Goodbye and good luck

After 16 years, 64 issues, and hundreds of reviews, this editorial is my last as Editor-in-Chief of *The Diabetic Foot Journal*. Lobbying and campaigning to improve diabetic foot care have been reported in this journal from the first edition, and it's this activity that I will focus on here.

In 1992, I remember accompanying Professor Harry Keen, Professor Geoff Gill, Susan Knibbs, and Michael Cooper – all representing the British Diabetes Association (BDA) – to a meeting at Richmond House, Department of Health (DH), to discuss the St Vincent Declaration of 1989 (see http://bit.ly/1ibcHDQ). Our agenda included the standards of diabetes foot care throughout the country. We met with Sir Kenneth Calman, then Chief Medical Officer of Health, and a proposal for a joint task force between the BDA and the DH was agreed upon to achieve the aspirations of the Declaration.

The subsequent reports of the task force were published in *Diabetic Medicine* (Keen, 1996), which provided the foundations for the *National Service Framework for Diabetes: Delivery Strategy* (DH, 2003). One of the goals of the St Vincent Declaration was to reduce the number of amputations as a result of gangrene by 50% over 5 years. Although this target has still not been achieved across the whole country, the Foot and Amputation Group report provided guidelines of how it could be achieved. The report went on to inform NICE's 2004 *Clinical Guidelines for Type 2 Diabetes: Prevention and Management of Foot Problems*. These guidelines were developed jointly by the Royal College of General Practitioners, BDA, Royal College of Physicians, and Royal College of Nursing.

Reviewing the archive of this journal, I came across an editorial that described yet another campaign, the Focus on Feet campaign (McInnes, 1998a). This was launched on 6 May 1998 at the House of Commons. The campaigners included the BDA, Society of Chiropodists and Podiatrists, and Royal College of Nursing. We had several aims, which included:

- Ensuring appropriate priority is attached to diabetic foot care by purchasers of services.
- Ensuring equal access to the optimum treatment for all patients.
- Reducing the number of amputations due to diabetic foot ulcers.

There were other laudable goals set out in the campaign, which I am sure many of you would have endorsed at that time. Perhaps the campaign ran out of resources, but there is very little documented evidence of its impact. It is interesting to note that, at the time, the NHS was undergoing transition – a familiar theme, perhaps?

Another early editorial (McInnes, 1998b) focussed on the white paper, *The New NHS: Modern, Dependable* (DH, 1997). I commented at the time that we should be cautiously optimistic about the future for health and social services and welcomed the implementation of the Health Improvement Programmes (HIPs). One goal of the HIPs was to redress the vagaries of geographical inequalities in service provision. The paper described local solutions to local difficulties, working within the framework laid down by the Commission for Health Improvement (DH, 2007).

You will recognise familiar patterns appearing today with some important additions, for example new legislation allowing non-NHS commercial organisations to bid to deliver publicly funded services. You will recognise too, the changing landscape of the NHS – from GP fund-holding then, to GP commissioning now. Yet we are still lobbying to achieve goals, and responding to – and hoping to influence – changes and developments in health policy in order to improve the foot health of people with diabetes.

Having recently been involved in the of the Parliamentary & Stakeholder Diabetes Think Tank (Adrian Sanders MP, Chair) and Putting Feet First (www.diabetes.org.uk/putting-feet-first) campaigns, I find the same enthusiasm, commitment and passion from all of the members of the campaign groups being replicated from the campaigners from all those years ago. However,

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today, the healthcare professionals are increasingly armed with quality information and evidence to aim them in making their case. In addition, they have joined forces with policy makers and politicians to achieve improved and equable diabetes services for all.

During the turbulent times of the transition of the NHS, there will be opportunities to influence Clinical Commissioning Groups (CCGs) to commission best practice for diabetic foot care, but we have to act fast and with an appreciation of the enormously complex task that they have to achieve. I am aware that the Putting Feet First campaign, having highlighted the unacceptable variations in amputation rates across the country, has prompted some CCGs to consider prioritising foot care. This is not the only strategy required to influence commissioning. We must continue to provide evidence to justify investment in the integrated foot care pathway that demonstrates it to be the best model for providing foot care and reducing amputations.

Inevitably, the new Strategic Clinical Networks will be desperately seeking to influence their areas of interest and expertise to address health inequalities and health improvements. The Diabetes Leads of the Cardiovascular Networks will have to shout very loudly to be heard around the table, and we have to ensure that foot care appears on the agenda.

I share many of my colleagues' concerns with the lack of robust evidence for positive outcomes in diabetic foot care and realise this may well affect CCGs decisions to commission the pathway. However, I do consider that the impact of the information that is available from the National Diabetes Audit (www.hscic.gov.uk/nda) and National Diabetes Information Service (www.diabetes-ndis.org) – along with our continued campaigning – may help to persuade and convince the CCGs to invest in diabetic foot care. One of the difficulties is the translation of integrated care models of diabetes into the commissioning process; I suspect that multidisciplinary foot care teams and foot protection teams are quite a conundrum for CCGs in the commissioning process.

I find it difficult to remain positive about the future of the NHS in England. The drive for efficiencies and profit that will come from the commercial sector may prevent the implementation of best practice for which we have campaigned. Much has been achieved through the stalwart efforts of many of you working tirelessly for decades.

I had wished to retire from the journal on a positive note, but I have struggled to find one in today's health service. However, the dedication, enthusiasm, commitment, passion, and friendship of many colleagues never ceases to impress me, despite successive Governments interference with poorly considered policies.

I leave the journal in rude good health, confident that with my friend and talented colleague Matthew Young at the helm, aided by the superb staff at SB Communications and the esteemed Editorial Board, the journal will continue to provide the go-to publication for all those interested in diabetic foot care. It only remains for me to wish you all good luck for the future. ■

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