Ensuring high-quality foot care through training and education

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The provocative, yet considered, editorial from Martin Fox in the last issue of *The Diabetic Foot* highlighted a number of key issues concerning optimum service structures for the management of the diabetic foot (Fox, 2006). He also alluded to the fact that no one clinician or multidisciplinary team is the sole arbiter of decision-making for the care of patients. The Department of Health (DoH) has developed key strategies that are currently affecting the delivery of all diabetes services, such as its white paper on community care (DoH, 2006b).

Martin also referred to the paucity of evidence that exists to help determine the best model of care for diabetes, although there have been some useful studies that were reviewed as part of *CG10 Type 2 diabetes - footcare: Full guideline* (National Institute for Clinical Excellence [NICE]; 2004). In essence, a highly skilled multidisciplinary team which is integrated into a shared care approach across primary and secondary care provision may prove to be the best model. This concept was also endorsed by Andrew Kingsley in the same issue of *The Diabetic Foot* (Kingsley, 2006).

There is no doubt that there are a number of threats to the current and future provision of diabetic foot care. The real challenge is to be able to identify where these threats may arise, to implement a strategy to deal with them and to secure good practice for the future. This, of course, may seem like wishful thinking. Can we identify the threats? Do they relate to individual failures, system failures or both? Clinical governance may be the instrument that provides the mechanisms to protect and improve diabetes foot care services.

On a personal note, I believe that the only failures in the provision of diabetic foot care are system related. When individuals make mistakes it may be due to system failure because they have not been provided with the appropriate education and training to enable them to provide diabetic foot care within their scope of practice. Systems need to be robust enough to ensure that no one healthcare practitioner remains unsupported in the provision of care for people with diabetes who have significant complex foot disease.

Quality assurance mechanisms for diabetic foot care are complex. One important quality assurance mechanism is the regulation of healthcare practitioners. There are several regulatory bodies that operate within legislative boundaries to protect and safeguard the general public. While physicians and nurses have their own bodies (the General Medical Council and the Nursing and Midwifery Council, respectively), the allied health professions are regulated by the Health Professions Council (HPC).

Health Professions Council proficiency standards

I do not wish to bore the readership with the processes involved with the 'grandparenting' arrangements for the registration of podiatrists and chiropodists in the recent past; however, the processes have highlighted some of the concerns that clinicians have regarding scope of practice and improving patient care.

The HPC has a set of proficiency standards (HPC, 2003; *Figure 1*), which were informed by the Quality Assurance Agency for Higher Education (2001). The standards provide the quality assurance framework against which higher education awards can be judged. They are regarded as threshold standards for entry to the profession.

The HPC proficiency standards are clearly set out and they provide a collection of minimum standards for practice. With regard to diabetic foot care, one of the standards is the ability to:

'interpret the signs and symptoms of systemic disorders as they manifest in the lower limb and foot.'

A second standard includes the ability to:

'carry out mechanical debridement of nails and intact and ulcerated skin.'

The interpretation of this standard might assume debridement of diabetic foot ulcers, although this is not stated.

Concerns have been raised to me over the appropriate level of skills and knowledge of 'grandparented' podiatrists and chiropodists,

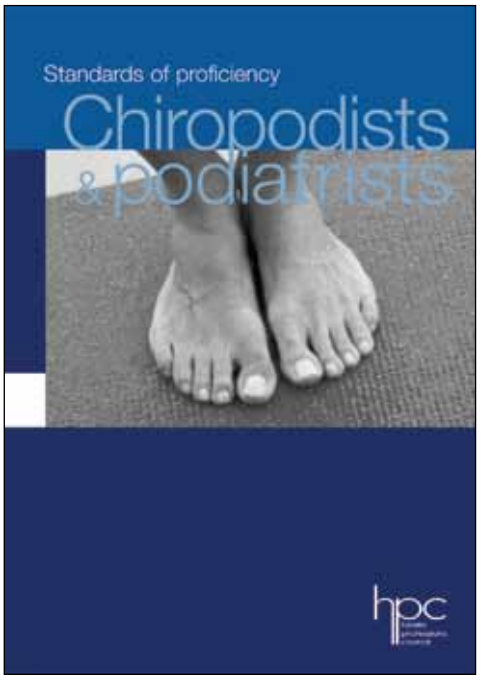

Figure 1. The front cover of the Health Professions Council (HPC)'s* Standards of proficiency: Chiropodists & podiatrists *(HPC, 2003).

as well as newly qualified podiatrists, who are registered with the HPC and may therefore consider themselves qualified to treat acute diabetic foot ulcers. However, it may assure readers that a further proficiency standard states that all registrants must:

'know the professional and personal scope of their practice and be able to make referrals'.

I believe that this is the nub of the issue.

It is not an unreasonable expectation, considering the above factors, that all registered podiatrists and chiropodists will be able to perform first aid for the diabetic foot ulcer and to refer appropriately in a timely and safe fashion to 'highly trained specialist podiatrists and orthotists' (NICE, 2004) as members of the multidisciplinary foot care team.

Training and education

Returning to my theme of system failure, there may be situations where there is not a fully trained multidisciplinary foot care team to refer to immediately or the multidisciplinary team does not have the capacity to manage all people with diabetes who have foot ulcers. Many podiatrists and nurses, in my experience, are able to manage people with foot ulcers perfectly well in the community and have agreed protocols and care pathways for speedy access to the hospital-based multidisciplinary team. Martin Fox outlined the shared care approach in a measured fashion in his editorial (Fox, 2006). However, I want to focus on the training and education aspects of the debate.

'There is an obligation for all clinicians to engage in continuing professional development.'

There is an obligation for all clinicians to engage in continuing professional development (CPD; HPC, 2006). The identification of training routes for all those involved in diabetes care has been a challenge for some time. There has been a great deal of work achieved in the aftermath of the St Vincent Declaration (International Diabetes Federation, 2006), with many valuable reports (e.g. Edmonds et al, 1996) being produced that have informed providers of education and training for all those engaged with diabetes services.

I have to confess to some confusion over the many different working groups, committees and other stakeholder opinions that inform and direct diabetes services. However, I hope that in light of Agenda for Change and the Knowledge and Skills Framework (DoH, 2006a) there may be some clarity of the role and scope of practice and the beginning of a career structure that supports the clinician in the management of the diabetic foot.

The Skills for Health initiative has led to the development of a series of competences which, although not role specific, may help to inform clinicians and other interested parties of the continuing professional development that they require for the future (Skills for Health, 2004).

I think that we have to carefully consider how clinicians can achieve and provide evidence for the competences in light of the current situation with regard to the provision of services, the available resources and the education and training that is on offer. This is a real opportunity for the key stakeholders (i.e. the service and education providers) to work together in order to enable the workforce to provide improved patient care.

Where to set the bar

If we raise the skills and knowledge 'bar' too high, we may restrict many able clinicians from career progression and, more

Department of Health (DoH; 2006a) *Agenda for Change – resource pack*. DoH, London. http://www.dh.gov.uk/PolicyAndGuidance/HumanResourcesAndTraining/ModernisingPay/AgendaForChange/AgendaForChangeArticle/fs/en?CONTENT_ID=4112440&chk=zUrl/6 (accessed 29.05.2006)

Department of Health (DoH; 2006b) *Our health, our care, our say: a new direction for community services*. DoH, London

Edmonds M, Boulton A, Buckenham T et al (1996) Report of the Diabetic Foot and Amputation Group. *Diabetic Medicine* **13**(Suppl 4): S27–42

Fox M (2006) Community-based diabetic foot teams: Are they the way forward? *The Diabetic Foot* **9**(1): 4–6

Health Professions Council (HPC; 2003) *Standards of proficiency: Chiropodists & podiatrists*. HPC, London. Available at http://www.hpc-uk.org/assets/documents/10000DBBStandards_of_Proficiency_Chiropodists.pdf (accessed 29.05.2006)

HPC (2006) *Continuing professional development*. HPC, London. http://www.hpc-uk.org/registrants/cpd/ (accessed 29.05.2006)

International Diabetes Federation (IDF; 2006) *St Vincent's Declaration (SVD)*. IDF, Brussels. http://www.idf.org/home/index.cfm?node=839 (accessed 29.05.2006)

Kingsley A (2006) Sharing the future in the care of the diabetic foot. *The Diabetic Foot* **9**(1): 8–10

National Institute for Clinical Excellence (NICE; 2004) *CG10 Type 2 diabetes - footcare: Full guideline*. NICE, London

Quality Assurance Agency for Higher Education (QAA; 2001) *Benchmark statement for podiatry (chiropody)*. QAA, Gloucester. Available at http://www.qaa.ac.uk/academicinfrastructure/benchmark/health/podiatry.pdf (accessed 29.05.2006)

Skills for Health (2004) *Take responsibility for the continuing professional development of self and others*. Skills for Health, Bristol. Available at http://www.skillsforhealth.org.uk/get_competence.php?id=1961 (accessed 29.05.2006)

importantly, deny patients access to key clinicians who cannot provide evidence that they possess the stated competences. On the other hand, underestimating the advanced competences that are required to manage the acute, complex diabetic foot effectively within the framework of the multidisciplinary team could be detrimental to patient care.

Moving forwards

There has to be a clear strategy to take this highly complex skills and knowledge project forward. Perhaps a first stage is the collection of robust data to reflect the current situation.

It is very difficult to measure the leg that has yet to be amputated or the foot that has not yet ulcerated. The collection of evidence of poor practice is difficult and complex. Sophisticated information systems are required to audit negative health outcomes that are the direct result of poor practice, and it is difficult to compare health trusts particularly with shared care systems being in place. Patient complaints, on the other hand, may provide useful data.

System failure is common and we need to identify the faults involved. For instance, as I mentioned earlier, there may be a fault in the training and education system. Universities provide undergraduate and postgraduate education and some are currently involved with the provision of CPD. There are different assurance systems that monitor the quality of that provision and all stakeholders have an opportunity to have their views represented, through various mechanisms.

Over the past decade, there has been a growth in Master's of Science programmes in diabetes management throughout the country and they have enabled many clinicians to develop their practice. Local diabetes experts from the NHS often have a significant input to the programmes, including module design, learning outcomes and assessment.

There is an argument that despite the emphasis on the development of problem -solving and critical skills, there may be a deficit in certain specific clinical and technical skills, training for which cannot be achieved within the university setting. This is a criticism that persists in the podiatry profession, although some are currently seeking to overcome this shortfall in training.

It is interesting to note that the Skills for Health use of competences differs from the method employed by the higher education sector to identify learning outcomes.

The use of competences often polarises opinion in the world of higher education. However, there is a real opportunity to bring the providers of higher education – with their quality assurance mechanisms, which are so important – together with colleagues from the NHS and other key stakeholders from the DoH and charitable bodies such as Diabetes UK in order to enable clinicians to continue to develop their skills and knowledge in the care of people with diabetes who have foot disease.

I am aware that colleagues have been involved with the Skills for Health programme and invite their comment in future issues of the journal.

Evidence of CPD is now mandatory and the evidence has to support the claims that clinicians are working within their scope of practice (HPC, 2003). It is reassuring that Agenda for Change has identified the support that is required of a newly qualified podiatrist with the introduction of the band 5 profile (DoH, 2006a). System failures occur when podiatrists are appointed to perform work that is outside their scope of practice.

Concluding remarks

I often hear universities being criticised for not providing appropriate training for students to successfully treat and manage diabetic foot ulcers. Conversely, I hear that there needs to be a programme for the advanced specialist podiatrist to manage diabetic foot ulcers effectively and that newly qualified podiatrists should not be allowed to treat foot ulcers. How and when are they deemed ready to treat a diabetic foot ulcer and to enrol on the suggested advanced programme?

Matching the career structure with the multidisciplinary team, achieving shared care and providing education and training for all healthcare practitioners will go a long way towards resolving the perceived inadequacies of some clinicians and improving patient care. Clinical audit has never been more important. ■