DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		UPDATE ON THE IMPLEMENTATION OF SOUTHAMPTON CITY FOOT CARE PATHWAY		
DATE OF DECISION:		23 FEBRUARY 2017		
REPORT OF:		DIRECTOR OF QUALITY AND INTEGRATION		
CONTACT DETAILS				
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STATEMENT OF CONFIDENTIALITY

None

BRIEF SUMMARY

As part of the overall Diabetes Improvement programme set out in the Diabetes Strategy 2013-16, NHS Southampton CCG implemented a new Foot Care Pathway from April 2016. The outline of the pathway and need for change was presented at HOSP in January 2016 with the recommendation that an update be presented in twelve months' time.

This paper provides an update based on the monitoring recommendations established in March 2016 by HOSP and the Podiatry Service Review Report for the period April 2016 to end September 2016 (Quarter 1 & Quarter 2). A verbal up-date for the period October to December 2016 will be available at the meeting if required.

RECOMMENDATIONS:

	(i)	That progress of the new Foot Care Pathway be noted
	(ii)	The Panel identifies any issues it may require further information/updates on.

REASONS FOR REPORT RECOMMENDATIONS

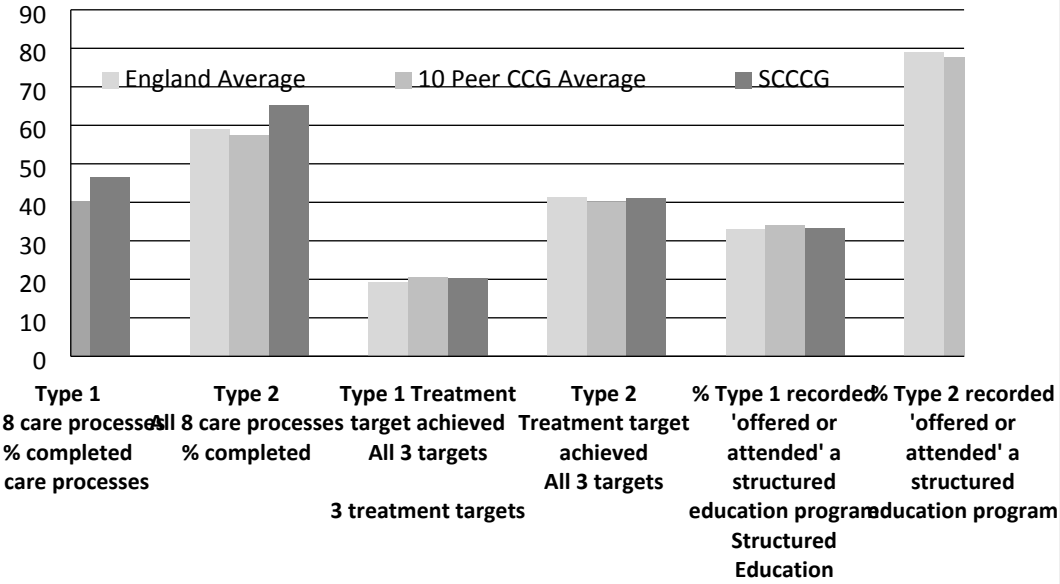
1.	To enable the Health Overview and Scrutiny Panel to examine key health issues.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2.	None

DETAIL (Including consultation carried out)

	Background - Diabetes
3.	In Southampton Diabetes has been a priority improvement area since 2013. As at April 2016, 12,497 people registered at GP practices in the city have a diagnosis of Diabetes, 5.3% of the adult GP registered population. Since 2013 the city has seen a 5.4% increase in the number of those diagnosed with Diabetes and it is likely that given the growing prevalence of obesity in the city that the number of those diagnosed with Diabetes will continue to grow.
4.	Actions set out in the Southampton City CCG Diabetes Strategy 2013-2016

	have been achieved in the last three years which has included new investment for a local insulin pump service, a new Foot Care Pathway which includes combined clinics, Multidisciplinary team working and a Diabetes Foot Protection Team, plus investment in Primary Care through quality improvement schemes. A summary of the achievements and outcomes of the Diabetes Strategy and three year plan is attached as Appendix 1.
5.	The city has also seen improvements in diabetes patient outcomes for 9 key care processes and treatment targets since 2011/12 when the city was reported to be in the bottom 25% of all CCGs in England and Wales. **Table One:** **National Diabetes Audit (NDA) 2014-15 Southampton CCG compared to England average and our 10 similar peer CCGs** 
6.	The City now compares well against the average for England and its ten peer CCGs. However, further improvement is required in the up-take of Patient Structured Education. The CCG's Two Year Operational Plan (2017-19) sets outs key actions for Diabetes Prevention which includes the improvement of the up-take of Patient Structured Education; implementation of the National Diabetes Prevention Programme; continued improvement of Treatment Targets and the enhancement of Self- Management linked to the personalisation of care for Long Term Conditions.
	Background – Foot Care Pathway
7.	Every patient with diabetes has an annual review undertaken at their GP surgery, most commonly by the practice nurse. As part of this annual review, the feet of each patient are examined and assessed. By doing this, the foot risk is identified and will be discussed with the patient. There are three levels of risk: • Low risk – managed in Primary Care • Increased / moderate risk – referred to NHS Solent Podiatry • High Risk – referred to NHS Solent Podiatry
8.	The majority of patients with diabetes, 70% will have a low risk of developing foot complications related to their diabetes, 20% will be a medium risk, 5%

	will be at high risk with a further 5% having active foot disease and Ulceration.
9.	The vast majority of diabetic amputations (85%) begin with a single ulcer. Diabetic foot ulcers require rapid and specialist support and can deteriorate rapidly. Good, joined up care delivered in a timely manner can ultimately prevent an acute hospital admission and an amputation. The survival rate following an amputation is poor, with approximately 50% survival after five years. Average life expectancy is reduced by 14 years, even in those with predominantly neuropathic disease.
10.	Southampton is particularly challenged by diabetes foot outcomes, as the following table demonstrates: **Table Two:**

Extracted data from PHE Diabetes Foot Care Profile	Hospital foot care activity (April '10 to Mar '13) **Published Mar 2014**		Hospital foot care activity (April '11 to Mar '14) **Published June 2015**		Hospital foot care activity (April '12 to Mar '15) **Published Aug 2016**	
	SCCCG	England avg.	SCCCG	England avg.	SCCCG	England avg.
Amputations per 1,000 people aged 17+ with diabetes	4.2% (137)	2.6%	4.3% (148)	2.6%	4.6% (165)	2.6%
Major amputations per 1,000 people aged 17+ with diabetes	1.0% (32)	0.9%	0.8% (28)	0.8%	0.8% (30)	0.8%
Minor amputations per 1,000 people aged 17+ with diabetes	3.2% (105)	1.7%	3.5% (120)	1.8%	3.8% (135)	1.8%

11.	It is important when reviewing the headlines about amputations to understand the context, for example the numbers of amputations undertaken, identified by the numbers in the brackets, over the period of time. Key observations are: • Major amputations are similar to the national average for England • Minor amputations are significantly higher than the national average for England Compared to our closest peer CCG, Portsmouth, the overall amputation rate is higher in Southampton by 0.6%. However, Southampton's rate for major amputations is lower at 0.8% compared to 1.2% in Portsmouth but the city's minor amputation rate is higher at 3.8% compared to 2.8% in Portsmouth.
	The New Foot Care Pathway
12.	To improve Diabetic Foot outcomes in Southampton a new foot care

	pathway commenced from 1st April 2016. It aims to meet the needs of those at low risk, medium to high risk and those with acute foot disease and ulceration, with the implementation of a community Diabetes Foot Protection Team (DFPT) and new Combined Foot Care Clinics and Multi-Disciplinary Team (MDT) delivered at the hospital. It will: • Improve management in primary care to support patients who are at low risk to self-manage better and maintain their low risk status • Through the implementation of the DFPT - Improve access to more responsive and timely care, greater patient satisfaction • Prevention of foot disease and improved management of ulceration to prevent further complication • Improved access to expert assessment and intervention through MDT and Combined Foot Care clinics • Reduction in major and minor amputations over the next 3 years • Improved outcomes for the city Please see Appendix 2 for a copy of the current foot care pathway.
	Total Contact Casting (TCC-EZ)
13.	Diabetic Foot Ulcers traditionally take 12 months to heal. To heal diabetic foot ulceration, appropriate offloading needs to be offered and used. There are two types of offloading devices available and recommended by NICE: **A non- removable device (which is worn 24 hours per day for 6-8 weeks)** • NICE NG 19 recommends non-removable offloading devices that reduce peak plantar pressures and redistribute pressure from the ulceration site in patients with acute foot problems (NICE, 2015). • Clinical evidence of the use of Total Contact Casting (TCC-EZ) demonstrates a healing rate of 86% at 8 weeks compared to an average healing rate of 52 weeks with conventional therapy **Removable device** • By their nature these devices (Air cast boots, Draco shoes, cast shoes etc.) can be removed so patient compliance is a major factor. • Whilst these devices can help they are more palliative in their approach as they can keep a wound static, but the risks of an open wound remain e.g. infection.
14.	Southampton City CCG has also commissioned for the provision of TCC-EZ locally which started in September 2016 for an initial 12 month period, pending review and evaluation to determine continuation of funding. This additional provision will help to further improve outcomes for those with Diabetes foot complications.
15.	The SCCCG Diabetes Development group, which meets bi-monthly, receives reports and feedback from the NHS Solent Trust lead Podiatrist on the progress of the new foot care pathway. Quarterly Service Review meetings are also undertaken with University Hospital Southampton NHS Trust, who delivers the combined foot care clinics and MDT and report on activity against the agreed performance indicators.
	Diabetic Foot MDT
16.	The Diabetic Foot Multi-Disciplinary Team (DFMDT) started in April 2016

	and is hosted at UHS within Victoria House Outpatients. The DF MDT clinic runs two clinics per week, a Tuesday PM and Friday PM which provides 14 appointments per week. The DFMDT is the top end of the Diabetic Foot Pathway. The frequency of DFMDT clinics are at present dependent on room availability within Victoria House. The clinics comprise of the following staff: • Clinics on a Tuesday are delivered by the UHS Consultant Diabetologist and the NHS Solent Lead Podiatrist. • Clinics on a Friday are delivered by the UHS Consultant Diabetologist and the NHS Solent Lead Podiatrist, UHS Vascular Surgeons and a Vascular Surgical Care Practitioner. In addition to the 7 slots for Southampton CCG on a Friday, and to enable the Vascular teams input, there are three additional slots per Friday (12 a month on average) for West Hampshire CCG patients.
17.	Referrals come through Podiatry SPA and the patient caseload in the DFMDT consists of the following four types of patients: • New Diabetic foot ulceration presentation from Primary care as per Diabetic Foot pathway. • Chronic diabetic foot ulcer within Podiatry caseload that is: o Non healing within 6/52 despite specialist podiatrist intervention o Ulcers that are penetrating to tendon, capsule or bone (Texas grade 2 and 3). o Those that are complicated by recurrent infections – such as osteomyelitis (Texas Grade B and D) • Charcot - Sudden onset hot, swollen neuropathic foot , with sudden change in shape of foot • Follow up of a diabetes patient admitted to hospital due to a foot condition under vascular and needing review in the MDT before returning to community services.
18.	Comprehensive management plans are communicated via letter to the patients GP and recorded on the NHS Solent IT system for future reference by the Podiatry team.
19.	In the period April to September 2017 88 patients have been seen, comprising of 66 new referrals and 12 follow-up appointments. There have been seven DNA appointments all of which were followed up and re-booked. This level of activity is under plan for the year to date however it is anticipated that activity will grow in quarter three as the pathway fully imbeds and more referrals are generated by Primary Care into the Podiatry service.
20.	Activity will continue to be monitored to ensure that the level of patients accessing the service increases in the remaining two quarters of the year. Depending on the outcome a review of the pathway may need to be undertaken.
21.	In addition there is a “virtual MDT” as all members of the team (UHS and Solent) are available to coordinate admission to UHS for those patients who

	become systemically unwell or who have limb threating foot disease that need urgent vascular intervention and would be unsafe to wait for an outpatient MDT appointment.
22.	To support the delivery of the MDT, the NHS Solent Podiatry team have added two additional clinics per week (Monday and Wednesday) that run as a step up / step down from the MDT clinic. This provides capacity for an additional 21 appointments per week so that the care plan identified via the MDT can be delivered. Within these clinics they offer: • Infection management via the 4 PGD and access to independent prescriber • Provision of appropriate non removable offloading device – TCC-EZ • Clinical advice to wider team for swab and X ray results • Advanced wound care • On-going education to the patient • Making Every Contact Count (MECC).
	Outcomes
23.	A key feature of the new pathway is to prevent non elective admissions with a preference to shift activity where possible from a non-elective episode to an elective or the prevention of any admission. During the period of April to September 2016 there have been 14 elective admissions as a result of those being seen by the MDT and 8 non elective admissions. One admission was for a major amputation, the others for minor amputations and IV antibiotics to prevent spreading of infection. The overall improvement of a reduction in amputation rates for the city is not anticipated until 2018/19.
24.	The implementation of the new foot care pathway required the discharge of low risk patients from the Podiatry service. Neither SCCCG nor NHS Solent has received any formal complaints from patients about the change in service provision.
25.	Any patient concerns have been promptly addressed by the Podiatry Team who has explained through either face to face contact or over the telephone why the changes have been made and patients have been able to fully understand and accept the change.
26.	GP and health care professionals were fully engaged in the development and changes made to service provision through the robust communication provided and sharing of the service criteria. All GP concerns raised at the time that the new pathway was implemented were again addressed promptly by the Lead Podiatrist and resolved.
	Quality improvements
27.	**Education -** Within quarters 1 and 2, there has been several key education events that have been delivered by the NHS Solent Podiatry team: • Diabetes UK supported patient education session 'Putting Feet First (April 2016) 45 attended • Diabetes UK support profession education session (Oct 2016) – 80 registered and 56 attended • Education session delivered to the Southampton CCG Pharmacists LPG : 28 attended • Education session delivered to the Nurses link advisors at UHS – 18

	staff attended • Education session to local Southampton Diabetes UK patient group on pathway - 25 Patients attended • Education event to the three Solent GP practice patient group - 32 patients attended • Solent Podiatry team update on pathway A patient engagement event was also held on Sunday 15th January at two Sikh temples in the city supported by the UHS Consultant Diabetologist and the NHS Solent Lead Podiatrist. Positive feedback has been received following the events.
	Patient experience
28.	In quarter 1 and 2, patient and staff feedback about the MDT has been positive. Examples of patient feedback: *"I saw a patient in clinic on Tuesday at the RSH (12:20) who had been referred by me to the MDT, she has expressed her gratitude for the service and care she has received. She is full of praise for the attention she received and the wound has responded well to the interventions recommended*" "*Re patient MR.P, I would like to let you know that he thanked me for referring him into the MDT team at Victoria House. He said he was so pleased with the treatment he got there, how nice and thorough everyone was with him and it was good to know everyone was doing all they could for him".*
29.	Clinical staff are reporting that they find the MDT plans are clear and are thankful that there is now a clear pathway for the acute foot to be seen in a timely manner.
	Future Developments
30.	The following developments are planned: • Alternative accommodation for clinics to be sort at UHS • Full audit of the impact of the DFMDT long term • Orthotist to start to attend the clinics • SystmOne access is nearly there for the UHS team • Links are developing with orthopaedics • Podiatry staff and others will be rotated trough the DFMDT to give resilience to the DFMDT • Explore need for Psychological support for these complex patients such as Intentional Peer Support and the Recovery Approach. Peer support is a term that covers a range of different relationships and can form traditional diagnosis-based support groups where people with similar experiences give and received support from each other.
RESOURCE IMPLICATIONS	
<u>Capital/Revenue</u>	
31.	CCG investment has been made
<u>Property/Other</u>	
32.	N/A

LEGAL IMPLICATIONS		
Statutory power to undertake proposals in the report:		
33.	N/A	
Other Legal Implications:		
34.	N/A	
POLICY FRAMEWORK IMPLICATIONS		
35.	N/A	
KEY DECISION?	No	
WARDS/COMMUNITIES AFFECTED:	All	

SUPPORTING DOCUMENTATION		
Appendices		
1.	Summary of the achievements and outcomes of the Diabetes Strategy and three year plan.	
2.	Southampton City Foot Care Pathway	
Documents In Members' Rooms		
1.	None	
Equality Impact Assessment		
Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out.		No
Privacy Impact Assessment		
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.		No
Other Background Documents **Equality Impact Assessment and Other Background documents available for inspection at: Appendices 1&2**		
Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)	
1.	None	