New NICE guidance: Care of the diabetic foot among inpatients

Tony Berendt

Department of Health (2010) *NHS Outcomes Framework.* DH, London. Available at: http://bit.ly/fuh7kv (03.03.11)

Diabetes UK (2009) *Putting Feet First: Commissioning Specialist Services for the Management and Prevention of Diabetic Foot Disease in Hospitals.* Diabetes UK, NHS Diabetes, London

McIntosh A Peters J Young R et al (2004) *Type 2 Diabetes: Prevention and Management of Foot Problems.* Revised version. University of Sheffield, Sheffield on behalf of NICE, London. Available at: http://bit.ly/hejPnj (accessed 14.03.11)

NICE (2011) *Diabetic Foot Problems: Inpatient Management of Diabetic Foot Problems.* NICE, London

The development of the guidance discussed here was undertaken by the National Institute for Health and Clinical Excellence. The views expressed in this publication are those of the author and not necessarily those of the Institute.

Tony Berendt is Executive Medical Director, Director of Infection Prevention and Control and Consultant Physician, Bone Infection Unit, Nuffield Orthopaedic Centre NHS Trust, Oxford.

Readers of this journal will, in the main, share a passion for improving the lot of people with diabetes, especially those with attendant foot problems. I am therefore sure that you will join me in welcoming new guidance on the care of the diabetic foot among inpatients (NICE, 2011), published as this issue of *The Diabetic Foot Journal* goes to press.

NICE has previously published general guidance on the management of the diabetic foot in type 2 diabetes (McIntosh et al, 2004). The new guidance completes the pathway between home and hospital that many people with diabetic foot problems will experience. Building on Diabetes UK's (2009) Putting Feet First, but with the rigorous evidence assessment that characterises NICE guidance, it provides clear guidance on investigation and treatment, and on the need for local protocols and foot care teams.

It will come as no surprise to readers that the Guideline Development Group (of which I was one member) for this new publication found significant shortcomings in the quality of evidence on which to base its recommendations. This issue besets all guidelines – national and international – on the management of the diabetic foot. The deficit in the literature is a problem in urgent need of addressing through large-scale multicentre trials.

These difficulties not withstanding, the guideline addresses a range of issues facing the diabetic foot in the hospital setting: the nature of, and need for, multidisciplinary diabetic foot care teams; the treatment of infection, including osteomyelitis; the role of adjunctive therapies; discharge arrangements. It remains to be seen how contentious the guideline's recommendations will be, following the changes made in response to consultation. It seems inevitable in a clinical area where there has been much non-evidence-based practice that, for some, this new guidance will present a challenge and potentially force through needed changes.

These are exciting times for any clinical area that is the subject of NICE guidance. Many NICE guidelines will be developed into NICE Quality Standards, which will be integral components of the NHS Outcomes Framework (current edition: Department of Health, 2010). The Outcomes Framework will be used to determine high-level metrics on health services performance. Thus, NICE Quality Standards (as part of the Outcomes Framework) will be built into commissioning standards, each generating a set of processes that must be followed by providers to achieve the required outcomes for patients. Metrics determined by the Outcomes Framework will be reported to Parliament by the Secretary of State.

Hence, if this new guideline is used to contributes to a Quality Standard, the journey that the management of the diabetic foot has undertaken – from the near-evangelical advocacy of individual clinicians to a mandated implementation of national guidance – will be complete. The care of the diabetic foot will have unequivocally entered the clinical mainstream, requiring the focused attention of healthcare professionals and commissioners alike.

There will, of course, be much work to do to achieve compliance with the guideline; some organisations may have to alter aspects of their clinical pathways, others will need to review what treatments are offered and by whom. But a major leap in inpatient care of the diabetic foot can start now; through documented implementation of this guidance, linked to audit of outcomes and execution of action plans, in cycles of rapid change. People with diabetic foot problems – whether in the community or inpatients – deserve nothing less. ■