FACULTY OF
PAIN MEDICINE
of the Royal College of Anaesthetists

A CREDENTIAL for the PAIN MEDICINE SPECIALIST

CURRICULUM PROPOSAL

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Section 1

Introduction

1.1 Purpose Statement

The purpose of a **Credential in Pain Medicine** is to allow the identification of doctors who have the necessary specialist professional and clinical capabilities to manage complex pain including where pain is a condition in its own right. This includes patients with acute and chronic (long-term) pain disorders. Pain management is a **basic human right,** and it is the responsibility of any health care system to ensure that there is a **sufficient workforce** of doctors **specifically trained** in **holistic Pain Medicine** to **safely alleviate pain.**

Specialists in Pain Medicine are doctors who undertake the comprehensive management of patients with acute, acute on chronic, chronic and cancer related pain using physical, pharmacological, interventional and psychological techniques in multidisciplinary and multi-professional settings: in-patient, out-patient and community.

The generic capabilities described in this document apply to all aspects of the scope of practice of a Pain Medicine specialist, while the specialist capabilities described can be focused to specific clinical environments. While the vast majority of pain specialists will work in a chronic pain outpatient service, some pain specialists will train to use their skills primarily in, a community-based service, inpatient (including perioperative and admissions with complex pain conditions) or cancer pain working in conjunction with palliative care services.

Definitions used in pain management:

- **Acute pain** is common following all forms of tissue injury but will usually resolve within 3 months once the traumatic, infective or inflammatory process that triggered the pain has been managed. A Pain Medicine specialist has the necessary knowledge and skills to lead an in-patient pain service, run an in-patient pain team session and contribute to patient care and service development for inpatient pain conditions occurring on surgical, medical and high dependency ward settings. [SCP: 1, 4, 5, 6, 8] These may include patients who require perioperative pain management and patients on medical wards who are admitted due to acute exacerbation of chronic complex pain conditions.
- **Chronic pain** is defined as pain lasting for longer than three months or pain that extends beyond that expected of normal healing time. Chronic pain affects 20% of the population worldwide and is responsible for up to 20% of visits to primary care doctors. At any one point in time 8 million people in the UK suffer from chronic pain with 6 – 8% of the population suffering chronic pain severe enough to interfere with normal aspects of daily living. Chronic pain can arise from many conditions including back pain, arthritis, post-surgical treatments, fibromyalgia, headaches, neuropathies and stroke. The healthcare costs of chronic pain patients are generally 2.6 times those of patients with mild or no pain. There are significant social issues associated with long term poorly managed chronic pain, including consequences for the welfare system, family and work disruption, opioid consumption risks and worsening mental health. A Pain Medicine specialist has the necessary knowledge and skills to lead a community, secondary or tertiary chronic pain service, independently run an outpatient clinic, treatment or intervention session and contribute towards the wider education needs and service development for the multidisciplinary team. [SCP 1, 2, 3, 4, 6, 7, 8, optional capabilities in Neuromodulation or Paediatrics]. This may include training of other doctors towards achieving a Credential in Pain Medicine and also training of other health

professionals in achieving an HEE (Health Education England) or other devolved nations Health Education *Credential in Pain Management.*

- **Cancer pain** arises directly from a cancer or as a consequence of the surgical, chemotherapy and radiotherapy techniques used to treat it. While palliative medicine specialists manage the burden of cancer pain, in complex cases not responding to palliative care measures, Pain Medicine assessment and management including interventional techniques, such as coeliac plexus blocks, intrathecal drug delivery and cordotomy, are recognised as being an important part of the cancer pain treatment pathway yet training in these techniques is within the domain of Pain Medicine. A pain specialist can perform interventions and work cooperatively with the palliative care service in a tertiary cancer centre or hospice setting to manage complex cancer pain. [SCP 1, 2, 3, 4, 6, 8 + specialist capabilities in cancer outcome 1&2]. Pain in 'survivors' of cancer, and its treatments, maybe a long-term complex multifaceted issue.

Epidemiological population studies anticipate the burden of chronic and cancer related pain will increase in the coming years, due to ageing and musculoskeletal frailty, increased surgical procedures, diabetic complications and cancer survival improvements. Workforce planning has identified that the pain management workforce is already overstretched and insufficiently placed to meet these future demands.

To date, consultants practising in Pain Medicine have had to complete Higher and Advanced Pain Training within the 2010 *Curriculum for a CCT in Anaesthetics*. In line with the GMC launching new curricula in 2021 (delayed from 2020 due to the COVID-19 pandemic), the new *2021 Anaesthetics Curriculum* includes Level 3 SIA (Specialist Interest Area) training in Pain Medicine and will supersede the previous Higher and Advanced Pain Training in the 2010 Anaesthetics Curriculum. Level 3SIA Chronic Pain Medicine training reflects the Generic and Specialist Capabilities within this curriculum, and it will be expected that trainers and trainees will use this curriculum (which sets out the syllabus in greater detail) to guide training.

a. Increasing Access to Training in Pain Medicine

This Credential will allow access to training not only to holders or would-be holders of a CCT, CCST or CESR in **Anaesthesia**, but it will also allow access to training for doctors who are either in Training (by way of an OOPT or OOPE) or holders of a CCT or CCST or CESR in **Palliative Care**, **Neurology**, **Rehabilitation Medicine** and **Rheumatology**. Cross mapping of the curricula has indicated that doctors in the aforementioned specialities have the necessary core knowledge and clinical skills to allow them to safely and successfully embark on training for a Credential in Pain Medicine.

The Credential will also allow access to training **Non-Consultant Career Grades** (NCCG) (SAS grade doctors) in the above five specialities. To date it has not been possible to train NCCG and recognise them as independent practitioners, but the Credential will allow this opportunity and we anticipate that this will have a positive impact on the workforce numbers. Once established, it may also be possible to open the Credential to other **doctors in other specialities,** but this will require further cross mapping of curricula.

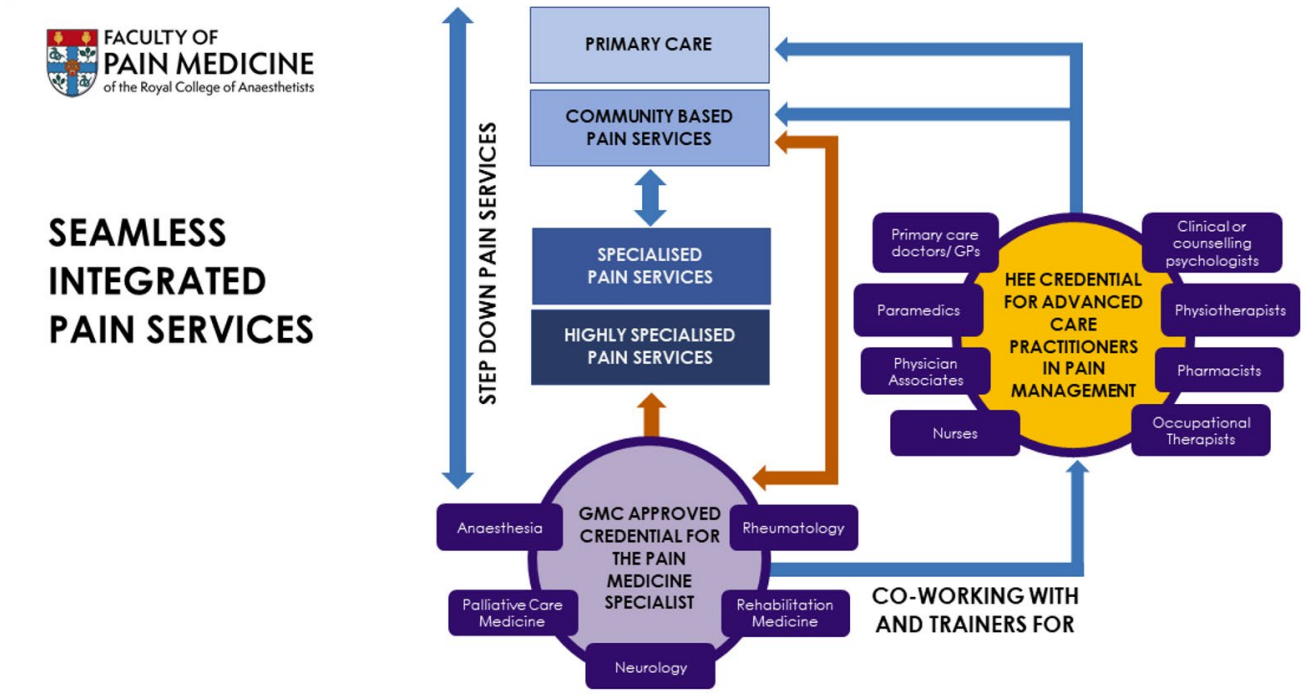
While **all Credential holders** will be expected to have the theoretical knowledge to be able to assess, refer, and manage complications arising from interventions, it is anticipated that procedural work will *not* be a significant focus for all specialists. All doctors training for the Credential will however be expected to achieve proficiency in a set number of procedures as indicated in the section on interventional practice in Pain Medicine on Page 11. Moreover, all doctors will be expected to have the necessary training in resuscitation skills required to manage rare but potential adverse events of interventional pain procedures, such as a total spinal, inadvertent intravascular injection of local anaesthetic or anaphylaxis.

For more specialist interventions, listed as key S and R in Annex C – Pain intervention procedures, holders of a Credential in Pain Medicine with a base specialty of Palliative Care and Neurology may opt not to perform many of the interventions whereas doctors with a base speciality of Rehabilitation medicine and Rheumatology may do more as there will be more overlap with their own speciality interventions. It is also recognised that there is flexibility within existing advanced training programs to tailor the amount of interventional exposure according to the career aspirations of the anaesthetist and the same flexibility will apply regardless of base speciality.

b. Interlinking with HEE for Advanced Care Practitioners in Pain Management

The Faculty of Pain Medicine is committed to working with the GMC and other stakeholders within the four nations, to support the development of Credentialing in Pain Medicine for doctors working in primary, secondary and tertiary care. The FPM is also currently working with Health Education England to implement a Credential for Advanced Care Practitioners in Pain management for other health professionals and primary care doctors.

The two Credential holders will interlink services offering a step up and step-down pain service, providing patients with a seamless journey in their diagnosis, treatment and long-term management of pain. Working effectively together Credential Holders will provide the population of patients living with pain, safe and timely effective access to Pain Medicine with multidisciplinary pain management, promoting personalised care and self-management, prevention of disability, promoting medicines optimisation and helping patients to remain or return to a functioning level commensurate with their age and full capabilities. This will in turn have a positive impact on reducing impact and dependence on the social welfare system, helping people with long term pain remain in work and education.



1.2 Specification for a doctor holding a Credential as a specialist in Pain Medicine

A Credential in Pain Medicine creates a GMC recognised specialist who:

- has the necessary knowledge and skills to safely manage complex in-patient, outpatient and community acute, acute on chronic, and chronic pain conditions
- has the ability to practise independently and within multidisciplinary teams,

- can perform or advise/signpost regarding the need or complications of certain interventional pain management techniques appropriate to their training and area of clinical practice,
- can undertake posts where a minimum of 4PA of weekly DCC sessions are related to working in the field of Pain Medicine
- is a leader in Pain Medicine quality improvement processes,
- undertakes lifelong learning to fulfil revalidation in Pain Medicine to maintain the Credential
- participates in training and teaching strategies at local and national level
- is affiliated to the Faculty of Pain Medicine (FPM) and upholds FPM Core Standards for Pain Management Services in the UK.

1.3 Why is a credential in Pain Medicine needed?

There are several reasons why Pain Medicine will benefit from becoming a credential under the new GMC pathway. These include:

a. Raising standards in pain management

There are clinicians practising Pain Medicine in isolation and others who practice beyond their base specialty, performing interventional pain procedures in isolation within the NHS and private sector. There are also consultants who have side-stepped internally within departments to provide service cover for pain clinics without undertaking formal re-training. Quality standards in pain management, as set down by the Faculty of Pain Medicine[1], recommend that pain services should be staffed by appropriately trained individuals who work within multidisciplinary teams and that interventional procedures should be not be performed in isolation, but as part of a holistic package of care. Establishing a credential in Pain Medicine as the *minimum* standard that a specialist in the UK must achieve to practice in this area, will encourage employers to seek appropriately qualified individuals to fill areas of need within Pain Medicine. A credential will encourage those interested in providing Pain Medicine to seek avenues of high-quality training and to work in environments appropriate for the delivery of good quality pain management. **This will raise standards of delivery of Pain Medicine and improve access to and quality of care and safety for patients.**

b. Improved access to Pain Medicine training

Pain management is a universal responsibility for all health care professionals, yet undergraduate teaching and postgraduate medical training in Pain Medicine is almost entirely limited to the anaesthetic curriculum. It is currently difficult for non-anaesthetic specialists to gain out-of-programme pain training; to date only a handful of non-anaesthetic trainees have been able to pursue advanced Pain Medicine training in the UK (this has mostly occurred at a post-CCT level).

Credentialing will raise the profile of Pain Medicine as a sub-specialty, providing candidates with a recognised 'qualification' to enhance their portfolio and justify the period of training within CCT programmes to Training Programme Directors. Credentialing will also broaden the delivery of pain management training beyond existing medical boundaries. Currently Specialists in Palliative Care medicine, Rheumatologists and Neurologists all care for patients with persistent pain. However, most do not have the necessary depth of training and service support to manage these complex patients well. Credentialing in Pain Medicine will allow specialists from other fields to enhance their skills in pain management and improve patient care within their own services, within multidisciplinary working and as part of a multidisciplinary pain service. Credentialing will also allow access to training to Non-Consultant Career Grades. All of this should lead to an increase the

[1] Core Standards FPM

breadth of access and in the current work force numbers which is greatly needed to meet the current needs and potential increase in future need, as is likely to be seen with 'Long COVID'.

c. Future workforce planning

Currently 98% of Pain Medicine specialists in the UK hold a CCT or CCST in Anaesthetics [2017 Pain Medicine census]. This contrasts to the situation in Australia where multi-speciality pain training is well established and approximately 66% of pain specialists are Anaesthetists. Recruitment into Pain Medicine training from anaesthetics alone is not expected to meet the predicted workforce shortage in the next 20 years (anaesthetic output is increasingly stretched by Intensive Care Medicine (ICM) and perioperative medicine expansion in secondary care). There are instances of regional shortfall where pain services have been decommissioned due to lack of suitably trained specialists. It is hoped that the professional status that a credential will confer will encourage anaesthetists and other medical specialists to undertake Pain Medicine training and stabilise the UK workforce in Pain Medicine.

Additionally, the transfer of some pain facilities to non-medical community treatment centres has been detrimental to training in Pain Medicine as alternative providers will rarely provide training opportunities. Credentialing will help to maintain professional standards in service redesign and ensure that wherever pain management services are being reconfigured they will be delivered by an individual that the FPM and GMC recognise as meeting recognised standards and who can also continue to provide training for the next generation of Pain Medicine specialists. **Credentialing will also allow seamless integration** between community, secondary and tertiary services, and will provide step up and stepdown opportunities for patients to be managed appropriately.

d. Improved recognition of Pain Medicine training

Pain Medicine is recognised as a speciality, in many other countries, including Australia and New Zealand. Since the closure of the new UK CCT applications routes in 2010, training in Pain Medicine has remained under the umbrella of anaesthetics and cannot be independently recorded on the specialist register. Yet an anomaly exists whereby non-EU trained Pain Medicine doctors are recorded on the GMC register as being pain specialists. In addition, there are consultants in the UK who practice only in Pain Medicine, yet they are still listed as anaesthetists on the GMC register.

The creation of a credential in Pain Medicine will help to solve these issues, providing recognition for UK trained Pain Medicine specialists, providing a better method to recognise the Pain Medicine skills of overseas doctors and it will also improve the accuracy of the GMC register for employers and patients. This will increase patient safety and confidence in their Pain Medicine Specialist.

Section 2:

The Credential within UK training

Successful completion of Pain Medicine training will allow the clinician to apply to the GMC for a Credential in Pain Medicine.

A specialist who is credentialed in Pain Medicine having successfully completed training and the FFPMRCA examination can apply to become a ***Fellow*** of the Faculty of Pain Medicine of the Royal College of Anaesthetists and use the post nominals FFPMRCA.

2.1 The Credential pre-CCT (Anaesthetics)

The credential will be taken in either ST6 or ST7 of the anaesthetic CCT training programme taking an indicative period of 12 months WTE training period for the average trainee. This mirrors the Stage 3SIA module in Pain Medicine of the *2021 Anaesthetics Curriculum*. It is expected that trainees will have achieved generic and specialist Pain Medicine competencies to Stage 3a training in Pain Medicine within the current anaesthetic programme before undertaking training leading to a Credential. (See RCOA HALO competencies in Annex A)

2.2 The Credential post-CCT (Anaesthetics)

An indicative period of training of 12 months WTE for the average doctor undertaken after the completion of CCT in Anaesthetics. CCT or CCST or CESR holders in Anaesthesia will have achieved Core and Intermediate (2010 Curriculum for a CCT in Anaesthesia) or Stage 1, 2 and 3a (2021 Curriculum for a CCT in Anaesthesia) or equivalent. Training in Pain Medicine for the Credential will build on this pre-existing training.

2.3 The Credential pre-CCT (non-Anaesthetic specialties)

On average an indicative 12 months period of pain training will be undertaken as an Out of Programme Experience (OOPE) or Out of Programme Training (OOPT), with approval of the Training Programme Director and Head of School/Dean supported by the Regional Advisor in Pain Medicine. It is expected that the trainee will be able to evidence competencies equivalent to those specified at Stage 3a competencies in the 2021 Curriculum for a CCT in Anaesthesia, before starting training leading to a Credential in Pain Medicine. If only Stage two level competencies can be evidenced it may still be possible to work towards the credential, but additional time may be required to achieve the necessary higher competencies. Cross mapping of curricula for CCT in Rheumatology, Neurology, Palliative Care and Rehabilitation medicine has shown that there is considerable overlap which are likely to meet most of the Stage 1 and 2 competencies. For other specialities, further cross mapping of the curriculum will be required to ensure that all the Credential requirements are met.

2.4 The Credential post-CCT (non-Anaesthetic specialities)

On average an indicative 12months of WTE period of training undertaken after completion of the base CCT will be required. It is expected that the applicant will be able to evidence competencies equivalent to those specified at Stage 3A Pain training in the 2021 Curriculum for a CCT in Anaesthesia, before starting training leading to a Credential in Pain Medicine. The local trainer (Regional Advisor in Pain Medicine) will liaise with the Training Committee of the Faculty of Pain

Medicine for advice on breadth and duration of training in situations where the evidenced pain competencies are markedly lower than those expected. As explained in 2.3, it is likely that for the specialities listed above there will be cross over competencies between curricula which will be taken into consideration.

2.5 The Credential for Specialty Grade Doctors

The training programme for Specialty Grade Doctors undertaking the Credential will depend on their base specialty or area of current medical practice. Each doctor will require to provide evidence of previous experience in Pain Medicine with their Regional Advisor in Pain Medicine and a training programme adapted accordingly. This will need to be approved by the FPM Training and Assessment Committee (FPMTAC). It is anticipated that a *minimum* of 12 months of training will be required in most circumstances.

For Specialty Grade Doctors, a Credential in Pain Medicine would lead to independent practice in the field of Pain Medicine, but this *would not* translate to an equivalent of a CCT or CCST or CESR in an additional area of practice. For instance, a NCCG doctor working in Anaesthesia who Credentials in Pain Medicine can practice independently within the field of Pain Medicine, but this does not provide equivalence to a CCT, CCST or CESR in Anaesthesia.

2.6 Training pathway

Trainees will apply to a UK Faculty of Pain Medicine-approved training post leading to a Credential in Pain Medicine. The Regional Advisor in Pain Medicine (RAPM) is responsible for the running of Pain Training within Deaneries and identifies Faculty Tutors (clinical supervisors) in each hospital where pain medicine training is undertaken. While the number of junior anaesthetists and other medical specialists who undertake stage 1 or stage 2 pain training can be substantial in some large regions, the number of trainees who undertake advanced pain training opportunities (credential training) is usually only 1 or 2 per year, and as such the RAPM assumes directly supervision and coordination, ensuring that the trainee is adequately supported through the indicative 12-month training programme. It will be the RAPM who will meet the trainee at a minimum once every three months to review progress and guide future training needs. The RAPM will also ensure that the training pathway is requisite to the individual trainee taking into account previous experience and base speciality.

Faculty Tutors in Pain Medicine, based at each training site within the program, will act as Clinical supervisors during placements and sign-off formative assessments. Trainees will be required to successfully complete training on overall clinical assessment as indicated in detail in Section 3 of this document and will be required to successfully sit for both MCQ and SOE sections of the FFPMRCA examination. The RAPM will sign-off summative milestones of progress at the quarterly meetings and will identify when successful completion of training has occurred, at which point they will commend the trainee to the Training and Assessment Committee of the FPM for ratification.

Current examination regulations stipulate that, trainees can sit for the MCQ section of the FFPMRCA examination when they so wish. Candidates however require to have been in training for a minimum period of six months (or equivalent if part time or if indicative period of training shorter or longer than one year) before they can sit for the SOE section. Moreover, the RAPM will be required to countersign the application to sit for the SOE exam. This is to ensure that trainees have had sufficient clinical exposure to allow them to have sufficient knowledge to pass the exam.

The FPM Training and Assessment committee will have the final decision on ratification of training. The FPM Board will be approached if there are any concerns or complaints arising from such decisions. The candidate will then be able to apply to the GMC to have their training formally recognised and become credentialed in Pain Medicine. Formal application to the Faculty of Pain

Medicine at this point would then lead to award of Fellowship of the Faculty of Pain Medicine and the FFPMRCA post nominals.

2.7 Flexibility

The duration of the Pain Medicine credential is typically expected to be an indicative 12-months of WTE (whole time equivalent) training, but it will be possible to adjust the training time according to previous clinical experience and, in an outcomes-based framework, will depend on the individual doctor in training. Evidence of prior generic and speciality capabilities in Pain Medicine will be considered by the RAPM when planning the training year. For example, an anaesthetic trainee will require more focused training in cancer pain than acute pain, while a trainee in palliative care medicine will likely require the reverse.

Training in pain intervention procedures will be adjusted to reflect previous training and also the area of pain practice that the credentialing doctor is planning to work in. The following table reflects which procedures all trainees are expected to become proficient in, and which procedures trainees are expected to have knowledge of and have seen as well as procedures which are only performed in highly specialised centres, which trainees will need to know of and be able to signpost patients to without necessarily seeing these procedures performed during their period of training.

KEY P	KEY S	KEY R
Superficial Procedures:		
• Trigger Point Injection • Scar Infiltration • TENS application • Infusion of drugs e.g., ketamine, magnesium	• Botox for migraine	• Cryotherapy
Regional Nerve Blockade:		
• Paravertebral/ESP • Suprascapular Nerve • Greater Occipital Nerve • Major peripheral N (ultrasound) • Intra-articular injection	• Stellate Ganglion block • Ganglion Impar block	• Greater Occipital Nerve stimulator • Ablative chemical blocks for cancer pain
Central/Neuroaxial Procedures:		
• Lumbar Epidural • Caudal epidural • Nerve Root Block (lumbar/sacral) • Facet joint injection • Medial Branch Block (MBB) • Radiofrequency ablation of facet joint • Pulsed Radio Frequency (PRF)	• Cervical epidural • Thoracic epidural • Cervical nerve block • Lumbar Sympathectomy • Dorsal Column Stimulator • Intrathecal implantation • Coeliac Plexus block	• Deep brain stimulation • Sacral Nerve Stimulator • DRG stimulator •

1. **P** = proficient in
2. **S** = procedure seen being done during training year, understands risks and benefits and indications, and may gain further experience in during post Credential or signpost to another doctor who is proficient in providing the procedure
3. **R** = procedure unlikely to have been seen during training year, but understands indications, risks and benefits and may signpost to a tertiary or other centre where the procedure is likely to be performed.

All trainees will be expected to have and maintain skills of life support to enable them to manage potential rare but catastrophic complications of such procedures for e.g., a total spinal or major anaphylactic reaction.

All trainees will be expected to train in paediatric pain, interventional cancer pain or implantable technology (including for example, spinal cord stimulation) to a level which would allow them to assess, manage and suitably signpost if more specialist intervention such as would be offered at tertiary level would be required. This guidance is reflected in the Higher Learning Outcomes below.

Should a trainee wish to train further in a more specialised Pain Medicine component (paediatrics, interventional cancer pain, implantable technology) to practise in highly specialised centres (usually at tertiary level) then an additional period of training and experience beyond the scope of the credential will be required to gain specific clinical competencies for independent practice. This is outside the scope of this Credential.

Further Guidance is provided in **section 3.3** of this document.

Section 3:

Programme of learning

The credential has been mapped to the core learning outcomes taken from advanced Pain Medicine training of the 2010 Curriculum for a CCT in Anaesthesia and stage 3SIA Complex Pain medicine section of the 2021 Curriculum for a CCT in Anaesthesia. The full list of knowledge and skills for advanced Pain Medicine training, and its areas of sub-specialty practice, can be found on the Faculty of Pain Medicine's website[2]. These form the granular detail from which formative assessments and examination questioning can be based.

However, the focus of the credential is the attainment of high-level outcomes, as recommended for the new style of curriculum, and these have been separated into **generic** and **specialised capabilities** in the following sections.

3.1 Generic Professional Capabilities in Pain Medicine

It is expected that the majority of doctors in training will have attained the following generic professional capabilities (GPC). These capabilities will have been achieved within earlier stages of medical training, at foundation, core and early specialist levels.

Communication and robust, empathetic consultation skills are the corner stone of effective pain management assessment, to ensure that the biological, psychological and social aspects of the pain are identified and managed. Where a doctor undertakes the credential from a non-training or SAS route, there may be the need for additional time or assessment(s) to achieve some of these domains.

GPC Domains are referenced in the following numeration:
Domain 1: Professional values and behaviours
Domain 2: Professional skills
Domain 3: Professional knowledge
Domain 4: Capabilities in Health Promotion and illness prevention
Domain 5: Capabilities in Leadership and team working
Domain 6: Capabilities in patient safety and quality improvement
Domain 7: Capabilities in Safeguarding vulnerable groups
Domain 8: Capabilities in Education and Training
Domain 9: Capabilities in Research and Scholarship

[2] https://fpm.ac.uk/training-examinations-training-and-curricula/pain-medicine-skills-and-learning-outcomes

These nine domains of Generic Professional Capabilities have been mapped out to the Practice of Pain Medicine. The capability descriptors are not exclusive but do mirror how a doctor practising in Pain Medicine would be expected to use and evidence these skills.

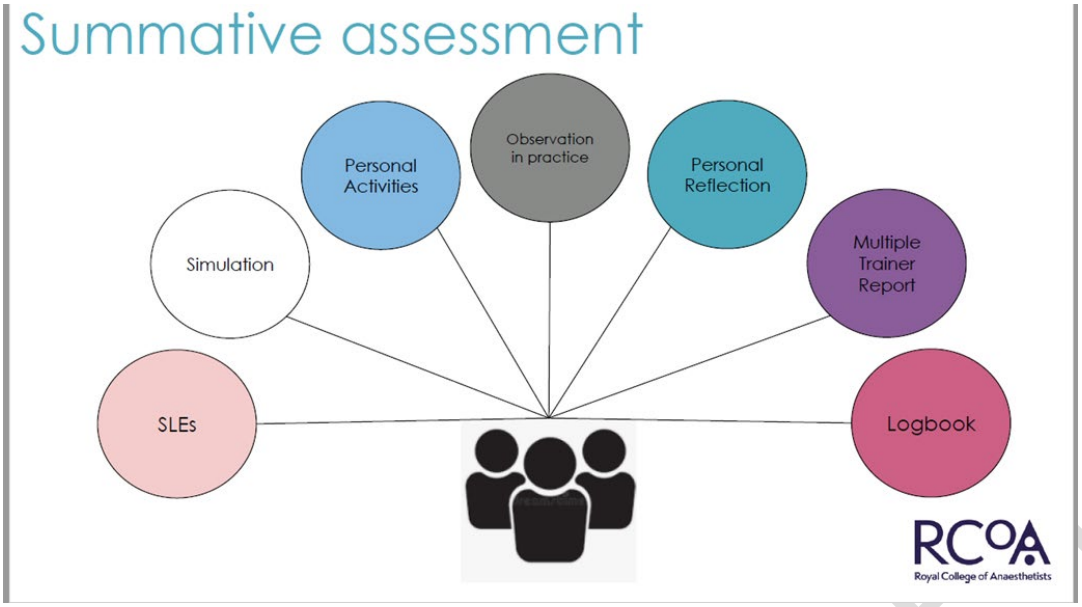
Each domain has been allocated assessment tools which would allow a trainer and trainee to discuss and evidence achievement of each descriptor.

The assessment tools are discussed in greater detail in section 4 and include:

1. **Supervised Learning Events: SLE, these include:**
   - **An A-CEX form**
   - **ALMAT form**
   - **A-QIPAT form**
   - **CBD form**
   - **DOPS form**
2. **Team Feedback/Multi-sourced feedback MSF**
3. **Multiple Trainer Report MTR (Consultants)**
4. **Patient feedback**
5. **Professional Practice Review**
6. **FFPMRCA examination**

These assessment tools provide a **combined formative and summative assessment** approach with the aim to achieve the goals of life long learning. This approach will also allow trainers to meet the needs of the diverse trainee population that this Credential is intended to be aimed at. The formative assessment tools will guide students towards the development of their own learning skills as they reflect on their own practice and its consequences. Frequent trainee and trainer interaction and feedback is essential.

The Holistic Assessment and Learning outcomes (see section 4) as well as the FFPMRCA examination are the summative assessments at the end of training, allowing the trainers an objective measure of the theoretical and clinical knowledge achieved by all trainees.



The following tables reflect assessment tools cross linked to each generic capability and how these can be achieved or evidenced in the practice of Pain Medicine.

Generic capabilities in practice		Assessments					
		Supervised Learning Events*	Team Feedback (MSF)*	MTR (Consultants)*	Patient Feedback (CARE)*	Professional Practice Review*	FFPMRCA Exam*
Category 1: Professional behaviour and trust							
Has the ability to function within Health care organisational and management systems (GPC 1,3)	Adheres to good medical practice and professional expectations		✓	✓	✓		
	Participates in appraisal and revalidation processes					✓	
	Evidences team working and quality improvement					✓	
	Engages constructively with service changes					✓	
Has the ability to deal with ethical and legal issues related to clinical practice (GPC 3,4,7,8)	Safeguards vulnerable groups of patients	✓	✓	✓	✓		
	Demonstrates awareness of pertinent legal issues e.g. DVLA prescribing	✓					✓
	Practices informed consent	✓		✓			✓
	Manages complaints and compliments		✓	✓	✓	✓	
Category 2: Communication, teamworking and leadership							
Communicates effectively and is able to share decision making (GPC 2,5)	Communicates clearly with patients and carers in a variety of settings	✓			✓		
	Communicates effectively with clinical and other professional colleagues		✓	✓			
	Identifies and manages barriers to communication	✓	✓		✓		✓
	Demonstrates effective consultation skills including effective verbal and nonverbal interpersonal skills		✓	✓	✓		
	Shares decision making appropriately for case management		✓	✓			✓
	Applies team working skills within MDT environments		✓				
Category 3: Safety and quality		**SLE**	**MSF**	**MTR**	**PF**	**PPR**	**EXAM**

Maintains patient safety within quality improvement (GPC 1-6)	Participates with critical incident reporting systems	✓				✓	
	Shares good practice appropriately					✓	✓
	Contributes to and delivers quality improvement					✓	
	Understands the importance of non-technical skills		✓	✓	✓		✓
	Recognises and works within limits of personal competence	✓				✓	
Category 4: Wider professional practice							
Can inform research and handle data appropriately (GPC 3,4,9)	Manages clinical information appropriately	✓		✓			
	Understands principles of research and academic writing					✓	✓
	Demonstrates ability to carry out critical appraisal of the literature					✓	✓
	Understands and applies evidence-based medicine to clinical practice	✓					✓
	Follows guidelines on ethical conduct in research and consent	✓				✓	✓
	Understands public health epidemiology	✓					✓
	Participation in health promotion strategies					✓	
Can act as a clinical teacher and clinical supervisor (GPC 1,8)	Delivers formal and informal teaching appropriately	✓				✓	
	Acts as clinical supervisor		✓				
	Organises learning and education opportunities for team	✓				✓	
	Acts as a Trainer for HEE and /or other devolved nation Credential for Advanced Care Practitioners in Pain management	✓	✓			✓	

**Refer to Section 4 for detailed explanation of assessment methodology*

3.2 Specialist Capabilities in Pain Medicine

In line with the General Medical Council guidance: *Excellence by design – standards for postgraduate curricula*, the following tables list specialist capabilities specific to Pain Medicine and required for each doctor to achieve in order to practice safely and effectively in Pain Medicine. Once again, each specialist capability has been defined as learning outcomes with sub-domains that aim to be as detailed as possible but may not be completely exclusive. Each descriptor been cross mapped against a combination of formative and summative assessment tools to inform both trainers and trainees.

Specialist capabilities in practice		**Assessments** **Refer to Section 4 for detailed explanation of assessment methodology*					
		Supervised Learning Events*	**Team Feedback (MSF)***	**MTR * (Consultants)**	**Patient Feedback* (CARE)**	**Professional Practice Review***	**FFPMRCA Exam***
Curriculum learning outcome 1							
Manages referrals/triages within pain service	Demonstrates professional behaviour with regards to patients, carers, colleagues and others (GPC 1, 2, 5)		✓	✓	✓	✓	
	Delivers personalised patient centred care including shared decision making (GPC 1, 2, 3, 5)		✓	✓	✓		
	Explains clinical reasoning (GPC 2, 3)	✓	✓	✓			✓
	Prioritises referrals appropriately (GPC 1, 2, 3, 4)	✓		✓			✓
	Appropriately requests and interprets relevant investigations (GPC 2, 3)	✓		✓			✓
	Liaises with specialty services and refers onward when necessary (GPC 1, 2, 3, 7)	✓		✓			
Curriculum Learning Outcome 2		**Supervised Learning Events**	**Team Feedback (MSF)***	**MTR * (Consultants)**	**Patient Feedback* (CARE)**	**Professional Practice Review***	**FFPMRCA Exam***
Manages an outpatient Pain Medicine clinic	Demonstrates comprehensive and focused assessment of patients with pain, including history taking and physical examination, (GPC 1, 2, 3)	✓		✓			✓
	Recognises indications for and interprets investigations (GPC 2, 3)	✓		✓			✓

	Demonstrates the ability to recognise patients with pain who have psychological problems and who require psychological evaluation, and the ability to apply established treatments for the management of psychological distress in those with pain (GPC 2,3,4,7)	✓		✓	✓		✓
	Demonstrates the ability to recognise patients with pain who require referral or support from other specialties (GPC 2, 3, 5)	✓		✓			✓
	Demonstrates the ability to accurately assess pain in complex scenarios, including those with cognitive impairment and limited verbal interaction. (GPC 2, 3, 5)	✓	✓	✓			✓
	Demonstrates professional behaviour with regards to patients, carers, colleagues and others (GPC 1, 5,6,7)	✓	✓	✓	✓	✓	
	Delivers patient centred care including shared decision making (GPC 1, 2,5,6)	✓			✓		✓
	Demonstrates effective consultation skills (GPC 2,3)	✓			✓		✓
	Formulates an appropriate differential diagnosis (GPC 2, 3, 4)	✓		✓			✓
	Formulates an appropriate diagnostic and management plan (GPC 2, 3, 4)	✓		✓			✓
	Explains clinical reasoning behind diagnostic and clinical management decisions to patients/carers/guardians and other colleagues (GPC 2, 3)	✓		✓		✓	✓
	Prescribes safely within recommended guidelines (GPC 2, 3, 6)	✓		✓			✓
	Appropriately manages medical comorbidities (GPC 2, 3, 6)	✓		✓			✓
	Manages time effectively within clinical session (GPC 1, 2, 6)	✓	✓	✓	✓		
	Is proficient in running multidisciplinary clinics in conjunction with physiotherapist and/or occupational therapist and/or clinical psychologist (GPC 2,5)	✓	✓			✓	
	Can supervise AHP led clinic assessments and AHP led prescribing where applicable. (GPC 1,5)	✓	✓	✓		✓	
	Works collaboratively with other specialist services to manage addiction to pain related medication (GPC 2, 5)	✓	✓	✓			

	Works collaboratively with step down pain management services in the community (GPC 2, 5)	✓	✓	✓			
Curriculum Learning Outcome 3		**SLE**	**MSF**	**MTR**	**PF**	**PPR**	**FFPMRCA Exam**
Manages pain procedural cases	Lists patients for pain interventions appropriately GPC 2, 3		✓				
	Practices informed consent and communicates risk effectively GPC 1, 2,6	✓		✓			✓
	Practices within limits of knowledge and skills GPC 1,2, 3, 4	✓	✓	✓			
	Practices to national standards and guidelines GPC 1, 3, 5, 6			✓		✓	✓
	Demonstrates competence in a range of pain procedures (See ***Annex C*** for example procedures) GPC 2, 3	✓		✓			✓
	Demonstrates an understanding of the safe and effective use of a comprehensive number of neural blockade procedures for pain management including cancer pain and may train to have proficiency in these techniques if appropriate GPC 2, 3, 6	✓					✓
	Demonstrates an understanding of the techniques for insertion of tunnelled or implanted peripheral and central neuraxial drug delivery or neuromodulation systems and may train to have proficiency in this technique if appropriate GPC 2, 3, 6	✓					✓
	Demonstrates the basic practice of stimulation induced analgesia e.g., TENS (Transcutaneous electric nerve stimulation) GPC 2, 3, 6	✓					
	Understands risks and benefits and the technique but only trained to perform diagnostic and therapeutic interventions safely if appropriate GPC 1, 2, 6	✓		✓			✓
	Administers medications within UK guidelines GPC 1, 2, 3, 6	✓		✓			✓
	Demonstrates the safe and competent use of imaging techniques during Pain Medicine procedures (IRMER regulations) GPC 2, 3, 6	✓		✓			✓

	Minimises unnecessary radiation exposure to patients and staff during fluoroscopic procedures GPC 1,6	✓		✓			✓
	Recognises and manages procedural complications GPC 1, 2, 3, 6	✓	✓	✓		✓	✓
Curriculum Learning Outcome 4		**SLE**	**MSF**	**MTR**	**PF**	**PPR**	**FFPMRCA EXAM**
Participates effectively within a Pain MDT	Lists patients for Pain Medicine MDT discussion appropriately GPC 2, 3, 5		✓	✓			
	Summarises salient case points and prioritises key issues. GPC 2, 3		✓	✓			
	Applies effective team working strategies to ensure effective prioritisation, communication and shared decision making occurs GPC 2, 5, 6	✓	✓	✓			
	Takes ownership of cases and works towards constructive closure of biological, social and psychological issues. GPC 1, 2	✓	✓	✓	✓		
	Refers to appropriate internal care pathways or discharge planning GPC 1, 2, 5	✓	✓				✓
	Communicates effectively with primary and secondary care colleagues, ensuring a record of the MDT discussion is recorded and disseminated appropriately GPC 2, 5	✓	✓	✓			
	Understands the role of the physiotherapist in the multidisciplinary team GPC 3, 5	✓	✓	✓			✓
	Understands the role of the occupational therapist in the multidisciplinary team GPC 3, 5	✓	✓	✓			✓
	Understands the role of other disciplines within the multidisciplinary team GPC 3, 5	✓	✓	✓			✓
	Understands the role of pain management programmes GPC 3, 5	✓	✓				✓
Curriculum Learning Outcome 5		**SLE**	**MSF**	**MTR**	**PF**	**PPR**	**FFPMRCA EXAM**

Manages inpatient pain and acute pain rounds	Demonstrates safe and effective pharmacological management of acute, acute on chronic in patient and procedural pain in all age groups. GPC 1, 2,3, 6	✓		✓			✓
	Demonstrates professional behaviour with regards to patients, carers, colleagues and others GPC 1, 6	✓	✓	✓	✓		
	Delivers patient centred care including shared decision-making GPC 1, 4, 5, 6	✓			✓		
	Takes a relevant patient history including patient symptoms, concerns, priorities and preferences GPC 2, 3	✓		✓	✓		✓
	Performs accurate clinical examinations GPC 2	✓		✓			
	Shows appropriate clinical reasoning by analysing physical and psychological findings GPC 2, 3	✓					✓
	Formulates an appropriate differential diagnosis GPC 2, 3	✓		✓			✓
	Formulates an appropriate diagnostic and management plan GPC 2, 3, 6, 7	✓		✓			✓
	Explains clinical reasoning behind diagnostic and clinical management decisions to patients/carers/guardians and other colleagues GPC 2, 3	✓		✓	✓		
	Appropriately selects, manages and interprets investigations GPC 3, 5	✓		✓			✓
	Recognises need to liaise with specialty services and refers where appropriate GPC 2, 3	✓					✓
	Prescribes safely GPC 2, 3	✓					✓
	Manages infusion pumps, including PCAs, wound catheters and epidurals GPC 2, 3, 5	✓		✓			✓
	Can lead an acute pain round GPC 2, 3	✓	✓	✓			
	Can supervise acute pain nurses including nurse led prescribing GPC 2, 3	✓	✓	✓			
	Recognises and manages acute medical illnesses GPC 2, 3, 5	✓		✓		✓	✓

	Recognises comorbidities and adjusts pain related medications accordingly GPC 2, 3, 7	✓					✓
	Demonstrates appropriate and timely liaison with other medical specialty services when required GPC 2, 3	✓		✓			✓
	Identifies patients with limited reversibility of their medical condition and determines palliative and end of life care needs GPC 2, 3, 5	✓		✓			✓
	Identifies the dying patient and develops an individualised care plan, including anticipatory prescribing at end-of-life GPC 1, 3, 5	✓		✓			✓
	Facilitates referrals to specialist palliative care when needed GPC 1, 2, 3	✓		✓			✓
	Demonstrates effective consultation skills in challenging areas (e.g., ICM) GPC 2, 3, 5	✓	✓	✓	✓		
	Demonstrates compassionate professional behaviour and clinical judgement GPC 1, 2, 3, 5	✓	✓	✓	✓		
Curriculum Learning Outcome 6		**SLE**	**MSF**	**MTR**	**PF**	**PPR**	**FFPMRCA EXAM**
Manages patients who are taking drugs of potential addiction – optimisation of medicines	Demonstrates appropriate pharmacological knowledge for safe short and long-term prescribing of opioids and other drugs of potential addiction GPC 3,4	✓					✓
	Can explain the risks and benefits of prescribing opioids and drugs of potential addiction for chronic non-malignant pain GPC 3,4	✓		✓			✓
	Can explain the risks and benefits of prescribing opioids for patients who have malignant pain GPC 3,4	✓		✓			✓
	Demonstrates the use of opioid risk tools and assessments in vulnerable groups GPC 3,4,5,6	✓		✓			✓
	Understands the monitoring of opioids and drugs of potential addiction and withdrawal strategies within pain management services. GPC 3,6	✓					✓

	Demonstrates awareness of the legal implications of the use and prescribing of opioids and drug of potential addiction relating to driving, misuse, addiction and diversion GPC 2, 3, 4,6	✓					✓
	Understands the need to collaborate effectively with drug and alcohol addiction services at inpatient and outpatient/community levels GPC 2,3,4	✓					✓
Curriculum Learning Outcome 7		**SLE**	**MSF**	**MTR**	**PF**	**PPR**	**FFPMRCA EXAM**
Has an understanding of the socioeconomic, occupational health and medicolegal aspects of Pain Medicine	Has an understanding of the Personalised Care institute and the principles of delivering personalised care GPC 3, 4, 6	✓					✓
	Has an understanding of the basic concepts of welfare benefit for e.g., Universal credit, personal independent payment, employment support allowance GPC 3, 4, 6	✓					✓
	Has an understanding of the impact of pain on aspects of daily living, the role of the occupational therapist within the multidisciplinary team, the role of social services in supporting patients with disability GPC 3,4, 6	✓					✓
	Has a basic understanding of the Equality Act 2010 with regards to disability and safe-guarding vulnerable adults and children GPC 3, 4, 7	✓				✓	✓
	Has an understanding of the Mental Capacity Act and the potential impact of pain on mental capacity GPC 3, 4, 7	✓				✓	✓
	Has an understanding of the impact of pain on occupation, legal aspects of reasonable adjustments and the importance of promoting return to work GPC 3, 4, 7	✓					✓
	Has an understanding of the importance of supporting children and young adults, and mature students in education GPC 2, 3, 6, 7	✓					✓
	Is able to compose letters of support with regards to application for welfare and occupational support GPC 2, 3	✓		✓			✓
	Has a basic understanding of the law relating to personal injury, law of causation including the impact that this has on pain management GPC 3	✓					✓

	Has a basic understanding of the concepts of expert evidence and medico-legal reporting GPC 3	✓					✓
	Has a clear understanding of the law in relation to health, drugs and driving GPC 3	✓					✓
	Has a clear understanding of data protection (GDPR) principles and policy GPC 3, 7	✓				✓	✓
Curriculum Learning Outcome 8		**SLE**	**MSF**	**MTR**	**PF**	**PPR**	**FFPMRCA EXAM**
Understands the Healthcare infrastructure and the pain service	Has an understanding of the structure of UK Health systems and their remit GPC 2,3,4	✓		✓		✓	✓
	Has an understanding of the current clinical commissioning groups within the NHS, in both primary and secondary care GPC 2,3,4	✓		✓		✓	✓
	Understands specialist and highly specialist commissioning GPC 3,4	✓		✓		✓	✓
	Understands the basic infrastructure within an NHS Trust or other healthcare provider in terms of managing a pain service GPC 3,4,5,6	✓		✓		✓	✓
	Has an understanding of coding in relation to activity within the pain service and in relation to remuneration and funding GPC 1,3,4,5,6	✓		✓		✓	✓
	Understands the basics of writing a business plan GPC 2,4	✓		✓		✓	✓

3.3 Further specialist capabilities within Pain Medicine

In **addition** to the generic and specialist Pain Medicine capabilities already identified, **each doctor training for the Credential is expected to achieve competency in the following three further specialist capabilities:**

1. *Paediatric Pain Medicine*
2. *Cancer Pain Medicine*
3. *Neuromodulation and Implantable Technology*

The specialist capabilities – paediatric, cancer and neuromodulation/implantable technology can be developed to a higher level, such that the practitioner can undertake highly specialised practice within these areas. While **all doctors** undertaking the Credential will be expected to have an understanding of the science and clinical needs underpinning these specialist capabilities, it is expected that for future career opportunities or to support succession planning only a few will go on to practice in such highly specialised (usually tertiary) units. **For most this will require additional training opportunities outside of the Credential.** Such additional training can only occur once the RAPM is satisfied that the core formative and summative assessments within the credential are successfully achieved.

In line with GMC Good Doctor guidance, credentialed doctors must recognise and work within the limits of their competence and refer a patient to another practitioner where they cannot safely meet their needs; if additional training time beyond that already approved for the credential is required to achieve sufficient clinical exposure in one or more of these highly specialised areas of Pain Medicine, then this will need to be sought separately from the employer and the Deanery.

a. Paediatric Pain Medicine

The Curriculum Learning Outcomes for the practice of Acute and Chronic Paediatric Pain medicine are listed below, once again cross mapped against assessment tools. As indicated above these outcomes must be **achieved** as part of the training leading to a Credential in Pain Medicine, no matter what the base specialty of the training doctor.

It is recognised that the emphasis on different aspects of paediatric training will be commensurate with the amount of clinical paediatric work that is undertaken beyond the pain clinic environment. For instance, this aspect of training may focus more on acute paediatric pain or acute on chronic paediatric Pain Medicine for the anaesthetic trainee who envisages working within a job plan that is mainly confined to this aspect of pain management. On the other hand, a trainee with a base speciality of Rheumatology may opt to focus more on outpatient complex paediatric Pain Medicine.

It is recommended that the pain training credential be undertaken **in addition to** any paediatric training requirements for the pain specialist who intends to hold:

- A consultant post in paediatric Pain Medicine, **OR**
- Will be a consultant in Pain Medicine and will manage a significant number of children in their chronic pain service.

- It is recognised that this additional period of training requires to be done in tertiary specialist paediatric units and the Faculty of Pain Medicine website provides information with regards to units that can provide this highly specialised level of training. **This training would be out with of the remit of this Credential.**

The following Curriculum Learning Outcome objectives and specialist capabilities for Paediatric Pain Medicine are required as part of the training leading to a Credential in Pain Medicine:

Specialist capabilities in practice (Paediatric Pain Medicine)		Assessments					
		Supervised Learning Events	Team Feedback (MSF)	MTR (Consultants)	Patient Feedback (CARE)	Professional Practice Review	FFPMRCA Exam
Curriculum learning outcome 1							
Managing pain in paediatric patients (chronic pain)	Demonstrates accurate assessment of pain intensity in infants, children and adolescents including the premature neonate and child with neurodevelopmental delay GPC 2 ,3	✓		✓			✓
	Demonstrates safe and effective pharmacological management of acute and procedural pain in all ages including the premature neonate GPC 2, 3	✓		✓			✓
	Demonstrates an ability to lead multidisciplinary management of chronic and cancer pain in children GPC 2, 3, 5	✓	✓	✓			
	Demonstrates an ability to perform necessary practical procedures for safe, effective evidence-based practice GPC 2, 3,6	✓	✓	✓			
	Promotes non-pharmacological and non-interventional pain management strategies when appropriate to do so. GPC 2, 3	✓					✓
	Demonstrates an ability to manage transition from paediatric to adult health and social services where appropriate GPC 2, 3, 6	✓	✓	✓			✓

	Demonstrates an ability to initiate and take an appropriate [including leading] role in child protection processes GPC 2, 3, 6, 7	✓					✓
	Demonstrates effective communication with children and families GPC 1, 2, 3	✓	✓		✓		
	Demonstrates effective communication with other paediatric healthcare professionals GPC 1, 2, 5	✓	✓	✓			
	Demonstrates effective communication and liaison with social, educational and community paediatric services GPC 2, 3, 4	✓	✓	✓			✓
	Demonstrates an appreciation of appropriate skills mix for multidisciplinary pain management in children of different ages, abilities and social educational needs GPC 2, 3, 5	✓					✓
	Demonstrates ability to take effective leadership role in children's pain management GPC 2, 5	✓	✓	✓		✓	
Curriculum learning outcome 2		**Supervised Learning Events**	**Team Feedback (MSF)**	**MTR (Consultants)**	**Patient Feedback (CARE)**	**Professional Practice Review**	**FFPMRCA examination**
Managing pain in paediatric patients (acute pain)	Demonstrates professional behaviour with regards to patients, carers, colleagues and others GPC 1		✓	✓	✓		
	Delivers patient centred care including shared decision-making GPC 1, 2	✓					✓
	Takes a relevant patient history including patient symptoms, concerns, priorities and preferences GPC 1, 2, 3	✓	✓	✓	✓		✓
	Performs accurate clinical examinations GPC 2,3	✓		✓			
	Shows appropriate clinical reasoning by analysing physical and psychological findings GPC 2, 3	✓		✓			✓
	Formulates an appropriate differential diagnosis GPC 2, 3	✓					✓
	Formulates an appropriate diagnostic and management plan GPC 2, 3	✓		✓			✓
	Explains clinical reasoning behind diagnostic and clinical management decisions to patients/carers/guardians and other colleagues GPC 1, 2, 3	✓					✓

	Appropriately selects, manages and interprets investigations GPC 2, 3	✓		✓			✓
	Recognises need to liaise with specialty services and refers where appropriate GPC 2, 3	✓	✓				✓
	Prescribes safely for age and weight GPC 3, 5	✓		✓			✓
	Manages infusion pumps, including PCAs, wound catheters and epidurals GPC 2, 3	✓					✓
	Can lead an acute pain team GPC 2, 5	✓	✓	✓			
	Recognises acute medical illness GPC 2, 3	✓		✓			✓
	Manages comorbidities and adjusts analgesia accordingly GPC 2, 3	✓		✓			✓
	Demonstrates appropriate and timely liaison with other medical specialty services when required GPC 2, 3, 5	✓	✓	✓			✓
	Identifies patients with limited reversibility of their medical condition and determines palliative and end of life care needs GPC 2, 3	✓					✓
	Identifies the dying patient and develops an individualised care plan, including anticipatory prescribing at end-of-life GPC 2, 3	✓		✓	✓		✓
	Facilitates referrals to specialist palliative care when needed GPC 2, 3, 5	✓	✓	✓			✓
	Demonstrates effective consultation skills in challenging areas (e.g., ventilated in ICM, non-verbal patient and those with learning difficulties) GPC 2, 3, 6, 7	✓	✓	✓	✓		
	Demonstrates compassionate professional behaviour and clinical judgement GPC 1, 2	✓			✓		

b. Interventional Cancer Pain Techniques

Within the credential, the curriculum learning outcomes should allow a specialist in Pain Medicine to have the skills to deal with a patient who has pain arising primarily from cancer.

It is recognised that **the level of skills required will vary** depending on the complexity of patients suffering from cancer pain and cancer related problems that present in different NHS hospitals as cancer services tend to now be localised to specific centres. However, it is expected that a doctor who has a credential in Pain Medicine **can manage and institute multidisciplinary cancer related pain management** and **recognizes the need to refer such patients to a specialist** cancer centre if further specialised interventions are required. There is no set number of procedures that convey interventional competence, and it is expected that training will continue beyond the period of formal pain training into the consultant appointment. However, as a guideline, a minimum of twenty (namely out-patient and MDT) sessions purely dedicated to cancer pain should form part of the training leading to a credential in Pain Medicine.

A further period of full-time training in cancer pain, split between hospices and a tertiary cancer pain centre, is recommended for a specialist in Pain Medicine who wishes to work in a cancer pain multidisciplinary service. This would normally be expected to be an indicative 3 months in order to safely learn the skills required.

If the individual wishes to perform interventional cancer pain techniques further procedural training is recommended at a centre with procedural capacity is sufficient to provide supervision and practice. This period of training **would be in addition to** the indicative one-year training period leading to the Credential in Pain Medicine and falls outside the remit of this Credential

Life-long learning will be required to attain independent practice for the most specialised interventional cancer pain techniques, e.g., cordotomy and intrathecal implantable devices. It will be important for the individual to work as part of a larger team or to have close links to other interventional cancer pain specialists to provide collaboration and support.

In ***addition*** to the generic and specialist capabilities for Pain Medicine already identified, the following specialist capabilities for cancer pain management **are also required for all doctors training for the Credential**. Once again, cross-mapping is done with relevant assessment tools:

Specialist capabilities in practice (Cancer Pain Medicine)		Assessments					
		Supervised Learning Events	Team Feedback (MSF)	MTR (Consultants)	Patient Feedback (CARE)	Professional Practice Review	FFPMRCA Exam
Curriculum learning outcome in Cancer Pain 1							
Managing pain in cancer patients	Demonstrates the ability to accurately assess pain in the cancer pain patient GPC 2, 3	✓		✓			✓
	Demonstrates compassionate professional behaviour and clinical judgement GPC 1, 2	✓	✓				✓
	Demonstrates the ability to work in a multidisciplinary team GPC 2, 3, 5	✓	✓	✓			
	Demonstrates the ability to set up and manage external and internal implantable drug delivery systems, both peripheral and central, for the management of cancer pain GPC 2, 3	✓					✓
	Demonstrates effective communication with patients and families/carers GPC 1, 2	✓			✓		
	Demonstrates effective communication with other healthcare professionals in primary and secondary care GPC 1, 2, 5	✓	✓	✓			
	Demonstrates appreciation of the need for multidisciplinary management in the cancer sufferer GPC 2, 3, 5	✓	✓	✓			✓
	Identifies patients with limited reversibility of their medical condition and determines palliative and end of life care needs, planning their pain management needs accordingly GPC 1,2, 3, 5	✓	✓				✓
	Identifies the dying patient and develops an individualised care plan, including anticipatory prescribing and pain management prescribing at end-of-life GPC 2, 3, 5	✓	✓				✓
	Facilitates referrals to specialist palliative care when needed GPC 2, 3, 5	✓	✓				✓
	Demonstrates an appreciation of appropriate skills mix for multidisciplinary pain management in Intrathecal drug delivery (IDD) service GPC 2, 3, 5	✓	✓				✓
	Demonstrates effective communication with other healthcare professionals in primary and secondary care, including but not limited to	✓	✓	✓	✓		

	general practitioners, surgical specialties for assessment and treatment of urgent complications, neurologists and/or paediatricians for patients with spasticity and communication with other specialist teams offering IDD therapy. GPC 2, 3, 5						
Curriculum learning outcome in Cancer Pain 2		**Supervised Learning Events**	**Team Feedback (MSF)**	**MTR (Consultants)**	**Patient Feedback (CARE)**	**Professional Practice Review**	**FFPMRCA Exam**
Performing interventions in cancer patients	Demonstrates an understanding of and where appropriate the ability to perform neurolytic blockade (including autonomic, peripheral and regional techniques) in the management of cancer pain GPC 2, 3	✓		✓			✓
	Demonstrates an understanding of and where appropriate the ability to deliver some of the highly specialised treatments for the management of cancer pain, including but not exclusively, percutaneous cordotomy GPC 2, 3	✓					✓
	Demonstrates ability to: •signpost/refer patients requiring interventional procedures for cancer pain to appropriate centres, •to recognise complications arising from such procedures and refer back to/ seek advice of other appropriate teams/specialists when required GPC 2, 3	✓		✓	✓		✓

b. Neuromodulation/Implantable technology

As part of the credential in Pain Medicine, one of the Curriculum Learning Outcomes that a trainee is **expected to achieve is an understanding of neuromodulation/implantable technology**. This will require, as a minimum, an understanding of the science underpinning this procedure and the ability to assess and refer patients who may benefit from neuromodulation techniques. It is anticipated that this will require the trainee to attend some clinical and theatre sessions during which patients are assessed and/or implanted with such devices to understand the multidisciplinary approach that is essential for successful neuromodulation.

In addition to the time spent during the pain training leading to the Credential, an indicative period of 3-6 months of focussed work in a centre performing spinal cord stimulation or equivalent neuromodulation techniques is recommended if the individual wishes to perform these procedures as part of their regular job plan as Consultant in Pain Medicine. ***This period of additional training would however be outside the remit of this Credential.***

In *addition* to the generic and specialist capabilities already identified, the following specialist capabilities for neuromodulation are required for all doctors training for the Credential:

Specialist capabilities in practice (Neuromodulation/Implantable Technology)		Assessments					
		Supervised Learning Events	Team Feedback (MSF)	MTR (Consultants)	Patient Feedback (CARE)	Professional Practice Review	FFPMRCA Exam
Curriculum learning outcome in Neuromodulation 1:							
Assessing patients for Neuromodulation	Demonstrates the ability to assess pain including, location, nature and any relevant psychosocial factors, in the context of neuromodulation suitability and risk. GPC 2, 3	✓					✓
	Demonstrates ability to work in a multidisciplinary team GPC 1, 2, 3, 5	✓	✓	✓			
	Demonstrates an appreciation of appropriate skill mix for multidisciplinary management in neuromodulation GPC1, 2, 3, 5	✓	✓	✓			✓
	Demonstrates effective communication with other healthcare professionals in primary and secondary care e.g., surgical specialties for assessment and treatment of complications and communication with specialist teams offering SCS therapy GPC 2, 3, 5, 6	✓	✓	✓	✓		
Curriculum learning outcome in Neuromodulation 2:		**Supervised Learning Events**	**Team Feedback (MSF)**	**MTR (Consultants)**	**Patient Feedback (CARE)**	**Professional Practice Review**	**FFPMRCA Exam**

Performing neuromodulation techniques	Demonstrates technical skills required for safe SCS and neuromodulation techniques GPC 2, 3	✓		✓			✓
	Demonstrates ability to recognise complications and refer to other appropriate teams/specialists when needed GPC 2, 3	✓		✓			✓

Section 4:

Assessment Blueprint

The Faculty of Pain Medicine

Established in April 2007, the Faculty of Pain Medicine (FPM) is the professional body responsible for the training, assessment, practice and continuing professional development of specialist medical practitioners in the management of pain in the UK. We support a multi-disciplinary approach to pain management informed by evidence-based practice and research.

The FPM functions through its secretariat and the work of its Board and two main committees; the Professional Standards Committee (FPMPSC) and the Training & Assessment Committee (FPMTAC). In addition, short-term working groups are appointed to look at specific issues. The Faculty's Board plans our strategic direction and leads our work. The Board of the Faculty of Pain Medicine comprises nine elected and appointed members including the Dean and the Vice-Dean. The Board also includes co-opted members, representing, the devolved Nations, The British Pain Society, Patient Liaison Committee, Acute Pain, FPM Professional standards committee, FPM Regional Advisors in Pain Medicine and FPM Trainees.

The Board has developed efficient working partnerships and alliances on behalf of our Fellows and Members, to include very close relationships with the RCoA and the British Pain Society (BPS) and joint working with the Chronic Pain Policy Coalition (CPPC), providing good patient links. We continue to work with the Clinical Reference Group for Specialised Pain Services who are developing specifications and policies for the NHS Commissioning Board.

The FPM takes part in regular consultations with all major stakeholders in Pain Medicine, including the Department of Health, the General Medical Council and the National Institute for Health and Care Excellence. We view this as a key opportunity to influence strategy and enhance and protect Pain Medicine as a specialist area in the UK.

The FPM's work is delivered by our key committees

There are two principal strands to these work-streams: professional standards and training & assessment. The FPM Professional Standards Committee (FPMPSC) is responsible for Pain Medicine matters relating to the standards, good practice documentation, revalidation and events, policies relating to patient safety, competencies, clinical audit and doctors in difficulty.

The FPM Training & Assessment Committee (FPMTAC) is responsible for Pain Medicine matters relating to the curriculum, assessment tools, the logbook, e-learning, examinations, specialty area training, recruitment and selection, the EWTD and quality assurance.

4.1 Learning and teaching

a. The Training

Pain training can be undertaken full-time or part-time and is recommended to be an indicative period of 12 months WTE duration for the average doctor. It can be pre-CCT or post-CCT. The Royal College of Anaesthetists, Faculty of Pain Medicine is the professional body responsible for specialty pain training

throughout the UK, and it ensures the quality of patient care through the maintenance of standards in Pain Medicine.

Post CCT posts will require funding by the parent Trust. It is expected that Credential training in Pain Medicine will encourage access to Pain Medicine training at a pre-CCT and post CCT level by non-anaesthetists particularly those coming from the specialties of Rheumatology, Neurology, Rehabilitation Medicine and Palliative Care medicine. Other specialities may be considered, and cross-mapping of curricula will be required to assess pre-training competencies and to ensure that the training programme fulfils the requirements of training. This will also apply to Specialty Grade Doctors who wish to embark on training leading to a Credential in Pain Medicine.

HALO forms for Stage 1 and Stage 2 training in Pain Medicine in Annex B indicate the capabilities in Pain Medicine which would be expected of a trainee in anaesthesia before they embark on specialist (level 3 SIA) training in Pain Medicine. These forms can be used as a guidance for trainers assessing requirements of a non-anaesthetic pre or post CCT doctor or Specialty Grade Doctor who may wish to undertake training for the Credential.

The FPM has a very comprehensive website https://fpm.ac.uk/ for trainees and trainers including several documents to guide training and professional standards.

b. The Trainers

The FPM manages a network of Regional Advisors and Faculty Tutors (Pain Medicine). These local trainers advise upon, quality assure and sign off on Pain Medicine training. The Board of the Faculty of Pain Medicine is responsible for the appointment and re-appointment of **Regional Advisors in Pain Medicine (RAPMs).**

RAPM are responsible to the Chair of the RAPM who is in turn answerable to the FPM Training and Assessment Committee (FPMTAC). FPMTAC meets four times a year and its Chair is a board member of the FPM, reporting regularly to the Board, the Dean and Associate Director of Faculties.

RAPMs are responsible for ensuring that training and education in Pain Medicine in their region is properly delegated and organised, fulfils the requirements of the curriculum, is accessible to all trainees at all levels of training through suitable communication channels and is appropriately supervised.

The RAPM acts as coordinator between the Regional Advisor in Anaesthesia, the Postgraduate Dean, Programme Directors, College Tutors, academic departments, clinical managers, the Schools of Anaesthesia and other specialties (such as palliative medicine and neurology) to enhance training in Pain Medicine and to ensure trainees are appropriately appraised, assessed and supported.

The RAPM is involved in the assessment and Annual Review of Competence Progression (ARCP) process for Advanced Pain Medicine Trainees. The RAPM also feeds back to the Faculty regarding any major problems or difficulties relating to Pain Medicine within their region. A Chairperson for the RAPM is elected on a triennial basis. All RAPM meet four times a year to discuss training issues and also run a biannual Faculty Tutor Pain Leadership conference for local pain tutors involving lectures, updates and workshops to keep FTPs up to date with current training information and provide an opportunity for networking across regions.

RAPM oversee training in the following 21 regions:

1. East of England
2. East of Scotland

3. Leicester & South Trent
4. Mersey
5. North of Scotland
6. North Thames
7. North West
8. Northern
9. Northern Ireland
10. Nottingham & Mid-Trent
11. Oxford
12. Sheffield & North Trent
13. South East Scotland
14. South Thames
15. South West – Peninsula
16. South West Severn
17. Wales
18. Wessex
19. West Midlands
20. Scotland West
21. Yorkshire & Humber

Every centre recognised for advanced pain training has a Lead Educational Supervisor, appointed by the Regional Advisor and called **a Faculty Tutor in Pain Medicine**. Faculty Tutors report regularly to their RAPM and are also expected to attend a biannual conference held by the FPM. Moreover, they receive regular updates from the FPM.

FTPs are responsible for ensuring the training site has a comprehensive pain training programme across all agreed areas of the Pain Medicine curriculum. FTPs will work with the RAPM to ensure cross-regional cohesion and with local trainers to ensure good quality training. Data is returned to the FPM annually through a report prepared by each RAPM, from the Trainee Survey and triennially via a Hospital Review Form (HRF). This information is combined and reviewed by our Training & Assessment Committee (TAC).

Regional Advisors meet with the Chair of Regional Advisors four times a year in a formal four nation meeting. They also correspond in real time through a support group maintained on a social platform.

Training is provided through Regional Schools of Anaesthetics and deanery funding is in place for pre-CCT training posts. Only specific hospitals are recognised for Pain training leading to a Credential in Pain Medicine.

The Hospital Review Form ensures all centres that provide Advanced Pain Training (APT) are able to meet the full requirements of the training programme. The FPM asks RAPMs to review the APT centres in their region on a triennial basis. The information collected should also show prospective trainees, trainers and consultants the opportunities available in each region.

The process encompasses the documents below and is explained fully on the Faculty of Pain Medicine website https://fpm.ac.uk/

The Hospital Review Form is sent to the Faculty Tutor (Pain) in each hospital/centre providing advance pain training in each region. They then need to be returned to the RAPM for summarising. Hospital review forms provide in depth detail of staffing, patient cohorts, detailed delivery of services and facilities available to do so. FPM usually would be expected to involved their Clinical Director in providing this information.

The Approval Checklist is for the RAPM to complete for each of the review forms within their region.

The APT Post summary is for the RAPM to complete for their region. This form will show prospective trainees what is available within each region.

The Hospital Review Form process is also designed for centres wishing to be recognised as an Advanced Pain Training provider.

The Approval Checklist is then completed by the RAPM in order to demonstrate if the centre is of the required standard for Advanced Pain Training.

All the FPM **Educational Supervisors** are expected to maintain mandatory training (HEE or Local) and be registered with the GMC as national trainers. Educational Supervisors in turn mentor and appoint **Clinical Supervisors**. All FPM Educational trainers are expected to comprehensively review their role as educational supervisors in their annual appraisal. Moreover, such evidence is also submitted to the GMC as part of the revalidation process of each trainer.

Our Regional Advisors who are the educational supervisors ultimately signing off completion of training work to the Gold Guide Standard: A Reference Guide for Postgraduate Foundation and Specialty Training in the UK 8th edition 2020.

c. Trainer and trainee interaction

Each Trainee will have a meeting with their Faculty Tutor in Pain Medicine (FTP) and their Regional Advisor in Pain Medicine (RAPM) before they start their training. Every trainee has a nominated Faculty Tutor in Pain Medicine as their Educational Supervisor.

Trainees are monitored by their faculty tutors on a very regular basis and have fixed quarterly assessments where progress is reviewed, feedback is provided and further development plan is made.

Each trainee will have clinical supervisors apart from their educational supervisors and feedback with regards to assessments will come from different sources and members of the pain team, which allows for a fair assessment of competencies.

Trainees also have a support group maintained on a social platform which allows them to share experiences and highlight any concerns. A trainee representative sits on both the Training and Assessment Committee as well as the FPM Board

The FPM also uses social media to promote information, updates and new guidance to its trainers and trainees.

d. Learning and teaching methods

Pain training is a clinical apprenticeship model, involving inpatient and outpatient assessments and an understanding of, and where appropriate, practical training in procedural work. Supervised learning events (SLEs) take place in clinical outpatient settings, in theatres for interventional work and within the multidisciplinary team environment. New specialist capabilities leading to curriculum learning outcomes will be taught in a process of progressively reduced supervision, from direct supervision through local and finally to remote supervision, of outpatient and where appropriate procedural cases. The aim is to allow attainment of clinical independence in all required learning outcomes by the end of the training period.

Every trainee is at all times, responsible to a nominated consultant, (**clinical supervisor**) when undertaking clinics, procedures or ward rounds whether this is under direct or without direct consultant supervision. The Consultant must be available to advise and assist the trainee as appropriate. Sometimes this will require the consultant's immediate presence but, on many occasions, particularly in clinics and ward rounds, less direct involvement will be needed.

Supervision is a professional function of consultants and they must be able to decide what is appropriate for each circumstance in consultation with the trainee. The safety of an individual hospital's supervision arrangements is the concern of the local department; it is necessary for them to agree local standards and protocols that take account of their particular circumstances. Further explanation of supervision levels is provided in the paragraphs below.

As an outpatient speciality, Pain Medicine training occurs Monday to Friday with no out-of-hours or weekend work generally. Trainees may still be required to provide on-call commitments in the evening or at weekends for their base specialty. Their Faculty Tutor in Pain Medicine should ensure that on-call commitments do not directly impinge on access to daytime training (APT). The Training and Assessment Committee of the FPM have supported RAPMs in the past where local service issues have impacted on training opportunities and will continue to be a point of support when issues cannot be resolved locally.

e. Academic training

It is possible to combine formal research activities alongside Pain Medicine training; however, the duration of Pain Medicine training may need to be extended pro rata if the research activity reduces the clinical Pain Medicine exposure to less than 80% per week. It is recommended that candidates undertake their research work in the same region as they are undertaking Pain Medicine training to avoid loss of clinical activity from excessive need to travel.

For trainees working in hospitals where academic research may not be readily accessible, Pain Train (https://www.paintrainuk.com/) in collaboration with the Faculty of Pain Medicine, and RAFT (Research and Audit Federation of Trainees) allows access to participate in national audit and research projects.

4.3 Assessment

Trainees will evidence appropriate attainment and progression through the curriculum. Daily interaction with Clinical Supervisors and at least weekly interaction with their Educational Supervisor (Faculty Tutor) is expected. Moreover, the RAPM will review progress at each quarterly meeting. The order in which the HALO forms are achieved will vary according to the clinical attachments in the preceding quarter and incomplete forms can be used to target future learning opportunities and clinical placements.

Assessment Tools

The credential has been divided into curriculum learning outcomes (CLOs), four generic and eight specialist CLOs, within which are sub-domains of practice mapped to generic capabilities [see Section 3.1 and 3.2]. **Formative assessment tools** will be used to record *structured learning events* (SLEs) to evidence sub-domains within the CLOs, [See Annex A for examples of these forms]. **Global assessments** of performance will also inform on progress. A single assessment may capture many aspects of clinical performance across several sub-domains, cumulatively they will demonstrate satisfactory attainment of CLOs, which will be recorded on Holistic Assessment of Learning Outcome (HALO) forms. Each trainee is expected to meet with their Regional Advisor on a Quarterly basis – the duration of the "Quarter" being determined by the indicative period of training.

We have also mapped HALO forms to Entrustable Professional Activities as explained below. The RAPM will review progress with these at each quarterly meeting. The order in which the HALO forms are achieved will vary according to the clinical attachments in the preceding quarter and incomplete forms can be used to target future learning opportunities and clinical placements.

In Section 3, we have explained how **formative assessment and summative tools** have been integrated to ensure that doctors training in the Credential achieve the highest standard of practice possible. Proformas for all the assessment tools are to be found in Annex B

The assessment tools are defined as follows:

Supervised Learning Events (SLEs):

SLEs should be used by doctors in training and trainers to promote professional educational discussions and guide future learning, with the emphasis on feedback. Developmental conversations that enhance the improvement in performance that comes with repeated cycles of experience, reflection, conceptualisation, and application. Feedback should include both the specialty specific and generic professional aspects of performance.

Features that are key to making SLEs effective are that the conversation happens soon after the observed activity, that this dialogue is aided by a credible facilitator, and that the conversation is seen as part of a continual process of development, rather than an assessment of performance at a single point in time.

It is important to note that one SLE can provide evidence for more than one of the Key Capabilities and there is no minimum number of SLE requirement for any of the Domains of Learning.

Levels of Supervision

Doctors in training will need to demonstrate progression through the different levels of supervision detailed in the table below for clinical activities.

The levels of supervision

1	Direct supervisor involvement, physically present in same clinic or theatre throughout
2A	Supervisor in other clinic room or in theatre suite, available to guide aspects of activity through monitoring at regular intervals
2B	Supervisor within hospital for queries, able to provide prompt direction/assistance
3	Supervisor on call from home for queries able to provide directions via phone or non-immediate attendance

4	Should be able to manage independently with no supervisor involvement (although should inform consultant supervisor as appropriate to local protocols

The trainer will identify the level of supervision that the doctor in training requires for that activity at the time the SLE is completed. This is the supervision level the doctor in training would require if they were to repeat that same activity again at that point in time. These supervision levels require to be used in conjunction with Entrustable Professional Activities as indicated further on in the curriculum.
SLEs and other activities should be used to illustrate engagement in the training programme and the opportunity to gain and record structured feedback on performance. Ongoing engagement in the training programme is also reflected in the Key Capabilities within the generic professional domains.
Supervised Learning events forms (see Annex B) include:

- **An A-CEX form**
- **ALMAT form**
- **A-QIPAT form**
- **CBD form**
- **DOPS form**

- **Clinical Evaluation Exercise (A-CEX)** — a global assessment of performance of more than one task within a learning event, e.g., running an outpatient clinic or procedural list, where several domains are simultaneously assessed (time management, staff interaction, clinical decision making). The level of supervision will also be relevant for progression of training and should progress towards a Level 3 or 4 'average' over the training time.
- **Direct Observation of Procedural Skill (DOPS**) — assessing selected aspects of performance within interventions or general professional skills, for example written communications. The level of supervision will also be relevant for progression of training, such that the same procedure could be used so long as the level of supervision required has changed.
- **Case based discussion (CbD)** — a peer led discussion around a clinical case or focused topic identified by the trainee as being of educational benefit.
- **ALMAT – form** can be used to assess how a trainee plans a pain intervention list including booking relevant number of patients, providing appropriate direction to theatre staff, knowledge of IRMER regulations.

- **A-QIPAT form -** an assessment form for reviewing and giving feedback on quality improvement projects has been developed - the Anaesthesia Quality Improvement Project Assessment Tool.

Logbook and e-Portfolio

Candidates are expected to log their clinical activity and sessional work in an electronic format that can facilitate extraction and analysis of core data points.

An FPM excel logbook currently exists for this purpose: (Logbook).

Alternatively, trainees can use the Royal College of Anaesthetists Lifelong Learning Platform and electronic logbook. Trainees may also choose to keep a logbook of their own preference, as long as this is fit for purpose.

There are no fixed numerical targets for any of the competencies related to the generic or specialist capabilities, but rather the trainee should demonstrate attainment of high-level outcomes and have

robust Consultant, MSF and patient feedback to convey confidence in their clinical decision making and overall performance. As a guideline however, it is expected that allowing for annual leave, study leave, administrative and professional development and on-call commitments, trainees are expected to achieve around 200 clinical sessions of Pain Medicine training within an indicative average 12-months of WTE training (4 to 6 clinical sessions per week on average), with an acceptable range of 170-230 sessions.

We recommend that:

Up to 20 sessions may be spent in acute pain (depending on previous experience).

A minimum of 20 sessions should be undertaken in cancer pain.

The bulk of training time must be spent in chronic pain work and related activity including multidisciplinary team working within a pain service including physiotherapy, occupational therapy, psychological therapy, Pain Management Programmes. Trainees who wish to develop specialist interests may also choose to spend additional time in specialist clinics for example clinics dealing with pelvic pain, headaches and facial pain.

Time spent understanding the concepts of interventional Pain Medicine should be spread across learning include peripheral nerve blocks, musculoskeletal blocks and neuraxial blocks, including exposure to radiofrequency, fluoroscopic and ultrasound guided techniques.

It is essential that the overall training experience reflects the multidisciplinary practice of holistic Pain Medicine and trainees and trainers should ensure that the sessions attended towards training reflect this.

Reflective log entry — a significant event analysis, morbidity or mortality case or holistic case review which can be used to formulate future learning needs. Discussion around complaints and compliments and communication (for instance a review of a summary letter from a consultation)

Team Feedback/Multi-sourced feedback MSF - A trainee is also assessed using a Multi-Source Feedback (MSF). Unlike the other work-place based assessment tools, the MSF looks at professional attitudes and behaviours, rather than the clinical skills and knowledge.

Multiple Trainer Report MTR (Consultants) - The MTR reflects the greater emphasis on the professional judgement of the trainer as part of a revised programme of assessment.

The MTR is a mandatory requirement to support progression at critical progression points of the new curriculum. The MTR will be triggered and collated by the Faculty Tutor or Educational Supervisor and the results discussed with the doctor in training and their educational supervisor.

A satisfactory MTR is an essential requirement in order to support the completion of each HALO for each of the Domains of Learning.

A satisfactory MTR is also an essential requirement for the attainment of the EPA process. Trainers have the opportunity to report on the progress of the doctor in training, including areas of excellence and areas for further development. Such feedback should encompass both the specialty specific and generic professional aspects of the curriculum.
A single MTR can illustrate progress across all the HALOs of the curriculum. The MTR process is distinct from the Multi Source Feedback (MSF).

Patient feedback e.g., FPM feedback form (see Annex B) or other validated feedback form – patient feedback is an essential part of revalidation. The questionnaires used for collecting patient feedback are consistent with the principles, values and responsibilities established in Good medical practice, and have been validated. They should be independently administered. The patients are asked to provide feedback from across the whole scope of practice. If feedback cannot be directly obtained from the patient it should be collected from others who can provide comment from their perspective.

Professional Practice Review – The Faculty of Pain Medicine shares the same ethos as its parent college, the Royal College of Anaesthetists, that the affective competencies for learning do not relate to particular stages of training; they should be developed and followed throughout practice, both during training and post-CCT. Thus, the professional attitudes, behaviours and common competencies listed are those expected of all doctors throughout their professional practice and, as a result, there are no changes to the competencies over the years of training.

Doctors undertaking the Credential as part of a pre CCT programme will undertake their Professional Practice Review as part of their ARCP. For doctors undertaking the Credential post CCT or as a Specialty grade doctor, the Professional Practice Review is part of the Annual Appraisal process and Revalidation Process.

Evidence of completion of necessary training modules, such as child protection, adults with incapacity consent, good clinical practice (GCP), simulation skills or cadaveric interventional labs, logbook evidence and letter summaries will all be supportive towards meeting educational goals. Engagement and output in teaching, audit, QI research or management activities can be used to evidence attainment of knowledge and skills within the CLOs.

FFPMRCA examination

The FFPMRCA exam has been established since 2011 and runs twice per year. The first part of the examination is an MCQ (multiple choice questions) paper. The second part which is the SOE (Structured Oral Examination) is recommended to be taken after a minimum of six months of training in the Credential for Pain Medicine (or equivalent Stage 3C training in the Curriculum in a CCT in Anaesthesia) has been completed.

Although passing an exam does not necessarily equate to clinical competency on a day-to-day basis, there is no doubt that a successful exam candidate demonstrates the breadth and depth of knowledge as well as some of the skills in the clinical practice of Pain Medicine, that underpins this to a level expected of a consultant practising in Pain Medicine.

The FFPMRCA examination is discussed further on Page 70 of the Curriculum.

Holistic Assessment of Learning Outcomes (HALOs)

HALOs provide a structured framework to reflect the evidence that the doctor in training has achieved the required learning outcome for the Domain of Learning.

Holistic Assessment of Learning Outcomes (HALO) is the Summative Assessment for each domain of the Curriculum.

The HALO forms also refer to **Levels of Entrustment** which have been developed with consideration of the professional responsibilities of medical practitioners to patient safety.

As per the GMC, excellence by design guidance for curricula, the period of training for the Credential is not set in stone, but is an indicative period of one year which may be shorter or longer depending on whether a trainee is pre- or post-CCT, base specialty, specialty grade and/or previous experience. Each trainee will meet with their RAPM prior to commencing training to agree on an indicative period of training. The duration of this may need to be adjusted depending on progress made throughout the training.

Moreover, there is natural variation in the complexity of case-mix within uni and multidisciplinary clinics, ward rounds and pain intervention lists, which therefore does not allow clear cut-off as to when a candidate will manage every case in a clinic, ward round or theatre list at a specific level by a fixed point in the training program.

We have therefore listed **Entrustable Professional Activities** as indicative milestones in training as a guide for trainers and trainees. For ease of reference, we have divided the Credential Period of Training into four Quarters, the duration of which can then be translated into each trainee's individual training programme. Satisfactory progression through the credential correlates with the global (average) change in the level of supervision as the candidate gains clinical confidence and moves towards independent practice and this will be monitored to ensure progress is being attained.

We have used the ten Cate model and Miller's pyramid with regards to assessment of competency as follows:

Levels of Entrustment for EPAs (ten Cate*)	**Miller's pyramid (Hierarchy of competence) ****
1. Observation without execution, even with direct supervision	KNOWS
2. Execution with direct, proactive supervision	KNOWS HOW
3. execution with reactive supervision i.e., on request and quickly available	SHOWS HOW
4. Supervision at a distance and discussed pre or post event	DOES
5. Supervision provided by the trainee to more junior colleagues	

*Olle ten Cate: Nuts and Bolts of Entrustable Professional Activities J Grad Med Educ. 2013 Mar; 5(1): 157–158

**Miller G E, The assessment of Clinical skills/Performance/Competence Acad. Med 1990 65 (9); 63 - 67

Entrustable professional capabilities

The following Higher Learning Outcomes have been mapped against Entrustable Professional Activities per Quarter of Training, with the duration of the Quarter being dependant on the proposed indicative period of training as agreed by the trainee and the Regional Advisor in Pain medicine before the commencement of training.

High Level Learning Outcome **Credential Pain Medicine - 1**	**Manages referrals/triages within pain service** **EPA – entrustable professional activity*** **(See key for guide to levels)**				
Examples of Evidence*					
Experience & Logbook	• Structured learning events including case discussions • Log book to reflect triage sessions attendance • MDT exposure				
Formative Assessments:		**EPA 1st quarter**	**EPA 2nd quarter**	**EPA 3rd quarter**	**EPA 4th quarter**
1	Identify history, examination requests and need for further investigations in different age groups within referrals	1,2	2,3.4	3,4	4,5
2	Identifies which patients need to be seen in person and which patients can be managed remotely if required	1,2	2,3,4	3,4	4,5
3	Demonstrates the ability to triage and prioritise pain in complex scenarios, including those with cognitive impairment, limited verbal interaction and settings such as intensive care	1	2,3	3,4	4,5
4	Formulation of an appropriate differential diagnosis and optimal pathway (medical or non-medical first contact within pain service).	1,2	2,3	3,4	4,5
5	Shared decision making, explanation of the clinical reasoning behind diagnostic and management plan	1,2	2,3	3,4	4,5
6	Professional behaviour with regards to colleagues	2	3,4	4,5	4,5
7	Appropriate prioritisation of referrals	1,2	2,3	4	4,5
8	Collaborative working with specialty services and refers onward when necessary, including the management of addiction to pain related medication	1,2	2,3	3,4	4,5
9	Recognition of patients with pain who have psychological problems and who require	1,2	2,3	3,4,5	4,5

	psychological evaluation, and the ability to apply established treatments for the management of psychological distress in those with pain				
10	Effective use of the pain medicine MDT discussion with understanding of the roles of physiotherapy, occupational therapy, clinical psychology and nurse within the team	1,2	2,3	4,5	4,5
11	Effectively communication with primary and secondary care colleagues	1,2	2,3	4,5	4,5
Personal Activities and Personal Reflections may include:	• Multi-disciplinary pain meeting reflections • Correspondence (response letters (e.g., back to referrer)				
Global Assessments	• Satisfactory MSF • MTR • FFPMRCA exam				
Trainee (signature)					
RAPM (signature)					
Date:					

* For example: number of sessions, number of patients seen, relates to specific SLE outcome or a specific case report

High Level Learning Outcome Credential Pain Medicine - 2	**Manages an outpatient Pain Medicine Clinic** **EPA – entrustable professional activity*** **(See key for guide to levels)**				
Examples of Evidence					
Experience & Logbook	• Record of clinic session attendance and case mix • Demonstrate time management (clinical/admin) • Demonstrates ability to run clinics in person or remotely				
Formative Assessments:		**EPA 1st quarter**	**EPA 2nd quarter**	**EPA 3rd quarter**	**EPA 4th quarter**
1	Comprehensive and focused assessment of patients with pain, including history taking, physical examination with appropriate requests and interpretation of investigations in different age groups	1,2	2,3.4	3,4	4,5
2	The ability to accurately assess pain in complex scenarios, including those with cognitive impairment, limited verbal interaction and settings such as intensive care	1	2,3	3,4	4,5
3	Formulation of an appropriate differential diagnosis and management plan	1,2	2,3	3,4	4,5
4	Patient centred care including shared decision making, explanation of the clinical reasoning behind diagnostic and management plan	1,2	2,3	3,4	4,5
5	Professional behaviour with regards to patients, carers, guardians, colleagues and others	2	3,4	4,5	4,5
6	Appropriate prioritisation of referrals	1,2	2,3	4	4,5
7	Collaborative working with specialty services and refers onward when necessary, including the management of addiction to pain related medication	1,2	2,3	3,4	4,5
8	Recognition of patients with pain who have psychological problems and who require psychological evaluation, and the ability to apply established treatments for the management of psychological distress in those with pain	1,2	2,3	3,4,5	4,5
9	Prescribes safely within recommended guidelines	1,2	2,3	4,5	4,5

10	Effective use of the pain medicine MDT discussion with understanding of the roles of physiotherapy, occupational therapy, clinical psychology and nurse within the team	1,2	2,3	4,5	4,5
11	Effective communication with primary and secondary care colleagues	1,2	2,3	3,4	4,5
12	Safe and effective pharmacological management of acute, acute on chronic, cancer and procedural pain in all age groups with different co-morbidities	1,2	2,3	3,4	3,4,5
13	Appropriate pharmacological knowledge for safe short- and long-term prescribing of opioids	1,2	2,3	3,4	4,5
14	Understanding of the role of pain management programmes	1	2,3	3,4	4,5
15	Demonstrates clear written and verbal communication	1,2	3,4	4,5	4,5
Personal Activities and Personal Reflections may include:	• Focused case review • Correspondence (letters and referrals) • Patient and colleague feedback				
Global Assessments	• Satisfactory MSF • MTR • FFPMRCA exam				
Trainee (signature)					
RAPM (signature)					
Date:					

High Level Learning Outcome Credential Pain Medicine - 3	**Manages pain procedural cases** **EPA – entrustable professional activity*** **(See key for guide to levels)** **(**Refer to procedures tables in Annex C)**				
Examples of Evidence					
Experience & Logbook	• Record of treatment room and DSU session attendance and cases • Time management (clinical/admin) • Acute pain procedures				
Formative Assessments:		**EPA 1st quarter**	**EPA 2nd quarter**	**EPA 3rd quarter**	**EPA 4th quarter**
1	• Ability to perform *core* interventional pain procedures	1,2	2,3.4	3,4	3,4
2	• Selection and referral of appropriate cases as per level of ability**	1	2,3	3,4	3,4
3	• Ability to manage complications from interventional procedures and related pharmacological sequalae.	1,2	2,3	3,4	3,4
4	• Ability to safely establish infusion pumps, including PCAs, wound catheters and epidurals in inpatient settings and establish TENS in outpatient settings	1,2	2,3	3,4	3,4
5	• Knowledge of radiation safety	1,2	3,4	3,4	3,4
6	• Appropriate informed consent	1,2	2,3,4	4	4,5
7	• Good practice in sterile environments	1,2	3	4	4,5
8	• Awareness of risk/benefits of more complex intermediate and advanced procedures**	1,2	2,3	3,4	4
9	• Referral of neuromodulation, intrathecal drug delivery and cancer pain patients to tertiary services.	1,2	2,3	3,4	3,4
Personal Activities and Personal Reflections may include:	• Focused case review • Clear understanding of information leaflets and consent law • Simulation and cadaveric study courses • Morbidity and mortality review • Patient and colleague feedback				
Global Assessments	• Satisfactory MSF • MTR • CARE response (Patient Feedback) • FFPMRCA exam				

Trainee (signature)					
RAPM (signature)					
Date:					

High Level Learning Outcome Credential Pain Medicine – 4	**Participates effectively within a Pain MDT** **EPA – entrustable professional activity*** **(See key for guide to levels)**				
Examples of Evidence					
Experience & Logbook	• Record of Pain MDT and vetting session attendance • Record of attendance at other related specialty MDT such as Spinal, Rheumatology, Palliative Care, Headache, Pelvic pain/Urogynae MDT				
Formative Assessments:		**EPA 1st quarter**	**EPA 2nd quarter**	**EPA 3rd quarter**	**EPA 4th quarter**
1	Summaries of case history and salient points for discussion	1,2	2,3.4	3,4	4,5
2	Prioritisation of complex scenarios and referrals	1	2,3	3,4	4,5
3	Formulation of an appropriate differential diagnosis and optimal pathway (medical or non-medical first contact within pain service).	1,2	2,3	3,4	4,5
4	Shared decision making, explanation of the clinical reasoning behind diagnostic and management plan	1,2	2,3	4	4,5
5	Professional behaviour with regards to colleagues	2	3,4	4	4
6	Collaborative working with specialty services and refers onward when necessary, including the management of addiction to pain related medication	1,2	2,3,4	4	4,5
7	Recognition of patients with pain who have psychological problems and who require psychological evaluation, and the ability to apply established treatments for the management of psychological distress in those with pain	1,2	3	4	4,5
8	Understanding of the roles of physiotherapy, occupational therapy, clinical psychology and nurse within the team	1,2	2,3	3,4	4,5
9	Effective communication with primary and secondary care colleagues	1,2	2,3	4,5	4,5
10	Understanding of the role of pain management programmes	1,2	2,3	4	4,5
Personal Activities and Personal Reflections may include:	• Multi-disciplinary pain meeting reflections • Colleague feedback				

Global Assessments	• Satisfactory MSF • MTR • CARE response (Patient Feedback) • FFPMRCA exam				
Trainee (signature)					
RAPM (signature)					
Date:					

High Level Learning Outcome 5	**Manages inpatient pain and acute pain rounds** **EPA – entrustable professional activity*** **(See key for guide to levels)**				
Examples of Evidence					
Experience & Logbook	• Structured learning events including case discussions • Log book to reflect management of both acute perioperative and trauma patients and complex patients with long term pain • MDT discussions • Understanding of perioperative care medicine				
Formative Assessments:		**EPA 1st quarter**	**EPA 2nd quarter**	**EPA 3rd quarter**	**EPA 4th quarter**
1	Demonstrates safe and effective pharmacological management of acute, acute on chronic in patient and procedural pain in all age groups.	1,2	2,3	3,4	4,5
2	Demonstrates professional behaviour with regards to patients, carers, colleagues and others	1,2,3	2,3,4	3,4	4,5
3	Delivers patient centred care including shared decision-making	1,2	2,3	3,4	4,5
4	Takes a relevant patient history including patient symptoms, concerns, priorities and preferences	1,2	2,3	4,5	4,5
5	Performs accurate clinical examinations	1,2	2,3	4,5	4,5
6	Shows appropriate clinical reasoning by analysing physical and psychological findings	1,2	2,3	3,4	4,5
7	Formulates an appropriate differential diagnosis	1,2	2,3	3,4	4,5
8	Formulates an appropriate diagnostic and management plan	1,2	2,3	3,4	4,5
9	Explains clinical reasoning behind diagnostic and clinical management decisions to patients/carers/guardians and other colleagues	1,2	2,3	3,4	4,5
10	Appropriately selects, manages and interprets investigations	1,2	2,3	4,5	4,5
11	Recognises need to liaise with specialty services and refers where appropriate	1	2,3	3,4	4,5
12	Prescribes safely	1,2,3	2,3,4	3,4,5	4,5
13	Manages infusion pumps, including PCAs, wound catheters and epidurals	1,2	1,2,3	2,3,4	3,4,5
14	Can lead an acute pain round	1	1,2	2,3,4	3,4,5

15	Can supervise acute pain nurses including nurse led prescribing	1,2	1,2,3	2,3,4	3,4,5
16	Recognises and manages acute medical illnesses	1,2,3	2,3	2,3,4	3,4,5
17	Recognises comorbidities and adjusts pain related medications accordingly	1,2	2,3	3,4	3,4,5
18	Demonstrates appropriate and timely liaison with other medical specialty services when required	1,2	2,3	3,4	4,5
19	Identifies patients with limited reversibility of their medical condition and determines palliative and end of life care needs	1,2,3	2,3,4	3,4,5	3,4,5
20	Identifies the dying patient and develops an individualised care plan, including anticipatory prescribing at end-of-life	1,2,3	2,3,4	3,4,5	3,4,5
21	Facilitates referrals to specialist palliative care when needed	1,2,3	2,3,4	3,4,5	3,4,5
22	Demonstrates effective consultation skills in challenging areas (e.g., ICM)	1,2,3	2,3,4	2,3,4	3,4,5
23	Demonstrates compassionate professional behaviour and clinical judgement	1,2,3	2,3,4	3,4,5	3,4,5
Personal Activities and Personal Reflections may include:	• Multi-disciplinary pain meeting reflections • Patient feed back				
Global Assessments	• Satisfactory MSF • MTR • FFPMRCA exam				
Trainee (signature)					
RAPM (signature)					
Date:					

High Level Learning Outcome 6	**Manages patients who are taking drugs of potential addiction –optimisation of medicines** **EPA – entrustable professional activity* (See key for guide to levels)**				
Examples of Evidence					
Experience & Logbook	• Structured learning events including case discussions • Logbook of acute and acute on chronic pain in patients who have addiction issues • MDT discussions				
Formative Assessments:		**EPA 1st quarter**	**EPA 2nd quarter**	**EPA 3rd quarter**	**EPA 4th quarter**
1	Appropriate pharmacological knowledge for safe short and long-term prescribing of opioids and other drugs of potential addiction	1,2,3	2,3	3,4	4,5
2	Risks and benefits of prescribing opioids and drugs of potential addiction for chronic non-malignant pain	1,2	2,3,4	3,4	4,5
3	Risks and benefits of prescribing opioids for patients who have malignant pain	1,2,3	2,3,4	3,4	4,5
4	Demonstrates the use of opioid risk tools and assessments in vulnerable groups	1,2	2,3	3,4	4,5
5	Understands the monitoring of opioids and drugs of potential addiction and withdrawal strategies within pain management services.	1,2	2,3	3,4	4,5
6	Awareness of the legal implications of the use and prescribing of opioids and drug of potential addiction relating to driving, misuse, addiction and diversion	1,2	2,3	3,4	4,5
7	The need to collaborate effectively with drug and alcohol addiction services at inpatient and outpatient/community levels	1,2	2,3	3,4	3,4
Personal Activities and Personal Reflections may include:	• Multi-disciplinary pain meeting reflections • Patient feed back • Co-working with drug addiction services, pharmacist, drug optimisation services				
Global Assessment:	• Satisfactory MSF • MTR • FFPMRCA exam				
Trainee (signature)					
RAPM (signature)					

Date:	

High Level Learning Outcome 7	**Has an understanding of the socioeconomic, occupational health and medicolegal aspects of Pain Medicine** **EPA – entrustable professional activity*** **(See key for guide to levels)**
Examples of Evidence	
Experience & Logbook	• Logbook to reflect working with occupational therapists, exposure to medicolegal practice within the hospital, writing letters of support • Local Mandatory Training programmes on relevant areas e.g., GDPR

Formative Assessments:		**EPA 1st quarter**	**EPA 2nd quarter**	**EPA 3rd quarter**	**EPA 4th quarter**
1	An understanding of the Personalised Care institute and the principles of delivering personalised care	1,2	2,3	3,4	4,5
2	An understanding of the basic concepts of welfare benefit for e.g., Universal credit, personal independent payment, employment support allowance	1,2	2,3	3,4	4,5
3	An understanding of the impact of pain on aspects of daily living, the role of the occupational therapist within the multidisciplinary team, the role of social services in supporting patients with disability	1,2	2,3	3,4	4,5
4	An understanding of the Equality Act 2010 with regards to disability and safe-guarding vulnerable adults and children	1,2	2,3,4	3,4	4,5
5	An understanding of the Mental Capacity Act and the potential impact of pain on mental capacity	1,2	2,3	4,5	4,5
6	An understanding of the impact of pain on occupation, legal aspects of reasonable adjustments and the importance of promoting return to work	1,2	2,3	3,4	4,5
7	An understanding of the importance of supporting children and young adults, and mature students in education	1,2	2,3	3,4	4,5
8	Ability to compose letters of support with regards to application for welfare and occupational support	1,2	2,3	3,4,5	4,5
9	An understanding of the law relating to personal injury, law of causation including the impact that this has on pain management	1,2	2,3	4,5	4,5

10	A basic understanding of the concepts of expert evidence and medico-legal reporting	1,2	2,3	3,4	3,4
11	A clear understanding of the law in relation to health, drugs and driving	1,2	2,3	3,4	4,5
12	A clear understanding of data protection (GDPR) principles and policy	1,2,3	2,3,4	2,3,4	4,5
Personal Activities and Personal Reflections may include:	• Multi-disciplinary pain meeting reflections • Patient feedback • MDT discussions • Interaction with Social services, Special Educational Needs Co-ordinators • Mandatory training regarding GDPR, Personalised care institute teaching modules				
Global Assessments	• Satisfactory MSF • MTR • FFPMRCA exam				
Trainee (signature)					
RAPM (signature)					
Date:					

High Level Learning Outcome 8	**Understands the Healthcare infrastructure and the pain service** **EPA – entrustable professional activity*** **(See key for guide to levels)**				
Examples of Evidence					
Experience & Logbook	• Logbook to reflect experience of management, attending business meetings, shadowing Lead Clinician for the service. • Background reading regarding the NHS infrastructure				
Formative Assessments:		**EPA 1st quarter**	**EPA 2nd quarter**	**EPA 3rd quarter**	**EPA 4th quarter**
1	An understanding of the structure of UK Health systems and their remit	1,2	2,3	3,4	4,5
2	An understanding of the current clinical commissioning groups within the NHS, in both primary and secondary care	1,2	2,3	3,4	4,5
3	Knowledge of specialist and highly specialist commissioning	1,2	2,3	3,4	4
4	Knowledge of infrastructure within an NHS Trust or other healthcare provider in terms of managing a pain service	1,2	2,3	3,4	4,5
5	Information coding in relation to activity within the pain service and in relation to remuneration and funding	1,2	2,3	3,4	4
6	How to write a business plan	1	1,2	2,3	3,4
Personal Activities and Personal Reflections may include:	• Multi-disciplinary pain meeting reflections • Quality Improvement work and audit. • Participation in service design and commissioning				
Global Assessments	• Satisfactory MSF • MTR • FFPMRCA exam				
Trainee (signature)					
RAPM (signature)					
Date:					

High Level Learning Outcome Paediatric Pain Medicine - 1	**Managing pain in paediatric patients (acute)** **EPA – entrustable professional activity*** **(See key for guide to levels)**				
Examples of Evidence					
Experience & Logbook	• Structured learning events including case discussions • Log book to reflect level of MDT and individual patient exposure				
Formative Assessments:		**EPA 1st quarter**	**EPA 2nd quarter**	**EPA 3rd quarter**	**EPA 4th quarter**
1	Demonstrates professional behaviour with regards to patients, carers, colleagues and others	1,2,3	2,3,4	3,4,5	4,5
2	Demonstrates compassionate professional behaviour and clinical judgement	1,2	2,3	3,4	4,5
3	Delivers patient centred care including shared decision-making	1,2	2,3	3,4	4,5
4	Takes a relevant patient history including patient symptoms, concerns, priorities and preferences	1	2	3,4	4,5
5	Performs accurate clinical examinations	1,2	2,3	3,4,5	4,5
6	Shows appropriate clinical reasoning by analysing physical and psychological findings	1,2	2,3	3,4	4,5
7	Formulates an appropriate differential diagnosis	1,2	2,3	3,4	4,5
8	Formulates an appropriate diagnostic and management plan	1,2	2,3	3,4	3,4
9	Explains clinical reasoning behind diagnostic and clinical management decisions to patients/carers/guardians and other colleagues	1,2	2,3	3,4	3,4,5
10	Appropriately selects, manages and interprets investigations	1,2	2,3	3,4	4,5
11	Recognises need to liaise with specialty services and refers where appropriate	1,2	2,3	4,5	4,5
12	Prescribes safely for age and weight	1,2	2,3	3,4	4,5

13	Manages infusion pumps, including PCAs, wound catheters and epidurals	1,2	1,2	1,2,3,4	2,3,4,5
14	Can lead an acute pain team	1	2	2,3,4	3,4,5
15	Recognises acute medical illness	1	1,2,3	2,3,4	2,3,4
16	Manages comorbidities and adjusts analgesia accordingly	1	2	2,3	2,3,4
17	Demonstrates appropriate and timely liaison with other medical specialty services when required	1,2	2,3	3,4	3,4
18	Identifies patients with limited reversibility of their medical condition and determines palliative and end of life care needs	1	2,3	3,4	3,4,5
19	Identifies the dying patient and develops an individualised care plan, including anticipatory prescribing at end-of-life	1	1,2,3	2,3,4	3,4,5
20	Facilitates referrals to specialist palliative care when needed	1,2	2,3	2,3,4	3,4,5
21	Demonstrates effective consultation skills in challenging areas (e.g., ventilated in ICM, non-verbal patient and those with learning difficulties)	1	2	2,3	3,4
Personal Activities and Personal Reflections may include:	• Multi-disciplinary pain meeting reflections • Patient and parent/guardian feedback				
Global Assessments	Satisfactory MSF • MTR • FFPMRCA exam				
Trainee (signature)					
RAPM (signature)					
Date:					

High Level Learning Outcome Paediatric Pain Medicine - 2	**Managing pain in paediatric patients (chronic pain)** **EPA – entrustable professional activity*** **(See key for guide to levels)**				
Examples of Evidence					
Experience & Logbook	• Structured learning events including case discussions, • Log book to reflect level of exposure to individual patients • MDT exposure				
Formative Assessments:		**EPA 1st quarter**	**EPA 2nd quarter**	**EPA 3rd quarter**	**EPA 4th quarter**
1	Demonstrates accurate assessment of pain intensity in infants, children and adolescents including the premature neonate and child with neurodevelopmental delay	1,2	2	3,4	3,4
2	Demonstrates safe and effective pharmacological management of acute and procedural pain in all ages including the premature neonate	1	2,3	3,4	3,4,
3	Demonstrates an ability to lead multidisciplinary management of chronic and cancer pain in children	1	2	3	3,4
4	Demonstrates an ability to perform necessary practical procedures for safe, effective evidence-based practice	1	2	3	3,4
5	Promotes non-pharmacological and non-interventional pain management strategies when appropriate to do so.	1,2	2,3	3,4	3,4,
6	Demonstrates an ability to manage transition from paediatric to adult health and social services where appropriate	1	2,3	3,4	3,4,
7	Demonstrates an ability to initiate and take an appropriate [including leading] role in child protection processes	1	2	3,4	3,4,

8	Demonstrates effective communication with children and families	1,2	2,3	3,4,5	3,4,5
9	Demonstrates effective communication with other paediatric healthcare professionals	1,2	2,3	4,5	4,5
10	Demonstrates effective communication and liaison with social, educational and community paediatric services	1,2	2,3	4,5	4,5
11	Demonstrates an appreciation of appropriate skills mix for multidisciplinary pain management in children of different ages, abilities and social educational needs	1	2,3	3,4	3,4,
12	Demonstrates ability to take effective leadership role in children's pain management	1	2	3	3, 4
Personal Activities and Personal Reflections may include:	• Multi-disciplinary pain meeting reflections • Patient and parent/guardian feedback				
Global Assessments	• Satisfactory MSF • MTR • FFPMRCA exam				
Trainee (signature)					
RAPM (signature)					
Date:					

High Level Learning Outcome Cancer Pain Medicine - 1	**Managing pain in cancer patients** **EPA – entrustable professional activity*** **(See key for guide to levels)**				
Examples of Evidence					
Experience & Logbook	• Structured learning events including case discussions • Log book to reflect in and outpatient exposure • MDT including oncology and palliative care				
Formative Assessments:		**EPA 1st quarter**	**EPA 2nd quarter**	**EPA 3rd quarter**	**EPA 4th quarter**
1	Demonstrates the ability to accurately assess pain in the cancer pain patient	1,2,	2,3,4	3,4,5	4,5
2	Demonstrates compassionate professional behaviour and clinical judgement	1,2	2,3	3,4	4,5
3	Demonstrates the ability to work in a multidisciplinary team	1,2	2,3	3,4	4,5
4	Demonstrates the knowledge and/or ability to set up and manage external and internal implantable drug delivery systems, both peripheral and central, for the management of cancer pain	1	1,2	2,3,4	2,3,4
5	Demonstrates effective communication with patients and families/carers	1,2	2,3	3,4,5	4,5
6	Demonstrates effective communication with other healthcare professionals in primary and secondary care	1,2	2,3	3,4	4,5
7	Demonstrates appreciation of the need for multidisciplinary management in the cancer sufferer	1,2	2,3	3,4	4,5
8	Identifies patients with limited reversibility of their medical condition and determines palliative and end of life care needs, planning their pain management needs accordingly	1,2	2,3	3,4	3,4
9	Identifies the dying patient and develops an individualised care plan, including anticipatory prescribing and pain management prescribing at end-of-life	1,2	2,3	3,4	3,4,5
10	Facilitates referrals to specialist palliative care when needed	1,2	2,3	3,4	4,5

11	Demonstrates an appreciation of appropriate skills mix for multidisciplinary pain management in Intrathecal drug delivery (IDD) service	1,2	1.2,3	3,4	3,4
12	Demonstrates effective communication with other healthcare professionals in primary and secondary care, including but not limited to general practitioners, surgical specialties for assessment and treatment of urgent complications, neurologists and/or paediatricians for patients with spasticity and communication with other specialist teams offering IDD therapy.	1,2	2,3	3,4	3,4
Personal Activities and Personal Reflections may include:	• Multi-disciplinary pain meeting reflections • Patient feedback				
Global Assessments	Satisfactory MSF • MTR • FFPMRCA exam				
Trainee (signature)					
RAPM (signature)					
Date:					

High Level Learning Outcome Cancer Pain Medicine - 2	**Performing interventions in cancer patients** **EPA – entrustable professional activity*** **(See key for guide to levels)**				
Examples of Evidence					
Experience & Logbook	• Structured learning events including case discussions • Log book to reflect exposure • Log book to reflect an understanding of risks and benefits. • Proficiency is optional and is likely to require additional training outside of the Credential				
Formative Assessments:		**EPA 1st quarter**	**EPA 2nd quarter**	**EPA 3rd quarter**	**EPA 4th quarter**
1	Demonstrates an understanding of and where appropriate the ability to perform neurolytic blockade (including autonomic, peripheral and regional techniques) in the management of cancer pain	1	1,2	1,2,3	1,2,3
2	Demonstrates an understanding of and where appropriate the ability to deliver some of the highly specialised treatments for the management of cancer pain, including but not exclusively, percutaneous cordotomy	1	1,2	2,3	2,3
3	Demonstrates ability to signpost/refer patients requiring interventional procedures for cancer pain to appropriate centres	1,2	2,3	3,4	4
4	Demonstrates ability to recognise complications arising from such procedures and refer back to/ seek advice of other appropriate teams/specialists when required	1,2	1,2	3,4	3,4
Personal Activities and Personal Reflections may include:	• Multi-disciplinary pain meeting reflections • Patient feedback				
Global Assessments	• Satisfactory MSF • MTR • FFPMRCA exam				
Trainee (signature)					
RAPM (signature)					

Date:	

High Level Learning Outcome Neuromodulation & Implantable Technology - 1	**Assessing patients for Neuromodulation & Implantable Technology** **EPA – entrustable professional activity*** **(See key for guide to levels)**				
Examples of Evidence					
Experience & Logbook	• Structured learning events including case discussions • Log book to reflect exposure • Log book to reflect discussion of risks and benefits				
Formative Assessments:		**EPA 1st quarter**	**EPA 2nd quarter**	**EPA 3rd quarter**	**EPA 4th quarter**
1	Demonstrates the ability to assess pain including, location, nature and any relevant psychosocial factors, in the context of neuromodulation suitability and risk.	1	1,2	2,3,4	3,4
2	Demonstrates ability to work in a multidisciplinary team	1,2	2,3	3,4	3,4
3	Demonstrates an appreciation of appropriate skill mix for multidisciplinary management in neuromodulation and implantable technology	1	2,3	3,4	4
4	Demonstrates effective communication with other healthcare professionals in primary and secondary care e.g., surgical specialties for assessment and treatment of complications and communication with specialist teams offering neuromodulation and Implantable technology	1	1,2	3,4	3,4
Personal Activities and Personal Reflections may include:	• Multi-disciplinary pain meeting reflections • Patient feedback				
Global Assessments	• Satisfactory MSF • MTR • FFPMRCA exam				
Trainee (signature)					
RAPM (signature)					
Date:					

High Level Learning Outcome Neuromodulation & Implantable Technology - 2	**Performing Neuromodulation & Implantable Technology** **EPA – entrustable professional activity*** **(See key for guide to levels)**				
Examples of Evidence					
Experience & Logbook	• Structured learning events including case discussions • Log book to reflect exposure to having seen these procedures being performed • Log book to reflect an understanding of risks and benefits. Proficiency is optional and is likely to require additional training outside of the Credential				
Formative Assessments:		**EPA 1st quarter**	**EPA 2nd quarter**	**EPA 3rd quarter**	**EPA 4th quarter**
1	Demonstrates an understanding of the technical skills required for safe SCS and neuromodulation techniques	1	1,2	1, 2	1,2
2	Demonstrates ability to recognise complications and refer to other appropriate teams/specialists when needed	1,2	1,2	1,2	1,2
Personal Activities and Personal Reflections may include:	• Multi-disciplinary pain meeting reflections • Patient feedback				
Global Assessments	• Satisfactory MSF • MTR • FFPMRCA exam				
Trainee (signature)					
RAPM (signature)					
Date:					

Guidance to supervision and attainment of High-Level Learning Outcomes:

1. Is there a minimum EPA level for which a trainee needs to meet across some/all domains of a HALO to be signed off?

Supervision level 1 is expected throughout the Credential should any trainee perform any procedures of implantable technology e.g., intrathecal pumps or dorsal column stimulators. Procedures which have a higher risk of potential to do harm, e.g., radiofrequency denervation, major sympathetic blocks require a high level of supervision until the trainer and trainee are confident that significant level of expertise (and hence safety margin) has been reached.

2. What proportion of the HALO form need to be >3 or >4 to be signed off?

The HALO forms list the recommended Entrustable Professional Activities that we would expect trainees to work towards and achieve at each milestone in training. We recognise however that there is a diversity in trainees, trainers and training and would therefore recommend that for patient safety reasons, *these are the minimum acceptable levels of supervision that we would expect by the end of training for each and every trainee:*

<u>Specialty specific domains</u>

1. Manages referrals/triages within pain service – Supervision 4
2. Manages an outpatient Pain Medicine clinic – Supervision 4
3. Manages pain procedural cases – Supervision 3
4. Participates effectively within a Pain MDT – Supervision 4
5. Manages inpatient pain and acute pain rounds – Supervision 4
6. Manages patients who are taking drugs of potential addiction –optimisation of medicines - Supervision 2B
7. Has an understanding of the socioeconomic, occupational health and medicolegal aspects of Pain Medicine – Supervision 3
8. Understands the Healthcare infrastructure and the pain service – Supervision 3

<u>Specialist capabilities in practice (Paediatric Pain Medicine)</u>

1. Managing pain in paediatric patients (chronic pain) – Supervision 2B
2. Managing pain in paediatric patients (acute pain) – Supervision 2B

<u>Specialist capabilities in practice (Cancer Pain Medicine) domains</u>

1. Managing pain in cancer patients – Supervision 3
2. Performing interventions in cancer patients – Supervision 2B

<u>Specialist capabilities in practice (Neuromodulation/Implantable Technology) domains</u>

1. Assessing patients for Neuromodulation – Supervision 3
2. Performing neuromodulation techniques – Supervision 1

3. Are there critical domains that must achieve a minimum level for reasons of patient safety?

With the exception of neuromodulation, 2B should be the minimum for chronic paediatric pain management.

4. There is clearly a progression from EPA 1 or 2 to EPA 3 to 5 across all the domains. What level of progression would we expect to see on average between each RAPM assessment and how will we

manage a trainee who fails to show progression each quarter or worse is still EPA 2 at the third or fourth quarter in the core domains?

At Quarterly reviews: (duration of the "quarter" will depend on indicative period of training for each trainee:

- 3 months – supervision 1 or 2A
- 6 months – supervision 2B
- 9 months – supervision 3
- 12 months – supervision 4 for those domains that require it (see list above)

If trainees are stuck on supervision level 2 at the third quarter on a domain that requires a supervision level 4 and the other domains are progressing, is there time to focus on that domain in the remaining training period? If trainees are failing to achieve their expected progression is their scope to extend training?

Focussing on areas of weakness would be advised as part of an educational plan agreed with the Regional Advisor in Pain Medicine, Faculty Tutor in Pain Medicine and the Training Programme Director if the trainee is in a pre-CCT programme. This will require more interaction/meetings with training further individually tailored to allow greater exposure to achieve the required recommended end points. If feasible and required, extension of the indicative training period may also be required. Our trainers are trained to help "trainees in difficulty" and will use their skills to ensure that each trainee achieves their maximum potential. For more information regarding management of the "trainee in difficulty" please see Section: 4.4d

Lifelong Learning Platforms

The FPM encourages trainees for the Credential in Pain Medicine to use the Royal College of Anaesthetists Lifelong Learning Platform (LLP) and electronic logbook. However, this is not mandatory, and trainees may choose to use their own electronic logbook of choice as long as this is fit for purpose. Electronic data collection will allow doctors training for a Credential in Pain Medicine to keep a real-time record of clinical assessments, multi-source feedback, portfolio developments, CPD learning and logbook data. It is encouraged that the e-Portfolio which has been developed to support lifelong learning, will continue to be used by all doctors in Pain Medicine both pre- and post-credentialing as part of their yearly appraisal and revalidation process.

Blueprint of work-place based assessments mapped to training points

A timeline example is shown below to illustrate how these assessments will typically be used in practice in an indicative 12-month training period:

	Month of training													
Assessment type	Pre	1	2	3	4	5	6	7	8	9	10	11	12	Post
Formative (CEX/DOPS/CbD/)														
Holistic Assessment of Learning Outcomes (HALO forms)														
Quarterly review														
Logbook														
FFPMRCA exam MCQ														
FFPMRCA exam SOE														
MTR feedback														
MSF feedback														
Patient feedback [CARE]														
Professional practice review														
Final sign-off														

Quarterly appraisal progression points

The RAPM (Regional advisor in Pain Medicine) will review formative assessments, logbook, consultant feedback and portfolio progression at each quarterly assessment. At the six-month and twelve-month assessment, patient feedback will also be reviewed. One MSF (multisource feedback) must be completed in the indicative 12 months period. It is recommended this is completed between the sixth to the tenth month so that remedial training and guidance can occur, if required, before the end of the training. RAPMs will use the logbook information at quarterly reviews to guide future clinical and procedural exposure so that sufficient clinical breadth of training is achieved to meet all curriculum learning outcomes. The RAPM will also review HALO forms as a summative assessment – these are completed throughout the whole period of training as various outcomes are achieved.

FFPMRCA examination

The FFPMRCA exam has been established since 2011 and runs twice per year. The Faculty of Pain Medicine Fellowship Examination was introduced in 2012. The FFPMRCA examination is made up of two sections. The first is a Multiple Choice (MCQ). Upon successful completion of the MCQ, candidates sit a Structured Oral Examination (SOE). The MCQ comprises of 40 Multiple True/False (MTF), 25 Single Best Answer (SBA) Questions and 25 Extended Matching Questions (EMQ). The SOE comprises of two sections, Clinical Pain Medicine (SOE1) and Clinical Science (SOE2). The regulations of the examination are available on the FPM website.

An FFPMRCA Examiner is one of a team of examiners (the Court of Examiners) responsible for assessing the performance of candidates taking part in FFPMRCA examinations. Examiners are recruited subject to a probationary year. Examiners will be expected to actively contribute to the continuous

development of examination content, procedure and processes and will give the highest priority to the examination above all commitment. The Court of Examiners is led by a Chair who is a Board member of the FPM and reports to the Board every three months.

The FFPMRCA exam is part of the summative assessment for attaining the Credential in Pain Medicine. Once a trainee has successfully sat for both parts of the examination, they will be invited to join the Faculty of Pain Medicine of the Royal College of Anaesthetists and will be able to use the post nominals FFPMRCA.

Trainees prepare for the exam using current FPM resources to guide their preparation, which includes up to date educational material (including amongst others access to e-Pain and FPM-learning hub on line), an FPM tutorial course run twice yearly and regional and national educational courses from a variety of sources.

The FPM firmly believes that the FFPMRCA exam in its current format has raised clinical standards for practicing Consultants working in Pain Medicine by having a suitably rigorous exam standard and process to which trainees in advanced pain medicine prepare for and aspire to.

The FFPMRCA examination is conducted in accordance with the highest standards and further raises standards of Pain Medicine in the UK. A successful exam candidate demonstrates the breadth and depth of knowledge as well as some of the skills in the clinical practice of Pain Medicine, that underpins this to a level expected of a consultant practising in Pain Medicine.

The FFPMRCA exam as an integral part of the Credential will apply only to future trainees rather than retrospectively.

The examination became an essential step to awarding Fellowship of the Faculty of Pain Medicine since 2012 and we do not envisage that this will change.

We have a robust system in place to support trainees who do not pass their exam.

Exam Data publishing strategy:

(i) Currently Pass-Fail lists are published on the exam pages of the Faculty Website from 2pm on the release of results date of which candidates will have previously been advised.

(ii) Candidates are identified on pass-fail lists by their candidate number and College/Faculty reference number only. Candidates can choose to opt out of the pass/fail list by contacting the examination department at least 48 hours before the release of results date, in which case such candidates will receive their results by conventional mail. Results cannot be provided to candidates by email or telephone.

(iii) We currently do not publish FFPMRCA exam statistics in the public domain. However, if the GMC approves the FFPMRCA exam as an integral part of the Credential so in essence the exam becomes regulated by the GMC, we will adopt the data publishing strategy that our parent college currently uses for the FRCA and FICM examinations.*

(iv) The following is the data publishing strategy for FRCA and FICM (please note that the MCQ process

FFPMRCA Exam Strategy:

Multiple Choice Questions:

- Data received from Test Reach

- Data transferred to MS Excel reliability calculator template and scrutinised by College statistics Lead identifying outlier Angoffers and poorly performing items. Quintiles produced per item.
- Data sent in advance to MCQ chair in preparation for their meeting
- Data analysed, reviewed and standard set by MCQ core groups (online meeting) with lead administrator and College stats lead in attendance
- Item statistics updated in item banks (by exams department – this will at some point be done in Test Reach)
- Data transferred from reliability calculator (Excel) to exams Master Spreadsheet (Excel) and checked by Examinations Department.
- Results emailed directly to candidates on pre-determined day by exams department via a merge from the master spreadsheet (Excel) to a mail merge exam results template email.
- Pass rate for each sitting published on website
- Director record updated on SharePoint
- Results reported annually to GMC and College
- Annual report on differential attainment
- Update to Exams Committee/Education, Training and Examinations (ET&E) Board (FRCA) & TAQ (FICM)

Clinical (SOE)

- Data analysed, reviewed and checked by Examinations Department.
- Examiner chairs check 'fail by ones' (SOE/OSCE) and jagged marking (SOE)
- Examination result breakdowns sent to examination chairs, OSCE WP, SOE core groups
- Results reported at Primary Examinations Review Group (PERG) meeting /Final Examinations Review Group (FERG) meeting / Examinations Review meeting (FICM) held after the exam week.
- Results emailed directly to candidates on pre-determined day by exams department via a merge from the master spreadsheet (Excel) to a mail merge exam results template email.
- Pass rate for each sitting published on website
- FRCA OSCE WP review all questions from the last exam diet. Criteria for questions that need to be rewritten and/or re-Angoffed
- Director record updated on SharePoint
- Chairman's report published on website after each exam diet (FICM only)
- Results reported annually to GMC and College
- Annual report on differential attainment
- Update to Exams Committee/Education, Training and Examinations (ET&E) Board (FRCA) & TAQ (FICM)

4.3 Interaction with Supervisors (RAPM & FTP)

a. Supervision

The Regional Advisor in Pain Medicine (RAPM) will coordinate the training programme according to the needs of the candidate — for example, an anaesthetic trainee is likely to require more guidance in cancer and palliative medicine training, whereas a trainee in palliative medicine will need more focal acute pain exposure.

The RAPM will meet the candidate quarterly to guide and review progress. The RAPM is also responsible for signing-off the training as successfully completed once the trainee has satisfactorily achieved all the curriculum outcomes. The roles and responsibilities of RAPMs can be found on the FPM site. (RAPMs)

Faculty Tutors in Pain Medicine or FTPs are allocated to each hospital recognised for pain training leading to a credential within the post graduate training in Pain Medicine. They will support the candidate locally, complete formative assessments and act as clinical supervisors. More information on their role can be found at the FPM site. (Faculty Tutors)

b. Feedback

To allow attainment of generic and professional skills, Consultant feedback, multi-source feedback (MSF) and patient feedback are embedded within the assessment process. Consultant and MSF feedback is linked to the e-portfolio. Patient feedback will be measured using the CARE measure or any another validated tool, at least twice within the training year.

c. Guidance for annual review of competency progression (ARCP) [within the CCT]

The sign-off completed at the 12-month review will be submitted as evidence of successful training for the ARCP process and counts towards the period of training leading to the candidate's CCT within their own speciality (for example Anaesthetics). The candidate can apply to the FPM to become a Fellow once the FFPMRCA examination is completed. Application will also need to be made to the GMC for the Credential to be added against the doctor's name on the List of Registered Medical Practitioners. Award of a Credential prior to achieving CCT is not equivalent to CCT status and does not at present allow for appointment to a Substantive NHS Consultant post without additional CCT status.

d. Guidance for review of competency progression [post CCT] or for Specialty Grade Doctors:

The sign-off completed at the 12-month review can be used for appraisal and revalidation and to inform future employers at interview. The candidate can apply to the FPM for Fellowship status once all assessments are completed in the 12-month review and the examination has been successfully completed at both stages. The trainee will also need to apply to the GMC to have their Pain Medicine training for award of a Credential and for this to be recorded on the List of Registered Medical Practitioners. For non CCT holders, a Credential is not equivalent to CCT training and although it will allow for independent practice, it does not translate into the right to apply for a substantive NHS Consultant Post.

4.4 Quality assurance and improvement

a. Ensuring quality in training and delivery

Training to achieve the Credential in Pain Medicine will take place in a UK Hospital that is recognised by the Faculty of Pain Medicine (FPM) as having met the core standards in pain management, such that the centre has the necessary capacity, supervisors and facilities to provide an environment conducive to supporting successful training.

Please refer to: Core Standards.

The FPM assesses training centres formally every three years requesting information regarding services, including capacity, staffing levels, specialist clinics, procedures performed, and governance data all submitted in a Hospital Review Form (HRF). The Hospital Review Form is published on the FPM website and is available for trainees to review and guide towards choosing their preferred region and/or hospital for training.

Moreover, annual review forms are also submitted via the Regional Advisor in Pain Medicine to the FPM to allow reporting of any issues about individual trainees or specific training hospitals. Both forms also allow up to date collation of data about work force.

The FPM also runs annual trainee satisfaction surveys and provides the trainees with an annual opportunity for trainees to meet members of the Training and Assessment Committee to discuss their training and any ongoing issues.

A trainee representative also attends the Training and Assessment Committee and sits as a co-opted member on the Board of the Faculty of Pain Medicine.

For more information on the FPM Quality Assurance process please refer to:
FPM QA

b. Curriculum governance

The FPM has worked in parallel with the Royal College of Anaesthetists to all levels of post graduate training in Pain Medicine to meet the new generic professional capabilities framework.

This credential reflects Level 3C training in Pain Medicine within the Royal College of Anaesthetists' *2021 Anaesthetics Curriculum* and will become the minimum standard for training for future pain specialists within the UK.

c. Equality & Diversity

The Faculty of Pain Medicine together with its parent college, the Royal College of Anaesthetists, commits itself to complying fully with the requirements of the Equality Act 2010 in respect of Equality and Diversity. It will strive to ensure that its educational and clinical supervisors have all undergone the necessary training to comply with these requirements as set out by the General medical council. It will also ensure that trainees are provided with the necessary training, guidance and support to ensure that they are fully supported in the true spirit of equality and diversity.

Compliance will be assured through:

1. Monitoring of recruitment, assessments, and the FFPMRCA examination
2. Quality assurance of all training processes for educational and clinical supervisors

3. Quality assurance of support processes for trainees, ensuring that they have a confidential and supportive mentor should they require one.

d. Mechanisms in place to appropriately manage the poorly performing trainees:

Each individual trainee has a nominated Faculty Tutor in Pain medicine who acts as an Educational Supervisor. This is separate to other medical and non-medical members of the multidisciplinary pain team, who act as Clinical Supervisors. Regional Advisors in Pain Medicine meet with Trainees at the beginning of their training and each trainee has regularly work based assessments with their Faculty Tutor as well as formal quarterly reviews with their RAPM which allow assessment of progress in real time.

The Faculty Tutor is answerable to a Regional Advisor in Pain medicine (RAPM) and there are 21 regions within the four nations of the UK. The RAPM also meets with the Trainee at the start of training to ensure that there is a complete programme in place to complete training. The RAPM can be called upon to meet with the trainee at any point during training either by the trainee or his/her trainers if there are any concerns.

RAPM are also governed by a Chair and meet four times a year to discuss both general issues in training as well as any individual concerns. If there is significant concern the relevant Head of School of Anaesthesia is also involved.

The RAPM Chair is part of the Training and Assessment Committee which oversees training and the committee in turn reports to the Board of the FPM. Serious concerns can be escalated up to and discussed at Board Level.

Governance and infrastructure are such that it is rare that we have trainees who face significant or unsurmountable problems during their training.

The FPM is also proactive in dealing with external issues that can affect training, as in for instance the recent COVID 19 pandemic. Each individual trainee in higher and advanced pain medicine was offered an interview with the Training and Assessment committee to mitigate as much as possible the impact of the pandemic on training. This was very much welcomed by our trainees and successfully implemented.

With regards to the FFPMRCA exam we do have a high pass percentage. If a candidate performs badly, we will communicate this to their RAPM who can then have a meeting with the trainee. This meeting will be focused on feedback from exams followed by a constructive plan towards preparing for the exams depending on individual trainee requirements. The FPM will help with this process as necessary.

Together with our parent college we also provide support for trainees in need due to personal or other circumstances, appropriately signposting them to support services as needed.

The FPM also has a buddying system to mentor and support doctors who may be in training in post CCT programs.

Annex A: Examples of Assessment Forms

HALOs for RCOA 2021 curriculum (stage 1-3A)

These are useful to guide trainers regarding equivalent experience or level of training doctors will need to have before embarking on the Credential in particular for doctors who are not pre or post CCT holders in Anaesthesia as a specialty and for Specialty Grade Doctors:

High Level Learning Outcome **Stage 1**	Recognises, assesses and treats acute pain independently. Differentiates between acute and chronic pain

Key Capabilities	
A	Can recognise, examine, assess and manage acute pain in the surgical and non-surgical patient
B	Can safely and appropriately prescribe medication for pain management in the perioperative period
D	Demonstrates effective communication skills regarding pain management with patients, relatives and carers

Examples of Evidence	SLEs throughout stage of training across range of surgical specialties including acute pain rounds
Supervision Level	Minimum 2b
Cross links with other domains and capabilities	Professional behaviours and communication

C	Demonstrates the basic assessment and management of acute on chronic and chronic pain in adults
E	Describes the concept of biopsychosocial multi-disciplinary pain management

Examples of Evidence	SLEs throughout stage of training across range of surgical specialties including acute pain rounds Personal activities such as teaching sessions, e-learning, attending pain clinic
Supervision Level	Minimum 2a
Cross links with other domains and capabilities	Professional behaviours and communication

F	Describes the special circumstances in assessing and managing perioperative pain in specific patient groups including children, pregnancy and breast feeding, the elderly and frail, those with learning and communication difficulties, autism, dementia, renal and hepatic impairment and substance abuse

Examples of Evidence	SLEs throughout stage of training across range of surgical specialties including those from obstetrics and paediatrics EPA 3 and 4

Supervision Level	N/A
Cross links with other domains and capabilities	General anaesthesia F, O, P, Q and R Intensive Care Medicine

G	Demonstrates the safe use of equipment used in pain management

Examples of Evidence	SLEs throughout stage of training across range of surgical specialties eg setting up PCA pump, epidural EPA 3
Supervision Level	Minimum 3
Cross links with other domains and capabilities	Safety and quality improvement General anaesthesia

High Level Learning Outcome **Stage 2**	Understands the aetiology and management of acute, acute on chronic and chronic pain

Key Capabilities	
A	Utilises a multi-disciplinary approach to the management of complex pain within a biopsychosocial model of care
B	Can confidently manage acute pain in the whole perioperative pathway in a timely manner

Examples of Evidence	SLEs throughout stage of training across range of surgical specialties, acute pain ward rounds and from specialist pain clinics Examples: Regional anaesthesia techniques for post-operative pain Management plans for the transition to oral analgesia from PCA, neuraxial or regional anaesthesia techniques Biopsychosocial approach in pain management programmes and multidisciplinary reviews **Personal activities and reflections:** Leading pain round Attendance at specialist pain clinic
Supervision Level	Minimum 3
Cross links with other domains and capabilities	General Anaesthesia Regional Anaesthesia Team Working Professional Behaviours and Communication

C	Is able to assess patients, interpret investigations and initiate management of chronic malignant and non-malignant pain in a timely manner under distant supervision
D	Can assess and manage acute on chronic and chronic in-patient pain in adults and recognise when referral to specialist pain services is appropriate
E	Identify barriers to effective pain management including those related to patient beliefs, society, culture, and healthcare provision

Examples of Evidence	SLEs throughout stage of training across range of surgical specialties, acute pain ward rounds and from specialist pain clinics **Personal activities and reflections:** Attendance at specialist pain clinic, pain intervention lists
Supervision Level	Minimum 2b
Cross links with other domains and capabilities	Perioperative Medicine and Health Promotion

F	Explains the risk factors for persistent post-surgical pain including measures to minimise its occurrence

Examples of Evidence	SLEs throughout stage of training across range of surgical specialties, acute pain ward rounds and from specialist pain clinics
Supervision Level	N/A

Cross links with other domains and capabilities	General anaesthesia Perioperative Medicine and Health Promotion Professional Behaviours and Communication

High Level Learning Outcome **Stage 3**	Able to initiate complex pain management for in-patients and to sign-post to appropriate pain management services

Key Capabilities		
A	Applies knowledge and understanding of assessment and management of pain in a multi-professional context	
B	Demonstrates safe effective pharmacological management of acute and procedure pain in all age groups	
C	Acts as an effective member of the inpatient pain team	
	Examples of Evidence	SLEs throughout stage of training across range of surgical specialties, acute pain ward rounds and from specialist pain clinics For example: Managing and planning analgesia for patients with chronic pain who present for surgery Leading an inpatient acute pain round Recognition of comorbidities and adjustment of pain medications accordingly **Personal activities and reflections:** Attendance at pain clinic, multidisciplinary pain meetings Development of an individual pain management care plan in pre-operative assessment clinic
	Supervision Level	4
	Cross links with other domains and capabilities	General anaesthesia Regional anaesthesia Team Working Perioperative Medicine and Health Promotion Intensive Care Medicine
D	Effectively engages with multi-disciplinary primary and secondary pain services and palliative care when necessary	
E	Recognises the need for and complications of interventional pain procedures	
	Examples of Evidence	SLEs throughout stage of training across range of surgical specialties, acute pain ward rounds and from specialist pain clinics For example: Recognition of end-of-life care and adjustments to pain medication accordingly Managing and planning analgesia for patients with acute on chronic pain Assessing patients with chronic pain **Personal activities and reflections:** Experience of management of pain in the terminal care setting Attendance at pain intervention lists
	Supervision Level	N/A

Cross links with other domains and capabilities	General anaesthesia Perioperative Medicine and Health Promotion Team Working

F	Prescribes appropriately in the perioperative period and recognises the long-term implications of not reviewing patient analgesia in the post–operative period following discharge

Examples of Evidence	SLEs throughout stage of training across range of surgical specialties acute pain ward rounds and from specialist pain clinics Examples: Managing and planning analgesia for discharge **Personal activities and reflections:** Identification and management of complications from patient-controlled analgesia, neuraxial techniques and continuous regional techniques
Supervision Level	4
Cross links with other domains and capabilities	General anaesthesia Regional anaesthesia Perioperative Medicine and Health Promotion

H	Plans the perioperative management of patients for surgery who are taking high dose opioids and other drugs of potential addiction

Examples of Evidence	SLEs throughout stage of training across range of surgical specialties, acute pain ward rounds and from specialist pain clinics For example: Management of the intra-venous drug user who presents for surgery Managing and planning analgesia for patients with chronic pain who present for surgery
Supervision Level	4
Cross links with other domains and capabilities	General anaesthesia Regional anaesthesia Perioperative Medicine and Health Promotion

Annex B: Assessment forms for Supervised Learning Events: SLE

a. Anaesthesia Clinical Evaluation Exercise (A-CEX) Assessment Form

FACULTY OF PAIN MEDICINE of the Royal College of Anaesthetists

Anaesthesia Clinical Evaluation Exercise (A-CEX)

Doctor in training: _____

GMC number (must be completed): _____

Observed by: _____

GMC number (must be completed): _____

Date (DD/MM/YYYY) ☐☐/☐☐/☐☐☐☐

Stage of training (please circle): **1** **2** **3**

Description of activity (case, complexity & context)	

Summary of reflective discussion between doctor in training and trainer To be completed by doctor in training and trainer	

Faculty of Pain Medicine of the Royal College of Anaesthetists
Churchill House, 35 Red Lion Square, London WC1R 4SG
Tel 020 7092 1550 Email contact@fpm.ac.uk Website https://ww.fpm.ac.uk

Level of supervision		
Based on this encounter, what is the level of supervision the anaesthetist in training would require if they were to repeat this activity 'right here, right now'?		Please indicate level of supervision:
1	Direct supervisor involvement, physically present in same clinic/theatre throughout	
2A	Supervisor in other clinic room or in theatre suite, available to guide aspects of activity through monitoring at regular intervals	
2B	Supervisor within hospital for queries, able to provide prompt direction/assistance	
3	Supervisor on call from home for queries able to provide directions via phone or non-immediate attendance	
4	Should be able to manage independently with no supervisor involvement (although should inform consultant supervisor as appropriate to local protocols	
N/A	Supervision level not applicable for this SLE	

Suggestions for future development To be completed by doctor in training and trainer *You may wish to consider: GPCs, targeted clinical experience, key learning resources, progression to next level of supervision*	

b. Anaesthetic List Management Assessment Tool (ALMAT)

FACULTY OF
PAIN MEDICINE
of the Royal College of Anaesthetists

Anaesthetic List Management Assessment Tool (ALMAT)

Doctor in training: _____

GMC number (must be completed): _____

Observed by: _____

GMC number (must be completed): _____

Date (DD/MM/YYYY) ☐☐/☐☐/☐☐☐☐

Stage of training (please circle): **1** **2** **3**

Description of activity (cases, complexity & context)	

Summary of reflective discussion between anaesthetist in training and trainer about the management of this list To be completed by doctor in training and trainer *You may wish to discuss:* • *List preparation* • *Patient interaction* • *Team interaction* • *Risk minimisation* • *Non technical skills* • *Efficiency in management* of list	

Faculty of Pain Medicine of the Royal College of Anaesthetists
Churchill House, 35 Red Lion Square, London WC1R 4SG
Tel 020 7092 1550 Email contact@fpm.ac.uk Website https://ww.fpm.ac.uk

Level of supervision		
Based on this encounter, what is the level of supervision the anaesthetist in training would require if they were to repeat this activity 'right here, right now'?		Please indicate level of supervision:
1	Direct supervisor involvement, physically present in same/ clinic/theatre throughout	
2A	Supervisor in other clinic room or in theatre suite, available to guide aspects of activity through monitoring at regular intervals	
2B	Supervisor within hospital for queries, able to provide prompt direction/assistance	
3	Supervisor on call from home for queries able to provide directions via phone or non-immediate attendance	
4	Should be able to manage independently with no supervisor involvement (although should inform consultant supervisor as appropriate to local protocols	
N/A	Supervision level not applicable for this SLE	

Suggestions for future development To be completed by doctor in training and trainer *You may wish to consider: GPCs, targeted clinical experience, key learning resources, progression to next level of supervision*	

c. Anaesthesia Quality Improvement Project Assessment Tool (A-QIPAT)

FACULTY OF
PAIN MEDICINE
of the Royal College of Anaesthetists

Anaesthesia Quality Improvement Project Assessment Tool (A-QIPAT)

Doctor in training: _____

GMC number (must be completed): _____

Observed by: _____

GMC number (must be completed): _____

Date (DD/MM/YYYY) ☐☐/☐☐/☐☐☐☐

Stage of training (please circle): **1** **2** **3**

Project aim Create a SMART aim linked to the problem identified

Faculty of Pain Medicine of the Royal College of Anaesthetists
Churchill House, 35 Red Lion Square, London WC1R 4SG
Tel 020 7092 1550 Email contact@fpm.ac.uk Website https://ww.fpm.ac.uk

Evaluation of Project Analysis of data (compared to predictions), learning points from project and evaluation of own role as part of the project. Include the next steps for the project and possible future tests of change.

What elements of the QI project were done well?

d. Case Based Discussion (CBD) Assessment Form

FACULTY OF
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Case Based Discussion (CBD)

Doctor in training: _____

GMC number (must be completed): _____

Observed by: _____

GMC number (must be completed): _____

Date (DD/MM/YYYY) ☐☐/☐☐/☐☐☐☐

Stage of training (please circle): **1** **2** **3**

Description of activity (case, complexity & context)	

Summary of reflective discussion between doctor in training and trainer To be completed by doctor in training and trainer	

Faculty of Pain Medicine of the Royal College of Anaesthetists
Churchill House, 35 Red Lion Square, London WC1R 4SG
Tel 020 7092 1550 Email contact@fpm.ac.uk Website https://ww.fpm.ac.uk

Level of supervision		
Based on this encounter, what is the level of supervision the anaesthetist in training would require if they were to repeat this activity 'right here, right now'?		Please indicate level of supervision:
1	Direct supervisor involvement, physically present in same clinic/theatre throughout	
2A	Supervisor in other clinic room or in theatre suite, available to guide aspects of activity through monitoring at regular intervals	
2B	Supervisor within hospital for queries, able to provide prompt direction/assistance	
3	Supervisor on call from home for queries able to provide directions via phone or non-immediate attendance	
4	Should be able to manage independently with no supervisor involvement (although should inform consultant supervisor as appropriate to local protocols	
N/A	Supervision level not applicable for this SLE	

Suggestions for future development To be completed by doctor in training and trainer *You may wish to consider: GPCs, targeted clinical experience, key learning resources, progression to next level of supervision*	

e. Direct Observation of Procedural Skill (DOPS) Assessment Form

FACULTY OF
PAIN MEDICINE
of the Royal College of Anaesthetists

Direct Observation of Procedural Skill (DOPS)

Doctor in training: _____

GMC number (must be completed): _____

Observed by: _____

GMC number (must be completed): _____

Date (DD/MM/YYYY) ☐☐/☐☐/☐☐☐☐

Stage of training (please circle): **1** **2** **3**

Description of activity (case, complexity & context)	

Summary of reflective discussion between doctor in training and trainer To be completed by doctor in training and trainer	

Faculty of Pain Medicine of the Royal College of Anaesthetists
Churchill House, 35 Red Lion Square, London WC1R 4SG
Tel 020 7092 1550 Email contact@fpm.ac.uk Website https://ww.fpm.ac.uk

Level of supervision		
Based on this encounter, what is the level of supervision the anaesthetist in training would require if they were to repeat this activity 'right here, right now'?		Please indicate level of supervision:
1	Direct supervisor involvement, physically present in clinic/ theatre throughout	
2A	Supervisor in other clinic room or in theatre suite, available to guide aspects of activity through monitoring at regular intervals	
2B	Supervisor within hospital for queries, able to provide prompt direction/assistance	
3	Supervisor on call from home for queries able to provide directions via phone or non-immediate attendance	
4	Should be able to manage independently with no supervisor involvement (although should inform consultant supervisor as appropriate to local protocols	
N/A	Supervision level not applicable for this SLE	

Suggestions for future development To be completed by doctor in training and trainer *You may wish to consider: GPCs, targeted clinical experience, key learning resources, progression to next level of supervision*	

f. Multiple Trainer Report (MTR) Assessment Form

FACULTY OF
PAIN MEDICINE
of the Royal College of Anaesthetists

Multiple Trainer Report (MTR)

Doctor in Training surname:

Doctor in Training name:

GMC number:

Assessor Name:

Assessor designation:

GMC number:

Date:

Stage of Training: _____ **Quarter**

Is the doctor in training making satisfactory progress for their stage of training?

☐ Yes
☐ No

If no, comment must be provided on areas of the curriculum that require development on the following pages.

FACULTY OF
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Assessment of doctor in training's performance in curriculum domains

Generic Professional Capability Domains

1. **Professional behaviours and communication:**
   - ☐ Excellent or outstanding practice
   - ☐ Satisfactory
   - ☐ Area for development
   - ☐ Unable to comment
2. **Management and professional and regulatory requirements:**
   - ☐ Excellent or outstanding practice
   - ☐ Satisfactory
   - ☐ Area for development
   - ☐ Unable to comment
3. **Team working:**
   - ☐ Excellent or outstanding practice
   - ☐ Satisfactory
   - ☐ Area for development
   - ☐ Unable to comment
4. **Safety and Quality Improvement:**
   - ☐ Excellent or outstanding practice
   - ☐ Satisfactory
   - ☐ Area for development
   - ☐ Unable to comment
5. **Safeguarding:**
   - ☐ Excellent or outstanding practice
   - ☐ Satisfactory
   - ☐ Area for development
   - ☐ Unable to comment
6. **Education and training:**
   - ☐ Excellent or outstanding practice
   - ☐ Satisfactory
   - ☐ Area for development
   - ☐ Unable to comment
7. **Research and managing data:**
   - ☐ Excellent or outstanding practice
   - ☐ Satisfactory
   - ☐ Area for development
   - ☐ Unable to comment

FACULTY OF PAIN MEDICINE of the Royal College of Anaesthetists

Assessment of doctor's performance in specialist learning outcomes

1. **Manages an outpatient Pain Medicine Clinic:**
   - ☐ Excellent or outstanding practice
   - ☐ Satisfactory
   - ☐ Area for development
   - ☐ Unable to comment

2. **Manages referrals/triages within the pain service:**
   - ☐ Excellent or outstanding practice
   - ☐ Satisfactory
   - ☐ Area for development
   - ☐ Unable to comment

3. **Manages pain procedural cases:**
   - ☐ Excellent or outstanding practice
   - ☐ Satisfactory
   - ☐ Area for development
   - ☐ Unable to comment

4. **Participates effectively with a Pain MDT:**
   - ☐ Excellent or outstanding practice
   - ☐ Satisfactory
   - ☐ Area for development
   - ☐ Unable to comment

5. **Understands the Healthcare infrastructure and the pain service:**
   - ☐ Excellent or outstanding practice
   - ☐ Satisfactory
   - ☐ Area for development
   - ☐ Unable to comment

6. **Has an understanding of the socioeconomic, occupational health and medicolegal aspects of Pain Medicine:**
   - ☐ Excellent or outstanding practice
   - ☐ Satisfactory
   - ☐ Area for development
   - ☐ Unable to comment

7. **Manages patients who are taking drugs of potential addiction – optimisation of medicines:**

- ☐ Excellent or outstanding practice
- ☐ Satisfactory
- ☐ Area for development
- ☐ Unable to comment

8. **Manages in-patient pain and acute pain rounds:**
   - ☐ Excellent or outstanding practice
   - ☐ Satisfactory
   - ☐ Area for development
   - ☐ Unable to comment
9. **Managing acute paediatric pain:**
   - ☐ Excellent or outstanding practice
   - ☐ Satisfactory
   - ☐ Area for development
   - ☐ Unable to comment
10. **Managing chronic paediatric pain:**
   - ☐ Excellent or outstanding practice
   - ☐ Satisfactory
   - ☐ Area for development
   - ☐ Unable to comment
11. **Managing pain in cancer patients:**
   - ☐ Excellent or outstanding practice
   - ☐ Satisfactory
   - ☐ Area for development
   - ☐ Unable to comment
12. **Performing interventions in cancer patients:**
   - ☐ Excellent or outstanding practice
   - ☐ Satisfactory
   - ☐ Area for development
   - ☐ Unable to comment
13. **Assessing patients for neuromodulation and implantable technology:**
   - ☐ Excellent or outstanding practice
   - ☐ Satisfactory
   - ☐ Area for development
   - ☐ Unable to comment
14. **Performing neuromodulation and implantable technology:**
   - ☐ Excellent or outstanding practice
   - ☐ Satisfactory
   - ☐ Area for development
   - ☐ Unable to comment

FACULTY OF
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For Dr _____

All doctors are expected to seek feedback on a regular basis from those they work with and treat. Information from patients, relatives and friends is an important part of this process. The feedback will be reviewed and acted upon where appropriate.

In responding to each question please tick the box that most represents your situation or viewpoint. You also have the opportunity to state what your Pain Medicine Doctor did particularly well, or anything he or she could improve on. The answers you give should only be about today's consultation with your anaesthetist.

Please do NOT write your name on this questionnaire. You will not be identified when your answers are given back to your Anaesthetist.

Please enter today's date (dd/mm/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

1. Are you filling in this questionnaire for:

☐ Yourself ☐ Your child ☐ A relative, spouse, partner or friend

If you are filling this in for someone else, please answer the following questions from the patient's point of view.

2. Why did you see the Pain medicine doctor today?

☐ It was my first appointment in clinic today ☐ I was attending for a follow up appointment today

☐ I was seen together with other members of the pain team ☐ I was attending for a pain-relieving procedure

☐ I was attending for acupuncture treatment ☐ Other, please specify below:

Other reason (please specify) _____

3 How would you rate your doctor at each of the following?
Please tick the relevant box

	Very poor	Less than satisfactory	Satisfactory	Good	Very good	Does not apply/do not know
Introducing themselves to you						
Being polite						
Putting you at ease						
Listening to you						
Assessing your problem						
Explaining to you about your condition						
Involving you in decisions about your treatment						
Answering your questions						

4. Please decide how strongly you agree or disagree with the following statements about your Pain Medicine Doctor:

	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree	Does not apply/do not know
The Doctor seems approachable						
I have confidence in the ability of the Doctor to provide me with safe care						
I was satisfied with this Doctor and would be happy to see him/her again						
The Doctor treated me with dignity and respect						
I was given enough privacy by the Doctor						

5. Was there anything else that this doctor di particularly well, or anything that he or she could improve on?

6 Are you:

☐ Male ☐ Female

7 Your age group:

☐ Under 15 ☐ 15-20 ☐ 21-40 ☐ 41-60 ☐ 60 or over

8 Is English (in Wales, Welsh or English) a main language for you?

☐ Yes ☐ No

9 What is your ethnic group? Please choose one section from A to E, and then tick the appropriate box to indicate your cultural background.

A White ethnic group	B Mixed	C Asian or Asian British	D Black or Black British	E Chinese or other
☐ British Caribbean	☐ White and Black	☐ Indian	☐ Caribbean	☐ Chinese
☐ Irish	☐ White and Black African	☐ Pakistani	☐ African	☐ Any other
☐ Any other White Background	☐ White and Asian	☐ Bangladeshi	☐ Any Other Black Background	
	☐ Any other Mixed Background	☐ Any other Asian Background		

g. Example of Quarterly HALO Assessment Form Pain Credential

High Level Learning Outcome **Credential Pain Medicine**	**Generic Capabilities**
Experience & Logbook	*comment*
Personal Activities/ Reflections	*evidence*
Global Assessments	***Comment on MTR/MSF/exam***

	Generic Capabilities		***Circle current EPA level***				
1	**Has the ability to function within Health care organisational and management systems**		1	2	3	4	5
2	**Has the ability to deal with ethical and legal issues related to clinical practice**		1	2	3	4	5
3	**Communicates effectively and is able to share decision making**		1	2	3	4	5
4	**Maintains patient safety within quality improvement**		1	2	3	4	5
5	**Can inform research and handle data appropriately**		1	2	3	4	5
6	**Can act as a clinical teacher and clinical supervisor**		1	2	3	4	5

Signed Trainee	
Signed RAPM	
Date	

High Level Learning Outcome **Credential Pain Medicine - 1**	**Specialist Capabilities** **Manages referrals/triages within pain service**
Experience & Logbook	*comment*
Personal Activities/ Reflections	*evidence*
Global Assessments	***Comment on MTR/MSF/exam***

	Specialist Capabilities	***Circle current EPA level***				
1	Identify history, examination requests and need for further investigations in different age groups within referrals	1	2	3	4	5
2	Identifies which patients need to be seen in person and which patients can be managed remotely if required	1	2	3	4	5
3	Demonstrates the ability to triage and prioritise pain in complex scenarios, including those with cognitive impairment, limited verbal interaction and settings such as intensive care	1	2	3	4	5
4	Formulation of an appropriate differential diagnosis and optimal pathway (medical or non-medical first contact within pain service).	1	2	3	4	5
5	Shared decision making, explanation of the clinical reasoning behind diagnostic and management plan	1	2	3	4	5
6	Professional behaviour with regards to colleagues	1	2	3	4	5
7	Appropriate prioritisation of referrals	1	2	3	4	5
8	Collaborative working with specialty services and refers onward when necessary, including the management of addiction to pain related medication	1	2	3	4	5
9	Recognition of patients with pain who have psychological problems and who require psychological evaluation, and the ability to apply established treatments for the management of psychological distress in those with pain	1	2	3	4	5
10	Effective use of the pain medicine MDT discussion with understanding of the roles of physiotherapy, occupational therapy, clinical psychology and nurse within the team	1	2	3	4	5
11	Effectively communication with primary and secondary care colleagues	1	2	3	4	5

Signed Trainee	

Signed RAPM	
Date	

h. Quarterly Assessment Form (FPM)

Quarter	
3mth	☐
6mth	☐
9mth	☐
12mth	☐

Date: _____

Trainee: _____

Supervisor: _____

PROGRESS SINCE LAST ASSESSMENT:

Clinical Progress & Logbook:

•Is able to assess a wide variety of patients with pain using a biopsychosocial model
•Is aware of the treatment options available to effectively manage patients with acute, chronic and cancer pain

Progress with SLEs.:

- **Formative assessments:** (comment on *CbD, ACEX, DOPS)*
- ***Global assessments:*** *(comment on MTR (MSF at 6mths), MSF or CARE)*
- ***Level of Supervision progress***

Involvement with Teaching & Education:

•Acts as an effective teacher of Pain Medicine topics

Involvement with Admin & Management:

•Has a comprehensive knowledge of Pain Medicine service delivery
•Provides clinical leadership in the development of comprehensive pain medicine services.

Involvement with Audit & Research:

•Is able to assess evidence from research related to Pain Medicine

Trainee comments:

HALO Progress (circle achieved)

Generic Capabilities			
1	Professional behaviour and trust	***3***	Safety and quality
2	Communication, teamworking and leadership	***4***	Wider professional practice
Specialist Capabilities			
1	Manages referrals/triages within pain service	***5***	Manages inpatient pain and acute pain rounds
2	Manages an outpatient pain medicine clinic	***6***	Manages patients who are taking drugs of potential addiction
3	Manages pain procedural cases	***7***	Has an understanding of the socioeconomic, occupational health and medicolegal aspects of pain medicine
4	Participates effectively within a pain MDT	***8***	Describes the healthcare infrastructure and the pain service
9	Paediatrics Acute Pain Medicine	***10***	Paediatrics Chronic Pain Medicine
11	Cancer Pain Medicine	***12***	Interventional Cancer Pain Medicine
13.	Neuromodulation & Implantable Technology 1	***14***	Neuromodulation & Implantable Technology 2

Agreed areas for development:

Signed Trainee:

Name: _____

Date: _____

Signed Supervisor:

Name: _____

Date: _____

Signed Regional Advisor in Pain Medicine:
(Required for the final quarterly assessment form to confirm satisfactory completion of Advanced Pain Training)

Name: _____

Date: _____

Annex C: Pain Intervention Procedures

The following list is not comprehensive or exclusive. **Please refer to the following key:**

It is meant as a guide to which interventions a trainee is expected to be

P = proficient in

S = procedure seen being done during training year, understands risks and benefits and indications, and may gain further experience in during post Credential or signpost to another doctor who is proficient in providing the procedure

R = procedure unlikely to have been seen during training year, but understands indications, risks and benefits and may signpost to a tertiary or other centre where the procedure is likely to be performed.

KEY P	KEY S	KEY R
Superficial Procedures:		
• Trigger Point Injection • Scar Infiltration • TENS application • Infusion of drugs e.g., ketamine, magnesium •	• Botox for migraine	• Cryotherapy
Regional Nerve Blockade:		
• Paravertebral/ESP • Suprascapular Nerve • Greater Occipital Nerve • Major peripheral N (ultrasound) • Intra-articular injection	• Stellate Ganglion block • Ganglion Impar block	• Greater Occipital Nerve stimulator • Ablative chemical blocks for cancer pain
Central/Neuroaxial Procedures:		
• Lumbar Epidural • Caudal epidural • Nerve Root Block (lumbar/sacral) • Facet joint injection • Medial Branch Block (MBB) • Radiofrequency ablation of facet joint • Pulsed Radio Frequency (PRF)	• Cervical epidural • Cervical nerve block • Thoracic epidural • Lumbar Sympathectomy • Dorsal Column Stimulator • Intrathecal implantation • Coeliac Plexus block	• Deep brain stimulation • Sacral Nerve Stimulator • DRG stimulator •

END OF DOCUMENT