I'm competent, hope you're competent too

Matthew Young

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I started medical school in 1980, qualified in 1985 and attended my first diabetic foot clinic as a trainee in 1989. I started as a consultant in 1995. Next year will see the 10th year of *The Diabetic Foot Journal* conferences and my 20th year of diabetic foot clinic experience. Now that, I am sure, the reader is bored with details of my CV and my tiresome obsession with pop culture references – the knowing nod to David Bowie in the title for example – I will try to explain the relevance.

When I started to train in diabetic foot care I had a pair of white jeans (which still fit today!) white socks and white shoes, mainly for special nights out, but as BBC TV's Ashes to Ashes demonstrates the look has dated badly. At that time foot care research was in its infancy, foot care practitioners did not have a specialist group (such as Foot in Diabetes UK), there was no diabetic foot journal and no one mentioned competency. One progressed by achievement, but this was not formally measured and this too is no longer acceptable.

The times they are a-changing. Music, clothes and clinical training have to go with them. The development of guidelines and protocols has its limitations but an emphasis on clinical quality is a welcome move for the NHS. The best foot care units in the UK have a number of similar attributes. These include dedicated staff with an interest and passion for the subject, a leader who can drive the service forward, a research and audit culture and a willingness to learn new skills and advance old ones. Such centres are also characterised by a sizeable clinical workload and a commitment to teaching. Medical training is now almost exclusively competency based. Much of my time as an educational supervisor of medical trainees is spent ensuring that competencies are achieved through supervised clinical experience and signing off my juniors when they are. This model is in its relative infancy for other healthcare groups. However, Agenda for Change has highlighted the need to map out the knowledge and skills framework for each post allowing the opportunity for a competency set to define a foot practitioner in a way that has never been done before.

The development of the minimum skills framework for diabetic foot care under the FDUK umbrella was a start. The Scottish Diabetic Foot Workforce Development Group are 6 months into doing the same for highly specialised or advanced practitioners in diabetic foot care. A full set of clinical and theoretical competencies has been developed. They have also been mapped to the skills for health framework.

The next problem is delivering fully competent practitioners. Most of the practitioners in centres such as those outlined above will of course be automatically included as they have demonstrated their clinical skills by doing the job. If necessary, theoretical aspects, such as X-ray requesting can be filled in with theory refreshers and conferences, such as this year's diabetic foot journal conferences which give the practitioner the opportunity to acquire the IRMER theory required to request X-rays in the UK and a certificate to prove it.

The next generation can go on the current haphazard serendipitous approach to training or we can grasp the nettle and reform foot care training from the beginning: like driving a car having only read the Highway Code, attending theoretical courses and modules does not make one a fully formed clinician. It is necessary to develop a practical modular based system of training through secondments to the leading centres for foot care. This will ensure that there is a steady supply of fully trained practitioners for foot care. They will be required to meet the needs of the rising tide of diabetes patients in the future and will increase the standing of such professionals to a point where I see them superseding the medical team in less than a decade. ■