Foot forum

In association with Foot in Diabetes UK

The idea of the Foot forum is to disseminate some of the discussion threads generated on the Foot in Diabetes UK (FDUK) Internet discussion forum to a wider readership. It will also act as a noticeboard for important announcements for healthcare professionals involved in the care of people with diabetic foot problems. If you wish to contribute with a question, an answer to a question or an important announcement please email editorial@sbcommunicationsgroup.com.

Justifying the service podiatrists provide

Justifying the service that podiatrists provide has been a hot topic on the forum. Here are some views on the issue, and examples of how departments have made their case.

Q. My podiatry department is currently undergoing the biggest review process in the history of its being – restructuring is obviously on the cards. I answer endless questions from management about the service we provide. When I can, I refer them to the available NICE guidelines and National Service Frameworks, but all I get back is: "they are only guidelines." Are other podiatry departments being asked to justify the service they provide?

Effie Jones, Lead Podiatrist Diabetes & Wound Care, NHS Warwickshire

A. I carry out an annual audit on amputation rates, bed days and admissions in conjunction with our vascular consultant. Using the audit data, we were able to prove that our service saved the primary care trust money on admissions, and reduced bed days for the acute care trust; our service saved thousands in admission and other costs. We were also able to take a retrospective look at data that preceded the setting up of our multidisciplinary foot service and demonstrate the need for such a facility.

Alexandra Duff,
Honorary Chief Diabetes Specialist Podiatrist,
Darent Valley Hospital.
Currently based at Kowloon West Cluster, Hong Kong

A. My organisation has recently experienced similar problems with management, who have no concept of what we do or the complexity of our roles. After carrying out a month-long snapshot audit, we proved that our service had prevented amputations, prevented admissions and saved thousands in admission and other costs. I don't know about other FDUK members, but where I am based it is a constant battle to justify the role of the podiatrist and increase understanding of what it is we do and why it is important.

Joanne McCardle, Diabetes Specialist Podiatrist, Edinburgh

A. I would like to stress the usefulness of both guidelines and audits in cases such as this. At my clinics we were able to show that approximately 70% of emergency diabetic foot admissions could have been avoided had resources been available to see patients, as per NICE guidelines, before they became acute emergencies. Subsequent to this, a business case has been fully funded by our primary care trust resulting in a large expansion of our service in both secondary and primary care. It was a hard fight , taking us well over 2 years to get our case approved, but well worth the effort.

Debbie Sharman, Consultant Podiatrist - Diabetes,
Bournemouth & Poole Teaching PCT

When to begin screening children with type 1 diabetes for foot problems

Q. I am interested to know what is the current practice in relation to commencing foot screening of children and young adults with type 1 diabetes. What is considered reasonable and practicable? A quick trawl of the NICE guideline did not provide any firm directions.

John Bridger, Diabetes Specialist Podiatrist,
Cheltenham General Hospital

A. Though some advocate beginning foot screening post-puberty, I think biomechanical problems can be identified earlier. I asked my biomechanics specialist to come along to a paediatric diabetes clinic and he was surprised to find almost half of those attending required orthotic intervention.

Sandra Jones, Podiatrist Diabetes Coordinator,
NHS Highlands

Centre validation models

Q. I am working as a diabetes specialist podiatrist in a hospital setting and am interested in comparing centres, practices and benchmarking against other teams. If anyone has been involved in peer group mentoring or centre validation I would be interested to hear about their experiences.

Ian Tarr, Diabetes Specialist Podiatrist, Walsall Manor Hospital

A. A good place to start for benchmarking might be the *National Minimum Skills Framework for Commissioning of Foot Care Services for People with Diabetes* (FDUK et al, 2006) or the *Guidelines for the Prevention and Management of Foot Problems for People with Diabetes* (North West Podiatry Services Diabetes Clinical Effectiveness Group, 2008). Both are available from www.footindiabetes.org. North West Podiatry Departments did some self-auditing based on the Diabetes Clinical Effectiveness Group's guidelines last year. This resulted in some tailored continuing professional development for podiatrists and specialist podiatrists in the region. Our team did some benchmarking and self assessment based on the NICE guidelines (2004) a year or two ago using a red, amber, green self-scoring tool. This process helped us to identify specific weaknesses and make plans for dealing with them.

Martin Fox, Clinical Lead Podiatrist, Tameside and Glossop PCT

A role for podiatrists on specialist teams

Q. With the advent of renal specialist podiatrists and vascular specialist podiatrists, I am interested to hear people's views on these posts. I feel that podiatrists playing a role in specialist teams can only be a good thing. This kind of involvement will both enhance the profession's stance within the health services, and will doubtless mean better care for patients. While roles for podiatrists on specialist teams are currently few and far between, are there any renal or vascular specialists out there who could share their experiences with us?

Adam Fox, Advanced Specialist Podiatrist, Diabetes & Wound Care, Surry PCT

A. In Northern Ireland we have four renal specialist podiatrist posts. Our renal podiatrists have founded a special interest group which has been quite active, even placing an advertisement in *Podiatry Now* for like-minded clinicians to get in touch with them. The renal podiatrists' special interest group has conducted a couple of audits, and have had the Department of Health in Northern Ireland commission the University of Ulster to develop and a run a short course module on renal disease and the lower limb (validated as a 30 credit M level). The course has been successfully completed by 17 clinicians so far this year and will be run again "on demand".

Jill Cundell, Lecturer Practitioner in Podiatry, University of Ulster

Any answers?

Email: editorial@sbcommunicationsgroup.com

Diabetes, smoking and rates of amputation

Q. Are there any data available that directly link smoking to rates of amputation? Yes, we know that smoking increases the risk of peripheral arterial disease, chronic heart disease and neuropathy, but I can't find anything that specifically looks at the relationship between smoking and the risk of amputation.

Alastair Hunt, Podiatrist, Greater Glasgow and Clyde NHS Trust

Bone biopsy for osteomyelitis

Q. Are any departments routinely using bone biopsy to identify infective organisms in osteomelitis? If so, who is performing the biopsy (orthopaedics? podiatry?) and what type of biopsy needle is being used?

In my department we send away any sequestrae that are removed from a wound for analysis. We only send cases where our usual antibiotic protocol is ineffective for biopsy. Perhaps we could be utilizing bone biopsy more frequently?

Gillian Harkin, Lead Clinical Specialist Podiatrist, Victoria Infirmary