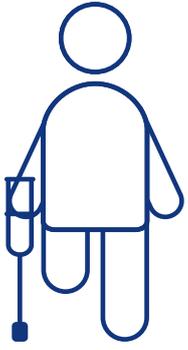
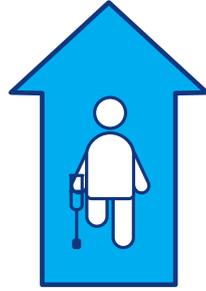


Six step guide to improving diabetes footcare





In England there are **over 140** leg, foot or toe amputations a week.



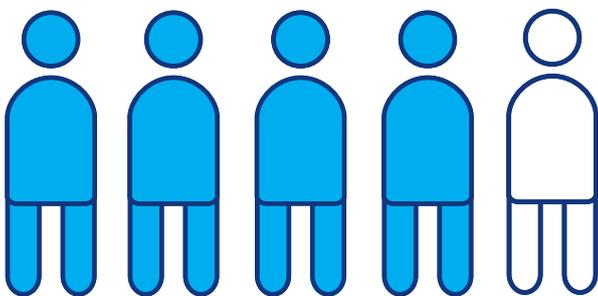
The number of ulcers and amputations **is going up.**



Diabetes related amputations and foot ulcers cost the NHS in England around **£1 billion a year.**



£1 in every £140 of NHS money is spent on diabetic foot problems.



Four out of five amputations could be prevented as 80 per cent are preceded by largely treatable foot ulcers.

Take the right steps to better footcare

Foot ulcers and amputations have a devastating impact on a person's quality of life. Diabetic foot disease is the most common reason someone with diabetes is admitted to hospital².

But we know CCGs can reduce costs by reorganising care to treat ulcers quicker, preventing more amputations and shortening hospital stays¹.

There's evidence on how to prevent amputations, and good guidance on how to do this, but it's not implemented well or consistently. There's also considerable variation in outcomes and processes across the diabetes footcare pathway from foot checks delivered in primary care, and the quality of them, to major and minor amputation rates.

Improving footcare for people with diabetes has been identified as a priority by NHS England³.

What you need to do

- 1 Make sure you're commissioning a full diabetes footcare pathway**
- 2 Use guidance and data to inform commissioning and performance measurement of local diabetes footcare**
- 3 Ensure all inpatients with diabetes receive foot checks and appropriate care**
- 4 Conduct a root cause analysis for all major amputations**
- 5 Take a full part in the National Diabetes Foot Care Audit**
- 6 Network – share your findings and learn from others**



Step 1

Make sure you're commissioning a full diabetes footcare pathway

The key features of a diabetes footcare service

- Everyone with diabetes should receive at least one quality foot check a year. This should include being told their risk of developing a foot problem, and advice on how they can look after their feet.
- Anyone at increased risk of foot problems should then be assessed by a foot protection service, usually led by a podiatrist with specialist training in diabetic foot problems. This service should give advice about caring for the skin and nails, and assessments of the vascular status of their lower limbs and the biomechanical status of their feet (including whether they need specialist footwear and orthoses). Their GP should be told about the outcome of the assessment and care plan.
- A specialist multidisciplinary footcare team (MDT) should manage diabetic foot problems in hospital, and complex and acute foot problems that cannot be managed by the foot protection service.
- There should be robust plans and clear local pathways for the continued and integrated care of people across all settings, including inpatient care, emergency care and general practice. These pathways should set out the relationship between the foot protection service and the multidisciplinary footcare service.

What can go wrong? Variations to look out for

Foot checks – quality and access

Good performance in the numbers of foot checks delivered at national or regional level can mask large variation at CCG and GP level. It can also hide poor quality foot checks delivered by staff who aren't adequately trained. We know that people don't always get information about how to look after their feet, their risk of developing foot problems and where to go if they have a problem⁵. Only 62 per cent of CCGs can confidently say there is training provided locally for those performing foot checks⁴.

Communication

You can have good local footcare services, but people with diabetes, GPs or emergency services might not know what services are in place and how to access them quickly. We know that there are significant links between the time it takes to assess an ulcer and the 12 week outcome (whether it has healed)⁴.

Insufficient capacity

Low capacity in foot protection services or specialist podiatry can lead to GPs not referring those at increased risk for assessment. It can also lead to people with diabetes not attending appointments because they are at an inconvenient time or because the service is too distant from home.

Also, not all hospitals have MDTs with the capacity to accept a referral for expert assessment within 24 hours for all cases of new or deteriorating foot disease⁵.



Step 2

Use guidance and data to inform commissioning and performance measurement of local diabetes footcare

NICE guideline NG19 sets out what should be commissioned and provided to prevent and treat diabetic foot problems:

[nice.org.uk/guidance/ng19](https://www.nice.org.uk/guidance/ng19)

Joint speciality guidance provides a framework for the delivery of hospital trust-based diabetic foot services, making sure that patients with acute diabetic foot disease get high quality care no matter where they present:

[diabetes.org.uk/foot-care-pathway](https://www.diabetes.org.uk/foot-care-pathway)

Diabetes footcare activity profiles provide information, by CCG, on the inpatient care of people with diabetes who are admitted to hospital for a range of foot problems and the local amputation rates. They'll help you understand the scale of activity and let you compare your CCG to similar ones across England:

yhpho.org.uk/diabetesprofilesfoot/default.aspx

The National Diabetes Audit (care processes and treatment targets) records the percentage of people with diabetes, by CCG and GP, accessing an annual foot check:

hscic.gov.uk/nda

The National Diabetes Footcare Audit (NDFA) enables all diabetes footcare services to measure their performance against NICE clinical guidelines and peer units, and to monitor poor outcomes for people who develop diabetic foot disease. It also has a structures audit for CCGs to make sure key parts of the pathway are in place:

hscic.gov.uk/footcare

The National Diabetes Inpatient Audit (NaDIA) provides information at hospital level on the percentage of people with diabetes receiving foot checks in hospital and access to the MDT:

hscic.gov.uk/diabetesinpatientaudit

The Diabetes Watch Online Tool shows you the standard of diabetes care in your area compared to the national average. It uses national data for England, Wales and Scotland, from annually updated publications:

diabeteswatch.diabetes.org.uk



Step 3

Make sure all inpatients with diabetes receive foot checks and appropriate care

What should happen?

Everyone with diabetes, whatever the presenting issue or reason for admission, should have a foot risk assessment on admission to hospital.

People found to be at increased risk of a foot problem should have their feet protected whilst they are in hospital to avoid the development of pressure ulcers or lesions.

People with active foot problems should be referred to the MDT within 24 hours.

What can go wrong? Variations to look out for

We know that currently the number of people getting foot checks in hospital is inadequate and there is large variation between hospitals. In the 2016 inpatient audit (NaDIA) only 30 per cent had their feet checked within 24 hours of admission and only 37 per cent had their feet checked at any time during their hospital stay². In 2015 the number of people with diabetes recorded as having foot risk assessments whilst in hospital ranged from five per cent in some hospitals to over 75 per cent in others. This variation has since increased.

How can this be improved?

Our shared practice resource library has examples of how people are improving diabetes footcare in hospitals:

diabetes.org.uk/professionals/resources/shared-practice/footcare

Step 4

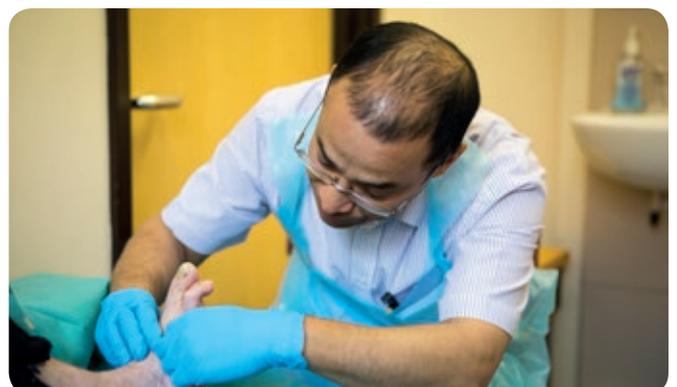
Conduct a root cause analysis for all major amputations

As an estimated 80 per cent of diabetes-related amputations are avoidable, it's important to continually review what leads to them. Conducting a root cause analysis (RCA) can help find ways to improve processes or services to help reduce the number of future amputations. RCAs can also help assess to what extent an amputation was avoidable and whether or not it was a necessary outcome. If the amputation was avoidable, completing the review process will help identify what changes are required to reduce the likelihood of the same issue happening again. Some areas have found it useful to conduct RCAs on minor amputations.

An RCA could be commissioned directly by a CCG, or a commitment to conduct RCAs of major amputations could be included in the contract with diabetes footcare providers. It's important to be clear from the start how the findings and recommendations of an RCA will be communicated to everyone and whose responsibility it is to act on these to improve care.

We've developed a guide based on the experiences of those who've used RCAs to investigate major amputations:

diabetes.org.uk/professionals/resources/shared-practice/footcare



Step 5

Take a full part in the National Diabetes Foot Care Audit

The National Diabetes Foot Care Audit (NDFA) is an ongoing audit of people with diabetic foot ulcers in England and Wales (about 60,000 are estimated a year). It documents variation in case-mix adjusted outcomes between commissioners, service providers and footcare services. The NDFA also aims to find out how variation in practice links to variation in treatment outcomes.

It also features the structures audit of CCGs which looks at whether key elements of the foot care pathway are in place.

Full participation in the audit means:

- registering with the audit
- submitting data to the audit
- acting on the results and using local and national findings to improve care.

Best practice is for commissioners to include participation in the NDFA in their contract with diabetes footcare providers and to make sure that the CCG itself registers and submits data to the structures audit:

hscic.gov.uk/footcare

Step 6

Network – share your findings and learn from others

Footcare networks are usually made up of people with diabetes, healthcare professionals and commissioners. They come together to improve the quality of footcare services for people with diabetes across primary, community and acute settings by:

- sharing data, analyses and audit
- develop information resources together
- some networks have organised and run a useful peer review process.

For contact details of local and regional foot networks see:

diabetes.org.uk/professionals/professional-groups/london-footcare-network

We've produced a guide to provide practical, step-by-step information for starting a new, or improving an existing, local network. The guide includes a network essentials checklist, frequently asked questions and a scorecard for measuring network effectiveness:

diabetes.org.uk/professionals/resources/shared-practice/networks

References

¹ Kerr, M (2017) *Improving footcare for people with diabetes and saving money – an economic study in England*, Diabetes UK. www.diabetes.org.uk/Professionals/Resources/shared-practice/Footcare

² Health and Social Care Information Centre (June 2016) *National Diabetes Inpatient Audit 2015 – National Report*

³ Department of Health (January 2016) *The Government's Mandate to NHS England for 2016–2017*

⁴ NHS Digital (2017) *National Diabetes Foot Care Audit Report 2014–2016 England and Wales*

⁵ Diabetes UK (2015) 15 HCE survey data

