**National Institute for Health and Care Excellence**

# Diabetic foot problems (update)
# Scope Consultation Table
# 17 April - 16 May 2013

| Stakeholder | Section No | Comments | Response |
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| Addenbrooke's Hospital | 2 | Delighted that artificial division into type 1 vs type 2 foot care has been removed. Well done. | Thank you for your comment. |
| Addenbrooke's Hospital | 4.1.1 | Is there a need for specific foot guidelines in children? Is not the strong message to prevent development of neuropathy and other complications not enough? Does diabetic foot disease "exist" in children and to what extent does it compare to the huge burden faced by older people? | Thank you for your comment. The guideline will examine the evidence for effective prevention strategies for children and young people. |
| Addenbrooke's Hospital | 4.3.1 a | A welcome addition. The concept of a multi-disciplinary foot team is accepted and recognised by patients and colleagues but what exactly is a "foot protection team" and what is their role- much confusion with patients about this, often to their detriment. | Thank you for your comment. The definition of foot protection and multidisciplinary foot care teams, and indications for referral, will be addressed by this guideline (please see scope sections 4.3.1a and b). |
| Addenbrooke's Hospital | 4.3.1 e and f | Why this particular, rather arbitrary collection of mixed terms? Should not all problems - be they ulcer, osteomyelitis or gangrene (wet or dry) - trigger thought on blood supply, offloading, treatment of infection, metabolic control etc? | Thank you for your comment. This section has been amended to be clear that this includes assessment and diagnosis of all foot ulcers, infection or gangrene in people with diabetic foot problems |
| Addenbrooke's Hospital | 4.3.1 g | Why just Charcot- A deficiency here in acknowledging the role of orthopapedic involvement in managing other more common disorders of architecture, especially of MTP and IP joints. | Thank you for your comment. The guideline development group will review the evidence on indications for referral to specialist services including orthopaedic services (please see scope |

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| | | | section 4.3.1i).<br><br>An orthopaedic surgeon has been added to the constituency for the diabetic foot guideline development group and was advertised from the 31 May – 7 June 2013. |
| Addenbrooke's Hospital | 4.3.2 a | A lost opportunity here in not looking at level and type of operation, in particular open vs closed healing post removal of digits. We increasing see problems from wounds that have been left without primary closure, meaning that an open lesion is brought ever more proximal on to the foot. Again, an opportunity to look at role of orthopaedic surgeon in team ( which I see has not been requested in panel) | Thank you for your comment. Amputation is outside the scope of this guideline. Prevention and management of diabetic foot problems have been prioritised. This update will look at treatment for gangrene up to the point of needing amputation, including indications for referral to vascular and orthopaedic specialist care. It is anticipated that recommendations covering this area of clinical practice may help to make amputation amongst people with diabetic foot problems less common. Surgical procedures for amputation were not identified as an area of significant variability in clinical practice.<br><br>People with diabetes are also identified as a population subgroup in NICE Clinical Guideline 147. This guidance identifies differences in clinical management and outcomes of people with diabetes.<br><br>Although an orthopaedic surgeon was |

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| | | | not advertised in the first round of recruitment for the diabetic foot guideline development group (GDG), the constituent has been added to the GDG and was advertised from the 31 May – 7 June 2013. |
| Addenbrooke's Hospital | 4.4 | How to record outcomes? What is most meaningful denominator, particularly when some centres receive many more complex (often initially poorly managed) cases from other centres? A centre which performs poorly and refers to other for surgery and amputation could come out looking like it performs well because it does no amputations. | Thank you for your comment. The outcomes section referred to main outcome measures that would be considered by the GDG in evidence reviews, not as outcomes for audit purposes. |
| Addenbrooke's Hospital | 4.5.4 | "Investigating and referring". Again a chance here to look a role of referral for architectural anomalies other than Charcot , esp in forefoot. Again at chance to look at merits of corrective surgery for eg Valgus deformity, clawed toes and again chance to look at role of orthopaedic surgeon- a different but complementary skill set to that of the vascular surgeon. | Thank you for your comment. The guideline development group will review the evidence on indications for referral to specialist services (please see scope section 4.3.1i). |
| Association of British Clinical Diabetologists | General | ABCD is happy that the scope covers all necessary areas for this consultation. | Thank you for your comment. |
| Association of British Healthcare Industries | General | Specific mention of primary care and GP care should be made in 4.2 or 4.3. For example, it should be mandatory that as part of the yearly Diabetic check carried out by GP's, the patients' feet are actually examined rather than just questioning the patient. The current scope is focused on secondary care, foot clinics and teams and is ignoring GP/primary care. | Thank you for your comment. The guideline applies to all settings where NHS care is commissioned or delivered, including primary care (please see scope section 4.2). |
| Association of British Healthcare Industries | 4.3.1 a | Every effort should be made to mirror pockets of best practice around the country. In King's College Hospital London, the diabetic foot clinic is an example of "gold standard" care and this type of systems should be implemented into all hospitals treating diabetic patients. | Thank you for your comment. The definition of foot protection and multidisciplinary foot care teams, and indications for referral, will be addressed by this guideline (please see |

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| | | The MDT is a collaboration between diabetology, vascular surgery, podiatry, interventional radiology and wound care. | scope sections 4.3.1a and b). |
| Association of British Healthcare Industries | 4.3.1 b | There is a requirement for a clear diabetic foot referral pathway from GP to multidisciplinary team available 7 days per week. | Thank you for your comment. The definition of foot protection and multidisciplinary foot care teams, and indications for referral, will be addressed by this guideline (please see scope sections 4.3.1a and b). |
| Association of British Healthcare Industries | 4.3.1 c | Foot examination and risk classification should apply to primary care as well as GPs and should include clear referral guidelines. | Thank you for your comment. The guideline applies to all settings where NHS support is provided, including primary care (please see scope section 4.2a). |
| Association of British Healthcare Industries | 4.3.1 e | Assessing and investigating diabetic foot problems:<br>Investigating the cause of diabetic foot problems is critical. Scans to assess whether the cause is vascular should not be considered as specialist investigation (4.3.1 h)) but as routine and be part of this section.<br>Rapid access to Duplex/Doppler scanning should be rolled out throughout the country – ideally within 24 hours of onset of symptoms. If the scan shows vascular disease being the cause of the patient's symptoms then rapid access to a revascularisation service (vascular surgery or interventional radiology) must happen within 48 hours rather than the 6-8 months in some areas of the country.<br><br>We suggest that duplex/Doppler scanning is part of routine assessment and investigation of diabetic foot problem | Thank you for your comment. Assessment, investigation and diagnosis of peripheral arterial disease (including the use of Duplex/Doppler scanning) are covered by NICE clinical guideline 147, which will be cross-referenced by this guideline during the development of relevant recommendations. |
| Association of British Healthcare Industries | 4.3.1 g and h | Investigating orthopaedic and vascular complications and referring to specialist services<br>This should be 4.3.1 g) and h) | Thank you for your comment. The formatting has been corrected. |

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| Association of British Healthcare Industries | 4.3.1 h | Consider earlier referral of claudicants for vascular intervention. Include in pathway from primary care via MDT to secondary service provider (interventionalist) | Thank you for your comment. The guideline development group will review the evidence on indications for referral to specialist services such as orthopaedic or vascular services (please see scope section 4.3.1i). |
| Association of British Healthcare Industries | 4.3.1 h | Rapid access to a revascularisation service (vascular surgery or interventional radiology) must happen within 48 hours rather than the 6-8 months in some areas of the country. | Thank you for your comment. The guideline development group will review the evidence on indications for referral to specialist services such as orthopaedic or vascular service (please see scope section 4.3.1i). |
| Association of British Healthcare Industries | 4.3.2 c | In critical limb ischaemia (CLI) diabetic foot patients with ischemic ulcers, vascular involvement is extremely diffuse and particularly severe in BTK with a high occurrence of long occlusions (Graziani 2010).Compared with non diabetics, similar disease patterns in a diabetic patient will demonstrate more pronounced ischemia and tissue necrosis.<br><br>Vascular /Endovascular treatments for diabetic foot ulcers should be reviewed to determine the clinical effectiveness and provide optimum treatment guidelines for ischemic diabetic foot disease. | Thank you for your comment. Diagnosis and management of peripheral arterial disease are covered by NICE clinical guideline 147, which will be cross-referenced by this guideline during the development of relevant recommendations. |
| Association of British Healthcare Industries | 4.4 a | The main outcome should be: prevention of amputation rate and/or reduction in amputation rate and/or reduction in variation in amputation rate. The rate and extent of amputation are not meaningful or positive outcomes for patients with diabetic foot – the reduction of the absolute rates and variation are meaningful outcomes. Focussing on the rate of amputation and its extent will do nothing but preserve current practice and status quo. | Thank you for your comment. The outcomes section referred to main outcome measures that would be considered by the GDG in evidence reviews, not as outcomes for audit purposes. |
| Bard Ltd | 4.3.1 b | Require a clear diabetic foot referral pathway from point of GP to multidisciplinary team Available 7 days per week | Thank you for your comment. The definition of foot protection and multidisciplinary foot care teams, and indications for referral, will be |

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| | | | addressed by this guideline (please see scope sections 4.3.1a and b). |
| Bard Ltd | 4.3.1 c | Include ABPI in screening programme with referral indications from GP (Primary Care) to diabetic foot MDT | Thank you for your comment. Foot examination and indication for referral will be addressed by this guideline (please see scope section 4.3.1b and c).<br>Assessment and diagnosis of peripheral arterial disease (including the use of ABPI) are covered by NICE clinical guideline 147, which will be cross-referred by this guideline during the development of relevant recommendations |
| Bard Ltd | 4.3.1 h | Consider earlier referral of claudicants for vascular intervention. Include in pathway from primary care via MDT to secondary service provider (interventionalist) | Thank you for your comment. The guideline development group will review the evidence on indications for referral to specialist services such as orthopaedic or vascular services (please see scope section 4.3.1j). |
| Bard Ltd | 4.3.2 c | In CLI diabetic foot patients with ischemic ulcers, vascular involvement is extremely diffuse and particularly severe in BTK with a high occurrence of long occlusions (Graziani 2010).Compared with non diabetics, similar disease patterns in a diabetic patient will demonstrate more pronounced ischemia and tissue necrosis.<br>Vascular /Endovascular treatments for diabetic foot ulcers should be reviewed to determine the clinical effectiveness and provide optimum treatment guidelines for ischemic diabetic foot disease. | Thank you for your comment. Diagnosis and management of peripheral arterial disease are covered by NICE clinical guideline 147, which will be cross-referenced by this guideline during the development of relevant recommendations. |
| Boston Scientific | General | Specific mention of primary care and GP care should be made in 4.2 or 4.3. For example, it should be mandatory that as part of the yearly Diabetic check carried out by GP's, the patients feet are actually examined rather than just questioning the patient. | Thank you for your comment. The guideline applies to all settings where NHS care is commissioned or delivered, including primary care |

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| | | The current scope is focused on secondary care and foot clinics and teams and is ignoring GP/primary care. | (please see scope section 4.2). |
| Boston Scientific | 4.3.1 a | Every effort should be made to mirror pockets of best practice around the country. In King's College Hospital London, the diabetic foot clinic is an example of "gold standard" care and every effort should be made to implement this type of system into all hospitals treating diabetic patients. The MDT is a collaboration between diabetology, vascular surgery, podiatry, interventional radiology and wound care | Thank you for your comment. The definition of foot protection and multidisciplinary foot care teams, and indications for referral, will be addressed by this guideline. |
| Boston Scientific | 4.3.1 c | Foot examination and risk classification should apply to primary care and GPs as well and include clear referral guidelines | Thank you for your comment. The guideline applies to all NHS settings, including primary care and GPs (please see section 4.2a). |
| Boston Scientific | 4.3.1 e | Assessing and investigating diabetic foot problems:<br>Investigating the cause of diabetic foot problems is critical. Scans to assess whether the cause is vascular should not be considered as specialist investigation (4.3.1 h)) but as routine and be part of this section.<br>Rapid access to Duplex/Doppler scanning should be rolled out throughout the country – ideally within 24 hours of onset of symptoms. If the scan shows vascular disease being the cause of the patients symptoms then rapid access to a revascularisation service (vascular surgery or interventional radiology) must happen within 48 hours rather than the 6-8 months in some areas of the country.<br><br>We suggest that duplex/Doppler scanning is part of routine assessment and investigation of diabetic foot problem | Thank you for your comment. Assessment, investigation and diagnosis of peripheral arterial disease (including the use of Duplex/Doppler scanning) are covered by NICE clinical guideline 147, which will be cross-referenced by this guideline during the development of relevant recommendations. |
| Boston Scientific | 4.3.1 g and h | Investigating orthopaedic and vascular complications and referring to specialist services<br>This should be 4.3.1 g) and h) | Thank you for your comment. The formatting has been corrected. |
| Boston Scientific | 4.3.1 h | Rapid access to a revascularisation service (vascular surgery or interventional radiology) must happen within 48 hours rather than | Thank you for your comment. The guideline development group will review |

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| | | the 6-8 months in some areas of the country. | the evidence on indications for referral to specialist services such as orthopaedic or vascular service (please see scope section 4.3.1i). |
| Boston Scientific | 4.4 a | The main outcome should be: prevention of amputation rate and/or reduction in amputation rate and/or reduction in variation in amputation rate. The rate and extent of amputation are not meaningful or positive outcomes for patients with diabetic foot – the reduction of the absolute rates and variation are meaningful outcomes. Focussing on the rate of amputation and its extent will do nothing but preserve current practice and status quo. | Thank you for your comment. The outcomes section referred to main outcome measures that would be considered by the GDG in evidence reviews, not as outcomes for audit purposes. |
| British Medical Association | General | We agree that standards for diabetic footcare are varied.<br><br>We believe that NICE could make a significant impact if a standardised diabetic foot referral system were produced and if criteria for access and accessibility were defined.<br><br>The review should look into the accessibility of foot care teams and 'hot foot' clinics.<br><br>We suggest that NICE should consider implementing a national foot-screening programme similar to that in Shropshire where a programme (comparable to the Retinal Screening Programme) was established in 2002. It is commissioned by local podiatrists who see their diabetic patients in general practices on a sessional basis at least once a year, and use a template which is embedded in the practice computer system. We believe that this programme works very successfully. | Thank you for your comment. The definition of foot protection and multidisciplinary foot care teams, and indications for referral, will be addressed by the guideline (please see scope section 4.3.1a and b).<br><br>Foot surveillance will be addressed by the guideline as a prevention strategy based on available evidence (please see scope section 4.3.1d). |
| British Society for Antimicrobial Chemotherapy | General | We would recommend Tony Berendt in Oxford and Paul Chadwick in Salford as key infection specialists | Thank you for your comment. |

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| British Society for Antimicrobial Chemotherapy | General | Where will the clinical microbiologist fit into the “foot care team”? | Thank you for your comment. The composition and definition of foot protection and multidisciplinary foot care teams will be addressed by this guideline (please see scope section 4.3.1a). |
| British Society for Antimicrobial Chemotherapy | 4.1.2 b | It is not immediately clear why “young people & children (younger than 18 years) with foot problem that need inpatient management” will not be covered. Presumably they will be covered by a separate NICE guideline that will replicate much of the advice contained in this one | Thank you for your comment. Specific in-patient management recommendations will be transposed from NICE Clinical Guideline 119 which did not examine the care of children and young people. In-patient management of children and young people with diabetic foot problems was not prioritised within the scope as a particular area of concern. |
| British Society for Antimicrobial Chemotherapy | 4.5.3 | We would like to see something on the microbiological diagnosis of infection in diabetic foot ulcers including appropriate specimen selection, collection method(s) & laboratory processing under this para. | Thank you for your comment. The guideline development group will consider clinical utilities and accuracy of different assessment or diagnostic tools/methods to diagnose diabetic foot infection (please see scope section under 4.3.1e). However, it is outside the scope to cover laboratory processing. |
| British Society for Antimicrobial Chemotherapy | 4.5.3 c | Will the “different antibiotic regimens” include advice on the application and suitability of OPAT versus oral or inpatient IV therapy | Thank you for your comment. The guideline will examine relevant antibiotic regimen identified from the evidence review. |
| British Society of Interventional Radiology | 4.3.1 and 4.5.4 | Criteria should be established for non-invasive vascular lab assessment and/or Doppler ultrasound. | Thank you for your comment. Assessment, diagnosis and management of peripheral arterial disease are covered by NICE clinical guideline 147, which this guideline will |

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| | | | cross-refer during the development of relevant recommendations. |
| British Society of Interventional Radiology | 4.3.1 d | Smoking cessation programme could be included as additional bullet point here | Thank you for your comment. Smoking cessation is addressed by NICE public health guidance 1 and 10, and referred to in NICE clinical guideline 147. These guidelines will be cross-referenced by this guideline during the development of relevant recommendations. |
| British Society of Interventional Radiology | 4.5.3 d | There is a dearth of high quality data regarding clinical outcomes of interventional radiology procedures in ulcer healing. Could this be an opportunity to review the literature and guide future research in this area? | Thank you for your comment. Interventional radiology procedures as adjunctive treatments for diabetic foot ulcer are outside the scope of this guideline. |
| Chartered Society of Physiotherapy | 4.3.2 b | The effect of rehabilitation following amputation will have an effect on the remaining limb and subsequent preservation or not of the remaining limb so is it appropriate to exclude this, in this context, in the guideline? | Thank you for your comment. Postoperative rehabilitation after amputation is outside the scope of this guideline. However prevention and management strategies for foot problems will be addressed and people who have had an amputation may be a specific subgroup if supported by evidence. |
| Chartered Society of Physiotherapy | 4.5.4 | The list of specialists should include physiotherapists and podiatrists, in view of potential for provision of walking aids to offload the affected foot. | Thank you for your comment. The list of specialist services in scope section 4.3.1i is intended to provide examples, not be exhaustive. The composition of foot protection teams and the multidisciplinary foot care teams will also be addressed by the guideline (please see scope section 4.3.1a) and b). |
| Department of | General | Thank you for the opportunity to comment on the draft scope for | Thank you for your comment. |

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| Health | | the above clinical guideline.<br><br>I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation. | |
| Diabetes UK | 4.1.1 a & b | It is important that this section is expanded to provide more detail on how children and young people are to be covered in this guideline. For example, it would not be an effective use of resource, or appropriate use of the QOF, to suggest that young children should be receiving an annual foot examination. | Thank you for your comment. The guideline will examine the evidence for effective prevention strategies for children and young people. |
| Diabetes UK | 4.1.1 c | This area should be developed to include patients with chronic renal failure or on dialysis. It should provide guidance on screening for risk factors such as peripheral arterial disease and anaemia and education on prevention and intensive care of the ulcerated foot. | Thank you for your comment. Specific subgroups, where supported by evidence, will be addressed by the guideline (please see scope section 4.1.1b).<br><br>Diagnosis and management of peripheral arterial disease are covered by NICE clinical guideline 147, which this guideline will cross-refer to.<br><br>Prevention strategies for diabetic foot problems will be addressed by the guideline (please see scope section 4.3.1d). |
| Diabetes UK | 4.2 a | This area should be expanded to specifically include details of the levels of care needed for those patients with diabetes in nursing or residential care settings, as this group is often at high risk of foot ulceration. | Thank you for your comment. This guideline will cover NHS services in all settings where healthcare is commissioned or delivered by the NHS, including nursing or residential care settings commissioned by the NHS. |
| Diabetes UK | 4.3.1 e | This list should be extended to include the following:<br>• consideration of the underlying aetiology for foot ulceration | Thank you for your comment. The underlying aetiology for foot ulceration is outside the scope of this guideline. |

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| | | • heel ulceration (especially where this occurs in hospital or institutional settings) | Heel ulceration will be considered as part of foot ulceration (please see scope section 4.3.1e). |
| Diabetes UK | 4.3.1 g | The final guidelines should provide detailed guidance on the diagnosis of Charcot osteoarthropathy. In particular, to enable clinicians to distinguish between a possible infection and early Charcot's foot. | Thank you for your comment. The scope has been amended to include diagnosing and managing Charcot arthropathy (please see scope section 4.3.1j). |
| Diabetes UK | 4.3.1 h | Wherever possible amputation should be avoided and seen only as a last resort where no other treatment is possible. As such, this section needs to include more detail under each heading:<br>- 'specialist investigative or interventional radiology' needs to be expanded to include angioplasty.<br>- 'specialist orthotics' is fully expanded to include specialist footwear and orthotics. | Thank you for your comment. The list of examples included in this section is for illustrative purposes only. |
| Diabetes UK | 4.3.2 b | This notes that 'rehabilitation' will not be included in this guidance. However, it is important that the psychological aspects of diabetic foot disease are included within this guidance. Particularly as there is a clear evidence base that those with active foot disease have significant clinical depression. | Thank you for your comment. The scope covers indications for referral to other specialist services which may include psychological support (please see scope section 4.3.1i).NICE clinical guideline 91: Depression with a chronic physical health problem has also now been added to section 5.1.3. Where appropriate, recommendations from NICE Clinical Guideline 91 will be cross-referenced during the development of this guideline. |
| Foot in Diabetes UK | General | FDUK would firstly like to congratulate NICE on identifying the management of the diabetic foot as a major healthcare issue and for planning the production of integrated guidelines (and so soon after CG119) to match the need for an integrated pathway of care from prevention, to management and to prevention of recurrence. FDUK would like to put forward the following points | Thank you for your comment. |

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| | | for your consideration. | |
| Foot in Diabetes UK | General | A link to the care planning approach should also be made. Please review the following reference; http://www.diabetes.org.uk/Professionals/Publications-reports-and-resources/Reports-statistics-and-case-studies/Reports/Care_planning_in_diabetes/ | Thank you for your comment. |
| Foot in Diabetes UK | General | In addition, we think it is very important that NICE is aware of the recommendations made for the adoption of prospective audit of foot care, as part of the National Diabetes Audit. These were submitted at the turn of the year and are currently under consideration. If approved for adoption, it would be confusing and counterproductive if NICE were to consider metrics which were not the same. | Thank you for the information. This will be taken into consideration during the development of the implementation/audit tools for the guideline. |
| Foot in Diabetes UK | General | It would also be useful to highlight people with diabetes who have undergone bariatric surgery and are “cured” of their diabetes, although their underlying neuropathy and established foot risk factors remain unchanged. This group of patients still require ongoing foot protection and education. | Specific subgroups, where supported by evidence, will be addressed by the guideline (please see scope section 4.1.1b). |
| Foot in Diabetes UK | 3.1 | FDUK would like to advise NICE that the epidemiology data for diabetes is now outdated and needs revising. | Thank you for your comment. The guideline will contain updated epidemiology data when it publishes. |
| Foot in Diabetes UK | 4.1.1 c | Special focus should be made on the prevention of, and management of, foot disease in people with established renal failure. | Thank you for your comment. Specific subgroups, where supported by evidence, will be addressed by the guideline (please see scope section 4.1.1b). |
| Foot in Diabetes UK | 4.3.1 a and b | FDUK recommends that the redefining of the Multidisciplinary Diabetes Team and the Foot Protection Team and the thresholds for referral is vital to give a more realistic view of diabetic foot management delivery. | Thank you for your comment. The definition of foot protection and multidisciplinary foot care teams, and indications for referral, will be addressed by this guideline (please see scope sections 4.3.1a and b). |
| Foot in | 4.3.1 c | Regarding foot examination and risk classification. This could be | Thank you for your comment. Foot |

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| Diabetes UK | | an opportunity to standardise the basic screening assessment, by recommending which tests are carried out. | examination and risk classification, and frequency of assessment will be addressed by this guideline (please see scope section 4.3.1c and d). |
| Foot in Diabetes UK | 4.3.1 d | An emphasis should be put on the role of the MDT and FPT in preventing diabetic foot complications and in reducing cardiovascular and cerebrovascular disease. In the context that systemic adverse CV outcomes linked to diabetic foot disease is more common than amputation<br>Although management of cardiovascular risk is often implied in Guidance, it is not always made clear who is responsible for flagging up, reviewing and influencing. | Thank you for your comment. The definition of foot protection and multidisciplinary foot care teams, and indications for referral, will be addressed by this guideline (scope sections 4.3.1a and b). Prevention strategies also will be addressed by this guideline (scope section 4.3.1d) |
| Foot in Diabetes UK | 4.3.1 f | FDUK would also suggest that focus on the management of infection is not a high priority. Although there appears to be an “evidence base” there is currently no hard data to help resolve the continuing controversies relating to the management of infection of either soft tissue or bone. In the absence of the information that we need, we are at the mercy of people with firm opinions and the choice of antibiotic therapy is a relatively minor consideration (and a potential smokescreen) when compared with more fundamental issues relating to the organisation of clinical care. | Thank you for your comment. The volume, quality and appropriateness of the evidence will be discussed by the GDG to inform decision on recommendations during the development of the guideline, followed by stakeholder consultation. |
| Foot in Diabetes UK | 4.3.2 d | It is notable that the importance of the management of the Charcot Foot is not reflected in the current scoping document. Because of the widespread uncertainty relating to diagnosis and management, and the relatively high incidence of litigation (for avoidable limb loss) - despite the rarity of the condition, FDUK feel strongly that if management of the Charcot foot is not included in these guidelines, then it is very necessary that the management of the Charcot foot should form the basis of an independent initiative. | Thank you for your comment. The scope has been amended to include diagnosing and managing Charcot arthropathy (please see scope section 4.3.1j). |

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| Foot in Diabetes UK | 4.4 | It is also often difficult to demonstrate the success of Foot Protection teams. A more positive outcome measure would be to look at ulcer- free survival | Thank you for your comment. This will be considered if reported in any of the evidence being reviewed. |
| Frimley Park NHS Foundation Trust | 3.2 a | Amputation rates vary 10-fold in the UK | Thank you for your comment. The guideline will contain updated epidemiology data when it publishes. |
| Frimley Park NHS Foundation Trust | 4.3.1 e | Classification of severity of Diabetic Foot Tissue loss.<br>There are currently several systems leading to confusion and non-uniformity of reporting in the literature. This will also hamper attempts to synthesize meaningful outcome data in future meta-analyses for the diabetic foot.<br>Can NICE lead the way and lend support to one recognised way of classifying the diabetic foot presentation? E.g. University of Texas Classification or the PEDIS classification | Thank you for your comment. The guideline development group will review the evidence on severity classification (please see scope section 4.3.1e). |
| Frimley Park NHS Foundation Trust | 4.4 c | Recommend “Ulcer free, Major Amputation free, Survival”<br>A composite outcome of the diabetic foot patient being alive + major amputation free + ulcer free would be more meaningful. | Thank you for your comment. The outcomes section referred to main outcome measures that would be considered by the GDG in evidence reviews, not as outcomes for audit purposes. |
| Medtronic | 4.3.1 a | Models of best practice already exist in parts of the country – Kings, Southampton and Ipswich. It is crucial that a foot protection team includes an interventional radiologist to allow for urgent referral for revascularisation. | Thank you for your comment. The definition of foot protection and multidisciplinary foot care teams, and indications for referral, will be addressed by this guideline (please see scope sections 4.3.1a and b). We have also advertised for an Interventional radiologist to participate on the guideline development group for this topic to provide expertise in this area. |
| Medtronic | 4.3.1 b | Many critical limb ischemia patients with diabetes are referred | Thank you for your comment. The |

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| | | too late to vascular specialists when little can be done to prevent lower limb amputation. A referral pathway from primary care to a foot protection team would help here. | definition of foot protection and multidisciplinary foot care teams, and indications for referral, will be addressed by this guideline (please see scope sections 4.3.1a and b). |
| Medtronic | 4.3.1 c | The referral pathway from primary care to a foot protection team should include diagnosis and risk classification. | Thank you for your comment. |
| Medtronic | 4.3.1 e | A foot protection team should be responsible for investigating the cause of problems. As the team includes an interventional radiologist, a routine scan should take place to assess whether the cause is vascular (development of critical limb ischemia) so patients can be referred rapidly for revascularisation to improve blood flow. | Thank you for your comment. The definition of foot protection and multidisciplinary foot care teams, and indications for referral, will be addressed by this guideline (please see scope section 4.3.1a and b). |
| Medtronic | 4.3.1 h | If the cause of diabetic foot ulceration is vascular the rapid referral to an interventional radiologist to improve blood flow will be the key to saving the lower limb. Amputation should be seen as a last resort rather than a routine treatment option. Tariff costs show that the cost of elective surgery and stump management is much lower than the costs for angioplasty and open surgical revascularisation. | Thank you for your comment. The guideline development group will review the evidence on indications for referral to specialist services (please see scope section 4.3.1j). |
| Medtronic | 4.4 a | In addition to amputation rates, the overall reduction in the number (and percentage wise) of lower limb amputations should be seen as a main driver for success. Lowering mortality during carotid procedures for stroke, and abdominal aortic aneurysms is seen as a sense of professional pride at many centres – the same should be done for lower limb amputation. | Thank you for your comment. The outcomes section referred to main outcome measures that would be considered by the GDG in evidence reviews, not as outcomes for audit purposes. |
| National Collaborating Centre for | General | It is extremely unusual for children and young people with diabetes to develop foot problems and so although the children and young people's guideline currently recommends annual foot | Thank you for your comment. The guideline will consider the frequency of review for all people with different risks |

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| Women's and Children's Health | | care reviews the issue of how to manage such problems is not a major concern in children and young people with diabetes | of foot problems (please see scope section 4.1.1d). |
| National Collaborating Centre for Women's and Children's Health | General | It is extremely unusual for diabetic women of child-bearing age to have foot problems as addressed in the proposed guideline. However, if there were such a woman the main interventions that would have to be reviewed and amended because of the pregnancy are:<br>• the use of antibiotics (some are contraindicated in pregnancy)<br>• surgery which may be best deferred until after the pregnancy is over. | Thank you for this information. |
| National Collaborating Centre for Women's and Children's Health | General | There are no apparent conflicts with the Diabetes in Pregnancy or Diabetes in Children and Young People's scopes and the topics we are updating in those guidelines | Thank you for your comment. |
| NHS England | 4.3.2 d | Why is treatment of Charcot osteoarthropathy not covered? | Thank you for your comment. The scope has been amended to include diagnosing and managing Charcot arthropathy (please see scope section 4.3.1j). |
| Royal College of Nursing | General | Also in the general wound care world there is currently a huge debate in the general wound care world about how to classify ulcers on the heel of patients with diabetes - are these diabetic foot ulcer or pressure ulcer in a patient with Diabetes? It would be good to have guidance on this. | Thank you for your comment. Classification of foot ulcer in people with diabetes will be addressed by the guideline (please see scope section 4.3.1e). |
| Royal College of Nursing | General | The Royal College of Nursing welcomes proposals to update this guideline. It is timely. | Thank you for your comment. |
| Royal College of Nursing | 4.1.1 | Surely we need to consider people with diabetes before they are at risk of foot disease. We need a health prevention strategy | Thank you for your comment. The amendment has been made to make it |

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| | | rather than just how do we treat it. | clear that the guideline applies to all people with diabetes. Prevention strategies for diabetic foot ulcer will be addressed by the guideline (please see scope section 4.3.1d). |
| Royal College of Nursing | 4.1.1 b<br>4.1.2 b | There seems a discord with 4.1.1b and 4.1.2 b, one says it will cover children without caveat the other says not if they are inpatients. | Thank you for your comment. Specific inpatient management recommendations will be transposed from NICE Clinical Guideline 119 which did not examine the care of children and young people. Inpatient management of children and young people with diabetic foot problems was not prioritised within the scope as a particular area of concern. However, the guideline will examine the evidence for effective prevention strategies for children and young people. |
| Royal College of Nursing | 4.2 a | This must include care homes, institutional settings and be culturally appropriate | Thank you for your comment. This guideline will cover NHS services in all settings where healthcare is commissioned or delivered by the NHS, including nursing or residential care settings. |
| Royal College of Nursing | 4.3.1 a | Skill mix is appropriate. See the traffic light system utilised within Scotland –<br><br>Diabetic Foot Risk Stratification and Triage<br>http://www.diabetesinscotland.org.uk/Publications/traffic%20light%20finalx3.pdf<br>Accessed May 2013 | Thank you for your comment. The definition of foot protection and multidisciplinary foot care teams, and indications for referral, will be addressed by this guideline (please see scope sections 4.3.1a and b). |
| Royal College of Nursing | 4.4 | Would it not also be worthwhile to capture the number of people who do not appear to have foot problems? | Thank you for your comment. The outcomes section referred to main |

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| | | | outcome measures that would be considered by the GDG in evidence reviews, not as outcomes for audit purposes. |
| Royal College of Nursing | 4.5.1 | See listed documents:<br><br>McCardle, J, Chadwick, P, Leese, G, McInnes, A.D., Stang, D and Stuart , L. (2012) - TRIE-POD document - *Podiatry competency framework for integrated diabetic foot care: a user's guide*, http://eprints.brighton.ac.uk/10715/ Accessed May 2013<br><br>Diabetic Foot Risk Stratification and Triage - traffic light system utilised in Scotland;<br>http://www.diabetesinscotland.org.uk/Publications/traffic%20light%20finalx3.pdf<br>Accessed May 2013 | Thank you for these references. |
| Royal College of Paediatrics and Child Health | General | Thank you for inviting the Royal College of Paediatrics and Child Health to comment on the Diabetic footcare draft scope. We have not received any comments from our members. | Thank you for your comment. |
| Royal College of Physicians | 4.1 | There appears to be some discrepancy within section 4.1. The groups covered for foot problems in section 4.1.1 b includes the management of children with foot problems. However, section 4.1.2 b excludes inpatient management of those under 18 with foot disease. The guidance should at least consider those aged 16 and above as they may be in an adult ward or hospital. However, if the guideline is going to consider outpatient management of children it should include inpatient treatment of the foot. | Thank you for your comment. Specific inpatient management recommendations will be transposed from NICE Clinical Guideline 119 which did not examine the care of children and young people. Inpatient management of children and young people with diabetic foot problems was not prioritised within the scope as a particular area of concern. |
| Royal College of Physicians | 4.3.1 e | This should include a review of ulcer classification under the severity of foot ulcers section. | Thank you for your comment. The guideline development group will review the evidence on severity classification |

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| | | | (please see scope section 4.3.1e). |
| Royal College of Physicians | 4.3.2 d | The management of the Charcot foot in the UK is often managed by a diabetologist without orthopeadic input routinely. Some diabetologists also still use bisphosphonate drugs for this condition. Our experts believe that it is vital that actual management of this condition is included in the NICE review. As stands, there is inconsistency of management and the potential to use drugs when evidence for efficacy may be lacking. It is vital this area is not left to considering indications for referral to orthopaedics only. | Thank you for your comment. The scope has been amended to include diagnosing and managing Charcot arthropathy (please see scope section 4.3.1j). |
| Royal College of Physicians | 4.4 c | This includes terminology not usually used with the foot ie cure rates, and should be eg survival, and ulcer free at eg 12 and 24 weeks. | Thank you for your comment. Changes have been made to the terminology. Ulcer status at 12 and 24 weeks are encapsulated in recurrent rates of ulceration, infection and gangrene. |
| Royal College of Surgeons of Edinburgh | 4.3.1 h | RCSEd believe that the importance of combined Orthopaedic and Vascular input should be reflected. | Thank you for your comment. |
| Royal College of Surgeons of Edinburgh | 4.3.2 c | The criteria for vascular referral need to be considered. | Thank you for your comment. The guideline development group will review the evidence on indications for referral to specialist services (please see scope section 4.3.1i). |
| Royal College of Surgeons of Edinburgh | 4.3.2 d | The criteria need to be considered for Orthopaedic referral. | Thank you for your comment. The guideline development group will review the evidence on indications for referral to specialist services including orthopaedic services (please see scope section 4.3.1i). |
| Royal College of Surgeons of Edinburgh | 4.4 a | To be correlated against severity of diabetes, not just raw figures. There is a need to define ‘major’ and ‘minor’ amputations. | Thank you for your comment. This will be considered in the evidence review. |

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| Royal College of Surgeons of Edinburgh | 4.4 b | Again, only to be measured when considering the severity of disease. | Thank you for your comment. The outcomes section referred to main outcome measures that would be considered by the GDG in evidence reviews, not as outcomes for audit purposes. |
| Royal College of Surgeons of Edinburgh | 4.4 e | Carefully defining the reason for admission and subsequent lengths of stay. | Thank you for your comment. In reviewing evidence that reports these outcomes, the guideline development group will consider the reasons for admission and subsequent length of stay. |
| Royal College of Surgeons of Edinburgh | 4.5.4 a | The importance of early vascular and orthopaedic input and links with good communications between diabetologists/foot team and surgeons needs to be reflected. | Thank you for your comment. The definition of foot protection and multidisciplinary foot care teams, and indications for referral, will be addressed in this guideline (please see scope sections 4.3.1a and b), |
| The All Party Parliamentary Group on Vascular Disease | General | We have referenced in this proforma evidence used when compiling our report – 'Putting Vascular Disease at the Centre of Government Thinking'. | Thank you for your comment. |
| The All Party Parliamentary Group on Vascular Disease | 4.3.1 a | The most efficient way to access, diagnose and treat vascular patients is to bring all the required skills under one roof. A multi-disciplinary foot team clinic can call on podiatrists, nurse orthotists, microbiologists, physicians, radiologists and surgeons, so that patients can be seen by all the relevant disciplines in the same place at the same time. This reduces the number of appointments a patient requires, providing a cost effective and rapid service.<br><br>More than 80 hospitals in England and Wales presently do not | Thank you for your comment. The definition of foot protection and multidisciplinary foot care teams, and indications for referral, will be addressed by this guideline (please see scope sections 4.3.1a and b). |

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| | | provide this service. | |
| The All Party Parliamentary Group on Vascular Disease | 4.3.1 b | A greater understanding of the diabetic foot and the causes in primary care is crucial if we are to improve patient outcomes. King's College Hospital's Professor of Diabetic Foot Medicine Mike Edmonds, terms the GP as often the first line of defence against "diabetic foot attack".<br><br>In some cases the condition can deteriorate rapidly and patients should be referred to specialist clinics quickly. Many secondary clinicians have reported that they are often seeing patients too late when little can be done to save legs. GPs should improve their understanding of the symptoms and the services available, especially considering that less than half of those patients who require amputation in England and Wales have benefitted from any attempt to treat poor circulation to their leg. | Thank you for your comment. The definition of foot protection and multidisciplinary foot care teams, and indications for referral, will be addressed by this guideline (please see scope sections 4.3.1a and b). |
| The All Party Parliamentary Group on Vascular Disease | 4.3.1 c | Ankle brachial pressure index (ABPI) tests can quickly identify peripheral arterial disease (PAD) and help tackle the problem before a patient develops foot ulcers and potentially requires amputation. This is a simple and cost effective test. Inclusion in a Clinical Guideline should ensure all patients receive the same level of care. | Thank you for your comment. Assessment and diagnosis of peripheral arterial disease (including the use of ABPI) are covered by NICE clinical guideline 147, which will be cross-referred by this guideline during the development of relevant recommendations. |
| The All Party Parliamentary Group on Vascular Disease | 4.3.1 h | Quote from – Mike Edmonds, Professor of Diabetic Foot Medicine, Kings College Hospital – oral evidence to the APPG on Vascular Disease:<br><br>"Essentially, to put it bluntly, you can have a high risk foot with neuropathy ischaemia on Monday, an ulcer on Tuesday, infection<br>on Wednesday, gangrene on Thursday and you can lose your leg on Friday. Then you have to survive the weekend in hospital." | Thank you for your comment. The guideline development group will review the evidence on indications for referral to specialist services (please see scope section 4.3.1i). |

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| | | This makes the case for rapid referral to a vascular specialist when critical limb ischaemia is identified. | |
| The All Party Parliamentary Group on Vascular Disease | 4.4 a | Amputation rates are already recorded in the Atlas of Variation. The Group heard oral evidence that amputation is too often seen as a treatment for diabetic foot related conditions. At Kings College Hospital London, the multi-disciplinary foot team would see amputation as a failure.<br><br>It would make sense to record the rate that the number of lower limb amputations are increasing or decreasing. | Thank you for your comment. The outcomes section referred to main outcome measures that would be considered by the GDG in evidence reviews, not as outcomes for audit purposes. |
| UK Clinical Pharmacy Association | 4.3.1 a | Please consider if there is a role for a pharmacist on the multidisciplinary foot care team. I am a diabetes specialist pharmacist and have been involved in a previous place of work, however had to push hard to do so as no guidance to date suggests there might be a benefit. E.g. of input - help in appropriate antibiotic selection and dose in view of co-morbidities [renal disease], checking glycaemic management medically optimised. | Thank you for your comment. The definition of foot protection and multidisciplinary foot care teams, and indications for referral, will be addressed by this guideline (please see scope sections 4.3.1a and b). |
| UK Clinical Pharmacy Association | 4.3.1 e | Please offer management advice on foot ulcer with microbial colonisation (from positive swab) but no sign of clinical infection | Thank you for your comment. The guideline development group will review the evidence on clinical effectiveness of treatments for diabetic foot ulcer with or without infection (please see scope section 4.3.1g). |
| UK Clinical Pharmacy Association | 4.3.1 f | Please comment on the need for good blood glucose management if patient has foot ulcer. ? benefit in good glycaemic management to limit risk of microbial growth and reduce risk of impaired wound healing etc | Thank you for your comment. Improving glycaemic control in people with diabetic foot problems will be looked at as part of review question H within the scope for this guideline (please see scope section 4.3.1f). |
| UK Clinical | 4.5.3 | Please comment on the question: Does improvement in | Thank you for your comment. Improving |

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| Pharmacy Association | | glycaemic management influence the outcome? i.e. is it too late to optimise glucose control, or is there still good reason to do so? Anecdotally I have noticed that often glycaemic management takes a back seat as focus is on the foot – however good glycaemic control would probably help and should not be overlooked. (Glucose levels often raised due to infection). | glycaemic control in people with diabetic foot problems will be looked at as part of review question H within the scope for this guideline (please see scope section 4.3.1f). |
| Welsh Endocrine and Diabetes Society | General | WEDS is pleased to see this scoping document for updated foot care guidance. We agree with most of the scope and with the majority of the content of the document. WEDS has some suggestions for improvement | Thank you for your comment. |
| Welsh Endocrine and Diabetes Society | 4.1.1 c | Specific attention should be directed to patients with disabling diabetic complications including<br>• Retinal and renal disease<br>• Patients living alone with support from families and social care | Thank you for your comment. Specific subgroups, where supported by evidence, will be addressed by the guideline (please see scope section 4.1.1b). |
| Welsh Endocrine and Diabetes Society | 4.2.a | The scope should actively consider certain non-NHS settings including prisons, private residential and nursing homes. | Thank you for your comment. This guideline will cover NHS services in all settings where healthcare is commissioned or delivered by the NHS, including nursing or residential care settings. |
| Welsh Endocrine and Diabetes Society | 4.3.1 a | The scope should comment on the setting for members of the foot protection team, making specific reference to primary, community and secondary care | Thank you for your comment. The definition and composition of foot protection and multidisciplinary foot care teams, will be addressed by this guideline (please see scope sections 4.3.1a and b). However, the settings for operationalizing the teams are outside the scope of this guideline. The delivery of these services will depend on local service configuration. |
| Welsh | 4.3.1 c | WEDS welcomes the focus on screening and risk stratification. | Thank you for your comment. |

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| Endocrine and Diabetes Society | | • A review of required screening frequency based on risk (eg reduced frequency in low risk) would be helpful<br>• A review and comment on any benefits of screening for foot complications alongside current and well established retinal screening services would be useful for development of this aspect of the service | |
| Welsh Endocrine and Diabetes Society | 4.3.1 g | Charcot neuroarthropathy is often missed for long periods even by specialised teams. In order to highlight the risk, WEDS feels that Charcot neuroarthropathy should feature in this list as well as in the specific section referring to orthopaedic and vascular referral. | Thank you for your comment. The scope has been amended to include diagnosing and managing Charcot arthropathy (please see scope section 4.3.1j). |
| Welsh Endocrine and Diabetes Society | 4.3.1 g | WEDS feels that Charcot neuroarthropathy and lower limb ischaemia should be separately specified | Thank you for your comment. The scope has been amended to reflect this. Please see section 4.3.1 h) in the scope. Assessing the evidence for Charcot arthropathy will include Charcot neuroarthropathy. |
| Welsh Endocrine and Diabetes Society | 4.3.2 a | WEDS does not agree that surgical procedures for amputation should be excluded from the scoping document<br>Inadequate surgical treatments often delay and occasionally prevent rehabilitation. It is often an area of disagreement between medical and surgical teams. | Thank you for your comment. Amputation is outside the scope of this guideline. Prevention and management of diabetic foot problems have been prioritised. This update will look at treatment for gangrene up to the point of needing amputation, including indications for referral to vascular and orthopaedic specialist care. It is anticipated that recommendations covering this area of clinical practice may help to make amputation amongst people with diabetic foot problems less common. Surgical procedures for amputation were not identified as an area of significant variability in clinical |

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| | | | practice.<br><br>People with diabetes are also identified as a population subgroup in NICE Clinical Guideline 147. This guidance identifies differences in clinical management and outcomes of people with diabetes.<br>. |
| Welsh Endocrine and Diabetes Society | 4.3.2 a and b | WEDS is disappointed to see the active exclusion of Rehabilitation and of Surgical procedures for amputation. We believe it to be a missed opportunity for major improvement<br><br>WEDS strongly feels that input from Rehabilitation and Artificial Limb Services should be central to the scoping document. This group of practitioners are often only involved at the end of the amputation process, They have a lot to offer in relation to timing of amputation, pre-amputation preparation of the patient and advice to surgical teams performing amputations | Thank you for your comment. Amputation is outside the scope of this guideline. Prevention and management of diabetic foot problems have been prioritised. This update will look at treatment for gangrene up to the point of needing amputation, including indications for referral to vascular and orthopaedic specialist care. It is anticipated that recommendations covering this area of clinical practice may help to make amputation amongst people with diabetic foot problems less common. Surgical procedures for amputation were not identified as an area of significant variability in clinical practice.<br><br>People with diabetes are also identified as a population subgroup in NICE Clinical Guideline 147. This guidance identifies differences in clinical management and outcomes of people with diabetes. |

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| Welsh Endocrine and Diabetes Society | 4.4 | WEDS advises that Charcot diagnosis rates, time to remobilisation and remaining deformity should be considered as outcomes | Thank you for your comment. The outcomes section lists main outcomes applicable to most review questions and is illustrative rather than exhaustive. The outcomes suggested may be used for individual review questions if evidence is available. |
| Welsh Endocrine and Diabetes Society | 4.4 c | WEDS advises the use of the word "healing" rather than "cure" | Thank you for your comment. This amendment has been made. |

**These organisations were approached but did not respond:**

3M Health Care UK
Abbott Diabetes Care
Abbott Vascular Devices
Abertawe Bro Morgannwg University NHS Trust
Air Products PLC
Ark Therapeutics Ltd
Association of Anaesthetists of Great Britain and Ireland
Associazione Infermieristica per lo Studio delle Lesioni Cutanee
Bailey Instruments Ltd
Barnsley Hospital NHS Foundation Trust
Bedfordshire and Hertfordshire Tissue Viability Nurses Forum
Betsi Cadwaladr University Health Board
Bolton Primary Care Trust
Brighton and Sussex University Hospital NHS Trust
Bristol-Myers Squibb Pharmaceuticals Ltd
British Dietetic Association
British Geriatrics Society

British Hyperbaric Association
British Medical Journal
British National Formulary
British Nuclear Cardiology Society
British Nuclear Medicine Society
British Orthopaedic Association
British Orthopaedic Foot & Ankle Society
British Pain Society
British Psychological Society
British Society for Paediatric Endocrinology and Diabetes
British Society of Rehabilitation Medicine
BSN Medical
C. R. Bard, Inc.
Capsulation PPS
Care Quality Commission (CQC)
Central Essex Community Services
Chadderton Health Centre
Cochrane Wounds Group
College of Occupational Therapists
Commission for Social Care Inspection
ConvaTec Ltd
Cook Medical Inc.
Countess of Chester Hospital NHS Foundation Trust
County Durham and Darlington NHS Foundation Trust
Criminal Justice Womens Strategy Unit
Croydon Primary Care Trust
Deaf Diabetes UK
Department for Communities and Local Government
Department of Health, Social Services and Public Safety - Northern Ireland
Dermal Laboratories
Dialog Devices
Dudley Group Of Hospitals NHS Foundation Trust
East Lancashire Hospitals NHS Trust
Education for Health
English Community Care Association

Expert Patients Programme CIC
Five Boroughs Partnership NHS Trust
Great Western Hospitals NHS Foundation Trust
Guidelines and Audit Implementation Network
Guy's and St Thomas' NHS Foundation Trust
Havencare
Hayward Medical Communications
Health Angels UK Ltd
Health Protection Agency
Health Quality Improvement Partnership
Healthcare Improvement Scotland
Humber NHS Foundation Trust
Institute Metabolic Science
ISPO UK NMS
James Paget University Hospitals NHS Foundation Trust
Johnson & Johnson
KCI Medical Ltd
Knowsley Primary Care Trust
Lambeth Community Health
Lancashire Care NHS Foundation Trust
Leeds Primary Care Trust (aka NHS Leeds)
Leeds Teaching Hospitals NHS Trust
Limbless Association
Liverpool Community Health
Liverpool PCT Provider Services
London Hyperbaric and Wound Healing Centre
Maquet UK Ltd
McCallan Group, The
Medac GmbH
Medicines and Healthcare products Regulatory Agency
Medway NHS Foundation Trust
Merck Sharp & Dohme UK Ltd
Met Office
Ministry of Defence
Molnlycke Health Care Ltd

Mother and Child Foundation
Napp Pharmaceuticals Ltd
National Care Forum
National Clinical Guideline Centre
National Collaborating Centre for Cancer
National Collaborating Centre for Mental Health
National Concern for Healthcare Infection
National Diabetes Inpatient Specialist Nurse
National Diabetes Nurse Consultant Group
National Institute for Health Research  Health Technology Assessment Programme
National Patient Safety Agency
National Public Health Service for Wales
National Treatment Agency for Substance Misuse
NHS Clinical Knowledge Summaries
NHS Connecting for Health
NHS Cornwall and Isles Of Scilly
NHS Diabetes
NHS Direct
NHS Halton CCG
NHS Manchester
NHS Plus
NHS Sheffield
NHS West Essex
NHS Worcestershire
NICE technical lead
Norfolk Community Health and Care NHS Trust
North East London Community Services
North Tyneside General Hospital
Northumberland Hills Hospital, Ontario
Northumbria Healthcare NHS Foundation Trust
Nottingham City Council
Novo Nordisk Ltd
Owen Mumford Ltd
Oxford Radcliffe Trust
Oxford University Hospitals NHS Trust

PERIGON Healthcare Ltd
Pfizer
Plymouth Hospitals NHS Trust
Primary Care Diabetes Society
Public Health Wales NHS Trust
Qinetiq
QResearch
ReNeuron Limited
RioMed Ltd.
Roche Diagnostics
Royal College of Anaesthetists
Royal College of General Practitioners
Royal College of General Practitioners in Wales
Royal College of Midwives
Royal College of Obstetricians and Gynaecologists
Royal College of Paediatrics and Child Health , Gastroenetrology, Hepatology and Nutrition
Royal College of Pathologists
Royal College of Physicians and Surgeons of Glasgow
Royal College of Psychiatrists
Royal College of Radiologists
Royal College of Surgeons of England
Royal Free Hospital NHS Foundation Trust
Royal Pharmaceutical Society
Royal United Hospital Bath NHS Trust
Sandwell Primary Care Trust
Scottish Intercollegiate Guidelines Network
Sheffield Teaching Hospitals NHS Foundation Trust
Sherwood Forest Hospitals NHS Foundation Trust
Sky Medical Technology Ltd
Social Care Institute for Excellence
Social Exclusion Task Force
Society and College of Radiographers
Society for Acute Medicine
Society for Vascular Technology of Great Britiain and Ireland

Society of Chiropodists & Podiatrists
Solent NHS Trust
South Asian Health Foundation
South London & Maudsley NHS Trust
South West Yorkshire Partnership NHS Foundation Trust
Southport and Ormskirk Hospital NHS Trust
SSL International plc
St Jude Medical UK Ltd.
Stockport Primary Care Trust
The Hyperbaric Medical Centre
The Rotherham NHS Foundation Trust
Tomorrow-Options
Trafford NHS Provider Services
University Hospital Aintree
University Hospitals Birmingham
Urgo Medical Ltd
Vascular Society of Great Britain and Ireland
Vifor Pharma UK Ltd
W.L. Gore & Associates
Welsh Government
Welsh Wound Network
West Suffolk Hospital NHS Trust
Western Cheshire Primary Care Trust
Western Health and Social Care Trust
Western Sussex Hospitals NHS Trust
Wirral University Teaching Hospital NHS Foundation Trust
Worcestershire Health and Care NHS Trust
York Hospitals NHS Foundation Trust