Diabetic foot care: Aussie rules!

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In this post-World Cup issue, the focus remains on Australia. Two interesting articles and a commentary highlight similar issues that we face in providing diabetic foot care in the UK and throughout Europe.

Margaret McGill (Manager of the Diabetes Centre at the Royal Prince Alfred Hospital) and Dennis Yue (Director of the Discipline of Medicine at the University of Sydney and a member of our International Editorial Board) have provided a commentary on the limitations of podiatry services to the increasing diabetes population in Australia and the requirement to rationalise and improve the standards of diabetes foot care.

The Diabetes Amputation Prevention Program

Margaret McGill and colleagues have written a clear, coherent account of the background and development of the Diabetes Amputation Prevention Program. Their commentary and views on multidisciplinary teams and referral pathways will be shared by many of their clinical colleagues in the UK. The fragile resourcing arrangements for the 'most established foot clinic in Australia' will not, sadly, surprise too many of us.

Similar problems with similar solutions in the UK have arisen in Australia with regards to the organisation and provision of podiatry care. Podiatry services in the public sector in the UK have largely developed assessment criteria for eligibility to the service and accompanying discharge policies. The exercise should result in the targeting of the 'at risk' people with diabetes who will benefit from fast track and clinical care. The Diabetes Amputation Prevention Program specifically targets the high risk group of patients with active foot ulceration and/or infection to benefit from the programme. This approach was pragmatic, adopted due to the programme designers' view that resources would be allocated to the groups most obviously in acute need.

There is an argument to focus on preventive measures before the stage of foot ulceration has occurred. Further demands on resources may remain unmet, and the evidence for the effectiveness of foot health education programmes is not compelling. Further research is clearly needed to establish best practice. According to Michael Edmonds (Scottish Conference, 2003) there are currently no randomised controlled trials that investigated the effect of education on foot outcomes. The burden of foot ulceration, infection and amputation remains significant and the best practice in changing patients' behaviour has yet to be identified.

The appointment of a clinic coordinator for the Australian programme helped to facilitate care pathways for the patients, ensuring that they were seen by the most appropriate healthcare professional(s) based on clinical need. This team approach to the decision making process is probably best practice and clearly requires sound coordinating skills.

The development of standardised clinical data and communication has led to a centralised database across the Central Sydney Area Heath Service which will enable the evaluation of the programme and provide much sought after data for audit purposes. The data reproduced in the article demonstrates the increase in distal amputations for those enrolled in the Prevention Program, with an accompanying decrease in above and below knee amputations which is to be welcomed.

Consulting stakeholders in high-risk foot care services development

The other Australian contribution in this issue provides interesting views from a variety of stakeholders in the provision of diabetic foot care services in the Australian Capital Territory. There is little published evidence of stakeholders' views being part of the process of developing services, rather, part of the evaluation process after they have been established. Many of the issues that were raised from the stakeholders in this article by Susan Nancarrow (research fellow at Sheffield University) and Nicole Devlin (Director of Nursing at Morsehead Home, Lyneham, Australia) will hold no surprises for the readership, with one notable exception. The concept of a centrally located 'at risk foot clinic' was rejected by all parties. This may seem at odds with the universally accepted model of care of a hospital-based multidisciplinary foot care team being at the heart of the diabetes foot service. However, given the nature of the distances between rural services and a central location, there

may be a need to maximise the services that can be provided locally by the community team. This may be a consideration for the UK.

Another point of interest was the consensus among the stakeholders that the GP should be the central manager of patient care, coordinating the different care pathways that may be required for individual patients. The development of these care pathways (which are quite different from the traditional models of care) have created a community-based focus. It is to be anticipated that there will be different models of diabetic foot care throughout the world. However, clear integrated care pathways, better communication and a standardised approach were all areas identified to improve the quality of diabetes services.

Back in the UK

The NSF for Diabetes (DoH, 2003) may not be a panacea that will improve our diabetic foot services, but the NHS Changing Workforce programme (DoH, 2000) may well facilitate screening and ulcer care programmes provided by diabetic foot practitioners as described by Matthew Young in his editorial (Young, 2003). At the inaugural launch of Podiatry Diabetes UK (PDUK) in November, 2003, there was an excellent discussion on the future education and training needs for those podiatrists who wish to become advanced practitioners, in order to facilitate the care programmes that Matthew Young previously described. Professional education and training is one of the key development and research issues for PDUK Exciting times are ahead and I would like to congratulate Louise Stuart and Neil Baker, co-chairmen of PDUK on their welcome commitment to this initiative.

The Diabetic Foot conference

The Diabetic Foot Conference 2003 programme resulted in excellent meetings in Glasgow and London. Matthew Young has put together a superb programme for 2004. Next year looks to be a busy year with several new developments on the education and conference front. We hope to keep you all engaged and involved. Please keep us informed of the good work that you do, so that we can exchange best practice. ■

DoH (2003) *The NSF for Diabetes: Delivery Strategy*. Department of Health, London

DoH (2000) *The NHS Changing Workforce Programme; new ways of working in the NHS*. Department of Health, London

Edmonds ME (2003) The evidence gap: future research. 4th Biennial Scottish Conference on the Diabetic Foot. Dundee

Young M (2003) Generalists, specialists and superspecialists. *The Diabetic Foot* **6(1)**: 6