Service	Podiatry - Foot Protection Team
Service specification number	P03

1.1 National/local context and evidence base

Diabetes is one of the most common chronic diseases in the UK and its prevalence is increasing. There are currently 3.8 million people diagnosed with diabetes in England (Diabetes UK, 2019).

Foot complications are common in people with diabetes largely because of neuropathy and peripheral arterial disease (PAD). A foot ulcer can be defined as a localised injury to the skin and/or underlying tissue, below the ankle, in a person with diabetes (NICE 2015).

A report "Diabetic Foot Care in England: an economic study" from Insight Health Economics found that ulceration and amputation are both associated with high mortality:

• Diabetes foot ulcer – 5-year survival rate = 58%

• Diabetes major amputation 2-year survival rate = 50%

Health-related quality of life for people with diabetes foot ulcers is lower than for people with a range of other long-term conditions and health needs, including those with COPD and people on haemodialysis. It is also considerably lower than for people who have diabetes and macrovascular complications without foot problems.

There is a large body of evidence indicating that targeted preventive services can identify those at risk of ulceration and improve outcomes, and that early access to multidisciplinary specialist care for patients with ulcers can reduce ulcer duration, improve healing rates, reduce amputations and increase survival rates.

NICE Guidelines NG19 "Diabetic foot problems: prevention and management" recommends that commissioners and service providers should ensure that the following are in place:

• A foot protection service for preventing diabetic foot problems, and for treating and managing diabetic foot problems in the community.

• Robust protocols and clear local pathways for the continued and integrated care of people across all settings including emergency care and general practice. The protocols should set out the relationship between the foot protection service and the multidisciplinary foot care service.

The guidelines also recommend that:

•Adults with diabetes should have foot risk assessment when diabetes is diagnosed, and at least annually thereafter

•Patients with active foot problems are referred within one working day to specialist foot care service, for triage within one further working day

Screening and assessment to identify those at risk of developing foot problems, early identification, monitoring and treatment of problems, prompt intervention when problems occur and foot care education can all help in the prevention of ulceration and amputation, and lessening the impact of diabetic foot disease. These skills are all a fundamental part of the podiatrist's role in the management of people with diabetes and foot disease, and an essential part of diabetes management.

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	✓
Domain 2	**Enhancing quality of life for people with long-term conditions**	✓

Domain 3	**Helping people to recover from episodes of ill-health or following injury**	✓	
Domain 4	**Ensuring people have a positive experience of care**	✓	
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	✓	

3.1 Aims and objectives of service

Aims:

- To provide a high quality, specialist podiatric led, foot protection team to help capture foot disease in the early stages of development, helping to improve patient outcomes through prevention, education and rapid access to expert intervention

Objectives:

- To improve foot screening and risk awareness for people living with diabetes
- To upskill healthcare professionals to be able to recognise and manage people at increased risk of developing foot disease
- To improve preventative care for people at increased/high risk of developing foot problems
- To improve care for people living with acute foot problems with diabetes
- To empower and educate people with diabetes to know how to look after their feet, when and how to seek help
- To provide clear robust pathways so equitable care provided across Nottingham and Nottinghamshire
- To speed up access to appropriate treatment to reduce time of ulcer healing, rates of recurrence and unnecessary amputations across Nottingham and Nottinghamshire

3.2 Service description/care pathway

The Foot Protection Team will deliver a specialist service for the assessment, diagnosis, and management of diabetes related foot problems. The service will categorise and prioritise the caseload according to medical and podiatric need and be able to demonstrate the management of a comprehensive range of complex conditions. Referral and transfer of care will be integral to ensure care for patients is appropriate as their risk of foot complications increases.

Eligibility criteria

The Foot Protection Team will be responsible for assessment, treatment and review of patients with:

- High risk foot disease with immediate concern - such as pre-ulcerative areas, blisters, traumatic wounds, pressure points, redness with swelling and heat
- Active foot disease - Small, superficial, non-infected diabetes foot ulcers, no evidence of peripheral arterial disease
- Step-down and shared care for stable/improving ulcers from Diabetes Foot Clinics

Care Pathway

The key stages along the core pathway are:

1. Referral

2. Triage

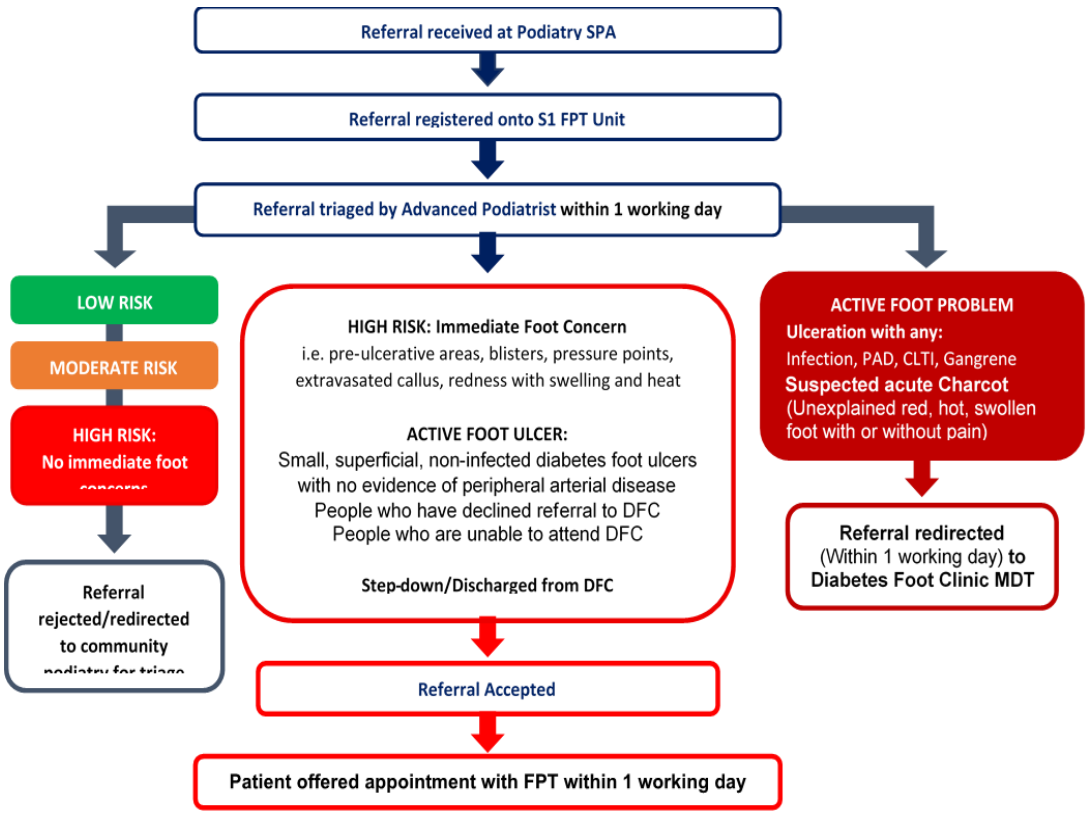
3. Clinical assessment

4. Treatment

5. Onward Referral

6. Discharge

Referral Pathway



Referral Route

The service accepts referrals from GP's and other Healthcare professional (excluding Social Workers, Nursing Home staff or Care Agencies) and secondary care through e-referral or paper referral (if no alternatives available to the referrer)

Completed paper referrals should be sent to Podiatry Footcare Service, Podiatry Single Point of Access, Mansfield Community Hospital, Stockwell Gate, Mansfield, Notts, NH18 5QJ

Email referral form to: PodCommunityAdmin@nottshc.nhs.uk

For further information about the service/appointment cancellations and changes the Foot Protection Admin Team can be contacted on

Tel: 01623 404615

Email: PodCommunityAdmin@nottshc.nhs.uk

Open: Mon – Fri from 8.30am – 4.00pm

(excluding bank holidays)

Triage

All referrals will aim to be triaged by the FPT podiatrists within 1 working day

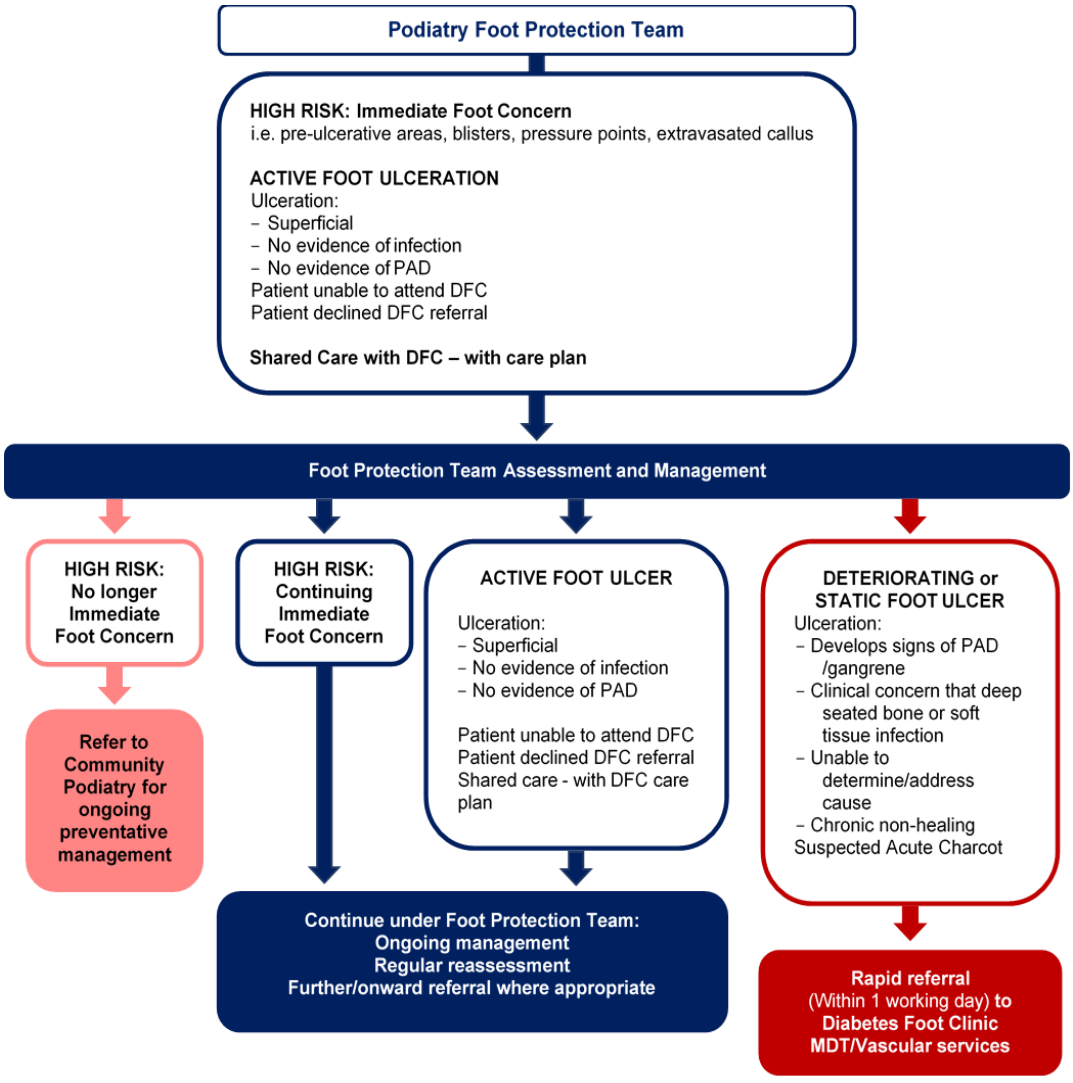
Assessment and Treatment

All patients (either new referred or urgent contact) will aim to be assessed within 1 working day.

Service may include:

Advanced arterial assessment
Offloading/Pressure Relief
Wound debridement
Liaison with other services (orthotics, vascular, DFC, GP, DN)
Treatment plan
Patient/carer advice and education
Referral to other services

Onward Referral Process / Step up / Step down



Promotion and support of self-care

- Care plans developed for patients on introduction to service

- Progress reviewed with patient / carer as appropriate
- Letters /assessments copied / offered to patients / carers
- Written / verbal information given as part of ongoing care plan, and / or prior to discharge from service available in other languages on request
- Foot education provided to patient/carer covering importance of foot care, signs of infection/deterioration, when and how to seek help, including SOS contact details

Discharge Criteria

Patients are discharged from the service when any of the following are the case:

- Patient and clinician agreed goals are met and there are no long-term needs
- Care is transferred to another service
- The patient has demonstrated poor attendance or compliance with interventions
- Discharge if there has been no contact for 6 months

Discharge Procedure

The Provider will be responsible for ensuring that the referring healthcare professional is sent a typed discharge summary letter outlining the management plan and patient advice within 10 working days of discharge. The patient will be sent a copy of the discharge letter and treatment plan in accordance with DoH policy.

All aspects of this service specification must be fully complied with. If any aspect is not achieved this constitutes non-compliance and must be discussed with Commissioners at the earliest opportunity for a way forward to be agreed.

Transition from Children's to Adult Services:

The service will work in partnership with Children's and Adult commissioners, the Nottinghamshire Integrated Community Children and Young People's Healthcare (ICCYPH) Service and related services involved in the care of young people with additional health needs including disability and complex needs and those requiring support specific to this service specification to ensure seamless continuity of care during transition from children's to adult services.

Proactive planning and care pathways will be developed in line with local and regional transition guidance and the Together for Short Lives transition care pathway (http:/www.togetherforshortlives.org.uk/professionals/care_provision/care_pathways/transition_care_pathway) which provides a generic framework that can be adapted locally to plan services specifically for teenagers and young adults with life threatening, life limiting or complex medical conditions.

The pathway sets out six standards that should be developed as a minimum, with the aim of achieving equality for all young people and families, wherever they live.

Development of transition planning and processes will include the following:

- Workforce development to meet the needs of young adults during and following transition
- Use of Nottingham ICCYPH Programme Families' Statement of Expectations as guiding principals
- Continuation of the personalisation approaches and systems used by the young person/adult

- Statutory duty to contribute to and provide services to young people/adults within Education Health and Care Plans (EHCP) up to age 25 in line with SEND legislation (http://www.gov.uk/government/publications/send-managing-changes-to-legislation-from-september-2014)

- Reference to the recommendations within the Nottinghamshire Joint Strategic Needs Assessment Children's Chapter – Transitions (http://jsna.nottinghamcity.gov.uk/insight/Strategic-Framework/Nottinghamshire-JSNA.aspx)

- Everybody's Business: East Midlands Best Practice Guidance for Young People Moving on from Children's Services November 2014 developed by the East Midlands Networks. Further work is being undertaken locally regarding this document and therefore should not be seen as definitive guidance.

3.3 Population covered

Any patient with diabetes registered with a Nottingham and Nottinghamshire GP Practice.

The provider will prioritise resource for areas of greatest need.

The provider must ensure the service delivers consistent outcomes for patients regardless of:

- Gender
- Race
- Age
- Ethnicity
- Education
- Disability (including access and regress)
- Sexual orientation

3.4. Any exclusion criteria and thresholds

The service accepts referrals from GP's and other Healthcare professional (excluding Social Workers, Nursing Home staff or Care Agencies) through e-referral or paper referral.

The service specification does not cover:

- Personal foot care defined as toenail cutting and skin care including the tasks that health adults would normally carry out as part of their everyday personal hygiene
- Podiatry service for people with diabetes with moderate or high-risk feet with no immediate concerns (service provided by community podiatry – core pathway)
- Nail surgery (service provided by community podiatry – nail surgery pathway)
- Podiatric surgery
- Complex biomechanics
- Podiatry for children with concurrent medical conditions
- Annual diabetic foot checks

3.5. Interdependence with other services/providers

Establish key working relationships and interdependencies with:

- People living with diabetes, their families and carers
- Nottinghamshire Healthcare NHS Foundation Trust – Podiatry and Podiatric Surgery
- Nottingham University Hospitals – Diabetes Medicine, Vascular Surgery, Orthotics
- Sherwood Forest Hospitals – Diabetes Medicine, Orthotics
- Primary Care/General Practice/PCNs
- Tissue Viability Nurses
- Pharmacists
- Community Diabetes Specialist Nursing
- Other Specialist Nurses
- MSK Physiotherapists/Occupational Therapists
- Community Matrons
- District Nurses
- Other statutory agencies involved in the care of people with diabetes
- Third/voluntary sector organisations associated with diabetes care and advice

Equipment / consumables

Provider is responsible for the provision of all instruments and equipment necessary to properly undertake the contract, as well as the supply of all medical consumables necessary to treat patients under this service.

Education

The provider will be expected to play a key role in working with and training primary and community care staff to improve the earlier identification of 'at risk' individuals, delivering a programme of foot education training and developing supporting educational materials. The provider will also provide healthcare professionals with access to advice and guidance via telephone and email.

The provider will deliver patient education and foot health advice including carers and families to ensure greater awareness of 'at risk' foot when action needed and to seek help.

The provider will ensure opportunities for mentorship, coaching and shadowing for wider podiatry workforce to ensure greater awareness of 'at risk' foot, as well as rotational opportunities to provide capacity and resilience.

Location of service delivery

Services need to be accessible to patients across Nottingham and Nottinghamshire.

The Foot Protection Team will deliver podiatry clinics from the following locations:

Initial Clinic locations have been identified as:

Mansfield Community Hospital

Bulwell Riverside

Clifton Cornerstone

Mary Potter

Arnold

Newark Hospital

However, these may alter as service develops according to service/population need.

Days/hours of operation

The service operates a core service from Monday to Friday between 8am and 4pm.

Patient appointment telephone lines (01623 404615) are open during following times:

Open: Mon – Fri from 8.30am – 4.00pm (Excluding bank holidays)