Tell my why (The Riddle)

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There are a number of questions that I am asked on a regular basis: "Did you really DJ semi-professionally?" The answer to that one is easy. Yes. I love trance, electro and progressive house and, to me, PvD is not just the subject of the latest dimension of the Podiatry Competency Framework (TRIEPodD-UK, 2013; McCardle and Fox, 2013). And then there's: "Are you really from Newcastle and if so, why do you not have an accent?" That one is a bit more complicated but again the answer is yes. I'm also asked: "Why did you choose to work with diabetic feet?" This is the most complicated question of all, but it has lessons for the future of diabetes foot care.

Multidisciplinary teams (MDTs) are the cornerstones of effective diabetic foot care. However, it is a sad truth that the best MDTs still require an interested, dedicated, consultant to drive them forward. Twenty-five years ago this month, I was looking for a direction. I found it in diabetes thanks to Colin Hardisty who mentored me and introduced me to Andrew Boulton and the astonishingly productive team gathered in Manchester. Under Andrew's stewardship, I developed my niche in diabetic foot care. However, I only learned my debridement and practical offloading skills when I moved away from Manchester to somewhere there was no MDT and I had to replicate some of the skills I had seen. I took my theoretical and newfound practical skills to Edinburgh and I have been very fortunate to work in a great department with fabulous colleagues and to meet so many wonderful "footies" from all over the world.

There are, however, a growing number of challenges facing diabetic foot care. The rise in the number of people with diabetes is out-stripping any improvement in outcomes through better care. The NHS landscape in England has, at least until the NHS Atlas of Variation (2011) highlighted potential issues, and Putting Feet First (Diabetes UK, 2009) received government endorsement, been hostile to acute-based diabetic foot care MDTs. The drive to inpatient diabetic care also requires foot protection teams and MDTs to care for the high risk and ulcerated feet of people with diabetes.

There are at least 166 NHS Trusts in England, 7 local health boards in Wales, and 14 health boards in Scotland. Some of these are so large that they would need two MDTs to be effective. This means we need more than 200 MDTs across the UK and, in the current best practice models, this means more than 200 skilled consultants would be needed to take charge of them. I am not sure that we have them at present. The staff and skills deficit in diabetic foot care has been raised before (Young, 2008; Stuart and McInnes, 2011).

In Scotland, specialist registrars are expected to attend 10 clinics (and similar numbers in the rest of the UK) during their training to become competent in recognising foot problems. In my view, this is not enough to really develop an interest or specialism in the area. It took me months of experience and mentoring to get most of the basics right, let alone the nuances.

Perhaps the more advanced levels of the Podiatry Competency Framework (TRIEPodD-UK, 2013) and independent prescribing for podiatrists will make medical consultants in MDTs less important than they currently are. However, in a crowded programme, with many other demands being placed on registrars, it is important for those of us who help to train them to set some minimum standards so they can confidently fill all of these potential MDT roles when they become consultants.

Therefore, in the spirit of myself, Neil Baker, Alistair McInnes, and Louise Stuart all those years ago, I would like to call for competency-based training for registrars in diabetic foot care.

Below, I present a subset of the podiatry competencies as the starting point for debate, and as a basis for a tool to ensure that registrars and others are able to practice core professional activities on completion of foot clinic attachments. The subset is as follows, where the clinician must:

Debridement

- Demonstrate awareness of when appropriate debridement is required.
- Demonstrate awareness of the various methods of debridement.

Pressure relief

- Demonstrate awareness of the need for pressure relief in managing foot ulceration.
- Demonstrate knowledge of the various methods of pressure reduction, including casting.

Infection control

- Demonstrate awareness of the signs and classification of infection.
- Demonstrate awareness of antibiotic guidelines and need for admission.

Peripheral vascular disease

- Demonstrate the ability to determine the difference between neuropathic and dysvascular feet.
- Demonstrate awareness of referral pathways to vascular surgery.

Charcot foot

- Demonstrate awareness of diagnostic criteria for Charcot.
- Demonstrate awareness of treatment and prognosis of Charcot change in the foot.

Painful neuropathy

- Demonstrate awareness of the presentation and diagnostic criteria for painful neuropathy.
- Demonstrate awareness of the various treatment options for painful neuropathy and their use.

With these, or similar, basic foundation stones in place, we might be able to ensure an effective consultant-led MDT wherever one is needed. ■

Diabetes UK (2009) *Putting Feet First: Commissioning Specialist Services for the Management and Prevention of Diabetic Foot Disease in Hospitals*. Diabetes UK, London

McCardle J, Fox M (2013) Introduction to the latest competency dimension: peripheral vascular disease. *The Diabetic Foot Journal* **16**: 54–5

NHS (2011) *Atlas of Variation 2011*. NHS, London

Stuart L, McInnes A (2011) Diabetes specialist podiiatrists in the UK: ensuring a competent, adequate workforce. *The Diabetic Foot Journal* **14**: 102–6

TRIEPodD-UK (2012) *Podiatry Competency Framework For Integrated Diabetic Foot Care: A User's Guide*. SB Communications Group, London

Young M (2008) I'm competent, hope you're competent too. *The Diabetic Foot Journal* **11**: 6