FACULTY OF PAIN MEDICINE of the Royal College of Anaesthetists

FPM guidance on resumption of pain services following disruption by the COVID-19 pandemic

15 May 2020

INTRODUCTION

Following the redeployment of many FPM members and the reduction or suspension of many Pain Management activities due to COVID-19, we now face the challenges of moving to the next phase and, in whole or part, re-establishing pain activities. Based on the directives from the NHS Executive, we consider the key components of this phase for pain services to be the following:[1]

- Reduced focus on COVID-19 work
- Rebound demand on the NHS
- Retention of COVID-19 surge capacity and impact for Pain Specialists and Pain Services
- Release of COVID-19 capacity back to routine care.

Judgements on local capacity for pain work and restoration of pain services in this transitional phase will vary greatly across the United Kingdom. The situation will remain highly fluid as the emergence of new cases of COVID-19 is monitored. In addition, there are new logistical challenges and evolving processes to ensure safe service delivery from patients and staff perspectives.

This guidance highlights considerations to help achieve this reset locally. As part of this approach, the FPM will be reviewing progress through surveys and invites reports of experiences of all kinds.

STRATEGIC CONSIDERATIONS

The FPM remains committed to the standards of care outlined in Core Standards for Pain Management Services in the UK[2] and the provision of safe, effective care for all our patients.

In principle, we must therefore strive to provide the highest standards of care in adversity and work to overcome existing limitations.[3]

There is scope to "lock-in beneficial changes," and pain doctors should rely on key principles advocated nationally by the NHS Reset campaign[4] and relevant membership bodies,[5] namely:

- Local initiative and flexibility
- Enhanced system working
- Strong clinical leadership
- Flexible and remote working where possible

Current COVID-19 pressures on Trusts should not downgrade pain services or lead to provision of substandard care in the long term. Currently unavoidable compromises in care and reduction of access to pain services are evident from the recent FPM national survey. The preliminary survey results show stoppage of all pain physician/patient interactions in 25% of units, use of rare face-to-face consultations for urgent patients and widescale stoppage of interventional procedures. A summary of the preliminary findings are contained in Appendix C. This reduction in service must be reversed in a timely and safe manner.

OPERATIONAL MATTERS

The FPM acknowledges that navigating the next few months will be complex and present considerable organisational difficulties.

Key considerations will be systematic prioritisation of cases, preferential use of non-face-to-face consultations, reintroduction of face-to-face consultations where unavoidable and restoration of treatment activities. Directives on social distancing and the use of PPE will likely remain in place. The restoration of all pain intervention procedures will take place in the context of competing NHS priorities with urgent treatments undertaken first. The FPM

has already submitted guidance to NHS England on the time dependency of different types of pain consultation and procedures which are contained in Appendix A and B. This guidance should help shape local decision-making.

The operational considerations are now listed and considered under the following headings:

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

Prioritisation, triage and stratification

1. The initial focus will be on urgent and time critical work with the aim of reverting to pre-COVID-19 capacity in the next 6 weeks as per recent NHS directive.[1] Urgent work includes cancer related pain, in-patient pain and clinic attendance to refill intrathecal pumps and manage malfunction of implantable devices. The FPM respects that there may be local variations in organisation and delivery.
2. Triage and prioritisation - key considerations include:
    a. liaising with Commissioners to develop interim referral guidance
    b. assessing the scale of the backlog
    c. re-triaging previously deferred patients
    d. scheduling of new referrals in the existing system
    e. identifying those where treatment effect may be greatest
    f. identifying and supporting patients with significant mental health issues where input from mental health services has been temporarily withdrawn or reduced, ensuring re-referral to mental health services as soon as possible
    g. recognising patients who may have safeguarding issues including ones with learning disabilities and domestic abuse, and referring to safeguarding teams where necessary.
    h. recognising patients who may be unsuitable for remote consultations for example, those with hearing difficulty, other impactful disability, or lack of access to required technology

i. considering ethnic groups which may be predisposed to increased risk from COVID-19
j. identifying language barriers and need for translation services
k. considering the issue of health and ethnicity vulnerabilities and co-morbidities in practitioners within the pain team when allocating roles
l. tracking patients where investigations may have been put on hold
m. considering paediatric patients as a group requiring specific attention, being aware that remote consultations may pose more risk and challenges in this patient group.

3. Multidisciplinary care should be carefully triaged to risk. Consider remote multidisciplinary input if appropriate.

Assessment

1. Modes of assessment should be based on patient needs respecting patient choice.
2. Assessment should be conducted in line with Core Standards for Pain Management Services in the UK[2] and FPM guidance on conducting quality consultations.[6]
3. Remote assessment in line with GMC guidance on such consultations should be used where possible, including video and telephone.[7] Pain doctors will need to adapt and learn from their experiences gaining an understanding of the limitations and benefits.
4. Challenges should be considered in both new and follow up consultations which may include:
    a. ensuring appropriate choice of patients, who have been pre-booked and signposted to mode of contact (telephone or video-linked)
    b. avoidance of prioritisation based on technological know-how rather than medical needs
    c. the need for clinical examination to be considered carefully and arrangements made to perform this at a later date if felt necessary during a remote consultation
    d. selection for face-to-face consultations where appropriate – this is particularly challenging in new patients
    e. ensuring confidentiality – potentially more difficult for remote consultations
    f. managing sensitive questions

g. managing the process of consent
h. difficulty in establishing rapport with patient and building up a therapeutic relationship
i. planning for necessary completion of assessments face-to-face where required
j. paediatric safe-guarding
k. adult safe-guarding
l. ensuring that documentation reflects reason for type of assessment and that above criteria were taken into consideration.
m. failure of technology
n. individual communication issues arising for instance from language barrier or difficulty in hearing, etc.

5. Face-to-face consultations will need to be planned and undertaken where needed, respecting the need for protection for patient and staff alike.
6. Processes to manage consent for pain intervention procedures will need careful reconsideration, in particular to ensure that patients receive appropriate counselling regarding 'standard' and additional potential risks (e.g. steroids), information and a two-stage consent process.
7. Problems of investigation may arise and should be considered, including:
    a. access and availability in hospitals
    b. risks of transmission of COVID-19 to patients and staff.
8. The use of proformas may help and, with permission, consultation recordings considered.
9. The patient clinic letter should report the mode of consultation and comment on limitations. Copying letter to the patient, enclosing patient information leaflets and referencing trusted internet resources will help to promote patient understanding.
10. Other types of practice may be considered if permitted locally, e.g. GP supported practice, patient initiated consultations and self-supported care.
11. It is important to remember that remote consultations have limitations and may lead to incomplete pain assessments. Medicolegal risks should be considered, as an incomplete assessment remotely may lead to decision errors with implications for future care and prognosis.

12. Cancer related pain services should be restored if currently limited. The urgency must be balanced against the real risks of social contact and interventions which are higher through immunosuppression.
13. Inpatient pain services may need to consider strategies to manage local medicine supply and shortages. Inpatient services should triage for remote or face-to-face consultations where appropriate.
14. In the future, pain services may need to manage and treat pain in patients arising from COVID-19. Though current understanding is limited, pain may arise from thrombotic events, nerve dysfunction and joint pains associated with chronic fatigue.

Treatments

15. Pain intervention procedures should be managed appropriately to mitigate risks. FPM guidance regarding steroid injections during COVID-19 should be followed and we continue to advise against non-urgent procedures requiring steroids at the current time.[8]
16. For urgent procedures, considerations may include:
    a. pre-admission COVID-19 testing by local policy
    b. if COVID-19 positive, ensuring local or national directives are followed
    c. option not to use steroid as part of the procedure
    d. patient self-isolation policies pre and post procedures
    e. consent
    f. uncertainty over risks in those who have had or may have had COVID-19.
17. Patients who opt to delay treatment due to risks should not be penalised by de-prioritisation. This may require discussion and agreement with local commissioners.
18. Medicine considerations include remote prescribing, issues with some medicines[9] and best use of patient information leaflets.[10] Increased vigilance is required as there is an incomplete picture on some pain medicines.
19. Implantable technology, including associated risks and appropriate management, has been assessed in guidance from the Neuromodulation Society of UK and Ireland.[11]
20. Access to multidisciplinary team assessments is key, as optimum pain management is based on the biopsychosocial model. Allied health professionals within the pain team will be guided by their own regulatory bodies. The considerations and adjustments

required will nevertheless be shared and managed by both medical and non-medical members of the team together.

21. Pain Management Programmes will face significant issues, including:
    a. management of multidisciplinary team assessments in clinic (MDT)
    b. organisation of MDT meetings
    c. problems of ensuring medical assessment and treatments are complete
    d. maintaining close professional working while managing various forms of remote care
    e. increased difficulty in making appropriate referrals to a PMP if making remote assessment as assumptions may not be guaranteed.
    f. Difficulty in running a PMP if multidisciplinary delivery is not possible due to staff redeployment.

Social distancing and PPE

22. Policies on social distancing will likely remain in place for a period of time. Restrictions in the waiting room will likely reduce throughput but must be respected.
23. PPE for pain services should be guided by local and national policy.[12]
24. As well as considering the health of patients, consideration should be made for the safety of staff with existing health conditions and/or vulnerability to COVID-19.

Supportive professional activities and education

25. All aspects of team education should be resumed.
26. Reinstatement of training should be arranged for core and intermediate trainees,[13] as well as for higher and advanced pain trainees.[14,15]
27. Structures of team support should be in place to enable psychological wellbeing in a new working environment.[16]
28. Home-working should be undertaken where possible especially for supporting professional activities .[17]

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Other Resources and links

GMC. Joint statement: Supporting doctors in the event of a Covid-19 epidemic in the UK. 11 March 2020. https://www.gmc-uk.org/news/news-archive/supporting-doctors-in-the-event-of-a-covid19-epidemic-in-the-uk

APPENDIX A

Time dependent pain appointments (for guidance only)

Time Dependent Adult Pain Appointments				
Emergency	**Within 7 days**	**Within 14 days**	**Within 30 days**	**Over 30 days**
Inpatient admissions with acute pain (e.g. rib fracture, sickle cell crisis)	Inpatient admissions with acute on chronic non-malignant pain	Cluster Headaches	Complex regional pain syndrome	All other referrals
Complex perioperative pain	Inpatient admissions with cancer pain	Obstetric patients with chronic pain (if on medication)	Severe chronic pain flare up leading to significant distress or mental health destabilisation	
Complications or malfunction of intrathecal pumps	Malfunction of spinal cord stimulator	Acute disc prolapse with severe radicular pain (outpatients)	Severe chronic pain flare up threatening loss of independence especially in older patients	
Suspected infection of Spinal cord stimulator		Cancer related pain	Trigeminal neuralgia	
Suspected complication from pain intervention procedure		Complications or severe side effects from previously prescribed pain medication	Obstetric patients with chronic pain but not taking medication	
Anaesthesia related pain intervention side effects such as epidural haematoma		Severe post herpetic neuralgia	Severe chronic pain flare up likely to lead to loss of employment	
Acute disc prolapse with severe radicular pain (inpatients)			Post herpetic neuralgia	
			Patients with chronic pain and a learning disability	

Time Dependent Paediatric Pain Appointments				
Emergency	**Within 7 days**	**Within 14 days**	**Within 30 days**	**Over 30 days**
Inpatient admissions with acute pain	Inpatient admissions with acute on chronic non-malignant pain	Cluster Headaches	Severe chronic pain flare up leading to significant distress or mental health destabilisation	All other presentations
Complex perioperative pain	Inpatient admissions with cancer pain	Complex regional pain syndrome	Severe chronic pain flare up leading to non-attendance at school	
		Cancer patients (outpatient)		

APPENDIX B

Time dependent pain procedures (for guidance only)

Time Dependent Adult Pain Procedures				
Emergency	**Urgent (72 hours)**	**Up to 4 weeks**	**Up to 3 months**	**Over 3 months**
Acute pain infusions (e.g. ketamine, magnesium, lidocaine)	Refill intrathecal pump	Transforaminal, Translaminar epidural steroid injection for radicular pain (including disc prolapse) in patients off work due to pain	Diagnostic medial branch blocks	Radiofrequency denervation procedures
Acute pain patient controlled analgesia	Change battery intra-thecal pump	Neurolytic block as an adjunct to manage cancer pain	Diagnostic nerve blocks	Implantation of spinal cord stimulator
Nurse acute pain controlled analgesia	Neurolytic block for intractable cancer pain	Greater occipital nerve blocks for migraine, headaches	Implantation of intrathecal pumps in patients with spasticity disorders	Infusions e.g. Lidocaine for chronic pain
Spinal infusions for acute postoperative pain	Transforaminal, Translaminar epidural steroid injection for patients with severe intractable acute pain due to disc prolapse (inpatient)	Gasserian ganglion block for intractable trigeminal neuralgia	Infiltration of post-surgical scars associated with severe pain	
Malfunctioning intrathecal pump	Nerve blocks to deal with acute pain e.g. rib fractures fracture neck of femur	Change battery or migrated/fractured leads for spinal cord stimulators		
Subcutaneous infusions for palliative care patients	Neurolytic sympathetic block for ischaemia secondary to peripheral vascular disease (inpatient)	Sympatholytic blocks to manage Complex Regional Pain Syndrome		
		Neurolytic sympathetic block for ischaemia secondary to peripheral vascular disease (outpatient)		

Time Dependent Paediatric Pain Procedures				
Emergency	**Urgent (72 hours)**	**Up to 4 weeks**	**Up to 3 months**	**Over 3 months**
Acute pain patient controlled analgesia	Neurolytic block for intractable cancer pain	Neurolytic block as an adjunct to manage cancer pain	Infiltration of post-surgical scars associated with severe pain	
Nurse acute pain controlled analgesia		Greater occipital nerve blocks for migraine, headaches		
Spinal infusions for acute postoperative pain				
Subcutaneous infusions for palliative care patients				

APPENDIX C

Preliminary Data Report from FPM Situational Survey:

Changes to delivery of Chronic Pain Management during the lockdown stage of the COVID-19 Pandemic

Based on data to 13 May 2020

Introduction

On 11 May 2020, the Faculty of Pain Medicine sent out the first of a series of COVID-19-related situational surveys to its Fellows and Members.

Aim: To gain information on the immediate response of individual services to the challenge of delivering care for people with chronic pain since the 23rd March 2020, and seek out examples of changes to practice.

This survey will be followed by a number of additional situational surveys over the next few months. This is in anticipation that practice in pain management delivery will be changing as we gradually move out from lock-down and levels of non-emergency health care are expected to rise. The impact of the COVID-19 pandemic and the long term impact on the way we work, deliver care and train junior colleagues in pain medicine and pain management needs to be monitored and any future guidance will consider lessons learnt from the feedback and experiences of our Fellows and Members. We are clear that this survey is not the first of its kind; recent surveys have addressed some of the questions included.

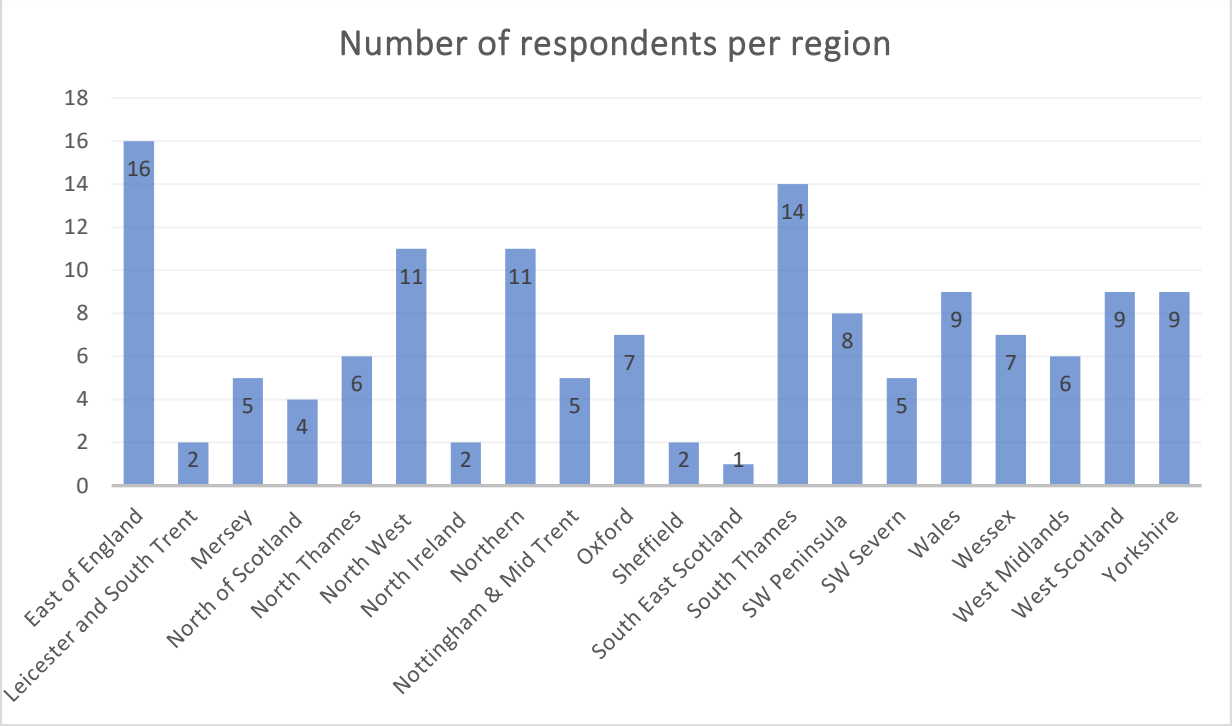
We received 139 responses in the first 48 hours and we would like to express our thanks to those Fellows and Members who responded so promptly. We encourage other Fellow and Members to continue to respond as this will help to generate meaningful information for professional guidance.

Preliminary Results

The FPM would like to share preliminary data from the survey in conjunction with the release of this guidance document on the resumption of pain services. Percentages are approximate as they have been rounded for ease of reading.

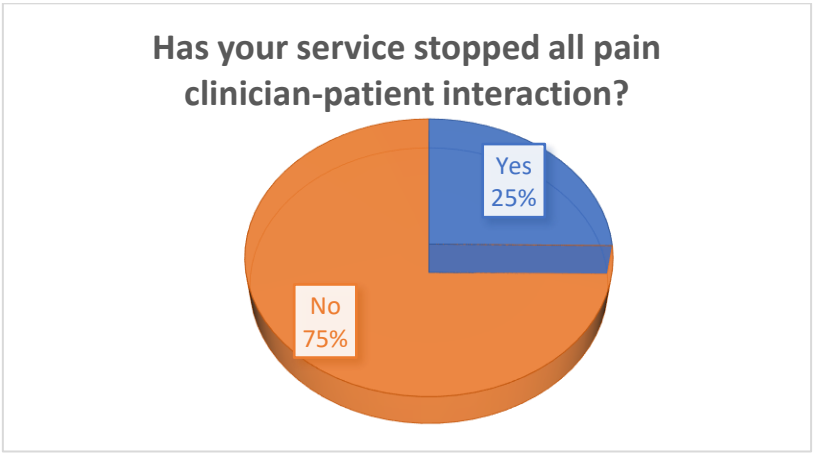
Demographics

- 139 responses received within 48 hours of the survey being sent out (as at 5.30pm 13 May)
- The responses were from clinicians working in 109 different pain services, covering 20 different regions, including all four nations



Suspension of pain services

- 75% of pain clinicians reported that their service was still interacting with patients
- 25% of pain clinicians reported that their services have been fully suspended



Service provision

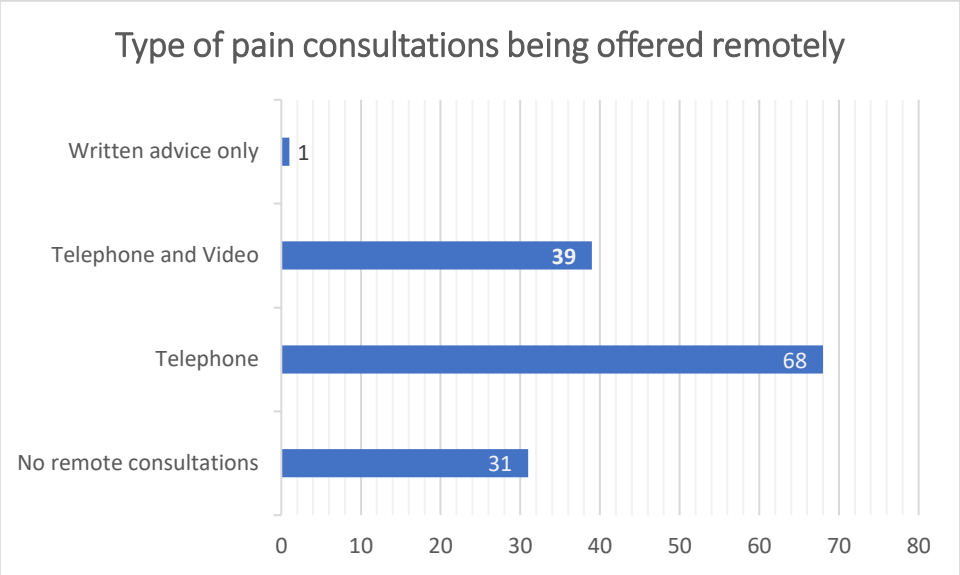
In those pain services still interacting with patients, we asked who was delivering care during lockdown. The responses showed that:

- 83.7% of active pain services still had Consultant or other doctor input
- 77.9% of active pain services still had Pain Nurse Specialist input

As part of this preliminary review, it was not possible to glean meaningful information at this point as to the input from other members of the team (physiotherapists, psychologists, occupational therapists).

Consultations

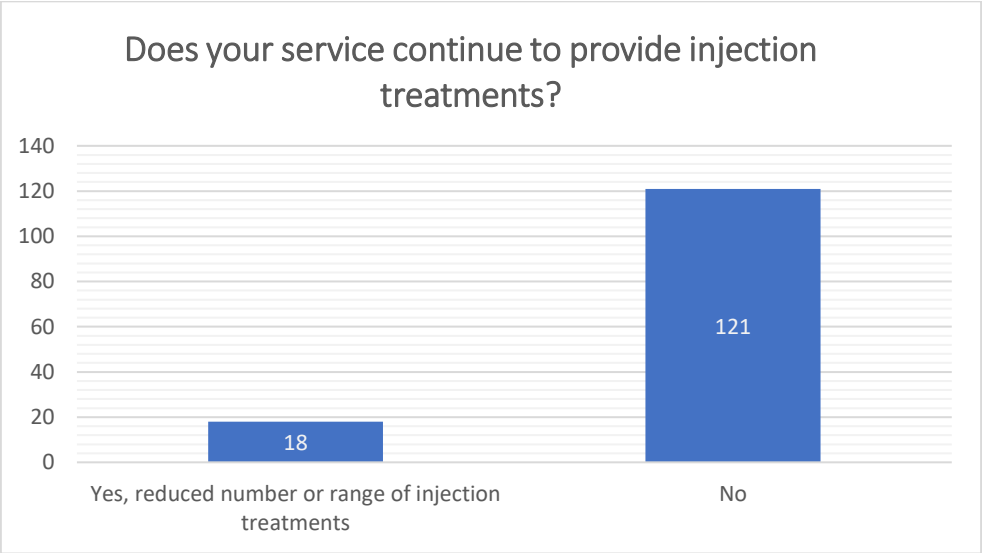
- 37.5% of active pain services are offering face to face consultations for urgent patients
- 78% of pain services are offering some form of remote consultation for patients
    - Telephone: 49%
    - Telephone and Video: 28%
    - Written advice only: <1%



Several clinicians are reporting that they are not seeing new patients, however this data is not complete enough to make a meaningful assumption.

Procedures

- 87% of services have stopped all procedure lists
- 13% are carrying on with reduced lists for cancer related pain and urgent cases, or non-steroid based procedures



Conclusion

We acknowledge that these are preliminary results only, but we believe that in light of the capture of data from all four nations and all regions specified, the survey is likely to represent a reasonably accurate snapshot of current delivery of pain services. We aim to share the complete data from this and forthcoming surveys as soon as possible.

Acknowledgements:

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