

Implications of the COVID-19 pandemic on the management of foot disease in diabetes

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The COVID-19 pandemic has had an abrupt and shocking impact on the routine management of disease, unsettling both professionals and the public, and resulting in the disruption of routine services, as well as being a frightening epidemic, resulting in many thousands of people in UK dying before their time. Its arrival has resulted in major changes to standard working practice being adopted and frequently remodelled; the pace of change has been bewildering for many.

Particular difficulties in the management of foot disease

Staffing of specialist services has been challenging because of the high rates of COVID-19 sickness and absence. Maintenance of hospital-based services has posed a particular problem because the majority of diabetologists are also general physicians.

On a more positive note, the crisis has melted some of the barriers to effective working practice that have built up over the years. The result has been highly productive collaborative problem-solving and effective sharing of scarce resources, both locally and nationally. Some vascular surgical teams have taken over, from diabetologists, the care of routine foot services for people with diabetes. Everybody is doing the best that they can.

Need for early expert assessment and treatment

The need for early expert assessment is believed to be a cornerstone of best practice of all new foot disease, but this has been hampered by both the constraints placed on the staff of foot care clinics, and on the fears and uncertainties of patients (see below).

Patient preference and patient fears

Many patients have always been ambivalent about the need for referral to hospital clinics (and frequent follow-up) and would often prefer to be managed in the community if possible, but this ambivalence is

now magnified by (a) a wish not to make things worse for others (professionals and patients), (b) a very real fear of being exposed to potential risk of infection in crowded waiting rooms, (c) increased difficulty of transport and (d) genuine confusion resulting from official notices relating to the need, or otherwise, to keep out-patient appointments or stay at home and (e) probable over-representation among foot ulcer patients of people advised to 'shelter' completely. Such fears and uncertainty are likely to be especially marked in those who develop a foot problem for the first time.

Strategies and solutions

Local specialist groups have obviously been working hard to agree pathways that can be adopted and promoted in their area, and the recommended solutions will vary, even though they may all be based on the same principles. The following principles underlie all:

- The continued provision of both in-patient and out-patient services for the management of disease of the foot in diabetes is essential
- The need for access to this service should be clearly promoted to every person with diabetes and should emphasise the need to seek urgent advice if they develop a new ulcer and/or unexplained inflammation of the foot
- Ideally, there should be just one access point by phone or email (but with a reserve number if the first is inaccessible).

The potential for an expanded role for community podiatry

While some services and communities will maintain arrangements for specialist referrals which already exist, others have variously adapted their service in response to changes resulting from the pandemic. One such change is to have given serious consideration to either establishing or expanding a triage service, administered by teams of community podiatrists with the necessary skills. Such a

community-based triage service by community staff will work most effectively if the lead podiatrists are known to, and work closely with, other relevant professionals (e.g. diabetologists, vascular surgeons), as part of a single integrated multidisciplinary team. Such a community facility would not replace the multidisciplinary service but could, and should, become a key component of it. Increased communication between community podiatry and both primary and secondary care would result in a simpler and more effective pathway for referral, and would facilitate a prepared 'step up' and 'step down' (or 'step across') approach, ensuring that the care needed for each individual is delivered at the right time and in the right place. Such systems could become integral to all high quality management once the COVID-19 pandemic is just an awful memory.

Management of the active Charcot foot

The principles of care of an active Charcot foot are unchanged, and so will be the time it takes for any one case to go into remission. The problem is that best practice has relied on frequent (each two weeks on average) cast removal and clinical review, which is usually undertaken in a hospital – and requires ambulance transport for many. It is difficult for many people to endure this protracted commitment, and it will be made harder by undeniable fears about time spent in waiting rooms and the relative shortage of transport. The result is that there is now considerable doubt about how such good care can be best delivered. This includes considering who does the plastering and how often, and whether greater use should be made of removable walkers (or walkers made irremovable for with tape: 'instant total contact casts'). The responsibility for long term provision (and repair) of orthoses and other specialist follow-up remains ill-defined in many areas, but this is nothing new.

Clinical audit during the COVID-19 pandemic

The priority for all healthcare professionals is to do

the best they can for all people at high risk, and that is what they do. But an inevitable consequence of a crisis is that the care of some conditions is not the same as it would have been before. The extent to which people, and which particular groups of people suffer, as a result of such changes in care emphasis, is not always known. It is for this reason that a decision has been made in England and Wales that some of the National Diabetes Audit (NDA) will continue as planned — so long as it is possible for clinical staff to provide the data.

In the case of the National Diabetes Foot Care Audit (NDFA), it is likely that some service providers will feel that they have neither the time nor the resources to complete the audit forms as much as they did previously, and may restrict it only to selected populations. It should be noted, however, that newly acquired data do not need to be uploaded at once, and bulk upload at a later date is a possible option. Therefore, the NDFA team is really hopeful that as many teams as possible can continue to register ulcer episodes and outcomes.

Later analyses by the NDFA should be able to show the extent to which outcomes have indeed been affected (or not) by the pandemic. Thus, they might show that hospital admissions or overall outcomes – such as healing times or major amputation rates – increased during the time of the pandemic, or they might show otherwise. Moreover, any changes might be restricted to certain groups, such as those with either severe or less severe ulcers. Clinical outcomes might also be shown to be no different, despite (as is likely) much reduced bed occupancy. In all of these ways, and more, the NDFA will provide invaluable information regarding those aspects of care delivery, which contribute most to best clinical outcomes. If such aspects of care can then be adopted for a wider population, it should be possible to reduce the variation that currently exists between localities and to improve overall outcomes. It is for these reasons we really want the clinical audits in diabetes, including the NDFA, to continue. ■