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 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.

There is scope to “lock-in beneficial changes,” and pain doctors should rely on key principles advocated nationally by the NHS Reset campaign and relevant membership bodies, 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 pro formas** 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.\(^\text{12}\)

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,\(^\text{13}\) as well as for higher and advanced pain trainees.\(^\text{14,15}\)

27. **Structures of team support** should be in place to enable psychological wellbeing in a new working environment.\(^\text{16}\)

28. **Home-working** should be undertaken where possible especially for supporting professional activities.\(^\text{17}\)
References

2. FPM. Core Standards for Pain Management Services in the UK. 2015. [https://fpm.ac.uk/standards-publications-workforce/core-standards](https://fpm.ac.uk/standards-publications-workforce/core-standards)
6. FPM. Conducting Quality Consultations in Pain Medicine. [https://fpm.ac.uk/media/286](https://fpm.ac.uk/media/286)
10. FPM. Patient Information Leaflets. [https://fpm.ac.uk/about-pain-medicine-patients-relatives/patient-information-leaflets](https://fpm.ac.uk/about-pain-medicine-patients-relatives/patient-information-leaflets)
11. NSUKI. Recommendations for the management of Implanted Neurostimulation & Intrathecal Drug Delivery Devices During the COVID-19 Pandemic. [https://nsuki.memberclicks.net/](https://nsuki.memberclicks.net/)
16. FPM. COVID-19: Publication of practical steps to support team wellbeing. 14 April 2020. [https://fpm.ac.uk/covid-19-publication-practical-steps-support-team-wellbeing](https://fpm.ac.uk/covid-19-publication-practical-steps-support-team-wellbeing)

Other Resources and links

### Time Dependent Adult Pain Appointments

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

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<tr>
<th>Emergency</th>
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<th>Over 30 days</th>
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<td>Cluster Headaches</td>
<td>Severe chronic pain flare up leading to significant distress or mental health destabilisation</td>
<td>All other presentations</td>
</tr>
<tr>
<td>Complex perioperative pain</td>
<td>Inpatient admissions with cancer pain</td>
<td>Complex regional pain syndrome</td>
<td>Severe chronic pain flare up leading to non-attendance at school</td>
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<td></td>
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<td>Cancer patients (outpatient)</td>
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### Time Dependent Adult Pain Procedures

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

We would like to thank Dr Anna Weiss as primary author of this survey. We would also like to acknowledge Dr Paul Wilkinson and Dr Lorraine de Gray for their efforts in reviewing and analysing the results.