A tale of two nations: Finding the way forward in podiatry

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The borders between English and Scottish health care are becoming less defined as changes to NHS commissioning, financing and service structure bring them closer together. What both nations certainly share is the prospect of no NHS growth for many years. What may differ between the nations is how that challenge is met. Here, podiatrists from either side of the border discuss their views on the future of diabetic foot care and the role for podiatrists in delivering that care.

Joanne McCardle: A perspective from Scotland

NHS financial restrictions are ever present, but the scrutiny of everyday service provision has never before been so powerfully felt. Predictions made in a previous strategic analysis (McCardle, 2008) are upon us, as are the effects of the European Working Time Directive on the workforce participation of junior doctors, and health service finances dwindle in the face of an increasing number of people with diabetes. All these changes mean that podiatrists are now becoming the most constant and experienced clinicians in the diabetic foot care team and the natural leaders, clinical researchers and decision-makers in those teams.

The transition of podiatrists to leaders in the field of diabetic foot care requires both greater recognition of the skills within the profession, and the reassignment of some historically podiatric tasks (e.g. routine foot risk screening, low-risk nail care) to other appropriately trained healthcare professionals. These measures will allow podiatrists to further focus and refine their specialist knowledge on the more complex presentations of diabetic foot disease.

As part of the *Scottish Diabetes Framework: Action Plan* (Scottish Executive, 2006) the Scottish Diabetes Group has developed a diabetic foot screening programme that can be undertaken by a range of healthcare professionals. It includes basic training in taking pedal pulses and using a monofilament, and the SCI-DC database gives direction on care and referral based on the input of results. This programme aims to move basic diabetic foot screening away from the clinical workload of specialist podiatrists.

It is no coincidence that podiatrists have been identified as one of the first allied healthcare professional groups to become independent prescribers. The opportunity to gain independent prescriber status is being pushed for by our professional body, and its achievement will be a recognition of the progression that the profession has made.

While extending the scope of practice may not be for all, we need to prepare the profession as a whole for progression. Currently, there are more and less skilled levels of practice, but no clear indication of how a professional might navigate up the skills ladder, should they wish to.

To address this, the Scottish Diabetes Group's subgroup, the Foot Action Group, have developed the *Diabetes Foot Competency Framework* (2010). This document provides a toolkit of clinical skill sets spanning the whole

diabetic foot service and has multiprofessional implications. It will enable and empower podiatrists to reach their full potential, is a model for standardised diabetic foot care across postcodes and nations, and it gives a picture of the professional skills that a person with diabetes needs access to, relative to their level of ulcer risk. Hopefully, the document will be adopted across the UK.

Richard Leigh: A perspective from England

The White Paper *Equity and Excellence: Liberating the NHS* (Department of Health, 2010) tells us that in the future there will be less money spent on bureaucracy and more on the frontline in the NHS. As the White Paper "plans to put allied health professionals at the heart of an integrated and responsive NHS" (thewhitepaper, 2010), adapting to this new environment will be essential in order to thrive. So, how do we in the podiatry profession meet this challenge?

As the population of people with diabetes increases, diabetes specialist podiatry needs a uniform approach to training, quality of care and data collection. Podiatrists will need to become the leaders, decision makers and "champions" for diabetic foot care in community, hospital and research settings. I feel that podiatrists are well placed to meet this challenge, but there will need to be changes to the traditional approach to the profession – perhaps most importantly in the appropriate allocation of clinical skills and time.

As commissioning evolves, and budgets are further limited, we will need evidence to demonstrate the quality of care our diabetic foot services offer people. Presently, data collection in primary care trusts and strategic health authorities frequently focuses on (i) head counts and (ii) time to treatment. But these targets are due to be phased out and we need more relevant and representative data in order to maintain and create funding.

I think there is a need for the standardised collection and recording of diabetic foot care statistics UK-wide. Such a system would promote understanding and research, provide data for local and national funding opportunities and create a national benchmark for high-quality diabetic foot care.

It is heartening to see that the Society of Chiropodists and Podiatrists' Faculty of Surgery have created a structured training plan for specalisation in podiatric surgery. Yet the route to becoming a "diabetes specialist podiatrist" – like the job title itself – remains variable and ill-defined.

Skills for Health's (2010) outlining of diabetic foot care competencies against the Knowledge and Skills Framework does not give a definitive pathway for specialist progression. As the scope of podiatry practice widens to include areas such as independent prescribing, the establishment of a pathway for specalisation in diabetic podiatric medicine would be hugely beneficial to professionals and patients. A draft of just such a framework has been developed in Scotland (Foot Action Group, 2010) and I hope that agreement and adoption across the UK can be achieved.

Quality of care for people with diabetes and their feet is not standard throughout England. Our guidance consists of NICE's *Clinical Guidelines for Type 2 Diabetes: Prevention and Management of Foot Problems* (McIntosh et al, 2003) and Diabetes UK and NHS Diabetes' (2009) joint publication *Putting Feet First*. However, these documents relate more to service provision than quality of care. Ensuring that all people with diabetes are receiving high-quality care, appropriate for their level of ulcer risk, is an area requiring urgent attention.

Conclusion

There is no doubt that some of the worst times may be ahead for the NHS. However, the best times for podiatrists are just beginning. The goals outlined here are achievable, if the profession continues to be creative and adaptable. Podiatrists' frontline involvement and professional expertise will help to build a sustainable future for the profession and a high-quality service for people in need of diabetic foot care across the UK. ■

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