Something good is going to happen: Who should screen?

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By the time this journal reaches you a remarkable event will have taken place. Scotland is a large country with a relatively small population and I have worked there for nearly 15 years. Since devolution health matters have been constitutionally Scottish and separate from England, it has been easier to implement national initiatives. Over the past few years the Scottish Diabetes Group has been looking at aspects of diabetes care and making national policy, which has the backing of the Scottish Government. A national eye screening programme is already in place and now a national foot screening programme using standardised methodology and recording is about to be launched.

This programme will use monofilaments and pulses as the baseline screening tools and allocate risk using the Scottish national computer system SCI-DC (Scottish Care Information – Diabetes Collaboration; McCardle and Young, 2006). Screeners will have a nationally agreed training booklet and DVD to standardise the screening process. The patients will also be given nationally agreed and approved leaflets for each stage of their foot care from low risk to active ulceration. These leaflets have been given the crystal mark for clear, easy to understand content (visit www.plainenglish.co.uk for a detailed explanation of the crystal mark).

Local issues have largely been set aside to serve the national good. This could be seen as totalitarian, but it is at worst, benign dictatorship, albeit one with a healthy national representation on its steering and advisory groups. Rolling this out across the 14 Scottish health boards will be challenging, and Duncan Stang – whom many will know from his presentations at *The Diabetic Foot Journal* conferences – has been leading this for over a year to get to where we are now (see page 82 for further commentary on SCI-DC by Duncan Stang). Hopefully, a similar initiative can be adopted across England, Wales and Northern Ireland.

Inherent in this process is that screening is not the role of podiatrists. Their role is assessment and care of patients at increased risk. Annual screening of low-risk individuals is an integral part of diabetes care whether it is feet or eyes. While the drive to retinal photography has removed eye screening from this list I see no logic for separating first-line foot screening and using highly trained podiatrists for this role. I, and others, believe that not only are there too few NHS podiatrists in the UK to fulfil this role, but it is wasteful of their talents. First-line screening should be performed by any competent healthcare practitioner reviewing that patient. If a person fails a first-line screen then that is the time for a fuller assessment of risk and a decision on follow up by a podiatrist (Mousley, 2006).

This brings me to my final assertion. Can there be a consensus on routine follow up care and does it do anything to reduce ulceration? We might have got screening about right in Scotland but unless the follow up is appropriate and effective then screening – other than the recognition of past ulceration – might not actually influence outcomes for diabetic patients. Even the presence of neuropathy or vascular disease does not increase the risk of ulceration as much as a previous ulcer and as yet, other than earlier referral and reduced amputations, the case for organised preventative care has yet to be proven. ■

McCardle J, Young M (2006) The SCI-DC form: Does its use improve diabetic foot stratification? *The Diabetic Foot Journal* **9**: 25–32