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The art of the possible: a whole system approach to foot protection redesign

David Wylie

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Article points

1. An NHS podiatry-led foot protection service should include and integrate all foot and ankle wounds, whether vascular, diabetes or pressure related
2. Podiatry services are uniquely placed to integrate, co-ordinate and lead on prevention, treatment and rehabilitation of all foot wounds.
3. Large-scale, sustainable NHS podiatry service redesign can be achieved via a structured, planned approach utilising a series of clear plans and processes.

Key words

- Foot Protection Service
- Podiatry
- Service redesign

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The need for radical service redesign of NHS foot protection services has never been more pressing. Demand is increasing exponentially due the perfect storm of an ageing population and the exponential rise in diabetes disease burden. Fully utilising the unique skills of the NHS podiatry workforce offers a sustainable, integrated opportunity to combine vascular and diabetes foot services together with a co-ordinated approach to prevention of caseload and hospital-acquired foot and ankle pressure damage in acute and community settings. This paper describes the methodological approach taken by podiatry services in NHS Greater Glasgow and Clyde to take full responsibility for all foot and ankle wounds for a population of 1.2m. The component organisational elements are described, together with key performance improvements in 1- and 2-day access.

There comes a time when a wee boy can no longer refrain from exclaiming: "The emperor has no clothes." A time when it is no longer acceptable to accept the way things have always been, and a time when, professionally, enough becomes enough and definitive action is required to be taken.

For the profession of podiatry, that time is now. For years we have wished to be granted the status of 'lower limb experts'. We have marketed ourselves as the 'go to' profession for all matters foot and ankle. Only it has not been true really, has it? For sure, we have come a long way as a profession. But we have further to travel than we have already come if we are to secure a sustainable future for the profession beyond the next 10 years.

When the need for such a paradigm shift beckons, it is highly unlikely that the full implications of the radical changes made will be known in advance — or even that such a step into the great unknown will be universally accepted or indeed encouraged by those trapped in the status quo. And so 'the art of the possible' requires to be explored. Risks need to be taken and vision needs to be actualised.

Take the historic scenario common in NHS podiatry services across the UK where a podiatrist visiting a hospital ward is informed by the senior charge nurse that two neighbouring patients on the ward have foot ulceration. One patient has diabetes, the other does not. The podiatrist responds thus: "I can see the one with diabetes, but not the other one". In other words "I am the foot and ankle specialist, but you are the wrong kind of patient." Frequently, what ends up happening is that podiatrists take responsibility for diabetic foot problems, but not for *all* foot ulceration or — perhaps even more damningly — all foot protection. For who is better placed? Who has more specialist knowledge? If not podiatry, then whom?

These intractable questions and challenges drove the podiatry service in NHS Greater Glasgow & Clyde to commission a review of high risk foot service provision for its 1.2m population, including some of the most challenging multiple deprivation data zones in Western Europe. The high-level methodological process and products of this review

are summarised here, together with some indication of outcomes and key performance measures delivered thus far.

Developing a service specification

This document was the starting place that provided everyone internal and external to the organisation with a clear, detailed description of what was going to be provided by the podiatry service. Importantly, it also clarified what was NOT going to be provided by the service. The service specification also outlined the proposed service model (*Figure 1*) to deliver the redesigned service, and described what levels of care were to be delivered within each redesigned tier. This was vitally important since it enabled the service managers to clearly articulate the triggers for escalation between each tier, thus ensuring that only more complex cases were appropriately escalated to higher tiers within the service where resource is more expensive. The redesigned foot protection service specification indicated that the podiatry service would assume responsibility for vascular AND diabetes foot ulcers from June 1, 2016, AND for all foot and ankle pressure damage from June 1, 2018.

This specification work was required to be completed in partnership with staff and their trades union representatives, in order to ensure that there was full service engagement. Staff engagement also had to be planned, proactive and visibly intentional within the podiatry service organisational development plan.

Creating a workforce plan

Having established a service specification and service model, these were then absorbed into a workforce plan. This important document described the workforce and the skill mix required by the foot protection service redesign based on what we already knew about the service, and about future demographic and public health factors, including data derived from the Scottish Index of Multiple Deprivation (SIMD) which, as a result of current 'big data' research emerging from Glasgow Caledonian University, is now showing clear links between deprivation and amputation rates. The capabilities that are required at each tier within the service to deliver services that are safe, person-centred and effective were also clearly defined — these were fully congruent with NHS Scotland's quality ambitions. Following the allocation of resource, costings were then attached showing present and future costs. This work indicated the need for an additional 8.4 whole time equivalent (wte) Band 6 specialist foot protection podiatrists to be appointed. These were created by redesigning vacancies on a population demand basis.

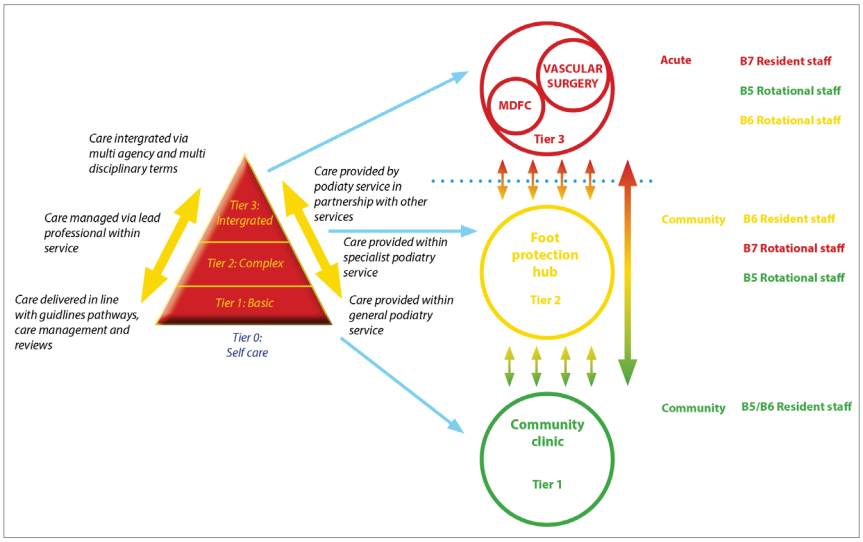

Figure 1. NHS Greater Glasgow & Clyde Podiatry Service Model.

Scoping a learning and education plan

Once the capabilities and competencies were matched to what was required to be delivered at each tier, a learning and education plan was developed to ensure that any self-assessed deficiencies in knowledge or skills were able to be addressed across the service to ensure that each member of the team was operating at the 'top of their license'. This plan also required to include information from individuals' Personal Development Plans that were aggregated up to inform the service-wide foot protection learning and education plan. Many of the skills required were resident within the existing workforce, and these were maximised by running internal clinical support sessions wherever possible, in order to keep attendance at expensive external courses to a minimum. This approach also utilised the leadership and education components within the B7/8 job descriptions for maximum organisational effectiveness. Elements from incident recording action plans and patient complaints were also

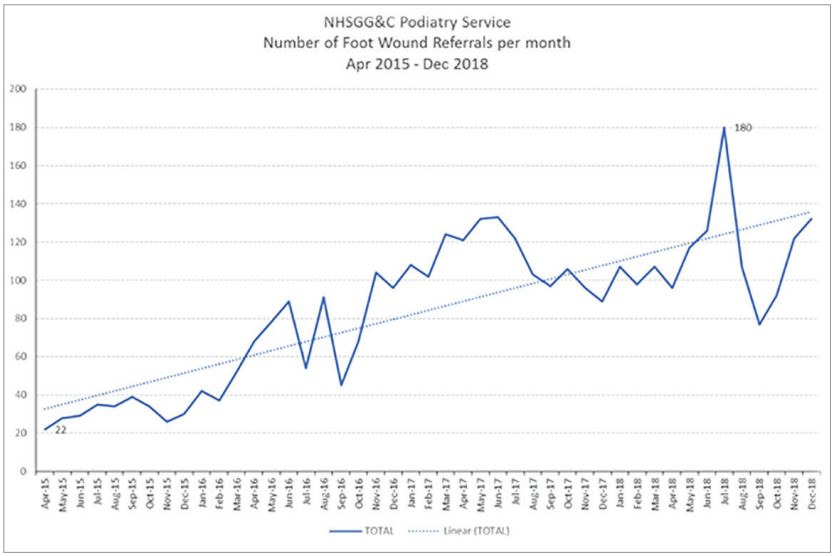

Figure 2. Foot wound referrals to NHS Greater Glasgow & Clyde Podiatry Service per month, 2015–18.

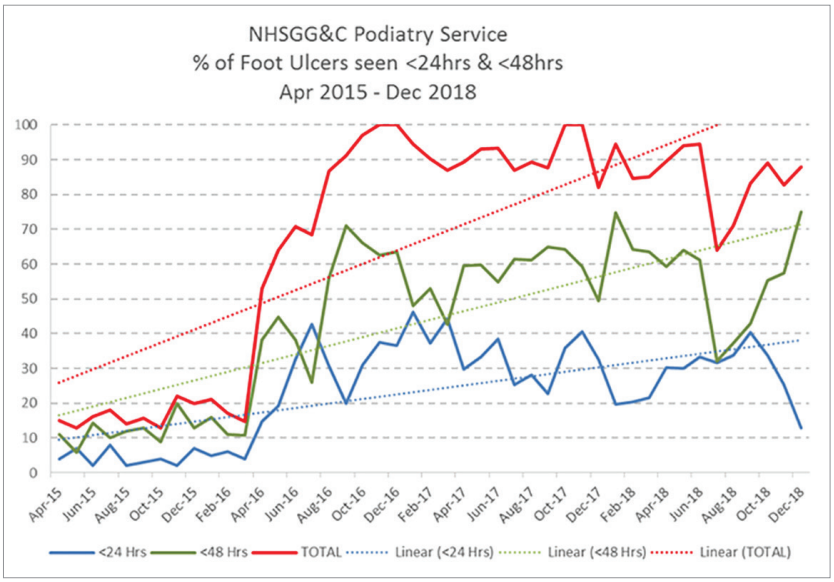

Figure 3. Percentage of foot ulcers seen within 1 and 2 working days, 2015–18.

incorporated into this plan to demonstrate the closing of the learning loop.

Ensuring an organisational development plan

As well as clinical skills development, there needed to be intentionality around the need for staff engagement and participation in organisational change. This was particularly important during the large-scale foot protection service redesigns, but was also not neglected even when small changes to 'the way we do things around here' were implemented. This plan incorporated a systematic approach to addressing change management with particular reference to culture and behaviours. Without intentional planning in this area, changes to processes and structures ran the risk of failing due to the impression that they were being imposed rather than agreed. This plan also adopted a 'you said, we did' approach to link each OD session and activity together into an integrated process, rather than simply running a series of disconnected 'events' that were not part of a co-ordinated process supporting the redesign journey.

Central to this were key stakeholder engagement sessions where the vision for an integrated foot protection service was presented and opportunity was given to shape the service model and transition points prior to implementation. A further stakeholder engagement session to review progress is planned during 2019.

Incorporating a staff governance plan

The Staff Governance Standard, published by the Scottish Government in 2012, requires NHS Boards to ensure that their staff are:

- Well informed
- Appropriately trained and developed
- Involved in decisions
- Treated fairly and consistently, with dignity and respect, in an environment where diversity is valued
- Provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.

In order to ensure that the service was demonstrably mindful of its responsibilities in this area, the staff governance plan contained the foot protection redesign work stream, which was agreed in partnership with trades unions, and requires ongoing annual monitoring and reporting.

This created internal accountability within the service for joint working and provided a framework for implementing changes, while ensuring staff were adequately supported and developed in the workplace during the implementation phase.

Specifying key performance indicators

These were the main deliverables against which the foot protection service is now held accountable within each financial year. These need to be measurable and also included 'softer' elements from within the staff governance standard, such as measuring the efficacy of the annual review process, to include personal development planning, as well as the 'harder' elements from service delivery and financial performance that included seeing >90% of all foot protection referrals within 2 working days. The increase in foot wounds into the podiatry service is shown in *Figure 2* and the performance of the service against the 2 working day target is shown in *Figure 3*.

Implementing the service improvement plan

Including the recommendations from the service review in the service improvement plan ensured that the planned changes were actually implemented. This also held the service accountable to its own specified performance measures and the means employed to achieve this. It also included quality improvement (QI) elements in each of the QI domains of safety, person centredness and effectiveness.

This approach ensured the creation of a supportive yet challenging culture, with mutual accountability. 'Failures' were not viewed as blameworthy, but as opportunities to better understand inequalities, variations in service delivery and gaps in learning. These were used to drive mutual learning and self-awareness both in terms of personal and team behaviours.

By adopting these seven organisational steps to service redesign, the NHS Greater Glasgow & Clyde podiatry service provided a robust basis for ensuring that planned changes were actually implemented as part of the organisational citizenship responsibilities of everyone within the service, thereby de-personalising issues that arose and providing a constructive framework within which to continue to deliver improved performance.

This service redesign provides a microcosm of the challenges facing the podiatry profession. In summary, we cannot survive as a profession without radical changes to the way in which we offer our services to the health and care system. Large-scale and radical service redesign is possible, but vision alone is not enough. If podiatry is to be the 'go to' profession for all foot protection service delivery within a health and care system, then a structured planning approach that addresses all aspects of the change management process will be required in order to ensure the successful implantation and sustainability of whole system change for the benefit of patients, clarity and development of podiatric practice and professional sustainability. It is time for podiatry to step up to the plate and to take full responsibility for all issues relating to the foot and ankle. Only then will the progress made over the past 30 years secure a professional future within a publicly funded health and care system. ■

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