



Long awaited formula for the improvement of foot care in diabetes

Despite the fact that foot disease (non-healing ulcers, gangrene, amputation etc) is a source of enormous morbidity, suffering and cost, it is a condition (or group of conditions) which tends to be managed badly by doctors and nurses alike, in both primary and secondary care. The main reason for this is that few professionals are trained in either the assessment or management of the diabetic foot. When confronted by a new ulcer, a doctor may simply prescribe a course of flucloxacillin for a week. Nurses will do their best but often feel isolated and unsupported and, if left to believe that outcome is closely linked to dressing choice, can become highly susceptible to the aggressive (and currently very successful) marketing strategies of dressings manufacturers. And while dressings manufacturers fatten on the proceeds of suboptimal care of a condition which is inherently chronic, it is the patient – often elderly and clinging to the vestiges of an independent existence – who suffers. It is commonplace for specialists to encounter episodes of apparent mismanagement: the misuse of antibiotics, for example, or the failure to diagnose osteomyelitis, the failure to realise that pain and redness of the forefoot may be the result of critical limb ischaemia, and the near total unawareness of the possibility of acute Charcot disease. Generalists will counter this observation by saying that it is easy for experts to be wise after the event and to criticise others for non-expert management of specialist disease. This, however, is the point: disease of the diabetic foot is specialist territory, and is a condition which threatens both limb and life.

It is therefore disturbing to observe how widespread among health care professionals is the failure to perceive the size of the threat posed by foot disease in diabetes, as well as the lack of awareness of the need for early expert assessment. Substandard practice of this degree would not be tolerated in any other form of life-threatening disease – such as malignancy, heart disease or incipient nephropathy – where there are clearly established responsibilities, skills and criteria for specialist referral as well as the ready availability of expert opinion.

Implications of changes within the NHS

This situation has not been helped by the ongoing changes within the NHS – associated as they are with inappropriate emphasis on shifting much of diabetes care into the community. No-one disputes the principle, and the majority of those with long experience of running hospital diabetic clinics have been striving for years to discharge as many patients as possible back to the GP for routine surveillance, with the aim, not least, of making the delivery of specialist services more effective. But the extent of the current move may well result in people with diabetes depending almost entirely on supervision by a raft of health care professionals who were not previously engaged in diabetes care, and who have limited training, experience and interest. The priority now is to ensure that these professionals have the skills and

knowledge necessary to undertake the work which they are required to do, while also having ready access to early expert assessment of any problem which arises.

National Minimum Skills Framework

It was for reasons such as these that FDUK (Foot in Diabetes UK), in collaboration with Diabetes UK, the Association of British Clinical Diabetologists, the Society of Chiropodists and Podiatrists and the Primary Care Diabetes Society, took up the challenge of defining the minimum skills necessary for managing any aspect of diabetes related foot complications. The result was the first National Minimum Skills Framework for the commissioning of foot care services – a framework designed to serve as a benchmark for all those involved in the management of foot complications of diabetes. The document (www.diabetes.org.uk/professionals/Education_and_skills/Competencies_-_Feet/) considers two broad issues: (1) *prevention* in those with varying degrees of risk, and (2) *management* of those with established ulcers. It acknowledges that the issue of prevention is generally supervised by clinicians (nurses, podiatrists, doctors) who are working on their own in either primary or secondary care and who personally require a minimum set of basic skills, while the management of established disease will usually need the involvement of a number of different clinicians, generally with specialist training, but whose input needs to be coordinated to be most effective.

The Skills Framework should not be regarded as a threat to the integrity of an individual professional. On the contrary, it should be regarded as a welcome safety net which allows the professional to understand the levels of competence required before they accept the role of first line care provider. Moreover, the Framework is not concerned exclusively with the skills and competence of individuals, because it also delineates the need for lead specialists to ensure that a system of expert care is provided which is both integrated and accessible. And by concentrating on the key issue of patient needs, this document provides a beacon for those caught in benighted arguments surrounding the ideal placement of diabetes care services, and the resultant sniping between those in primary and secondary care.

In truth, no single professional or professional group (nurses, podiatrists, doctors) has all the skills necessary to cover every aspect of management and the patient needs the coordinated input of all. The key to good management lies in effective collaboration of appropriately skilled health care professionals, wherever they work.

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