Lessons learned from COVID-19: Building a 'new normal' in podiatry services

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Article points

1. The COVID-19 pandemic has affected service delivery and clinicians have had to work with reduced resources.
2. Patients and clinicians have been affected by changes in care, and risk of complications has increased.
3. There have been opportunities for innovation, with podiatry leading the way, and these need to be considered for the future.

Key words

- COVID-19
- Service delivery
- Supported care

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Like many sectors, podiatry services have been affected by and had to learn lessons from the COVID-19 pandemic. The pandemic has had an impact on service delivery and patient communication, and there has been some debate over whether this will permanently change the ways in which care is delivered. A group of podiatry specialists met online via Zoom on 16th June 2021 to discuss how care has evolved since the start of the pandemic, and what this might look like as we move forward. This builds on a previous discussion that took place one year earlier (in early July 2020), in which a similar group discussed the challenges of delivering care at the height of the pandemic, which was published in *The Diabetic Foot Journal* in September 2020 (Chadwick et al, 2020).

The group agreed that, while the COVID-19 pandemic has been a huge challenge, there have also been some positive aspects to how care has evolved during this time. Embracing technology has allowed some aspects of care to be delivered remotely, which in some cases will continue beyond the pandemic. Importantly, this time has demonstrated podiatry to be a leading field that should be recognised for their achievements in maintaining and promoting care under challenging circumstances.

COVID-specific challenges

Most importantly, the pandemic has had a significant effect on an already vulnerable patient population, and patients have been hit hard by this. It was difficult to predict the effect that COVID would have on patients, as some relatively fit and healthy patients did not survive, while some patients not expected to survive did. The effects have, in many cases, been devastating.

For some services capacity was already a challenge before COVID. Logistical and staffing issues have exacerbated this problem. Staff shielding or suffering with long COVID has affected capacity in many services, as well as staff being redeployed.

In podiatry services, 'COVID toes' were seen in the first wave of the pandemic but less so as time has gone on. These have now healed and had generally good outcomes.

Patients' mental health has been and remains a challenge. Some patients are vulnerable and have become isolated, or had challenging personal circumstances such as relationship breakdowns. In some cases, this has resulted in personal neglect and made patients less able to cope. Alcohol and diet have been an issue for many people during this time. This all contributed to the second wave being 'horrendous', with many patients suffering not only with COVID but with other issues.

Impact on healing

As some patients were reluctant to be seen, the risk of complications increased. Previous patients of moderate risk have frequently deteriorated, and some patients have lost a degree of mobility. The number of foot wounds remained broadly the same, but they were often more complex by the time they were seen, with issues such as increased

infection, osteomyelitis, and deeper wounds. There has also been an increase in patients who were previously at moderate risk for diabetes-related foot complications (as per NICE guidelines) going on to develop wounds as a result of not being able to access regular routine podiatry services for issues such as callus reduction or biomechanics for the offloading of high-pressure joints. These often healed very quickly once the patient had accessed appropriate podiatry services.

There has been an increasing number of amputations during the pandemic. Anecdotally, there has also been a significant increase observed in cases of dramatic gout with considerable destruction. This could be due to a number of reasons, such as not seeing a GP, poor diet or increased alcohol consumption during lockdown.

While there has been a definite increase in complicated wounds and amputations, at the moment, it is too soon to determine the full impact the pandemic has had on healing rates, and more data is required. Some complexities and repercussions for patients are still emerging; an example was given of a patient with complicated osteomyelitis who had not seen a clinician and so was only recently assessed. Cases such as these have seen patients develop complications without early intervention.

However, it was noted that it is difficult to gauge precisely how the pandemic may have affected healing rates without knowing exact pre-pandemic rates, and this is not always well documented in practice, due to time constraints or a lack of accurate recording processes. There can also be a lack of clear, documented assessment, making it more difficult to track healing trajectories and outcomes. This has highlighted the importance of record-keeping and trying to ensure as many patients as possible are being included in the NDFA.

Logistical issues

Reduced services and, in some cases, reduced space resulted in logistical issues for service delivery, such as patients waiting in car parks or not being able to access face-to-face services. To reduce hospital footfall, some services were moved to community clinics or domiciliary visits. In some cases, this made patients feel more secure as they did not want to visit a hospital setting, and some of these new services have now become permanent.

At the height of the pandemic, patients who needed to be seen were often still reluctant to attend, resulting in hospital admissions with severe issues.

There was some redesigning of services, such as sending patients to 'hub' hospitals, which became chaotic. It was difficult to keep track of patients and their whereabouts, with some patients experiencing issues such as lack of transport home due to disorganisation of support services.

Particularly during the second wave, it was a challenge to obtain new footwear for patients, as shops weren't open. Temporary footwear had to be used for too long and patients were unable to be fully rehabilitated. In retrospect, there should have been pressure on the government that this was a priority for podiatry patients. There was also some difficulty in obtaining bespoke footwear due to some orthotists working in hospitals were furloughed as they were employed by an outsourced company.

As services began to resume, timing appointments around taking lateral flow tests was difficult. At one point, it was necessary to do a test for every home visit, but this was untenable due to the time involved (i.e. having to wait for a result). Generally, staff are now taking a test every morning.

Technology and remote consultations

Staff being able to work remotely had a positive effect, particularly for staff who were vulnerable or shielding, enabling more efficient and flexible working for teams. Telemedicine was also used by necessity during the first wave when clinicians were unable to get into care homes.

Patient appointments could be carried out remotely, either via telephone or video. The efficiency of virtual consultations meant that patients could then be admitted quickly if necessary, while still reducing any unnecessary footfall in the clinic or hospital setting.

Routine new patient assessments are now generally conducted over the phone and many will continue to do so. If patients meet the criteria, they are then booked in for a face-to-face consultation, improving efficiency. Nail surgery assessments can also be triaged and prioritised according to clinical need based on photographs where appropriate.

As home visits have resumed, having laptops to write up notes at home afterwards has resulted in time savings for clinicians; however, this could also lead to clinicians working beyond their working hours.

Communication and collaboration

In some cases, communication and interdisciplinary working have been found to improve, resulting in better understanding between departments and staff. Interconnectivity with orthopaedic and vascular surgeons has been good, with surgeons often more available, and in general communication with secondary colleagues has been improved. Redeployment of staff also helped to build bridges between different departments.

This improved communication has helped to show the critical role of the foot. Podiatry services have continued to provide care in the most challenging conditions, and staff have really been able to show what they are capable of. This has started a dialogue about the caseloads staff have managed to see, both within teams and with other disciplines.

Nursing staff and podiatrists have led the way with care throughout the pandemic, especially with colleagues who are less familiar with use of personal protective equipment (PPE) and infection control. As infection control and knowledge of aseptic technique is part of regular practice for podiatrists, we have been able to teach colleagues from other departments, such as physiotherapists.

Improvements in care

Developments made during the pandemic have resulted in improvements in care that will continue beyond the pandemic. One of the key improvements is the adoption of treatment pathways to inform practice. For example, a traffic light triage system has been developed to support preventative care and help to keep patients mobile. It was agreed that incorporating evidence-based pathways needs to be part of care going forward into 'the new normal'.

The process is ongoing of reviewing caseloads and prioritising patients appropriately: assessing which patients have coped well and who may need additional face-to-face clinician support.

Resuming services

Services are now generally resuming, with lessons being learned from evolution to care during the pandemic. Nail surgery was paused in many settings – although severe cases carried on in some clinics – but is now up and running. Patients can now send pictures for initial assessment to their clinician, which helps to manage the caseload efficiently.

Patients, many of whom were initially reluctant, are now generally becoming more comfortable with coming back into the clinic. In some cases, it has been a surprise that patients have been happy to come back and it hasn't been as big an issue as expected.

It is still a struggle for patients to get GP appointments, which is causing issues in day-to-day practice. Annual foot checks are still not routinely happening in some care settings, meaning that patients may still not receive early intervention to avoid complications developing.

Patient self-care

Patients have become more involved in their own care where appropriate, which has generally been a positive development. Appropriate patient selection for self-care has been key, particularly in high-risk patients (whether with physical health issues or mental health/environmental/social issues). While high-risk patients need to be carefully monitored, in practice it is patients at moderate risk who are most in danger of not receiving clinician attention or 'slipping through the net'. This is where remote consultations have been particularly useful. It is vital to be cautious in providing patients with support where necessary.

To facilitate supported care, carers were also invited to consultations where appropriate, and given training on suitable elements of care such as simple redressing of a wound.

Moving forward, patients should be involved in their own care where possible, but will need education, particularly in issues such as changing dressings and knowing who to contact if they need to. It is important that any education is pitched at the correct level and tailored to the individual.

Many patients have responded positively to being involved in self-care. Some have engaged well and others less so. Attitudes towards care models vary, with some patients liking the

reassurance of a 'doctor knows best' paternalistic approach, but others have enjoyed being more self-sufficient. Going forward, a middle ground needs to be found that addresses individual patient needs and preferences.

The future of podiatry

In some ways, the pandemic has escalated progress and demonstrated to other departments what we can do as podiatrists, gaining recognition for the profession. Lessons have been learned and innovations developed that will improve practice in the long term.

More integrated working and improved communication have improved practice, and being able to conduct some consultations remotely has enabled more efficient caseload management. Similarly, being able to manage less complex wounds in the community should continue.

There is a danger of falling back into ritualistic care, but we must make sure that we use the lessons learned to develop a 'new normal' that benefits patients, clinicians and healthcare services. There is also a need to invest in the profession of podiatry, preparing the next generation of podiatrists and considering succession planning. Recruitment is currently a challenge, so thought needs to be given about how recruitment and training can be delivered.

In many cases, existing staff are now burned out and need support. During the pandemic, staff have kept services running and cared for their patients under challenging conditions. There have been real opportunities to innovate, but staff are now tired and it will be important to find ways to keep this enthusiasm and motivation going as we move forward.

Online events and conferences have opened up opportunities for staff logistically, making it easier to attend, but there is also now an appetite for learning and networking in person, and colleagues being together to network. Many people have 'screen fatigue' by this point. In the longer term, blended learning will be a good option.

The group discussed the importance and value of commercial company support and how this has helped to develop services during the COVID-19 pandemic. Companies have worked with clinicians to deliver appropriate — and sometimes urgently needed — training and education to maintain an acceptable level of skills and knowledge. Companies have also developed resources and educational materials to support clinicians and their patients, particularly around shared care and how this can work in practice. Commercial companies have built closer relationships with some lead clinicians by ensuring their needs were met.

It was agreed that streamlined working with industry is now more important than ever: staff need to be supported in any way possible while services are still evolving, and we find the 'new normal'. ■

Chadwick P, Bowen G, Hart S et al (2020) Learning from COVID-19: Developing a more efficient podiatry service. *The Diabetic Foot Journal* 23(3): 60–3