Integrated Care Fund 2018/19
Project Brief

Project Title	Vascular Podiatry Ceredigion.
Is this a new project or continuation?	New project for Ceredigion but Continuation of existing Carmarthen /Llanelli project
What alternative delivery concept is being tested?	No
In which financial year will the project complete testing of concept?	N/A
Which ICF theme does it align with?	Community health services and burden to social care, with regard to health and well being
Regional Project Lead/Link Representative	Linda Williams. County Director
Local Authority Project Lead/Leads and/or Link Representative/ Representatives	Mike Mulroy, Head of Podiatry. Joanne Morris Principal Podiatrist
HDUHB Project Lead/ Link Representative	Joanne Morris Principal podiatrist
Third Sector Project Lead/ Link Representative	N/A

1. **Background/Rationale:** *(No more than 300 words, including how your proposal (1)* ***tests alternative delivery concepts*** *(2)* ***links with local strategies and plans such as Transforming Clinical Services; Integrated Medium Term Plan; Well Being Plans etc.*** *(3)* ***contributes to regional priorities*** *and (4)* ***supports delivery of objectives within the West Wales Area Plan.****)*

Vascular/diabetic podiatry
Within Hywel Dda University Health Board we are aware that there are significant differences in the incidence of Diabetes. This is reflected in our hospital data that shows we have approximately 20% of in patients in Llanelli with diabetes whereas in Aberystwyth the figure is closer to 15%. This is likely to reflect the differences in overall health and levels of social deprivation of people in these areas. Peripheral Arterial Disease (PAD) incidence in Hywel Dda is not known as it is not yet screened in primary care, but if we go on the CG 147NG Lower Limb Arterial disease estimations of 20% of people over 60 years, and the fact that due to social deprivation, and our increasing aging population within Hywel Dda that figure may be higher in this health board. However all these patients are currently being referred to vascular surgeons for assessment and management and the waiting list for vascular referral is rising. This adds to cost for Hywel Dda now as the vascular service is now based outside our health board in ABMU.
Outpatient attendances in vascular services have increased considerably over the past three years in Ceredigion vascular service was almost non existent , however with the new SLA for vascular services for Hywel Dda there is cover of Vascular surgeon once a month in Bronglais

hospital and it is essential that these attendances can be supported by Advanced practice podiatry for a co-ordinated and more efficient service. Linking Primary Care and secondary care vascular patients and their management to a visiting vascular team to improve that patient contact and make the use of the monies spent for this service to be more effective, and deliver better patient outcomes.

This new vascular podiatry team will address the new referrals and triage them in community clinics before referral to secondary care teams.
Vascular podiatry in OPD clinics can also undertake vascular consultant follow up appointments, reducing long follow up waiting lists.
Treatment for complications and related co-morbidities represents much of the total cost for diabetes. The main possible cost savings are focused on achieving a reduction of avoidable emergency admissions (Ambulatory Care Sensitive Conditions) due to complications of diabetes and co-morbidities.
Clinical evidence suggests that there is considerable potential to improve the quality of foot care for people with diabetes. Targeted preventive services from podiatry and trained Nursing teams can identify those at risk of ulceration and improve outcomes, and rapid access to multidisciplinary foot care can lead to faster healing, fewer amputations and improved survival. This will lead improving patient outcomes; strong links to the community podiatry services can generate savings for the NHS that exceeds the cost of the team.
Evidence for this type of service from Manchester based circulation service has shown Referrals have been reduced by over 30% (North Manchester leg circulation service, 2014) and amputations have been reduced by over 50% (Diabetes UK, 2014) where hospitals have introduced multidisciplinary foot care teams and promoted rapid access to them. In addition, through the reduction of costly amputations, such teams can save over four times their cost.

Community vascular assessment clinics can be set up in the Ceredigion area , and link to vascular secondary care team from neighbouring health board, provides a patient pathway for management of peripheral arterial disease for Hywel Dda patients across health boards, addressing the acute vascular problems and prompt referral and also addressing the prevention agenda for these patients at an earlier stage.
This meets with the aims of transforming clinical services, and the IMTP, and well being plans.

2. **Purpose: What will you do and how will you do it?** *The proposal should support at least one of the aims identified within the Welsh Government* Guidance *for use of the ICF. Please outline how your service would meet a particular Aim (or Aims).*

ICF Aim	Description of how your proposal will meet the Aim(s)
Partnership working and co-operation Regional partnership boards must utilise the ICF to support schemes and activities that provide an effective integrated and collaborative approach in relation to the following regional partnership board priority areas for integration: □ older people with complex needs and long term conditions.	The aim is to change the focus of intervention on the low risk diabetic and PAD patient so that at this stage when the patient is first diagnosed with these chronic disease, emphasis is placed on the possible complications and their avoidance. This service is to be further supplemented by the development of a Specialist vascular podiatrist working with the vascular team. This podiatrist would be able to asses the patient for Lower limb peripheral arterial disease (PAD) which is a marker for increased risk of cardiovascular events even when it is asymptomatic. The most common initial symptom of peripheral arterial disease is leg pain while walking, known as intermittent claudication. Critical limb ischaemia is a severe manifestation of peripheral arterial disease, and is characterised by severely diminished circulation, ischaemic pain, ulceration, tissue loss and/or gangrene. Incidence is also high in people who smoke, people with diabetes and people with coronary artery disease. In most people with intermittent claudication the symptoms remain stable, but approximately 20% will develop increasingly severe symptoms with the development of critical limb ischemia. A MDT care pathway has been developed which will ensure that there is an integrated and collaborative approach to all the factors above, together with addressing the prevention agenda for chronic disease. Linking to all public health schemas for improving the quality of life for the Hywel Dda patients.

ICF Aim	Description of how your proposal will meet the Aim(s)
Prevention There is a need to focus on prevention and early intervention to make services sustainable into the future. Section 15 of the Act places statutory duties on local authorities to providing or arrange the provision of preventative services to achieve various purposes set out in subsection 15 (2) of the Act, including preventing or delaying the development of care and support needs. Local authorities and local health boards must when exercising their functions have regard to the importance of achieving these purposes in their areas. Further guidance and detail on section 15 is set out within the Code of Practice in relation to	This new role based in community setting close to home for the patient would assess and manage these patient's who are not yet needing vascular surgery intervention and tackle the engagement of the patient to management prevention for further deterioration before the need of referral to secondary care, and reduce vascular waiting lists. This role would concentrate on vascular assessment, taking into account management of high blood pressure, suboptimal cholesterol, poor glycaemic control, smoking cessation, and lack of CV exercise and BMI> 30 and link with structured programmes for all these. It would monitor the adherence to these programmes while monitoring vascular status and starting foot pressure relief for potential problems of foot care and therefore preventing ulceration. This would then have an effect on the amputation rates in Hywel Dda, which in turn would effect the high costing of amputees in the community and for social services. So it will maintain older people's independence and unnecessary hospital admissions. (Intermediate Care Fund Guidance, Aim 1.3) (ICFG, Purpose and objectives 2.2, a support frail and older people).

3. **Outcomes:** *Please list which of the outcomes from the regional outcomes framework attached will your proposal contribute towards and how it will do so (minimum of 1, maximum of 3.)*

Regional Outcome(s)	Description of how your proposal will meet the Outcomes(s)
Citizens access the right information, when it's needed, in the way they want it and use this to manage and improve their well-being.	Vascular assessment at an earlier stage before tissue loss, a proactive service instead or a reactive service, taking into account management of high blood pressure, suboptimal cholesterol, poor glycaemic control, smoking cessation, and lack of CV exercise and BMI> 30 and link with structured programmes for all these.

Citizens get the right care and support, as early as possible	Recent development of a Limb at risk pathway as part of the role of the new vascular podiatrists, which is across two health boards is now under final approval. This pathway will ensure prompt referral and treatments for acute vascular or diabetes emergencies are seen by the right people in the right place in an appropriate timescale. The acute problems together with the prevention agenda will be addressed and also vascular podiatry providing the link from primary to secondary care for seamless management, of diabetes and vascular disease.
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4. **Implementation Timescales –** *please indicate the following:*

When will project development commence?	The project has commenced in Carmarthen and Llanelli , some funding has been received in Pembrokeshire however no funding has been given to Ceredigion area for this service to develop.
When will initial expenditure commence?	Appointment of a Band 7 Advanced practice podiatrist
When will staff recruitment commence (if required)?	ASAP
When will project delivery commence?	Funding pending
Expected date of completion of project concept testing.	On going in Carmarthen /Llanelli and Pembrokeshire
Expected date of project review/embedding learning into mainstream practice or termination.	On going

5. **Amount Requested** (*include detailed breakdown of costs and if revenue or capital*)

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6. **Proposed Performance Indicators:** *(What will it enable you to achieve in addition to what you are doing now. i.e. how many additional participants/outcomes? Please refer to ICF 17/18 C)*

Performance Indicators	
How much will you do? (Quantity)	**How well will you do it? (Quality)**
• Percentage of people that received the right information or advice when they needed it • Percentage of people whose care and support has helped them have a better quality of life	• Reduction in amputation rates, for HDHB allowing patients to maintain mobility • Raise awareness and encourage early referral of Peripheral arterial disease

• Citizens understand what care, support and opportunities are available and use these to help them achieve their well-being.	• Offer patients an appointment within 1 month of referral • Perform non-invasive peripheral arterial assessments and diagnosis • Provide education on cardiovascular risks and healthy options • Promote best medical therapy in partnership with General practice • Negotiate key healthy lifestyle changes – smoking, exercise and well-being • Refer patients with severe or deteriorating circulation problems to vascular consultants • Provide a fast communication link from secondary or primary care teams to vascular consultant in neighbouring trust • Refer patients with non –vascular symptoms to other clinical services • Promote independence ,reducing long term health and social burden
How will people be better off as a result? (Quality and Quantity of effect)	
All of the above quality statements.	

7. Sustainability: *After testing and review, how will successful concepts be incorporated into either mainstream delivery, IMTP, TCS, Area Plan or Well-Being developments and what is the exit strategy? (no more than 100 words*)

To continue with changes to pathway and increase number of assessment clinics, to reach as many patients as possible in Hywel Dda.
Provide links from primary to secondary care for diabetic and vascular disease.
Continue health care education for better treatment planning and referrals to HCP's and MDT.
Sustainability of this will be the savings made in amputation rates (estimated at £75,000 per Above knee or Below knee for each patient) also the new at risk pathway will be redirection services from secondary care to community podiatry.

9. What are the implications if this business case isn't supported?

Increasing amputation rates, together with increasing age of population, and increasing diabetes.
Continued ICF Funding would therefore have an impact on those patients using social services stopping them from becoming chronic reducing some numbers for residential care

as they would be more mobile, and promoting independence and mobility enabling patients to remain in their own homes.

10. **Please provide supporting evidence of engagement with key stakeholders, in the development *or* delivery of the project, particularly 3rd sector and community partners when alternative delivery concepts are being tested.**

This is also key for Diabetes UK and WAG and their prevention agenda**.**

11. **Please ensure a completed 12 month budget profile is attached.**