



**National Improving Diabetes
Foot Care Conference: 7 June 2016**

Conference Report
July 2016

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Introduction

The Improving Diabetes Foot Care Conference was a collaborative project between the National Diabetes Foot care Audit (NDFA) and Diabetes UK.

The first part of the conference provided an overview of improvement methodology and a presentation of the National Diabetes Foot care Audit (NDFA) 2014-15 findings. There was also a presentation by a person with diabetes about their own experiences of diabetes foot care.

The remainder of the conference was an opportunity for delegates to hear from services that had made improvements and to discuss the challenges and opportunities these presented. There were 3 workshops, which were repeated – giving delegates an opportunity to attend 2 workshops.

About this report

This report presents an overview of the conference content and a summary of the workshop discussions.

A copy of each of the presentations is provided within the report. The discussions were captured by volunteer note-takers, who were advised to take brief notes. So, the notes provided in the report may not capture the entirety of the discussions, but highlights the key points raised.

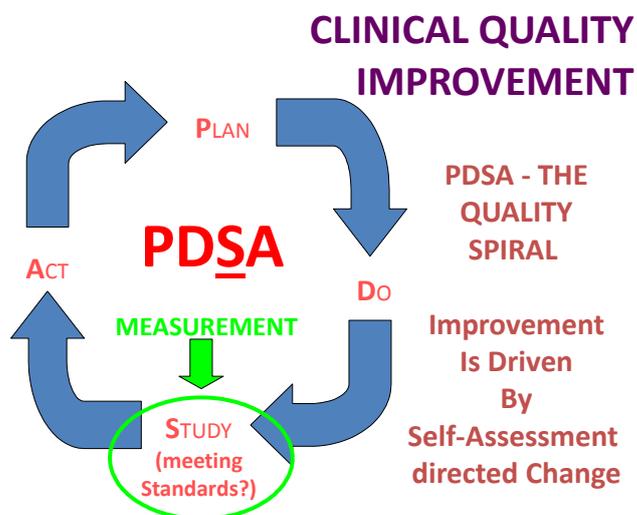
The report concludes with a summary of the table discussions about how the NDFA recommendations can be taken forward.

Welcome and introduction

Bob Young, Specialist Clinical Lead, National Diabetes Audit

Bob Young introduced the conference and provided a brief overview of using audit data to make improvements to diabetes foot care.

He stressed that measurement (audit) is not improvement in itself, but that measurement enables improvement. He highlighted the Plan, Do, Study, Act (PDSA) model, as an approach to improvement.



Using information/data to improve patient outcomes:

- Get all stakeholders around the table
- Select **measurements** appropriate to the service
- Review and use comparisons with peers to choose manageable number of priorities
- Assign leaders to improvement projects
- Develop and implement action plans with agreed goals
- Use **measurements** to determine whether goals have been achieved
- Start again!

National Diabetes Foot Care Audit (NDFA)

William Jeffcoate, National Clinical Lead, National Diabetes Foot care Audit



National Diabetes
Foot Care Audit (ND

Following the NDFA presentation, delegates were asked to discuss the key recommendation from the NDFA report.

Recommendation: All healthcare professionals should be aware of the need for prompt expert assessment of newly occurring foot ulcers in people with diabetes and should know how this assessment can be arranged.

The following prompts for discussion were provided.

- Why doesn't prompt referral always happen? What are the barriers?
- What needs to happen to facilitate prompt referrals? And who needs to be involved?

The discussion was captured on post-it notes. Over the lunchtime period, the post-its were reviewed and summarised at the end of the conference. See **px** for summary.

Improving diabetes foot care: the national picture

Bridget Turner, Head of Policy, Care and Improvement, Diabetes UK



Improving Diabetes
Foot Care - the Nati

WORKSHOP A:

Challenges and opportunities: primary care and commissioning

- Commissioning a diabetes community service with foot protection service
Raquel Delgado, GP Lead, Hounslow CCG



Workshop A 1 -
Raquel Delgado - Di

Words of advice to anyone considering setting up a similar service:

- Start small, but aim big
 - Patience
 - Engage stakeholders
 - Use local and national data
 - Do not re-invent the wheel
- Can clinical information from primary care help identify those at risk of diabetic foot ulceration?
Alex Harrington, Clinical Lead Podiatrist, Gloucester Care Services NHS Trust



Workshop A 2 -
Alex Harrington.ppt

Conclusions: Validation of the risk model within primary care

- Acceptable sensitivity and specificity to those already identified using the foot risk score (i.e. those referable to podiatry)
- Model could be used for patient management within a practice (health Ed)
- Understanding your population, importantly those at risk
- Mapping risk across the county

Discussion

Q: IT connectivity is a huge problem. Any solutions?

- Salford has an integrated system. Solutions exist, but there needs to be a willingness of the whole system

- Hounslow CCG Chair insisted all services sign up to SystemOne. Providers now on the system and trying to get social care on board.

Q: How can you improve referrals?

- In London, trying to train Health Care Assistants to do foot checks, but it is challenging due to high turnover of staff.
- Nottingham are developing a predictive tool.
- Need to educate GPs and community staff to assess and refer 'at risk' patients
- Must reduce complications and allow simple referral, bypassing the GP if necessary
- Clear, simple pathway to the MDT clinic is needed. Not a 'scattergun' multi-referral process

Other issues raised:

- GP practices reluctant to change
- Suggestion of included non-engaged GP practices on a dashboard to be shared at monthly meetings. 'Naming and shaming' won't work. Need to offer support/training to those who aren't engaged.
- In Buckinghamshire, records are reviewed to see who has referred to podiatrists
- Suggestion of working with pharmacists to target antibiotic usage
- Difficulty in recruiting podiatrists.
- Issues of bursaries and sustainability of services
- Suggestion of employing lower band assistants, training them to provide screening services.

All of the above requires leadership and collaboration. Face to face meetings essential, not just email communication.

WORKSHOP B:

Challenges and opportunities: integrated diabetes foot care pathway

- Creating and implementing an integrated diabetes foot pathway in Camden, London
Lesley Roberts, (Former Camden Diabetes IPU Project Lead), Senior Project Manager, Diabetes SCN London, NHS England
Richard Leigh, Head of Podiatry, Royal Free London NHS Foundation Trust and Member Diabetes SCLG London, NHS England



Workshop B 1 -
Lesley Roberts Richa

Summary:

- Reviewed staffing – new Band 7 Podiatry post to lead the FPT
 - Foot Protection Team and MDT Diabetes Foot teams
 - Referral processes developed
 - Discharged Tier 1 back to GP with standardised Care Plan
 - Foot Check Training and support (for Practice Nurses and District Nurses and HCAs)
 - Risk Stratification Tool implemented- Move appropriate patients to clinics dependent on foot risk
 - Pathways agreed across all tiers
 - Patient leaflets standardised
 - National Diabetic Foot Audit
 - Use of a common IT system; EMIS
- Exploring ways of working together across the pathway
Louise Mitchell, Podiatrist, Birmingham Community Healthcare



Workshop B 2 -
Louise Mitchell.ppt

Challenges:

- Team work
- Communication
- Improved patient journey
- Reduce delays in care

- KEY – link Primary & Secondary Care

Opportunities:

- RCA of major amputations
- Vascular ward round
- Improved MDT ward service
- Become 100% NICE compliant

Discussion

Q: How was (Camden) service redesigned?

A: GPs, mental health hospital, teaching hospital, district general and community hospital got together to redesign service.

- EMIS web used across the board to have a shared record and no new investment needed.
- Large group of patients guided the vision.
- Made chains of communication shorter
- A whole multidisciplinary team was created.
- No focus on high risk care. Needs to be covered all the time
- All patients risk stratified. A large percentage were low risk and discharged. This freed up a lot of podiatrist time.
- Upskilling and training provided to podiatrists, practice nurses and GPs
- Patients re-referred to podiatry service if problems arose
- Pathway opened up so that any healthcare professional can refer in
- No tariff as all the money was put in one pot. Joining money up is a good incentive for entire pathway to be improved
- Low risk patients are sent to Birmingham Nail Care Service for nail care. Staff are trained by podiatrist
- High risk patients can be seen regularly
- Never discharge anyone, but do 'transfer care'

Q: How does the (Camden) service work?

A: 6 CCGs refer into the hospitals. Reaches to prisons, care homes and mental health units

Q: Are there issues with the new model?

A: the new plan/model has been agreed by one CCG and need to implement in the other 5 CCGs

Q: how can CCGs be urged to take on the new model?

A: A national foot care pathway would help. Value based commissioning – risk/reward contract. Money follows patient

Q: What were the barriers to setting up the pathway (in Birmingham)?

A: Lack of understanding/communication between hospital and community podiatrists. Now 4 podiatrists rotate in diabetes foot care, to allow for cross cover and continuation of care. Shared care helps with capacity issues and service is closer to home for patients. Community only sees high risk patients

Q: Who debrides wounds (in Birmingham service)?

A: all pressure ulcers are referred to Tissue Viability Nurse. Service works closely with them

Q: Is the nail cutting service commissioned (in Birmingham service)?

A: yes, but it is subsidised by patients who pay c£10. Staff have an NVQ type qualification and will often do home visits

Q: Management of services. High risk movement

Preventing of amputations to long term illness – figures not presented in audit

Q: How do you start the service and get everyone talking to each other?

Q: how does everyone receive training when there is such a large turnover of staff?

WORKSHOP B: Challenges and opportunities: tools for improvement

- Peer review in South West England
Richard Paisey, South Devon Healthcare NHS Trust



Workshop C 1 -
Richard Paisey - Peer

Summary of South West network peer review programme:

- Patient education at Practice annual review
 - Rolling education programme for community health care professionals
 - Adequate community podiatry numbers and skill mix and rotation into MDT
 - Job planned MDT weekly
 - Admin and IT support
 - Pathways and communication
 - Identification of diabetic in-patients and their foot checks
 - Orthotist an integral part of MDT
 - Vascular presence in spoke hospitals
 - Ulcer data base and root cause analysis 3 monthly of all amputations
- Root cause analyses of major amputations in York and Scarborough
Katharine Speak, Podiatrist, Harrogate and District NHS Foundation Trust



Workshop C 2 -
Katharine Speak - Rc

Additional benefits of RCA

- Monthly meeting briefly allows time to discuss other issues affecting the MDT
- Opportunity to share other news
 - NDFA local results
 - Joint Specialty Recommendation Document
- Consensus on documentation – Multi-site Admission Forms
- Better engagement with other network groups

Areas for attention:

- Patient feed-back – Post op forum planned
- Caldicott Principles - queries from other Trusts
- Duty of Candour – identifying who this falls to

- Responses from primary care – Will need to follow up letters where no response has been received
- Ensuring CCG comprehension of value of podiatry services
- End of year review of trends

Q: Who was involved in the root cause analysis?

A: Clinical network in Yorkshire and Humberside, patient safety team. Engagement with the CCG is mixed, but where there is good engagement, GPs are more likely to be on board.

Q: Are the monthly RCA meetings in job plans

A: No. people attend because they want to be involved. The new monthly meetings they hold in Scarborough are very useful for educating, but sometimes challenging when talking about what a reasonable timeframe actually is for referring and treating patients.

Q: What common messages have been picked up to date from the root cause analyses (RCA)?

A: Late referrals, healthcare professionals not picking up on signs quick enough and patients not attending.

Q: Are you likely to add to the data collection tool used in the RCA?

A: We would like to look at how to address the issues such as delayed referral. It was also noted that there is a problem with community teams missing from MDT meetings. Possibly skype is an option but we are not currently there with technology.

Q: Do you manage to discuss patients in your RCA that have been discharged without being to foot clinic first and how do you pick those numbers up?

A: The biggest revolution was a Band 7 who goes around the wards and is always there when patients are admitted, so not a lot of people escape the system.

It was also noted that in Wolverhampton they have one generic email account to register all patients that have been discharged. It would also be ideal if an inpatient podiatrist was commissioned to help follow up with patients that DNA.

There is always the concern of patients who have been discharged and never make further contact for a follow up appointment, as they are not aware they need to be seen again.

One area had also used a failsafe system to track where patients are within the system as well as DNA's. This has made a big difference but it is not an automated system and still takes time.

At the end of the discussion it was suggested that many retinopathy service pathways could also be translated for use across the foot care pathway and some areas such as Wales they run both services combined.

Q: What does your education programme look like in the South West?

A: A rolling programme of education for primary care staff e.g training on SystemOne. It was added that in Salford they have a record system that pulls information together without using SystemOne.

Q: How is the peer review conducted?

A: Importance of preparing the group and to explain the purpose. Team comprising podiatrist, diabetes consultant and vascular surgeon visit providers. 10 sets of notes reviewed, interviews with 4 patients and total process takes about 6 hours per visit. Report writing is challenging, as this is subject to Freedom of Information Act.

Q: how did you overcome the barriers to peer review?

A: NHS England representative persuaded CCGs to be involved, involving respected colleagues. 'Name and shame' campaign instigated the peer review. Approach was 'no blame'. Focus on the benefits and attributed good practice and promoted it. Funding from the CVD clinical network

Q: Are there any correlations between RCA and peer review process?

A: Getting access to GP practice records and problems with patient engagement

Concerns were raised about the vascular 'hub and spoke' model. Services can feel isolated when trying to improve care

How the recommendations from NDFA can be taken forward

Summary of morning table discussion

- Patient education
 - Improve understanding of the risk at all stages
 - Improve understanding of the referral pathways and what to do
- Professional education for generalists in primary, secondary and community care
 - Improve awareness of importance of need for urgent action when lower limb disease starts in someone with diabetes
- Risk assessment
 - Ensure reliability of scoring and action
 - at annual review
 - on admission to hospital
- Commissioning
 - Understanding the whole pathway and the importance of foot care
 - Stakeholder engagement
 - Start with local assessment of need
 - Incentives to change (resource allocation, value based commissioning)
 - Leaders to develop and drive change
- Capacity needs to be created for
 - Risk assessments
 - Foot protection
 - MDT (vascular services)
- Pathways – essential enablers
 - Clarity (there is a pathway)
 - Consistency (single point of referral, national pathway like with MI/stroke)
 - Connectivity (integrated record is optimal)
 - Convenience (Community based MDFT access points)
- Special groups may need special arrangements
 - Mental health
 - Care homes
 - Pre-diabetes

APPENDIX A: Conference Programme

9.30 – 10.00	Registration/Coffee and tea
10.00 – 10.10	Welcome and introduction <i>Bob Young, Specialist Clinical Lead, National Diabetes Audit</i>
10.10 - 10.30	A journey along the foot care pathway: A person with diabetes' experience <i>Alison Currie</i>
10.30 - 10.50	National Diabetes Foot Care Audit (NDFA) <i>William Jeffcoate, National Clinical Lead - NDFA</i>
10.50 – 11.30	Taking forward the NDFA recommendations Table discussions
11.30 – 11.50	Coffee and tea break
11.50 – 12.45	WORKSHOPS – delegates choose one workshop
Workshop A	<p>Challenges and opportunities: primary care and commissioning</p> <ul style="list-style-type: none"> • Commissioning a diabetes community service with foot protection service <i>Raquel Delgado, GP Lead Hounslow CCG</i> • Can clinical information from primary care help identify those at risk of diabetic foot ulceration? <i>Alex Harrington, Clinical Lead Podiatrist, Gloucester Care Services NHS Trust</i>
Workshop B	<p>Challenges and opportunities: integrated diabetes foot care pathway</p> <ul style="list-style-type: none"> • Creating and implementing an integrated diabetes foot pathway in Camden, London <i>Lesley Roberts, (Former Camden Diabetes IPU Project Lead), Senior Project Manager, Diabetes SCN London, NHS England</i> <i>Richard Leigh, Head of Podiatry, Royal Free London NHS Foundation Trust and Member Diabetes SCLG London, NHS England</i> • Exploring ways of working together across the pathway <i>Louise Mitchell, Podiatrist, Birmingham Community Healthcare NHS Trust</i>
Workshop C	<p>Challenges and opportunities: tools for improvement</p> <ul style="list-style-type: none"> • Peer review in South West England <i>Richard Paisey, Honorary Consultant and Diabetes Foot Care Lead, South West Cardiovascular Disease Clinical Network</i> • Root cause analyses of major amputations in York and Scarborough <i>Katharine Speak, Podiatrist, Harrogate and District NHS Foundation Trust</i>

12.45 – 13.45	Lunch Networking/exhibition/opportunity to speak to NDFA team about participation and data collection
13.45 – 14.00	Improving diabetes foot care: the national picture Bridget Turner, Director – Policy, Care and Improvement, Diabetes UK
14.00 – 15.00	WORKSHOPS – delegates choose one workshop
Workshop A	Challenges and opportunities: primary care and commissioning <ul style="list-style-type: none"> • Commissioning a diabetes community service with foot protection service <i>Raquel Delgado, GP Lead Hounslow CCG</i> • Can clinical information from primary care help identify those at risk of diabetic foot ulceration? <i>Alex Harrington, Clinical Lead Podiatrist, Gloucester Care Services NHS Trust</i>
Workshop B	Challenges and opportunities: integrated diabetes foot care pathway <ul style="list-style-type: none"> • Creating and implementing an integrated diabetes foot pathway in Camden, London <i>Lesley Roberts, (Former Camden Diabetes IPU Project Lead), Senior Project Manager, Diabetes SCN London, NHS England</i> <i>Richard Leigh, Head of Podiatry, Royal Free London NHS Foundation Trust and Member Diabetes SCLG London, NHS England</i> • Exploring ways of working together across the pathway <i>Louise Mitchell, Podiatrist, Birmingham Community Healthcare NHS Trust</i>
Workshop C	Challenges and opportunities: tools for improvement <ul style="list-style-type: none"> • Peer review in South West England <i>Richard Paisey, Honorary Consultant and Diabetes Foot Care Lead, South West Cardiovascular Disease Clinical Network</i> • Root cause analyses of major amputations in York and Scarborough <i>Katharine Speak, Podiatrist, Harrogate and District NHS Foundation Trust</i>
15.00 – 15.20	Summary of morning table discussion, next steps and close <i>Bob Young, Specialist Clinical Lead, National Diabetes Audit</i>

APPENDIX B: Delegate list

Ahmed	Miku	Central London Community Healthcare NHS Trust
Ambrose	Lawrence	The College of Podiatry
Anderson	Stephanie	Cambridge University Hospitals NHS Trust
Bateman	Ann	Whitehorse Care Trust
Baughen	Sally	North Derbyshire CCG
Bennett	Natalie	South West Yorkshire Foundation Trust
Boddington	Lucy	Ipswich Hospital
Bowen	Rebecca	NHS North Lincolnshire CCG
Burston	Sheila	Putting Feet First Advisory Group
Bushby	Phyllis	Hardwick CCG
Camfield	Liz	Guys and St Thomas Hospital
Cawley	Scott	Cardiff and Vale UHB
Cheesley	Amanda	Royal College of Nursing
Coll	Tony	Addenbrookes
Colling	Sophie	Diabetes UK
Cooper	Trudi	Nottingham University Hospital
Coward	Trusha	Central London Community Healthcare NHS Trust
Currie	Alison	Diabetes UK
Dave	Mika	East Sussex Healthcare Trust
Davenport	Rebecca	Hardwick CCG
Delgado	Raquel	Hounslow CCG
Drake	Michelle	Coventry and Warwickshire Partnership Trust NHS
Elston	Debbie	Pennine Care NHS Foundation Trust
English	Sarah	Whittington Health/Islington
Fargher	Laura	Diabetes UK
Gadsby	Roger	National Diabetes Audit
Gentleman	Jasmine	Ashford St Peters NHS Trust
George	Nichola	Whitehorse Care Trust
Glazebrook	Jaclyn	Nottingham University Hospital NHS Trust
Gohil	Krishna	Northamptonshire Healthcare NHS Foundation Trust
Gooday	Catherine	Norfolk and Norwich University Hospital
Green	Jean	Stoke Mandeville Hospital
Greensmith	Matt	NHS England Clinical Networks
Hariman	Christian	Wolverhampton Hospitals NHS Trust
Harrington	Alex	Gloucestershire Care Services NHS Trust
Hilston	Keith	Royal Berkshire NHS Foundation Trust
Hodgkins	Suzanne	Whitehorse Care Trust
Holmes	Jane	Cambridge University Hospitals NHS Trust
Huddart	Susan	The Royal Wolverhampton NHS Trust
Hurwitz	Amanda	Diabetes UK
James	Ceri	Sheffield CCG
Jeffcoate	William	National Diabetes Foot care Audit
Johnson	Roy	Diabetes UK
Joule	Nikki	Diabetes UK

Keast	Trudi	South Tyneside Foundation Trust
Khatun	Salma	Health and Social Care Information Centre
Kong	Wing May	London North West Healthcare NHS Trust
Latham	Tom	Health and Social Care Information Centre
Laybourn	Susan	Central and North West London NHS Foundation Trust
Lee	Erin	Buckinghamshire Healthcare NHS Trust
Leigh	Richard	Royal Free Hospital
Leith	Caroline	Hertfordshire Community Trust
Lyons	Sean	University College London
Majumder	Barun	Ashford and St. Peter's foundation trust
Malik	Waqar	Heartland Hospital
Martin	Liz	Leeds CCG
Mattu	Pam	Birmingham Cross City CCG
McClennon	Joanne	NHS Bolton
McInnes	Alistair	South-Eat Coastal Clinical Network
Mehta	Sanjeev	London North West Healthcare NHS Trust
Mildred	Jacqueline	Northamptonshire Healthcare NHS Foundation Trust
Millward	Victoria	NHS England West Midlands SCN
Mitchell	Louise	Birmingham Community Healthcare
Mousley	Maria	Northamptonshire Healthcare
Nayar	Rahul	City Hospitals Sunderland
Paisley	Richard	SW CVD Clinical Network
Pankhurst	Christian	Guy's and St. Thomas' NHS Foundation Trust
Parkin	Kevin	Virgin Care Doctors
Patel	Ripal	NHS Whittington Health
Patel	Nisha	Foot Repair
Patterson	Joanne	Northamptonshire Healthcare NHS Foundation Trust
Phelps	Kirsty	North Somerset Community Partnership
Phillips	Cathy	North Somerset Community Partnership
Rayman	Gerry	Ipswich Hospital
Richards	Toby	UCL
Roberts	Lesley	Strategic Clinical Networks
Sadler	Networks	Heart of England NHS Foundation Trust
Saraf	Sanjay	Good Hope Hospital
Shah	Rakhee	London Northwest Healthcare NHS trust
Sharma	Sanjeev	Ipswich Hospital
Sharma	Margaret	Coventry and Warwickshire Partnership NHS Trust
Sharpe	Andrew	Southport and Ormskirk NHS Trust
Sharpe	Rebecca	Diabetes UK
Shorrick	Peter	Diabetes UK
Speak	Katherine	Harrogate and District Foundation Trust
Stansfield	Tom	Service Redesign and Improvement Consultancy
Syed	Ateeq	Heart of England NHS Foundation Trust
Todd	Gaytree	London North West Healthcare NHS Trust
Townson	Mike	Wessex Diabetes SCN
Treby	Helen	Somerset Partnership NHS Foundation Trust

Turner	Bridget	Diabetes UK
Turns	Martin	Sussex Community Trust
Vas	Prash	Kings College Hospital
Watts	Kim	Salford Royal NHS Foundation Trust
Welch	Donna	Humber NHS foundation Trust
Whalley	Alexandra	NHS Bolton
Will	Hazel	Central London Community Healthcare NHS Trust
Wilson	Oonagh	University Hospitals Bristol and Bristol Community Health
Wykes	Corinne	Diabetes UK
Yearsley	Peter	Buckinghamshire Healthcare Trust
Young	Bob	National Diabetes Audit

APPENDIX C: Resources

Diabetes UK resources – diabetes foot care

- [Examples of good practice – foot care](#)
- [Footcare resources](#)
- [Service redesign and improvement consultancy](#)
- [Training courses](#)

Resources – improvement

[Quality improvement in diabetes care](#)

[NHS Improving Quality e-learning modules](#)

[NHS Improving Quality - A simple guide to improving services \(PDF, 3MB\)](#)

[Healthcare Quality Improvement Partnership \(HQIP\) - Guide to quality improvement methods \(PDF, 2MB\)](#)