Learning from COVID-19: developing a more efficient podiatry service

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The COVID-19 pandemic has had a huge effect on podiatry services, both from a clinician and patient point of view. This has resulted in changes to the way care is being delivered, some of which may result in permanent shifts — both positive and negative. An expert group of podiatrists met online in early July 2020, to discuss the challenges of delivering podiatry services during a pandemic, how they have addressed these challenges, and how this may change delivery of care in the future.

How has your service changed during the COVID-19 pandemic?

The principle change reported across the group was that clinics and services were immediately reduced. Within the group members' geographical areas, the prevalence of COVID-19 has varied, but all services have been reduced, and in some cases non-urgent face-to-face treatments have been suspended entirely. Only those for urgent foot problems have been continued, to prevent hospital admissions. Many clinics have been moved out or drastically reduced in order to reduce hospital footfall; this posed an immediate challenge, as multidisciplinary team (MDT) support has no longer been as easily accessible. In some clinics, being able to maintain social distancing as per government guidance has been a challenge: not just clinical space, but areas such as waiting rooms.

In some cases, staff members have been redeployed, either to COVID wards or collaborating district nurses. Some staff members have also been shielding, so have not been able to work in their usual posts. There has been a need to adapt and respond quickly to the new changes.

Where clinics have stayed open, in some areas there has been patient screening, taking patients' temperatures and using infrared cameras. Patients receive a phone call in advance of their appointments to make sure they do not have COVID symptoms.

Challenges faced

Unfortunately, one of the key challenges during this time has been patients presenting late (either not wanting to see a clinician due to shielding, or not being able to get to their GP for a referral), and often having deteriorated or developed limb-threatening complications or infection. Although there are not yet overall statistics on this, anecdotal reports from clinicians in practice suggest that amputation rates have gone up as a direct result of this.

The focus has been on acute foot wounds, so some patients with chronic wounds have deteriorated. Due to reduced clinic services, some areas have only been able to see 'limb or life threatening' patients. It has sometimes been a challenge to admit patients where necessary, as vascular departments have been conducting 'life-saving procedures only'. This will pose an ongoing challenge going forward, as waiting lists and patient numbers will have increased in the interim.

Both as a direct and indirect result of COVID, there has been an increase in patients experiencing complications. For example, some patients with COVID have had necrosis/gangrene, and more acute ischaemia has been observed. 'COVID toes' have been seen in practice and are thought to have a vascular element.

Overcoming the challenges

In some ways, overcoming the challenges has been positive, as this has promoted the ethos of 'making

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every contact count'. Podiatrists have had an increased presence on dialysis units in some areas, so that if patients have to come in for dialysis, they could also see a podiatrist. Aiming to create a 'one-stop shop' wherever possible has been useful during this time.

'Shared care' has been promoted, with podiatry teams working alongside nurses. This has been highly beneficial in some cases, as this new way of working allows access to some patients who hadn't previously been seen by a podiatrist. Orthotists have also now been working in community and wound care clinics alongside the podiatry team, which has been helpful when there are other staff shortages.

Domiciliary visits

Numbers of domiciliary visits have increased, both through clinic settings not being available and due to patients not wanting to come into the clinic.

The current guidelines and additional use of personal protective equipment (PPE) mean that domiciliary visits are taking longer than usual, therefore fewer patients can be seen and there is increased pressure on the clinician's time. For instance, after each session, the clinician will go home and shower straight away, prior to typing their notes up on their laptop. The precautions for domiciliary visits mean that clinicians have had to plan visits carefully, taking measures such as cutting down on the equipment carried for domiciliary visits in order to reduce contamination, putting on PPE before going into the patient's house, and considering extra preparation such as keeping equipment in boxes and putting plastic sheeting in cars to protect equipment from potential contamination. This all takes up extra travel and administrative time, as well as the number of visits having increased.

How care is delivered may need to be examined post-pandemic. Many patients now prefer being seen at home and have appreciated not having to travel.

Patient communication and self-care

Remote appointments and patient communication have also been utilised, through platforms such as Microsoft Teams and WhatsApp. This has enabled communication in the absence of clinic or domiciliary visits, which in many cases has been highly useful.

'Rehab My Patient' is a platform that has been used with good results, which can provide an individualised management plan for the patient. In some cases, where patients are now starting their recovery before they have a face-to-face appointment, remote care has been found to be sufficient — i.e. a face-to-face appointment ends up not being needed.

Video consultations have been used, but this has been found not to be necessary across the board. In some instances, doing a telephone consultation first has been enough. In Glasgow, for example, all patients now receive a telephone appointment first. Using the telephone appointment to obtain the relevant information from the patient and asking them to describe their wound has in some cases been challenging, but overall highly useful.

Using remote technology has also enabled virtual MDT discussions (e.g. communication with other relevant departments) before the patient is seen by a podiatrist. As GPs have been seeing fewer patients, for instance, they have been easier than usual to get hold of and happy to help. Vascular referrals have now in some cases been conducted via email, as it is possible to send photos via email rather than formal referrals, which has worked well.

It is important to note that some patients are not able to engage with self-care or with telemedicine, due to not having either the technology or the capacity (e.g. older patients and those with learning difficulties). It's vital to make sure technology does not lead to exclusion. In care homes, this has worked well because carers can help and be instructed. In some cases, care homes have had an iPad in the home and remote appointments can be conducted through the iPad with the support of carers, which means a clinical assessment can be carried out without having to go into the care home.

In order to facilitate this level of patient involvement and self-care, full integrated electronic records between primary and secondary care are required. In some areas, for example in Glasgow, this has been treated as priority and full electronic records and pathways are in place.

In many areas, clinicians have found that it has been beneficial to make the move to supported self-care for patients, and that the COVID pandemic has enabled teams to 'make the leap' to new ways of working. In some cases, this has been 'an eye-

opener' and 'a pleasant surprise' that some patients are capable of being more involved in their own care and this has been beneficial for them.

Consideration will need to be given to how this patient activation continues, and ensuring that we continue to encourage self-care where possible and do not to go back to seeing people unnecessarily. It has become apparent that where a patient would have been seen once a week and with home visits in between (e.g. for dressing changes), being seen once a week and self-caring in the interim works well. For example, appointments have now been reduced post-nail surgery, encouraging patients to self-care and only contact a clinician if necessary. In Glasgow, post-nail surgery appointments had already been phased out, with good results.

Some areas have introduced new simple measures such as information sheets for patients to encourage self-care. It has been noted that, particularly in rural areas, keeping up remote appointments and encouraging self-care will be beneficial on an ongoing basis. However, it is important to remember that remote consultations are not 'a panacea' and bring challenges of their own.

Expansion of the podiatry role

Due to the pandemic, the scope and workload of podiatry teams have increased. Podiatry teams are now dealing with a wide range of wounds. Many podiatry clinics have now taken on all lower limb wounds within their service. Teams have had to 'upskill' and adapt quickly. While physical services and clinics have been reduced, the numbers of patients and wounds have gone up.

Podiatrists are now managing leg ulcers and prescribing compression. As a result, there is more overlap between nursing and podiatry, which is beneficial. However, going forward, we must remember that podiatry is not 'just' managing wounds, so that the full services and skills of podiatry don't get lost post-COVID.

There may be a need, post-COVID, to focus on the 'USP' of podiatry so that skills and services do not get lost. There is also a need to protect the future workforce and focus on education.

Widening the podiatry skillset, and maximising the skills of podiatrists, could be very important as we move forward. Given the changes that have been made during the COVID pandemic, it makes sense for podiatrists to be seen as the 'go-to people' for foot and ankle. There needs to be a balance between specialisation and not working in silos, advocating for podiatry services and making our voices heard.

How can lessons learned influence future care?

We need to define and be intentional about what 'the new normal' will look like, to ensure we do not go back to 'the old normal'. It was noted that 'crises often drive development of healthcare' and provide lessons that we can learn from going forward.

It is important to think about training and the next generation of podiatrists. While some online training may be beneficial, it is vital to make sure we protect education and the integrity of the profession. There will be a need to support new ways of working from a leadership perspective – considering how we lead and maintain podiatry services, in order to drive change and support next generation of podiatrists.

On a practical level, post-pandemic there will be huge numbers of patients to be seen. Podiatrists are starting to get patients on waiting list for foot and ankle surgery now, ready for when services are resumed.

Some measures that have been introduced as a matter of necessity during the pandemic can now be continued to benefit clinicians and patients. For example, phone consultations for newly healed wounds can be continued and may be extended to other cases.

While services are being slowly introduced, some staff are still shielding and unable to work face to face. Some areas are now starting to reintroduce appointments for high-risk patients who need to be seen. There is still a need to reduce footfall, so there is less capacity for appointments, with more time having to be left between patients. Lower priority patients will still have to wait, and currently don't know when they will be able to be seen. Post-COVID, there will be the challenge of reengaging 'lost' patients.

In terms of team and MDT communication, more regular huddles and team meetings should be maintained – these have been found to bring great value to staff and patients. Sharing of learning during this time has been vital. Nurses

and other clinicians have seen what podiatrists do, and podiatrists have been able to educate nurses about offloading and other important skills. In many cases, there is now a 'newfound respect' between healthcare professionals.

In some community cases, having a podiatrist able to see the patient has meant interventions have happened more quickly and outcomes have improved. In some cases, podiatry intervention has saved time and money, as well as improving patient outcomes.

Post-COVID, it is apparent that many patients will be in need of rehabilitation, and there is huge scope for podiatry to be involved in this. Many patients have experienced vascular compromise, and may have been on vasopressor medication for many months, so the input of podiatry will be invaluable going forward as patients will need additional care. ■