New guidelines for the diabetic foot: Let's make it a giant leap forward

Gadsby (2011) and Chadwick (2011) have provided clear summaries of the possibilities raised by the new Quality and Outcomes Framework (QOF) targets for the management of the diabetic foot (British Medical Association and NHS Employers, 2011), as well as some of the limitations. The QOF changes were released within days of the NICE (2011a) guidelines for the management of the diabetic foot in hospitals and the NICE (2011b) Quality Standards, which is likely to be the main platform for commissioning of foot care services. All three come hard on the heels of the 2011 National Minimum Skills Framework released jointly by Diabetes UK and NHS Diabetes (2011). Such a tumble of guidance and instruction can make clinicians weary: they enter "can't cope" mode, put their heads down and get on with the work while hoping that something good will come out of it in the end.

Such a reaction is very understandable, but should not be encouraged as we believe that these directives offer an unparalleled opportunity to make sure that from now on the diabetic foot will be treated with the seriousness it deserves, and the quality of clinical management will finally become something to be proud of. It is true that the QOF indicators are limited in their scope and the Quality Standards programme (Quality Statement 10) is flawed by being poorly drafted, but it is up to us to make both initiatives work to the advantage of people with, or at risk of, foot disease – because we won't be given anything better in the foreseeable future. This is as good as it gets and it is up to us to make it great.

Change to QOF indicators

The main change to the QOF indicators (and this will to a large extent be implemented because it is linked to GP practice income) is the requirement that each person with diabetes should not only have their feet examined each year, but their risk status is documented as well. It does not really matter that the system of foot risk classification system being promoted by both QOF and NICE is poor or that it differs from the simpler and better Scottish scheme which has the additional advantage of having been validated (Leese et al, 2006), the new requirement to define risk is a stride forward.

Although Gadsby (2011) is correct in regretting that the opportunity was not taken to link the definition of individual risk to any need for the GP to do anything with the results, NICE Quality Statement 10 clearly states that local arrangements should exist to ensure that people who are found to be "at risk" should receive regular review by a foot protection team (FPT). So it is important that GPs and commissioners are made aware


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that although QOF appears to stop at risk stratification, the NICE quality standards link these to referral to the FPT. This means that providers of specialist care should create FPTs where none exist, and need to make sure that this team reaches out to all GP surgeries in order to make them aware of who to refer, and to whom. It is up to those directly involved in the organisation of foot care to make sure that it happens because no-one else will.

Does everyone need to be screened each year ?

Chadwick (2011) makes the valid point that there is no need for annual rescreening of someone who has already been defined as being "at risk". Once someone is defined as being at risk, whether they are Grade 2 or Grade 3, they should be under regular surveillance by the FPT. It is an unnecessary intrusion on their time to require them to attend for an annual screening examination when the only outcome will be completion of returns necessary for the administration of the GP contract.

What is a foot protection team?

The majority will not know the answer to this question, even though the involvement of such a team is not new, and was actually central to the 2004 NICE guidelines on diabetic foot care. The fact that most professionals remain vague as to the nature and function of an FPT is an illustration of the extent to which the 2004 NICE guidelines have been ignored. But the need for an FPT cannot be ignored any longer because its establishment is spelled out in the NICE Quality Statement 10 and this is likely to be the plank on which future commissioning of specialist foot care is built. In truth, the establishment of an FPT will not require a major change – simply a reconfiguration of the way in which we work already; its constitution and roles have been spelled out in the National Minimum Skills Framework (Diabetes UK et al, 2011).

Serious thought has to be given to the point made by Chadwick (2011), however, about whether the (principally podiatric) staff who will constitute the FPT can cope with the workload, especially as it would probably involve the regular surveillance of 30% of all people with diabetes in the area. This is an issue for the Society of Chiropodists and Podiatrists to address, as well as all local podiatry managers, with decisions being made on how podiatrists should best use their time. There should be a national moratorium on GPs using podiatrists to do their annual screening for them (unless this is an agreed part of local policy), and the FPT will instead organise regular training of GP staff to ensure – as far as it is possible – that those who do the screening in the surgery have the necessary clinical competence together with knowledge of referral pathways.

Risk category 4: Active disease of the foot

The flawed classification of risk embedded in the QOF criteria includes as its 4th category – the presence of active foot disease (which many would say is not a risk criterion at all, but an actuality). It is, however, essential that all newly occurring, or deteriorating, disease of the foot is assessed as quickly as possible by a member of a multidisciplinary foot care team, and this is emphasised in all existing guidelines – there being good evidence that ulcer duration at the time of first referral correlates directly with time to healing (Margolis et al, 2002; Ince et al, 2007).

The only problem is that the wording of the new NICE Quality Statement 10 conflicts with NICE's 2004 guidelines on diabetic foot care. Specifically, the wording of the 2009 *Putting Feet First* (Diabetes UK et al), which was written entirely by experts in the field and which was the trigger for the production of NICE's inpatient foot care guidelines (2011a), stated with great care that all new or deteriorating disease of the foot (in both inpatients and outpatients) should be referred for expert assessment within one working day.

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This has been changed in Quality Statement 10 to read that all such disease must be *assessed and treated* by the multidisciplinary team within 24 hours. Not only is that not necessary, it is also impossible. It also takes no account of the potential need for investigation, uncertainty over the diagnosis, or the fact that treatment may not be indicated. Those who currently run instant rapid access service and who receive referrals by fax, phone or email, determine how quickly each patient needs to be seen and by whom – depending on their personal needs and restrictions. It is interesting that NICE Quality Statement 10 also drives a bus through the intention of professionals and which is spelled out in *Putting Feet First* (Diabetes UK et al, 2009), the *National Minimum Skills Framework* (Diabetes UK et al, 2011), and both the 2004 and 2011 sets of NICE clinical guidance for the diabetic foot. Thus, the Quality Statement specifies that prompt referral is required only of those who need urgent medical attention – which is not the aim at all.

Those of us who work in the field have to embrace the intention behind NICE's Quality Statement 10 and turn a blind eye to its being poorly worded. It is up to us to ensure that processes are established whereby all people with newly occurring diabetic foot disease are referred promptly (which, in practice, cannot reasonably be other than within one working day), and are seen as quickly as possible, depending on need.

Conclusion

And so, while it may be tempting to dwell on the limitations of all these various documents, and to use these limitations, perhaps, as a subconscious reason for not changing what we do, it is much more important that we do change what we do, and that we grasp the opportunities which these new guidelines present. It is essential that those involved in the delivery of specialist foot care make sure that they use them to establish the pathways of care which are so urgently needed. If this can be done, then we will indeed have made more than a step but a giant leap forward. ■

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