

Integrated Diabetes Foot Pathway Suffolk

Executive Summary

Our aim is to ensure people with diabetes within Suffolk have rapid access to an efficient, effective integrated foot service delivering care when needed to prevent diabetes related foot complications and reduce their severity.

This integrated pathway has been developed to incorporate nationally recognised guidance (Putting feet first ^[1] and National Diabetes Foot Audit ^[2]) and is NICE compliant ^[3].

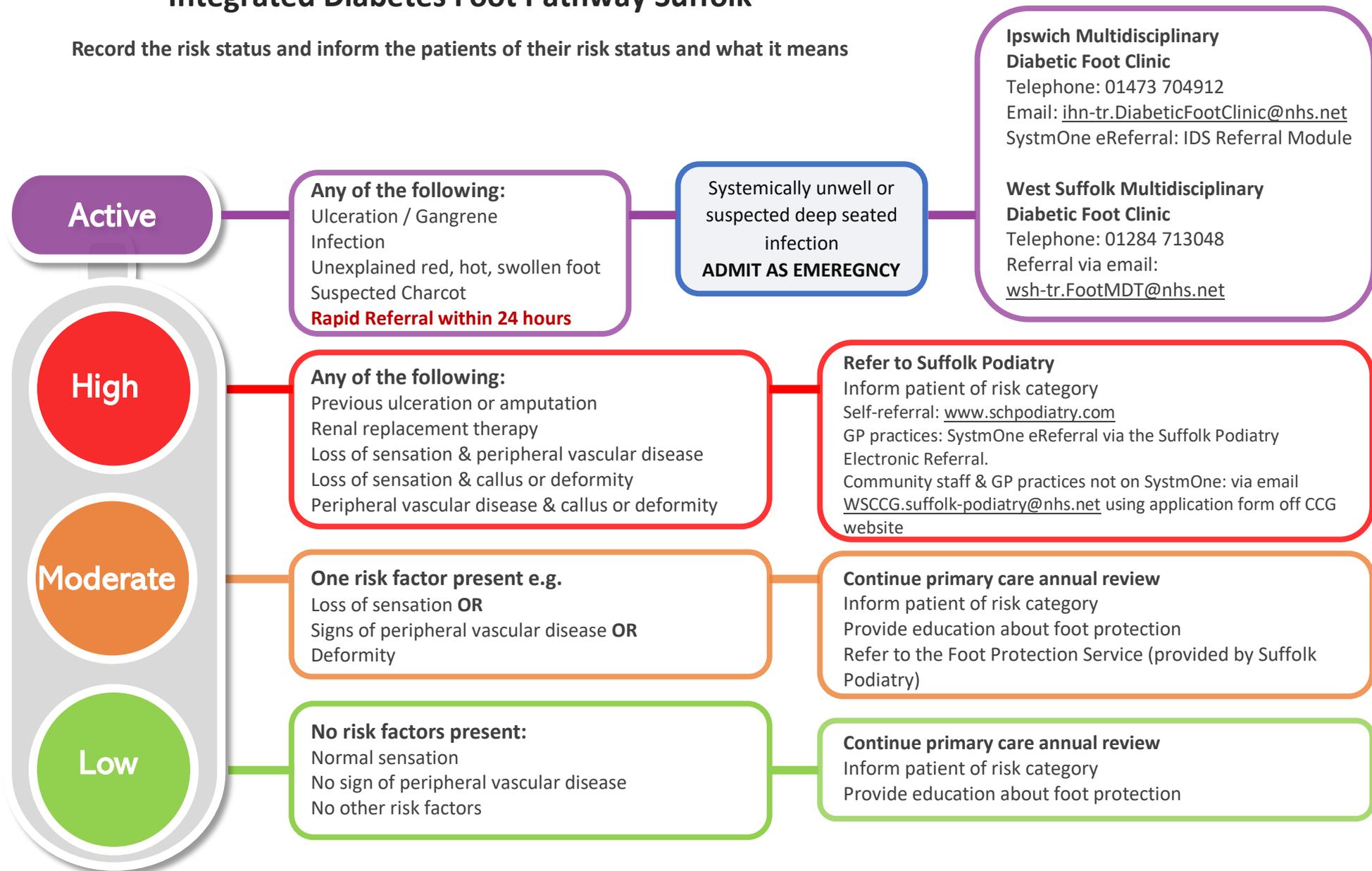
Aims of the Integrated Diabetes Pathway

1. **All** patients over 12 years old with diabetes in Suffolk will receive a foot examination at diagnosis and annually thereafter.
2. **All** patients will be informed of the foot risk at their annual review.
3. Any foot wound or suspected Charcot will be **referred within 24 hours** to a multidisciplinary diabetic foot clinic.
4. All new foot wounds will be triaged by the multidisciplinary service within 1 working day.
5. **All** adults with diabetes admitted to hospital will have their feet inspected within 24 hours of admission.

By achieving these five basic aims we can provide a well-informed, streamlined journey for patients ensuring rapid access to specialist care when needed. This pathway covers community services, primary care services and into secondary care.

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Record the risk status and inform the patients of their risk status and what it means



Provide Foot Risk Information Leaflet

Note: Any patient with diabetes in the low or moderate risk categories that develops a graze, crack, blister or infection must be regarded as high risk for the duration of the pathology with intensive treatment

Identification of foot risk status

Diabetes foot risk can be categorised as follows in accordance to NICE NG19 guidelines:

Low

Moderate

High

Active Foot Disease

How to do an annual foot check

- Remove shoes and socks/ stockings.
- Test foot sensations using 10g monofilament.
- Palpate foot pulses
- Inspect for any deformity or discolouration.
- Inspect for significant callus and areas of cracked skin.
- Check for signs of ulceration
- Ask about any previous ulceration.
- Inspect footwear
- Ask about any pain.
- Tell patient how to look after their feet and provide written information.
- Tell patient their risk status and what it means. Explain what to look out for and provide emergency contact numbers.

Advise the patient to:

- Check their feet every day.
- Be aware of loss of sensation.
- Look for changes in the shape of their foot.
- Not use corn removing plasters or blades.
- Know how to look after their toenails.
- Wear shoes that fit properly.
- Maintain good blood glucose control.
- Attend their annual foot review.
- Look for discolouration.
- Talk to them about the importance of stopping smoking and signpost to help and support to quit.

Ongoing Diabetes Specific Foot Care in Suffolk

People assessed as Low Risk:

- All people with diabetes at low risk will receive annual foot screening from an appropriately trained non-podiatry health care professional at their GP practice.
- They will have the screening recorded and if there is any change to their risk score their care plan will be amended accordingly.

- All people at low risk will be advised to seek immediate review should they develop any significant problems with their feet and also provided with appropriate contact information.

People assessed as Moderate Risk:

- All people with diabetes at moderate risk will receive a minimum of one assessment per year by a member of the Foot Protection Service (FPS) in addition to their annual foot screening at their GP practice.
- Individualised care plans will then be developed based on need, if there is any change to their risk stratification the care plan will be amended accordingly.
- All people with diabetes at moderate risk will be advised to seek immediate review should they develop any significant problems with their feet and also provided with appropriate contact information.

People assessed as High Risk:

- All people with diabetes at high risk will receive a minimum of one assessment per year by a member of the FPS in addition to their annual foot screening at general practice.
- Individualised care plans will then be developed based on need, frequency of visits will depend of presenting problems and risk of ulceration and may range from 1-2 months^[3]. If there is any change to their risk stratification the care plan will be amended accordingly.
- All people at high risk will be advised to seek immediate review should they develop any significant problems with their feet and also provided with appropriate contact information, such as the diabetes foot risk information card.

People with Active Foot Disease

- All people with diabetes presenting with active foot problems e.g. ulceration, spreading infection, critical limb ischemia, gangrene or potential Charcot arthropathy should have a rapid referral to a MDFS within 24 hours of presentation and will be offered an appointment when possible within one working day.
- All people with diabetes presenting with a life or limb threatening presentation such as ulceration with fever or signs of sepsis and gangrene should have a rapid referral to hospital without delay. Such cases are deemed an emergency requiring admission unless they can be seen the same day in the multidisciplinary diabetes foot clinic (MDFS).

- The management of active foot disease may involve shared care between the FPS, community nursing and the MDFS. The first contact may be with a diabetes specialist podiatrist within the community setting before being followed up within the MDFS.
- All people with diabetes discharged from the MDFS will have a pre-planned follow up with community based podiatry services or a member of the FPS within a community setting.
- All people with diabetes high risk with an active foot disease will be advised to seek immediate review should they have concerns of deterioration or development of any new problems with their feet and also provided with appropriate contact information, such as the diabetes foot risk information card containing emergency contact details.

Diabetes Foot Service Provision in Suffolk

Changes have been made to improve foot care in Suffolk. These improvements mean patients with higher risk of foot complications, or who have active foot disease will get specialist care more quickly when they need to.

This means patients with diabetes who are low risk requiring routine foot care such as nail cutting will no longer be offered podiatry services. The services below are described specifically for diabetes related foot complications.

Foot Protection Service (FPS)

Suffolk Podiatry is an NHS service delivered by Suffolk GP Federation (CIC). These specialised clinics ensure that those patients with diabetes who have a high foot risk or a history of foot ulceration, amputation or Charcot neuro-arthropathy are seen regularly by podiatrists with advanced diabetic foot care training. Their aim is to:-

- To provide quick access to those patients with diabetes identified as High Risk according to NICE
- To provide a step up/step down service between Community Podiatry and the Hospital Multidisciplinary Diabetes Foot clinics
- To provide first-class assessment, monitoring and care of those patients who have had a foot ulceration or Charcot Neuro-arthropathy
- To enhance communication and good links between all staff groups involved in patient care
- To promote appropriate patient self-care

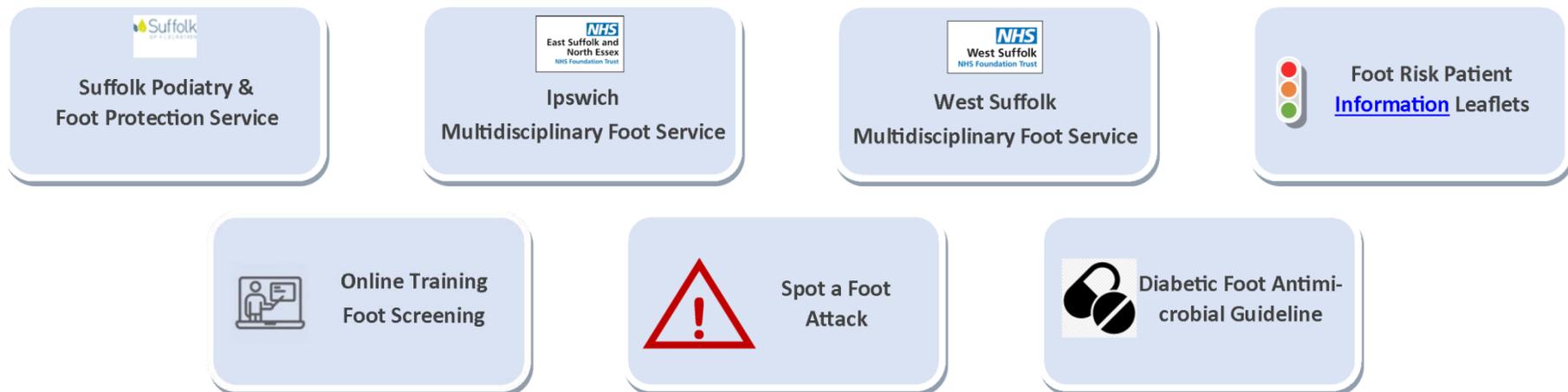
Multidisciplinary Diabetes Foot Service (MDFS)

Multidisciplinary Diabetes Foot Services are based at West Suffolk Hospital and Ipswich Hospital providing rapid access to specialist clinics for patients with active diabetes foot complications from Monday to Friday both for inpatients and outpatients. Both inpatient and outpatient services triage referrals within 24 hours of receipt (Monday-Friday) and aim to offer an appointment or ward review within 24 hours. The MDFS aims to:-

- Rapid review of new referrals within 24 hours
- Consultation with and if necessary referral to other specialist members of the MDFS
- Provide and organise advanced vascular assessments
- Provide optimal offloading including total contact casting for those suitable.
- Provide patients with an emergency contact number and high risk information card.

Further Information

Click on the links below for more information including foot screening education, patient information leaflets and links to useful services.



References

- [1] Diabetes UK (2015) Putting Feet First: Diabetes UK position on preventing amputations and improving foot care for people with diabetes.
- [2] National Diabetes Foot Care Audit Fourth Annual Report (2019) NHS Digital <https://files.digital.nhs.uk/50/8E75BA/NDA%20AR%20-%20Main%20Report%20v1.0.pdf>
- [3] NICE, 2015, *Diabetic foot problems: prevention and management* NG19 <https://www.nice.org.uk/guidance/ng19>