

## SCHEDULE 2 – THE SERVICES

### A. Service Specifications

<b>Service Specification No.</b>	03/CVDS/0039
<b>Service</b>	Community Diabetic Foot Protection Service
<b>Commissioner Lead</b>	Cardiovascular Disease Clinical Commissioning Programme
<b>Provider Lead</b>	
<b>Period</b>	1 April 2014 to 31 March 2015
<b>Date of Review</b>	

#### 1. Population Needs

##### 1.1 National/local context and evidence base

To comply with [NICE CG10 guidelines](#) for best practice in care of the Diabetic foot.

This service is for people with a high risk of a diabetic foot ulcer and will have previously been treated in the foot ulcer multi-disciplinary team clinic. They will then attend the community foot protection clinic for regular check-ups ad infinitum in line with NICE guidance.

The person who has had an episode of foot disease has a 40% increased risk of a second episode within 12 months and therefore on-going clinical appointments are necessary. The average life expectancy is reduced by 14 years for people, with diabetes who have had an episode of foot disease.

The need for good footcare and the necessary interventions are summarised in the [Diabetes UK 'Putting Feet First'](#) document. The intention of the Community Foot Protection Service is to work to the guidelines and pathway set in that document.

#### 2. Outcomes

##### 2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	
Domain 2	Enhancing quality of life for people with long-term conditions	X
Domain 3	Helping people to recover from episodes of ill-health or following injury	
Domain 4	Ensuring people have a positive experience of care	
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	

##### 2.2 Local defined outcomes

- To contribute to the reduction and / or maintain the amputation rate at [March 2014 \(2.8\) annual amputations per 1000 adults with diabetes](#)
- To contribute through recommendations and education of professionals and patients to compliance with the Dorset Formulary for the treatment of foot ulcers

#### 3. Scope

##### 3.1 Aims and objectives of service

###### Aim:

To provide a high quality, specialist podiatric service for people with a high risk of diabetic foot ulcers.

**Objectives:**

- To provide the podiatric treatment and long term management of people with a high risk of diabetic foot ulcers
- To provide a written treatment plan for every patient
- To provide a service that works within a self-caring ethos, as demonstrated by patient audit of their knowledge of their foot health, who to contact and when to contact them
- To provide regular education sessions to primary and community professionals on examination, treatment and care of the diabetic foot
- To provide a single point of contact for community and primary care professionals to request advice and guidance related to the care of patients who have been under the care of the community diabetic foot protection service
- To be able to demonstrate that photographs or tracings are recorded at all clinically appropriate intervals
- To be able to demonstrate that both feet are always checked
- Patients will be offered a choice of clinic locations

**3.2 Service description/care pathway**

The Commissioner aspires for the Community Foot Protection Service to meet the needs of people with diabetes who have had previous ulceration, amputation or more than one risk factor present which identifies their feet as being at 'high risk e.g. loss of sensation, signs of peripheral vascular disease with callus or deformity. This is in line with NICE guidance. However, the capacity of the service does not enable this to be met at this time and the service will prioritise people who have had a previous ulceration or amputation.

The hospital multi-disciplinary team or podiatry will refer to the community foot protection clinic. This referral route aligns to the service priorities.

Appendix 1 outlines the different levels of podiatric care for people with diabetes and the key features of the Community Foot Protection service. This reflects the current capacity constraints within the service rather than the commissioner aspirations.

Once the patient has been accepted by the Community Foot Protection service, the patient will be assessed and the review timescales will be based on individual clinical need. The service may identify people who have healed ulcers for more than a year where they can be managed within podiatry services with robust support arrangements with the foot protection team. The service will meet the need of non-ambulatory patients unsuitable for transport services.

**3.3 Population Covered**

All patients registered with a GP Practice within Dorset CCG.

**3.4 Any acceptance and exclusion criteria.**

Referrals are accepted from podiatrists and the hospital MDT Team. Occasionally GPs will refer people who have moved into the area and have a healed ulcer or amputation and need follow up within the foot protection service but do not require a consultation within the hospital MDT.

**Exclusion criteria;**

- Patients with a moderate / increased risk of a diabetic foot ulcer – see Appendix 1. These patients are treated by the primary care podiatry service
- Patients presenting with a current foot ulcer. These patients will be treated in the MDT foot clinic
- Patients with a presenting problem at the ankle or above

**3.5 Interdependence with other services/providers**

- Primary care podiatry
- MDT foot clinic
- Primary care practitioners, GPs and Practice Nurses
- Diabetes Nurse Specialists
- Consultant Diabetologists
- Specialist Dietician in Diabetes

#### 4. Applicable Service Standards

##### 4.1 Applicable national standards (eg NICE)

- To comply with [NICE CG10 guidelines](#) for best practice in care of the Diabetic foot

##### 4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

##### 4.3 Applicable local standards

- To offer an appointment to patients within 3 working days which reflects the urgency as defined by the referrer. Patients will be within the hospital MDT or podiatry services who will reflect the urgency required for an appointment.
- 90% percent of patients seen within 6 weeks of referral
- Provide high quality care to minimise the need to refer back to the hospital MDT (percentage to be defined after collecting actual data for 1 year).

#### 5. Applicable quality requirements and CQUIN goals

##### 5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

- To be able to demonstrate a suitably trained and supervised workforce with the required competencies to treat diabetic patients with a high risk of a foot ulcer
- To be able to demonstrate that a locally agreed information leaflet is given to every patient
- All patients will have an up to date documented footcare plan with emergency contact details for the Community Foot Protection Service
- To have, at the least, an annual review of their foot care needs
- To communicate the current treatment plan to the patient's GP at least yearly, or sooner if there is a clinical need
- To undertake at least 4 half day training events per year equitably within Dorset aimed at primary care nurses and GPs on the assessment and treatment of the diabetic foot
- Patients who are non-ambulatory and unsuitable for hospital transport will be able to access treatment within their home.

##### 5.2 Applicable CQUIN goals (See Schedule 4 Part E)

#### 6. Location of Provider Premises

##### The Provider's Premises are located at:

The service will be provided in suitable locations to minimise the travel time for a patient to a clinic.

## APPENDIX 1: DIABETIC FOOT RISK STRATIFICATION AND TRIAGE/IDENTIFICATION OF RISK STATUS



