FACULTY OF PAIN MEDICINE
of the Royal College of Anaesthetists

SPRING 2023

TRANSMITTER

THE MEMBERSHIP MAGAZINE FOR THE FACULTY OF PAIN MEDICINE ISSUE 27

What is the future direction of Fibromyalgia management?

DIGITAL AUTOMATED PROMs PLATFORM

FPM THRIVE

INDEPENDENT EXAMS REVIEW

FACULTY OF
PAIN MEDICINE
of the Royal College of Anaesthetists

UPCOMING EVENTS 2023

FFPMRCA SOE Online Exam Tutorial

Monday 14 September 2023

Communication Skills Course

Thursday 19 October 2023

15th Annual Meeting of the Faculty

Tuesday 28 November 2023

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Faculty of Pain Medicine Study Day

De-escalation of opioids

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Friday 9 June 2023

Location: RCoA, 35 Red Lion Square, London WC1R 4S

09:00	**Registration**	
09:20	Welcome	Dr Dev Srivastava
09:30	Public health impact and contribution of prescription opioids (including post-surgery) to the opioid epidemic in the UK	*TBC*
10:10	Neurobiology of substance abuse and addiction	Dr Katherine Herlinger
10:50	**Tea break**	
11:10	Best practices in opioid prescribing	Dr Sunil Dasari
11:50	Pharmacological principles of de-escalation of opioids	Prof Roger Knaggs
12:30	Discussion	
12:50	**Lunch break**	
13:50	Psychosocial interventions and community de-escalation of prescription opioids (I-WOTCH trial)	Prof Sam Eldabe
14:30	Opioid Tapering in Secondary Care: The Clinician and the Patient's perspectives	Dr Sailesh Mishra & Helen Franklin
15:10	**Tea break**	
15:30	Opioid de-escalation service — A nurse's view	Helen Burke
16:10	**Discussion, feedback and closure**	

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Face to face

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Dr Manohar Sharma
Clinical Editor

WELCOME

I welcome you to this spring edition of *Transmitter*. Winter brought with it significant pressure on the National Health Service due to backlog and the impact of industrial action involving various healthcare professional groups. I am sure many of you might find it increasingly challenging to deliver pain management services to a reasonable standard.

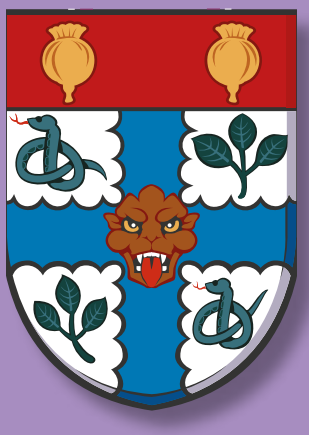
Despite the above challenges the FPM Board together with the Professional Standards (PSC) and Training & Assessment (TAC) committees continue to strive and develop relevant workstreams to support Pain Medicine. Work is imminent on updating the evidence and guidance in Opioids Aware. This project is supported by an Annabel's Foundation grant and will be led by Dr Barry Miller and Dr Ganesan Baranidharan, with assistance from two part-time fellows.

The Royal College of Anaesthetists' external examination review report has been reviewed in detail by the Faculty. FPM considers this external review of utmost importance for future adjustment to examination processes. I would like to reassure you the FPM examination has been conducted to a high standard. I will also request the views of Fellows and trainees on this review and any recommendations on the FPM website. Our Gap Analysis workstream is progressing well via PSC led by Dr Dev Srivastava. A survey will soon be sent to FPM Fellows. I request you to kindly respond to this as understanding gaps in pain management services benchmarked by published core standards will be key to further FPM efforts to improve services for our patients.

Dr Qureshi and Dr Rastogi from Newcastle Upon Tyne Hospitals NHS Trust have provided an update in this edition on "Integration of a Novel Digital Automated PROMs Platform into Pain Management". They highlight a better and efficient process of pain outcome collection and its relevance to revalidation and providing outcome data to service users and commissioners. This will probably have implications for your services.

We are always keen to receive articles from FPM educational meetings presenters. In this edition, I bring to your attention the summary of a captivating talk by Professor Sam Eldabe (recipient of the Patrick Wall lectureship) on his experience in working in pain management services between Middlesborough and Morges. Dr Andreas Goebel summarises his vision for the future of fibromyalgia services in light of evolving immune mechanisms' relevance to pain medicine, though it is early days. I would also like to invite you to attend FPM June 2023 Study Day themed on best practice in opioid prescribing, the neurobiology of substance abuse and addiction and I hope you will find it most useful to your day-to-day clinical practice including valuable networking with colleagues.

Manohar Sharma



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FACULTY UPDATE

New Fellows by Examination and Assessment

Kerry Bosworth
Andrew Bretherick
Rajashree Madabushi
Melanie Morrison
Richard Pertwee
Nina Plant
Candice Ramdin
Martina Rekatsina
Adam Samways
William Shankey-Smith
Azra Zyada

New Affiliate Members

Muhammad Munir
Greta Mattocks
Angela Deeley

Dr Lorraine de Gray
FPM Dean

MESSAGE FROM THE DEAN

It has been a long and hard winter. The NHS has had to face unprecedented demands due to winter pressures, industrial actions involving various health professional groups, the ongoing pandemic and significant back logs in care created as a result. Never has it been more important for us all to watch out for and support each other.

I confess that when the going is tough, I find the following quote which I came across recently, very comforting:

"It was in that moment that I realised something about human beings: We always care. Even when we don't care, or don't want to care, or we've been broken beyond the capability of caring... We always do. It's our ultimate infallibility" — Preston Norton, *Neanderthal Opens the Door to the Universe*.

RCoA governance

Following the Royal College of Anaesthetists' Extraordinary Annual General Meeting held in December 2022, the Deans of the Faculty of Pain Medicine and Intensive Care Medicine are no longer automatically appointed to the Board of Trustees (BoT). This is because the composition of the RCoA BoT has now changed to include a smaller number of members, which will include elected members from the RCoA Council, President and Vice Presidents, the Chair of the Finance and Resource Board as well as three lay persons. The BoT is the RCoA's governing body and meets four times a year to deliver the College objectives, set the College's strategy in consultation with the RCoA Council, monitor progress, and ensure proper and effective management of the College's finances and assets.

The BoT is separate from the Council of the RCoA. Whilst the BoT is charged with governance of the College, the College Council is responsible for the professional aspects of the specialty of anaesthesia as well as fulfilling formal and ceremonial matters. It sets and oversees strategic College policy in clinical and professional matters and responds to current issues affecting professional practice and standards[1]. The Dean of the FPM is a co-opted member of the RCoA Council. Until now, co-opted RCoA Council members did not have a vote.

Faculties on Council

Following the AGM, the Dean of the Faculty of Intensive Care Medicine, Dr Danielle Bryden and I met with Dr Fiona Donald, President of the RCoA and Mr Jono Bruun, CEO of the RCoA. The outcome of the AGM had effectively left both Faculties without a vote although we have been advised that we would be asked to attend the BoT if matters relating to the Faculties were on the agenda.

Subsequent to these discussions, it was agreed that a proposal would be made to give each Dean a full vote on the RCoA Council including a vote on who gets elected to the BoT. I am very pleased to report that this was separately voted on and passed unanimously by the BoT and RCoA Council in February 2023. It has also been agreed that at the next RCoA AGM, likely to be held towards the end of this year, a motion would be proposed to allow the Dean of either Faculty to stand for BoT Membership. I will keep you updated in the next few months.

References

1. https://www.rcoa.ac.uk/about-us/how-college-governed

PAIN MANAGEMENT BETWEEN MIDDLESBROUGH AND MORGES

Prof Sam Eldabe
Consultant in Pain Medicine

In January 2022 I took my retirement with a 50% return to the NHS. At the same time I was tempted by an offer from my long-time friend, Prof Eric Buchser to join him as a part time pain consultant in the Hôpital de Morges, a medium-sized hospital serving the town of Morges on the shores of lake Geneva, only you're very much frowned upon if you call it lake Geneva. It is lac Leman and ours is the Centre Lemanique d'Antalgie et Neuromodulation, the Leman centre of pain and neuromodulation.

Swiss clockwork

Morges is a pretty market town of 17,000 inhabitants set on the shores of the lake. Hôpital de Morges, established in 1869 perches on top of the town, and boasts 240 beds and seven operating rooms. This provided a sharp contrast to my UK base, The James Cook University Hospital, Middlesbrough, with 1,007 beds, a major trauma centre, a cardiothoracic and neurosurgery centre and a spinal injuries unit served by 39 operating rooms. I found myself transported back to my training years in smaller DGHs where everyone knew everyone, and the place functioned like a family, and you could just knock on colleague's offices and ask a question or discuss cases over lunch in the canteen.

Hospital medicine however has a different feel here. For a start the place is spotless, and work starts at 8am but some doctors are here well before 7am, I have no idea when the cleaners start but I did find them already hard at work on the day I arrived at 6:30. Most patients arrive on time and those who don't grumble about the lack of spaces in the car park (plus ça change). Most expect to be seen on time and some will get very uptight if you are late by more than 15 minutes (affectionately known as the Vaudois 15-minute delay). The day is organised to the minute. New consults are booked by the secretary, medics and nurses have an electronic diary where we book our own reviews and procedures in 30-minute slots.

A different feel

Procedure work is no different from the UK except for the twin luxuries of a pain dedicated procedure room with fluoroscopy, ultrasound RF and PRP facilities and a six-bedded day unit. All injections are done under local anaesthesia with the help of a single nurse with no WHO checks!

Docs are trained to operate the fluoroscope and must undergo a mandatory radiation safety training; the only mandatory training piece I have come across so far, and even then, there was no obligatory test at the end! Most importantly, the unit is blessed with a fantastic team of eight nurses who work together quietly and efficiently in a model of patient-centred care.

DNAs are rare and even those are telephoned, and most are reappointed by the nurses although you may choose to bill the appointment and the patient will be responsible for the payment. Health insurance is mandatory in Switzerland and is paid for by the individual. The cost varies according to age and the area you live in, and can range from 300 CHF (~260 GBP) per month to 1,000 CHF (~885 GBP) for private insurance where patients can only be seen by consultants and are admitted to single rooms with a lake view.

The medical practice has an overall less defensive feel about it with less legalistic concern and a lot less confrontational attitude. Most patients will ask you what you think is best and adopt your suggestions albeit the majority are very well informed, not only about their condition but will have read your CV before seeing you. That is not to say malpractice suits are unheard of, but they are rarer. As a result, I don't miss the burden of the multiple layers of governance that are now common practice in the NHS. Access to overnight beds is never a problem, albeit access

Recovery with Vineyards in background.

to ICU beds can be limited. I certainly came across a patient who had to spend the night in the recovery till an ICU bed became available. Having said that the recovery unit overlooks the hospital owned vineyard that produces the Hôpital de Morges Chasselas, a view only rivalled by that of the home end of Ayresome park (the old Middlesbrough FC ground) which could be seen from the neurosurgery theatre window in the 1990s.

Reflection

So, is the Swiss healthcare system perfect? I would say far from it. Certainly, the service is patient-centred, and we work when the patient wants to see us rather than the other way around. Overall, while the insurance system affords the patient more choice (they can refer themselves to you and ask the GP for a referral letter afterwards), it allows for what is known as 'medical tourism' where patients go on seeking multiple opinions from several specialists when the opinions don't fulfil their expectations.

Short waiting times and competition between centres clustered in close proximity make doctor shopping easier and lead some centres to resort to procedures that are not practiced in the UK on grounds of poor evidence or cost effectiveness. It is of course likely that the willingness to pay threshold is higher than the UK, however there is a big outcry every year that the cost of medical insurance rises.

Medication averse

The system remains very much medically delivered and as such more interventional but with much less prescribing. Most patients are medication averse and will refuse to take even 25mg pregabalin/day. Opioids are rarely prescribed.

Although multidisciplinary work is established in university hospitals, little multidisciplinary work is possible in smaller pain centres, and most do not offer a pain management programme. We have just co-opted a psychiatrist onto the team and are exploring joint working.

Gastronomy

Finally, one of the most enjoyable aspects of our six-weekly shuttling between Switzerland and the UK is the leisurely weekend gastronomic drive through France and the Swiss Jura, which my wife and I, and our two beagles have come to enjoy tremendously.

Dr Andreas Goebel
Consultant in Pain Medicine
Liverpool/UK
Walton Centre

FIBROMYALGIA MANAGEMENT — DO PAIN CLINICS NEED TO EVOLVE TO MANAGE FIBROMYALGIA? WHAT IS THE FUTURE DIRECTION?

The nature of Fibromyalgia Syndrome (FMS)

Patients with symptoms of widespread pain and distress may have been described in biblical times[1]. Diagnostic criteria for FMS define a patient-reported phenomenon. These patients describe both experiences of widespread pain and hypersensitivities not restricted to any discernable anatomical structures, and associated non-pain symptoms including distress, dysfunction, fatigue and cognitive problems. A systematic review of FMS diagnostic criteria is available (online RCP UK *FMS Diagnostic Guidelines*, appendix 3)[2].

The most recent (2016) American College of Rheumatology (ACR) diagnostic criteria (Figure 1) stipulate that FMS is not a diagnosis of exclusion[3]; FMS can be associated with other conditions and will then typically not improve if the 'primary' condition, such as rheumatoid arthritis or Hashimoto's thyroiditis, is successfully treated. Independently, rarer conditions such as polymyalgia rheumatica can mimic FMS and appropriate treatment for these conditions, e.g. with steroids, may also resolve 'FMS' symptoms.

Is this diagnosis relevant?

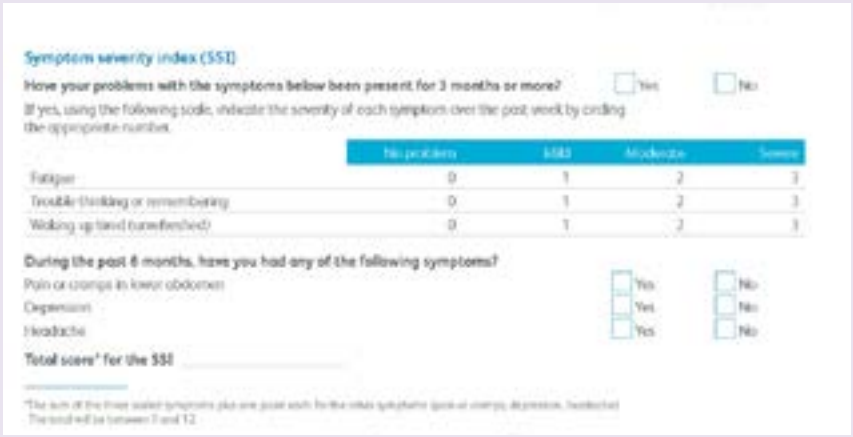
FMS is an accepted diagnosis amongst rheumatologists[3]. In Pain Medicine, whereas many UK colleagues use this term, others don't think it is relevant. For some UK colleagues it does not really matter which 'label' we give a patient with chronic pain, however what matters is a multi-disciplinary biopsychosocial approach to their pain.

The WHO has now classified FMS as a chronic primary pain condition (CPP, Box 1)[4]. Given that NICE advises[5] that (i) current medications typically don't reduce CPP, with few exceptions, and (ii) there is no evidence for any particular specific treatment for patients with specific CPPs such as FMS or CRPS, one can perhaps see why some colleagues conclude that whatever diagnostic 'label' we give is of little pragmatic relevance.

While there are complexities around applying the FMS diagnosis in patients *scoring just below the diagnostic threshold* (Figure 1)[2], clearly *not* diagnosable are: (i) those patients with widespread pain who have only few systemic symptoms such as fatigue and unrefreshing sleep, and (ii) patients with only regional pain, even if they

BOX 1: CHRONIC PRIMARY PAIN[4]

- Chronic pain in one or more anatomical regions.
- Characterised by significant emotional distress (anxiety, anger/frustration or low mood) or functional disability (interference in daily life activities and reduced participation in social roles).
- Multifactorial aetiology: biological, psychological and social factors contribute to the pain syndrome.
- The diagnosis is appropriate independent of identified biological or psychological contributors unless another diagnosis would better account for the presenting symptoms.


Symptom severity index (SSI)

Have your problems with the symptoms below been present for 3 months or more? Yes No

If yes, using the following scale, indicate the severity of each symptom over the past week by circling the appropriate number.

	No problem	Mild	Moderate	Severe
Fatigue	0	1	2	3
Trouble thinking or remembering	0	1	2	3
Waking up tired (unrefreshed)	0	1	2	3

During the past 6 months, have you had any of the following symptoms?

Pain or cramps in lower abdomen Yes No

Depression Yes No

Headache Yes No

Total score* for the SSI

*The sum of the three added symptoms plus one point each for the other symptoms (pain or cramps, depression, headache). The total will be between 0 and 12.

Figure 1: *Symptom severity index (SSI) of the ACR 2016 diagnostic criteria for FMS. For the FMS diagnosis, additionally a body map of pain-affected areas is completed allowing calculation of the 'widespread pain index' (WPI, not shown). SSI plus WPI counts constitute the total diagnostic score (reproduced with permission from Royal College of Physicians. UK clinical guidelines. London: RCP, 2022)*

have severe systemic symptoms. I argue that the FMS diagnosis does matter because i) their systemic symptoms have huge importance for patients, independent of their pain[6], and ii) patients with regional pain typically suffer substantially less in terms of functionality and quality of lifethan people with widespread pain. Correspondingly, it is likely that biological causes determine both pain distribution and systemic symptoms, compelling future bespoke treatments.

Nevertheless, for as long as the FMS diagnosis remains purely phenomenological, I suspect that the debate about its relevance may continue, and some of us may wish to apply the 'label' of either CPP, or nociplastic pain (Box 2) to patients with FMS. This field will develop, and first potential future serum-biomarkers distinguishing FMS from widespread pain are discussed below.

What are the recent scientific results that might change our FMS pain services?

I have been fascinated by the colorfulness of FMS patients' descriptions of their conditions. For example, some patients report that they are almost completely "cured" of their FMS while they are on holidays at 30C ambient temperature, whereas others with similar pain intensity and fatigue avoid heat because it increases their pain[7]. Some describe that their skin is burning, whereas others describe a gnawing, lead-like pain in their bones; yet others explain that the constant muscle ache drives them to despair. Also remarkable is the variability in FMS onset patterns. Some patients recall how they had, for the first time ever become inexplicably anxious only from a few months before their widespread pain suddenly started, although they had in fact experienced severe episodic back pains all their lives. Others give account of a long history of misery, starting with low mood and constant pelvic pain 20 years ago, with a recent pain "spread" to shoulders, then arms and hands, and "really all my body". Although these concise reports about specific symptoms appear to suggest yet-undiscovered biological causes, the sheer variability between presentations and the often evident strong distress had discouraged me from investigating FMS with similar methods as we had previously successfully done for severe persistent CRPS; in CRPS we demonstrated causal contribution from autoantibody-mediated autoimmunity in all examined patients[8-10].

But following a serendipitous observation in our CRPS experiments, we began to evaluate FMS patients' sera and ultimately identified pro-nociceptive serum-autoantibodies in each examined patient with severe FMS[11]. We achieved this by injecting patient IgG antibodies into mice and recording the mouse phenotype, which was characterised by widespread soreness to pressure

BOX 2: NOCIPLASTIC PAIN[17]

- Prompted by the redefinition of neuropathic pain[18], which now specifically excludes primary 'dysfunction' (without structural change or defined disease directly affecting the somatosensory system).
- Defined as caused by a disturbance/dysfunction in peripheral and/or central nervous system processing.
- Diagnosed where nociceptive or neuropathic mechanisms cannot better explain the patient's condition.

and cold, decreased muscle strength, reduced movement at peak activity times, mild skin neuropathology, and hyperexcitability of nociceptors. We had hence 'transferred' important aspects of the FMS condition. Such transfer is classical proof of autoantibody contribution and autoimmunity[12], and these studies were voted by scientists amongst the *Guardian*'s Top 10 science stories 2021.

Other centres have since repeated our results. Swedish and Canadian patients with FMS harbour similar pronociceptive autoantibodies as our Liverpool patients[13]. Furthermore, two independent US laboratories have recorded congruent rodent behavioural results following injection of IgG from one of our patients (unpublished).

In the FMS rodent model, unlike in the earlier CRPS model[10] no injury was required: pronociceptive autoantibodies in CRPS are different from those in FMS. This constitutes biological evidence for the sub-classification of CPP/nociplastic pains.

The FMS patients' antibodies bind to several peripheral rodent tissues, including satellite glial cells, (SGC) which surround nociceptive neurons within the dorsal root ganglia. The intensity of FMS patient IgG SGC binding directly correlates with the patients' self-reported spontaneous pain intensities, but not with their age, sex, disease duration, BMI or cold pressure thresholds - a measure of the brain's ability to suppress painful signals[14]. Although more research is needed, these findings suggest that patient-reported symptoms have biologically discernable immunological correlates, which diagnostic terms and tests ought to reflect and pick up, and which should lead to bespoke new immune treatments.

How may our pain clinics evolve to manage FMS?

The consequence of these findings is that diagnostic serum tests and immune modulating treatments for FMS should become available. For clarity, our autoantibody results do not necessarily support treatment with anti-inflammatory drugs such as anti-TNF. We have not found evidence for any classical inflammatory effects of these antibodies, rather these antibodies might predominantly change cell function by altering cell surface proteins. One obvious solution may therefore be to either reduce their serum titre — with FcRn[15], immune adsorption/plasma exchange, or plasma cell modulators — or to find a way of interfering with their cell interactions. Box 3 provides a possible, speculative technology development scenario, however, crucially, what will happen in our clinics will be determined by us as pain specialists.

We may decide not to become involved in using immune-therapeutic strategies and instead focus on pain education, rehabilitative management approaches and non-immune medication advice. We might therefore refer suitable patients for immune treatment on to colleagues with experience with such drugs. Signals from rheumatology colleagues are positive — while perhaps not typically with a core interest in managing pain, there is huge expertise and keenness in managing immune treatments. Such treatments require infrastructure; existing setups in rheumatology and neurology are often nurse led, with a consultant responsible for the overall service.

We conducted a survey amongst pain specialists in the UK and the Netherlands (2007) to find out whether pain experts would be interested in taking on the challenge of treating their patients with immune drugs, if such treatment was supported by evidence. Response rates were between 23-30% and therefore the results are not representative. The majority of pain specialists in both countries were keen to be involved in immune modulation treatment after appropriate training; in the UK 80% voted to be involved, of which half thought that pain specialists only should take this task on, whereas the other half felt that both pain specialists and other appropriate specialists such as neurologists or rheumatologists should jointly carry responsibility[16].

It is therefore likely that there is interest amongst at least some colleagues to involve themselves in the future immune diagnosis and treatment of severe persistent pains. I suggest that this future is not far away. The small trial of Rozanolixizumab (an FcRn blocker[15]) in FMS has started recruiting. Although its outcomes might well conclusively show that the antibodies which we discovered are of no consequence in humans, any positive signal will foster further trials. We should know results within two years.

COI statement

Dr Goebel is supported by the Pain Relief Foundation, Liverpool. He has received consultancy fees from UCB and Novartis.

BOX 3: HYPOTHETICAL SCENARIOS OF TECHNOLOGY DEVELOPMENT FOR FMS IMMUNE DIAGNOSIS AND THERAPY

In 5-7 years:

- A diagnostic serum test is available.
- A NICE-recommended immune modulation treatment option exists for severe cases.
- Multidisciplinary assessment for immune modulatory treatment has been fashioned to neuromodulation approaches.

In 15-20 years:

- A range of serum tests will i) identify patients at risk, ii) discern subgroups, and iii) inform patients about their prognosis.
- A choice of NICE-supported immune modulation treatments will permit patient-centered choices, balancing effects with adverse effects.
- Understanding the pathogenesis of overlapping conditions[19], such as pelvic pain or back pain will have progressed sufficiently to offer evidence-based treatment choices.

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Dr Ganesan Baranidharan
PSC Chair & Vice Dean

PROFESSIONAL STANDARDS

The Professional Standards Committee continues its work with new members appointed. We have updated most of the key documents on the Faculty website, thanks to all the hard work from the PSC members. We are updating patient information leaflets with involvement of PatientsVoices@RCoA.

Opioids

The FPM has been successful in getting a grant from Annabel's Foundation. The funding has helped appoint two part-time fellows who are currently reviewing all the documents within Opioids Aware, updating the references, and aligning with various new publications in this area, such as CDC guidelines. Dr Barry Miller and I will oversee the work. The guidance for fellows on opioid reduction is currently under review. Once patient and public involvement is completed, this will be published.

Education and innovation

The FPM Education Sub-Committee is being established, which will report to the Training & Assessment Committee. It will help develop the educational needs of the members of the Faculty and the broad speciality The 'Innovations' page on the FPM website provides an excellent opportunity to share any best practices with the Fellows. We invite you to consider sending a short review of an innovative work done within your service: www.fpm.ac.uk/standards-guidelines/innovations.

Publications

We are always happy to receive suggestions from fellow members on essential areas to focus on and improve. We are happy to consider any proposals.

Core Standards Gap Analysis Survey

The *Core Standards for Pain Management Services* (CSPMS 2021) set out the expected standards for chronic pain services operating in the United Kingdom. The CSPMS covers both acute and chronic pain services.

This gap analysis survey aims to identify the existing gap between the desired best practice in chronic pain as laid out in CSPMS and the actual reality on the ground. This will highlight the current state of pain management in the UK post Covid.

Addressing the cause of the identified gap (knowledge, skills, local resources etc) would then be helpful to move towards the desired best practice state. The results will be fed back to you to compare your service with the national compliance of the standards.

The second part of the Gap survey aims to obtain your opinion on the standards[2] that should be recommended to ACSA (Anaesthesia Clinical Services Accreditation) RCoA as clinical accreditation standards. The FPM is in conversation with ACSA RCOA on this issue and has received a positive response.

This survey exercise is very important from the point of view of Pain Medicine as a specialist service and we do hope that you will respond by giving about 45 min of your time to complete this survey to provide a national snapshot of the state of pain services and where improvements are needed.

References

1. www.fpm.ac.uk/standards-guidelines/core-standards
2. www.rcoa.ac.uk/safety-standards-quality/anaesthesia-clinical-services-accreditation

Dr Nick Plunkett
Chair FFPMRCA

RCoA INDEPENDENT EXAMS REVIEW — FPM PERSPECTIVE

In 2022, Professor John McLachlan was requested by the RCoA to conduct an independent review into the principles and processes of all examinations that take place under the auspices of the RCoA — FRCA Primary, FRCA Final, FFICM examination, and the FFPMRCA examination.

Professor McLachlan conducted a rigorous process, reviewing relevant data, procedures and processes, and interviewed colleagues within the RCoA and Faculties executive structures, as well as from the RCoA Examinations Department, examiners, candidates and trainees to produce a final report which was published in January 2023.

Delivery difficulties

It is worth noting that the specific reasons for commissioning the external review was in response to some communication and exam delivery issues that occurred in FRCA exams, as well as an unexpectedly low pass rate for the FICM exam. There had been no specific issue in relation to the delivery of the FPM exam. It was noted that these exams took place during the COVID-19 pandemic — responsible for so much stress on the health system — and was a particular factor in the difficulties that arose. In the FPM exam, we have perhaps been fortunate that there were no glitches with the delivery of our exam remotely. However, as an exam we have not been complacent – and the issues that beset other examinations could equally have impacted our own.

I would encourage you all to read the external review, or if time constrained the executive summary. Professor McLachlan has been focused on numerous aspects of the exam; looking at the structure and content of assessment, standard-setting, and examination governance. He also reviewed examiner culture and conduct, candidate engagement, communication, and back-office functions such as data, infrastructure, and psychometric capacity, producing a total of 28 recommendations — a wide-ranging and in-depth review.

Positive reflections

We have reflected on the recommendations with great positivity, and have formed a view that all recommendations of particular relevance to the FPM exam will be considered for future adoption. We consider that the recommendations with respect to changes in standard-setting (to be adopted across all RCoA exams) will represent only a modest change to our current exam quality assurance processes including pass mark setting for the MCQ and SOA exam. The standard required will remain the same, and although the particular assessment modalities will change (see below), candidates, Members and Fellows should be reassured that the exam quality assurance methodologies will remain rigorous as expected for a high stakes exit-type examination. With respect to changes to assessment modalities, we have agreed to adopt the recommendation to end the use of MTF (Multiple True False) questions as part of the MCQ exam and expand the use of SBA (Single Best Answer) and EMQs (Extended Matching Questions).

In addition, we wholeheartedly agree with the recommendation to consider OSCEs as a more substantive part of our assessment process. SOEs we feel have served the exam and candidates well in the past. However, OSCEs have the ability to specifically test aspects of communication skills, which is a very significant part of our professional work, and more practical aspects such as demonstrating knowledge and skill in assessing anatomy, imaging, and performing interventions.

As per the recommendations we are also keen to continue close engagement with trainees through the Trainee Representative at Board level. In addition, as advised, we

hope to continue to encourage the widest possible application for FPM examinerships, as we continually renew our examiner pool, and in particular invite applicants irrespective of gender or ethnicity.

Development and assurance

As a College response to the recommendations, RCoA has convened a specific body — the Exam Development and Assurance Group (EDAG). This group is made up of leads from all the exams, as well as senior representation from the Examinations Department, including the Head of Examinations (Fiona Daniels), as well as the Director of Examinations Training and Education (Russell Ampofo), which will plan and deliver the required changes according to a timetable going forward, with new exam delivery for the academic year of 2026/2027.

Fellows will also be aware that the Faculty is progressing with the Credential for Pain Medicine with the GMC. It is envisaged that the FPMRCA exam will be a key component of the credential. It is important that whilst we develop the new examination format, in principle the newly developed exam is fit for purpose for assessing candidates who may come from a different parent college — such as the Royal College of Physicians.

In terms of feedback to date, it is gratifying that candidate feedback with regard to the content and conduct of examinations remotely during the pandemic (and continuing with remote delivery of the MCQ) has on the whole been overwhelmingly positive, which is in many ways the most important and relevant endorsement to take forward. In addition, the RCoA has held two listening events — one for examiners and one for all Fellows/trainees, and no specific concerns have been raised in relation to the adoption of recommendations relevant to the FPM examination as outlined above.

We are keen to continue to canvass the views of Fellows and trainees on the Review and Recommendations, and invite comment via https://forms.office.com/e/ZP0K8fBA7R. We would also like to reassure all future candidates that any changes will be signalled well in advance.

To read the full report and the Faculty's response, please visit:

www.fpm.ac.uk/fpm-statement-response-independent-review-assessment-processes-rcoa

FFPMRCA EXAMINATION CALENDAR

	FFPMRCA MCQ	FFPMRCA SOE
Application and fees not accepted before	Monday 22 May 2023	Tuesday 1 August 2023
Closing date for FFPMRCA exam applications	Thursday 6 July 2023	Friday 15 September 2023
Examination date	Wednesday 23 August 2023	Tuesday 17 October 2023
Examination fee	£585	£815

Visit www.fpm.ac.uk/training-examinations/ffpmrca-examinations for the latest news.

Dr Jonathan Rajan
RAPM Chair

RAPM UPDATE

Persephone is the Greek Goddess of Spring. I am sure she would approve of the blossoming array of challenges and opportunities, that sets the tone for 2023.

New curriculum

There is no doubt that the new curriculum has raised the bar and the relevance of Pain Medicine training. Many will be getting to grips with the new curriculum at the coal face. To that end please do visit the training section of the FPM website, which have been updated to reflect the new curriculum. Feedback about any of the challenges and possible solutions to implementing the new curriculum are warmly welcomed. As a reminder, Stage 1 should be signed off with some oversight from the local Faculty Tutor and Stage 2 and 3 should have direct input from local Faculty Tutors.

The availability of pain training sessions within region and accessibility of pain training posts nationally continues to be an issue. Recent discussions are focused on overcoming challenges with regards to training opportunities for the Special Interest Area (SIA) in chronic pain, with two possible contributory solutions. One model being explored endeavours to ensure pain vacancies not filled locally are then made available by Health Education England for pain trainees out of region — rather than being usurped by anaesthesia locally.

Another option being discussed is whether trainees completing a SIA in chronic pain can do so across different hospitals within region. This may help to combat the potential pitfall of reduced pain sessions in individual centres traditionally used for SIA level pain training and make the most of region wide educational opportunities.

Paediatric pain training has always been somewhat challenging to achieve nationally. For Stage 1 and 2 paediatric pain training, Supervised Learning Events (SLEs) may be obtained in paediatric anaesthesia, augmented in part by e-learning from the excellent RCPH resource.

The Triple C forms available on the Lifelong Learning Platform will also enable trainees to collate different learning outcomes from different hospital training locations. This should help provide the evidence required to sign off HALOs in Pain Medicine.

Trainee Representatives

Responding to feedback from trainee representatives, the RAPMs have given permission for the Faculty to send their emails to registered trainees. Moving forward there may be a national induction day for pain trainees which Dr Berwick, the outgoing Trainee Representative has been spearheading. Pleasingly there has been an increased appetite to become a trainee representative of the Faculty.

RAPM and Faculty Tutor Day

I look forward to welcoming you on the November Regional Advisors' Day and a Faculty Tutor study day. Please can Regional Advisors ask their trainees to submit any questions that they wish to have answered regarding pain training and a career in Pain Medicine in general, for the upcoming Faculty Tutor study day.

FPM Thrive

I would encourage you all to have a look at the FPM Thrive section of the Faculty website and consider signing up: www.fpm.ac.uk/careers-workforce-wellbeing/fpm-thrive. In conjunction with other initiatives such as EPM, this will strengthen the link between consultants and prospective pain trainees.

Last but not least I would like to thank Dr Peter Cole for his work as RAPM for Oxford, and congratulate his successor, Dr Mohjir Baloch. My thanks also to Dr Dominic Aldington for his work as RAPM for Wessex, and congratulations to his successor, Dr Jo Harding.

Dr Victor Mendis
FPMTAC Chair

TRAINING & ASSESSMENT

I would like to welcome Dr Jonathan Rajan (new RAPM Chair), Dr Sibtain Anwar (new EPM Lead) and Dr Nicola Johnson (new trainee representative), and wish to thank Dr HooKee Tsang (outgoing RAPM Chair), Dr Helen Makins (outgoing EPM Lead) and Dr Richard Berwick (outgoing Trainee Representative) for their hard work and contributions to TAC.

A special thank you also goes out to Mrs Claire Driver-Edwards, the Training and Membership Administrator who has now left the Faculty.

Exam review

The independent review of the College's exams was published recently which captures the experiences and views of trainees and examiners and we are aware of the impact of the exams not only on our trainees' careers but also on their personal lives. Discussions are underway around the alignment.

Standards and preparation

]The standard setting methods and the timetable will run from 2023 to 2026. It has been designed in line with the capacity of the exams team and examiners. The new Exams Assurance & Delivery Group (EDAG) has now been formed with representatives from FICM, FPM and RCoA. A minimum of 12 months' notice will be given to any changes to the exam. We therefore request that candidates do not change the way they currently prepare for the exams.

Unfilled posts

TAC is aware of unfilled APT posts in some regions and is exploring the possibility of enabling trainees from outside these regions to apply. We will reach out to the deaneries to support their trainees in all elements/stages including the use of Inter-Deanery transfers, OOPT and the adoption of a more flexible approach with the support of HEE for APT posts.

EPM and FPMLearning

The expansion of the online content continues with a fourth module in the series currently being finalised. EPM is keen to recruit more instructors and further information will follow. There are now opportunities to run courses with the Mercy Ships charity over the next year and further self-funded places will become available.

There has been progress in terms of searchability of the FPMLearning hub site and the area on pain guidance has been enhanced. A new section on radiology and Pain Medicine is now live: www.fpm.ac.uk/fpmlearning/radiology-corner.

Communication skills

Dr Helen Makins has done a fantastic job in planning an event on this topic, which we plan to run in autumn 2023. Watch this space for more details and booking information in due course.

Workforce

The workforce census has now been completed and the report will be published in due course. Workforce shortages across our specialities are well-known and are severely limiting the ability of the NHS to treat patients. I do hope that this data can be used to urge the government not only to take steps to increase the workforce. We understand the importance of improving the working lives of our junior doctors and their financial situation in order to retain them within the NHS and hope this issue is resolved soon.

INTEGRATION OF A NOVEL DIGITAL AUTOMATED PROMS PLATFORM INTO PAIN MANAGEMENT

Dr Adnaan Qureshi
Consultant Anaesthetist
Newcastle upon Tyne

Dr Sachin Rastogi
Consultant Anaesthetist
Newcastle upon Tyne †

An Electronic Healthcare Record (EHR) is an electronic version of a patient's medical history. These applications are becoming increasingly ubiquitous in NHS organisations and are actively promoted in national strategy documents such as the *NHS Long Term Plan* and the *NHS 5 Year Forward View*, by way of the Digital Global Exemplar initiative[1].

Whilst these systems have undoubtedly improved end user access to clinical data, few of these large packages incorporate patient reported outcome measures (PROMs) data into their core platform. The NHS itself has also lagged behind in the adoption of PROMs data into routine clinical practice, with their use previously limited to elective arthroplasty patients[2].

Cloud-based solution

The lack of means to collect, analyse and use PROMs data to drive clinician led quality improvement and assurance projects in his own Trust led Dr Adnaan Qureshi to develop his own bespoke cloud-based solution, named after his place of work. www.NewcastlePROMs.co.uk allows clinicians to invite, collect, analyse and report data and trends in patient provided data. The platform is purely mobile phone text message (SMS) based and allows patients to access mobile device optimised, fully accessible and language switchable web forms which are created specifically for each client or clinical service.

At the time of inception in 2018, the platform was used to collect outcome and satisfaction data from patients on a well-established upper limb regional block day-case trauma pathway. The platform allowed for the dissemination of patient information, safety net instructions and collection of quantitative and qualitative/satisfaction based postoperative data. The platform was popular amongst colleagues and expanded to other similar day case pathways, including obstetrics which made use of the clinician alerts (red flags) and action lists which aided front line staff in capturing and managing potential complications, such as post-dural puncture headache, at an earlier stage than without automated data collection.

Why SMS?

SMS was used as the primary method of communication with patients for two reasons:

1. It has a far superior 'open rate' when compared to email[3], which is generally troubled by unsolicited messages and spam.

2. SMS allows the whole process to be automated after the initial patient registration and provides a log of all messages exchanged with the patient. The result is a reliable end to end process which requires minimal human involvement. A recent publication evaluated the use of this platform in their day case surgery patients and reported an overall follow-up rate of 85%, which is consistent with other clinical services[4]. (See Figure 1)

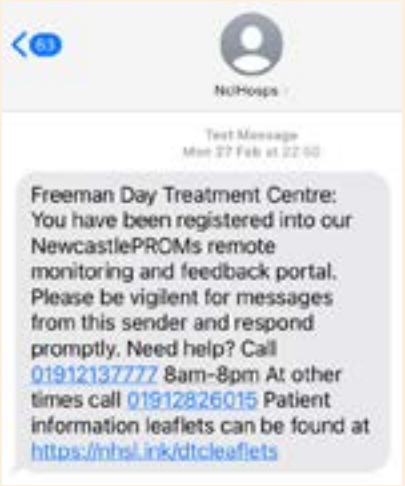


Figure 1: *Example patient SMS with client-specific Sender and auto-generated short link to digital documents.*

Functionality

Interest in the platform has been consistently on the rise, with expansion to other NHS Trusts and non-NHS organisations / care providers. The reason for this continued growth in this platform is likely down to the unique aspects and functionality it provides. Being able to call upon the experience of an NHS Consultant with a track record in implementing PROMs solutions is highly valued by clients tasked with creating packages for use within their own clinical services. Whilst front line staff ultimately get on demand access to patient data, which can be used to support quality improvement and audit / research activity, line managers also get access to rich and interactive data. These Key Performance Indicator (KPI) dashboards and at-a-glance traffic-light coded graphical snapshots of data facilitate identification of areas of notably good or poor outcomes. (See Figures 2 and 3)

Feedback

Within Pain Medicine, Dr Qureshi and colleague Dr Sachin Rastogi, a consultant in chronic pain management, are currently planning a bespoke application to digitise and automate the process of PROMs data

Figure 2: *KPI Dashboards are available for operational measures as well as clinical outcomes*

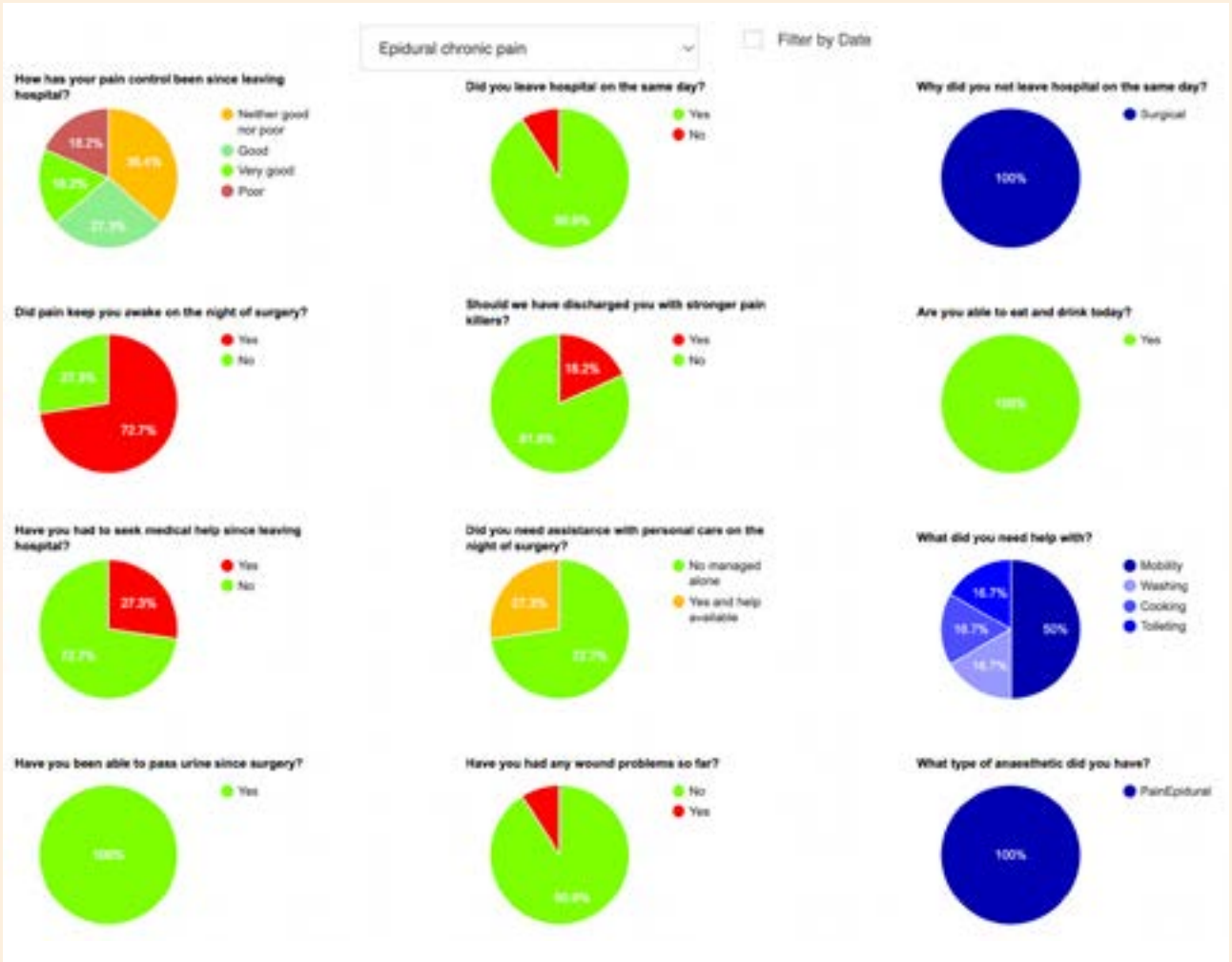


Figure 3: *At a glance "Quickcharts" providing colour coded filterable overviews of large data sets.*

collection from patients undergoing interventional pain procedures (eg medial branch blocks, rhizolysis, nerve root injections) within their own Trust. The process of post procedure feedback is currently undertaken using traditional methods of paper forms in the post, adding a practical burden on patients to complete and return these surveys, which are eventually manually transcribed onto spreadsheets. This process represents a significant administrative burden, and the lack of on demand access to live data and trends has restricted the real world application of this information on the development of the clinical service.

The new system will aim to provide patient specific and overview charts of various surveys and measures over time, including numeric pain scores, functional outcomes, and patient satisfaction (see figure 4). The goal will be to enhance the clinical decision making of chronic pain specialists as well as providing more accurate and precise outcome data on demand.

Showing value

It is hoped information derived from the platform will support the pain service to demonstrate to commissioners the outcomes and value of chronic pain interventions over time. It will also support individual clinicians in understanding and improving their own performance and outcomes, and ultimately that of the pain service. This will be

aided by the addition of the optional Consultant Feedback module, which collects anonymised GMC feedback from patients for use in Consultant appraisal and revalidation processes.

An additional objective of the incorporation of digital PROMs into the service will be to assess ongoing safety and efficacy of patients prescribed specialist pain medications such as ketamine and nabilone, and to collect multidimensional outcomes measures within the paediatric chronic pain service.

NIAA research

www.NewcastlePROMs.co.uk is also the chosen supplier of digital services for an upcoming National Institute of Academic Anaesthesia (NIAA) funded research project: the POPPY study — Patient reported Outcomes, Postoperative pain and Pain relief after day case surgery. This will be a SMS based observational cohort study across the UK, looking at PROMs data for day case surgical patients after hospital discharge up to the third month after surgery.

The focus will be on determining the prevalence of persistent post-surgical pain and persistent post-operative opioid use in this population for the first time in the UK. The study will also evaluate and comment on the feasibility of using SMS based digital systems for this type of research in the future.

Special acknowledgements to Miss Kate Woodhouse, Admin Team Lead at Newcastle Pain Service, who has been instrumental in driving the pain management aspect of this project forwards.

References

1. https://www.england.nhs.uk/five-year-forward-view/next-steps-on-the-nhs-five-year-forward-view/harnessing-technology-and-innovation/

2. https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/patient-reported-outcome-measures-proms.

3. https://www.campaignmonitor.com/

4. Jennison H, Vanstone R. A service improvement report on the use of text messages to follow-up after day case surgery. The Journal of One-Day Surgery (JODS — a publication of the British Association of Day Surgery S32.2 May 2022.)

Figure 4: *Automatically generated Wordclouds can be configured on free text fields.*

EVENTS UPDATE

Dr Devjit Srivastava
Lead Educational Meetings Advisor

Dr Adam Samways
Educational Meeting Advisor - Trainee representative

The FPM Annual Meeting was held on 25 November 2022. This year, we were delighted to hold the event in person at the RCoA. The quality of the speakers and presentations was excellent with good attendee feedback.

Dr Cathy Stannard opened the day, giving a very interesting insight into skills professionals working with people in pain may consider taking further training in, such as trauma informed care, motivational interviewing, health coaching and attachment disorder. Dr Ganesan Baranidharan followed with a discussion of the potential to treat vertebrogenic low back pain in patients with associated MRI modic changes with basivertebral nerve targeting. Dr Andreas Goebel then delivered a very informative talk on fibromyalgia management, the future direction and whether pain clinics need to evolve to manage fibromyalgia (see page 11).

An update on Faculty developments and ongoing projects, such as credentialing and FPM Thrive, was provided by Dean Dr Lorraine de Gray. Congratulations to Dr Helen Makins, Dr Rob Searle, Dr James Taylor and Dr Anna Weiss who received commendations for their contributions to the Faculty.

Patrick Wall Lecture

The Patrick Wall Lecture is the highest lectureship awarded at the FPM, and this year it was a pleasure to welcome Prof Sam Eldabe. Prof Eldabe gave us a wonderful insight into his extensive career, including research on persistent postoperative pain following lumbar spine surgery, the long-term impact of spinal cord stimulation in failed back surgery syndrome and the I-WOTCH study.

The first winner of the trainee poster competition was Dr Ahmed Salama. Dr Salama presented the results of a very interesting audit looking at 'Assessing virtual pain clinic efficiency in the UK'.

In the afternoon Dr Raj Munglani delivered his lecture on the ICD-11 pain classification and chronic primary pain definition. Dr Munglani explained and looked at how NICE applied this new ICD-11 pain classification to its latest NG-193 Guidelines, and how these may be interpreted in everyday practice.

Dr Mick Serpell then discussed the use of NSAIDs in acute low back pain.

Debate

Following on from this, there was a compelling debate between Dr Lars Williams (For) and Dr Arun Bhaskar (Against) who questioned if interdisciplinary pain management programmes are evidence-based. After a lively and informative discussion, both sides were able to agree that although everyone is striving to deliver individualised and cost-effective patient-centred care, more evidence in this area would be beneficial.

The final presentation was delivered by consultant neurologist Dr Benjamin Wakerley, who gave an insight into Botulinum Toxin (Botox), its uses for migraine and mechanism of action at the neuromuscular junction.

Any suggestions?

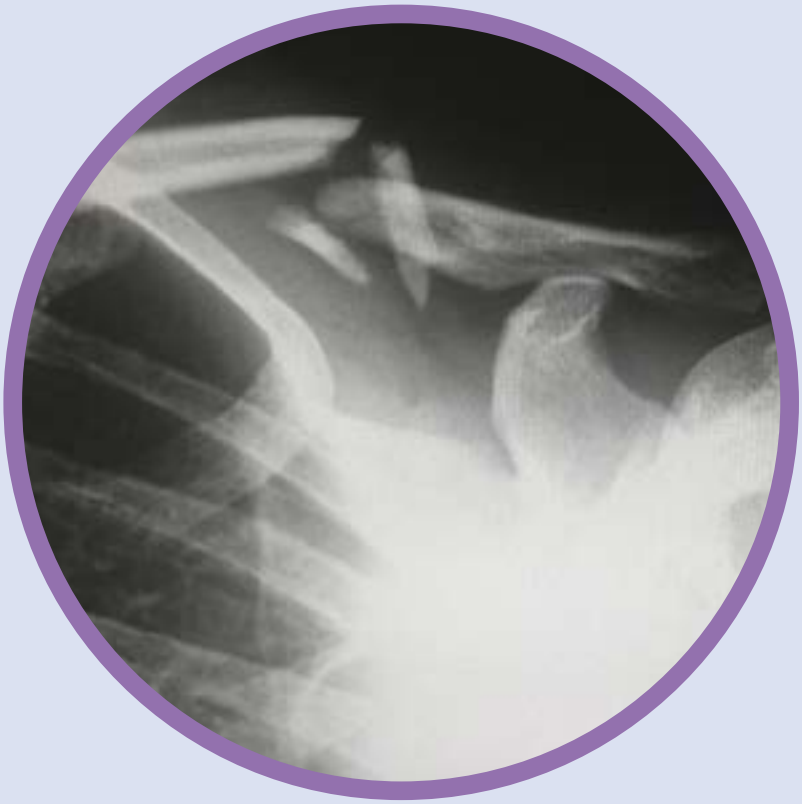
If you have a relevant event topic or speaker suggestion, please email dev.srivastava@nhs.scot.

Faculty Commendations: *Dr James Taylor, Dr Anna Weiss, Dr Rob Searle. Dr Helen Makins*

Patrick Wall Lectureship: *Dr Ganesan Baranidharan, Prof Sam Eldabe, Dr Lorraine de Gray*

The FPMLearning Editors are pleased to introduce

RADIOLOGY CORNER



Promoting learning about different radiological presentations related to chronic pain.

Send us your contributions at contact@fpm.ac.uk.

www.fpm.ac.uk/fpmlearning/radiology-corner

FPMLearning is updated every month. Be sure to have a look at the FPM's open resource for all pain trainees, providing a variety of teaching materials including case reports, journal club, recommended reading and podcasts.

www.fpm.ac.uk/fpmlearning

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