BAPO Clinical Guidance during Covid-19 pandemic

As the initial peak of COVID-19 infections appears to have past, the UK Government has stated that the NHS will gradually return to providing normal services.

Note should be taken regarding guidance specific to the devolved administrations, as this may periodically vary. The timelines of when certain services will re-start will be a local decision. To allow and support organisations and our members to plan and re-start routine orthotic and prosthetic services, BAPO, in collaboration with BHTA, has created the following guidelines, which have also been shared with ISPO UK and NOMaG.

They are intended to assist NHS managers and Service Providers with their post COVID-19 recovery plan. This is a dynamic document and will be periodically reviewed as circumstances and available Government guidance is updated. A measure of social distance will remain for many months in order to reduce the rate of Covid-19 spreading. For routine clinical services to re-start, services will have to be delivered differently to protect the public and staff.

Risk assessment

A risk-based approach must be employed to ensure the new and exceptional risks resulting from COVID-19 are fully considered. Risks must be managed to provide a safe environment for patients and staff.

All decisions in relation to clinical management and a return to routine face to face activity will require reference to risk assessments and documented actions plans will need to be agreed by both managers and clinicians.

Where services are subcontracted, the employing organisation should undertake risk assessments to verify the safety of their staff and the services they will provide. This should be undertaken in partnership with the host provider (Trust/Board). Lessons learnt should be shared across local services, organisations and service provider contracts in the interests of safety and appropriate management of care.

Where private providers are delivering prosthetic and orthotic services, they must develop their own policies and procedures, including dynamic risk assessments, to ensure safe and compliant work practices.

All risk assessments should be conducted by a suitably trained person. All organisations providing P&O services should have access to qualified risk assessors.

During the period of the pandemic, risk assessments should be conducted with a higher level of frequency to reflect changes in how services operate, and the demand placed on Prosthetists and Orthotists.

Triage

The risk associated with delayed orthotic care should be evaluated alongside any COVID-19 risk factors. Following this consideration, the patients' care should be prioritised and planned reflecting the balance of risk.

Patient consent to attend appointments is essential and should not be taken for granted, even if given prior to the pandemic. Triage should address consent.

A red, amber, green (RAG) rating can be used to classify patients and the risk associated in exposing them to face to face contact for prosthetic or orthotic appointments. Decisions should reflect local circumstances.

The RAG approach will provide for a systematic framework to ensure that the process for review is robust and aligned to the choices and challenges that each service is faced with.

		Covid-19 transmission		
		Low Risk	Moderate Risk	Higher Risk
Prosthetics/Orthotics Service	Emergency			
	Urgent			
	Routine			

Note should be taken of those factors affecting those at greater risk of being affected by COVID-19 with reference to the comprehensive guidance

https://www.nhs.uk/conditions/coronavirus-covid-19/people-at-higher-risk/

The following guidance is helpful when considering risk management

https://www.hse.gov.uk/simple-health-safety/risk/steps-needed-to-manage-risk.htm

Management of clinical sessions

The required social distancing will have an impact on patient flow.

All P&O services will need to control the timing of people arriving and leaving clinic. The manner of how they arrive and leave should be reviewed to reduce footfall in acute sites and support social distancing.

Measures should be agreed to reduce the numbers waiting in waiting areas. Where waiting areas are shared with other hospital departments cross service planning will be required.

Where the location supports this, patients may be asked to wait in their car and only enter the department when required to do so.

The numbers in waiting need to be controlled as well as cleaning down rooms and waiting areas in between each patient. This will be dependent on the individual environment and geography of each clinical site as well as consideration of other clinics and users of the space.

As well as clinical areas, additional safety measures must ensure all workplace spaces, offices and workshop areas comply with the UK Governments “Covid Secure Standards” https://www.gov.uk/guidance/working-safely-during-coronavirus-covid-19

Guidance is updated to outline the requirements that ensure staff are safe in all areas, including the required use of PPE.

https://www.england.nhs.uk/coronavirus/secondary-care/prevention/personal-protective-equipment-ppe/

Service delivery plans should by updated as the guidance evolves, with managers remaining vigilant and informed.

The Government has now mandated that all NHS staff in England must always wear a surgical face mask; in all workplaces, no matter where you work. This includes people who do not have a clinical role and those based in offices. This is to offer greater protection for everyone.

Clinic schedules

During the pandemic, many prosthetic and orthotic services have continued to see urgent patients. Appointment schedules will need to support appropriate social distancing and allow thorough infection control procedures (PPE, cleaning down of clinical environment, tools and equipment).

Schedules will reflect the nature of the individual service, appointment type, equipment use and the availability of safe access to and from the facility. Each service's documented risk analysis must illustrate how these elements have been considered.

Revised clinical schedules must provide time to:

- Enable the clinician to conduct a clinical appointment in line with local infection control policy, ensuring they and their patients are safe at all times
- Provide adequate time to safely enter and leave the building
- Clean down check in/reception and waiting areas between each patient contact

Administrative staff, volunteers and clinical assistants should be trained to and tasked to:

- Assist with clean down of clinical, check in/reception and waiting areas between appointments
- Ensure patients are fully informed about access arrangements
- Patients are reassured, with space managed and information provided to avoid unwanted congregation in waiting areas
- Manage patients in virtual waiting areas to optimise contact time with clinicians e.g. ensure devises to be reviewed are available and the home environment is appropriate for the consultation

Communication plans

Clear plans should be in place to support these changes which illustrate:

- Access to the department
- Exit from the department
- Additional requirements, such as the wearing of masks
- Arrival at appointment time
- Limiting the number of family members/carers to a minimum
- Process for the safe drop off or collection of orthoses

Capacity planning

Although initial demand for services may be slow to return to previous levels, this may be short-lived.

As waiting lists for P&O services will have been extended during the lockdown, challenges are to be expected with regard to meeting the demand for patients requiring treatment essential to their health and well-being.

New strategies for delivering services and managing capacity may have to be considered. This may include the transfer of services to Trust sites which allow easier access and movement or the commissioning of new sites. This would be to facilitate an increase in the level of clinical activity provided as deemed necessary by commissioners and service providers.

Clinic templates may have to be adjusted and different sessional times considered to permit access into departments occupied by other services, such as adding additional slots to a session with early or late appointments.

The most efficient schedule is likely to involve a mix of virtual with face to face appointments to minimise the risk of patient to patient contact and optimise the numbers of patients seen per session.

Virtual clinics, using approved platforms, should be used to provide:

- Triage
- Advice
- Assessment
- Review ongoing care

- Provide devices or components e.g. orthoses
- All activities in lines with governance requirements (considering confidentiality etc.)

Summary of BAPO recommendations

(1) Decisions regarding appointment schedules, clinical coverage, PPE and patient safety must be based on documented risk assessments; with appropriate input from the team of Prosthetist/Orthotists who deliver that service. Departmental standard operating procedures must be revised to reflect the new circumstances and informed by advice from local infection control teams.

(2) Referrals must be triaged by a designated Prosthetist/Orthotist in line with local policies and BAPO guidelines. Due to the risk of transmitting the virus, face to face consultations should, for the duration of the pandemic or until advised otherwise by the relevant Public Health agency, be a last resort. Flow charts should be used in each P&O department to illustrate and determine if a face to face visit is necessary or whether other forms of consultations would be sufficient, such as telephone or virtual consultations.

(3) Triage policies should address prioritisation based on clinical risk. Policies must also address the specific needs due to growth in children which may affect both fit and function of any required prostheses or orthoses. To aid clarity tiered RAG rating may be applied to document processes and support clinical decisions. Waiting areas should be configured to maintain social distancing and allow appropriate infection control procedures. If clinical waiting areas do not allow effective social distancing, then other measures should be considered (i.e. leaving patients in their cars or in larger areas until the clinician is ready to see them). If the clinical environment does not support social distancing, then consideration may be given to alternative premises which enable improved levels of safety for patients and staff.

(4) Departmental communications should advise the appointed patient that where possible only they should attend the clinic. This is to minimise those present at

each appointment and support measures taken to deliver social distancing. When carers are required to attend an appointment, whenever possible these should be limited to one person.

(5) MDT input via virtual technology e.g. joint consultation with AHPs should be adopted to reduce those required to attend appointments face to face, even when those staff are on site.

(6) Wherever possible establish a separate entrance and exit to the clinical area and adopt one-way movement of people within that department.

(7) Communicate with patients before arriving to explain procedure for the appointment, provide reassurance and ensure patients act to minimise unnecessary contact with other service users and hospital staff.

Additional Information

The following links contain complementary advice and information from International Society of Prosthetics and Orthotics (ISPO) and British Orthopaedic Association (BOA)

1. https://www.ispoint.org/general/custom.asp?page=COVID-19
2. https://www.boa.ac.uk/uploads/assets/21ff8d6d-39c0-4697-aa3f6a12d42a37d7/BOA-Guidance-for-restart-summary-final.pdf
3. https://www.boa.ac.uk/policy-engagement/journal-of-trauma-orthopaedics/journal-of-trauma-orthopaedics-and-coronavirus/evidence-based-suggestions-for-the-return.html