

CAPABILITY FRAMEWORK FOR INTEGRATED DIABETIC LOWER LIMB CARE: *A USER'S GUIDE*



The Diabetic
Foot Journal



CAPABILITY FRAMEWORK FOR INTEGRATED DIABETIC LOWER LIMB CARE: A USER'S GUIDE

The following companies provided unrestricted educational grants to support the publication and distribution of this document:



Short-Life Working Group

Joanne McCardle, Independent Consultant Podiatrist*
Leanne Atkin, Lecturer Practitioner/Vascular Nurse Consultant, Yorkshire
Graham Bowen, Clinical Lead for Podiatry, Southampton
Paul Chadwick, Visiting Professor Birmingham City University, Birmingham
Fran Game, Consultant Diabetologist, Derby
Martin Fox, Vascular Specialist Podiatrist, Manchester
Christian Pankhurst, Clinical Specialist Orthotist, London
Debbie Sharman, Consultant Podiatrist – Diabetes, Professional Lead for Podiatry, Dorset
Duncan Stang, Diabetes Foot Co-ordinator, Scotland
David A Wylie, Head of Podiatry, Greater Glasgow & Clyde

2012 Development Group

Joanne McCardle, Advanced Acute Diabetes Podiatrist, Edinburgh
Paul Chadwick, Principal Podiatrist, Salford
Graham Leese, Consultant Physician, Dundee
Alistair McInnes, Senior Lecturer, Brighton
Duncan Stang, Diabetes Foot Co-ordinator, Scotland
Louise Stuart, Consultant Podiatrist, Manchester
Matthew Young, Consultant Physician, Edinburgh

How to cite this document:

Short-life Working Group. *Capability Framework For Integrated Diabetic Lower Limb Care: A user's guide*. London: OmniaMed Communications Ltd. 2019. Available to download from: www.diabetesonthenet.com

Publisher

Omniamed Communications Ltd
108 Cannon Street
London
EC4N 6EU, UK

Tel: +44 (0)20 3735 8244
Web: www.diabetesonthenet.com

Copyright remains with the original TRIEPodD-UK, SDFAG and FDUK professional groups.

Front cover images: *Top right*: courtesy of Martin Fox.
Bottom right, bottom left, top left: iSTOCKPHOTO

*At time of print, Joanne McCardle is National Diabetes Specialist at Urgo Medical.

Foreword	4
Capability statements in context	5
Frequently asked questions	7
Capabilities statements	9
1. Generic	9
2. Screening and assessment	11
3. Dermatology	12
4. Pharmacotherapy	13
5. Peripheral arterial disease	14
6. Radiology	16
7. Painful diabetic peripheral neuropathy	17
8. Ulcer and lower limb amputation prevention	18
9. Wound management	19
10. Post-ulcer care	22
11. Charcot neuro-osteoarthropathy	23
12. Health improvement	24
13. Research and audit	25
14. Leadership	26
15. Load distribution, load sharing and axial offloading in an active diabetic foot	27
16. Psychology screening and assessment	29
References	30

We are delighted to bring you the *Capability Framework For Integrated Diabetic Lower Limb Care: A User's Guide*, an update of the *Podiatry Competency Framework For Integrated Diabetic Foot Care: A User's Guide* (TRIEPodD-UK, 2012).

The *Diabetic Foot Competency Framework* (Scottish Diabetes Foot Action Group and Skills for Health, 2010) remains one of the pioneering clinical competency frameworks that is underpinned by theoretical components. The original user guide was developed by the professional groups TRIEPodD-UK, FDUK (Foot in Diabetes UK) and SDFAG (Scottish Diabetes Foot Action Group) to identify and standardise podiatric clinical competencies in diabetic foot care, from clinical practice through to research and leadership.

In the current climate it is essential that these skill sets are transferable and adaptive to the needs of the whole workforce, not just podiatry. As such, the framework has been updated to be relevant for other clinicians in the multidisciplinary foot team, such as clinical support workers, GPs, orthotists, surgeons and tissue viability nurses; in fact, anyone that comes into contact with the diabetic foot. We have also used this opportunity to reflect current practice and have adopted the terms 'core skills and capability' instead of competency. This aligns with modern frameworks and Skills for Health.

This framework continues to be an important tool to facilitate benchmarking of existing skill sets, and to guide the professional development of clinicians who are not only keen to become specialists in diabetes foot care, but also those who review patients with diabetes. As the framework spans all levels of practice – from healthcare technicians to consultant clinicians – managers and services providers can use the framework to assess the scope and capability of their workforce. Whilst we cannot provide a monitoring tool, we have added a self-scoring element to each dimension so you can record your own capability.

The recent development of the multi-professional framework for advanced clinical practice in England (NHS Health Education England, 2018) and the advanced practice toolkit in Scotland (NHS Education for Scotland, 2018) provides an opportunity to map the core skills and capabilities within this document to the developing education and apprenticeship agenda across the UK. Moving forward, it is envisaged that there will be a capability framework related to high-risk lower limb disease for all practitioners.

This user guide was produced by a Short-life Working Group comprising members from TRIEPod-UK, SDFAG and FDUK and experts in the field of the foot in diabetes. There are three new dimensions: "Peripheral arterial disease" (page 14), "Load distribution, load sharing and axial offloading in an active diabetic foot" (page 27), and "Psychology screening and assessment" (page 29). I am sure you will agree that these are reflective of our current needs in clinical practice.

Our main aims throughout practice is to ensure that all people with diabetes in the UK have their feet cared for by healthcare professionals with appropriate skill sets to improve patient outcomes, such a ulcer-free and amputation-free survival.

Dr Joanne McCardle
Chair of Short-Life Working Group

Foot disease is a devastating complication of diabetes. Diabetic foot complications are the largest single reason for hospital admissions among people with diabetes (Boulton et al, 2005), and the financial implications are correspondingly huge. The NHS cost of diabetic foot ulcers (DFUs) is estimated at £1 billion per year (Kerr, 2017; Guest et al, 2018), but this does not include the additional social costs, which are estimated at £13.9 billion per year.

Additionally, survival rates post-ulceration are up to 60% and rates of mortality in DFUs are higher than for certain cancers (Robbins et al, 2018). With this in mind, it is essential that clinicians, service leads and commissioners have a tool that can support development of appropriate staff and services.

The indirect, intangible costs to the person with diabetic foot disease are also high, with many unable to work and experiencing a poorer quality of life than those without foot disease (Vileikyte, 2001).

A CAPABILITY FRAMEWORK FOR DIABETIC FOOT CARE

As the UK population with diabetes continues to grow, so too will the demand for foot care. Diabetes UK (2019) estimates that there are around 4.7 million people with diabetes in the UK, and by 2025, it is expected that this number will reach 5 million. In the ‘Burden of Wounds’ Study, Guest et al (2015) estimated there were 169 000 diabetic foot ulcers across the UK, equating to 5% of adults with diabetes having a foot ulcer. Meeting the foot care needs of this growing group is likely to require the redesign of current services and an increase in the size of the workforce delivering foot care (McCardle, 2008).

In the UK, clinicians providing diabetic foot care – from basic screening through to holistic management of diabetic foot complications – have attained their professional skills in a range of ways; there is no standardised route by which the theoretical and clinical skills needed to provide safe and effective diabetic foot care are obtained (Stuart and McInnes, 2011). Current workforces still require a structured approach to detailing professional capabilities in the delivery of diabetic foot care.

In answer to this need, a group of clinicians involved in diabetic foot care came together to develop the *Podiatry Competency Framework for Integrated Diabetic Foot Care* (TRIEPodD-UK, 2012). This comprehensive document

began the process of establishing standards of professional competence in delivering diabetic foot care to improve patient outcomes, at all levels.

This updated user guide is divided into 16 dimensions of capability (pages 9–29). Three new dimensions have been incorporated, “Peripheral arterial disease” (page 14), “Load distribution, load sharing and axial offloading” (page 27), and “Psychology screening and assessment” (page 29). The “Load distribution, load sharing and axial offloading” and “Psychology and assessment” capabilities were written for this edition. The “Peripheral arterial disease” dimension was originally published in *The Diabetic Foot Journal* (McCardle and Fox, 2013) and has been updated and incorporated.

The dimensions are divided into Levels A–F, which reflect increasing complexity of care. The working group wishes to stress that no single clinician needs to possess all of the capabilities to the highest level, rather these capabilities should be reflected across the team or service responsible for delivering local diabetic foot care.

CAPABILITY BENCHMARKING

Within this framework, we have also added a simple scoring guide for clinicians to self-assess, record and benchmark their own capabilities and skill set against five levels. This is based on the *Tissue Viability Leading Change Competency Framework* (2015) method of scoring.

- Level 1:** You have observed the skill/procedure in a practice setting.
- Level 2:** You have participated in the skill/procedure under direct supervision.
- Level 3:** You have performed the skill/procedure on a number of occasions and required minimal supervision.
- Level 4:** You can perform the skill/procedure safely and competently, giving the rationale for your actions.
- Level 5:** You are able to critically appraise/teach the skill/procedure to others.

Achievements and goals for each capability can also be documented and recorded.

WHO IS THE FRAMEWORK FOR?

Diabetic foot care is best delivered holistically and within a multidisciplinary team (MDT) context. As such, the consensus of the working group was that this updated user guide should be updated to be relevant to all healthcare

professionals working in diabetes care. The complexities of diabetes foot care from low-risk to active foot disease require different levels of skill, and this framework aims to support development in this specialised area. The framework continues to have benefits for clinicians, patients and managers/service leads and commissioners.

Clinicians can use the framework to:

- Benchmark their existing skills and capabilities.
- Identify areas in which to increase their capability.
- Support them in planning performance reviews.
- Identify a career pathway in the specialism of diabetic foot care.

Patients will benefit from the adoption of the framework by clinicians and services by:

- The assurance that they will be treated by a clinician with core skills and capabilities specific to the management of the diabetic foot, relative to their level of need.
- The emphasis the document places on patient empowerment, education and, wherever possible, self-management.
- The improvements in patient outcomes that should flow from receiving care from a workforce that is demonstrably competent in the care of the diabetic foot.

Managers and commissioners can use the framework to:

- Streamline services (in line with NHS Modernisation Agency [2005] guidance) by ensuring the right mix of staff capabilities to meet the various levels of foot care needed by people with diabetes.
- Plan appropriate professional development activities, leading to improvements in staff satisfaction, retention, and succession planning (McCardle, 2008).
- Define those capabilities that they require groups or individuals tendering to deliver diabetic foot care services under “any qualified provider” initiatives (DH, 2011; 2012) to be able to demonstrate.

Educational and training institutions can use the framework to:

- Ensure their curriculums include training in appropriate diabetic foot capabilities; specifically, Level C capabilities are appropriate for new clinical graduates.
- Identify where gaps exist in the provision of continued professional development courses.

WORKFORCE PLANNING BASED ON PATIENT NEEDS

Reliance on the podiatry workforce alone for the management of all levels of foot care for people with diabetes is believed to be unsustainable (Diabetes UK and NHS Diabetes, 2011). The multidisciplinary team approach should enable an increase in capacity. *Figure 1* is a helpful aid to understand the hierarchy of foot care needs of people with diabetes based on their DFU risk and the capabilities required for care.

Patients at low risk of diabetic foot disease

People at low risk of diabetic foot disease have no risk factors present, e.g. loss of sensation or evidence of peripheral arterial disease (SIGN, 2017), but may have some degree of callus (NICE, 2015). They comprise approximately 70% of adults with diabetes (Leese et al, 2011). Leese et al (2011) estimate that this group have a 1 in 500 chance of foot ulceration per year. With a low risk of ulceration, this group do not require routine podiatry care. However, they do require annual screening and foot care education. Furthermore, they should have access to a diabetic foot care service within one working day should their foot rapidly deteriorate.

Several groups (SIGN, 2017; Diabetes UK, 2017) recommend that the first healthcare professional to see the patient with diabetes in any given calendar year should provide foot screening if they are competent to do so.

The capabilities required to provide care for this group are detailed in Levels A–C of this framework.

Patients at moderate risk of diabetic foot disease

This group includes patients classified at moderate for diabetic foot disease as per NICE (2015) or SIGN (2017).

People with significant peripheral sensory and/or arterial impairment at moderate risk, who have not had an episode of active foot disease, comprise approximately 20% of the adult population with diabetes (Leese et al, 2011). The risk of people within this group ulcerating is between 3% and 7% per year (Leese et al, 2011).

It is recommended that this group receive regular podiatry care, depending on individual needs. This care should be provided in dedicated diabetic foot care sessions at community treatment centres where available. They should have access to a diabetic foot care service within one working day should their foot rapidly deteriorate

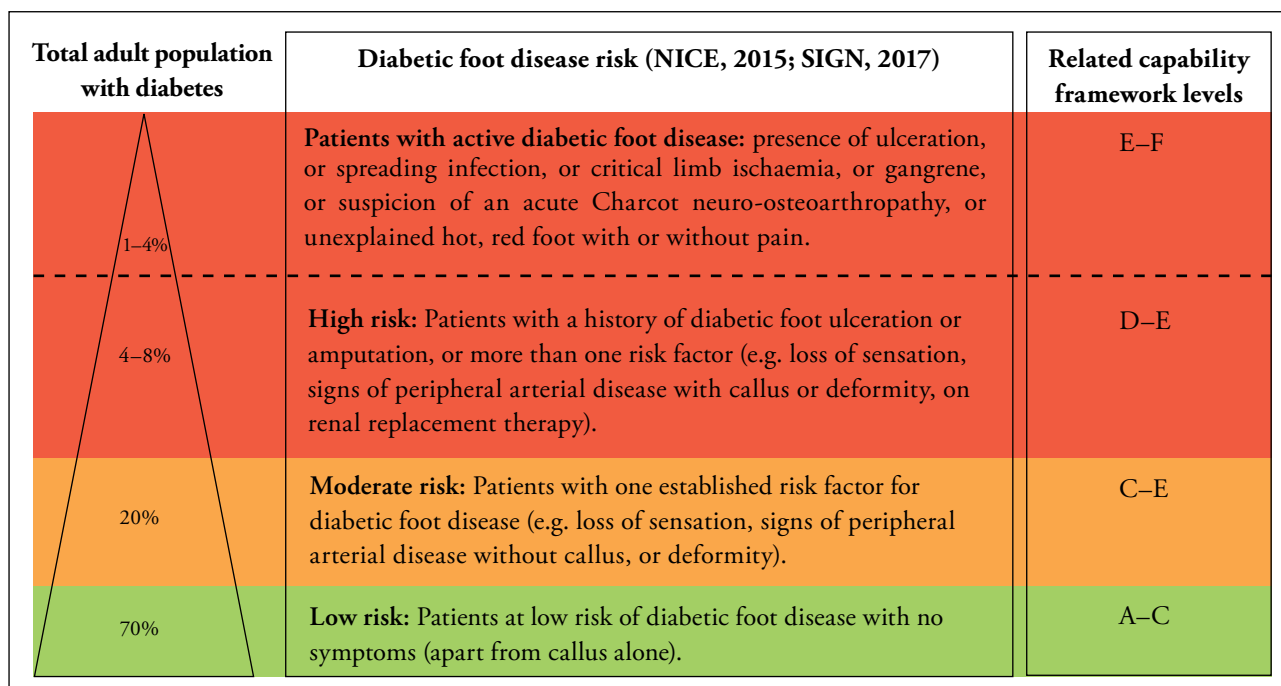


Figure 1. A representation of the adult population with diabetes, their risk of diabetic foot disease, and the capability framework levels related to their care (Leese, 2011; TRIEPoD-UK, 2012; NICE, 2015; SIGN, 2017).

(NICE, 2015; Diabetes UK, 2017; SIGN, 2017). The capabilities required to provide care for this group are detailed in Levels C–E of this framework.

Patients at high risk of diabetic foot disease

This group are at high risk of ulceration (NICE, 2015; SIGN, 2017) having more than one risk factor present or having had at least one previous episode of active foot disease (including those who have undergone a diabetes-related amputation). This group forms 4–8% of the adult population with diabetes (Leese et al, 2011). This group has a 40–50% risk of reulcerating each year (Maciejewski et al, 2004; Pound et al, 2005). The high risk of active foot disease in this group necessitates careful follow-up by appropriately skilled podiatrists in the community-based foot protection team (FPT) who have robust support from, and referral pathways into, the MDT. The capabilities required to provide care for this group are detailed in Levels D–E of this framework.

Patients with active diabetic foot disease

Patients classified with an active diabetic foot disease as per NICE (2015) or SIGN (2017) (Figure 1).

At any one time, 1–4% of adults with diabetes have

active foot disease (Leese et al, 2011). This group requires careful management and frequent review by an MDT, with the support of a network of community-based FPTs and nurses who undertake care between MDT clinic visits. It is widely acknowledged that the management of active diabetic foot disease by an MDT improves patient outcomes (Bowen et al, 2008; Canavan et al, 2008; Krishnan et al, 2008; Schofield et al, 2009). The capabilities required to provide care for this group are detailed in Levels E–F of this framework. ■

FREQUENTLY ASKED QUESTIONS

There are a number of recurring questions about the framework. In this section the authors aim to address the most frequently asked questions about the framework.

Q – Do I need to be proficient in all dimensions?

A – No. The dimensions include everything required to manage people with diabetes. This spans basic screening through to complex care of active foot disease. It provides guidance on the capabilities required in each dimension, and the opportunity for the clinician or manager to benchmark existing skills or services against them. For example, if the clinician is a supplementary prescriber, the

capability would be Level E–F. However, if the clinician is not a prescriber, it would be acceptable to be Level D or below. It is for the clinician and managers to decide what capabilities they require, based on individual professional and service needs. It is not compulsory that higher level clinicians have the highest skill levels in all dimensions.

Q – Is the framework applicable throughout the UK?

A – Yes. The framework is not region specific, it provides guidance and clarity on the capabilities required to provide a comprehensive diabetes foot service. It is compatible with both NICE (2015) and SIGN (2017) clinical guidance. It can also be used by commissioners to define the capabilities that they require groups or individuals tendering to deliver diabetic foot care services under “any qualified provider” initiatives to be able to demonstrate.

Q – Is the framework part of professional registration requirements?

A – No. Clinicians are not required to prove capability as defined by the framework in order to practice in the UK; the standards of proficiency to practice are defined by the Health Professions Council. However, the framework is relevant to those providing any level of diabetic foot care and the authors hope it will be voluntarily adopted by these healthcare professionals. The level of integration of the framework into practice should be made at the local level.

Q – Does my level of capability within the framework impact on my Agenda for Change pay banding?

A – There is no direct read-across from the Agenda for Change pay bands and the framework levels.

Q – I am a manager, how can I use the framework?

A – As a manager, the framework can be used to identify the needs of the service by mapping current staff capabilities to the dimensions to ensure all areas of care are covered. It can also be used on an individual basis and linked to the Knowledge and Skills Framework (KSF; administered by the Department of Health; www.dh.gov.uk) to inform professional development plans.

Q – I am a clinician, how can I use the framework?

A – This document is designed to be used by clinicians

to identify their current skill level. It can be used for informing professional development plans. It is also a tool for planning career progression, should you wish to specialise in diabetic foot care.

Q – I am a strategic healthcare planner, how can I use the framework?

A – This document provides guidance on the staff capabilities required across the spectrum of diabetic foot care. It can be used to identify gaps in services, and provide guidance on the capabilities required at each level. It can be used by commissioners or equivalent to define competent providers and services.

Q – Can the framework be used in private practice (e.g. private podiatry practices)?

A – Yes. Private practitioners are often essential in providing core podiatry care for people with diabetes and they can use the framework to identify their capabilities in this area. However, some levels of care described in the framework are only safe to undertake within a supported clinical team and would be unsuitable for clinicians – in any sector – to undertake while working in isolation. ■

CAPABILITY LEVEL KEY

Referenced from the *Tissue Viability Leading Change Competency Framework* (2015):

Level 1: You have observed the skill/procedure in a practice setting.

Level 2: You have participated in the skill/procedure under direct supervision.

Level 3: You have performed the skill/procedure on a number of occasions and required minimal supervision.

Level 4: You can perform the skill/procedure safely and competently, giving the rationale for your actions.

Level 5: You are able to critically appraise/teach the skill/procedure to others.

1. GENERIC

To provide effective care for people with diabetes, clinicians and assistants should be able to demonstrate the following capabilities:

Add your capability level (1,2,3,4,5) in the second column (capability level key on page 8)

<p>1.1 Level A: Healthcare technician</p>	<p>Knowledge</p> <ul style="list-style-type: none"> • A general knowledge of the nature of diabetes, including its signs and symptoms. • Recognises the limits of own knowledge about diabetes. • Aware of national guidance for the diagnosis and management of diabetes (e.g. NICE, SIGN). <hr/> <p>Skills</p> <ul style="list-style-type: none"> • Applies information to clinical context within agreed boundaries and protocols. • Uses relevant patient record systems and decision support tools. • Uses up-to-date information and terminology to communicate with patients and colleagues. • Updates medical histories appropriately. • Undertakes protocol-led clinical examinations within the scope of their agreed practice and capability. • Supports other clinicians in communicating to patients the benefits of good glycaemic, cholesterol and blood pressure control, self care and prevention of complications of diabetes. <hr/> <p>Behaviours</p> <ul style="list-style-type: none"> • Knows when to refer to, and seek guidance from, appropriately skilled colleagues when necessary. • Reflects on and improve their own practice with support from senior colleagues. • Constructively challenges inappropriate practices. • Utilises available professional networks for support, reflection and learning. • Takes responsibility for their own continuing professional development.
<p>1.2 Level B: Healthcare assistant/practitioner</p>	<p>Knowledge, skills and behaviours as for Level A.</p>
<p>1.3 Level C: Qualified clinician</p>	<p>Knowledge as for Level B, and:</p> <ul style="list-style-type: none"> • A general knowledge of the aetiology of diabetes and the potential for development of complications of diabetes. • An understanding of non-pharmacological and pharmacological approaches to the management of diabetes. • Familiar with diabetes-related national guidance and NHS frameworks. • Aware of the World Health Organization (WHO) criteria for diabetes diagnosis. • Can recognise normal and abnormal blood glucose, cholesterol and blood pressure ranges and HbA_{1c} levels, and knows how they are monitored. • Understands national guidelines and NHS frameworks for the appropriate referral pathways for people with diabetes. • A general knowledge of the biomechanical risk factors leading to friction, shear and pressure risk. <hr/> <p>Skills as for Level B, and:</p> <ul style="list-style-type: none"> • Appraises and applies new information on the principles of evidence-based medicine to their practice, taking a critical approach to accessing and applying new information. • Undertakes examination and assessment to form a diagnosis. • Takes and/or reviews medical and medication histories. • Carries out non-physical examinations to determine any mental health, cognition or health-literacy factors which may be present. • Assesses the patient's understanding and reinforces the benefits of good glycaemic, cholesterol and blood pressure control, self-care and monitoring to prevent complications, including the provision of lifestyle advice and signposting to relevant support (i.e. smoking cessation, and exercise and diet advice appropriate to the patient). • Accurately discusses diabetes management with the patient based on available information. • Requests and interprets relevant tests in the management of diabetes. <hr/> <p>Behaviours as for Level B, and:</p> <ul style="list-style-type: none"> • Communicates clearly with the patient about diabetes care, while recognising that the patient may find the diagnosis, or ongoing management, of diabetes stressful. • Seeks out and develops their own professional networks for support, reflection and learning. • Establishes multi-professional links with clinicians within the specialism. • Contributes to health improvement by working with relevant local agencies (e.g. social services, patient support networks).

1. GENERIC *CONTINUED*

To provide effective care for people with diabetes, clinicians and assistants should be able to demonstrate the following capabilities:

Add your capability level (1,2,3,4,5) in the second column (capability level key on page 8)

1.4 Level D: Specialist clinician

Knowledge as for Level C, and:

- Comprehensive knowledge of the aetiology of diabetes and the impact of disease progression.
- Comprehensive understanding of pharmacological and non-pharmacological approaches to the management of diabetes.

Skills as for Level C, and:

- Communicate clearly to the individual what is involved in the assessment and management of the presenting condition.

Behaviours as for Level C, and:

- Able to critically reflect on, and improve, their own practice.

1.5 Level E: Advanced clinician

Knowledge as for Level D, and:

- In-depth knowledge of the aetiology of diabetes and the development of complications of diabetes.
- In-depth understanding of pharmacological and non-pharmacological approaches to the management of diabetes.
- In-depth knowledge of the signs and symptoms of diabetes, including the WHO diagnostic criteria.
- In-depth knowledge of normal and abnormal blood glucose ranges, HbA_{1c} levels and how they are monitored.
- In-depth understanding of diabetes-related national guidance and NHS frameworks.

Skills as for Level D, and:

- Evaluates and interprets clinical information from diverse sources and makes informed judgements about its quality and the appropriateness of disseminating it to colleagues.
- High-level clinical decision making skills that are effectively translated into clinical practice.
- Influences and contributes to the design of patient record systems and decision support tools.
- Employs their in-depth diabetes knowledge to engage with patients about their care.
- Provides patients and/or carers with information that supports them in providing informed consent for clinical interventions.
- Contributes to the development of evidence-based, clinical and cost-effective diabetes care.

Behaviours as for Level D, and:

- Reflects on the performance of their service/clinic relative to other local and national services/clinics.
- Engages in the critical review of their own and others' practice, and learns from them.
- Where appropriate, contributes to diabetes-related local, regional and national guidance and NHS frameworks.
- Seeks out and develops professional networks for their own, and colleagues', support, reflection and learning.
- Establishes and/or monitors the multi-professional approaches to integrated patient care.
- Acts as a professional mentor for junior colleagues.
- Creates formal links with relevant local agencies (e.g. social services, patient support networks, commissioners).

1.6 Level F: Consultant clinician

Knowledge as for Level E.

Skills as for Level E, and:

- Takes a leading role in the development of diabetes-related national guidance and NHS frameworks.
- Takes a leading role in the design of patient record systems and decision support tools.
- Takes a leading role in supporting commissioners and NHS Trusts in developing specialist diabetes foot services locally, regionally and nationally.
- Contributes to the development of evidence-based, clinical and cost-effective diabetes care, and takes a leading role in disseminating this information to colleagues.

Behaviours as for Level E, and:

- Influences national policy on diabetes care.
- Proactively identifies the need for clinical and service innovations to meet the needs of people with diabetes, and takes a leading role designing and implementing these innovations.

Achievements and goals

2. SCREENING AND ASSESSMENT

Screening is an algorithmic process that categorises people into mutually exclusive groups and will give a reasonably good indication of the likelihood/risk of a person with diabetes developing a diabetes-related foot complication, such as ulceration or amputation. **Assessment** is a more complex process requiring clinical decision making by which a diagnosis is reached and treatment/management is initiated.

To effectively carry out diabetes foot screening and assessment, clinicians and assistants should be able to demonstrate the following capabilities:

Add your capability level (1,2,3,4,5) in the second column (capability level key on page 8)

<p>2.1 Level A: Healthcare technician</p>	<p>Screening</p> <ul style="list-style-type: none"> • Carries out recognised and ratified online or face-to-face training to ensure competence is at the required level, thus ensuring screening is carried out in an evidence based, standardised manner. • Clearly communicates what is involved in the screening process to the patient. • Carries out diabetes foot screening in line with training, national guidance and/or local protocols. • Assigns an ulcer risk status based on the results of the screening, using relevant decision making tools when available (e.g. diabetes foot risk stratification and triage traffic light grading system [Crawford et al, 2015]). • Records the screening results on the relevant patient records system(s). • Explains the results of the screening to the patient and/or carer in an appropriate manner. • Provides the patient with verbal and written, up-to-date nationally agreed, foot health advice relevant to the risk status resulting from foot screening. • Aware of, and appropriately uses, local referral pathways for any patient who presents with any condition/concern out with competence level and arranges further assessment.
<p>2.2 Level B: Healthcare assistant/practitioner</p>	<p>As for Level A</p>
<p>2.3 Level C: Qualified clinician</p>	<p>Screening as for Level B</p> <hr/> <p>Assessment</p> <ul style="list-style-type: none"> • Aware of local policies regarding screening and assessment of the diabetic foot. • Carries out thorough assessment of the diabetic foot, including vascular insufficiency, peripheral sensory neuropathy, deformity and infection. • Makes appropriate, specific referrals for specialist intervention.
<p>2.4 Level D: Specialist clinician</p>	<p>Screening as for Level C</p> <hr/> <p>Assessment</p> <ul style="list-style-type: none"> • Aware of local and national guidance and policies regarding diabetic foot screening and assessment. • Facilitates the training of colleagues in screening and assessment according to local policies.
<p>2.5 Level E: Advanced clinician</p>	<p>Screening and assessment as for Level D, and:</p> <ul style="list-style-type: none"> • Provides expert opinion on screening and assessment programmes. • Where possible, participates in the development of local, evidence-based screening and assessment programmes. • Facilitates colleagues' learning of screening and assessment techniques to support service needs.
<p>2.6 Level F: Consultant clinician</p>	<p>Screening and assessment as for Level E, and:</p> <ul style="list-style-type: none"> • Works with stakeholders to develop and implement local, regional and national screening and assessment programmes. • Proactively identifies the need for clinical or service innovations to effectively screen and assess the feet of people with diabetes, and takes a leading role designing and implementing these innovations. • Leads collaborative working and networking with higher educational institutions and other agents to meet the needs of the population with diabetes.

Achievements and goals

3. DERMATOLOGY

To provide effective care for people with diabetes and dermatopathologies of the lower limb, clinicians and assistants should be able to demonstrate the following capabilities:

Add your capability level (1,2,3,4,5) in the second column (capability level key on page 8)

<p>3.1 Level A: Healthcare technician</p>	<ul style="list-style-type: none"> • A knowledge of the appearance of healthy skin. • Recognises changes in ageing skin and how this increases risk of developing skin problems. • Identifies callus and understands how this increases risk of foot ulceration. • Recognises predisposition to skin dryness in people with diabetes. • Refers the patient to a colleague when skin abnormality is suspected or observed.
<p>3.2 Level B: Healthcare assistant/practitioner</p>	<p>As for Level A</p> <ul style="list-style-type: none"> • An understanding of the appearance of healthy skin and recognises simple skin conditions, such as calluses. • An understanding of how dry skin can lead to loss of skin resilience and the potential for tissue breakdown. • Reports care interventions and concerns to senior clinician in a timely manner.
<p>3.3 Level C: Qualified clinician</p>	<p>As for Level B, and:</p> <ul style="list-style-type: none"> • An in-depth understanding of the appearance of healthy skin and recognises common skin conditions. • Recognises dermatological conditions associated with diabetes and how they may increase risk of foot ulceration (e.g. skin dryness, callus, fungal infections) and non-healing wounds (e.g. venous eczema and pyoderma). • Formulates evidence-based treatment pathways for non-malignant, common skin conditions. • Identifies suspicious skin lesions and refers in a timely manner. • Uses the appropriate referral pathway for the investigation of suspected dermatopathologies, including microscopy and culture, biopsies and allergy testing.
<p>3.4 Level D: Specialist clinician</p>	<p>As for Level C, and:</p> <ul style="list-style-type: none"> • A knowledge of dermatological conditions and associated investigations (e.g. biopsy and allergy testing). • Possesses advanced assessment skills and deferential diagnostic skills. • Diagnoses and develops treatment plans for non-malignant dermatological conditions, including appropriate use of topical treatment based on local, regional and national stewardship policies. • Where appropriate, undertakes clinical management of dermatopathologies based on an agreed care plan. • Refers patients directly to dermatology services. • Makes urgent, appropriate referrals to exclude malignancy.
<p>3.5 Level E: Advanced clinician</p>	<p>As for Level D, and:</p> <ul style="list-style-type: none"> • An in-depth understanding of investigations for dermatopathologies, including microscopy and culture, biopsies and allergy testing.
<p>3.6 Level F: Consultant clinician</p>	<p>As for Level E, and:</p> <ul style="list-style-type: none"> • Collaborates with the multidisciplinary team to establish clear referral pathways between relevant services for dermatological intervention and treatment of the diabetic lower limb (e.g. dermatology, plastic and vascular).

Achievements and goals

4. PHARMACOTHERAPY

To provide effective care for people with diabetes, clinicians should be able to demonstrate pharmacotherapeutic knowledge and associated clinical skills in the following capabilities:

Add your capability level (1,2,3,4,5) in the second column (capability level key on page 8)

4.1 Level A: Healthcare technician	Not applicable.
4.2 Level B: Healthcare assistant/practitioner	Not applicable.
4.3 Level C: Qualified clinician	<ul style="list-style-type: none"> • An awareness of the modes of action and effects of relevant medicines, including pharmacokinetics and pharmacodynamics. • An awareness of the potential for unwanted effects (e.g. allergic reactions, drug interactions, precautions, contraindications). • An up-to-date knowledge of relevant products – including licence indications, formulations, doses and relative costs – in the BNF drug tariff. • An awareness of the potential misuses of relevant medicines. • Demonstrates an awareness of no treatment, non-drug and drug treatment options (including preventative measures and referrals for non-drug interventions) and discusses options with patient. • Where applicable, uses Patient Group Directions (PGDs) appropriately in line with local policy. • Where applicable, use Podiatry Exemptions (POM-S and/or POM-A) appropriately, in line with relevant legislation, professional standards and local policy. • An awareness of reporting mechanism for adverse drug reactions (e.g. MHRA yellow card, and submits reports as appropriate).
4.4 Level D: Specialist clinician	<p>As for Level C, and:</p> <ul style="list-style-type: none"> • Where annotated as a Supplementary or Independent Prescriber, practices in line with relevant legislation, personal sphere of competence, professional standards and local policy relating to non-medical prescribing. • An awareness that patient-specific factors (e.g. age, renal impairment) impact the pharmacokinetics and pharmacodynamics of relevant medicines and that regimens may need to be adjusted based on these factors. • If prescribing, gives clear information to the patient about their medication(s), including how/when to take/administer the medications, where to obtain them, and possible side effects. • Ensure that any prescribing decisions are communicated to the GP in writing. • Aware of, and accepts, legal and ethical responsibility for prescribing, within the context of the care plan. • Works within local protocols for prescribing requests and uses as appropriate. • Understands local drug budgetary constraints.
4.5 Level E: Advanced clinician	<p>As for Level D, and:</p> <ul style="list-style-type: none"> • Negotiates treatment plans (including, where appropriate, non-pharmacological therapies) that both patient and prescriber are satisfied with. • Identifies, requests and interprets appropriate blood tests relevant to prescribing activity. • An awareness of common medication errors and medication error-prevention strategies. • Plays a role in developing local protocols for prescribing requests. • Understands current legislation on prescribing practice at local and national levels. • Stores prescription pads (where applicable) securely in line with local policy, and reports any stolen or lost pads. • Audits own prescribing practice and uses tools to improve prescribing practice (e.g. review of prescribing data, feedback from patients and peers). • Complies with regulatory body standards (e.g. HCPC Standards of Prescribing/NMC) evidenced via CPD and prescribing portfolio. • Reports prescribing errors and near misses according to local policy, and reviews practice to prevent recurrence. • Understands local area prescribing guidelines and can discuss the cost effective decisions behind them with colleagues and patients. • Provides support and advice to other prescribers when appropriate. • Establishes appropriate support from colleagues to train and practice as an independent prescriber.
4.6 Level F: Consultant clinician	<p>As for Level E, and:</p> <ul style="list-style-type: none"> • Takes a leading role in supporting and advising other prescribers and colleagues. • Contributes to local, regional and national discussion and policy regarding non-medical prescribing. • Leads collaborative working and networking with higher educational institutions and other agents to meet the needs of the population with diabetes.

Achievements and goals

5. PERIPHERAL ARTERIAL DISEASE

To provide effective identification and treatment for people with diabetes and peripheral arterial disease (PAD), clinicians and assistants should be able to demonstrate the following capabilities:

Add your capability level (1,2,3,4,5) in the second column (capability level key on page 8)

5.1 Level A: Healthcare technician

- Clearly communicates to patients and carers why foot pulse palpation is necessary.
- Can palpate for the presence or absence of foot pulses.
- Records the foot pulse palpation results on the relevant patient records system(s).
- Assigns a foot ulcer risk category based on the result of pulse palpation and other screening tests, in line with national guidance, algorithms and/or local protocols.
- Aware of and appropriately uses local referral protocols where foot pulses are not palpable.

5.2 Level B: Healthcare assistant/practitioner

- As for Level A, and:**
- Communicates the results of foot pulse palpation and risk score to the patient in appropriate language.
 - Undertakes manual ankle brachial pressure index (ABPI) and toe systolic pressures.
 - Reports investigation results to the referring clinician and records information on the relevant system.
 - Aware of the signs and symptoms that require both urgent and non-urgent assessment or review by a podiatrist or the foot protection team.

5.3 Level C: Qualified clinician

- As for Level B, and:**
- Carries out a peripheral arterial assessment, including clinical history, palpation of foot pulses and Doppler insonation of posterior tibial, anterior tibial, peroneal and popliteal pulses and record the information on the relevant system.
 - Identifies acute/critical limb ischaemia and facilitate emergency (acute ischaemia) or urgent (critical ischaemia) referral to a vascular multidisciplinary team.
 - Identifies and recognises symptoms likely to be due to intermittent claudication, embolic disease or ischaemic rest pain and differentiates from other non-arterial foot and leg conditions.
 - An awareness of local policies and services available to further assess or treat these conditions.
 - Makes appropriate, specific referrals for associated further vascular assessment and interventions.

5.4 Level D: Specialist clinician

- As for Level C, and:**
- Understands and interprets Doppler, ABPI, post-exercise ABPI and toe pressure results, in the context of clinical findings, to diagnose PAD.
 - Communicates the clinical diagnosis to the patient and explains effective interventions available and implications of treating or not treating the PAD.
 - Initiates appropriate treatment and referrals in relation to lifestyle, medicine or surgical interventions, depending on the severity of PAD and patient choice.
 - Provides and facilitates the training of colleagues in lower limb peripheral vascular assessment and clinical management.

5.5 Level E: Advanced clinician

- As for Level D, and:**
- Carries out a range of non-invasive vascular diagnostic assessments and interpretation of results for suspected peripheral arterial disease, in line with national clinical guidance and local vascular team training and preferences (e.g. palpating popliteal and femoral pulses).
 - Discusses with the patient the implications of their PAD diagnosis and personal treatment planning, in relation to potential morbidity, disease management, modifiable risks to life and limb, and non-surgical and surgical interventions.
 - Initiates and reviews the impact of key non-surgical vascular interventions, such as medicines, structured/supervised exercise, support for smoking cessation, compression bandaging/hosiery and associated wound care.
 - Identifies people with known PAD who have severe, deteriorating or critical ischaemia and would benefit from further vascular and surgical opinion.
 - Orders and interprets appropriate vascular diagnostic imaging.
 - Provides education and training to colleagues in all aspects of lower limb clinical vascular assessment and decision-making.
 - Develops local evidence-based PAD care and referral pathways in partnership with local vascular teams and relevant clinical stakeholders.

5. PERIPHERAL ARTERIAL DISEASE *CONTINUED*

To provide effective identification and treatment for people with diabetes and peripheral arterial disease (PAD), clinicians and assistants should be able to demonstrate the following capabilities:

Add your capability level (1,2,3,4,5) in the second column (capability level key on page 8)

5.6 Level F: Consultant clinician

As for Level E, and:

- Works with a range of lower limb stakeholders, to develop and implement clinical pathways for all aspects of PAD, including both urgent and non-urgent management.
- Proactively monitors, audits and implements changes in the delivery of peripheral vascular assessment and management by clinicians working with foot health.
- Leads collaborative working and networking with GPs, diabetes and vascular teams and other stakeholders, in relation to the care of people with PAD.
- Works strategically with professional bodies, higher educational institutions and other agents to improve the early detection and best management of the population with PAD.

Achievements and goals

6. RADIOLOGY

To provide effective care for people with diabetes, clinicians should be able to demonstrate radiological knowledge and associated clinical skills in the following capabilities:

Add your capability level (1,2,3,4,5) in the second column (capability level key on page 8)

6.1 Level A: Healthcare technician	Not applicable.
6.2 Level B: Healthcare assistant/practitioner	Not applicable.
6.3 Level C: Qualified clinician	<ul style="list-style-type: none"> • An understanding of the Ionising Radiation (Medical Exposure) Regulations (Her Majesty’s Stationery Office, 2017). • An understanding of the available radiological investigations and the rationale for their use. • An understanding of the side-effects of radiological investigations and why, in some circumstances, a non-radiological method of investigation may be more appropriate. • Keeps up-to-date with changes in clinical practice related to requesting or interpreting radiological images. • Refers for radiology examination under protocol, i.e. as directed by doctor, notes or standard operating procedures.
6.4 Level D: Specialist clinician	<p>As for Level C, and:</p> <ul style="list-style-type: none"> • Has completed and updated training, as appropriate, in the Ionising Radiation (Medical Exposure) Regulations (Her Majesty’s Stationery Office, 2017). • Assesses the patient and refers for radiology examination based on clinical signs according to local protocol. • Requests radiological investigations frequently enough to maintain capability. • Up-to-date knowledge of the actions, indications, contraindications, interactions, cautions, dose and side-effects of the radiological investigations ordered. • Works within, and contributes to the development of, local protocols for radiological requests (e.g. standard operating procedure, patient group directions).
6.5 Level E: Advanced clinician	<p>As for Level D, and:</p> <ul style="list-style-type: none"> • Makes preliminary interpretations of radiological reports. • Clearly communicates to the patient and/or carer the rationale behind undertaking a radiological investigation, and the potential risks and benefits of doing so. • Communicates the results of radiological investigations to the patient and/or carer in terms they understand. • Provides support and advice to other radiological requesters and colleagues where appropriate. • Develops and works within local frameworks for radiological requests and uses appropriate protocols and guidelines. • Keeps up-to-date with any changes in clinical practice which may influence the requesting or interpreting of radiological images.
6.6 Level F: Consultant clinician	<p>As for Level E, and:</p> <ul style="list-style-type: none"> • Interprets resultant radiological images to develop care plans. • Negotiates the appropriate level of clinical support for requestors of radiological investigations to undertake this aspect of their role safely and effectively. • Proactively identifies the need for clinical or service innovations to radiological investigations of the lower limb for people with diabetes, and takes a leading role designing and implementing these innovations.

Achievements and goals

7. PAINFUL DIABETIC PERIPHERAL NEUROPATHY

To provide effective care for people with painful diabetic peripheral neuropathy (PDPN), clinicians should be able to demonstrate the following capabilities:

Add your capability level (1,2,3,4,5) in the second column (capability level key on page 8)

7.1 Level A: Healthcare technician	<ul style="list-style-type: none"> • Accesses local referral pathways appropriately for further investigations and treatment.
7.2 Level B: Healthcare assistant/ practitioner	As for Level A.
7.3 Level C: Qualified clinician	<p>As for Level B, and:</p> <ul style="list-style-type: none"> • Awareness of the causes of PDPN. • Recognises the common signs and symptoms of PDPN when reported by a patient and refer appropriately according to local, regional and national guidelines. • Differentiates between PDPN and other painful symptoms (such as ischaemic rest pain) and arrange further tests as required. • A knowledge of the evidence-based treatment modalities available for the relief of the symptoms of PDPN. • Provides the patient and/or carer with information on PDPN in a suitable format.
7.4 Level D: Specialist clinician	<p>As for Level C, and:</p> <ul style="list-style-type: none"> • Demonstrates a knowledge of the causes of PDPN.
7.5 Level E: Advanced clinician	<p>As for Level D, and:</p> <ul style="list-style-type: none"> • An in-depth knowledge of the causes of PDPN. • An in-depth knowledge of the signs and symptoms of PDPN. • An in-depth knowledge of the evidence-based treatments available for the relief of the symptoms of PDPN. • Helps the patient and/or carer to understand the actions they can take to manage the symptoms of PDPN. • Provides the patient and/or carer with information on PDPN in a suitable format and encourages them to engage in active self-management and treatment compliance. • Supports or leads specialist PDPN clinics.
7.6 Level F: Consultant clinician	<p>As for Level E, and:</p> <ul style="list-style-type: none"> • Works with stakeholders to develop and implement PDPN care pathways. • Proactively identifies the need for clinical or service innovations to effectively manage PDPN, and takes a leading role designing and implementing these innovations. • Leads collaborative working and networking with higher educational institutions and other agents to meet the needs of the population with diabetes.

Achievements and goals

8. ULCER AND LOWER LIMB AMPUTATION PREVENTION

To effectively reduce the risk of the development of foot ulceration among people with diabetes, clinicians and assistants should be able to demonstrate the following capabilities:

Add your capability level (1,2,3,4,5) in the second column (capability level key on page 8)

<p>8.1 Level A: Healthcare technician</p>	<ul style="list-style-type: none"> • Understands how the complications of diabetes increase the risk of foot ulceration. • Understands the necessity of urgent referral and treatment in the event of suspected ulceration. • Supports and signposts patients in their healthy lifestyle decisions and achievable modifiable risk factors. • Ensures that the person with diabetes and/or carer knows and understands the review procedure and any onward referrals which may be necessary.
<p>8.2 Level B: Healthcare assistant/practitioner</p>	<p>As for Level A.</p>
<p>8.3 Level C: Qualified clinician</p>	<p>As for Level B, and:</p> <ul style="list-style-type: none"> • Carries out a foot ulcer risk assessment, including the identification of callus, vascular insufficiency, infection, neurological deficit, motor neuropathy, changes to range of movement, significant foot deformity, trauma or increased pressures. • Communicates what is involved in foot risk assessment and obtains the patient's informed consent. • Assesses whether the patient and/or carer is aware that they are at increased risk of developing foot ulceration. • Provides the patient and/or carer with up-to-date verbal and written advice on the prevention of foot ulceration. • Assesses the patient's understanding of the information on ulcer prevention provided, confirming the main areas that contribute to their risk of ulceration, and their ability to undertake appropriate self-care behaviours. • Maintains an up-to-date knowledge of the available topical products (e.g. urea- or paraffin-based emollients), and their role in reducing the risk of foot ulceration. • Maintains an up-to-date knowledge of biomechanical load distribution strategies and specialist devices and their role in reducing the risk of foot ulceration. • Maintains an up-to-date knowledge of preventative surgical interventions/strategies available. • Recognises when high-street footwear is appropriate, and when referral for specialist footwear is needed, depending on the patient's needs. • Uses biomechanical load distributing strategies to minimise the risk of foot ulceration. • Monitors the effectiveness of specialist footwear and other orthotic devices, or refers for further assessment and provision, as appropriate.
<p>8.4 Level D: Specialist clinician</p>	<p>As for Level C, and:</p> <ul style="list-style-type: none"> • A knowledge of preventative surgical procedures available. • Constructs a care plan which will include regular reviews in order to determine an individual's level of concordance, wear of materials and the need for replacement. • A knowledge of tissue mechanics and the effect of shear, linear and non-linear forces. • Uses observational gait analysis to determine total body biomechanics and to decide on the impact this may have on the risk of ulceration and alter care plan as appropriate
<p>8.5 Level E: Advanced clinician</p>	<p>As for Level D, and:</p> <ul style="list-style-type: none"> • Provides expert advice to the patient and/or carer on the benefits of ulcer prevention and self-care. • Refers to an appropriately trained healthcare professional for specialist or stock footwear and other orthotic devices. • Can hold difficult/challenging conversations regarding cardiovascular risk modifying strategies, with appropriate recognised training.
<p>8.6 Level F: Consultant clinician</p>	<p>As for Level E, and:</p> <ul style="list-style-type: none"> • Reviews and revises patient information relating to the prevention of diabetic foot ulceration and re-ulceration. • Engages with and influences national bodies regarding strategies on providing information for preventative care.

Achievements and goals

9. WOUND MANAGEMENT

To provide effective wound care for people with active diabetic foot ulceration, clinicians and assistants should be able to demonstrate the following capabilities:

Add your capability level (1,2,3,4,5) in the second column (capability level key on page 8)

9.1 Level A: Healthcare technician

Generic

- Understands how the complications of diabetes mean that a wound on the foot must be seen by a suitably skilled colleague as a matter of urgency.
- Accesses local referral pathways appropriately for further investigations and treatment.

Debridement - Not applicable

Infection control

- Demonstrates a working knowledge of basic infection control procedures (e.g. hand hygiene) and techniques for minimising cross infection.

Load distribution, load sharing and axial offloading

See chapter 15

Evidence-based wound care products and devices

- Carries out dressing changes as instructed and within the scope of their practice.
- Encourages the patient and/or carer to comply with recommended dressing regimens.

9.2 Level B: Healthcare assistant/ practitioner

As for Level A.

9.3 Level C: Qualified clinician

As for Level B, and:

Generic

- A working knowledge of diabetic wound management-related local, regional and national guidance.
- Recognises and classifies active foot ulceration, including identification of vascular insufficiency, neurological deficit, significant foot deformity, trauma, increased pressures, and extent and degree of infection.
- An understanding of the wound healing process and the potential complications of, or delays to, that process.
- An understanding of the psychological impact of active diabetic foot ulcer on the patient.
- Confirms that the patient and/or carer understands the purpose and nature of a proposed care plan.
- Assists in a proposed care plan.

Debridement

- Understands the principles of debridement and wound bed management to optimise the process of healing (Strohal et al, 2013).
- Carries out wound management techniques within the scope of their practice (e.g. antimicrobial treatment, basic sharp debridement, wound irrigation).
- An understanding of the requirement to refer onwards for multidisciplinary input as per local, regional and national guidelines and pathways.

Infection control

- Recognises the clinical signs and symptoms of wound infection and refers quickly and appropriately.
- Carries out basic microbiological culturing (e.g. wound swabbing) and ensures results are interpreted by an appropriately skilled colleague as per local policies.

Load distribution, load sharing and axial offloading

See chapter 15

Evidence-based wound care products and devices

- A working knowledge of available dressing products, their modes of action, and appropriate use.
- Aware of their local wound management formulary and formulary group and related groups.

9. WOUND MANAGEMENT *CONTINUED*

To provide effective wound care for people with active diabetic foot ulceration, clinicians and assistants should be able to demonstrate the following capabilities:

Add your capability level (1,2,3,4,5) in the second column (capability level key on page 8)

<p>9.4 Level D: Specialist clinician</p>	<p>As for Level C, and; Generic</p> <ul style="list-style-type: none"> • A broad understanding of the wound healing process and its potential complications. • A broad understanding of the psychological impact of active diabetic foot disease on the patient. <hr/> <p>Debridement</p> <ul style="list-style-type: none"> • Carries out sharp debridement of simple and complex wounds within the scope of their practice. • Appropriately recognises the need for advanced debridement and refers the patient accordingly. • An in-depth knowledge of debridement techniques other than sharp debridement. • Critically analyses wound care interventions to develop evidence-based, individualised care plans. • Carries out advanced wound management techniques with appropriate support and supervision. <hr/> <p>Infection control</p> <ul style="list-style-type: none"> • Recognises the signs and symptoms of local wound infection and manages them effectively. • Recognises when to refer the patient for infection control by appropriately skilled colleagues. • Undertakes comprehensive microbiological sampling (e.g. wound swabbing, tissue biopsy) and reporting. • Ensures the results of microbiological investigations are seen and interpreted by an appropriately skilled colleague. <hr/> <p>Load distribution, load sharing and axial offloading See chapter 15</p> <hr/> <p>Evidence-based wound care products and devices</p> <ul style="list-style-type: none"> • A good knowledge of available dressing products, their modes of action, and appropriate use.
<p>9.5 Level E: Advanced clinician</p>	<p>As for Level D, and; Generic</p> <ul style="list-style-type: none"> • An advanced understanding of the wound healing process and its potential complications. • An advanced understanding of the psychological impact of active diabetic foot disease on the patient. • Classifies active foot ulceration, including advanced investigations of vascular insufficiency (e.g. ankle-brachial pressure index, Doppler ultrasound), neurological deficit, foot deformity, trauma, increased pressures, extent and degree of infection. • Contributes expert opinion on the development of care plans for complex diabetic foot ulceration. • Contributes to the development of local guidance related to diabetic wound management. • A working knowledge of national guidance related to diabetic wound management. • Contributes to the development of local referral pathways. • Applies high-level clinical reasoning in the management of complex diabetic foot ulcers. <hr/> <p>Debridement</p> <ul style="list-style-type: none"> • Carries out advanced debridement (with a range of debridement tools) of complex wounds, within the scope of their practice. • Carries out advanced wound management techniques (e.g. topical negative pressure systems). • Recognises the need, and refers the patient, for surgical debridement appropriately. • Supports less-experienced colleagues in developing advanced debridement skills. <hr/> <p>Infection control</p> <ul style="list-style-type: none"> • Leads colleagues and prescribes comprehensive microbiological sampling (e.g. wound swabbing, bone sampling, tissue biopsy) and reporting. • Interprets results from microbiological sampling. • Recognises deep infection (e.g. foot abscess) and refers appropriately. • Recognises the need for inpatient treatment of diabetic foot ulceration, and facilitates the process of the patient's admission to hospital using local pathways. • Contributes to the development of local antibiotic use guidance.

9. WOUND MANAGEMENT *CONTINUED*

To provide effective care for people with active diabetic foot ulceration, clinicians and assistants should be able to demonstrate the following capabilities:

Add your capability level (1,2,3,4,5) in the second column (capability level key on page 8)

<p>9.5 Level E: Advanced clinician <i>(continued)</i></p>	<p>Load distribution, load sharing and axial offloading See chapter 15</p> <hr/> <p>Evidence-based wound care products and devices</p> <ul style="list-style-type: none"> • An advanced knowledge of available dressing products, and their modes of action. • Extensive experience in the appropriate use of available dressing products. • Supports other colleagues in choosing appropriate dressings for patients with diabetic foot ulceration. • Makes dressing product choices based on consideration of clinical indications, wound type, patient needs, and formulary and budgetary directives. • Provides expert opinion to their local wound management formulary group and other related wound dressing groups.
<p>9.6 Level F: Consultant clinician</p>	<p>As for Level E, and:</p> <p>Generic</p> <ul style="list-style-type: none"> • Contributes to the development of relevant national guidance. • Facilitates the development of local referral pathways and enables their implementation. • Works with stakeholders to develop and implement care pathways for patients with active foot disease. • Proactively identifies the need for clinical or service innovations to effectively manage active diabetic foot ulceration, and takes a leading role designing and implementing these innovations. • Leads in the integration of theoretical wound management into clinical practice, and collaborates with higher educational institutions and other educational providers to achieve this. • Ensures there is local capacity to facilitate, support and mentor colleagues seeking to develop their clinical practice (e.g. advanced debridement, total-contact cast fabrication). <hr/> <p>Debridement</p> <ul style="list-style-type: none"> • Leads in the evaluation of novel wound care products. • Provides clinical leadership in advanced wound debridement techniques. • Leads in the establishment of working relationships with surgical staff responsible for surgical debridement. • Provides expert opinion on debridement products, techniques and indications in local and national expert groups. <hr/> <p>Infection control</p> <ul style="list-style-type: none"> • Leads, in conjunction with appropriate stakeholders, the development and implementation of local antibiotic use guidance. • Collaborates with higher educational institutions and other educational providers on meeting the diabetic foot-related educational needs of colleagues. • Leads in establishing relationships with surgical staff for infection control and vascular reconstruction. • Leads in liaising with local infection control, microbiology and multidisciplinary teams to minimise patient risk associated with infection. <hr/> <p>Load distribution, load sharing and axial offloading See chapter 15</p> <hr/> <p>Evidence-based wound care products and devices</p> <ul style="list-style-type: none"> • Provides expert opinion on dressings and medical devices in local and national wound formulary and associated groups.

Achievements and goals

10. POST-ULCER CARE

To provide effective care for people with a history of diabetic foot ulceration, clinicians and assistants should be able to demonstrate the following capabilities:

Add your capability level (1,2,3,4,5) in the second column (capability level key on page 8)

<p>10.1 Level A: Healthcare technician</p>	<ul style="list-style-type: none"> • Aware that people with a history of diabetic foot ulceration are at high risk of reulceration. • Recognise when there is a need for referral of a patient with a history of foot ulceration. • Uses local referral pathways appropriately. • Follows instruction from colleagues to ensure load redistribution devices are used appropriately.
<p>10.2 Level B: Healthcare assistant/ practitioner</p>	<p>As for Level A.</p>
<p>10.3 Level C: Qualified clinician</p>	<p>As for Level B, and:</p> <ul style="list-style-type: none"> • Communicates to the patient and/or carer the risk of reulceration in an appropriate manner, while recognising the potentially stressful nature of the information. • Discusses the concept of ulcer being in 'remission' with patient. • Provides education for the patient and/or carer aimed at the prevention of reulceration. • Assists in implementing the care plan to prevent ulcer recurrence. • Maintains up-to-date knowledge of the available topical products (e.g. urea- or paraffin-based emollients), and their role in reducing the prevention of reulceration. • Maintains up-to-date knowledge of biomechanical load redistribution strategies and their implementation. • Recognises when high-street footwear is appropriate, and when referral for specialist footwear is needed, depending on the patient's needs. • A knowledge of the materials used in the manufacture of foot orthoses for the prevention of reulceration. • Uses biomechanical load distributing strategies to minimise the risk of foot reulceration. • A knowledge of the technology used in foot and plantar pressure measurement.
<p>10.4 Level D: Specialist clinician</p>	<p>As for Level C, and:</p> <ul style="list-style-type: none"> • An increased understanding of the natural history of diabetes and its complications, and how to assess severity of complications in relation to preventing foot ulcer recurrence. • Works collaboratively with all other colleagues to optimise patient compliance with footwear advice and orthotic devices.
<p>10.5 Level E: Advanced clinician</p>	<p>As for Level D, and:</p> <ul style="list-style-type: none"> • An advanced understanding of the natural history of diabetes and its complications, and how to assess its severity in relation to preventing foot ulcer recurrence. • Establishes the cause of previous ulceration in order to develop and implement an appropriate ulcer prevention care plan. • Recognises the need for specialist footwear and refers to an appropriately trained healthcare professional. • Develops footwear and orthotic ulcer prevention care plans in collaboration with an orthotist. • Monitors the effectiveness of load redistribution devices, and recognises when modification or replacement of such devices is required, and ensures the necessary changes are undertaken appropriately. • A knowledge of the technologies used in the assessment of foot pressure and gait analysis. • A working knowledge of the materials used in the manufacture of foot orthoses for the prevention of recurrence of ulceration. • Uses of observational gait analysis to determine total body biomechanics and to decide on the impact this may have on the risk of re-ulceration and alter care plan as appropriate. • Performs modifications to stock or bespoke orthoses as required.
<p>10.6 Level F: Consultant clinician</p>	<p>As for Level E, and:</p> <ul style="list-style-type: none"> • Evaluates and provides specialist education for the patient and/or carer on the prevention of foot reulceration. • Contributes to and, when appropriate, leads local, regional and national strategies for prevention of diabetic foot reulceration. • Leads the implementation and integration of specialist diabetic footwear services. • Proactively identifies the need for clinical or service innovations to prevent diabetic foot reulceration, and takes a leading role in designing and implementing these innovations. • Creates an environment that encourages collaboration among colleagues to optimise patient compliance with ulcer prevention footwear interventions.

Achievements and goals

11. CHARCOT NEURO-OSTEOARTHROPATHY

To provide effective care for people with diabetes and Charcot neuro-osteoarthropathy (CN), clinicians and assistants should be able to demonstrate the following capabilities:

Add your capability level (1,2,3,4,5) in the second column (capability level key on page 8)

11.1 Level A: Healthcare technician	<ul style="list-style-type: none"> • A knowledge of local guidance on the management of diabetes and the potential risk of diabetic foot disease. • Follows instruction from colleagues to ensure CN care plans are carried out, within the scope of their practice. • Refers a patient with diabetes and an inflamed, swollen foot promptly to an appropriately qualified clinician. • Supports patients to wear offloading devices supplied for the management of CN.
11.2 Level B: Healthcare assistant/ practitioner	As for Level A.
11.3 Level C: Qualified clinician	<p>As for Level B, and:</p> <ul style="list-style-type: none"> • A working knowledge of local and national guidance on the diagnosis and management of CN. • Recognises patients at increased risk of CN. • Recognises the clinical signs and symptoms of acute onset CN and refers the patient to a specialist team in an appropriate and timely manner according to local, regional and national guidelines. • A knowledge of identifiable biomechanical changes associated with CN • Recognises when further investigations are required for the diagnosis of suspected CN and ordering these in accordance with local pathways. • An understanding of the different radiological and non-radiological methods of assessment and screening (including, transcutaneous temperature readings, plain x-ray, MRI). • An understanding of the rationale for biomechanical load distribution strategies in the management of CN and the ability to implement them. • Assists in the implementation and applications of care plans for the management of CN. • An understanding of the psychological impact of CN on the patient. • Communicates to the patient and/or carer the implications of CN in an appropriate manner to provide specialist education, while recognising the potentially stressful nature of the information.
11.4 Level D: Specialist clinician	<p>As for Level C but with an increased understanding, and:</p> <ul style="list-style-type: none"> • A knowledge and understanding of the interventions for a suspected or diagnosed CN. • Assists in the implementation of care plans for acute CN. • Confirms that the patient and/or carer understands the purpose and nature of the proposed CN care plan. • Undertakes long-term care plans following the resolution of CN, ensuring timely referrals to other disciplines (such as orthotics) to ensure MDT approach.
11.5 Level E: Advanced clinician	<p>As for Level D, and:</p> <ul style="list-style-type: none"> • Undertakes differential diagnosis of CN, distinguishing acute CN from other acute conditions (e.g. cellulitis, ankle sprain, deep venous thrombosis). • An up-to-date knowledge of the current management strategies of CN. • Assists in the design and implementation of the care plan for acute CN. • A knowledge of load distribution and load sharing strategies for the management of acute CN. • Monitors the effectiveness of pressure-relieving strategies for the management of acute CN (e.g. total-contact casting) and makes changes, or refers for further assessment, appropriately. • Uses clinical reasoning and reflection on their practice to ensure the safe management of acute CN, especially in the use of casts.
11.6 Level F: Consultant clinician	<p>As for Level E, and:</p> <ul style="list-style-type: none"> • Leads the design and implementation of care plans for the management of acute CN in collaboration with colleagues (e.g. consultant physicians, plaster technicians, orthotists). • Plans and implements complex load distribution, load sharing and axial offloading strategies for the management of CN. • Applies stock or specialist bespoke pressure redistribution devices (including total-contact casts) for the management of CN. • Monitors the effectiveness of CN care plans and makes changes where appropriate through the progressive stages of CN. • Understands, and refers for, radiological and non-radiological assessments of CN. • Communicates to the patient and/or carer the long and short-term implications of a diagnosis of CN. • Recognises the challenges faced by the patient with acute and resolved CN and provides them and/or carer with appropriate support. • Leads the design of long-term care plans for the patient following the resolution of acute CN. • Contributes to the development of local, regional and national guidance on the management of diabetes-related CN. • Works with stakeholders in the development of local referral pathways for the management of CN and enables their implementation. • Proactively identifies the need for clinical or service innovations to effectively manage CN, and takes a leading role designing and implementing these innovations.

Achievements and goals

12. HEALTH IMPROVEMENT

To provide effective health improvement and self-management strategies relating to diabetic foot, clinicians and assistants should be able to demonstrate the following capabilities:

Add your capability level (1,2,3,4,5) in the second column (capability level key on page 8)

<p>12.1 Level A: Healthcare technician</p>	<ul style="list-style-type: none"> • Recognises need to support public health behaviours. • Understands the importance of self management and patient education in long-term conditions. • Understands the psychological impact on the patient and/or carer of having a long-term condition. • Aware of the kinds of misinformation the patient may have about diabetes and provides appropriate literature or signposting to endorsed support mechanisms/resources to assist the individual in managing their condition. • Undertakes, and encourages, honest, clear communication with patients and/or carers. • Aware of services designed to assist the patient and/or carer in the self-management of diabetes.
<p>12.2 Level B: Healthcare assistant/ practitioner</p>	<p>As for Level A.</p>
<p>12.3 Level C: Qualified clinician</p>	<p>As for Level B, and:</p> <ul style="list-style-type: none"> • A critical understanding of the importance and effects of patient education and self management. • Awareness of the impact of culture and social context on how the patient feels about health-related behaviours and about changing them. • Awareness of multiple, complex public health factors affecting health including literacy, social assets, poverty and issues relating to multiple deprivation. • Recognises and corrects misinformation the patient may hold about their condition, and the effects of this misinformation on self-care behaviours and their consequences. • Understands and uses a range of tools and techniques in the assessment and evaluation of the patient’s health status, concerns, personal context and priorities. • Provides access to relevant information, in a suitable format, to the patient and/or carer to support their understanding and self-care. • An understanding of the need for detailed personal action plans to achieve and maintain health-related goals for patients at increased risk of diabetic foot complications.
<p>12.4 Level D: Specialist clinician</p>	<p>As for Level C but with an increased understanding, and:</p> <ul style="list-style-type: none"> • A working knowledge of how to develop detailed personal action plans to achieve and maintain health-related goals for patients at increased risk of diabetic foot complications. • An awareness of counselling techniques, interview methods and motivational interviewing.
<p>12.5 Level E: Advanced clinician</p>	<p>As for Level D, and:</p> <ul style="list-style-type: none"> • Understands, and manages, the psychological impact of diabetic foot disease in the patient. • An in-depth understanding of the tools and techniques for assessment and evaluation of the patient’s health status, concerns, personal context and priorities. • Leads engagement and education strategy in local diabetes services to deliver public health initiatives in a way that is relevant to the needs of individual patient populations. • High-level skills in undertaking, and encouraging, honest, clear communication with the patient and/or carer about active diabetic foot disease.
<p>12.6 Level F: Consultant clinician</p>	<p>As for Level E, and:</p> <ul style="list-style-type: none"> • Influences the design and dissemination of relevant, suitably presented, patient information on the prevention and management of diabetic foot disease. • Leads and influences regional and national engagement and education strategies in diabetic foot to coordinate and implement public health initiatives to individual patient populations. • Leads collaborative working and networking with higher educational institutions and other agents to meet the needs of people with diabetic foot disease.

Achievements and goals

13. RESEARCH AND AUDIT

To provide effective care for people with diabetes, clinicians and assistants should be able to demonstrate the following capabilities in research and audit:

Add your capability level (1,2,3,4,5) in the second column (capability level key on page 8)

13.1 Level A: Healthcare technician	<ul style="list-style-type: none"> Assists with research or audit data collection according to local guidelines and where appropriate.
13.2 Level B: Healthcare assistant/ practitioner	<p>As for Level A, and:</p> <ul style="list-style-type: none"> An understanding of the importance of research and audit data collection methods.
13.3 Level C: Qualified clinician	<p>As for Level B, and:</p> <ul style="list-style-type: none"> Understands the importance of adopting evidence-based practices in the clinical setting. An awareness of current literature that underpins practice (i.e. best practice statements, national guidelines, local, regional and national policy). Critically appraises methods and results of clinical evaluation. Can locate research evidence and undertakes literature searches to answer clinical questions. A knowledge of current research in diabetic foot disease. Uses research and audit tools to improve their clinical practice and patient outcomes. Can lead an audit.
13.4 Level D: Specialist clinician	<p>As for Level C but with an increased understanding, and:</p> <ul style="list-style-type: none"> Facilitates the integration of evidence-based practices in the clinical setting. A good knowledge of current research in diabetic foot disease. Questions practice and uses research evidence to support new practices. Designs and manages audit including analysis of results, report writing and implementation of findings. Participates in clinical trials where appropriate.
13.5 Level E: Advanced clinician	<p>As for Level D, and:</p> <ul style="list-style-type: none"> Critically appraises the validity of information and disseminates the findings to colleagues as appropriate. Actively contributes to research in diabetic foot disease. Possess an advanced knowledge of research and audit methodology. Participates in the design and implementation of research and audit activities. Implements research and audit tools to improve clinical practice and patient outcomes. Supports colleagues using research and audit tools in the clinical setting. Highly skilled in undertaking literature searches to answer clinical and non-clinical questions. Highly skilled in the presentation (oral and written) of research and audit results to colleagues.
13.6 Level F: Consultant clinician	<p>As for Level E, and:</p> <ul style="list-style-type: none"> Leads the design and implementation of research and audit activities. Has undertaken recognised research training/education into research methods. Creates opportunities for colleagues to participate in research and audit activities. Collaborates with higher educational institutions, research funding bodies, health boards and other stakeholders to develop innovative research and audit activities. Ensures appropriate access to research resources for colleagues. Highly skilled in the presentation (oral and written) of research and audit results at local and national levels and is influential in the implementation of findings. Creates an environment that facilitates colleagues to improve their knowledge about, and participation in, research and audit activities.

Achievements and goals

14. LEADERSHIP

To provide effective care for people with diabetes, clinicians and assistants should be able to demonstrate the following capabilities in leadership and service development:

Add your capability level (1,2,3,4,5) in the second column (capability level key on page 8)

<p>14.1 Level A: Healthcare technician</p>	<ul style="list-style-type: none"> • Contributes to the team ethos and organisational culture.
<p>14.2 Level B: Healthcare assistant/ practitioner</p>	<p>As for Level A.</p>
<p>14.3 Level C: Qualified clinician</p>	<p>As for Level B, and:</p> <ul style="list-style-type: none"> • Provides clinical leadership within their workplace by taking responsibility for clinical decision making and escalation as appropriate. • Influences others positively within own profession and undergraduates. • Shares own learning with colleagues. • Aware of local diabetes services protocols and works within them. • Participates in peer review of their own and colleagues’ clinical practice.
<p>14.4 Level D: Specialist clinician</p>	<p>As for Level C but with an increased understanding, and:</p> <ul style="list-style-type: none"> • Constructs peer review processes for own level and participates in peer review of colleagues’ clinical practice. • Provides clinical mentorship and coaching for professional colleagues.
<p>14.5 Level E: Advanced clinician</p>	<p>As for Level D, and:</p> <ul style="list-style-type: none"> • Demonstrates clinical leadership within their local diabetic foot services. • Shares own learning with colleagues to enhance service delivery. • Provides clinical and academic mentorship and coaching for professional colleagues across professional boundaries. • Provides a role model in professional behaviour, integrity, organisational citizenship and proactive learning. • Offers appropriate education and advice to podiatry and other colleagues in relation to clinical and service practices in diabetic foot. • Plans and initiates collaborative training programmes for service improvement and delivery. • Leads the review of their own and their colleagues’ clinical practice. • Creates opportunities for colleagues to undertake self-directed and supported learning. • Contributes to the coordination of diabetes foot services across organisational and professional boundaries. • Challenges local services to improve diabetes foot services. • Participates in the development of guidance, protocols and recommendations related to diabetic foot. • Provides expert knowledge in relation to diabetic foot services. • Leads projects designed to improve diabetic foot patient and service outcomes. • Participates in the development of professional networks related to diabetic foot. • Designs, delivers and evaluates educational packages for appropriate colleagues, and students, on diabetic foot and service development and delivery.
<p>14.6 Level F: Consultant clinician</p>	<p>As for Level E, and:</p> <ul style="list-style-type: none"> • Provides clinical leadership on diabetic foot at local, regional, national and international levels. • Leads diabetes foot services across organisational and professional boundaries. • Leads the development of professional networks related to diabetic foot, and facilitates the participation of colleagues in these networks. • Develops, and implements, clinical guidance and protocols related to diabetic foot at local, regional and national levels. • Communicates the sometimes complex and challenging needs of providing diabetic foot to key opinion leaders, policy makers and politicians nationally; and influences related policy. • Supports colleagues in bringing about service improvement in diabetic foot. • Proactively identifies the need for clinical or service innovations in diabetic foot, and takes a leading role in designing and implementing these innovations. • Develops and implements strategies to ensure the best use of local resources and technologies in diabetic foot.

Achievements and goals

15. LOAD DISTRIBUTION, LOAD SHARING AND AXIAL OFFLOADING IN AN ACTIVE DIABETIC FOOT

To provide effective care for people with diabetes, clinicians and assistants should be able to demonstrate the following capabilities in load distribution, load sharing and axial offloading for prevention and treatment of ulceration in an active diabetic foot:

Add your capability level (1,2,3,4,5) in the second column (capability level key on page 8)

15.1 Level A: Healthcare technician (Note: capabilities for this level refer to specific roles such as a plaster, orthotist or podiatry technician)

- Encourages the patient and/or carer to comply with instructions on the use of load redistribution, load sharing and axial offloading devices for the treatment and prevention ulceration.
- Clearly communicates to patients treated with load redistribution, load sharing and axial offloading devices the signs and symptoms that would warrant an emergency reassessment by a specialist clinician.
- Identifies and reports faulty machinery.
- Understands the principles of safe cast removal of load redistribution, load sharing and axial offloading devices (e.g. use of a plaster saw).
- An awareness of emergency situations where a load distribution, load sharing or axial offloading device requires quick removal.
- Under guidance can prepare patients for application of a load redistribution, load sharing and axial offloading device by a specialist clinician.
- Assesses for, fits and educates patients on the use of additional aids, such as crutches, walking sticks and frames.
- Fits off-the-shelf removable load distribution and sharing devices as directed by a specialist clinician.

15.2 Level B: Healthcare assistant/practitioner (Note: capabilities for this level refer to specific roles such as a plaster, orthotist or podiatry assistant)

As for Level A

15.3 Level C: Qualified clinician

As for Level B, and:

- Demonstrates a knowledge of load distribution, load sharing and axial offloading devices in the management of diabetic foot complications and associated benefits and risks.
- A knowledge of additional interventions (i.e. crutches or contralateral raise) that may be required.
- Refers the patient for assessment for, and supply of, specialist load distribution devices based on a patient's needs, site and severity of foot disease and mobility status.
- Understands the need for load redistribution, load sharing and axial offloading devices in active Charcot neuro-osteoarthropathy and active foot problem and to refer immediately.
- Provides first-line load distribution, load sharing or axial offloading devices while the patient awaits specialist assessment if this is not available immediately.
- Able to manufacture, modify and provide different types of load redistribution devices on the recommendation and the supervision of the multidisciplinary team.
- Clearly communicates to the patient and/or carer the need for load redistribution, load sharing and axial offloading devices for the treatment and prevention ulceration.
- Provides basic gait training to ensure the patient is safe to walk with load distribution, load sharing and axial offloading devices provided.
- Monitors the effectiveness of load redistribution, load sharing and axial offloading modalities provided and seeks advice from senior colleagues when response to treatment is sub-optimal.
- A working knowledge of local, regional and national guidance relating to load redistribution, load sharing and axial offloading.

15.4 Level D: Specialist clinician

As for Level C, and:

- Demonstrates a broad working and practical understanding of load distribution, load sharing and axial offloading devices for prevention and treatment of ulceration.
- An awareness of the different load distribution, load sharing and axial offloading options available and accurately assesses the patient for their suitability for different options.
- A knowledge of the contraindications for load distribution, load sharing and axial offloading devices.
- Discusses the different treatment options available for load distribution, load sharing and axial offloading with the patient and gives evidence-based advice on the rationale for choice.
- Develops individualised and mutually agreed load redistribution, load sharing and axial offloading management plans with the patient.
- Discusses with senior colleagues the use of load distribution, load sharing and axial offloading in patients who have infection and non-critical ischaemia.
- Assesses vascular status prior to load redistribution, load sharing and axial offloading being applied and identifies patients who are suitable to cast (i.e. peripheral arterial disease [ABPI ≥ 0.7] and toe systolic pressure ≥ 55 mmHg).
- Identifies when to begin weaning patients out of non-removable load redistribution, load sharing and axial offloading and organise temporary removable devices.

15. LOAD DISTRIBUTION, LOAD SHARING AND AXIAL OFFLOADING IN AN ACTIVE DIABETIC FOOT *CONTINUED*

To provide effective care for people with diabetes, clinicians and assistants should be able to demonstrate the following capabilities in load distribution, load sharing and axial offloading for diabetic foot prevention and treatment of ulceration in an active diabetic foot:

Add your capability level (1,2,3,4,5) in the second column (capability level key on page 8)

<p>15.5 Level E: Advanced clinician</p>	<p>As for Level D, and:</p> <ul style="list-style-type: none"> • Demonstrates current advanced knowledge of advanced and customised load distribution, load sharing and axial offloading strategies. • Initiates treatment and applies load redistribution, load sharing and axial offloading for the management of acute diabetic foot complications. • Demonstrates the ability to plan and implement complex load distribution, load sharing and axial offloading strategies. • Considers and makes recommendations on the use of load redistribution, load sharing and axial offloading in high-risk patients (i.e. advanced vascular disease and infection). • Monitors the effectiveness of load distribution, load sharing and axial offloading strategies, and appropriately refers patients for further foot pressure assessment. • Understands the technologies used in the assessment of foot pressure and gait analysis. • Understands the biopsychosocial impact of prolonged load redistribution, load sharing and axial offloading regimens on the patient. • Understands different load redistribution, load sharing and axial offloading device materials and their properties. • Can fabricate, modify and supply insoles as part of the management of diabetic foot disease. • Teaches and demonstrates the application of load redistribution, load sharing and axial offloading devices to other colleagues and provides supervision for those developing capabilities. • Evaluates the effectiveness of new load redistribution, load sharing and axial offloading options before introducing them into routine clinical practice. • Develops pathways to ensure onward referrals to colleagues to assess and provide optimal load distributing, load sharing and load-sharing devices for wound healing.
<p>15.6 Level F: Consultant clinician</p>	<p>As for Level E, and:</p> <ul style="list-style-type: none"> • A knowledge of, and experience in using, technologies for gait analysis and foot pressure measurements. • Reviews and revises patient information relating to the use of load redistribution, load sharing and axial offloading devices in the management of the diabetic foot. • Identifies the need for clinical or service innovations to improve diabetic foot outcomes through load redistribution, load sharing and axial offloading devices, and takes a leading role in designing and implementing these innovations. • Engages with and influences national bodies regarding strategies on load redistribution, load sharing and axial offloading devices.

Achievements and goals

16. PSYCHOLOGY SCREENING AND ASSESSMENT

To effectively carry out psychological screening and assessment for depression and anxiety in people with diabetes, clinicians and assistants should be able to demonstrate the following capabilities:

Add your capability level (1,2,3,4,5) in the second column (capability level key on page 8)

16.1 Level A: Healthcare technician	<p>Screening</p> <ul style="list-style-type: none"> • Awareness of the psychological impact on the patient and/or carer of having a long-term condition. • Awareness of the increased psychological burden when an active diabetes foot condition exists.
16.2 Level B: Healthcare assistant/ practitioner	<p>Screening as for Level A, and:</p> <ul style="list-style-type: none"> • Completes certified training which explores integrating care, depression, anxiety and physical illness. • Clearly communicates the purpose of mental health screening to the patient and what is involved in the screening process. • Uses a recognised psychological assessment tool (e.g. GAD-7, HADS, PHQ-9, DSM-IV), allocates a psychological risk status, and records the information on the relevant system.
16.3 Level C: Qualified clinician	<p>Screening as for Level B.</p> <ul style="list-style-type: none"> • Aware of local policies regarding mental health screening of the person with diabetes. <hr/> <p>Assessment</p> <ul style="list-style-type: none"> • Understands the integration between physical and mental health in the management of health conditions. • Carries out recognised and ratified training to ensure conversations regarding mental health are carried out in an appropriate, evidence-based, standardised manner. • Explains the results of the screening to the patient and/or carer in an appropriate manner. • Provides up-to-date verbal and/or written mental health advice, support and signposting, relevant to the risk status in an appropriate language. • Carries out thorough discussion with a person identified with clinical anxiety or depression to determine if any interventions may be required. • Provides treatment as within remit of professional practice. • Aware of, and appropriately uses, local referral pathways for patients who require specialist, and potentially urgent, intervention. • Carries out a thorough discussion of anyone with identified suicidal ideations to determine the immediacy of risk, making an immediate onward referral as appropriate.
16.4 Level D: Specialist clinician	<p>Screening as for Level C.</p> <hr/> <p>Assessment as for Level C, and:</p> <ul style="list-style-type: none"> • Aware of local, regional and national guidance and policies regarding psychological screening and assessment. • Facilitates the training of colleagues in screening and assessment according to local policies.
16.5 Level E: Advanced clinician	<p>Screening and assessment as for Level D, and:</p> <ul style="list-style-type: none"> • Where possible, participates in the development of local, evidence-based screening and assessment programmes. • Facilitates colleagues' learning of psychological screening and assessment techniques to support service needs and assists with the development of local referral pathways.
16.6 Level F: Consultant clinician	<p>Screening and assessment as for Level E, and:</p> <ul style="list-style-type: none"> • Works with stakeholders to develop and implement local, regional and national screening and assessment programmes and develops local pathways. • Instigates and leads inter-professional collaboration across primary/secondary care, acute/mental health and other interfaces. • Proactively identifies the need for clinical or service innovations to effectively screen and assess the psychological needs of people with diabetes, and takes a leading role designing and implementing these innovations. • Leads collaborative working and networking with higher educational institutions and other agents to meet the needs of people with diabetes.

Achievements and goals

REFERENCES

- Boulton AJ, Vileikyte L, Ragnarson-Tennvall G, Apelqvist J (2005) The global burden of diabetic foot disease. *Lancet* 366(9498): 1719–24
- Bowen G, Barton H, Haggan G et al (2008) The impact of a diabetic foot protection team (DEPT) on outcome for patients with diabetic vascular disease. *Br J Surg* 95(Suppl 1): 4–5
- Canavan RJ, Unwin NC, Kelly WF, Connolly VM (2008) Diabetes and non diabetes-related lower extremity amputation incidence before and after the introduction of better organized diabetes foot care: continuous longitudinal monitoring using a standard method. *Diabetes Care* 31: 459–63
- Crawford F, Cezard G, Chappell FM et al (2015) A systematic review and individual patient data meta-analysis of prognostic factors for foot ulceration in people with diabetes: the international research collaboration for the prediction of diabetic foot ulcerations (PODUS). *Health Technol Assess* 2015;19(57)
- DH (2011) *Operational Guidance to the NHS on Extending Patient Choice of Provider*. DH, London. Available at: <https://www.gov.uk/government/publications/operational-guidance-to-the-nhs-extending-patient-choice-of-provider--2> (accessed 13.02.19)
- DH (2012) *Podiatry: Any Qualified Provider Implementation Pack*. DH, London
- Diabetes UK, NHS Diabetes (2011) *A Survey of The Diabetes Specialist Podiatrist Workforce – UK Pilot*. NHS Diabetes, Newcastle-upon-Tyne. Available at <https://www.diabetes.org.uk/resources-s3/2017-11/PR%20Podiatry%20Survey%202010%20SUMMARY.pdf> (accessed 13.02.19)
- Diabetes UK (2019) *Us, diabetes and a lot of facts and stats*. Diabetes UK, London. Available at: https://www.diabetes.org.uk/resources-s3/2019-02/1362B_Facts%20and%20stats%20Update%20Jan%202019_LOW%20RES_EXTERNAL.pdf
- Guest JF, Fuller GW, Vowden P (2018) Diabetic foot ulcer management in clinical practice in the UK: costs and outcomes. *Int Wound J* 15: 43–52
- Her Majesty's Stationery Office (2017) *The Ionising Radiation (Medical Exposure) Regulations 2017*. The Stationery Office Limited, London. Available at: <http://www.legislation.gov.uk/ukSI/2017/1322/contents/made> (accessed 13.02.19)
- Kerr M (2017) *Diabetic foot care in England: An economic study*. London: NICE. Available at: <https://is.gd/ilgCoV> (accessed 13.06.18)
- Krishnan S, Nash F, Baker N et al (2008) Reduction in diabetic amputations over 11 years in a defined UK population: benefits of multidisciplinary team work and continuous prospective audit. *Diabetes Care* 31: 99–101
- Leese GP, Stang D, McKnight J (2011) A national strategic approach to diabetic foot disease in Scotland – changing a culture. *Br J Diabetes Vasc Dis* 11: 69–73
- Maciejewski ML, Reiber GE, Smith DG et al (2004) The effectiveness of diabetic therapeutic footwear in preventing reulceration. *Diabetes Care* 27: 1774–82
- McCardle J (2008) Diabetes and podiatry in the 21st Century – Is specialism the way forward? *The Diabetic Foot Journal* 11: 129–40
- McCardle J, Fox M (2013) Introduction to the latest capability dimension: Peripheral vascular disease. *The Diabetic Foot Journal* 16(2): 54–5
- NHS Education for Scotland (2018) *Pillars of Practice*. NHS Education for Scotland. Available at: <http://www.advancedpractice.scot.nhs.uk/education/pillars-of-practice.aspx> (accessed 25.02.19)
- NHS Health Education England (2018) *Advanced clinical practice*. NHS Health Education England Available at: <https://www.hee.nhs.uk/our-work/advanced-clinical-practice> (accessed 25.02.19)
- NHS Modernisation Agency (2005) *Good Care Planning for People With Long-Term Conditions: Updated Version*. London: NHS. Available at: <https://optimityadvisors.com/sites/default/files/research-papers/Good%20care%20planning%20for%20people%20with%20long-term%20conditions.pdf> (accessed 13.02.19)
- NICE (2015) *Diabetic foot problems: prevention and management. NG19*. London: NICE. Available at: www.nice.org.uk/ng19 (accessed 13.02.19)
- Pound N, Chipchase S, Treece K et al (2005) Ulcer-free survival following management of foot ulcers in diabetes. *Diabet Med* 22: 1306–9
- Robbins JM, Strauss G, Aron D et al (2008) Mortality rates and diabetic foot ulcers: is it time to communicate mortality risk to patients with diabetic foot ulceration? *J Am Podiatr Med Assoc* 98(6):489–93
- Schofield CJ, Yu N, Jain AS, Leese GP (2009) Decreasing amputation rates in patients with diabetes – a population-based study. *Diabet Med* 26: 773–7
- Scottish Diabetes Foot Action Group and Skills for Health (2010) *Capability framework for the prevention, treatment and management of diabetic foot disease*. Edinburgh: Scottish Diabetes Foot Action Group and Skills for Health. Available at <http://www.diabetesinscotland.org.uk/publications/Foot%20capability%20document%20draft.pdf> (accessed 13.02.19)
- SIGN (2017) *Management of diabetes – A National Clinical Guideline. CG 116*. Edinburgh: SIGN. Available at <https://www.sign.ac.uk/assets/sign116.pdf> (accessed 13.02.19)
- Strohal R, Apelqvist J, Dissemmond J et al (2013) EWMA Document. Debridement. *J Wound Care* 22 (Suppl. 1): S1–S52
- Tissue Viability Leading Change (2015) *TVLC Competency Framework*. London: TVLC
- TRIEPodD-UK (2012) *Podiatry Competency Framework for integrated diabetic foot care: A User's Guide*. Edinburgh: TRIEPodD-UK. Available at <https://www.wounds-uk.com/resources/details/podiatry-capability-framework-integrated-diabetic-foot-care-users-guide> (accessed 13.02.19)
- Vileikyte L (2001) Diabetic foot ulcers: a quality of life issue. *Diabetes Metab Res Rev* 17: 246–9

Lined area for notes.

