

## Success Story

<b>Project title</b>	Increasing access to podiatry services in the BME community
<b>Topic area</b>	Footcare

<b>Organisation(s)</b>	Solent Healthcare Podiatry Services
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<p><b>Aims of the project</b></p> <p>The aims of the project were:</p> <ul style="list-style-type: none"> <li>• to improve access and uptake of the podiatry service</li> <li>• to promote health education as a preventative measure</li> <li>• to provide greater access by locating drop in clinics within areas of high BME population.</li> </ul>
<p><b>Why was the project undertaken?</b></p> <p>As a result of Southampton's health and wellbeing strategies and research both nationally and locally, looking at the issues surrounding diabetes, a pilot study was conducted to ascertain the number of patients seen within the current podiatry clinics in Southampton Central PCT (now Solent West). The study highlighted a poor uptake of podiatry services by black and ethnic minorities, despite the incidence of diabetes being around four times more likely to occur within this population (3 times higher for Afro Caribbean and up to six times higher for people of Southern Asian descent).</p> <p>The Health Survey for England 2004: Health of Ethnic Minorities showed the prevalence of doctor-diagnosed diabetes was significantly higher in Black Caribbean (10 percent men, 8.4 percent women), Indian (10 percent, 5.9 percent), Pakistani (7.3 percent, 8.6 percent) and Bangladeshi (8.2 percent, 5.2 percent) men and women than in the general population (4.3 percent men, 3.4 percent women)</p> <p>Diabetes is the most common cause of non traumatic lower limb amputation with diabetic foot ulcers preceding more than 80 percent of amputations in people with diabetes. It is estimated that in the UK one in ten ulcerations lead to amputation (NICE, 2004)</p>
<p><b>Demographics and description of the local health community</b></p> <p>Southampton is ranked as the 96<sup>th</sup> most deprived out of the 354 local authorities in England. Southampton has a range of cultures and ethnic groups, which make up the estimated 228,600 people living within the city boundary. There is a large Polish population in the city, with estimates as high as 20,000, or 1 in every 11 of the total population. Southampton also has a large Asian community.</p> <p>The 2001 Census showed that 92.4 percent of the city's populace were white, 3.8 percent were South Asian, 1.0 per cent Black, 1.3 percent Chinese or other ethnic groups, and 1.5 percent were of mixed</p>

race.

80 percent of the city's ethnic minorities live in the St Mary's district which was the centre of the project area.

### **How was the project approached?**

The original plan for the project, and the local audit to establish need, was undertaken by a member of the podiatry team who had a special interest in diabetes and BME. She approached the podiatry health promotion lead to ask for support to design and undertake a project to improve access and awareness of diabetes and podiatry services for people living in an area with a high BME population.

The project aimed to raise foot health and podiatry awareness. It focussed on issues associated with the diabetic foot, thereby promoting good foot health and reducing the risk of the foot complications associated with diabetes. The project had also been designed to ensure timely and relevant clinical intervention when required. The entire project ran for 2 years.

Funding was secured for a project to run for 1 year. The team member who initiated the project left the service before the project was fully established and the project continued to be implemented and maintained by the podiatry health promotion team who reported directly to the clinical lead.

All of the team were asked to ensure that they read and understood trust policies relating to the project. These included lone worker, health and safety and equality and diversity. The team were mainly working in premises not under the guidance of the NHS and safety was a priority. Training of staff relating to advice and treatments were not required as all of the team were qualified podiatrists of band 6 or above. All of the staff also specialised in health promotion and also undertake diabetes for life talks as part of their current role.

Some areas which held drop in days had risks associated with lone working. For example, the Afro Caribbean centre was opened and then left with just a podiatrist. Risk assessments were done and as a result two podiatrists were sent to any area with lone working or other safety concerns. All staff are trained to risk assess and the service has a lone working policy which was adhered to.

The main barriers to implementing the project were lack of funding; clinical locations within the area of high BME population; and finding a project partner. An application for financial support for a 1 year period was made to the Southampton City Council Health and Wellbeing Community Development Fund with Age Concern Southampton as a partner. The application was successful and enabled the first phase of the project to take place. A clinical location was secured for a half day a month for drop in clinics within the project area. All further treatments required were undertaken just outside (approximately 1 mile) of the main BME locality.

The second phase of the project was developed to address findings from phase 1. This phase was funded by NHS Diabetes.

#### **Project phase 1**

The project provided a monthly half day drop-in clinic running out of the 3<sup>rd</sup> Age millennium centre over a one year period. The drop in clinic was staffed by a community podiatrist who provided assistance, support and onward referrals to other foot health disciplines such as nail surgery and tissue viability, as required. Individuals attending the drop in clinic with foot problems were offered a follow up appointment at a podiatry centre to be fully assessed and, where appropriate, given foot health equipment, foot care advice and information on danger signs to be aware of. The project also promoted training family members to provide foot care and to monitor the condition of the feet.

The project incorporated a woman and child drop in day run from the 3<sup>rd</sup> Age Centre to ensure comfortable access for women. This was set up to address service user feedback partway through the project which highlighted the need for a separate drop in service for this group. Only four females had previously attended the drop in and no children had attended. Feedback suggested this was because the drop in was held on 'elders day' when traditionally it is older males who attend. The introduction of an alternative drop in day was therefore necessary to ensure equality regardless of age and gender.

A visiting foot health advice service was also available and sessions were undertaken for various ethnic minority groups including the Chinese Association, Asian Carers Group, Asian Elders Group and the Afro Caribbean Centre.

## **Phase2**

The findings from phase 1 (shown below in the 'outcomes achieved section) of the project directly influenced phase 2.

Phase 2 focussed on:

- taking the service to the patient with visiting advice and drop in sessions
- raising awareness of NHS podiatry services to other allied health professionals (AHPs) and social services professionals caring for and supporting patients and clients in this area
- improving the awareness among carers of the importance of good foot health and how they can support their family / clients.

Sixteen advice and drop in sessions were held at various venues within the project area over the 1 year period. Any follow up appointments were undertaken at their nearest podiatry clinic. Four of these sessions were specifically aimed AHPs and Social Services.

Information (non patient identifiable in line with trust policy) was collected and put on spreadsheets wherever possible to be collated for final reports. Verbal information was relied upon from patients due to some language / communication barriers.

The advice sessions were adapted to suit the type of group that was being addressed. The sessions consisted of a group talk regarding all aspects of foot health from washing feet through to fitting of footwear. Specific advice regarding diabetes and foot health was then discussed. The sessions were often interactive to keep them interesting and fun. Foot creams and other foot health items were also given out for free when available. After the session a drop in clinic was made available where people could talk confidentially or have their feet examined and discuss care plans. As most of the sessions were aimed at a specific ethnic group, interpreters and same language carers / English speaking friends were on hand to translate as required.

A drawback to advice sessions is the difficulty in collating specific information regarding age and diabetic status / history. Attendance at the drop in clinic after the advice session was voluntary and therefore it was not possible to gather detailed medical information from participants who chose not to use the drop in.

Before the start of the project there were no interventions specific to people from BME areas. The nearest clinic which was accessible to patients from the area was a mile outside of the area. This clinic closed in January 2010 and the next nearest podiatry clinic was 3 miles outside of the project area. The podiatry service adheres to Trust and DH policies regarding equality and diversity. Interpreters and male and female clinicians are available upon request. All staff are aware of and adhere to trust policies regarding equality and diversity.

As a direct result of the two year project a clinic at the Royal South Hants Hospital (RSH) which is in the centre of the project locality, is now running twice a month with the capacity to increase to once a week if required.

Advice sessions taken to the targeted communities via coffee mornings and day centres etc. were an accessible, non threatening and relevant way to impart foot health advice, thus improving awareness of foot health risks and service access and helping to reduce the incidence of future foot health problems. This service is likely to continue. It is envisaged that each venue will be visited annually. Work is currently in progress with a diabetes specialist nurse to arrange joint diabetes advice sessions to ensure that all aspects of diabetes are covered and not only related to the foot.

**Quality, innovation, prevention and productivity outcomes achieved**

**Phase 1**

During phase 1 there was a high failure (DNA) rate of over 50 percent of diabetic service users attending booked clinical appointments, although at the time of booking they were willing to attend. Feedback was that many people found it uncomfortable or difficult to come ‘outside’ of their local area for treatment.

**Phase 2**

During phase 2, 19 people were referred in to podiatry services for ongoing podiatry care. 15 of them were diabetic with a foot problem which had not been treated previously.

Using the RSH Diabetic Resource Centre as a clinical location, over a 3 month period the failure (DNA) rate is down to 22 percent. Overall 30 percent of appointments were new patients with 63 percent of them diabetic. 32 percent of patients were from a BME background.

**Patient Feedback**

Due to the ethnic diversity of the population and the subsequent language barriers, a written questionnaire was not used. Feedback was therefore verbal wherever possible and noted by the attending podiatrist.

The type of information collected included attendance / failure to attend rates; existing patient or new to the service; opinion on the service; age; sex; ethnicity; disability; clinical information such as whether patients had diabetes; whether onward referral was required; whether there was presence of a foot problem (e.g. ulcer, callus etc.).

Feedback from drop in sessions highlighted that many people found it uncomfortable or difficult to come ‘outside’ of their local area for treatment. People were generally aware that services were available but were not sure how to access them. Awareness of the importance of good foot health and diabetes in this area was low.

Feedback from visiting advice sessions highlighted that many people are unable or unwilling to obtain appropriate advice due to physical disabilities, age related infirmness and ‘not knowing where to go’. Awareness of the NHS podiatry services available to them and the importance of good foot health was poor.

**Health economic benefits**

The project work undertaken was over and above the normal podiatry service provision.

The RSH clinic situated within the project area was already a part of the service but only for diabetics with chronic ulcerations. Due to reorganisation of clinic locations and services provided at these

locations, the freeing up of a possible day a week at the RSH has not incurred any direct costs and addresses some of the findings of the project.

The running of advice sessions incurs the cost of a band 6 podiatrist at each session and the costs of administration and travel. The knock on effect of the advice sessions is the increase in awareness which results in an increase of diabetic patients into the service as a result which incurs an ongoing cost for continued care.

#### **Measures/metrics were used to assess the success of the project**

The measures/ metrics used were verbal feedback from patients, DNA rates and numbers of new patients diagnosed as diabetic who required foot care.

During phase 1 of the project 387 people used the services offered by the project.

During phase 2 of the project 357 people used the services offered by the project, of which 53 were health care professionals.

Over the course of the project 691 people of all races, but mainly from BME groups, received advice or treatment regarding foot health and diabetes, and 53 health professionals received podiatry, diabetes and foot health awareness training. A total of 744.

The project was unable to identify all people who were diabetic due to the nature of the delivery of advice to groups and diabetic data is based on drop in and referral data only. 68 people were identified as diabetic from attending a drop in. Over 50 percent of the people identified with diabetes were not aware of the foot health risks associated with their condition and 76 percent of people who were identified as diabetic had an existing foot problem.

Over the course of the project the total number of new patients who were identified as diabetic and required a clinical appointment for a foot problem was 32 in phase 1 and 15 in phase 2. This is 47 new patients in total from an identified 68 diabetics.

To summarise the findings from the project:

- Almost 10 percent of the 691 people reached by the project were identified as diabetic.
- 76 percent of people identified as diabetic had an existing foot problem.
- 69 percent (47) of the 68 people identified as diabetic had not received any professional treatment for an existing foot problem.

Comparing the reduction in DNA rates for clinical appointments when the clinic was relocated to the local area:

- Overall the service has a DNA rate currently of less than 8 percent.
- Phase 1 of the project showed the DNA rate to be above 50 percent within this population when offered an appointment in a location 1 mile outside of the project area. Relocation of the clinic to within the project area shows a DNA rate of 22 percent.

Future work in this area would be beneficial to try to measure the percentage of people with diabetes and / or other medical conditions which put them at risk of disease associated foot complications, who attend advice sessions. Any future project using advice sessions as a pathway to reach people from areas of high BME populations may wish to incorporate an 'approach the patient' technique after the advice session to establish if they are at risk as described above. Solent West Podiatry Service will be piloting this technique with future advice sessions and will evaluate its effectiveness in measuring this

outcome.

To measure existing foot complications clinically at advice sessions is not possible and any service wanting to measure this as an outcome would require clinical premises at the advice sessions and have 100 percent of advice session participants willing to be assessed. As very few of the premises used have such a facility this is not a viable option.

**Pathway/ intervention used**

Patient care changed by allowing an open access approach. The drop in clinics enabled people to attend without the need to see a GP or fill in a self referral form. Further appointments or onward referral could be made at the first point of contact.

The visiting advice and drop in sessions were the most effective way of reaching people. Taking the service to the patient raised awareness and resulted in people with foot problems feeling comfortable within their own environment with interpreters on hand to approach and ask for help.

**Resources/ workforce required to initiate and deliver the project**

- Premises to hold the drop in within the project area were required for the project to go ahead.
- To secure phase 1 funding a business partner from an outside agency was required.
- Two band 6 podiatrists with a background in health promotion and diabetes were required.
- Administrators for administrative duties relating to the project were required.
- Project lead to support the team and ensure the project was on track and meeting its aims.
- The project shows that a clinical setting within areas of high BME for ongoing care is necessary to ensure that this population is reached.

To initiate the first phase of the project the funding required totalled £6,492.29 (costed 2008)

12 drop in sessions at 3.5 hrs per session	£1,507.59
12 clinical sessions at 3.5 hrs per session	£1,507.59
6 x 2 hrs of visiting group advice sessions	£430.74
4 x 1 hr AHP advice sessions	£143.58
24 hrs administration	£861.48
24 hrs management time	£1,031.31
Travel cost (238 miles per annum)	£179.00
Consumables (gloves, dressings etc. at £2 per patient)	£446.00
Clerical Administration	£385.00
<b>Total cost</b>	<b>£6,492.29</b>

The phase 2 of the project removed the need for specific clinical sessions and consumables and also significantly reduced the need for clerical administration. Travel time and costs increased as did time spent in advice sessions. There was also a need for a second podiatrist due to some lone working concerns.

12 drop in and advice sessions of 5.5 hrs average per session	£2,376
4 x 2 hrs AHP advice podiatry	£287.16
24 hrs administration	£861.48

24 hrs management time	£1,031.31
Travel costs (357 mile per annum approx)	£268
Clerical administration (10 hrs approx)	£100
Podiatrist to support with lone worker issues (3 x 5.5 hrs)	£594
<b>Total cost (costed 2009)</b>	<b>£5,517.95</b>

These costs do not take in to account the effect of identifying at risk patients who then require follow up appointments. Also they do not reflect long term savings to the trust by reducing hospital admissions and amputation rates due to early identification of at risk patients.

**Evidence base on which the project is based**

- NICE guidance - Type 2 Diabetes prevention and management of foot problems. Supports the use of patient education in the management of diabetic foot care.
- NSF Diabetes
- Health survey for England 2004 Health of Ethnic Minorities.

NICE Guidance on the use of patient education models for diabetes 2003 (TA60) states that

*'sessions should be accessible to the broadest range of people, taking into account culture, ethnicity, disability and geographical issues, and could be held either in the community or at a local diabetes centre'*

**and**

*'The aim of education for people with diabetes is to improve their knowledge and skills, enabling them to take control of their own condition and to integrate self-management into their daily lives'.*