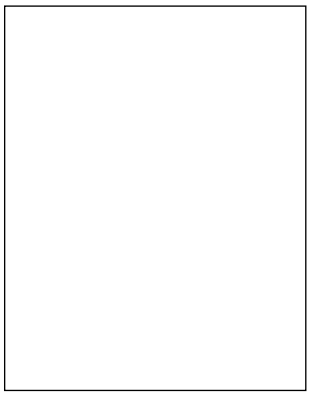

Alistair McInnes

Clinical governance: will it improve diabetic foot care?

Delivering quality diabetic foot care in the NHS requires a myriad of different skills, including that of 'managing change'. With each successive Government, the NHS has to brace itself for radical reform, accompanied by a raft of health policies which require strenuous efforts to implement and sustain. In the age of political 'spin', the cynics among us may regard clinical governance as no more than a sound bite provided by the Government in an attempt to assuage the nation that the NHS will be more accountable in the provision of quality care, but that the reality will be yet another avalanche of bureaucracy that may well impede the provision of healthcare with no real tangible benefits.

How will clinical governance affect diabetic foot care?

From its inception, *The Diabetic Foot* journal has published articles that demonstrate quality care which has been delivered throughout the country. However, from the Clinical Service Advisory Group (CSAG) report on diabetes (CSAG, 1994), it is clear that equity of quality foot care services remains an elusive goal, despite the well published data on foot morbidity that permeates across the UK and beyond.

Clinical governance has been described as:

'A framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish' (DoH, 1998).

There are a number of aspects that underpin clinical governance with which the readership will be familiar. There has been a plethora of recently published guidelines which may inform the setting of national quality standards for diabetes. Although the research literature suggests that national guidelines and standards are poorly received and under utilised, one of the Government's initiatives that may facilitate clinical governance is the provision of a National Service Framework for Diabetes which will be in place by Spring 2001. Perhaps this Framework of quality standards may enable the purchasers and providers to secure quality diabetes care. This may be realised with the advent of Primary Care Groups, as the purchaser/provider conflict will be replaced by a more collaborative approach in dealing with local health economies with shared responsibility and accountability.

Another familiar strand of clinical governance is that of evidence-based practice. There is a paucity of evidence from randomised controlled trials (RCTs) to support the use of the many different therapeutic interventions that are selected for the management of diabetic foot disease. While RCTs may not be the only acceptable evidence to inform protocols of care, as was clearly illustrated by Masson (1999) in the last issue of the journal, there is insufficient evidence to identify best practice in the care of the diabetic foot. This discrepancy affects the setting of quality standards as far as treatment is concerned, with the resultant treatment protocols appearing somewhat anodyne.

Identification of best practice

The recently published *Practical Guidelines on the Management and Prevention of the Diabetic Foot*, which is based upon the *International Consensus on the Diabetic Foot* (International Working Group on the Diabetic Foot, 1999), provides much useful information. However, while the guidelines may enable some quality standards to be set, the identification of best practice remains elusive. With the advent of clinical governance, it is hoped that an environment may be created to allow the appropriate research to flourish, which may lead to the creation of national quality standards of care with which we can be confident. The environment will be enhanced by the newly formed National Institute for Clinical

Alistair McInnes is Senior Lecturer at the Wessex Centre for Podiatric Studies, Southampton, and Editor of *The Diabetic Foot*.

'With the advent of clinical governance, it is hoped that an environment may be created to allow the appropriate research to flourish, which may lead to the creation of national quality standards of care with which we can be confident'

Excellence and the Commission for Health Improvement. These organisations have been set up to fulfil a number of functions which include:

- Appraisal of new and exciting technologies
- Development of clinical guidelines
- Promotion of clinical audit and confidential enquiries.

To ensure that measurable quality standards are delivered, the Commission for Health Improvement will monitor and audit the services accordingly.

Clinical governance will shape the future provision of diabetic foot care. While the raising and monitoring of standards is to be applauded, there are some areas of concern that have to be addressed. Currently, performance in the NHS is measured by intervention outcomes and volume of patient throughput. While these measures are useful indicators of health service activity, it may be an appropriate time to consider a change of focus towards prevention and education as suggested by Crawley in his paper 'Will primary care groups improve diabetes care?' (Crawley, 1999). With particular reference to diabetic foot disease, the outcomes of prevention and education programmes need to be recorded across the UK. If we can be successful in developing reliable tools to measure our efforts, and enhance our practice from the evidence, we may look forward to improving the foot health status of the diabetic population.

Finally, one of the most important aspects that underpins clinical governance is the requirement for continuing professional development. The strategies suggested in the NHS document, *Continuing Professional Development: Quality in the new NHS* (DoH, 1999), have been carefully considered, with the focus clearly on improving patient care. The lifelong learning needs of healthcare professionals and all staff involved in the delivery of healthcare have been addressed, and the suggested partnership between Government, NHS employers, the health professions, regulatory bodies, higher and further education is to be welcomed and encouraged.

Patients' and carers' views will also be considered within the new initiatives, and it is only in this spirit of collaboration that clinical governance has a chance to succeed. ■

Clinical Service Advisory Group (1994) *Standards of Clinical Care for People with Diabetes.* HMSO, London

Crawley D (1999) Will primary care groups improve diabetes care? *Diabetes and Primary Care* **1**(1): 19–21

Department of Health (1998) *A First Class Service: quality in the new NHS.* HMSO, London

Department of Health (1999) *Continuing Professional Development: quality in the new NHS.* HMSO, London

International Working Group on the Diabetic Foot (1999) *Practical Guidelines on the Management and Prevention of the Diabetic Foot.* International Working Group on the Diabetic Foot, Noordwijkerhout, The Netherlands

Masson E (1999) Is foot care evidence based? *The Diabetic Foot* **2**(2): 44–46