Retrospective service evaluation of a single-region First Contact Practitioner Podiatry service

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Background

Funded by Additional Roles Reimbursement Scheme yet roles still in infancy

National variation in implementation approach and clinical scope

Job plans may include:

- Econsult list reduction
- Internal/external referral
- Case review +/- ‘clinical firm’ model
- Pathway focused work (e.g., gout pathway, or PVD reduction) +/- QoF/IIF contribution

Little empirical evidence about demand, optimal scope, and how to adjust for regional demographic/ population health needs

Methods

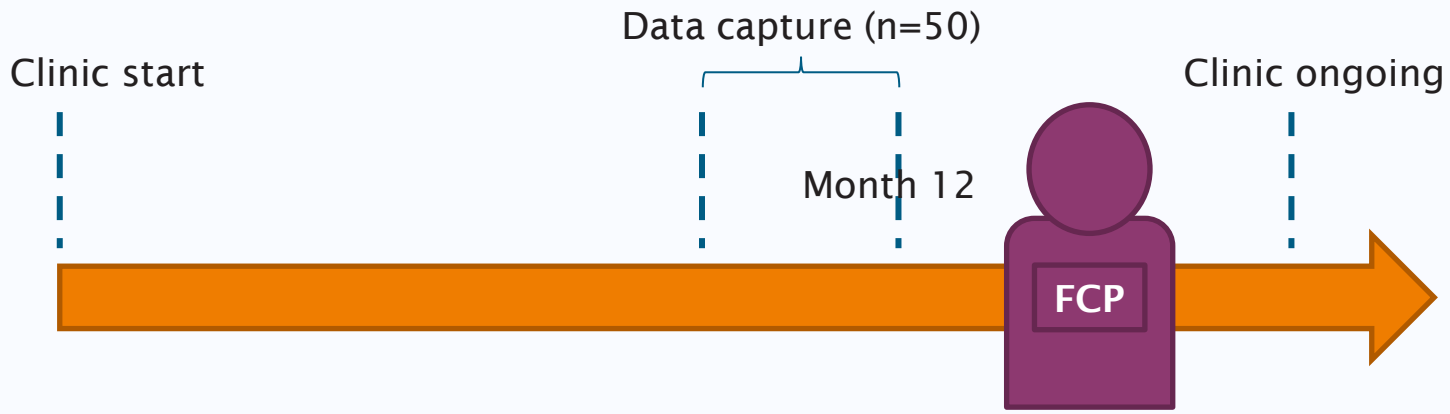
A single-region FCP clinic was iteratively piloted over a 12-month period

Minimal instruction given to teams; ‘below the knee comes to me’

50 cases were retrospectively reviewed from month 12 backwards

Data captured regarding:

- Referral method/ econsult
- Nature of consultation
- Consultation outcome



Results- what did we see?

Main presenting complaint	N=
Dermatological	22
Musculoskeletal	20
Neurovascular	4
Paediatric	2
Pain (non-MSK)	2

Dermatological =
- Nail complications (O/X, O/C, O/M)
- Rashes & blisters (TP, VP, eczema, psoriasis, DM EB, chillblains)
- Wounds (DM ulceration, 2 x people with learning disability)

Musculoskeletal =
- Ankle injury
- Arthritis (non-diagnosed inflammatory & OA)
- Gout
- HAV
- Pain (single & multi-site)
- Extra-articular (e.g., neuroma/ bursa)

Neurovascular =
- Pain (complex, night, cramping, IC)
- Gait change & weakness

Paediatric =
- Talipes progression
- ‘growing pains’
- Nail health

Results – what happened next?

Main consultation outcome	N=
Supported self-care	28
Podiatry referral	11
Other referral	11

- 56% supported self-care
- Of podiatry referral, 8 x orthoses, 2 x nail surgery, 1 x high-risk status needing wound care
- 22% needed immediate wound care and advice
- Other referrals included:
  - Dermatology
  - Rheumatology
  - Radiology/ orthopaedics
  - Diabetes MDT & TVNs
  - Talipes clinic
  - Age UK foot care services
  - Smoking cessation
  - Social Prescribing Link Workers

Discussion – the ‘extra actions’

Initially clinics were slow to fill; referral methods and case complexity came with time

GP supervision is essential; ‘extra actions’ came with time, including:

- Hypertension review
- Medicine review, prescribing recommendations
- QoF/IIF contribution e.g., Diabetic foot health assessment
- Case reviews & joint consultations
- Supported Shared Decision making; e.g., mobility plans, surgical referral, medicine use, healthcare access

Patient satisfaction consistently rated as ‘outstanding’ or ‘excellent’

Time and flexibility is needed to develop and adapt a bespoke service

Discussion & recommendations

- ✓ Our clinic offer is limited by FCP confidence, capability and availability = **potential**
- ✓ There is evidence that the service addresses a need & is well-received = **meets need**
- ✓ Starting with broad scope and iteratively developing as a team worked well = **responsive**
- ✓ One size is unlikely to fit all – PCNs vary in nature, as do population demographics, therefore working with local partners is essential = **collaborative**
- ✓ Need to consider local and system level workforce planning; talk with NHSE/ regional AP centres/ ICB/ AHP faculty/ primary care school colleagues… = **sustainable**
- ✓ FCP network, via RCPod, is a useful resource = **peer support**

YOUR QUESTIONS

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