

A partnership approach between podiatrists and vascular surgeons to tackle peripheral arterial disease — will it pave the way for saving more limbs and lives?



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Despite the best intentions of this journal and the army of passionate and enthusiastic clinicians, researchers, educators, managers and others who support it, people with diabetes and lower-limb complications are dying early, losing limbs and suffering months or years of debilitating pain, ulceration and poor quality of life. A major culprit behind these avoidable, reducible and generally unnecessary events and outcomes is vascular disease. We have known this for decades and the spiral of decline for patients is often slow, with many 'red lights' flashing on the way, potentially warning both the patient and the clinicians they regularly see.

As with any long-term condition, structured care, pathways and processes have been implemented in the NHS to try and prevent ulceration, amputation and early death. The growth of multidisciplinary foot teams (MDTs), foot protection services and foot-screening programmes are all evidence of this. The headline events, such as foot ulceration and the sudden onset of a Charcot foot, tend to dominate the agenda, while the insidious, but deadly, creeping onset of progressive arterial disease rarely commands the same attention to treatment, until the obvious crisis of ischaemic rest pain, a non-healing wound or gangrene occurs. Until the early detection and aggressive, proactive treatment of arterial disease becomes a priority and key responsibility of every diabetes foot team in the NHS, will we achieve the reduction in amputation and vascular-related deaths we have long strived for and so far failed to deliver?

The dire situation for people with lower limb peripheral arterial disease was highlighted to the diabetes clinical community by a group of leading vascular clinicians almost 8 years ago (Belch et al, 2007). Under-diagnosis and under-treatment was the norm for peripheral arterial disease (PAD), resulting in unacceptably high rates of avoidable cardiovascular-related deaths and morbidity. As a

consequence of increasing lobbying by these and other vascular champions, PAD has since been given some positive attention with National Institute for Health and Care Excellence (NICE) guidance (2012), subsequent quality standards and GPs have been incentivised with Quality and Outcomes Framework indicators to develop PAD practice registers and instigate best medicines targets (NICE, 2011). These developments are now the 'green shoots' of hope for PAD and indirectly for people with diabetes related foot disease. A small number of specialist podiatrist and nurse-led PAD services have also evolved recently and been commissioned in NHS organisations, usually working alongside existing diabetes foot services (Fox et al, 2012; Smith et al, 2014).

For the first time in the NHS, resources and commitment to deliver early diagnosis and optimum clinical management of PAD has been realised. Support for lifestyle changes and best medicines is key as a replacement for the late-stage 'trigger' events, such as the appearance of ulcers or gangrene. This has come about mainly through partnership working and collaboration between podiatrists in high-risk foot teams and hospital vascular teams. The clinical pathways to stimulate early diagnosis and then to guide best cardiovascular and limb management are starting to become more visible, robust and sustainable. The days of the person with diabetes with the chronic critical limb ischaemia turning up at the vascular unit with no prior recorded history of PAD or previous plan of treatment are now perhaps numbered.

However, until a structured, time and training resourced, clinical approach to early PAD diagnosis and treatment is the norm in all NHS organisations, vascular-related early death and limb amputation for people with diabetes will remain largely a late-stage salvage operation, dependent on the availability of and access to diabetes and vascular MDTs.

Largely because of this, a multidisciplinary initiative has been commenced by Foot in Diabetes UK (FDUK) over the past few years, to secure an agreement between The College of Podiatry and The Vascular Society of Great Britain and Ireland, on a common approach to the challenge of tackling PAD, from both a podiatrist and vascular surgeon perspective. This initially led to the development and publication of a set of peripheral vascular disease-related competencies for podiatrists (McCardle and Fox, 2013). Following this, meetings between members of the College of Podiatry and The Vascular Society of Great Britain and Ireland have resulted in the signing of a Memorandum of Understanding (MOU) on peripheral vascular disease, by both professional bodies in November 2014. Following a decade or more of informal cooperation and joint working between a few specialist podiatrists, specialist nurses and vascular surgical teams, a common forward direction for podiatrists and vascular surgeons has now been agreed and formalised (Fox et al, 2015).

The College of Podiatry is the main national professional body representing over 10,000 podiatrists in the UK, including 3,000 who work in the NHS, 500 as diabetes/high risk foot specialist podiatrists and currently less than 10 vascular specialist podiatrists. All these clinicians commonly see people who may have PAD throughout the UK, both within and outside of the NHS. Although PAD is currently taught as part of the undergraduate podiatry degree, it is not given anywhere near as much emphasis as musculoskeletal or skin pathologies. Our role, responsibilities and training in relation to this common lower-limb condition has been largely undefined and variable; ranging from no specific involvement, through to providing diagnosis and treatment services or working as members of multidisciplinary diabetes and vascular foot and foot protection teams.

Investment in strengthening undergraduate training in PAD assessment and cardiovascular risk management, as well as provision of postgraduate clinical placements in vascular & PAD clinics, would greatly incentivise more new podiatrists to develop a vascular focus. With our clinical knowledge and skills in a variety of common lower-limb disorders and the advent of independent prescribing, the potential for all podiatrists to play a key role in the early detection and best clinical treatment of PAD is huge.

The vision at the heart of the MOU is that all podiatrists will play a leading role in the early detection, diagnosis and best clinical treatment of people PAD, to help save more limbs and more lives, throughout the UK.

The key objectives embedded in the MOU are for the partners to:

- Establish a national PAD coalition, in partnership with other key PAD stakeholders, to develop common goals
- Develop a core PAD competency route for all podiatrists and a validated career route for vascular specialist podiatrists in the UK
- Promote early detection, diagnosis and ensuring best treatment of PAD, as a key responsibility of all podiatrists in the UK — NHS and private practitioners, general and specialist podiatrists.

The fight against diabetes-related foot disasters and the shockingly high vascular associated mortality rates is only half won. The current generation of podiatrists, working in close partnership with other members of diabetes and vascular teams, have made big strides. With the signing of the MOU, the potential for developing a new generation of vascular-focused podiatrists with the key knowledge and skills to help diagnose and tackle lower-limb arterial disease earlier and more effectively is here. Where will these PAD foot soldiers come from? Well, a large proportion of the readership of this journal would make a very good start and every NHS podiatry team has a potential PAD champion hidden within, who could be redeployed to put down their scalpels and pick up their handheld Dopplers. ■

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Erratum

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In the last issue of *The Diabetic Foot Journal*, we published two images in the Stang and Munro article 'Making prevention pay' in error (pages 20–24). Regrettably, Figure 1 showed two images that were the same, when the intention of the figure was to show the effectiveness of Liqua Care insoles compared to a regular shoe, using a heat map of the foot in both instances.

The editor would like to apologise to the authors and direct you to the online version of the article, which has the correct figures embedded. Please visit <http://www.diabeticfootjournal.co.uk/journal-content/view/making-prevention-pay> to view the correct version of this interesting article.

Kind regards,

Adam Bushby, Editor