It was the best of times ...

Matthew Young

It was worst of times. As the Monty Python team might have said: "When I were a lad there were power cuts and 3-day weeks and the telly went off at 10.30pm so everyone would go to bed early (with the resultant baby boom 9 months later), rubbish piled up in the streets and the dead were left unburied. Try telling that to the youth of today and they wouldn't believe you."

The global recession fills our news sources, and yet most English Premier League footballers earn more in a week than an NHS consultant earns in a year. Podiatrists and nurses struggle to rent, let alone buy, a one bedroom flat in many of the UK's cities and towns. In the NHS, cut-backs mean our gloves get thinner and our syringes get lower in quality. Commissioning is distorting priorities and diabetic foot teams are being down-sized, or facing the threat of clinic closures. Things are looking bleak for the diabetic foot in 2009. Or are they?

In my opinion, 2009 is going to be an exciting year for diabetic foot teams. After years of in-fighting between community and hospital teams, the battle has been won; of *course* people with the most complex diabetic foot problems need to be seen by multidisciplinary foot-care teams in the hospital setting. The new national in-patient guidelines for diabetic foot care in England (developed by the FDUK, www.footindiabetes.org) are an excellent example of the recognition of this fact. Setting minimum standards for the treatment of people admitted with diabetic foot problems starts to return some power to the hospital-based multidisciplinary foot-care team. Hopefully, these guidelines will be widely adopted and make a real difference to inpatient care.

At the same time, the importance of secondary prevention of cardiovascular death is in the spotlight more than ever. Having banged my drum about this for nearly a decade, studies from my own and many other units have shown convincingly that treating those with diabetic foot ulcers in the same way as we treat those who have suffered a heart attack – with intensive cardiovascular risk modification – will dramatically prolong their lives (Nather et al, 2008; Young et al, 2008).

In my adopted homeland of Scotland, this year will see the release of the new SIGN guidelines, new minimum standards for diabetic foot services and a new national antibiotic guideline. I am sure we will let the rest of the world borrow them.

This year will also see the completion of the NHS competency framework for diabetic foot care. With competency sets spanning the diabetic foot-care team from screener to service lead, I am hopeful that service managers will have the vision to restructure services along the lines of the Kaiser Permanente long-term conditions models (www.kaiserpermanente.org). If they do, then the competencies for each tier will be there for them to use.

And finally, a plug so blatant I should be on the Jonathan Ross show: if these exciting developments in the world of diabetic foot care make you want to learn more, take a wider view of your diabetes service, treat patients holistically, as well as get updates on ulcer management, then can I recommend the 10th Annual Diabetic Foot Journal Annual Conference 2009 to be held in both Edinburgh (15–16 June, see the programme on pages 23–26) and London (12–13 October). It might not change your life, but it should improve the way you treat your patients. ■

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