

Thames Valley Regional Foot Conference

Summary of presentations and discussions

Chair - Dr Richard Croft, TV SCN Diabetes Clinical Lead

Dr Shahed Ahmed, Medical Director NHS England South Central

- Thames Valley SCN has some of the most outstanding performance in the country
- The best performing CCGs in South Region are
 - Slough – blood pressure
 - Aylesbury Vale – glucose
 - N&W Reading – cholesterol (2nd)
- Achieving to the level of the best CCG in England (of 0.6/1000), there will be 450 fewer amputations by 2020. Financial savings equate to £2.4m.
- Nine out of ten TV CCGs are ranked best in South of England
 - Bracknell and Ascot CCG
 - WAM CCG
 - North & West Reading CCG
 - Oxfordshire CCG
 - Slough CCG
 - Surrey Downs CCG
 - Wokingham CCG
 - Newbury and District CCG
 - South Reading CCG
 - Chiltern CCG

Keynote Address: Professor Jonathan Valabhji, NHS England National Clinical Director for Obesity and Diabetes

- Bids for the transformation funding have been reviewed and an announcement will be made shortly on the successful bids.
- Diabetic foot disease is very much on the agenda.
- The updated National Diabetes Audit will soon be published – 7th March 2017, which should deliver a more granular picture of the situation with ulcers and mortality rates.
- There is a lot of discussion around QOF – there is a feeling that QOF should continue, or be replaced by another incentivisation mechanism.
- Fewer people now die as a direct result of diabetes, as diabetics are dying from heart attacks and stroke, so diabetes treatments are working well.
- An integrated pathway between podiatry and diabetes is now the focus for delivery in order to ensure successful implementation of preventative measures and early diagnosis.

Update on the Work of the All Party Parliamentary Group on Vascular Disease, Neil Carmichael, Chair of the APPG on Vascular Disease

- The All Party Parliamentary Group on Vascular Disease (VAPPG) is a cross party group of Members of Parliament and Members of the House of Lords who come together to promote a particular issue.
- The VAPPG produced a report 'Saving Limbs, Saving Lives: A Review of Strategic Clinical Networks', which was launched at Parliament in February 2016. The group is now embarking on a series of regional events designed to promote the group's messages and collate best practice locally.
- Upon the completion of this series of events, the VAPPG will produce a report with recommendations to Government on steps that can be taken to reduce regional variation in service provision and patient outcomes.

Thames Valley Foot Reference Group - Dr Hema Heffernan, Chair of the TV Foot Reference Group

- The diabetic foot was identified as an area of key focus early by the Thames Valley Diabetes SCN.
- Although amputation rates were mostly average across the patch it was felt that more could be done to go from average to excellent.
- A foot reference group was established, covering the Thames Valley area. The clinical teams and GP diabetes leads were invited to join. A focus on root-cause analysis was established, and so the multidisciplinary team came together to share their analysis and build a broader and more detailed picture.
- A multi-professional working group set up, the membership of which was:
 - Diabetologists
 - GP Diabetes Leads
 - Podiatrists
 - Vascular Surgeon
 - Patient Representatives (links with DUK)
 - NHS England
 - TV SCN Diabetes Lead
 - TV CVD Manager
 - Facilitated and hosted by the Thames Valley SCN
 - Met four times 2015-16
- A Diabetes Footcare Pathway was created and can be found [here](#). This provides a Clinical guideline with TV-wide agreed standards; a framework for the commissioning of local diabetic foot services; and is customisable for local use.
- This work would not have been possible without facilitation, learning from other networks, hosting the website, and supporting the regional meetings going forward.

Update on the work of the Vascular Disease CRG - Steven Duckworth, Specialised Vascular CRG

- Steven Duckworth is the lead commissioner for the Specialised Vascular Clinical Reference Group (CRG)
- The structure and composition of the CRG:
 - Each CRG sits under one of the 5 Programme of Care Boards (in this case, the Internal Medicine Programme of Care Board).
 - The clinical chair is Robert Sayers.

- There are 8 clinical representatives who come from across the country.
- There are 2 patient and public representatives.
- There is a public health representative.
- There are a number of affiliated members.
- The purpose of the CRGs is to provide clinical guidance and leadership to NHS England and start developing commissioning policies and quality standards.
- Recent work of the CRG includes producing guidance on tariff for acute procedures given the changes under HRG4+.
- The CRG is looking to refresh the service specification and condense it in the process by trying to centrally procure devices and to remove them from the tariff.
- Developing specialised dashboards.
- Developing guidance on what a good multidisciplinary team model might look like.
- Looking at what a reasonable CQUIN scheme might look like over next 2 years to incentivise good practice.
- Looking at how to eliminate variance (in quality and outcomes) of spend and activity across the country by improving value and ensuring that schemes are cost effective.
- NHS England has already overshoot its projected activity by more than 4000% percent, expecting to deliver 250,000 procedures, having already delivered more than 2 million. Extra days in bed are also adding to the unexpected costs.
- There may be a national service review in 2019.

Update on Vascular Services - Ed Sideso, Vascular Surgeon, John Radcliffe Hospital

- Outlined the importance of centralising vascular services into a hub. This hub has a 24/7 vascular surgeon and interventional radiologist.
- The major arterial centre deals with aortic surgery, carotid surgery, lower limb bypass surgery and major limb amputation. The non-major arterial centre deals with angioplasty, minor amputations and venous surgery.
- The successes of this model include:
 - 24/7 Consultant Vascular input to patient care in the OUH
 - 24/7 Consultant IR availability
 - Dedicated Vascular anaesthetist
 - Daily theatre list for vascular
 - Good patient outcomes
 - Fewer mortality rates from aneurisms (due to stents)
 - Patient satisfaction
- The challenges of this model include:
 - Repatriation from Major arterial Centre
 - Information transfer
 - Travel for patient families
 - Ward Pressure
 - Changing attitudes – “we have lost vascular surgery!”
- There remain opportunities for further improvement. These include innovation within the clinical setting, information transfer (for which tele-meds could be an effective solution), communication to patients about the benefits of having a specific vascular services centre. research and teaching (within a designated vascular training centre).
- All clinicians and all trusts are fully engaged with the process of centralisation.
- Governance structure is in place via the Thames Valley Vascular Network.

Podiatrist perspective: In-patient MDFT, Erin Lee, Senior Podiatrist, Buckinghamshire Healthcare NHS Trust

- Explained the Bucks Integrated Podiatry Service. The MDFT includes MDFT includes those specialising in diabetes, vascular, podiatry, FCA and a specialist nurse.
- Aims of the Putting Feet First inpatient service:
 - Routine basic assessment and care of the diabetic foot within 48 hours of admission.
 - Expert assessment and management of existing ulcer/Charcot
 - Education for patient to prevent new ulcerations
 - Prevention of new onset foot disease in patients admitted to hospital for unrelated reasons.
 - Education for ward staff.
- Actions included:
 - Nov 2012 band 6 podiatrist was release from duties to complete a pilot.
 - For 1 week at one site – SMH.
 - Developed a mobile screening tool to be used on ward with PFF guide as an aid.
 - Kit included.
 - Locate which patients have diabetes.
 - 5 Wards visited and 37 Patient with diabetes identified.
 - Results presented at board level with first draft business case.
- Limitations of the service include:
 - Duplication of patients screened.
 - Multiple Podiatrist performing screening.
 - Lack of good communication.
 - Patient were not screened within 48 hours but 72.
 - Identifying which patient are diabetic on the wards.
 - Follow up for those identified as High and Active Risk.
 - Patients with active foot – capacity.
 - Patients living outside area.
 - Increase in administration.
 - GPs cannot refer patients to diabetic foot teams, only podiatrists can.
- Recruitment can be a challenge – there are a number of vacant posts at any given time.
- Considerations for the future include:
 - Identifying diabetic patient on wards – this is not always made clear.
 - Not yet achieving our target of screening within 48 hours.
 - Introduce Root Cause Analysis to MDFT.
 - PFF Inpatient ward round with Diabetes team.
 - Rota for all Band 6 Podiatry staff to be involved in PFF Inpatient.
 - Necessary to implement an education program for ward staff.
 - Work alongside TVN to prevent hospital acquired pressure in feet.

Cost-effectiveness of MDFTs, Marion Kerr, Insight Health Economics

This presentation outlined key findings from a piece of work commissioned by Diabetes UK and undertaken by Marion Kerr, a health economist. It highlighted key findings from the 'Foot care in diabetes: the human and financial cost' report, which is about to be released.

Findings from the report include:

- Approx. 7,000 leg, foot or toe amputations in people with diabetes in England are carried out every year.

- The presence of diabetes increases the risk of an extremity amputation 23-fold than in patients without diabetes.
- It is estimated that 2-2.5% of the diabetes population has foot ulcers at any given time: 68,000 people in England.
- Amputation rates in England:
 - 2014-15 HES data record 7,407 amputation admissions;
 - 1 for every 390 people with diabetes;
 - 3,016 major amputation admissions;
 - 4,015 minor amputation admissions.
- Ulceration admissions in England:
 - 2014-15 HES data record 89,085 diabetes admission with ulceration;
 - 1 for every 33 people with diabetes;
 - Ulceration associated with 8.26 day increase in length of stay.
- Cost of inpatient care is £322 million in 2014-15.
- 86% of inpatient costs are for ulcer admissions.
- It is estimated that 68,000 people in England have foot ulcers at any given time, with an annual cost estimated at £629-786 million.
- 46% of patients with severe ulcers account for 80% of costs.
- The estimated financial cost of ulceration and amputation in England was estimated at £972mil - £1.13bil in 2014-15. This accounts for £1 in every £140 the NHS spends.
- The estimated NHS cost is higher than the combined annual cost of three of the four most common cancers. The NHS Programme Budgeting data for cancer spend is: £495mil on breast cancer; £378mil on bowel cancer; £360mil on prostate cancer; £177mil for lung cancer.
- Health related quality of life for those living with diabetes related foot problems is considered poor. QOF data indicate that around 81% of people with diabetes receive a foot check every 12 months. However, there is little correlation between foot review and amputation incidence at CCG level, there is more variation between different GP practices within CCG areas than across CCGs nationally.
- NICE guidance recommends that those with an active foot problem should be referred to a MDT or foot protection service within one working day and triaged within one further working day. National Diabetes Foot Audit data show that only 1 in 5 of 5,015 patients followed were seen in this timeframe (excluding self-presenters).
- The National Diabetes Inpatient Audit (NaDIA) found that in 2015, 31% of sites had no MDFT, and it is these MDFT which are reducing mortality rates

Group Discussion: Adopting best practice pathways for the reduction of lower limb and local solutions

Key points raised during the discussion include:

Barriers

- Identifying the inpatient cohort with diabetes in an acute setting is very challenging.
- The integration of community services and in-hospital services, and ensuring the two work well together. Where there is no link between acute and community podiatry services there is a breakdown in the patient experience.
- Communication and a clear transfer of information throughout the pathway – from initial presentation until treatment is complete – is very important.
- IT systems do not currently communicate with one another well.
- Regular MDT meetings are crucial in order to allow podiatrists to expedite a referral.
- Education and accessing GPs is a big barrier.
- Ownership of the patient.

- Communication with orthotists and having their input into the MDFT can improve patient outcomes and experience.
- Video conferencing between vascular consultants and podiatrists facilitates more effective communication between healthcare practitioners.
- The time scale to intervention is important to maximise patient outcomes, which is why early diagnosis – and therefore education within primary and community care – is so important.
- Needs to be better utilisation of healthcare assistants for foot monitoring and reporting.
- Medical photography, with the consent of the patient, would be a useful tool for capturing and monitoring a patient's foot condition.
- Multidisciplinary clinics should not just be more patients with ulceration, but patients with at risk feet with no ulceration.
- Follow-up (post discharge) should be with the appropriate person/clinic.
- There is a business case for extra inpatient podiatry.
- Non-engagement of patients, which can lead to the escalation of a condition.

Incentives

- Could having RCAs be helpful to motivate people? This should be across the entire pathway, not just part of it. Currently no one has access to notes from primary care though to acute care, so the practicality of RCA is very difficult.

For further information please contact sara@mailpbconsulting.com