

Smells like team spirit



Matthew Young

As services adapt over time, we need to examine all aspects of diabetic foot care. With this in mind, there is a major service delivery theme running through this year's *Diabetic Foot Journal* Conferences.

I am sure we have all seen presentations on diabetic foot care where the multidisciplinary team (MDT) is discussed and a diagram, list or photographs illustrate everyone – from the patient to the clinic cleaning staff – who are “must have” team members. However, although I believe I work in an interdisciplinary team where each of us works across the other's professional boundaries, we do not meet some specifications of the idealised MDT.

My podiatry colleagues request X-rays, take drug histories, measure blood samples and can dispense antibiotics with a patient group directive. I debride and dress ulcers. Everyone else needed for the running of our, and probably many other, diabetic foot services is part of a wider network, but fortunately for us they are nearly all in the same hospital. Our diabetes nursing colleagues are in the same clinic, surgical colleagues practice in parallel clinics and inpatient care is just a lift ride away. Only the rehabilitation team is on a different site, and we are trying to link more closely with them too.

This absence of all but the core professionals of the MDT (myself, my podiatry colleagues and an orthotist for one session a week) in our clinic, makes ours unlike the crowded clinic that seems to be the nirvana for diabetic foot services. On a number of occasions our team has discussed possible solutions to this “deficiency”.

We considered joint surgical review clinics, perhaps once a month, but then we thought: “What if the Charcot presents a week after the orthopaedic clinic?”, or “What if we have a black foot the week before the vascular surgeon attends?”. If there were no relevant referrals to be seen that month, how could we justify using a session of surgical time?

In light of these concerns, we moved towards a virtual MDT. In this model, the core communicates with, and draws on the skills of, the wider team, as and when required. The wider team, in turn, provides a rapid response service and unnecessary reviews are minimised. Until recently, however, there has been no evidence that this approach works as well as the full MDT model.

Hellingman and Smeets (2008) provide support for the streamlined MDT. While they report a clinic that deals with wounds in general, not just diabetic foot ulceration, do not provide a before-and-after comparison, and do not take a randomised approach to measuring the outcomes of the streamlined MDT, the paper does have some relevant insight.

The authors demonstrate that healing rates achieved in their streamlined clinic are similar to those of larger MDTs. This was achieved with the patient being seen by the most appropriate person for that visit, leaving the rest of the team free to see other patients. Thus, more patients can be seen more quickly and the model has significant potential advantages for NHS resource management. Furthermore, a streamlined team could be used for areas where a full MDT cannot be brought together, in one place or at one time, without compromising care. For this model to work effectively there must be clear, common standards for referral, and communication and documentation must be shared effectively among all team members.

Such services may never match the heights of the flagship MDTs around the world, but they are better than no MDT. Such teams may overcome barriers of geography and budgeting to allow the creation of MDTs for the benefit of people with diabetic foot disease everywhere. ■

Hellingman AA, Smeets HJ (2008) Efficacy and efficiency of a streamlined multidisciplinary foot ulcer service. *J Wound Care* 17: 541–4

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NOTE TO READERS

The way that HbA_{1c} values are reported in the UK has now changed. To reflect this, as of this issue, all HbA_{1c} values will be dual reported both in percentages and mmol/mol.