**West Hampshire Diabetes Foot Care Pathways.**
**NHS Solent Podiatry and University Hospital Southampton**
Romsey, Eastleigh Southern Parishes, Totton and Waterside, West New Forrest

**Overview**

Within West Hampshire diabetes footcare is provided by two community podiatry services and four acute trusts. The precise pathways therefore vary slightly with geography and will therefore be outlined separately. They do however contain the same elements.

- **Foot risk assessment.** Done in primary care as part of the annual diabetic checks under GMS/PMS. It includes risk reduction advice to all people.
- **Diabetes foot protection.** This is a risk management and risk reduction service for people who have an increased (moderate) or high risk of diabetic foot ulceration. It is done by the community podiatry services.
- **Management of diabetic foot ulcers and acute Charcot foot.** This is done by secondary care multidisciplinary diabetic footcare clinics supported by community podiatry, vascular surgery and other specialties.

The pathway used by an individual patient will broadly be governed by the community podiatry service commissioned to cover the practice they are registered with, however some flexibility can be accommodated to allow patient choice.

**NHS Solent FT Podiatry Pathways**

The Solent podiatry service provides podiatry to people registered with practices in the Eastleigh Southern Parishes, Romsey, Totton and Waterside and West New Forrest localities. It also works with University Hospitals Southampton to provide a multidisciplinary diabetic foot clinic and has referral links to the multidisciplinary diabetic foot clinics at the Royal Bournemouth Hospital and Salisbury District Hospital. It operates a single point of access system.

- **Diabetic Foot Protection.** People with feet at increased or high risk of diabetic foot ulceration should be referred to the Solent Podiatry Service routinely for foot protection. The standard podiatry referral form can be accessed through DXS and should be sent to Solent’s SPA. People with increased risk may expect to be reviewed every 3-6 months and those with high risk every 2-3 months. If necessary direct referral will be made for orthotics or bespoke footwear.

- **Acute Diabetic Foot Problems (Ulcers, Charcot Foot).** People presenting with an acute diabetic foot problem in primary care (or to any health professional in fact) should be given “first aid” -
  - Assess for any critical limb ischaemia
  - Assess for any infection start empirical antibiotics as per HIOW antibiotics guidelines,
  - Appropriate wound care and dressing,
  - Advise patient to rest

**Action:** then referred urgently by fax or phone to Solent podiatry’s SPA. Note that in some cases such as critical ischaemia or severe infection emergency admission may be appropriate instead.

On receipt of a referral Solent Podiatry will arrange a clinical assessment of the patient. The aim is for this to be within 24 hours but a 7 day service is not yet commissioned. After initial treatment onward referral to the multidisciplinary clinic in UHS, Bournemouth or Salisbury will be arranged (depending on geography and patient choice). A treatment plan will then be arranged which may involve secondary care, community podiatry and primary care input. On completion of treatment people will be followed up in the foot protection clinics because they have high risk of further ulceration.
Clinic locations
Solent currently provides general podiatry and diabetes foot protection in the following locations:

- Totton Health Centre
- Hythe Medical Centre
- New Milton Health Centre
- Ringwood Health Centre
- Romsey Hospital
- North Baddlesley Health Centre

The UHS Multidisciplinary clinic operates on Tuesday and Friday in Victoria House on the Southampton General Hospital Campus. It is staffed by specialist podiatrists and a Diabetologist. On Friday a vascular surgeon also attends.

An acute foot clinic operates at Adelaide Health Centre on Monday and Wednesday to support the UHS MDT.

Contact Details

Solent Podiatry SPA
Fax: 023 8082 5283
Tel: 0300 300 2011
Diabetic Foot Protection

Annual Foot Risk Assessment
Neuropathy
Pulses
Deformity

Low Risk
Normal Sensation
Normal Pulses
No Deformity

Increased Risk
One Risk Factor
Neuropathy or Ischaemia
or Significant deformity

High Risk
More than one risk factor
or Previous Ulceration or amputation

Advise patient about their Risk Assessment.
Give Advice about looking after your feet and the low risk leaflet.
Continue annual review

Advise patient of their Risk Score
Give advice about looking after your feet and the increased or high risk foot leaflet as appropriate.

Refer to Podiatry Service Foot Protection Team for risk reduction
Southampton and Solent  Acute Foot Ulcer Pathway

Person Presents
with acute foot Ulcer  New
discoloration or possible Charcot
Foot.

Consider Admission
Critical Ischaemia
Severe Infection
Acute Charcot Foot

First Aid for Foot Ulcer
Treat Infection
Debride necrotic tissue
Offload pressure
(Absolute bed rest if suspected
charcot and not admitted.)

Urgent Referral
Solent Podiatry Single Point of
Access
Tel:  0300 300 2011
Fax:  023 8082 5283

Triage and Initial Treatment
Solent Podiatry

Podiatry
Treatment
Solent Podiatry

UHS  MDDFCC

Bournemouth
MD

Salisbury
MDDFCC

Ongoing Podiatry treatment then Foot Protection Surveillance of High Risk Foot
**First Aid For Foot Ulcers**

And Other Acute Diabetic Foot Problems

**Introduction**

People will often present with acute foot problems in primary care and unfortunately cannot be seen immediately in a foot ulcer clinic. Some “First Aid” is therefore needed. This can be summarised as:

- Relieve Pressure
- Treat Infection
- Debride necrotic tissue.
- Dressing.

**Relieve Pressure**

Neuropathic foot ulcers occur as a result of neuropathy, ischaemia and abnormal loading. Ulcers will not heal if pressure continues to be applied.

- Encourage rest and elevation. Unfortunately even a short period of weight bearing on an ulcer eg to make a cup of tea or to go to the loo, will undo many hours of rest. If social care can be increased to enable this it will help.
- Use of walking aids
- Pressure re-distribution by building up padding around the ulcer but not over it. Podiatry felt is excellent.

**Treat Infection**

(Also see H&IOW Guidelines on Antibiotic Treatment in the Community)

Signs of infection are a purulent discharge, erythema greater than 5mm around the ulcer, and a raised temperature should prompt treatment with antibiotics. More severe signs of infection such as evidence of deep tissue infection, erythema greater than 20mm around the ulcer or systemic signs of sepsis indicate admission to hospital for IV antibiotics.

Ideally samples should be sent for culture. These should be swabs from the base of the ulcer after superficial cleansing of any exudate. Better still is debrided tissue sent in normal saline.

**First line**

- Flucloxacillin 500mg qds for 7 days. Or Clarithromycin 500mg bd for 7 days.
- Add metronidazole 400mg if anaerobic infection is suspected (foul odour)

If Known to have had MRSA in the lasyt year

- Doxycycline 100mg bd for 7 days.

Antibiotics do not help in the absence of signs of infection

**Debride**
There is often thick keratin around and overlying much of the ulcer. It is helpful to healing if this can be carefully removed. Refer to Podiatry for this.

**Dressing**

A simple non occlusive wound contact dressing should be applied. There is no evidence to support the use of more expensive technical dressings. Since ulcers are usually moist an occlusive dressing causes maceration and should be avoided. If the foot ulcer clinic is delayed for any reason dressings will need to be changed regularly.

**Charcot Foot**

Charcot foot is an inflammatory condition which occurs in neuropathic feet. The inflammatory process results in bone resorption and the bones then deform under pressure. This causes permanent and gross deformity of the foot. Signs of acute charcot foot are mild erythema over the foot and the foot will usually feel warmer. Therefore any new and unexplained redness or discolouration of the foot should raise the possibility of the diagnosis. To avoid bone collapse absolute non weight bearing must be achieved and this will usually mean admission to hospital. Plain X rays are normal in the acute phase and are therefore unhelpful and provide no reassurance. Imaging with MRI or isotope scanning can be diagnostic but this is clearly beyond primary care. Treatment requires long term non weight bearing and total contact casting is the preferred option.

- If acute charcot foot is suspected admit to hospital
- If this is not possible immediately, absolute non weight bearing is essential.