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COVID-19 Service Recovery Discussion Document for resumption of pain management services in Scotland

May 2020

Introduction

On 14 May 2020, John Connaghan, Interim Chief Executive NHS Scotland, wrote to all NHS Boards to request mobilisation plans (covering the period to the end of July 2020) for the next phase of service recovery following disruption by the COVID-19 pandemic. It asks Boards to set out which services can be re-introduced safely and on what timescale, whilst maintaining appropriate capacity to respond to COVID-19. Further information on whole system mobilisation is included at Annex A.

The aim of this document is to stimulate a national discussion with stakeholders and partners to inform local and regional planning to undertake a phased resumption of hospital based pain management services. The purpose is also to inform improving access to community pain management services. It draws on national guidance on COVID-19[1], including the Framework for Decision Making[2], the route map[3], personal protective equipment (PPE) and the prevention of infection, as well as guidance issued by professional bodies such as the Faculty of Pain Medicine[4] (FPM) and the British Pain Society[5] (BPS). Annex B provides an initial overview of factors that may be usual to consider with COVID-19 and the population of people living with chronic pain.

Supporting Resumption of Delivery

Many pain management services pre-pandemic were reporting waiting lists excessive of waiting time targets and challenges of delivering the Faculty of Pain Medicine Core Standards for Pain Management Services in the UK[6]. The decision to postpone all non-urgent elective activity across specialties, including pain management, will have placed additional pressure on waiting lists.

Staff have been re-deployed during the pandemic and the return to normal roles will vary by hospital and specialty. There is recognition that Health Boards will need to ensure there is flexibility in the system to continue to provide care and support for COVID-19. This may mean consultant anaesthetists and other disciplines that normally deliver pain management clinics may continue to be deployed elsewhere. In considering a phased return, Health Boards must ensure staffing levels are sufficient to provide safe care for patients and staff before deciding to resume pain management services.

Opportunities to work in a different way to mitigate the challenges set out above and to ensure pain management is fully accounted for when identifying clinical priorities (Annex A) include taking the best of what worked well before, together with re-designing services to improve outcomes and access to care and support that match people's needs at the right time, by the right professional at the right place.

The Scottish Access Collaborative workshops and report[7] and follow on survey from the Modernising Patient Pathway Programme has allowed stakeholders priorities to be aligned and themes of workforce, de-prescribing, improving access to self-management resources and the interface between primary and secondary care highlighted. These themes remain and will be supported through the planning for resumption of pain management services in Scotland to improve delivery of services within a quality framework.

In planning the re-mobilisation of pain management services, Health Boards will take account of national guidance on what type of PPE should be worn in each setting and scenario[8] and testing arrangements[9]. Appropriate measures will also need to be put in place to consider the number of patients for face-to-face consultations per session by individual doctors to:

- ensure adequate time for safe donning and doffing of PPE
- minimise overcrowded waiting rooms to ensure physical distancing for patients
- provide access to appropriately sized clinic rooms to enable physical distancing between patient, clinician and other healthcare staff and students
- facilitate easy cleaning of rooms between patients and at the end of the session, as per current national and local infection control guidance[10] and advice for secondary care[11].

Trainees should, as a minimum, have access to onsite clinical supervision for advice and support when undertaking face-to-face consultations.

Telephone/video consultation is different to traditional face-to-face consultation and staff must be sufficiently experienced and trained prior to undertaking telephone or video consultation with appropriate supervision.

Telephone and video consultations can take longer than traditional face-to-face consultations, including the consent process, dealing with IT and record keeping. Therefore, Health Boards should consider the number of consultations per session.

Traditional multi-disciplinary meetings may take place if in line with physical distancing guidance or via virtual platforms to allow for sharing of confidential information, documents and video conferencing.

Hospital facilities and equipment such as treatment rooms, diagnostic services including radiography and theatres will be subject to additional safety guidelines introduced during COVID-19 that will mean they operate at reduced capacity in the context of increased demand when services resume. In line with the clinical priorities set out in John Connaghan's letter of 14 May to Health Boards, re-mobilisation plans should factor the prioritisation of treatment room services such as pain management into facilities and equipment scheduling.

When services resume, the letters to patients and their GPs should clearly state how the consultation is due to be conducted and provide a process for people to ask questions, discuss concerns and opt for an alternative where circumstances allow e.g switching from a virtual to telephone consultation.

Staff wellbeing must also be considered as the resulting psychological strain of working during a global pandemic will have an impact. FPM has developed structures of team support[12] and further information is available on the Health Protection Scotland website[13].

Prioritisation and Triage

Using the FPM key considerations as a guide, Health Boards should be able to demonstrate that they are:

- liaising with primary care to develop interim referral guidance
- assessing the scale of the backlog and re-triaging previously deferred patients
- identifying those where treatment effect may be greatest
- identifying and supporting people whose pain is associated with significant mental health issues, and involving mental health services when possible
- scheduling new referrals in the existing system
- recognising patients who may be unsuitable for remote consultations, for example those with hearing difficulties, other impactful disability, or lack of access to required technology
- considering ethnic groups which may be predisposed to increased risk from COVID-19
- considering the issue of health and ethnicity vulnerabilities and comorbidities in practitioners within the pain team when allocating roles
- tracking patients where investigations may have been put on hold
- considering paediatric patients as a group requiring specific attention, being aware that remote consultations may pose more risk and challenges in this group.

FPM lists urgent work as cancer related pain, in-patient pain and clinic attendance to refill intrathecal pumps and manage malfunction of implantable devices[14]. Implantable technology, including associated risks and appropriate management, has been assessed in guidance from the Neuromodulation Society of UK and Ireland[15].

The FPM guidance on the resumption of pain management services also provides a guide about the time dependency of appointments and treatments according to clinical need and procedures such as nerve blocks and lidocaine infusions[16]. Health Boards will take account of clinical guidance but will make decisions based on local needs and capacity. Planning regionally or nationally may provide opportunities to assist prioritisation where there are difficulties resuming the full range of services in specific local areas.

Treatment

Across all services, Health Boards will need to consider procedures in place to obtain consent from patients. This includes ensuring people receive appropriate counselling about the typical and additional risks of treatment during COVID-19.

Steroid injections

In resuming access to pain management services, Health Boards will wish to take account of clinical guidance providing advice about the risks of specific treatments. This includes the use of steroid injections during the COVID-19 pandemic published by FPM and BPS[17]. In such cases the possible benefit of corticosteroids has to be judged against any possible adverse effect on an individual's capacity to fight COVID-19 infections. It is anticipated that non-urgent procedures will not be performed at this time. FPM states that, for urgent procedures, considerations may include:

- pre-admission COVID-19 testing
- if COVID-19 positive, ensuring local or national directives are followed
- option not to use steroid as part of the procedure
- patient self-isolation policies pre and post procedures
- consent
- uncertainty over risks in those who have had or may have had COVID-19.

Some people may opt to delay treatment due to risks and your planning should enable a system of re-prioritisation if new evidence provides assurance about the safety of performing steroid injections.

Group Education Sessions and Pain Management Programmes

Group education sessions and Pain Management Programmes (PMP) are central to rehabilitation aspects of pain management; they help improve functional goals such as the reduction of pain medications. This is even more important when physical distancing and lockdown measures are restricting access to many services that can support people to cope with pain including exercise and social prescribing activities.

Unless already conducted remotely, these pain programmes have been paused within NHS Scotland pain management services, which are by configuration multi-disciplinary in nature and therefore interdependent on disciplines resuming pain management duties in a synchronised way.

Health Boards will therefore need to consider how these programmes can be re-introduced if multidisciplinary professionals are still deployed in connection with COVID-19 for some time to come. This may include exploration of regional working and different digital platforms that can host larger NHS group activity. For example, NHS Grampian is currently testing CISCO Meeting Service (CMS) for secure group sessions for up to 50 people joining from several web browsers. The added benefit is that people would be able to access these programmes from their own homes.

The Connecting Scotland project[18] (that is being delivered by the Scottish Government, in partnership with local authorities, Healthcare Improvement Scotland, the Scottish Council for Voluntary Organisations (SCVO) and the digital and IT sectors led by ScotlandIS), will enable eligible people identified by local authorities and third sector organisations to access a device with a mobile internet data package to be delivered to their homes.

Health Boards will need to ensure that medical assessments that are undertaken remotely are robust in nature, reflecting the core standards for pain management services in the UK[19], and arrangements are in place to maintain close professional dialogue while managing various forms of remote care. Assessments should also take account of an individual's needs and their preference on conducting a consultation[20] within the parameters of safety guidelines. Medicolegal risks should be considered, as an incomplete assessment remotely may lead to decision errors with implications for future care and prognosis.

<u>Scottish National Residential Pain Management Programme (SNRPMP)</u>

The Scottish National Residential Pain Management Programme in Glasgow continues to review appropriate individuals by telephone with discussions to commence *Near Me* consultations and virtual groups as capacity allows.
In terms of national adult screening programmes – these have been suspended and will restart as soon as it is safe to do so. NSS is working with Health Boards to understand capacity and interdependencies with diagnostics and treatment.

Finally, plans will need to take account of current restrictions in the provision of services. This includes, but is not restricted to access to primary care, availability of community services such as leisure centres, and guidance on physical distancing and outdoor exercising. These factors will likely change frequently over coming weeks and months, and pain services should ensure routes of communication and dialogue with people attending their services so that management plans can be modified and updated accordingly.

Mobilisation to respond to COVID-19

The NHS in Scotland has undertaken an extraordinary re-organisation of services since March 2020 to increase its capacity to respond to COVID-19. This has quadrupled the number of adult ICU beds and provided additional capacity through the creation of NHS Louisa Jordan.

In Scotland, non-urgent elective appointments were postponed across numerous specialties to minimise face to face contact and to enable the workforce to be re-deployed to critical and emergency care. The introduction of Near Me consultations and community led outpatients (e.g. diabetes and emergency community eye treatment centres) have transformed delivery of care; shifting traditionally acute sector care and treatment successfully into community settings.

The delivery of pain management provision in Scotland, as elsewhere in the UK, has been significantly affected by the COVID-19 pandemic. The FPM[21] has published preliminary findings about the extent of disruption and the reasons for this, which reflect experiences described by pain management services in Scotland during this time.

Where possible, people have been directed to online/telephone resources to support management of their condition and/or offered telephone/video consultations. The Scottish Government also published guidance[22] to signpost individuals to pain management resources.

Planning for the next phase

The continuing presence of COVID-19 in the population will prevent the immediate return to pre-pandemic activity and changes to traditional ways of working will need to be made to ensure the safety of patients and staff. Boards will need to continue to carefully consider the configuration of emergency care service: ensuring effective provision of both a regular and COVID-19 response.

The Scottish Access Collaborative and the Modernising Patient Pathway Programmes are able to support Boards with an accelerated rollout of the following:
- Expansion of remote consulting across all secondary care specialties through the telephone and *Near Me* (working with the programme as part of their wider health and social care scale up);
- Implementation of Active Clinical Referral Triage (ACRT)[23] to support prioritisation and Patient Initiated Review (PIR) to optimise outpatient pathways;
- Scaling up of outputs from the Scottish Access Collaborative commissioned Speciality Reports, working with the clinical networks to implement redesigned pathways of care in high volume areas
- Waiting List Validation;
- Team Service Planning; and
- Accelerating the Development of Enhanced Practitioners (ADEPt).

In addition to the above, Health Boards will also need to consider what further re-organisation of services will be required, e.g. mutual aid and regional working; split of COVID and non-COVID sites and/or treatment pathways; and how we might use national facilities like the Golden Jubilee National Hospital and the NHS Louisa Jordan to support this.

Clinical Priorities to resume elective activity

The Scottish Government's Interim Chief Medical Officer and National Clinical Director have provided an initial view on those services that could be prioritised in the next phase of Board mobilisation planning, as follows:
- cancer (especially referrals and treatments postponed);
- non-cancer urgent inpatients and outpatients (Board clinical teams will take a view on which specialties and how many);
- outpatient therapies where delay will mean clinical risk increasing (e.g. macular degeneration, paediatrics, respiratory);
- mental health; and
- treatment room services (MSK, B12 injections, monitoring bloods, etc.).

This is not an exhaustive list and Boards are expected to identify priorities based on local need. NHS Boards must work with Health and Social Care Partnerships and other planning partners to factor primary and community healthcare services into their mobilisation plans, and to fully take account of the implications for social care. It is critical that all parties – the Health Board, Third Sector, Local Authority and Integration Authority – work together to ensure planning is aligned. Boards have been advised to establish interface groups with primary/secondary care involvement to support whole system recovery.

Health Boards are asked to review the management of all long-term conditions and chronic disease in primary care, ensuring the capacity and capability of the workforce to respond to needs of their areas including the future of community hubs and assessment centres. Community and third sector organisations have provided a valued source of support to the pain management community during the COVID-19 pandemic, and support should be an integral part of re-mobilisation planning.

In recognition that COVID-19 is going to have an increasingly detrimental effect on the mental health of many people, Health Boards have been asked to provide specific information about the mobilisation of mental health services within their plans.

COVID-19 and Chronic Pain

Chronic pain is estimated to affect around 20% of people in Scotland, and 5% of people have severe, disabling chronic pain. This adversely and significantly affects all aspects of physical, psychological and social health.

People with a chronic pain condition in Scotland have been shown to have the following co-morbidities[24]:
  • 24% with coronary heart disease
  • 23% with COPD
  • 23% with heart failure
  • 19% with hypertension

For many people it will be their pain, rather than any comorbidity and risk of severe illness from COVID-19, that is their most distressing symptom and concern. It should also be noted that chronic pain disproportionately affects older people[25], who are more at risk of severe COVID-19 disease.

Although chronic pain by itself has not been identified as being at the highest risk of severe illness from COVID–19, some people with underlying condition(s) or medications that reduce immunity will have been advised to shield to protect themselves from the virus[26].

Chronic pain is recognised to exacerbate, and is exacerbated by, depression and social isolation[27]. The current need for shielding, physical distancing and self-isolation will therefore greatly increase the distress caused by chronic pain, and its effects on mental and social health. It is anticipated these consequences will place a growing burden on NHS and social care services. While the evidence is still emerging, one consequence of COVID-19 may be pain arising from thrombotic events, nerve dysfunction and joint pains associated with chronic fatigue.

The implications of COVID-19 are starting to be researched in terms of harms from the virus, harms from disruption to non-COVID-19 healthcare and harms from the introduction of physical distancing and impact of loss of wider freedoms on wellbeing and lifestyles. COVID-19 is likely to be with us for some time to come and we must continue to review our response in light of this emerging evidence to ensure the arrangements in place are effective and enable the best outcomes for people. This work is being informed by research studies led by the National Institute for Health Research[28] (in which Scotland participates) and the Chief Scientist Office, which has funded 55 rapid research projects[29].

Emerging findings from the openSAFELY collaborative (2020)[30] highlights co-morbidities as significant risk factors for death from COVID-19 and shielding during the pandemic has the potential to further impact physical and emotional well-being. Socio economic circumstances, health literacy and access to devices to view online resources and enable virtual consultations need to be factored into service planning, as people should not be disadvantaged due to the current changes to services.

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