Best practice foot care models are required

In my work, the biggest challenge I am confronted with is foot complications associated with diabetes and peripheral arterial disease (PAD). Lower limb amputation rates continue to rise, the variation in outcomes widens across the country, the number of elderly people and those with diabetes and obesity are ever increasing. Healed foot ulcers create a demand for ongoing monitoring and care, placing greater pressure on services. The evidence shows that prevention is cheaper than ulceration and amputation not only in terms of treatment costs but also in relation to lost tax revenue, sickness and housing benefit, re-housing and onward rehabilitation costs (Kerr, 2011). While the number of multidisciplinary footcare teams (MDFTs) are increasing, 28% of hospitals in England and Wales lack an MDFT (Health and Social Care Information Centre, 2013).

There is still a misunderstanding of podiatrists' scope of practice. You will recognise the look of surprise when you explain that podiatrists have a role in cardiovascular disease prevention by undertaking ABPIs and diagnosing PAD. The high level of debridement and offloading mechanisms involved with complex wound care is another area that does not fit with this perception. If commissioners' understanding of our profession is no more than "toenail cutters and bunion scrapers" – à la Michael Palin as a chiropodist in the 1947-set film *A Private Function* – then why would they relate raising amputation rates to redundancies in their local podiatry team?

There are examples of excellent leadership and clinical practice in podiatry, however this needs to be consistent across the UK. As a profession, we need podiatrists working in diabetes to speak out and speak to me. When we get stories of reduced amputation rates, I want to take the opportunity to promote this good news and use these examples in my negotiations. Likewise, where amputation rates are rising, I want to hear what action is taking place with high-level decision-makers and supporting teams in constructing a plan to reduce them.

We are witnessing an increasing caseload of high-risk and ulcerated patients with multiple comorbidities. Once a foot ulcer has healed, we have a duty of care to prevent re-ulceration. This requires a huge resource of skilled practitioners and we must ensure this resource is sustainable. The challenge of the increasing numbers of bed-bound elderly and those in residential care already appears to be insurmountable. There is a lack of financial support to ensure that these people have a 2-hourly turning regime in place, therefore teams are inundated with heel pressure ulcers. This issue is not something we hear politicians discussing, but is a serious drain on the NHS budget. Again, prevention would be less costly.

No commissioner or MP wants to have high amputation rates in their area. Therefore those in the diabetic foot community need to describe the process for reducing amputations as clearly as possible. While we have key planning documents from Diabetes UK (2012; 2013), do we need another all-encompassing document? Or do we need to provide the silver bullet to reduce amputation rates? Obviously there is no one size fits all model, but fully staffed MDFTs and foot protection teams and services should be a given in preventing ulceration and amputation.

This is only half the story, however. Rather than keep our collective heads down, we need to innovate and look at smarter ways of working to prove our worth and value for money.

I see my role as a facilitator between clinical practice, professional strategy and national policy; to influence health policy through lobbying and making contacts with decision-makers. I cannot do this in isolation and I need the expert diabetic foot community to be my resource. Therefore I would ask that you send me examples of best practice and innovation in reducing and preventing amputation and ulceration. At the SCP, we aim to produce models of best practice to present to politicians and commissioners. I am coordinating this work in England, while my colleagues are doing the same in Scotland, Northern Ireland and Wales.

We need to continue to argue for increased numbers of podiatrists in training and employed within the NHS, and make it easier for politicians and commissioners to see how to reduce local amputation rates. We need evidence of what works; to share and replicate this and undertake audits so we can present evidence to commissioners. We also need to use every opportunity to promote our unique and critical role. By making quality care and outcomes our priority, we will know we have done our best to help people with diabetes live more active lives. ■

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Diabetes UK (2012) *Putting Feet First: Commissioning/Planning a Care Pathway for Foot Care Services for People With Diabetes*. Diabetes UK, London

Diabetes UK (2013) *Best Practice for Commissioning Diabetes Services: An Integrated Care Framework*. Diabetes UK, London

Health and Social Care Information Centre (2013) *National Diabetes Inpatient Audit 2013*. www.hscic.gov.uk/diabetesinpatientaudit

Kerr M (2011) *Inpatient Care for People with Diabetes: The Economic Case for Change*. NHS Diabetes, Newcastle Upon Tyne