Clinical Design & Innovation
Person-centred, co-ordinated care

HSE
The Model of Care for the Diabetic Foot (2021)

Assumpta Coyle

National Clinical Programme - Diabetes – Podiatry Lead

Podiatry Manager Saolta Healthcare Group

Integrated Care Programme for the Prevention and Management of Chronic Disease

Sláintecare.

Right Care. Right Place. Right Time.

Rialtas na hÉireann
Government of Ireland

Sláintecare is a vision for a new health service in Ireland

Sláintecare's aims are to:

- improve patient and service user experience
- improve clinician experience
- equal access to services based on need, not ability to pay
- A focus on integration

Sláintecare Fundamental Principles

01
Patient is Paramount
All care is planned and provided so that the patient/service user is paramount, ensuring appropriate care pathways and seamless transition backed-up by full patient record and information.

02
Timely Access
To all health and social care according to medical need.

03
Prevention and Public Health
Patients accessing care at the most appropriate, cost effective service level with a strong emphasis on prevention and public heath.

04
Free at the Point of Delivery
Care provided free at the point of delivery, based entirely on clinical need.

05
Workforce
The health service workforce is appropriate, accountable, flexible, well-resourced, supported and valued.

06
Public Money and Interest
Public money is only spent in the public interest for the public good (ensuring value for money, integration, oversight, accountability and correct incentives).

07
Engagement
Create a modern, responsive integrated public health system, comparable to other European countries, through building long-term public and political confidence in the delivery and implementation of this plan.

08
Accountability
Effective organisational alignment and good governance are central to the organisation and functioning of the health system.

Figure 1: Sláintecare Principles from Sláintecare Oireachtas Report 2017

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https://www.gov.ie/en/publication/0d2d60-slaintecare-publications/

Community Healthcare Organisations (CHO's)

Delivering Community Healthcare through Community Healthcare Organisations

- CHO 1 - Donegal, Sligo, Leitrim, /West Cavan, Cavan, Monaghan
- CHO West - Galway, Roscommon, Mayo
- CHO 3 Clare, Limerick, North Tipperary/East Limerick
- CHO 4 Kerry, North Cork, North Lee, South Lee, West Cork
- CHO 5 South Tipperary, Carlow, Kilkenny, Waterford, Wexford
- CHO 6 Wicklow/Dun Laoghaire, Dublin South East
- CHO 7 Kildare/West Wicklow, Dublin West, Dublin South City, Dublin South West
- CHO 8 Laois/Offaly, Longford/Westmeath, Louth, Meath
- CHO 9 Dublin North, Dublin North Central, Dublin North West

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HSE Health Regions

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HSE West and North West

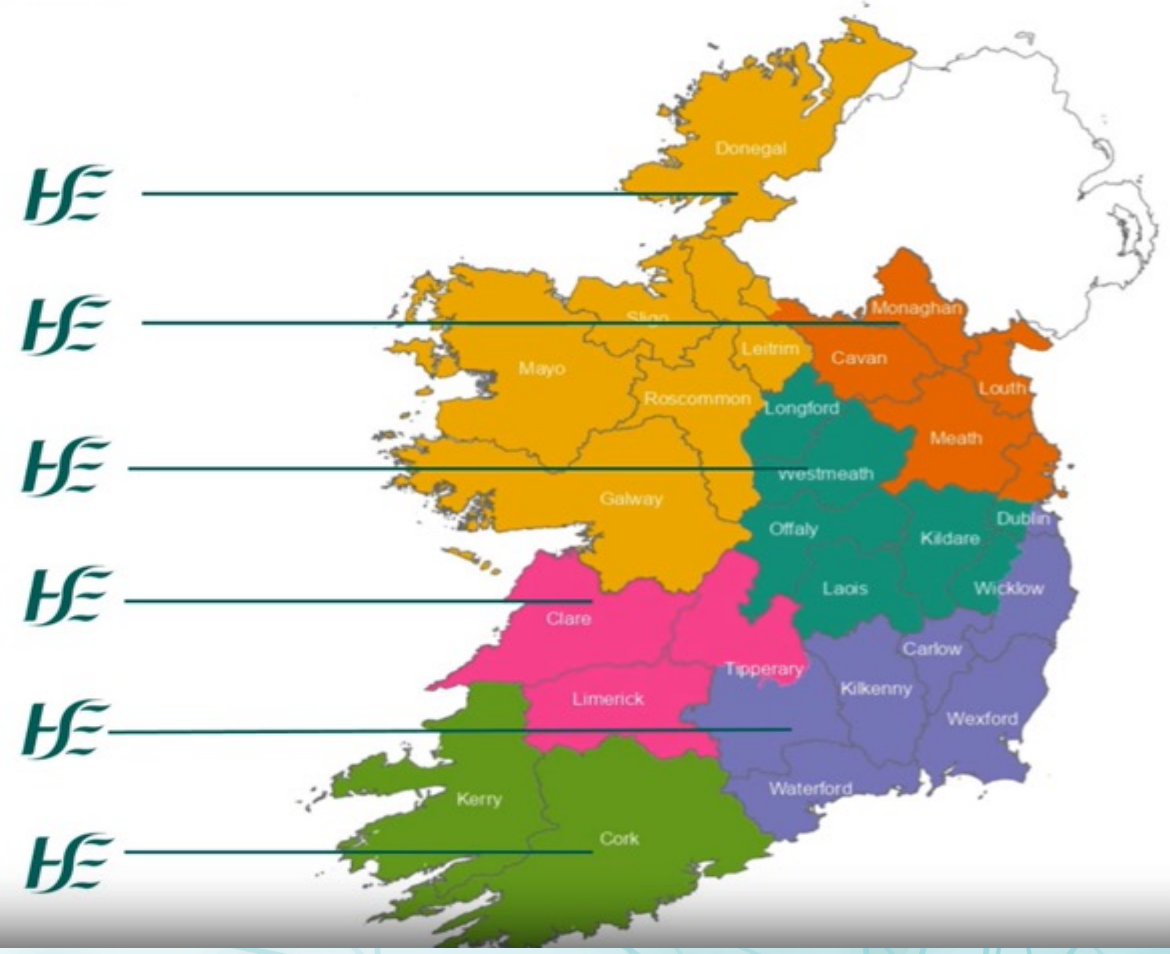
FSS Bhaile Átha Cliath agus an Oirthuaiscirt
HSE Dublin and North East

FSS Bhaile Átha Cliath agus Lár na Tíre
HSE Dublin and Midlands

FSS an Iarthar Láir
HSE Midwest

FSS Bhaile Átha Cliath agus an Oirdheiscirt
HSE Dublin and South East

FSS an Iardheiscirt
HSE South West



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7 Hospital Groups

- Saolta University Healthcare Group
- RCSI Hospitals Group, Dublin NE
- Dublin Midlands Hospitals Group
- University of Limerick Hospitals
- South/South West Hospitals Group
- Ireland East Hospitals Group
- Children's Hospital Group

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What is integrated care?

"Healthcare delivered at the lowest appropriate level of complexity through a health service that is well organised and managed to enable comprehensive care pathways that patients can easily access, and service providers can easily deliver. This is a service in which communication and information support positive decision-making, governance and accountability; where patients' needs come first in driving safety, quality and the coordination of care."

Sláintecare, 2017

Right care. Right place. Right time.

Integrated Care programmes (ICP) are based on population needs and are encapsulated in the work, a key component of the National Clinical programmes

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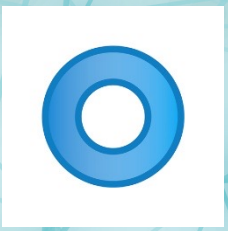
Integrated Care Programme for the Prevention and Management of Chronic Disease

- One of a number of integrated care programmes in Ireland
- Focuses on Cardiovascular disease; Type 2 diabetes; COPD; Asthma
- Encompasses three National Clinical Programmes
  - National Heart Programme
  - National Clinical Programme for Diabetes
  - National Clinical Programme for Respiratory



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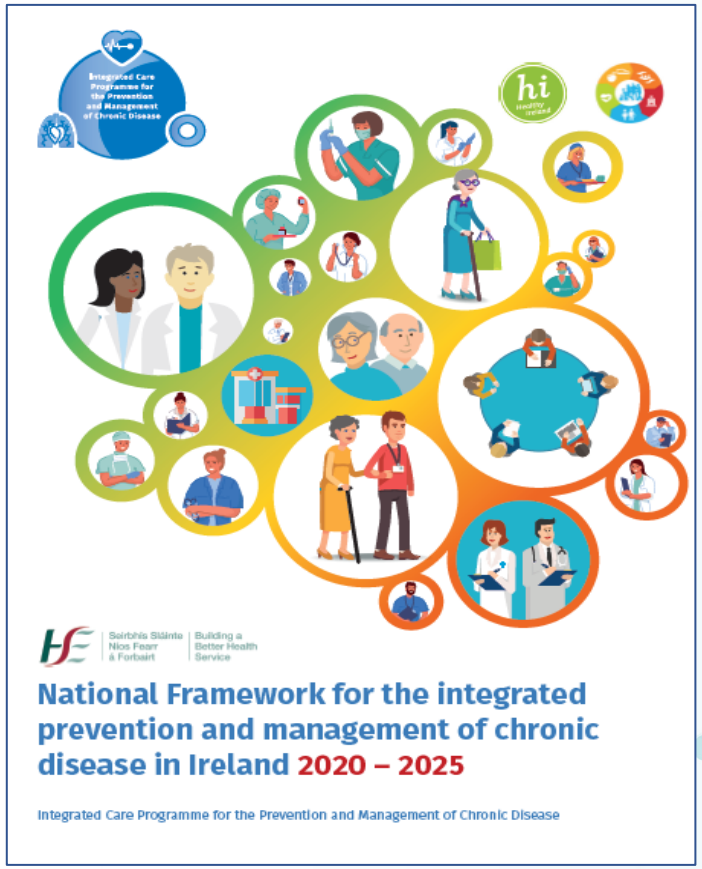
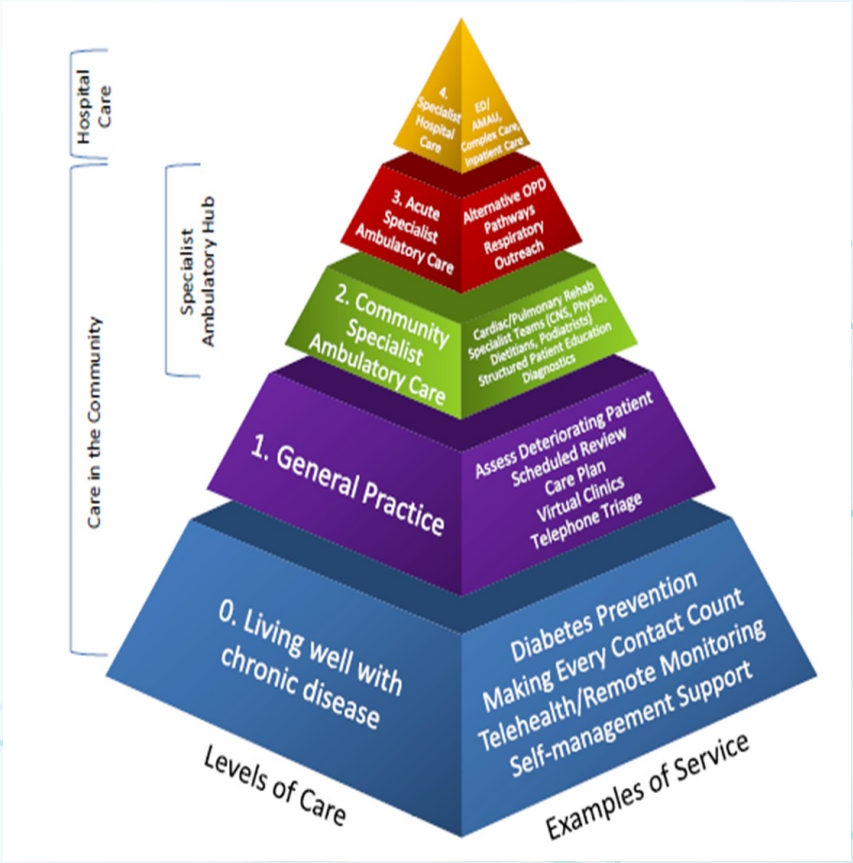
Within ICPCD - Model of Care for Chronic Disease





- Resourced - specialist community teams
- These teams provide specialist level support to General Practice
- End to end care
- Foot Protection Teams – Community
- Multidisciplinary Diabetic Foot Teams In the Acute Service

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ECC Staffing- Community Specialist Team

Full Team	
Revised staffing per hub agreed 05.10.2020	WTE Required
DIABETES	
CNS Diabetes	3
Clinical Specialist Podiatrist	1
Senior Grade Podiatrist	1
Basic Grade Podiatrist	1
Senior Dietitian	3
Staff Grade Dietitian (Weight Mgt/ DPP)	3
CARDIOLOGY	
CNS Cardiology	3
Senior Physiotherapist	1
Cardiac Rehab Co-ordinator	1
Staff Nurse Cardiology	1
Cardiac Rehabilitation Admin	0.5
Clinical Psychologist	0.2
RESPIRATORY	
CNS Respiratory	3
Senior Physiotherapist	3
CS Physio Rehabilitation Co-ordinator	1
CNS Rehabilitation	1
Staff Grade Physio Rehabilitation	1
Pulmonary Rehabilitation Admin	0.5
GP Lead with Specialist interest	
GP Lead with Specialist interest	0.2
Admin / Management	
Service Improvement Lead	1
Project Officer	1
Administration staff	2
Total per hub	32.4

What is a hub

- Community Specialist ambulatory Care hub
- 32.4 WTE per CST
- Supports 3 networks/population of approx. 150,000
- Integrated care consultant provides 50% of their service in the hub

Primary Function of hub:

- provide GPs with an additional layer of support to care for their patients with chronic disease in the community.
- provide GPs with timely access to a multidisciplinary team in the community to support them to provide holistic, integrated, proactive and preventive care for their patients with a focus on early intervention and hospital avoidance where possible.

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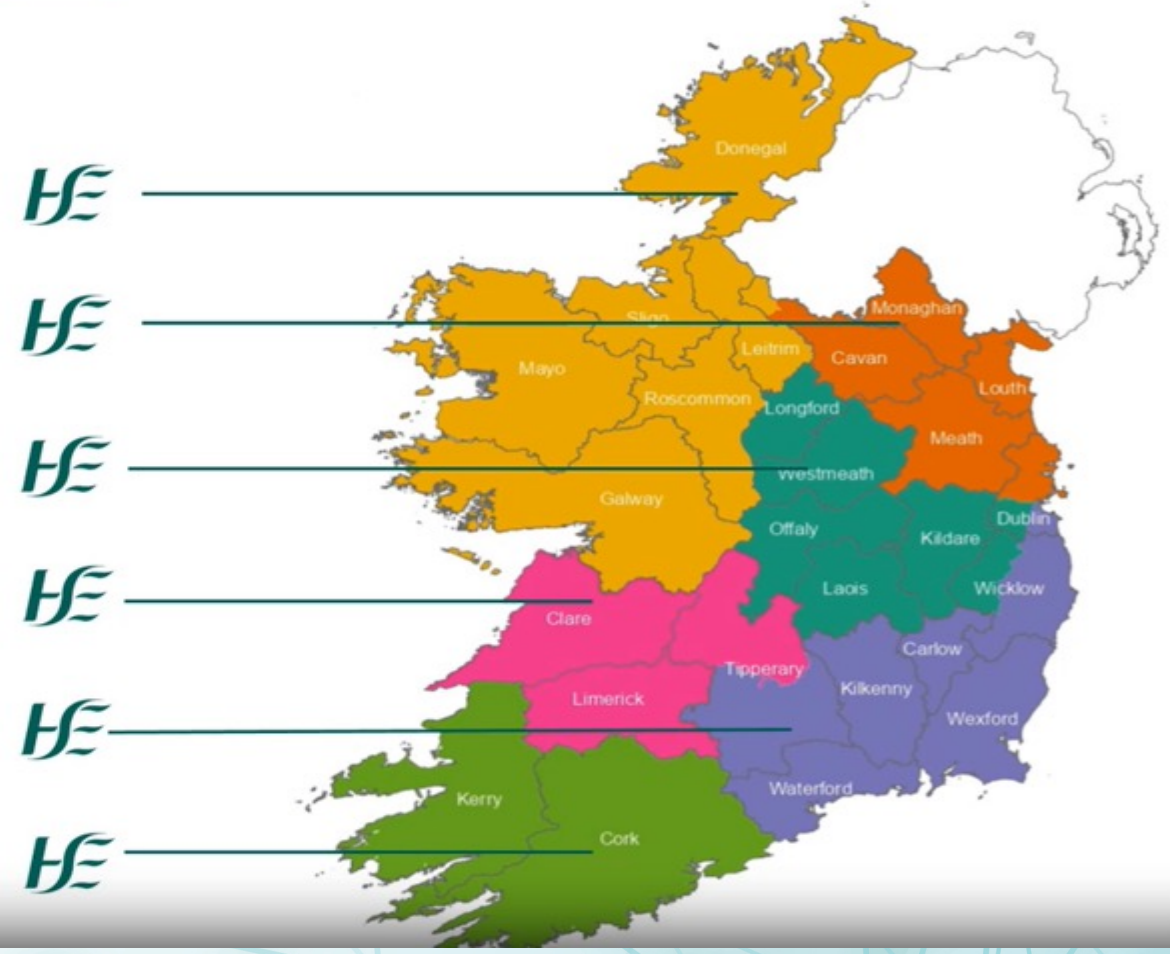

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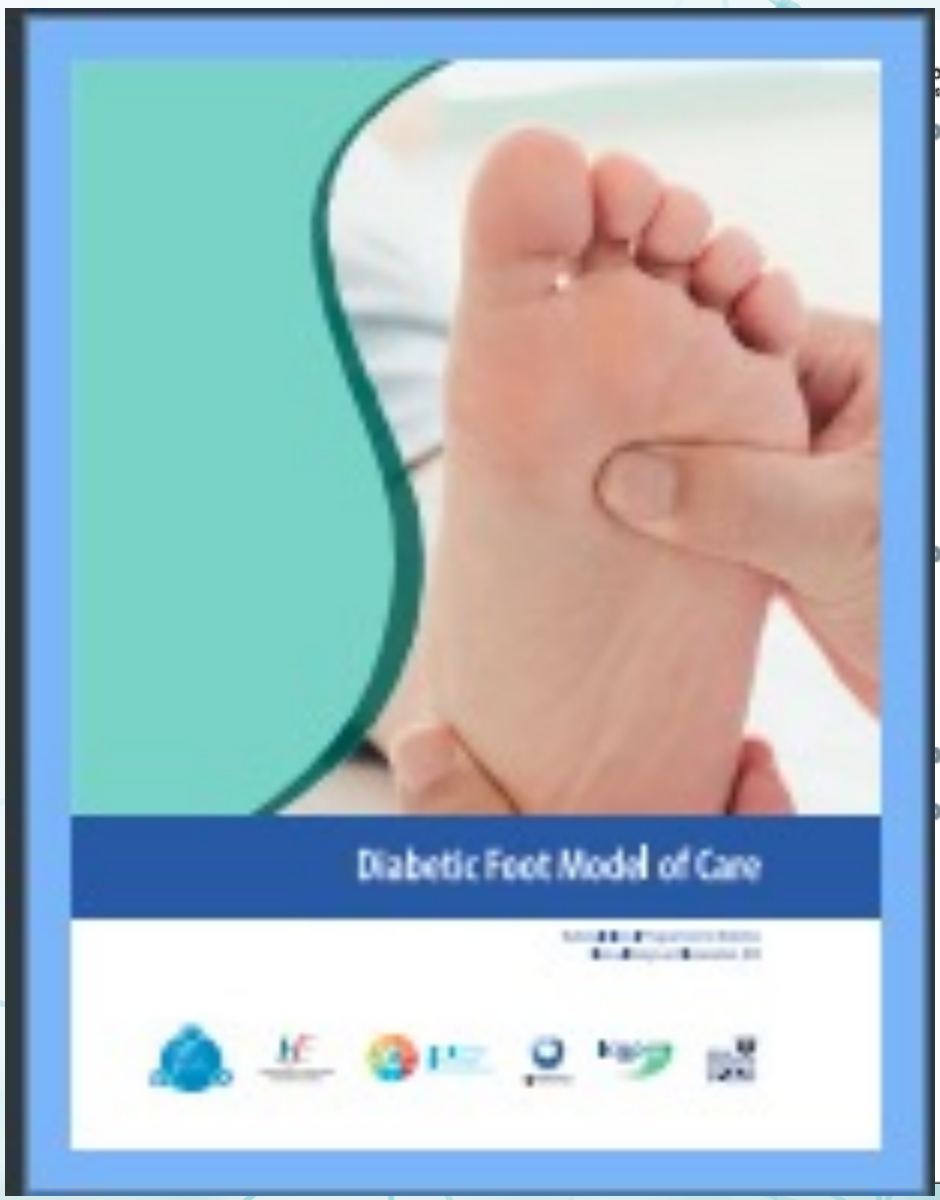
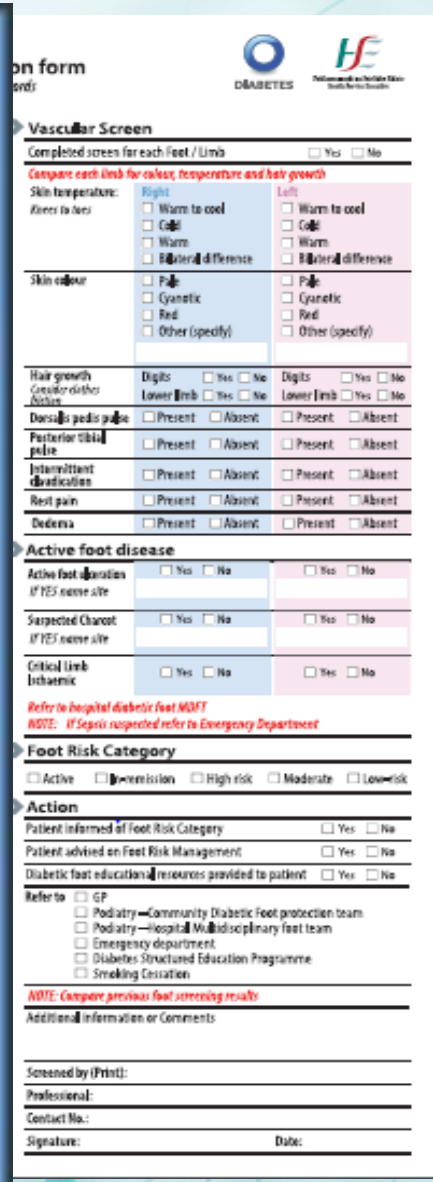
The Diabetic Foot Model of Care was published in December (2021)

by the National Clinical Programme for Diabetes, Integrated Care and Preventation of Chronic Disease (ICPCD) within the Office of Clinical Design and Innovation, HSE





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DIABETIC FOOT SCREENING AND CLASSIFICATION PROTOCOL

DIABETIC FOOT SCREENING

On diagnosis of diabetes and at every diabetic foot review thereafter, a clinician will examine patient's feet and lower limbs for risk factors. This should include:

Medical History

Review of medical history and comorbidities including kidney function

- History of Charcot foot; foot surgery; previous ulceration and/or amputation (all types; on either foot)
- Presence of intermittent claudication or rest pain

Foot Inspection

Skin and nail inspection

- Inspection for structural foot deformity
- Inspection of any existing foot wounds
- Examination of footwear
- Review of orthotic devices and aids and appliances

Peripheral Sensory Assessment

- Vibration perception testing (128 Hz tuning fork)
- Cutaneous pressure perception testing (Semmes Weinstein Test: l0g monofilament)

Peripheral Vascular Assessment

- Palpation of dorsalis pedis and posterior tibial pulses in both feet

LOW RISK	MODERATE RISK	HIGH RISK	IN-REMISSION	ACTIVE FOOT DISEASE
Clinical Findings • Normal inspection • Normal peripheral sensory assessment[1] • Normal peripheral vascular assessment[2] • No previous ulcer [6] **or** lower limb amputation [7] • No foot deformity	**Clinical Findings** **One** of the following risk factors is present: • Impaired peripheral sensation[3], **or** • Impaired circulation[4], **or** • Foot deformity	**Clinical Findings** Two or more of the following risk factors are present: • Impaired peripheral sensation[3] and impaired circulation[4] , **or** • Impaired peripheral sensation[3] with significant callus/deformily, **or** • Impaired circulation[4] with significant callus/ deformily, **or** • End stage renal failure **or** • Chronic kidney disease (stage 4 or 5)[5]	**Clinical Findings** • Previous foot ulcer [6], **or** • Previous lower limb amputation[7], **or** • Previous Charcot arthropathy	**Clinical Findings** • Current foot ulcer, **or** • Spreading infection, **or** • Critical limb schaemia, **or** • Suspicion of an acute Charcot arthropathy, **or** • An unexplained hot, red, swollen foot with or without pain.

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Geneal Practice (T2DM)/Hospital Endocrinology Team (T1DM)

Management Plan for TYPE 1 DIABETES

- Annual Rveiew in Secondary Care
- Ongoing diabetes care in Secondary Care
- Education on diabetic footcare and risk status
- Referral to diabetes self-management education programme
- Ongoing Self-care

Management Plan for TYPE 2 DIABETES

- Annual review in General Practice
- Ongoing diabetes care in General Practice
- Education on diabetic footcare and risk status
- Referral to Diabetes Self-Management Education (DSME)
- Ongoing self- care

Community Foot Protection Team

Management Plan for TYPE 1 DIABETES

- Ongoing diabetes care in Secondary Care

Management Plan for TYPE 2 DIABETES

- Ongoing diabetes care in General Practice

Management Plan for both TYPE 1 + TYPE 2 DIABETES

- Annual Review by FPT Podiatrist
- Referral to DSME
- Lifestyle interventions: smoking cessation; alcohol reduction; exercise
- Education on diabetic foot care and risk status
- Biomechanical assessment
- Footwear assessment
- Consider need for onward referral to other HSCP
- Ongoing self- care

Management Plan for TYPE 1 DIABETES

- Ongoing diabetes care in Secondary Care

Management Plan for TYPE 2 DIABETES

- Ongoing diabetes care in General Practice and secondary care *(shared care)*

Management Plan for TYPE 1 + TYPE 2 DIABETES

- Annual Review by FPT Podiatrist
- Referral to DSME
- Lifestyle interventions: smoking cessation; alcohol reduction; exercise
- Education on diabetic foot care and risk status
- Biomechanical assessment
- Footwear assessment
- Consider need for onward referral to other HSCP
- Ongoing self- care

Management Plan for TYPE 1 DIABETES

- Ongoing diabetes care in Secondary Care

Management Plan for TYPE 2 DIABETES

- Ongoing diabetes care in General Practice and secondary care *(shared care)*

Management Plan for TYPE 1 + TYPE 2 DIABETES

- 3-6 monthly review by FPT Podiatrist
- Referral to DSME
- Lifestyle interventions: smoking cessation; alcohol reduction; exercise
- Education on diabetic foot care and risk status
- Biomechanical Assessment
- Footwear Assessment
- Consider need for onward referral to other HSCP
- Ongoing Self- care

Hospital Multidisciplinary Foot Team

Management Plan for TYPE 1 + TYPE 2 DIABETES

- Refer within 24 hours to MDFT
- M DFT Clinical Specialist Podiatrist or Senior podiatrist to review patient within 24 hours of referral (or next working day)
- Frequency of MDFT review based on clinical need
- Ongoing care by the MDFT diabetes specialist team with collaboration with GP as required
- Education on diabetic footcare and risk status
- Biomechanical Assessment
- Footwear Assessment
- Consider need for onward referral to other HSCP
- Ongoing Self- care

I changed the dressing my self, I got it wet I got some new dressings from the chemist woman

I went into get my tablets and got some plasters for that cut

I took my sock off and showed the chemist man the sore when I went to town

Patients would often ask the pharmacists or there team in where they could go for services

Patients will usually speak with the pharmacist about foot /skin products

Diabetic Foot Education

Fantastic first line contact in communities for many patients with foot problems especially outside the cities

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Area Finder

Using Area Finder to identify service user's referring geographical location:

Search and Click on https://hseareafinder.ie then insert service user's Eircode

This will identify the service users affiliated

- Community Healthcare Network,
- Nursing Service,
- Integrated Care Programme for Older People (ICPOP) hub and
- Chronic Disease (Integrated Care) hub.

Resources on A-Z

Menu

Home › Health A to Z

Diabetes

Type 1 diabetes
Find out about type 1 diabetes and living with the condition ›

Type 2 diabetes
Find out about type 2 diabetes and living with the condition ›

Diabetic Retina Screen
How the RetinaScreen programme can detect changes in vision in people with diabetes ›

Courses and support
Courses and support to help you manage type 2 diabetes or pre-diabetes ›

Pre-diabetes
Pre-diabetes is very treatable and type 2 diabetes can often be prevented or delayed ›

Diabetes and pregnancy
You can have a healthy pregnancy with diabetes but managing your diabetes might be harder ›

https://www2.hse.ie/conditions/type-2-diabetes/living-with/foot-care.html

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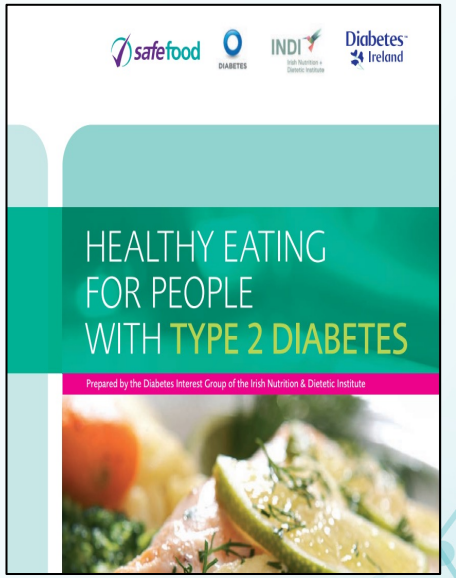

Menu

Home › Health A to Z › Type 2 diabetes › Living with type 2 diabetes

Diabetes and mental health

Menu

Home › Health A to Z › Type 2 diabetes › Living with type 2 diabetes

Alcohol and smoking

Diabetic RetinaScreen
An Clár Náisiúnta Scagthástála Reitiní do Dhiaibéitigh
The National Diabetic Retinal Screening Programme

Home | COVID-19 | Diabetic retinopathy | Screening

Self registration

CORU

Set up under the Health and Social Care Professionals Act 2005 (As Amended)

Irelands Multi-professional Health Regulator

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Thank you for your invitation, your time,

Questions

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