Cheshire and Merseyside Diabetes Network
Diabetes Primary Care Foot Pathway

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The authors would like to thank all those who have engaged in the stakeholder events and provided comments and advice throughout the process including members of Merseyside Diabetes Patient Action Group.
Summary

The following pathway represents the consensus of clinicians working as part of Cheshire and Merseyside Diabetes Network to improve footcare across the region. The primary care pathway has been developed through discussion and debate at three regional stakeholder events, through ongoing correspondence with stakeholders and with reference to relevant national guidance (NICE CG10 and NICE CG147). The pathway has been developed to align with the recently developed secondary care footcare pathway.

The primary care pathway is designed to ensure:

- All patients with diabetes have access to regular high quality foot screening which includes risk stratification.
- Foot screening is delivered by an appropriately trained workforce and quality assurance is built into the process.
- Foot problems are identified early resulting in rapid assessment and treated when required.
- Patients are provided with high quality supporting education.
- Active foot disease is rapidly identified and referred for urgent medical/surgical input.
- Patients requiring access to specialist support from a podiatry foot protection team have rapid access to these services.
- Patients requiring access to a specialist multi-disciplinary footcare team have rapid access to these services.
- All members of the primary and secondary care foot service, commissioners and patients are clear on the expected minimum timescales and pathway for referral and treatment.
- A focus is placed on management of diabetes to reduce the risk of foot and other diabetes related complications.

Additional supporting materials are available to improve the quality of initial foot screening including a training package and e-learning tool which is designed to support the face to face competency based training sessions. The package provides participants with the knowledge and skills required to identify those with low risk feet and to be able to identify and refer anyone with increased risk, high risk or ulceration appropriately and promptly for specialist management. **Please note- This package does not replace face to face competency training and is designed to support this learning.**

The training package and e-learning support tool can be accessed by clicking the link below.

Primary care footcare pathway

**Date of diagnosis**
On same day, patient should be asked if they have any problems with their feet. If yes, full foot screening to be carried out immediately, if no then within first 12 weeks

Within first 12 weeks

Up to 3x contact with practice nurse to include footcare education

Within first 12 weeks

Initial foot screening and risk stratification (box 1 and 3)

**Low risk**
Annual foot screening and risk stratification

**Increased/ high risk**
Referral to foot protection team. To be seen by podiatry FPT within 4 weeks

Podiatry FPT to carry out stratification and onward referral if required (box 2, 3 and 4)

**Active foot disease**
Active foot disease:
Referral to Multi disciplinary foot team immediately. To be seen by MDFT within 24 hours.
Clinical emergency; ensure referral for immediate surgical/ medical input

**Low Risk**
Referral to GP for on-going foot screening

**Increased Risk**
Assessment by FPT and development of clinically appropriate management plan including at least 3-6 month follow up

**High Risk**
Request referral to lower limb Diabetology service for medical management of diabetes if uncontrolled. Development of clinically appropriate management plan including at least 1-3 month follow up

GP practice to record risk stratification at least annually. Check if still known to FPT/MDFT. Re-refer if necessary as per box 1, 2, 4

Discharge back to Foot protection team for management based on risk status

Within 1 week

Within 1 month

Initiate referral to appropriate education session

Provide standardised footcare education network agreed footcare information and supplementary resources

Consider box 4 (decision triggers)

MDFT to follow secondary care footcare pathway

Version 2 November 2014
Box 1 Initial Foot Screening Requirements

Screening and stratification should identify low risk, yes or no, and identification of active foot disease.

Quality assurance:
* GP practices require on-going update of competences
* Podiatry service to offer rolling quality assurance of screener competence: three yearly via practice visit
* Revalidated every 3 years (certificate as evidence)
* Forms part of induction

Requirements of screener
* Undertake face to face network agreed training session
* Screening of patients is a short (up to 5 minute) assessment with minimum:
  * Shoes and socks must be removed
  * Pedal pulse palpation
  * 10g monofilament check
  * Visual inspection for foot deformity, callus, corns, footwear
  * Issuing a current low risk foot care leaflet/onward referral

Box 2 Risk stratification Criteria

Current low risk
All pedal pulses palpable, no loss of 10g monofilament sensation and no other factors such as visual impairment or unable to manage own foot care.

Increased (moderate) risk
Either absent pedal pulses (palpation) OR loss of 10g monofilament sensation OR other risk factors e.g. unable to manage own footcare or podiatric foot problem e.g. callus/corns or visual impairment

High risk
Combination of 2 or more: absent pedal pulses (palpation), loss of 10g monofilament, foot deformity (with or without callus) OR history of ulceration or amputation

Active Ulceration
See box 4

Box 3 Podiatry FPT stratification

Undertake assessment including history

Pulses not palpable:
* Baseline vascular assessment (includes: pulse palpation, clinical signs and symptoms incl. Edinburgh Claudication Questionnaire), Doppler sounds (mono-, bi-, tri-phasic).
  If:
  * Pulse present, no symptoms, Doppler bi- or tri-phasic – repeat assessment each visit if clinically appropriate
  * Pulse absent AND/OR present ensure vascular assessment (including: ABPIs, lower limb assessment (femoral, popliteal and pedal pulses), absolute brachial ankle pressures
  * Suspected peripheral arterial disease see appendix 1
  * Symptoms of severe critical limb ischaemia urgent access/telephone on call surgical registrar.

Neurological Assessment:
* Consider 10g monofilament, vibration sensation, neuropathy disability scoring and/or neuropathic pain screening questions.

Orthotics/casting
* Orthotics within shoes to be provided by podiatry service.
  * If combination of orthotics and footwear ensure referral to orthotics service for fitting within 8 weeks of referral
  * If casting required for plantar diabetic foot ulcers ensure referral for casting within 2 weeks

Box 4 Decision triggers for MDT referral (note: If at any stage a clinical emergency is suspected refer immediately for specialist input)

MDT decision triggers
1. New foot ulceration
2. Recurrent foot ulceration
3. Unexplained foot pain, swelling & deformity
4. Cellulitis of the foot
5. Suspected osteomyelitis of the toes
6. Suspected Charcot neuroarthropathy
7. Severe neuropathic pain
8. Deteriorating foot ulcer, inspite of earlier assessment by MDT

Clinical Emergency
1. Critical limb ischaemia
2. Acute Charcot suspected
3. Spreading cellulitis
4. Gangrene
5. Significantly deteriorating foot ulceration

These decision triggers do not represent an exhaustive list and a clinical emergency should be based on clinical judgement.
Appendix 1

NICE suggested approach to suspected peripheral arterial disease.

Available: https://www.nice.org.uk/media/default/sharedlearning/582_padintegratedcarepathwayguidance2011nice.pdf)