Community-based diabetic foot teams: Are they the way forward?

Martin Fox

Martin Fox is Clinical Lead Podiatrist, Tameside and Glossop Primary Care Trust.

In response to the question asked in the last editorial of *The Diabetic Foot* (McInnes, 2005), 'Where were you on World Diabetes Day?' (14 November 2005), I was in a small Pennine town, doing diabetic foot risk screening at a GP practice. But it was other comments in the editorial that prompted my reply.

That editorial as well as several others over the past few years have put an inherent value on the multidisciplinary foot team being sited in the hospital setting. This, I think, is mainly due to the emergence over the last 20 years of hospital-based models, which have demonstrated benefits to local diabetes populations (Edmonds et al, 1986; Thomson et al, 1991). Around the UK the teams at sites such as Central and North Manchester, Edinburgh, King's College London and Ipswich are well known and respected by the current generation of diabetic foot clinicians, myself included.

Hospital-based consultants and podiatrists have been vocal in justifying the strengths of the hospital-based teams and perceived weaknesses of community clinicians, usually in relation to the management of people with diabetic foot ulcers (DFUs; Rayman et al, 2000). Concerns have also been raised about the development of community-based diabetes posts in podiatry (Young, 2002). Having worked on both sides of the fence over the past few years, I have experienced the strengths and weaknesses from each perspective, along with distrust and a lack of subsequent planning around provision of integrated diabetic foot care.

In the absence of recognised training routes for diabetes specialist or lead podiatrists, the case for locating diabetes podiatrists in hospital settings remains opinion only. Around the specific issue of DFUs it can be argued that some specific components of clinical management, such as x-ray ordering and interpretation or rapid admission decisions for acute surgical or complex medical care, are best facilitated in the hospital outpatient setting. But equally it can be argued that within an integrated clinical framework, many components of ulcer management can and should be provided in community settings.

Recently in the UK, linked to the publication of key clinical strategy documents (Department of Health [DoH], 2003; DoH, 2006), the framework for diabetes management and resources have started to shift out of hospitals and into the community. This is a move that is understandably seen as threatening by many hospital-based teams, including foot teams.

The National Institute for Health and Clinical Excellence (NICE; formerly the National Institute for Clinical Excellence) guideline has given us a consensus framework based on the strongest evidence available, as regards implementing best care for those with foot problems (NICE, 2004). The guideline recommends the referral of all people presenting with DFUs to a multidisciplinary foot team. It does not, however, specify where this team should be located. I would guess that the opinion of most hospital clinicians is that the team should be situated in the hospital.

With the emergence of modern integrated clinical frameworks such as that in Salford (Middleton et al, 1997), there is a case that DFUs may well be initially managed by structured community-based teams providing assessment, treatment and review, with referral to hospital teams only when presented with the most static, unstable, complex or limb-threatening ulcers. This idea was noted in a recent editorial (McInnes, 2003) and a related article (Nancarrow and Devlin, 2003), which reported the findings of stakeholder consultations, where all parties rejected the concept of a centrally located 'at-risk foot clinic'.

Can DFU management as recommended by NICE (2004) be delivered by community-based diabetes teams? If we look carefully at the five key components of management of such ulcers, how much could be facilitated in community settings by structured and resourced teams?

1. Prompt referral of patients who may benefit from revascularisation

This would depend on appropriate assessment of lower limb vascular status, which can be performed by a skilled clinician who has the availability of Doppler or Vascular Assist (Huntleigh Diagnostics, Cardiff). A community model for this type of assessment and rapid referral pathway from community podiatrist to hospital vascular consultant was

Department of Health (DoH; 2003) *National Service Framework for Diabetes: Delivery Strategy*. DoH, London.

DoH (2006) *Our health, our care, our say: a new direction for community services*. DoH, London

Edmonds ME, Blundell MP, Morris ME, Thomas EM, Cotton LT, Watkins PJ (1986) Improved survival of the diabetic foot: the role of a specialized foot clinic. *The Quarterly Journal of Medicine* **60**(232): 763–71

Hawksworth L (2005) Tameside model: role re-design podiatry in vascular triage. Presented at *PDUK: Paving the Way for the Management of P.A.D.* Bolton, 1 December 2005

McInnes A (2003) Diabetic foot care: Aussie rules! *The Diabetic Foot* **6**(4): 162–4

McInnes A (2005) Where were you on World Diabetes Day? *The Diabetic Foot* **8**(4): 164–6

Middleton A, Webb F, Bayliss B, Gould V, Young RJ (1997) Implementation of a pilot project to provide a district-wide mechanism for effective communication in the management of diabetic foot ulceration. *Practical Diabetes International* **14**(1): 20–3

Nancarrow S, Devlin N (2003) Consulting stakeholders in high-risk foot care services development. *The Diabetic Foot* **6**(4): 190–200

National Institute for Clinical Excellence (NICE; 2004) *Type II diabetes: Prevention and management of foot problems*. NICE, London

Knowles EA, Armstrong DG, Hayat SA, Khawaja KI, Malik RA, Boulton AJ (2002) Offloading diabetic foot wounds using the scotchcast boot: a retrospective study. *Ostomy/Wound Management* **48**(9): 50–3

Rayman G, Baker N, Barnett S (2000) Diabetes specialist podiatrists: time for recognition. *The Diabetic Foot* **3**(2): 38–40

Stuart L, Gambling T, McInnes A (2004) Patient-centred education: time to reflect. *The Diabetic Foot* **7**(4): 156–60

Thomson FJ, Veves A, Ashe H et al (1991) A team approach to diabetic foot care—the Manchester experience. *The Foot* **1**(2): 75–82

Yates I, Fox M, Crewdson M et al (2003) Larvae – a key member of the multidisciplinary foot team? *The Diabetic Foot* **6**(4): 166–71

Young M (2002) When is a diabetes specialist podiatrist not a DSP? *The Diabetic Foot* **5**(1): 6–10

recently presented by our own primary care trust (PCT; Hawksworth, 2005).

2. Wound management: Review, debridement and infection

This would depend on the running of specific clinics where clinicians skilled in wound care, sharp debridement (knowing when to and not to) and infection management can assess, treat and review patients, liaising closely with other key stakeholders such as GPs, district nurses and nursing home nurses. Facilities for taking deep tissue samples, provision of first-line antibiotics (obtained via GPs) for minor infections, and rapid referral pathways to hospital teams for patients with severe or deteriorating foot infections need to be in place. Again there are teams that have set up and are running such clinics in the community with close links to the hospital diabetic foot team (such as Middleton et al, 1997).

3. Total contact casting or other off-loading methods

There are some arguments for the locating of casting clinics in hospitals, but there is no key reason why such clinics cannot be run in the community. Scotchcast boots have been made for many years by the Manchester foot team at Rusholme Health Centre, and we have experience in our own PCT of making them in community wound clinics (Knowles et al, 2002; Yates et al, 2003). With the introduction of materials such as Softcast (3M Healthcare, Bracknell) for use in the manufacture of both Softcast slippers and below-knee casts, such casting techniques could be performed in community clinics, by skilled clinicians using the raw materials and cast scissors. Removable walking casts can be fitted and reviewed in similar settings.

4. Optimising glucose levels and controllingcardiovasculardiseaserisk factors

These are interventions that can be managed in the majority of cases by community diabetes teams involving the GP, the practice nurse and the diabetes specialist nurse, working alongside podiatrists. Our PCT is piloting a community podiatry-led vascular triage service which works with GPs and community diabetes specialist nurses at identifying and managing cardiovascular disease risk factors for people with diabetes and peripheral vascular disease (Hawksworth, 2005). It has been set up with the support of and direct access to the hospital vascular consultant.

5. Managing the patient at high risk of re-ulceration when healed

This is best delivered via effective education, reinforcement and easy access to NHS podiatry clinics which are linked to a diabetic foot protection team. Again all these factors can be provided in a structured community podiatry service, without the need for these patients to receive their ongoing palliative podiatry treatment in the hospital setting. It might even be preferable to implement structured patient-centred education for people with diabetic foot disease, such as that recently described in another editorial (Stuart et al, 2004), outside of hospitals.

Conclusion

So, perhaps most of the best-practice interventions for people with DFUs can be delivered outside of the hospital setting? With the ongoing trend to shift more of the diabetes services into community settings, maybe now is the time for the hospital foot teams to evolve in order to survive, by responding constructively to the aforementioned stakeholders (Nancarrow and Devlin, 2003; DoH, 2003; DoH, 2006). Last issue's editorial (McInnes, 2005) expressed concerns that hospital foot teams may be dismantled if they don't evolve. I share those concerns. As a community-based diabetes clinician I have an absolute interest in their survival, because for some patients, particularly when they have urgent or complex medical needs, there is no better place for me to send them for an opinion. Currently, our consultant-led hospital foot team are looking at working with us to set up a diabetic foot ulcer clinic in a community setting to function as a satellite site and provide an alternative choice of location for patients.

I guess my observations and opinions will not be popular with the majority of readers. So, I nervously throw down an evolutionary challenge to my hospital-based podiatry, nursing and medical colleagues who have contributed so strongly to this journal over the past few years. Come out into community and work with us at planning, piloting and developing what the people want – an integrated foot protection framework working across primary, secondary and tertiary care settings, based on a relay system, passing the clinical baton at just the right time. We are ready and waiting for you… in some places. The biggest challenge will come in learning how to pass the baton on and trusting each other with it. ■