pain Management Services in England

Providing guidance to support collaborative commissioning for patients' persistent or chronic pain conditions that is simple, practical, affordable, and effective.

The full guidance is available by clicking here.

Resumption of Interventions and Implants

Dr Ganesan Baranidharan

Consultant in Anaesthesia and Pain Medicine

It has been six months since the initial lockdown secondary to the COVID-19 pandemic. This has had a significant impact on our routine life and has caused personal and financial losses to many across the globe. COVID-19 has not left us yet and constant changes with regional variations will be expected for the foreseeable future.

The Faculty of Pain Medicine published their recommendations on resumption of services. The key operational considerations are:

- Prioritisation, triage and stratification
- Assessment
- Treatment
- Social distancing and PPE
- Supportive professional activities and education

Most services have adopted technology and so have the patients. Remote consultation is made possible and this has helped in having management plans for patients in place. Consultation and advice might not be sufficient for every patient. There is some role in interventions such as Facet MB Block/RF for back pain (NICE 59), Spinal Cord Stimulation for refractory neuropathic pain (NICE TA159), Nerve root block for acute sciatica and other cancer interventions. These interventions will need appropriate set up to perform.

MDT working, psychology consultations, nurse implant education sessions are all performed using Teams or Attend Anywhere or other acceptable portal. These can be very effective and there is a role for these technologies even after the pandemic settles. The satisfaction from the patient is huge as they do not need to take time off from work, travel, find a parking space and spend nearly half a day in the hospital.

Private providers such as Spire, Nuffield and BMI have been contracted by NHS during the pandemic to deliver some NHS work. This has helped in certain areas as pain implants and injections can be moved and treated with appropriate self-isolation and swab as per the hospital requirements. With time, the areas within the hospitals will be able to return to new normal and pain services should be able to resume. We have to take leadership and a drive to achieve this via our management role.

The key is finding out what works in your region and to be able to address the need for pain patients. Pain patients attending acute services such as A&E can have a negative effect on the current constraint in health services. We need to collate the capacity in our region and work towards offering the services to our patient. This has to be an individualised approach rather than one shoe fits all.

I have personally learnt that 99% of the pain interventions can be done with no sedation or occasional use of Entonox. This has raised the question of the role in setting these up outside the acute trust. If we can have an integrated service with community and the secondary care, we could deliver these interventions in a timely fashion for the areas such as acute sciatica in an area away from the acute trust. These might also be able to function with special precautions to the pandemic management without the need to close services.

Education has taken a new shape in the form of webinars. These are very useful and can be attended at the comfort of your home, reducing the need for study leave and budget. However, these can not replace the face-to-face meetings as networking and learning from conversations, building referral network and friendships cannot be achieved by webinars.

Pain Services: The New Normal

Dr Victor Mendis

Lead Consultant in Pain Medicine, Mid and South Essex NHS Foundation Trust

Lynne Mustard RN

Nurse Consultant and Service Manager

Instigating Change

The COVID-19 pandemic presented significant challenges to pain services across the UK. The sudden and necessary cessation of all consultations from March 2020 saw an unprecedented situation.

As organisations reviewed the effect of the hiatus, contingency for reviving services and mitigating detriment to patient care took priority, whilst navigating government and local guidelines for COVID safety.

Innovative thinking furnished projects such as remote consultations via telephone or video-link, triaging electronically with these options available, and multidisciplinary team discussions and other meetings using remote platforms. These technologies have been available for some time, but fuelled by the catalyst of the situation, two major developments appear to have evolved:

- Risk and mitigation thresholds were assessed and managed within expedient timeframes
- Practical application of agreed strategies were instigated quickly

It could be argued that this would not have happened outside of these extraordinary circumstances.

Our experience has been that many of the apprehensions around the integrity of patient assessments by these means have not come to fruition, neither has there been a lack of uptake by the patient population requiring consultations. Cases identified as requiring face to face assessments, either during a remote consultation or at triage, have attended appointments with a varying degree of anxiety. This seems to have been allayed largely 'at the door' when greeted by a staff member explaining the process.

Exploring the idea of virtual Pain Management Programmes (PMP) fuelled lively discussion, and feedback from other centres trialling this approach was mixed. Ultimately it was decided that the logistics of setting up and managing a group forum remotely would be a significant undertaking with unpredictable reward. As the COVID-19 situation allows, we find ourselves resuming live PMPs, albeit with added precautions and boundaries. However, with second COVID-19 wave around the corner it is difficult to predict how long live PMPs can continue.

Risks and Benefits

On reflection it can be said that after the initial six weeks of lockdown and redeployment, services resumed in stages as staffing allowed. Technology permitting, remote engagement between healthcare professionals and patients was rolled out methodically. Allowing time for discussion at service level and engagement with organisational advisory platforms ensured robust clinical governance. Clinical risks were considered and underpinned by increased multidisciplinary discussion and acknowledgement of these limitations in all correspondence.

Administrative re-organisation of clinics required substantial input from the medical secretariat and team, mitigating the additional risk of patients being missed from other waiting lists. Letters were reworded to provide comprehensive explanation of the new appointment systems, text reminders were halted to avoid confusion, voicemail messages changed to reflect the service approach to managing patient care. These details and additional training for staff fielding calls from concerned patients combined to ensure satisfactory patient experience and were not

without teething problems.

The benefits that appear to be evident as we become used to the dual approach of virtual and real patient contact are for further consideration. However, it is apparent that we are unlikely to return to the previous systems of pain clinic management.

On the whole, our experience is that the flexibility that this 'new normal' offers is of benefit to all. Inviting a colleague into the virtual clinic from another room or site has advantages over rebooking an appointment. Recognising the need to see a patient in vivo after an initial video consultation means that the consultation has already been furnished with a clinically reasoned assessment saving time and steering decisions.

Considerations

Technology as available at the moment must be significantly improved to mitigate challenges faced by helathcare providers and recipients. It would seem imperative that immediate investment is required in IT renovation and implementation across the UK. Systems that interface with each other are long overdue to coordinate patient care, and have the potential to improve multidisciplinary clinical inputs.

Careful scrutiny and vigilant audit to recognise shortcomings or failings remain as relevant as always in promoting good clinical practice as we embrace 'the new normal'.

CSPMS: The Definitive Reference

Keep an eye out for the second edition coming soon with a new design!

Core Standards for Pain Management Services (CSPMS) is a collaborative multidisciplinary publication providing a robust reference source for the planning and delivery of Pain Management Services in the United Kingdom. It is designed to provide a framework for standard setting in the provision of Pain Management Services for Healthcare professionals, commissioners and other stakeholders to optimise the care of our patients.

Structure

CSPMS is broken down into chapters and sections which are clear and concise. After Chapter Two, each has the standard format of Introductions, Recommendations, Standards, Background and References.

Advice statements are made in CSPMS in two ways:

1) Standards *must* be routine practice in UK Pain Management.
2) Recommendations *should* be routine practice in UK Pain Management.

Professional Standards Committee Update

Dr Paul Wilkinson
FPMPSC Chair

Without doubt, the last six months have been the most turbulent of times for the Professional Standards Committee. Best laid plans were laid to bed (temporarily at least) with the tsunami of COVID-19.

For a largely unknown period, highly important projects were put on hold to deal with the greater bad. It is unsurprising therefore that I start with COVID-19 before moving onto other issues which we have only recently been able to move forward.

COVID-19
The extensive guidance on COVID from the Board and the Professional Standards Committee will be known to most as well as some of the complex decision making required in an environment of week by week change. The Faculty presented guidance on the transitions required to deal with the COVID situation and then undertook a member's survey to examine the changes that had been made. With improvements of the COVID situation a document on guidance of re-opening services was provided and a second survey was undertaken in order to make a contemporary assessment of stages, process and problems of re-opening. There was also advice about medicine safety. Coupled to this was a major problem over whether the use of steroids in spinal injections was absolutely safe. When infection rates were high and with inadequate information about the safety of steroids, decisions were made to approach this issue with great caution but hopefully, absent any serious COVID surges, we will continue to move back to normal activity thought local decision making supported by the FPM's advice. The Professional Standards Committee will continue to serve its members by providing the most contemporary advice and evidence on COVID and I refer to continued guidance on the COVID section of the Faculty website.

Other matters
I can now move onto a few other items that were temporarily put on hold. First, the multi professional guidance on perioperative opioids is in the final stage of consultation and will be published very soon. The purpose of this document is to manage the opioid load in the community that may follow surgery. This starts with pre-operative assessment of all patients and runs through the perioperative period with a particular focus on post discharge practice. In anticipation of its release, I would like to thank all representatives from the FPM and RCoA but in particular the engagement and effort from other bodies including the Royal College of Surgeons of England and the Royal College of General Practitioners. The Faculty is also to publish a generic framework for best practice in commissioning.

Of concern to members, NICE draft guidance for Chronic Pain has caused much anxiety and along with other groups, the Faculty has presented a detailed appraisal of this document.

A further matter is the document defining the role of a Specialist in Pain Medicine which targets outside stakeholders while fully highlighting the importance and role of the multi-disciplinary team. It is important that we continue to emphasise the importance of our own professional role which is the purpose of this document but plan to review the publication in light of recent feedback. Further ongoing work also includes the revision of Core Standards which is in an advanced stage and an important part of our work.

Summary
With COVID problems moving on, we expect to be able to move forward and complete other project following our next PSC meeting.

I provide a huge thanks for the total commitment of members of the Professional Standards Committee during the most complex period as my time as chair.

MAG UPDATE: Prescription Creep and COVID

Dr Barry Miller

Medicines Advisory Group Chair

"Knowing that a trap exists is the first step in avoiding it"
Frank Herbert, Dune

As I write, we appear to be on the verge of a second COVID wave – my own hospital, largely empty of cases for some months, is seeing its Critical Care facilities filling up once more.

The medium and long-term situation is dependant on the development of some form of widespread immunity; whether by vaccination or by controlled exposure (the various degrees of lockdown) to reduce overwhelming health & social services, the economy, and population morale. Some medications may reduce mortality, but to-date medical science has never really found a common mode of viral attack, beyond vaccines, in the way that penicillin, and subsequent antibiotic development has (the rise of superbugs not-with-standing). There may be a bit of a wait.

The initiation, optimisation and cessation of medication is a core part of everyday practice for all doctors; in every speciality. In Pain Medicine, we have a particular responsibility in that many of the medicines we prescribe have significant euphoric, depressant or cognitive potentials beyond their intended use, with additional risks of physical and psychological dependence; and combinations of such drugs are common.

Concerns over the rise in Opioid and Gabapentinoid prescribing have been highlighted over the last few years, and there is increasing emphasis on the management of long-term prescribed medications, with more attention on the details of prescribing outcomes, and of timely optimisation and cessation when there is little evidence of improved pain or function.

As more medication variants and formulas enter the market it can be more difficult to recognise, or accept, the overall failure of a class of drug or of drug therapy in general.

Changes in healthcare economics to reduce costs have made it easy to prescribe, but reduced follow up opportunities making these critical decisions more difficult.

This has affected Pain Medicine very deeply, at exactly the time that medications are under greater scrutiny; injection therapies are limited, by concerns over the use of steroids in individuals at-risk of, or incubating, COVID, or by reduced access to a suitable interventional environment (for non-steroid procedures), many of our other modalities of interaction, to provide support and educational mechanisms of coping have also been removed, replaced or limited by remote consultations, often voice-only.

For the simpler problems this has upsides, and many patients have found the conveniences an improvement. But many of our patients have complex issues, and the more limited access to examination, investigation, interventions (all of them) is 'challenging' at best.

Reviewing the figures for common analgesic and co-analgesic prescribing in the UK, shows a complex picture - for a simple one, see a national newspaper, but comparing data from May-July 2019 and 2020 (the most up-to-date comparable figures at time of writing) show that although there has been little overall change, it is apparent that while these medications showed a decrease month on month in 2019, there is a reverse trend in 2020. This should act as a warning call.

Electronic prescriptions have increase nearly a fifth, from 68% in April 2019 to 86% by April 2020, and it is likely that this figure will be in the 90s by the end of the year, this is not a signpost of increased prescribing, and the benefits to patients are significant. But as professionals we should always apply a two-tailed approach to innovation, as much as to research, and the easier something becomes, for doctor or patient, the easier it is to be overused.

It may be that a prescription is the right choice, or it may have been a second choice, moved by the lack of the first. We live and practice in the real world, these are the real decisions that are made daily. But it is important that we all recognise the risk of prescription creep that a sudden and rapid change in circumstances, combined with unfamiliar ways of working, and pre-existing trends make us all susceptible to.

Spotlight on: University College London Hospital Complex Pain Team

Dr Fausto Morell-Ducos, Dr Victoria Tidman and Dr Natasha Curran

Consultants in Pain Medicine and Anasethesia at UCLH

Those who regularly take part in inpatient pain rounds will recognise the challenge posed by complex pain – repeated, prolonged inpatient stays, and extreme levels of pain and distress regardless of the analgesic doses or combination of drugs administered. Unfortunately these patients often fall between the gaps of available pain services, as their repeated admissions make it difficult for them to participate in meaningful outpatient therapy, yet there is no multidisciplinary support to treat them in the inpatient setting.

In 2016, University College London Hospital (UCLH) piloted a novel Complex Pain Team (CPT), funded by the UCLH Charity and Camden Clinical Commissioning Group. The team comprises doctors, nurses, psychologists and physiotherapists with a specialist interest in pain management, who provide intensive, bespoke and evidence-based treatment borrowed from outpatient work, which is then integrated with community and primary care.

We know that inadequately treated pain causes high degrees of distress and disability, and that it results in delayed hospital discharge, repeated admissions, staff distress and inadequate handover into primary care. There is evidence that providing MDT care to this group of patients as early as possible can result in significant savings across all areas of healthcare expenditure, not just pain. This is achieved by teaching patients self-management techniques that are known to reduce disability and distress, to improve physical function, and facilitate return to work.

At UCLH, inpatients with complex pain can be referred to the CPT by any healthcare professional. The criteria for consideration include:

- Multiple pain-related attendances to the emergency department (ED) or primary care
- High opiate use, greater than 120 mg oral morphine equivalents per day or rapidly escalating
- Non-malignant diagnosis or malignant diagnosis not appropriate for palliative care input
- Ongoing pain for more than 6 months

Once accepted by the CPT, patients undergo a tailored treatment plan and regular evaluation. The interventions offered include pharmacological optimisation, cognitive–behavioural therapy, targeted physiotherapy, and education on self-management and distraction techniques. These interventions are offered in the inpatient setting and intensively over a short period, rather than waiting for an outpatient appointment and further consultations. The interventions are also individualised, maximising the time spent with the health professional with the most relevant set of skills to each patient. The CPT also facilitates efficient communication between the patient, primary care and specialist teams treating the

patient for other comorbidities by organising regular MDT meetings. We also follow patients up once discharged with regular telephone consultations and outpatient appointments as appropriate, and provide advice to primary care.

The team plays an active role in pain management education in the trust through collaborative working, as well as delivering an educational programme to hospital staff and local GPs.

We won the UCLH Celebrating Excellence Award for Improving and were described as "the new face of innovation in delivering healthcare". Following this, the team were finalists in the National Healthcare Service Journal Awards.

The CPT has been shown to improve patient experience and outcomes, and has proven to be financially sustainable. An evaluation of 145 treated patients demonstrated reduced GP, outpatient and ED attendances, fewer admissions and shortened length of stay. Our unpublished data suggests commissioners save more than the service costs. Validated patient-reported outcome measures collected at patient assessment and six months later show clinically significant improvements in terms of pain severity,

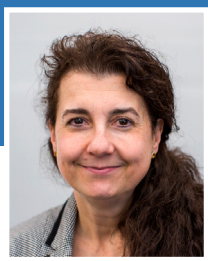
Photo: The Complex Pain Team won the "improving" award at the 2017 UCLH Excellence Awards.

depression, catastrophising and self-efficacy.

The Complex Pain Team may be the first truly integrated UK inpatient-community-outpatient service for patients with persistent pain. Patients become active managers of their long-term health conditions and pain, improving mental health and function. Examples of their stories can be found at https://www.patientvoices.org.uk/complexpainteam-htm.

Faculty Mentoring/Buddying scheme

If you would like to be a mentor, mentee or buddy to another Pain Medicine doctor please email **contact@fpm.ac.uk** to register your interest and we will send you further information and an application form.



Training and Assessment Update

Dr Lorraine de Gray

FPMTAC Chair and Vice-Dean

Since the last Transmitter update, the Training and Assessment Committee has had to rise to the challenges imposed on us all by the COVID-19 pandemic. Several meetings have occurred remotely by the Committee and subgroups within. The last few months have been challenging for all anaesthetic trainees and trainers alike with the great majority being redeployed in order to help provide intensive or high dependency care within hospitals across the UK. This has had a significant impact on training in pain medicine across all levels. Pain services across the UK have also been disrupted although a survey of Fellows and Members done in May showed that 77% of services continued to provide skeleton services even at the peak of the pandemic. In the past few months, services have slowly started to broaden access and training once again. This will most likely be affected by the current second wave.

The FPM has issued guidance to help support and reassure trainees and together with Schools of Anaesthesia will continue to ensure that no trainee is penalised for the disruption in training. Units of core and intermediate training can be deferred up to 12 months and complementary methods of training suggested to help trainees complete their units.

Delivering higher and advanced pain training, however, continues to pose challenges as trainers and trainees alike are having to adapt to an evolving situation as pain services adopt alternative modalities of service delivery and learn from challenges faced in real time. The FPM is committed to ensure that training is delivered to the high standards required and that trainees will be enabled to progress and complete their training. We have offered every higher and advanced pain trainee the opportunity to meet with TAC members if they have concerns regarding their training that cannot be resolved locally.

However, all is not doom and gloom and once again it has become apparent that resilience and resourcefulness are fruits of adversity. Who would have thought six months ago that remote consultations, alternative ways of delivering individual and group multidisciplinary pain management and the dilemma of dealing with new risks in delivering pain intervention procedures would become part of our daily clinical life? Teaching and training through remote platforms, exam tutorials and exams on line have very quickly become accepted as part of the norm. None of this would have been possible without incredible support from the FPM secretariat.

Continuing to compound the situation are regional variations in commissioning of pain services with areas where alternative providers only deliver services. Prior to the pandemic, the FPM had started to explore whether these alternative providers could also contribute to training and we will continue to explore this possibility in the near future.

Moreover, progress with the proposed credentialing of Pain Medicine and the new curriculum had stalled as the GMC rightly has directed all its attention to supporting the NHS in this pandemic. The new curriculum including three levels of training in pain medicine will now be rolled out in 2021 and the Training and Assessment Committee is currently reviewing the new assessment forms and guidance documents that will be rolled out concomitantly. The FPM has also recently resumed discussions with the GMC regarding the future of a credential in Pain Medicine and I hope to be able to update you more on this in the Spring of 2021.

I cannot end this update without saying an enormous thank you to Daniel Waeland, Head of Faculty who has moved on to pastures new and welcome James Goodwin in his role, albeit with a different title as Associate Director of Faculties.

FFPMRCA Trainee Perspective

Dr Mohamed Eid and Dr Helen Laycock

Consultants in Anaesthesia and Pain Medicine

Preparation for exams is always a daunting task. Each of us had been a doctor for over ten years, we were many years past passing the Final FRCA, had clinical and family commitments, so preparation for the FFPMRCA exam felt like quite a challenge. One of us was the only pain trainee in their region undertaking the exam and the other was returning following maternity leave, so we both felt a sense of isolation. Passing the exam felt unachievable at times. However, adopting a clear revision strategy and reaching out to other trainees meant we found preparation for the exam was a positive experience. We were able to gain the breadth of knowledge required, not only to pass the exam, but importantly to improve our confidence as pain physicians, which in turn we feel will benefit our patients. Notwithstanding there are many ways to revise for exams, in this article we highlight and reflect on our strategies to passing the FFPMRCA.

When approaching revision, e-PAIN is an excellent starting point. Although it lacks the depth of knowledge required for the exam, it is useful to gain an overview of topics and get into revision mode. Browsing through both the syllabus and previous exam topics listed on the Faculty website ensured we could create a comprehensive list of topics that needed to be covered. A useful resource was the advice by Graham Simpson found on the FPM website, which is detailed and hard to improve on. We read all of the BJA Education article on pain topics (helpfully catalogued in e-PAIN). Other useful resources include the Faculty of Pain Medicine (FPM), British Pain Society and International Association for the Study of Pain (IASP) documents and publications, alongside NICE guidelines related to pain management. Whilst there are a range of textbooks available, comprehensive texts such as Wall and Melzacks Pain Management, Raj et al's Interventional Pain Management and refresher course books from IASP conferences were useful to provide more in-depth reading on certain topics. We categorised our revision into broad categories including: anatomy and interventions; basic science/physiology; statistics; pharmacology; psychology; and a final category involving broad range of topics such as outcome measures, acute pain and pain physiotherapy.

After initial reading, MCQ practice began. With few published resources to practice MCQ's we started by using those attached to the BJA Education articles and all MCQs related to pain that appear in both the primary and final FRCA standard revision texts. FRCA.co.uk also has a question bank which includes pain questions and there are sample questions on the FPM website. We both used American Pain MCQ textbooks, however we found that the answers often did not reflect UK practice. Furthermore the FPM runs an exam tutorial day that although aimed at preparing candidates for the viva, we both found very useful in preparing for the MCQ.

The pain trainee whatsapp group is an excellent platform that connects trainees from different regions. Via this forum we both expressed interest in connecting with people for practice viva sessions and three months before the exam we setup regular viva sessions using video calls as we were based hundreds of miles apart. Initially we organised one session a week, then slowly this increased the frequency. Just like practice sessions for the FRCA, each would prepare a set of questions on different topics. This provided us with the opportunity to learn from and teach each other. We were honest early on, regarding our perceived areas of topic weakness, with the other ensuring these topics were covered in detail. We were organised, covered every topic on our "list", ticking them off one by one. The sessions became forced revision time, which was essential around full time clinical work and on call commitments. Revising together was very important in boosting our confidence and reducing the sense of isolation.

Both parts of the exam felt fair and manageable. There was only one topic that came up in the SOE that we hadn't practiced together and that made us more confident on the day about our performance. It would be wrong to say we didn't discuss afterwards the one or two more difficult viva questions, but overall we felt the questions covered topics from the syllabus. Our ability to pass the exams and the effectiveness of our revision was greatly enhanced by "remote" practice. Not only did this lead to us both passing the exam that sitting, but also has led to a friendship and what we hope will be continued networking and collaborations in the future.

FFPMRCA Examination Update

Dr Nick Plunkett

Chair FFPMRCA

Dr Anthony Davies

Outgoing Vice-Chair FFPMRCA

Dr G. Baranidharan

Incoming Vice-Chair FFPMRCA

As Chair of the FPM examination, it is fair to say that we are in unprecedented times. The COVID pandemic continues to impact on our lives, consultant and trainee, professional and personal. Due to the ongoing government restrictions on freedom of movement and association, the RCoA and Faculty have made the decision to run examination assessments remotely until further notice.

A notable casualty for the FPM was the SOE exam in spring, which was cancelled. There was insufficient time to consider any other option, and so cancellation was appropriate given the very short duration between the date of lockdown and the examination itself. The FPM Court of Examiners communicated to all potential candidates as soon as the decision had been made, and while we regretted the impact on all potential candidates, there were soon plans afoot to develop remote assessments, starting with the summer 2020 MCQ exam.

The MCQ examination was run on the 26 August 2020 as previously scheduled. It was considered important to retain this date so that candidates who had made prior provision in terms of timing for the examination could continue to work to this. The Faculty provided communication on all aspects of the exam including the process and procedures set up by the remote proctoring company, TestReach, which also communicated directly with candidates on the run-up to the exam. The hope was to give candidates confidence in their own preparations, as well as expectations that TestReach would deliver the examination in a straight forward and trouble-free manner.

There were 17 candidates for the examination, all attending as planned on the day. There were no reports from TestReach of any irregularity, or of any significant incident with respect to the delivery of the exam in terms of its process. In addition, the RCoA examination department asked for feedback on the remote process and delivery, which indicated a small number of candidates had initial technical difficulty logging in and/or accessing the examination. All candidates who reported this delay prior to the exam were found to have passed. Feedback from other candidates indicated a particularly positive experience especially in avoiding the effort and expense of having to journey and stay in London.

The Anghoff group met remotely on 10 August, to conduct its usual rigorous and robust processes in terms of quality assurance of the exam content, standard setting, and agreement on a pass mark, all done using similar process to those previously described, albeit via a remote video meeting. The questions were reviewed in the usual way, two MTFs stems were removed due to perceived ambiguity and two MTF stems reversed due to changed evidence base. The raw pass-mark was 271/398, giving a pass mark of 68.09%, which is within the range of previous pass-marks. A total of 14 out of 17 passed, a pass rate of 82.35%, which is in the upper range of pass rates for this exam, and which, given the procedural change with remote process, was robustly reassuring for all concerned.

The SOE examination occured on 13 October as previously scheduled. The window for application was extended due to the third party (TestReach) delivery of the MCQ exam and resultant later notification of results to candidates. This examination was remotely delivered via Zoom. It was important to reassure all candidates that all examiners were trained in Zoom technology, and the additional

skills in delivering the SOE remotely with particular attention to audio-visual quality, and actions and mitigations that should occur as a result of technical failure/glitches, supported as ever by the RCoA examinations department. All examiners conducted practice examination questioning remotely including being placed in the candidate hot seat and have therefore given feedback on the potential candidate experience to optimise this as much as possible. The RCoA examinations department sent out detailed advice on candidate preparation for the technical aspects of remote assessment, including actions in the event of technical glitches or failure. It is important for candidates to understand that the College is confident in its ability to deliver the SOE examination remotely, and to make it as near normal an experience as it would be in its face-to-face iteration, and similarly that the FPM Court of Examiners are confident about its validity and relative ease and "normality" of delivery. In addition we are seeking feedback from candidates on their remote examination experiences to further triangulate this process.

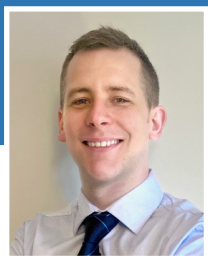
The Court of Examiners will meet remotely during the three days of the examination to quality assure every step of the examination, using standard processes and procedures. There may be a slight delay in the notification of results on this occasion.

We appreciate the forbearance of all candidates as we endeavour to deliver the examination in a new way under different circumstances, and thank them for their continued interest in sitting the exam which for successful candidates will be their guarantor of the highest quality of Pain Medicine training.

Finally, I would like to thank the RCoA examinations department for their extraordinary efforts to deliver examinations in exceptional circumstances - Fiona Daniels as Head of Examinations, who has the task of developing and overseeing the delivery of all examinations, David Rowand who has co-ordinated and delivered Zoom processes and examiner training for the SOE, Beth Doyle for her ever-present assistance with examination questions and remote delivery, and Samara Brankar our statistician, who undertook the prodigious work on the data necessary for the MCQ Anghoff processes. Note that much of this work was done out of hours to assist remote examiner involvement. Thank you all very much- the examinations quite simply could not occur without the amazing work you have done!

FFPMRCA Examination Calendar October 2020

	FFPMRCA MCQ	FFPMRCA SOE
Applications and fees not accepted before	Mon 26 Oct 2020	Mon 1 Feb 2021
Closing date for FFPMRCA Exam applications	Tues 8 Dec 2020	Tues 2 Mar 2021
Examination Date	**Wed 6 Jan 2021**	**Tues 13 Apr 2021**
Examination Fees	£555	£775



Trainee Update

Dr David Gore

Faculty Trainee Representative

In fear of stating the obvious, throughout the pandemic our work changed dramatically – this was evidenced across the two surveys of pain trainees. As the majority of us have an anaesthetic background we were in high demand and mostly redeployed, whereas some of us faced protective isolation. Everything happened within a whirlwind of rapid adaptation and learning. In our strange new PPE-laced environments, with different rotas in new areas I know many experienced a rapid succession of contrasting emotions including stress, pride, sadness, achievement, reward and fatigue. It has been challenging and hard work that has not gone unnoticed by the FPM who want me to pass on their sincere thanks.

This article will keep it simple and address our evolving new normal in pain training and the support available to get your training back on track as we transit the pandemic.

The New Normal in Pain Training

Our new normal is enabling most of us to return to pain training, albeit in different formats. Many of us have fewer face-to-face clinics and new remote consultations represent both a challenge and an interesting opportunity. Access to intervention lists are reduced for most but capacity continues to increase. Moreover, many individual training programmes require a blend of adaptation, extension and creativity as we all reintegrate into training schemes and try to fill gaps left in our training.

Thanks to the hard, responsive work of our exam team the FFPMRCA examinations are still taking place. In August, candidates sat the written examination online and in October, our SOE will be held online for the first time.

Pain teaching has restarted with a noticeable increase in attendance. Whilst the face to face teaching held in London had been available online for the past few years it is now being accessed by many more trainees in its online only format. A big thanks to Dr Ellie McGarry (the London trainee rep) who has worked very hard on this recently. The strong desire from trainees to have more educational and exam-based resources has been acknowledged by the Faculty who are planning a new pain e-learning platform.

Unfortunately, our national pain trainee day on the 2 October will not be taking place this year. As a group of trainees spread across the UK, ensuring access to pain teaching has always been a challenge, especially outside of London where some hospitals have only one pain trainee. We had planned the day as a chance for trainees from across the UK to attend some formal teaching and, more importantly, network/socialise. Given the difficulties socialising and meeting currently we plan to postpone it until we can all safely meet again in person.

Points of Contact and Support

The current pandemic has demonstrated the need to think outside of the box, and to that end it has been much easier to effect change. As an example, my training is now part advanced pain and part higher anaesthetics until more pain services resume locally. There is growing experience within the Faculty and many creative training ideas. Therefore, if you feel your training is not going according to plan, if you have concerns or require support, do make contact with either myself or the Faculty contacts below:

- Your local Faculty Tutor (Pain), (previously known as LPMES)
- Your training programme director locally
- Me! The FPM Rep via email FPMTraineeRep@gmail.com or via WhatsApp.
- The Faculty directly (contact@fpm.ac.uk)
- Via a 1:1 meeting with your Regional Advisor in Pain Medicine (via contact@fpm.ac.uk)

Relevant Faculty Statements

The Faculty have been working hard to support trainees and adapt training:

- FPM guidelines on provision of higher and advanced training in pain medicine in light of the COVID-19 pandemic (May 2020) - Higher and Advanced trainees should have their

future training requirements managed on a flexible and individual basis.

- FPM guidelines on provision of core and intermediate training in pain medicine in light of the COVID-19 pandemic (May 2020)
- FPM statement on the impact of COVID-19 pandemic on training & wellbeing of our trainees (March 2020)
- FPM guidelines on the provision of higher and advanced training in pain medicine (April 2016) – General principle 4: Advanced and higher pain trainees should not undertake weekday daytime on calls in anaesthesia or ICM – although COVID-19 is an extenuating circumstance its worth being aware of this supportive statement as things move back towards normal.

When I wrote my previous Transmitter article COVID-19 was a distant wave on the horizon, but by the time my Spring Transmitter article was published it had arrived. As I currently write we have slipped off the back of the swell and are looking out to sea in anticipation of possible further waves. We may face a turbulent winter, but I am confident that our ability to work together and creatively adapt will see us through.

e-PAIN is free for all NHS staff, OpenAthens account holders and students

For more information and to register for free access, please visit www.e-pain.org.uk

FACULTY OF PAIN MEDICINE of the Royal College of Anaesthetists

e-LfH e-Learning for Healthcare

NHS Health Education England

THE BRITISH PAIN SOCIETY

The e-PAIN online e-learning resource (aimed at all NHS staff) is 12 modules of interactive e-learning. We have recently appointed a new Deputy Lead, Dr Sadiq Bhayani, Consultant in Pain Medicine and Anaesthesia at the University Hospitals Leicester NHS Trustand look forward to working with him to take the resource to the next level.

Regional Advisors in Pain Medicine - Updates

Dr Peter Cole
RAPM Chair

Dr Madan Thirugnanam is taking on the role of deputy RAPM Nottingham/Mid Trent working closely with Dr Yehia Kamel RAPM for Leicester/ South Trent. Dr Arasu Rayen takes over from Shyam Balasubramanian as RAPM for the West Midlands.

In January, HooKee Tsang will take over as RAPM Chair for the two year term of office and I am sure he will do an excellent job in this role. HooKee is the RAPM for Mersey and already represents the Faculty's Training and Assessment Committee (TAC) on the RCoA TAC, is a member of the Faculty and RCoA curriculum writing group and a Primary FRCA examiner. HooKee will be continuing with the strategy outlined previously of delivering a regular educational meeting for Faculty Tutors (Pain) (FTPs), encouraging completion of annual appraisal forms, annual reports and hospital review forms. Our aim is to collect a completed registry of FTP's terms of office. Please email the Faculty (contact@fpm.ac.uk) with your details and start date if you have not already done so.

The three educational FTP meetings held so far have been attended by a total of 220 delegates and this free event has provided the opportunity to learn more about the role and the Faculty. The plan was for this to be biennial but events have overtaken us so this will be reviewed or delivered in another format.

Please visit the FPM membership webpage to join if you have not done already, or forward to colleagues in your department if they are not members of the Faculty. No affiliation means that it will not be possible to be involved in the work of the Faculty, membership of committees or take on the roles of Faculty Tutor or RAPM.

I recently set up a RAPM WhatsApp group and all 21 Regional Advisors joined and participate. This provides the opportunity for questions and quick responses and generally seems a very good format for a group of this size. We have recently (I write this mid-September) been discussing how, following the first wave and redeployment, trainees are getting back into regular pain training. There are challenges and of course training opportunities vary across the UK. However Pain Clinics are in the main back and running. Consultations are usually remote as a first line, this varies from telephone (some without a speakerphone option) through to Attend Anywhere or similar. Patients are brought in for a face to face appointment as necessary. Some trainees are using Near Me if there is not enough space in the room to sit in. Pain management programmes and physiotherapy are on the whole running virtually and in many cases trainees can join these. Interventions vary from not restarted at all through to full lists.

It has been great to hear of the innovative teaching practices that have been developed, these include webinars, teaching via WebEX, Zoom, amongst others. For example Sonia Pierce, Wales RAPM, has with the help of two trainees, Kate Wainwright and Richard Wassall developed online interactive pain medicine training sessions available to trainees undertaking Intermediate Units of Training in Pain. This is very impressive and I am sure we will hear more about this and similar projects in the future.

RAPMs are encouraged to create a WhatsApp group for their Faculty Tutors, if there isn't one set up in your area and you are a Faculty Tutor please contact your RAPM.

The next Regional Advisors meeting will take place by MS Teams on 19 November.

National Neuromodulation Registry (NNR) Update

Dr Ganesan Baranidharan
NSUKI President

Neuromodulation is an ever-expanding field and we are currently in an era of electroceuticals. The National Institute for Health and Care Excellence (NICE) has recognised this as a cost-effective therapy for neuropathic pain management in their guidance (TA 0159). The technology is expanding with newer anatomic targets such as dorsal root ganglion and newer wave forms such as high frequency, burst, high density, whisper etc.

The Neuromodulation Society of UK and Ireland (NSUKI) is an organisation working towards education and development of Neuromodulation. NSUKI in partnership with Northgate (manages the National Joint registry) launched the national neuromodulation registry in Feb 2018.

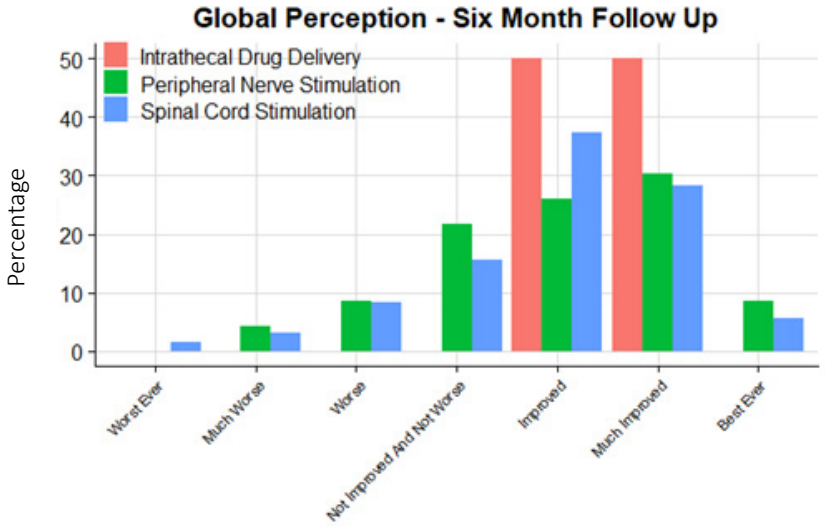
The aims of the registry in the first phase is to collect demographics especially postcode for access details and NHS number, Implant device registry as required by Medicines and Healthcare Products Regulatory Agency (MHRA), length of refractory pain, Occupational status, Global Perceived Effect, Quality of life data using EQ5D 5L, trial to permanent implants rates, Complications and revisions. This will be for all Spinal Cord Stimulation (SCS), Peripheral Nerve Stimulations (PNS) and Intrathecal Drug delivery (ITDD) systems. The clinical governance group includes NSUKI, NICE, MHRA, the Faculty of Pain Medicine and the commissioners.

The National Neuromodulation Registry (NNR) has analysed the first 2 years of the data collected. We had 1420 new implants registered during this period with 98% follow up data at 6 months. Failed Back Surgery Syndrome (FBSS) formed nearly 70% of the patients for spinal cord stimulation. Headache was the predominant condition for the use of PNS. There was high patient satisfaction on global perceived effect scale (Figure 1). These are early results and we hope to learn more from the national dataset on neuromodulation in the coming years.

The device industry has sponsored the running of the registry for the first three years. We are in the process of making this registry independent from industry. The cost of the registry will be met by various means such as device levy, hospital fee to use the registry and fee for generating reports to the industry. Individual operators will also get a report benchmarking their outcomes with the national outcome data and standards. We currently have 83 Neuromodulators on the registry and will have more in the coming years.

NNR is mandated by the Get It Right First Time (GIRFT) report and also a performance indicator for the hospitals implanting neuromodulatory devices. With NNR, we should be able to offer valuable information to the commissioning process.

Figure 1:



EPM Update

Dr Helen Makins

EPM Clinical Lead

Dr Sibs Anwar

EPM Deputy Lead

It seems there is nothing quite like a global pandemic to push digital projects forward!

We've known for a while that the future of medical education lies - at least in part - with e-learning and the use of a 'flipped approach' to combine this with traditional face-to-face sessions. Taking the leap towards this felt daunting until COVID made it necessary.

Video teaching
EPM enthusiasts around the world have risen to this challenge providing digital content to enhance the reach of this project further, adding to the 55 countries where the course is already being taught. A succinct and consistent approach to helping patients in pain, using the simple framework taught in the EPM course, is key to effective pain management in all settings. We are now developing plans for instructors to run courses based in one country while delivering the sessions to colleagues thousands of miles away.

Closer to home, UK anaesthetists, including Dr Karen Gilmore in Plymouth and Dr Venkat Hariharan in Milton Keynes, have used video conferencing software to deliver traditional EPM courses to medical students with great success. Read more about their experience on our EPM webpage.

e-PAIN Resources
We are continuing to work on our e-PAIN content for the e-Learning for Healthcare platform, providing sessions covering the background to EPM, tips on using the structure in all teaching related to pain management (acute and chronic) and specific sessions for medical students and foundation doctors. Once these are complete, students will be able to work through the fundamental EPM course and learning objectives in their own time and online. We anticipate complementing this with face to face case discussions as well as bedside teaching to enhance the learning experience and allow interactive discussion.

Podcast
We have also joined the Faculty of Pain Medicine in its first foray into the world of podcasting. Three members of the EPM Advisory Group were privileged to discuss the management of complex pain in hospital settings with our psychology colleague, Dr Zoey Malpus, from Manchester University Hospitals.

Many of you will be aware of the benefits of psychology as part of the multi-disciplinary approach to inpatient pain management but may not be aware of how we might influence this ourselves. Following some skilful editing from the RCoA team, we are pleased to share with you a podcast exploring the complexities, challenges and potential approaches to inpatient pain. We anticipate that this might be useful listening for everyone involved in inpatient pain management, especially colleagues who are frequently called to help where nothing else seems to be working.

Online resources for pain teaching
The Essential Pain Management project team within the FPM encourages all anaesthetists to consider the use of the EPM resources and the simple algorithmic structure whilst teaching aspects of pain management in any setting. We have recently uploaded Pain Medicine learning objectives for medical students and foundation doctors to the website which have been agreed with the national curriculum leads.

We have uploaded a number of example case studies to the website demonstrating the use of this structured approach to teach and guide the management of complex pain presentations. We also provide written outline 'answers' which may be useful for those teaching colleagues and for exam preparation. Please have a look at them here.

As always, please do get in touch with the team contact@fpm.ac.uk if you have any suggestions, comments or queries.

The New FPMLearning Webpage

Dr Lorraine de Gray

FPM Vice Dean

Every cloud has a silver lining and the pandemic is proving to be no exception. The last few months have been challenging in many ways but on a positive note have proved to be a great catalyst for innovation and rapid implementation thereof.

The FPM has risen to the occasion and in response to significant request and support from trainees and trainers alike is introducing FPMLearning, a remote source of learning accessible to trainees and trainers through the FPM website.

FPMLearning will incorporate a broad range of teaching and learning modules including excellent resources that are already available: **e-PAIN** (with special thanks to Dr Douglas Natusch), **Essential Pain Management**, including teaching modules and case-based studies (special thanks Dr Helen Makins) and **Opioids Aware.** The site will have a separate section on **Exam Resources** including suggested reading material, topics from previous exams, MCQ and SOE practice questions. It will also allow access to the FFPMRCA examination tutorial online, for a small fee, recommended for all trainees sitting the exam (special thanks to Dr N Plunkett and Dr N Mulla).

FPMLearning is proud to promote **Communication skills** with signposting to internet sites with relevant material, modules on health coaching. Communication skills are essential skills for all doctors and in pain medicine in particular need to be honed to perfection to build up the therapeutic relationship required to motivate and educate patients with chronic pain. These patients frequently come with years of disillusion and distrust of health professionals behind them and communication is key.

Further sections on FPMLearning will include **podcasts and webinars** specifically produced to promote teaching mapped across the curriculum. We also aim to have a regular **Case presentation** including presentations commonly seen in pain clinics but also focussing on some unusual cases which pose ethical dilemmas. We hope that these will promote an appetite for further reading and discussion.

The website will also allow access to a **library of online resources** and will also link to relevant NHS resources, and **guidelines**, including National Institute for Health and Care Excellence (NICE) and Cochrane guidelines.

As the site evolves, we aim to produce further sections aimed at Core, Basic and Intermediate trainees not only to promote teaching in pain medicine at these levels but also to generate more interest in the pursuit of a career in pain medicine. The sections on EPM and e-PAIN will also be relevant to medical students, foundation year doctors and doctors training in other specialities.

The website will also become a platform for delivery of study days and will link to the Calendar for events for the FPM.

Developing and maintaining this site would not be possible without the contribution of many members of TAC and Board members. I would particular like to single out Dr John Hughes, Dean of the FPM, Mr James Goodwin, Associate Director of Faculties and Dr David Gore, Trainee Representative for their unwavering support of this project. My greatest appreciation however goes to Miss Caitlin McAnulty, FPM Professional Affairs Manager, without whom this project would not have got off the ground.

We welcome feedback regarding this evolving project and if you have any suggestions or contributions that could be uploaded on the website please contact us at contact@fpm.ac.uk

Events Update

Dr Manohar Sharma

Educational Meetings Advisor

Dr Devjit Srivastava

Deputy Educational Meetings Advisor

The Faculty of Pain Medicine is committed to engaging with its members and address new challenges including those arising out of the COVID crisis.

We hosted the acute/in-hospital pain management meeting on 3-4 February 2020. The first day kicked off with topics related to basic science (lessons from congenital insensitivity to pain, the science and diagnosis of neuropathic pain). Topics related to clinical practice included the report from the national in-hospital pain services, safe use of Lidocaine infusion, perioperative care of CRPS patients, de-escalating opioids and presentation of the top 10 pain articles in 2019. On day two, the issues of managing pain after emergency laparotomy and chronic post-surgical pain were covered. The chief legal officer of Scotland gave a master class on Consent issues and the day concluded with two excellent quality improvement initiatives in pain from the emergency department and Intensive care. The feedback from the delegates was very good.

In March 2020, the COVID-19 crisis erupted and after a terrible few months, with elective services partially or totally suspended in most parts of the NHS, the FPM had to cancel the June 2020 pain meeting (management of complex pain cases at the coalface).

However, since then, we have had a bit of roller-coaster ride in terms of restrictions arising from the COVID crisis. We are now aware of population health statistics as never before and use of hitherto technical terms like 'R number' or the not so technical 'circuit breaker' is quite usual in public conversations. Given the fears of a second wave in the winter, the FPM felt that it might be wiser to switch to a webinar concept in November/December 2020.

The winter meeting/webinar content is being considered and likely to include an overview of the COVID crisis from the pain management perspectives to cover important topical issues. These are likely to include guidance to pain medicine doctors on remote consultations, running remote pain management programmes, the role of steroids in pain injections and in-patient pain issues.

We are aware of the 'webinar fatigue' many of you might be experiencing but we do think that the future portends that COVID issues will predominate the health system delivery requirements but also equally that non-COVID activities like pain management may have to continue. We have to adapt to this new post COVID world and this webinar is a small practical step in that direction.

Learning is a two way exercise, with discussions between the taught and the teacher often providing the key learning points for clinical practice. We aim to provide sufficient time for discussions in the webinar and your participation and feedback will enrich the educational content of the day. We hope to see most of you attending the webinar and if you have any new ideas and interests in contributing to these events in the future, then, please contact either Dr Devjit Srivastava (dev.srivastava@nhs.net) or Dr Manohar Sharma (manoharpain@yahoo.co.uk).

Faculty Update

New Fellows by Examination and Assessment

Bijam Nejad

New Affilate Fellows

Matthew Roe

Sailakshmi Murugesan

New Affilate Members

Kevin Mo

Mohamed Attia

Ali Al-ALi

Hemkumar Pushparaj

In Memory of Fellows and Members

We regret to announce the recent passing of three Pain Medicine Consultants.

Dr Peter Toomey had worked at York Hospital as a Consultant in Anaesthesia and Pain Medicine.

Dr Rajesh Gupta was a Consultant in Anaesthesia and Pain Medicine at Wexham Park Hospital.

Dr Keith Budd, prior to his retirement in 1997, was Consultant in Pain Management & Director of Pain Management Services, Bradford Trust Hospitals.

The Faculty of Pain Medicine
of The Royal College of Anaesthetists

Churchill House
35 Red Lion Square
London WC1R 4SG

tel: **020 7092 1682**
email: **contact@fpm.ac.uk**

www.fpm.ac.uk **Follow @FacultyPainMed**