Diabetic Footcare Networks: Why another network?

In recent years some crucial improvements in diabetes care have been achieved (NHS Diabetes, 2012), but foot complications are still not synonymous with diabetes, even in specialist parlance. Yet, the burden of diabetic foot disease on the NHS and the patient can no longer be ignored, with the combined costs of ulceration and amputation estimated to be in the region of £600 million and a substantially reduced quality of life and high mortality rate (NICE, 2011a).

Getting the message out

Many patient education tools mention diabetic foot complications only briefly – if at all – and as a result, people with diabetes often do not recognise the early warning signs of foot disease. Likewise, the deterioration of an infected ischaemic diabetic foot ulcer, worsened by neuropathy, is scarcely taught at medical school or post-graduate level. Thus, the diabetic foot is not recognised by clinicians or patients as a medical emergency that is limb and life threatening.

The media and healthcare professionals are promoting the need for rapid interventions for myocardial infarction – or a "FAST attack" – but are not aware that "the foot attack" is just as costly in terms of quality of life and budgetary spend in the NHS. It must be hoped that Diabetes UK and the Society of Chiropodists and Podiatrists' 2012 campaign to ensure that people with diabetes have access to good foot care is successful in raising the profile of diabetic foot disease.

Delivering gold-standard care in a shrinking NHS

The *NHS Atlas of Variation* (Right Care, 2011) revealed significant variation in amputation rates across England, with a two-fold variation at Strategic Health Authority level increasing to as much as six-fold at PCT level. These marked variations have many possible explanations but variation in service provision and the attitude and behaviour of those providing the service are among the most important factors. These variations may be amplified with the development of Clinical Commissioning Groups and new legislation on service provision by "any qualified provider".

What has been clearly demonstrated is that management by a specialist multidisciplinary foot team can reduce amputation rates and improve outcomes rapidly and dramatically in the diabetic foot (Apelqvist and Larsson, 2000). Yet in the current political climate, with its emphasis on reductions in spending, many clinicians feel unsupported in implementing the range of best-practice guidelines, policies and NICE standards that relate to the care of the diabetic foot.

One of the great barriers to achieving gold-standard diabetic foot care is the lack of a joined-up approach to service delivery. The integration of acute and community services, and now of PCTs, gives us a great opportunity to develop pathways that ensure the right patient is seen by the right clinician at the right time. Key to this is the primary

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care team's role in foot screening people with diabetes, because every person with diabetes needs to know their current level of risk of ulceration. Most importantly, primary care teams need to refer those at high risk to a foot protection team for management (NICE, 2011b).

Clinical networks

Last year, Secretary of State for Health Andrew Lansley guaranteed that the government will fund England's 28 NHS Cancer Networks in 2012–13, despite the austerity measures being widely implemented, and that the NHS Commissioning Board will support strengthened NHS Cancer Networks in the future. He said: "Over the last decade, Cancer Networks and clinical networks in other areas of care have had a crucial role, taking the lead in the development of great advances in treatments, promoting excellence and improving outcomes" (Department of Health, 2011).

Diabetic Footcare Networks

Based on the success of the Cancer Networks, and others, NHS Diabetes has undertaken an initiative to launch a national clinician-led Footcare Network – comprising four regional sectors (Northern, Midlands, Southern, Pan-London). The Network provides support for clinicians who care for the diabetic foot to establish best practice and implement national guidelines locally. Through the Network there is also the potential for data collection, research and the early adoption of new technologies. Furthermore, as the Network develops and strengthens it will become a powerful voice that will inform Clinical Commissioning Groups.

The Pan-London Diabetic Foot Network have now held three successful local meetings. At these meetings I have seen that excellence in practice already exists in a number of areas, as does a great willingness to share innovations and support colleagues. You can access more information about the national and local networks, the work they are undertaking, and how you can get involved in your local network through the NHS Diabetes website (www.diabetes.nhs.uk/networks/footcare_network).

Conclusion

It is imperative that people with diabetes have access to services that fulfil NICE clinical guidelines and Quality Standard Statement 10 (NICE, 2004; 2011b; 2011c), and your local footcare network can support you in achieving this goal. Failing to provide such a service is to allow a true "postcode lottery" and the continuation of the unacceptable variation in diabetic foot care that currently exists in the NHS. ■

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