# EDFN Clinical Strategy for Service Management of Foot Care During 'Phase 2' and Second Wave of the COVID-19 Pandemic, September 2020

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Patients who have diabetes and attend a foot service either a foot protection team (FPT) or a multidisciplinary foot care team (MDFT) require regular close surveillance and management to prevent reoccurrence of ulceration, prevention of primary ulceration hospital admission and possible amputation. Such care is critical given the dreadful outcomes for diabetes foot disease. Foot complications require timely multidisciplinary input; specialist podiatry, diabetes, infection control, vascular and orthopaedic consultation are required. NICE has recommended that all new diabetic foot ulcers (DFUs) should ideally be reviewed within 24 hours of referral by the MDFT. This recommendation has not changed throughout the pandemic.

People with diabetes-related foot disease (DFD) are often frail and elderly. Many of them have active comorbidities and also suffer cognitive and biophysical complications with many in supportive accommodation. FPTs and MDfTs, therefore, offer an additional degree of care coordination, over and above that offered by most outpatient/ambulatory systems.

The impact of COVID-19 virus was rapid and required strategic change to the NHS. Medical and allied health service personnel were strategically redeployed to meet the increasing needs within hospitals to meet frontline care needs. We now need to carefully consider how to deliver quality foot care for people with diabetes while being resilient to ongoing demands on the NHS. Patients with DFD are at high risk for severe COVID-19 virus complications and many have been 'shielding'. There have been reports of a reduction in health-seeking behaviour. New ways of working, such as telemedicine, have been implemented to reduce the need for clinical visits. However, other services, such as vascular and orthopaedic surgery, whose operating lists were stopped in many parts of the UK during first wave of the pandemic, are only just restarting surgical work. Also community podiatry services increased the delivery of podiatry in the home when clinics were closed as they were designated 'Covid Hubs'. This situation is not sustainable.

We recognised the need for a new strategy during phase 2 and second wave of the COVID-19 Pandemic. Therefore, the English Diabetes Footcare Network has produced guidance for the second wave of COVID-19 in response to these changes.

## The guidance

This guidance attempts to clarify the current best practice position with an aim to support patients, healthcare professionals and providers.

The guidance is here, in full:

1. Provision of Community Foot Protection Service

a) Community podiatry services should be repatriated to clinics where safe to do so.

b) Designated Foot Protection Teams should be formed where not already available.

c) Levels of home visits should be reduced as 'shielding' is relaxed and local clinics reopen to increase community podiatry capacity. Patients should be made aware that NHS clinics and staff are using full preventive precautions.

d) High-risk patients with intact feet should be given foot protection information and signposting to urgent care. Clinic appointments should only be considered for those requiring preventive footcare, e.g. reducing pre-ulcerative callus

e) Local plans should be reviewed and it should be ensured all clinic staff, doctors and patients are aware of service changes

f) Foot Protection Clinics should develop 'shared care' with secondary services where not already in place to enable capacity to see all active foot wounds within a health care setting.
g) Community Hot Clinics should continue where available or implementation should be considered.
h) Telemedicine and virtual review should be maintained where available or implementation should be considered
i) Podiatrists who were redeployed to COVID-19 teams should return to their original posts
j) Surgical Appliance Clinics should be reinstated
k) Patient ambulance transport should be fully reinstated for foot clinics.

2. Provision of outpatient multidisciplinary foot service is an essential service

a) Access to a diabetes foot service should continue for those with acute or limb-threatening problems to current patients and to new referrals
b) All new referrals should be reviewed within the NG19 (NICE, 2019) recommended target of 24 hours
c) Patients with active foot disease who have self-isolated and missed/cancelled clinic appointments should be contacted for review. Patients should be made aware that NHS clinics and staff are using full preventive precautions
d) Patients should be encouraged to continue self-care where applicable to reduce clinic visits
e) Telemedicine and virtual review should be maintained where available or implementation should be considered
f) MDFT members who were redeployed to COVID-19 teams should return to their original posts
g) MDFTs should be formed where not already designated
h) Surgical Appliance Clinics should be reinstated
i) Patient ambulance transport should be fully reinstated for foot clinics
j) A specialist vascular surgery opinion should be available to the MDFT at all times: ideally be via the Joint Foot Health clinic during workings hours on weekdays, and via the on-call vascular registrar during other times
k) Lower-limb vascular duplex ultrasound imaging should be available, where clinically indicated, on an urgent outpatient basis within a week of specialist review. This should be performed at the same site as the Joint Health Clinic wherever possible, in order to ensure timely review and to prevent unnecessary multiple patient visits
l) Revascularisation procedures should continue to be undertaken and wherever possible these should be performed as day case, endovascular procedures, under local anaesthetic
m) Specialist reconstructive orthopaedics for foot conditions, such as Charcot's arthropathy, should recommence to prevent future ulceration, infection and amputation.

3.Provision of inpatient multidisciplinary diabetes foot service is an essential service

a) All units with active inpatient foot service should continue to provide the full complement of services
b) Inpatient MDFTs should be formed where not already designated
c) All new diabetes foot inpatient referrals should be reviewed by a member of MDFT within 24 hrs of admission
d) Access to infection control surgery should be prioritised when clinically indicated
e) Patients requiring revascularisation should be triaged for priority
f) MDT meetings with radiology should continue as usual, be reinstated or be formed where not already designated
g) Aim for early assessment of social, mobility and environmental needs of the individual to facilitate rapid treatment and early discharge to community
h) MDFT members who were redeployed to COVID-19 teams should return to their original posts
i) There should be provision of at least a half day operating list per week to enable minor amputations and wound debridement. Wherever possible, this should take place at a non-COVID site.

4. Patients presenting to the emergency department (ED) (in hours and/or out of hours)

a) Liaise with the ED to treat and discharge well patients from ED with clear pathway for early review in MDFT. A ‘duty podiatrist’ is beneficial in assessing, treating and triaging patients to the correct pathways during working hours
b) Patients presenting with suspected COVID-19 infection and DFD should be treated as positive for the virus until otherwise advised (see 5d)
c) MDFT Hot Clinics have proved useful during the initial pandemic and should continue. Where not currently available MDFT Hot Clinics should be considered.

5. Protecting patients and staff while providing essential services
All staff and patients should wear a face mask when entering hospitals and clinics. Please refer to local and national guidance.
a) Ensure patients are social distanced in waiting rooms. Relatives and carers should only attend where absolutely necessary.
Guidance: The Public Health England (PHE) advice continues to evolve and it is recommended that you appraise yourselves of the most recent advice on maximum crowd numbers.
b) Reduce the need for aerosol producing procedures. Example; debridement procedures that generate significant aerosols.
Guidance: Those without major foot deformities may be able to safely transition into a removable orthotic walker (e.g Aircast type). If significant foot deformities exist, consider the option of a TCC made removable (bivalve cast).
c) Managing staff with COVID-19 symptoms.
Guidance: Please follow local Trust and the continuously updated PHE recommendations
d) Manging patients with COVID-19 symptoms.
Guidance: Please follow local Trust and the continuously updated PHE recommendations. Ensure Safe PPE recommendations are followed.

6. Risks
a) Capacity — due to social distancing and cleaning, all foot clinics will have reduced capacity
b) Staff sickness
c) Child welfare if school groups are sent home
d) Failure to continue/implement Hot Clinics and Virtual Clinics
e) Equipment shortage
f) Slow repatriation of services
g) Long waiting times for surgery; revascularisation, reconstruction

7. Mitigation recommendations
a) Multidisciplinary foot service to review capacity with aim of maximising provision for active foot disease. All secondary care MDFT’s to review the service arrangement and ensure the service is maintained in hospital as essential activity
b) Foot Protection clinics to increase capacity by reducing appointments for patient with low or moderate risk of ulceration whilst providing them with signposting information and foot care guidance, seeing only people with high-risk or in-remission feet either virtually or face-to-face based on individual risk assessments
c) Use virtual appointments, especially with other HCPs present, to review patients in care homes or who are housebound
d) Secondary and community podiatry to form integrated care plans for ulcer care and make arrangements for new reviews, shared care, unwell patients or deteriorating foot conditions
e) Services to contact all patients with active foot disease who have not attended clinic for a review
f) It should be recognised that service redesign may not be recognisably ‘business as usual’ or to expect every fail-safe check to be in place
g) The identification of different staff groups who can work together, i.e. other wound care staff, such as tissue viability all working together will increase resilience
h) Reassure patients that they are being cared for. Continuously reassure staff that their concerns are being listened to. Address them as clearly as you can where possible
i) Ensure staff take annual leave.

Other COVID-19 guidance
https://www.wounds-uk.com/resources/details/lower-limb-amputation-prevention-guidance

https://cop.org.uk/news-and-features/covid-19
https://www.gov.uk/coronavirus
https://iwgdfguidelines.org/covid-19/
https://www.england.nhs.uk/coronavirus/ ■