

# Twenty years of change in the diabetic foot world

Twenty years ago, I met Simon Breed and Sophie Perks to discuss their proposal to become the editor of a new journal, which would be dedicated to the diabetic foot. This new journal, *The Diabetic Foot Journal*, would provide a focus for enthusiastic clinicians from different backgrounds and help develop a community forum for continuing education and practical advice. At that time, I had no thoughts to the potential longevity for the journal or how health policy and organisational change would impact on the diabetes foot care service in the future. The service, as Simon described in his poignant editorial earlier this year, was frequently described as a Cinderella service, that is a service that is neglected, ignored or something that is given little attention or care.

1998 was the year of political devolution in the UK, which led to four distinctly different health systems. Devolution gave Scotland, Wales and Northern Ireland their local political systems and the autonomy to choose different policies, and they rapidly did (Greer, 2016). It is beyond the scope of this editorial to discuss the merits of the four different health systems, but suffice to say that purchasers and providers of care have been at the heart of English health policy (Greer, 2016). The merits or otherwise for this policy is one for debate. The belief that internal competition between different health providers drives up standards remains to be seen for diabetes foot care.

It is difficult to measure the direct or indirect impact that numerous health policies and organisational changes have made over the past 20 years. For example, the Patient's Charter (Department of Health [DoH], 1997a) outlined the rights of patients regarding the receipt and quality of service they should expect (1991) or the publication of the white paper, *'The Health of the Nation'* (DoH, 1992), which targeted five specific key areas and also highlighted the individual's responsibility for their health.

However, the white paper entitled *The new NHS: Modern, Dependable* (DoH, 1997b) aimed to replace the internal market with a more integrated approach and access to the NHS, based on need and need alone. In addition, the document *A First Class Service: Quality in the New NHS* (DoH, 1998) led to the creation of the National Institute for Health and Care Excellence (NICE) in 1999. This initiative helped to provide guidance on the use of technology and strengthen quality. Clinical governance, which is an essential component of the NHS quality system, was introduced to the NHS following publication of this paper. Clearly, the impact that NICE guidelines, evidence-based practice and clinical governance has on diabetes footcare has led to improved quality of care and greater accountability.

Professor Andrew Boulton suggested that "much progress has been made in both research and clinical practice" in relation to the diabetic foot in his insightful editorial in this journal (Boulton, 2017). It is this progress that has informed NICE guidance and driven up the improvements in diabetes foot care.

1998 heralded the arrival of NHS Direct and the following year there was another reorganisation when GP fundholding was abolished and new primary care groups (PCGs) were established. In 2000, the NHS Plan — a 10-year modernisation programme of investment and reform — was introduced. There was an increased focus on performance and further reorganisations in 2002, The National Health Service Reform and Health Professions Act, with strategic health authorities (SHAs) and primary care trusts replacing district health authorities. This Act legislated for recommendations in light of the Bristol enquiry (DoH, 2001a).

Reforms, law changes and an array of health policies followed, including a ban on smoking in public places, (2006) Lord Darzi's report 'High Quality Care For All' (DoH, 2008), the NHS Constitution (2009) and the establishment of a new



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health and social care regulator, the Care Quality Commission (CQC).

The pivotal changes in NHS culture seemed to stem from both the Bristol enquiry (DoH, 2001a) and the tragic events at the Mid-Staffordshire NHS Foundation Trust (DoH, 2010). The need for greater transparency and accountability became a top priority for all healthcare providers, including those delivering diabetes footcare; the CQC is ideally placed to ensure this.

At this point of our 20-year odyssey of health policy reform, it is becoming clear to the writer and reader that identifying a particular impact on diabetic foot care is challenging; so far Cinderella seems to still have her broom! The impact on diabetes footcare from some of the various health policies and organisational changes include:

- The publication of the government's quality standards for diabetes services entitled *National Service Framework for Diabetes* (DoH, 2001b). Standards included those for the detection and management of long-term complications
- The establishment of the National Diabetes Audit in 2003, the National Diabetes Inpatient Audit in 2011 and the National Foot Ulcer Audit in 2014 (NHS Digital, 2017). These audits collected and analysed data to drive improvements in the quality of services and outcomes for people with diabetes
- Public Health England's publication of Diabetes Foot Care Profiles, which provide data on episodes of foot care (inpatients) and numbers of minor and major amputations which allows a comparison with similar CCGs and the national average
- The NICE guideline *Diabetic Foot Problems: Prevention and Management* (NG19) (2016) has a significant impact on diabetes foot care in terms of the best evidence for organisation and provision of footcare accompanied by key measurable quality standards that all people with diabetes foot disease deserve. In addition, the guidelines provide invaluable information and guidance for CCGs for the development of service specifications for provider organisations who wish to deliver high-quality diabetic foot care. The guidelines include evidence for integrated footcare pathways, the

multidisciplinary footcare service and the foot protection service

- The NICE Quality and Outcomes Framework (QOF) recommended annual diabetes health checks provided by primary care, include those for foot surveillance, which includes identification of risk status for active foot problems. So far, there is little evidence of its impact in practice
- Clinical networks that work in partnership with commissioners and provider and voluntary organisations to provide support with decision making and strategic planning. There are several diabetes foot groups working within the Networks. The foot network also provides a forum for sharing best practice and support
- The Scottish Care Information-Diabetes Collaboration (SCI-DC). SCI-DC provides a fully integrated, shared electronic patient record to support treatment of patients with diabetes. The database provides valuable information on patient outcomes, including diabetic foot problems and amputations.

These are only some examples of the impact that organisational and policy has had on diabetes footcare. The impact that reconfiguration of vascular services with arterial and non-arterial services will have on diabetes footcare services is yet to be evaluated.

On reflection, as well as policy and organisational change, perhaps the greatest impact on diabetes footcare over the past 20 years in the UK has come from key publications, campaigns and ‘foot champions’.

The landmark papers, the *Diabetes Control and Complications Trial Research Group* (1993) (type 1 DM) and the *UK Prospective Diabetes Study* (type 2 DM) (King et al, 1999), concluded that diabetes complications could be reduced by improving blood glucose and blood pressure. These studies helped to guide practice and improve diabetic foot health. Another landmark study was the variation in the recorded incidence of amputation of the lower limb in England (2012). This paper helped to raise awareness of the shocking variation across the country for diabetes-related lower-extremity amputations. The paper provided the catalyst for the successful ‘Putting Feet First’ campaign run by Diabetes UK. The

campaign to reduce unnecessary amputations has been far reaching and encouraged many provider organisations and CCGs to evaluate their foot services and make improvements.

Marion Kerr, a leading health economist, has published two key economic analysis papers (2014; 2017) on diabetes foot disease, which have provided provider organisations and commissioners with invaluable data on the significant economic impact of the disease. Marion has also provided evidence that the introduction of multidisciplinary diabetes foot care teams directly leads to a reduction of foot ulcer and amputations. I am aware from personal communications that this information has led to an increased focus by commissioners to ensure that MDFTs are key to improve diabetes foot care for their provider organisations.

With the development of Sustainability and Transformation Partnerships (STPs) in 2016 to improve health and care, the evidence that we now can share demonstrates that with MDFTs, limbs and lives can be saved, as well as money from the reduced number of foot ulcers and amputations. This clearly fits the STP agenda.

Finally, the impact of 'foot champions'. Over the past 30 years, I have had the privilege to meet and work alongside many healthcare professionals whose drive, enthusiasm and passion has led to the provision of excellent diabetes foot care. The future remains uncertain, but the latest Diabetes Foot Care Profiles (September 2017; Public Health England, 2017) show that the major amputation rate in England has reduced, while the rate for minor amputations has increased. Of course, these figures do not tell the whole story. There is no room for complacency. The excellent National Diabetes Foot Ulcer Audit (NDFA) reported that less than half of responders confirmed all three NICE recommended care structures were in place and only 54% of commissioners responded to the survey in 2016.

I think that while Cinderella arrived at the ball, Prince Charming has yet to appear to help her vanquish the ugly sisters — 'underfunding' and 'poor education'. We must continue to raise public awareness, provide support to colleagues in primary care, secondary care including A&E,

residential and care homes, and community services. We need to ensure integration with social services to facilitate appropriate rehabilitation for amputee patients. Health organisations have to improve to recognise that the patient who presents with an infected diabetic foot ulcer is a medical emergency. Delayed referral is the scourge for patients and the MDFT. They deserve better. ■

- Boulton A (2017) The diabetic foot: a 20-year history. *The Diabetic Foot Journal* 20(1): 10–2
- Department of Health (1992) *The Health of the Nation — A Strategy for Health in England*. DoH, London. Available at: <http://bit.ly/2wPJ58v> (accessed 12.10.2017)
- Department of Health (1997a) *The Patient's Charter*. DoH, London. Available at: <http://bit.ly/2zi1exm> (accessed 12.10.2017)
- Department of Health (1997b) *The New NHS: Modern, Dependable*. DoH, London. Available at: <http://bit.ly/2g4V2UP> (accessed 09.10.2017)
- Department of Health (1998) *A First Class Service: Quality in the New NHS*. DoH, London. Available at: <http://bit.ly/2y5KLfy> (accessed 09.10.2017)
- Department of Health (2000) *The NHS Plan: A Plan for Investment, a Plan for Reform*. DoH, London. Available at: <http://bit.ly/2i0Qrml> (accessed 09.10.2017)
- Department of Health (2001a) *The Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984-1995*. DoH, London. Available at: <http://bit.ly/2ya99yb> (accessed 09.10.2017)
- Department of Health (2001b) *National Service Framework: Diabetes*. Available at: <http://bit.ly/19NaieV> (accessed 09.10.2017)
- Department of Health (2002) *The NHS Reform and Health Care Professions Act 2002*. DoH, London. Available at: <http://bit.ly/2yA1Dhz> (accessed 09.10.2017)
- Department of Health (2006) *The Smoke-free (Premises and Enforcement) Regulations*. DoH, London. Available at: <http://bit.ly/2wHmcEb> (accessed 09.10.2017)
- Department of Health (2008) *High Quality Care for all: NHS Next Stage Review Final Report*. DoH, London. Available at: <http://bit.ly/2yaE2mf> (accessed 09.10.2017)
- Department of Health (2010) *Robert Francis Inquiry report into Mid-Staffordshire NHS Foundation Trust*. DoH, London. Available at: <http://bit.ly/2yVDvIS> (accessed 10.10.2017)
- Greer S (2016) Devolution and health in the UK: policy and its lessons since 1998. *Br Med Bull* 118(1): 16–24
- Kerr M, Rayman G, Jeffcoate WJ (2014) Cost of diabetic foot disease to the National Health Service in England. *Diabet Med* 31(12): 1498–504
- Kerr M (2017) *Diabetic Foot Care in England: An Economic Study*. Insight Health Economics, London
- King P, Peacock I, Donnelly R (1999) The UK Prospective Diabetes Study (UKPDS): clinical and therapeutic implications for type 2 diabetes. *Br J Clin Pharmacol* 48(5): 643–8
- The Diabetes Control and Complications Trial Research Group, Nathan DM, Genuth S et al (1993) The effect of intensive treatment of diabetes on the development and progression of long-term complications in insulin-dependent diabetes mellitus. *N Engl J Med* 329(14): 977–86
- NHS Digital (2017) *National Diabetes Transition Audit, 2003–14* (2017) NHS, London. Available at: <http://bit.ly/2gyUCTL> (accessed 12.10.2017)
- NICE (2016) *Diabetic Foot Problems: Prevention and Management*. NICE, London. Available at: <http://bit.ly/1NdG8mM> (accessed 09.10.2017)
- Public Health England (2017) *Diabetes Footcare Profile By Area*. Public Health England, London. Available at: <http://bit.ly/2hD1Rts> (accessed 12.10.2017)