Diabetes specialist podiatrists in the UK: Ensuring a competent, adequate workforce

Louise Stuart MBE

Alistair McInnes

Author details can be found on the last page of this article.

There have been a number of changes in the diabetic foot world since NICE's 2004 publication of *Type 2 Diabetes: Prevention and Management of Foot Problems* (McIntosh et al). In March 2011, NICE published further guidance on the inpatient management of diabetic foot problems (NICE, 2011a). This welcome document – with NICE's characteristic robust assessment of the evidence on investigations and treatments – also highlighted the need for diabetic foot care teams (Berendt, 2011), indicating that clinical guidance alone will not impact on the recently reported 10-fold variation in amputation rates across England (Jones et al, 2011). If we are to improve outcomes for people with diabetic foot disease, the provision of an adequate workforce of accessible and appropriately trained healthcare professionals is essential.

The revised version of the National Minimum Skills Framework (Diabetes UK et al, 2011) provides a much needed outline of the skills that each person with diabetes should have access to, depending on their need. These skills range from routine basic assessment of the foot without ulceration, through to expert management of an active ulcer. The purpose of the Framework was to define the skills required in diabetes foot care, but did not limit the skills to any single profession.

In March 2011, NICE published 13 Diabetes Quality Standards of which the foot was the only complication to receive its own standard. Quality Standard 10 (NICE, 2011b) heralds a potential milestone for the care of people with diabetes-related foot disease and states that:

> ***"People with diabetes with or at risk of foot ulceration receive regular review by a foot protection team in accordance with NICE guidance, and those with a foot problem requiring urgent medical attention are referred to and treated by a multidisciplinary foot care team within 24 hours."***

This Quality Standard, together with the new Quality and Outcomes Framework indicators – in particular DM29 (British Medical Association and NHS Employers, 2011) – should inform the commissioning process.

The pessimists among us may be reluctant to believe that all people with diabetic foot disease have, or will have, access to either a foot protection team (FPT) or a multidisciplinary team (MDT) as described in the National Minimum Skills Framework, but developing a clear picture of the situation remains difficult. It is hoped that the activities reported here will shed some light on the issue.

"The survey results highlighted that there is no typical, transparent or formal route to becoming a diabetes specialist podiatrist."

Getting the picture

For Quality Standard 10 to be achieved it must be underpinned by an accessible, adequately resourced and appropriately skilled workforce. The diabetes specialist podiatrist (DSP) is typically the leading figure within the FPT, and is a crucial member of the MDT. Yet the DSP role – like many other specialties in diabetes care – is poorly defined.

Is there anybody out there?

There is currently no accurate data on the numbers of DSPs working in the UK, their skills profiles or further training requirements. To redress this knowledge gap, Diabetes UK and NHS Diabetes, in partnership with FDUK, undertook a pilot survey in 2010 – the first of its kind to be undertaken to the authors' knowledge – to determine the characteristics of the UK's DSP workforce. The survey aimed to capture a snapshot of the diversity of DSP roles, job titles, training and work settings in England, Northern Ireland, Scotland and Wales.

Respondents to the survey were 512 podiatrists working largely within diabetes. Among the 512 survey respondents, 233 different job titles were cited, of which only 40% identified them specifically as a diabetes specialist. Most respondents reported working with high-risk diabetic feet for at least 70% of their total working hours. Almost half of the respondents working in the community reported that they had no direct access to a MDT.

The survey highlighted considerable variation in post-graduate training in this group, which ranged from mentorship within a hospital MDT, to attending local or national conferences. Only 28% of DSPs reported holding a Master's degree (partially or fully completed) and less than half at Band 7 held one or more post-graduate qualification.

With very few common factors between the respondents, the survey results highlighted that there is no typical, transparent or formal route to becoming a DSP; training is, at best, based largely on clinical mentorship – at worst, only patchy access to educational programmes.

This variation in DSP competency does not bode well in a time when healthcare professionals are subject to increased scrutiny to justify their posts. Nor do these findings bode well for people with diabetes, who, the survey results suggest, cannot confidently expect to receive high-quality diabetic foot care regardless of their postcode – perhaps a contributory factor in national diabetes-related amputation data varying widely by region (Jones et al, 2011).

The survey also showed that one in ten DSPs surveyed anticipate retiring in the next 10 years. In the current NHS climate, where many posts are being frozen and private practice is the most likely employment option for newly qualified podiatrists, fears for the future of NHS-based DSPs loom on the horizon. This begs the question: how can the stated national standards be met in the face of rising levels of diabetes in the population, with fewer healthcare professionals to deliver care?

A DSP by any other name?

One of the largest difficulties faced in administering this survey was distinguishing DSPs from those specialist podiatrists who are involved in managing all patients – regardless of diabetes status – with high-risk lower-limb conditions. The survey has highlighted that only hospital-based podiatrists are likely to work exclusively in diabetic foot care. In the community setting, the majority of specialist podiatrists manage a range of high-risk foot problems relating to peripheral arterial and musculoskeletal diseases, in addition to those associated with the diabetic foot.

A further limitation of the survey was the absence of a definitive DSP database. Potential respondents were sourced through FDUK, *The Diabetic Foot Journal* readership, the Society of Chiropodists and Podiatrists, as well as conferences attendees across the four nations. In response, FDUK are currently collating a DSP database. If you would like to add your details to the list visit fduk.org.uk

Berendt T (2011) New NICE guidance: Care of the diabetic foot among inpatients. *The Diabetic Foot Journal* **14**: 8

British Medical Association, NHS Employers (2011) *Quality and Outcomes Framework Guidance for GMS Contract 2011/12*. NHS Employers, London. Available at: http://bit.ly/iIAWlP (accessed 25.07.11)

Diabetes UK, Foot in Diabetes UK, NHS Diabetes et al (2011) *Putting Feet First: National Minimum Skills Framework*. Diabetes UK, London. Available at: http://bit.ly/ma8fbq (25.07.11)

Foot Action Group (2010) *Diabetes Competency Framework Draft Consultation Document*. Scottish Diabetes Group, Glasgow. Available at: http://bit.ly/q2vSq1 (accessed 25.07.11)

Jones S, Young B, Jeffcoate W, Holman N (2011) Variation in the incidence of lower limb amputations in adults with diabetes. *Diabet Med* **28**(S1): P189

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 25.07.11)

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

NICE (2011b) *Diabetes in Adults: Quality Standards*. NICE, London. Available at: http://bit.ly/is5YAn (accessed 25.07.11)

The first National Diabetes Footcare Structural Audit

This year the National Diabetes Information Service will be undertaking the first National Diabetes Footcare Structural Audit, which will be an optional module on the DiabetesE website (www.diabetese.net). From 1 September 2011, providers will be able to compare their answers with national results and have instant access to these reports.

A framework for competency

Initiated and developed by the Scottish Foot Action Group (2010), the *Competency Framework for the Prevention, Treatment and Management of Diabetic Foot Disease* will offer the first formalised framework for progression from support worker (Level 2) to consultant practitioner (Level 8) in diabetic foot care. The framework is currently being refined at the national level to provide a user-friendly tool to benchmark competencies required for DSP status. The tool will provide essential support for clinicians, educationalists, commissioners and service providers to ensure that national standards are delivered by an appropriately skilled workforce.

Conclusions

The findings of the survey reported here provide a much needed wake-up call for those engaged in workforce planning and commissioning – and for DSPs, who need to take a critical look at how they can gain and prove competency, and the future of their profession. Future – and existing – shortfalls in the DSP workforce are clear and must be addressed to protect people with diabetes from the ravages of foot complications. ■

Authors

Louise Stuart MBE is a Consultant Podiatrist based at Pennine Acute Hospitals NHS Trust; Alistair McInnes is Editor-in-Chief (Education) of *The Diabetic Foot Journal* and Senior Lecturer, University of Brighton, Brighton.