Covid-19: Guiding Principles for Recovery in Psycho-Oncology

Introduction

Adult Psycho-oncology services carry out most of their work in a face to face capacity. As a result of COVID-19, therapeutic sessions are now delivered virtually for a significant number of patients. Where work is carried out over the telephone or by video-conference, certain adjustments need to be made to ensure that this work is safe, ethical and effective.

These principles highlight the necessary adjustments to face to face practice and should be read in conjunction with services' standard operating policies. The principles take into consideration the need for services to understand their recent fluctuations in demand in order to support future changes in psycho-oncology referrals and how services will manage these changes in referral patterns.

In preparation for COVID-19 restoration and recovery planning, a working group was stood up in May 2020 following a meeting with Trust psycho-oncology leads across London. Transforming Cancer Services Team (TCST) has facilitated working group meetings to develop these resources for all psycho-oncology services in London.

The psycho-oncology community recognises that there are many uncertain decisions and compromises that will be made with regard to patient care (direct work) and support to the NHS workforce (indirect work). Often there is little or no solid evidence of equivalence with usual care and this is an area for future research.

Acknowledgements

This document has been drawn together from expert professional opinion within psycho-oncology services across London, representing the following cancer alliances:

- North Central London
- North East London
- South East London
- RM Partners (South West and North West London)

It has been led and coordinated by Transforming Cancer Services Team (TCST) for London, part of the Healthy London Partnership through a COVID & psychosocial clinical working group.

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Guiding Principles for delivering psycho-oncology services during COVID.

The principles below have been described by the psycho-oncology community in London. They provide some guidance on providing virtual therapies during COVID pandemic as well as tips and tools to support the new ways of working.

1. **Psycho-oncology teams provide an essential service for patients diagnosed with cancer**. During recovery and restoration, it is imperative that psycho-oncology teams who were redeployed during the crisis phase return to their substantive roles. Where psycho-oncology teams have short term funding, ICS' should refer to TCST's system level psychosocial guidance to plan for long term security of these services. Guidance includes an integrated pathway, business case, psycho-oncology service specification and mapping of services in London.

2. **In responding to changing demand during COVID recovery, future surges and long term sustainability, Trusts will need to consider a number of options for services to flex their capacity**:
    - Limiting the number of sessions per patient/couple
    - Consider the balance between increasing the number of appointments and reducing indirect work such as training, supervision, administration
    - Opportunities for collaboration with local services such as Maggie's centres, hospices etc
    - Health and wellbeing of the psychological workforce to prevent burnout/ sickness, through redeployment, increasing individual patient facing hours per week and complexity/volume of clinical supervision sessions
    - How local planning is aligned with COVID-19 restoration and planning in the local Cancer Alliance.
    - Sustainable funding for appropriately trained and resilient psycho-oncology workforce in order to meet changes in demand (in volume, in complexity or both).

3. **Referrals and triage/screening should continue to be made in the usual way, regardless of the nature or medium of the intervention.** Likewise, all referrals should be screened in the same way to assess eligibility and suitability. Referrers may wish to discuss with psycho-oncology teams about appropriateness of individual referrals, particularly during peak times, for example services will vary in the extent to which they are able to pick up more of the broader COVID-19 anxiety referrals (which may or may not be related to cancer or wider cancer care). It is also the referrer's responsibility for obtaining consent and Psycho-oncology services should record that consent has been obtained and confirm that the patient has accepted support in a virtual format. There are some resources that can help professionals to obtain virtual consent and these are listed on the Association for Cancer Physicians website. This triage should be carried out by a professional who has sufficient training/experience to make an appropriately informed decision.

4. **Shared decision making should be used to identify when patients should be supported face to face or virtually (either by telephone or video consultation), where possible**. Risk of harm from infection, physical health and social factors should be considered. Where appointments are delivered virtually, clinicians and patients should discuss what to do in case of an emergency during a virtual contact. It should be clearly documented why any medium (face to face, telephone or video-conference) has been chosen. It is recognised that mediums may change during the course of the intervention and this should also be recorded. It is considered good practice to give patients information prior to virtual consultation on what to expect from the service, along with expectations from the service (e.g. being in a quiet space etc, cancelling appointments etc).

5. **As services will need to be flexible regarding working virtually and face to face with patients and NHS staff, Standard Operating Procedures should be in place and reviewed when scenarios change**. Services will need to consider:

    a. Criteria for virtual versus in-person consultations (see table below).
    b. Process for declining requests for either virtual face to face consultations, even if that results in no service being offered or accepted by the patient (see Appendix 2 for an example). Decision should be based on need rather than preference. Administrative staff should pass on requests to the clinical team. The decision should be discussed between the patient/s and a member of the clinical team.
    c. Process for managing a waiting list for patients who do not meet the criteria for face to face and do not want to have virtual appointments.
    d. Explain changes in ways the service and individual clinicians communicate with patients.
    e. Ongoing compliance with Trust Infection, prevention and control policies and procedures, especially as these change through waves and spikes of COVID-19.

Reasons for virtual consultation?	• Client preference • Positive or suspected COVID infection • Self-isolating or shielding • Physical health/ mobility difficulties that make attending an appointment in person more difficult • Travel or time restrictions. • Other
Reasons for NOT choosing virtual consultations?	• Lack of private space • Fear/lack of confidence to use the technology • More intimidating than in-person • Couple/ family work for telephone. • High levels of risk of harm to self. • Unstable patterns of behaviour, e.g. impulsivity, drug/ alcohol use. Known domestic abuse/ safeguarding. • Other • English as an additional language

6. **All services should identify ways to reduce a wide range of inequalities in access to virtual and physical services**. This includes but is not limited to:
    a. Language – for example The Big Word or Language Line can provide telephone interpreting services; for videoconference the interpreter can be in the clinic room with the clinician or can be sent their own link to join the consultation remotely.
    b. Patients with hearing loss - people may still access telephone counselling if they have a telephone with amplification, although they will need to consider if this compromises their privacy. Video-conferencing may enable patients with hearing loss to lip-read during their session and use closed captions. The Big Word provides British Sign Language interpreters. Attend Anywhere has a text 'chat' function that could be used.
    c. Lack of access to digital devices and/or stable internet connection – for example using telephone instead.
    d. Lack of privacy at home to ensure a confidential appointment – for example if a person wishes to be in an outdoor setting, it might be appropriate to use the text function in Attend Anywhere.
    e. Referrals from tumour groups – for example people with head and neck cancers may have challenges in using telephones. Video calls can be intimidating where people are seeing themselves on screen.
    f. Single parents/carers – where people don't have access to childcare or respite services. For example the need for flexibility re time of appointments, such as in the evenings.
    g. Anticipating surges in activity, relating to delays in diagnosis, delays to treatments, changes to treatment regimes because of COVID and the impact that this may have on specific cohorts of cancer patients.

    Services should also review NHS guidance on providing video consultations in hospital settings.

7. **Where psycho-oncology services deliver group therapy**, Trusts will need to identify clinical software to facilitate virtual groups sessions. This software will need to be appropriate for therapeutic group interventions delivered by psycho-oncology services. Trusts should engage with their psycho-oncology teams in choosing preferred software. Examples of software used by Improving Access to Psychological Therapies (IAPT) services include IAPTus (70% of London services) or PCMIS (30% of London services).

8. **Information and Support Services should work with their patient support groups to set up virtual sessions.** Support groups may be co-facilitated between patient representatives and NHS healthcare professionals. Where possible, these should be held using NHS approved software that is accessible for patients. Consideration in access must be given for people who may have vision or audio impairments and those who may not have access to smart devices or wifi.

9. **Trusts should work with psycho-oncology services to enable capture of outcome data as part of the electronic patient record**. The software used by IAPT services for example includes outcome questionnaires. All data from the completed questionnaires are captured on these systems.

10. **Trusts and psycho-oncology services should review their ways of working regarding workforce resilience.** Healthy London Partnership and London Region have established an NHS Workforce Resilience clinical expert group to develop guidelines for the capital. When published, the guidelines will outline what is expected in terms of identifying staff that need further mental health support post COVID, how they access services, the treatment on offer as well as sustainability. NHS People signposts resources to help NHS staff manage their own health and wellbeing whilst looking after others.

11. **Services should keep up to date with best practice guidance and pathways for remote and in-person consultations.** NHS England/Improvement is developing Best Practice Pathways for remote consultation in London. All services should review their ways of working to improve in the context of this guidance. Multi-body guidance for psychological professionals during COVID-19 was published in March 2020. The British Psychological Society has also published COVID guidance in June 2020: Psychological insights for cancer services recovery planning. The Association of Clinical Psychologists UK recently published guidance for in person consultations during COVID.

12. **Psycho-oncology services should review the Level 2 training that they deliver** to ensure relevance to new ways of working and within the context of COVID/cancer. As psycho-oncologists have expertise in communication skills, adjustment, behavioural adaptation and systemic ways of working, services may wish to offer their cancer colleagues more support to help in their own adaptations during such unprecedented times. Trusts and Psycho-oncology services will need to consider the constraints of bringing together groups of people face to face, and where this is not possible they need to identify the necessary systems (i.e. technology and privacy) to deliver remote training.

13. **Trusts should prioritise and maintain the delivery of level 2 supervision throughout the COVID recovery period and any future surges.** Services may wish to provide Level 2 supervision for their colleagues face to face (with social distancing) or virtually (ensuring adequate technology and privacy is sufficient). As a way to manage the group process, supervisors should consider:
    - Delivering group and/or individual supervision, subject to the needs of Level 2 staff and capacity of the psycho-oncology team
    - Pros and cons for delivering group supervision face to face for all, virtually for all or using a blend
    - How to transition Level 2 staff who have been redeployed back into clinical supervision
    - Changing and degree of complexity of current caseload
    - New and changing challenges about communicating with patients
    - The diverging experiences of different Level 2 staff, depending on what they did during the acute phase of pandemic
    - The range of issues brought by Level 2 staff are all likely to have evolved during the pandemic
    - New staff members joining supervision groups

14. **Psycho-oncology teams should consider whether they would provide bereavement support during COVID surges**. Some services have reported that they offer bereavement services for (a) families already known to the service (ie. prior to the bereavement), (b) complex bereavements that may need immediate intervention, (c) bereavements in which there may be unresolved issues relating to hospital care (e.g. trauma). Resources for bereavement guidance during COVID include: British Psychological Society, Cruse and Sudden Death. The National Bereavement Service is endorsed by Hospice UK, and can help with both the practical and emotional consequences of a death. The Child Bereavement Network supports professionals working with bereaved children and young people, with information updates, key resources and networking opportunities. For people who do not meet a psycho-oncology team's criteria for access to bereavement services, people should be signposted to local services. www.cancercaremap.org is a useful site to find a wide range of local services. Services may also wish to add known local services to the Cancer Care Map.

Appendix 1

Recommended audit criteria

The working group has provided a list of recommended audit criteria to support services in evaluating new ways of working with patients. These data could be used in future for research and service improvement.

If London services collect same/similar data, then this supports potential for future collaboration in research and development in strategic business cases for psycho-oncology provision within integrated care systems.

The Transforming Cancer Services Team for London produced system level psycho-oncology guidance in February 2020. This also includes a sample business case and service specification. The service specification includes suggested tools for measuring patient outcomes and key performance indicators.

Theme	Criteria
Appointment details	• Patient demographics • Date of Session • Time • Facilitator/Therapist Initials • Patient initials: • Face, Phone or Video consultation • Number attended • Location • Time spent together • Planned/unplanned • Patient/carer/family member present? • This session no. • Palliative? • Discharge Session no. (1-16) • Translation service required: specify language
Where has the referral come from?	• Inpatient • Outpatient • Emergency Department • Acute oncology • Primary and Community Care • Other – please specify
Who made the referral?	• Consultant Oncologist • Junior doctors • Cancer CNS • Ward nurse • Radiographer • Acute care Allied Health Professional • Surgeon • Psych Liaison

	• IAPT clinician • GP • General Practice nurse • Primary care Allied Health Professional • Community Allied Health Professional • Community nurse • Other – please specify
Reasons for virtual consultation?	• Client preference • Positive or suspected COVID infection • Self-isolating or shielding • Physical health/ mobility difficulties that make attending an appointment in person more difficult • Travel or time restrictions. • Other
Reasons for NOT choosing virtual consultations?	• Lack of private space • Fear/lack of confidence to use the technology • More intimidating than face to face • Couple/ family work for telephone. • High levels of risk of harm to self. • Unstable patterns of behaviour, e.g. impulsivity, drug/ alcohol use. Known domestic abuse/ safeguarding. • Other • English as an additional language
Risks status?	• Self harm • Social issues – eg finance, housing, domestic abuse • Other
Reasons for DNA?	•
Session themes?	•
Care plan updated and actions	• Exercises/psychoeducation • Signposting required • Items to be shared • Next appointment? • Feedback?

Appendix 2

Sample criteria and decision-making regarding face to face appointments

Source: Royal Marsden Hospital NHS Foundation Trust (2020), Standard Operating Procedure for resuming face to face appointments in the Adult Psychological Support Service.

1. When a patient(s) meets one of the criteria below and both the clinician and patient agree that a face to face appointment is necessary this can be arranged. Currently, patient preference for a face to face appointment is not sufficient to warrant this. The decision to bring a patient in for a face to face appointment also needs to consider the potential infection risk to the patient:

a) Risk (including the client being at risk to violence/ abuse) which is difficult to manage remotely

b) Conflict/ tension in relationships among families/ couples which is difficult to manage remotely

c) Where the formulation and intervention require exposure to the hospital environment

d) Where the patient's distress is preventing access to/ continuation with cancer treatment and they will only agree to a face to face appointment

e) Multiple people are in the consultation and this cannot be managed remotely

f) Demonstration is needed and this cannot be managed remotely, e.g., psychosexual and art therapy

g) Communication is challenging because of language, for example, use of interpreters, or physical impairment e.g. deaf/ blind/ speech impairment

h) Learning differences/ cognitive difficulties that requires face to face communication so that therapy is effective

i) A lack of private/ confidential space to have a remote appointment

j) A lack of technology for the phone or video consultation

2. Existing patients. It is the responsibility of the treating clinician to decide if the patient meets the criteria outlined above

3. New patients:

a) The Duty Clinician or in their absence the lead of the pathway/ clinic that the patient is accessing will make the decision

b) Where patient preference is for face to face appointments and it is unclear to the clinician if the patient meets one of the criteria above, a face to face assessment can be offered. However, staff need to explain to the patient that during the assessment it may be decided that it is possible for any follow up appointments to be delivered remotely and so the option of face to face appointments would be removed. Additionally, if there is a new spike in COVID-19 cases then all face to face appointments may be stopped.

4. Patients who do not want to engage remotely and who do not meet our criteria for face to face appointments will be discharged. We will explain the rationale for this, signpost them to any known alternatives and offer to send them a self-referral form once face to face provision resumes more fully.