Volume 20 Number 10 | **October 2017**

PODIATRY NOW

The Society of Chiropodists and Podiatrists The College of Podiatry

SAVING LIMBS AND LIVES THROUGH PUBLIC HEALTH.

THE KEY ROLE OF PODIATRY

#ProudtobeaPod

Formthotics™

Custom Medical Orthotics

PROUD TO BE
PRINCIPAL SPONSOR OF

osgo LIVE 2017

THE ANNUAL PRIVATE PRACTICE CONFERENCE FOR PODIATRISTS

Friday 13th October

THE LOWRY, SALFORD

To find out more and buy tickets:

visit **osgo.co.uk/live** or call **0161 714 4114**

CONTENTS

PODIATRY NOW: CONTENTS

EDITORIAL

NEWS

CLINICAL

FEATURES

REPORTS

MEMBERS

BOOK REVIEW

REGULARS

CONTACTS

EDITORIAL CONTRIBUTIONS
podnow@scpod.org

CLASSIFIED ADVERTISEMENTS
classifieds@scpod.org

COURSES
courses@scpod.org

DIARY
diary@scpod.org

SUBSCRIPTIONS
td@scpod.org

ADVERTISING
Joanne Rose
020 7880 6231, joanne.rose@redactive.co.uk

EDITORIAL TEAM
Clare Richards 020 7234 8638, cr@scpod.org
Tina Davies 020 7234 8639, td@scpod.org
Michelle Flood 020 7234 8624, mlf@scpod.org

WEBSITE
www.scpod.org

PUBLISHED BY
The Society of Chiropodists and Podiatrists
Quartz House, 207 Providence Square, Mill Street, London, SE1 2EW, 020 7234 8620, enq@scpod.org

PRINTED BY
Warwick Printing Co Ltd, Caswell Road, Leamington Spa, Warwickshire, CV31 1QD, www.warwickprinting.co.uk

Podiatry Now, incorporating *The British Journal of Podiatry*, *The Journal of British Podiatric Medicine* (*The Chiropodist* incorporating the *British Journal of Chiropody* and *The British Chiropody Journal)* and the *British Journal of Podiatric Medicine and Surgery*, *Society News* section of *The Journal of British Podiatric Medicine*, *SeaRCh News* and *Instep*

SAVING LIMBS AND LIVES THROUGH PUBLIC HEALTH. THE KEY ROLE OF PODIATRY

One of the key ambitions of our Society's new five-year strategic plan (currently under consultation and to be launched at this year's conference) is to develop the role of podiatry in public health. Ultimately the aim is that podiatrists will be seen as leaders in public health

Public health is 'The science and art of preventing disease, prolonging life and promoting health through the organised efforts of society'.[1] Prevention of disease is becoming a major focus for the NHS, especially since its inclusion in the NHS five-year forward view.[2]

Whilst public health strategies have been devised and often delivered by specialists, the central role of health professionals 'at the coal face' is increasingly recognised because patients are more ready to hear such messages as they are symptomatic on presentation. In reality, podiatrists already have a key public health role in promoting physical activity, for example.

A number of evidence-based strategies to increase activity have been described,[3] many of which can be initiated and delivered through podiatry such as the NICE recognised model at Salford Royal (NHS) Foundation Trust. Here, patients with vascular insufficiency are referred to exercise programmes delivered through cardiac rehabilitation.[4] Podiatry can therefore help increase physical activity in patients and address the public health issues of 6 million people not even taking a monthly 10-minute brisk walk and physical inactivity contributing to 1 in 6 deaths - the same number of deaths attributable to smoking.[5] Through such measures podiatry can help reduce the £900m cost to the NHS resulting from physical inactivity.[5]

In order to understand how and why podiatrists are crucial to an overall Public Health strategy, as well as describing a programme to co-ordinate such vital work, an appreciation of the principles underpinning public health, i.e. social justice, the social determinants of health and the public health paradox, is required. To do this we can refer back to the landmark World Health Organisation publication immediately after the Second World War.

DR PAUL CHADWICK CLINICAL DIRECTOR COLLEGE OF PODIATRY

MR NASEER AHMAD, CONSULTANT VASCULAR SURGEON, MANCHESTER VASCULAR CENTRE, MANCHESTER ROYAL INFIRMARY

PRINCIPLES BEHIND PUBLIC HEALTH

Social Justice

Reducing health inequality is at the core of public health and is grounded in the concept of social justice. The public health goal has been defined by the World Health Organisation as:

'The highest standards of health should be within reach of all, without distinction of race, religion, political belief, economic or social condition'. World Health Organisation, 1946.[6]

Social Determinants of Health

The causes of ill health are multi-factorial and related to both biological and environmental causes, i.e. poor health is a product of social, economic and physical factors that interact with the behaviour and biology of individuals. These factors have been put together into one model by Dahlgren and Whitehead[6] that acknowledges the responsibility of the individual but

Three lifestyle behaviours	Four Conditions	50% deaths
Smoking Poor diet Lack of exercise	Diabetes Cardiovascular disease Chronic respiratory disease Cancer	

The 3,4,50 framework

incorporates several elements that are primarily the responsibility of government in creating an environment where health is promoted.

Policies that seek to improve health outcomes, therefore, need to address these social determinants in addition to biological and lifestyle factors.

Public Health Paradox

Associated with any organised public strategy is the public health paradox. This is the concept that most cases of disease to be prevented do not occur in the 'at-risk' population. An example is alcohol-related problems, where most societal alcohol-related issues are not found in dependant drinkers. An appreciation of the concept of 'sick individuals' versus 'sick societies' is therefore important.[7] The application of this public health paradox is the understanding that most societal benefit will be achieved through small changes in a large population, whereas most individual benefit will be achieved through targeting high-risk individuals. Podiatry has a role in both areas.

Here we focus on one area of practice where individual benefit is maximised: the central role of podiatrists in treating foot ulcers secondary to diabetes and peripheral arterial disease.

These two conditions are the main causes of the vast majority of the 10,000 major and minor amputations performed in England every year in people over 50: the equivalent of over one amputation every hour.[8] These patients often have additional co-morbidities and lifestyles that increase their risk of not only amputation, but also, perhaps more importantly, early death. It is in these high-risk foot patients where the most individual difference can be made.

A COMPREHENSIVE PUBLIC HEALTH STRATEGY APPLICABLE TO PODIATRY: THE 3,4,50 FRAMEWORK

The 3,4,50 framework is a tool to simply focus a public health strategy. It is based on the principle that three lifestyle behaviours contribute to four chronic diseases, which are in turn responsible for over 50% of preventable deaths.

It is ultimately based on data that states that the four non-communicable diseases, i.e. diabetes, cardiovascular disease, chronic lung disease and cancer, are the leading causes of death worldwide, and accounted for 65.5% of the 52.8 million global deaths in 2010.[9] The principle was derived by the Oxford Health Alliance and is designed to support collaborative community strategies.[9] Essentially, the 3,4,50 is a way to bring the strategies together in a co-ordinated approach across the whole community to which it is applied. It can be applied across multiple settings; schools, workplaces, health centres and communities, and requires champions to raise awareness, drive policy change and implement evidence-based strategies.[9]

THE ROLE OF PODIATRY IN PUBLIC HEALTH AND THE 3,4,50 STRATEGY

In simple terms it is easy to see how podiatrists can have an impact on all three of these behaviours. We usually have double the amount of time of a GP appointment to deliver key health messages and making every contact count.[10] Making every contact count is a way of making use of everyday health interactions to support behaviour change. These could include smoking cessation[11] or switching from tobacco to 'E' cigarettes, which have been shown to be 95% safer than traditional cigarettes.[12] Interventions around healthy eating can also be delivered in this non-threatening environment. As described earlier, podiatrists have a key role in keeping people mobile, with this ranging from core and musculoskeletal podiatric interventions through to surgical interventions to reduce deformity and pain.

CONCLUSION

We have described in this short editorial a model (the 3,4,50) and only a few of the possible myriad of interventions where podiatrists can have a role in public health. Over the next few months and years as we refine and develop the strategy and put podiatry at the forefront of the public health agenda this will grow into an established and an accepted part of our role. This is not only good for the profession but also ultimately and more importantly for our patients and wider society.

REFERENCES

1. Bhopal R. *The Practice of Epidemiology in Public Health in Concepts of Epidemiology.* Oxford University Press, Oxford, 2008.
2. NHS England. Five Year Forward View. 2014. Available at https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdfNHS 5 year plan (last accessed 30 August 2017).
3. Public Health England. Everybody active, every day. An evidence-based approach to physical activity. 2014. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/374914/Framework_13.pdf (accessed 30 August 2017).
4. NICE. Community triage for lower limb vascular concerns: reducing the burden on hospitals. 2016 available at www.nice.org.uk/localpracticecollection.
5. Public Health England. Six million adults do not do a monthly brisk 10 minute walk (press release). 2017. Available at https://www.gov.uk/government/news/6-million-adults-do-not-do-a-monthly-brisk-10-minute-walk (accessed 30 August 2017)
6. Dahlgren G, Whitehead M. Tackling inequalities in health: what can we learn from what has been tried? Working paper prepared for the King's Fund International Seminar on Tackling Inequalities in Health, 1993, London, King's Fund. Accessible in: Whitehead M, Dahlgren G. *Concepts and principles for Tackling Social Inequities in Health: Levelling up Part 1*. World Health Organisation 2007. Available at http://www.euro.who.int/__data/assets/pdf_file/0010/74737/E89383.pdf (accessed 30 August 2017)
7. Rose G. Strategy of prevention: lessons from cardiovascular disease. *BMJ* 1981;282:1847-1851.
8. Ahmad N, GN Thomas, Gill P, Torella. The prevalence of all cause major and minor lower limb amputation in the diabetic and non-diabetic population of England 2003-2013. *Diabetes and Vascular Dis Research* 2016:13:348-353.
9. Dyson PA, Anthony D. Community Interventions for Health: A monograph. The Oxford Health Alliance 2015. Available at www.oxha.org/images/results.pdf (accessed 30 August 2017).
10. NHS England. Making Every contact count (2014) available at https://www.england.nhs.uk/wp-content/uploads/2014/06/mecc-guid-booklet.pdf (accessed 30 August 2017).
11. Stead LF, Buitrago D, Preciado N, Sanchez G, Hartmann-Boyce J, Lancaster T. Physician advice for smoking cessation. *Cochrane Database Syst Rev* 2013;5:CD000165 (accessed 30 August 2017).
12. Public Health England. E cigarettes: an evidence update. 2015. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/457102/Ecigarettes_an_evidence_update_A_report_commissioned_by_Public_Health_England_FINAL.pdf (accessed 30 August 2017)

SCP NEWS

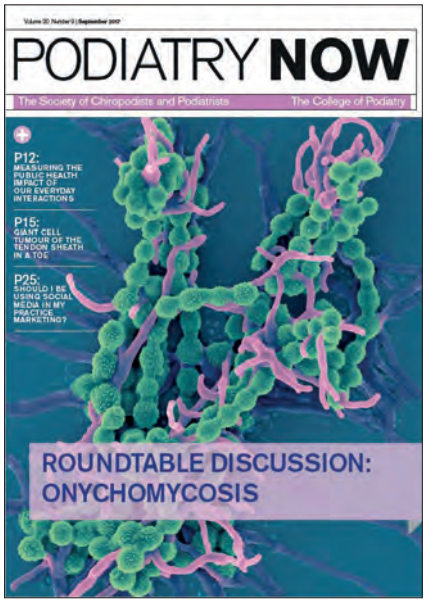
COMMITTEE OF PRIVATE PRACTICE ENGLAND REPRESENTATIVE RESULTS

The call for nomination for England Representatives on the Committee of Private Practice closed on Friday 11 August 2017. We now have a full complement of England Representatives on the committee.

We had four nominations within the time frame for the four seats, meaning there was no need to ballot members.

The following members have been duly elected:

- Claire Bateson-Cooper; re-elected, she has been a committee member since 2010.
- Anne Hogben; newly elected, a private practitioner with a clinic in Surrey.
- Janet McGroggan; newly elected, a private practitioner with a clinic in Cheshire.
- Allan Wood; re-elected. He has been a committee member since 2006 when the committee was created. He is also Dean of the Directorate of Private & Independent Practice



PODIATRY NOW

If you do not want to receive *Podiatry Now* each month as part of your membership services, then please contact the membership department, member@scpod.org.

STAFF

CHIEF EXECUTIVE'S OFFICE

CHIEF EXECUTIVE
Steve Jamieson
020 7234 8630, sj@scpod.org

ASSISTANT COMPANY SECRETARY
Helena Basarab-Horwath
020 7234 8635, hb@scpod.org

INTERIM GENERAL COUNSEL
I. Stephanie Boyce
020 7234 8635, sb@scpod.org

ASSISTANT TO CHIEF EXECUTIVE'S OFFICE
Natasha Smith
020 7234 8633, ns@scpod.org

COLLEGE OF PODIATRY

CLINICAL DIRECTOR
Paul Chadwick
020 7234 8628, pjc@scpod.org

POSTGRADUATE EDUCATION OFFICER
Kim Bryan 020 7234 8627, ka@scpod.org

UNDERGRADUATE EDUCATION OFFICER
Alison Hart 020 7234 8629, ah@scpod.org

CPD OFFICER
Debra Barlatt-Browne
020 7234 8636, db@scpod.org

DEVELOPMENT OFFICER
James Coughtrey
020 7234 8655, jc@scpod.org

EDUCATION ASSISTANT
Sally Lock (part-time) 020 7234 8651, sl@scpod.org

EMPLOYMENT RELATIONS & BUSINESS SERVICES

INTERIM HEAD OF ER & BUSINESS SERVICES
Martin Furlong
020 7234 8634, mcf@scpod.org

PROFESSIONAL & PRIVATE PRACTICE OFFICERS
Sharon Gray (Tues, Wed, Thurs)
020 7234 8652, professionalofficer@scpod.org
Katie Collins
020 7234 8652, professionalofficer@scpod.org

EMPLOYMENT RELATIONS OFFICERS
Graham Pirie (Wed, Thurs & alternate Tue)
0141 883 2286/07825 839336, gp@scpod.org
Steve Morse
07787 421337, sm@scpod.org
Chris Burns 01706 849071/07768 552462
cb@scpod.org

DELEGATE ASSEMBLY COORDINATOR
Jilly Frisch (Tues, Wed, Thurs)
020 7234 8632, jf@scpod.org

BUSINESS DEVELOPMENT MANAGER
Louise Dolan 07557 946596, ld@scpod.org

ADMINISTRATOR
Maureen Jonas 020 7234 8631, mj@scpod.org

EXTERNAL AFFAIRS

DIRECTOR OF EXTERNAL AFFAIRS
Liz North 020 7234 8645, ln@scpod.org

HEAD OF COMMUNICATIONS
Clare Richards 020 7234 8638, cr@scpod.org

HEAD OF MARKETING
Adam Thomas 020 7234 8637, at@scpod.org

LEAD POLICY OFFICER
Lawrence Ambrose 020 7234 8643, la@scpod.org

POLICY OFFICER FOR NORTHERN IRELAND
Julie Williams-Nash (part-time)
07813187301, jwn@scpod.org

POLICY OFFICER FOR SCOTLAND
Ross Barrow 020 7234 8643, rb@scpod.org

POLICY OFFICER FOR WALES
Tess Saunders 020 7234 8643, ts@scpod.org

DIGITAL CONTENT MANAGER
Andy Stow 020 7234 8625, as@scpod.org

INTERIM MARKETING & COMMS OFFICER
Michelle Flood 020 7234 8624, mlf@scpod.org

MARKETING & COMMUNICATIONS ASSISTANT
Tina Davies 020 7234 8639, td@scpod.org

FINANCE, ADMIN & MEMBERSHIP

DIRECTOR FINANCE & OPERATIONS
George Wood 020 7234 8623, gw@scpod.org

FINANCIAL CONTROLLER
Layo Caulcrick 020 7234 8653, lc@scpod.org

MEMBERSHIP OFFICER & IT COORDINATOR
Elaine Garnett 020 7234 8641, eg@scpod.org

MEMBERSHIP & FINANCE OFFICER
Tamsyn Hutchings 020 7234 8622, th@scpod.org

MEMBERSHIP & FACILITIES OFFICER
Lisa Thomas 020 7234 8626, lt@scpod.org

RECEPTION & FACILITIES OFFICER
Nuria Feshaye 020 7234 8620, reception@scpod.org

THE SOCIETY OF CHIROPODISTS AND PODIATRISTS: SUMMARY OF COUNCIL MEETING 7TH JULY 2017

COUNCIL CHAIR ELECT

George Dunn was voted in as Chair Elect. He will take over as Chair from Debbie Delves in 2018.

COUNCIL VICE PRESIDENTS

The following Council members were elected as Vice Presidents

- Alan Borthwick
- Tom Kelly
- Michael Stephenson
- Emma Supple

MANAGEMENT TEAM

Council noted it was the last Council meeting for Rosemary Gillespie, Interim Chief Executive. Council expressed thanks for her work over the last year. It was noted that Steve Jamieson had been appointed as the new Chief Executive, and would be joining at the end of September. Council welcomed three new Directors, Dr Paul Chadwick (Clinical Director in the College of Podiatry), Liz North (Director of External Affairs) and George Wood (Director of Finance and Corporate Services), who would be Acting Chief Executive for the interim period.

FIVE YEAR STRATEGIC PLAN

Council agreed the draft plan. There would be a staff day on 11 July and, subsequently, a consultation with members over the remainder of the summer.

ORGANISATIONAL DEVELOPMENT PROGRAMME

The Council received an update from the CEO in respect of the rest of the Organisational Development Programme (ODP). The Council noted that Phase 1 is to put in place the restructured senior management team of new Directors and recruitment has been completed with the exception of the Director of Operations role.

As previously reported, Phase 2 will involve each Director, once in place, working with their teams to review roles in their team. The Council agreed that Phase 2 is to be 'cost neutral'.

2017 AGM

Council noted that all AGM resolutions had been passed.

DIVERSITY AND INCLUSION

Council agreed to the establishment of a diversity group, with Dr Morriss-Roberts as 'Diversity Champion'.

FINANCE

Council agreed funding to support the development of a diabetes toolkit aimed at clinical commissioners in the NHS.

NEXT MEETING

The next meeting of the Council is on Friday, 6 October 2017.

CELEBRATING THE BIRTHDAY OF OUR ROYAL PATRON, HRH THE DUCHESS OF CORNWALL

Chair of Council Debbie Delves attended an official reception, hosted by HRH Prince of Wales and HRH The Duchess of Cornwall in the Clarence House garden, to celebrate the 70th birthday of The Duchess, who is Royal Patron of the College of Podiatry, alongside supporters and representatives from the charities Her Royal Highness supports.

Debbie attended the event on 13 July on behalf of the College, along with representatives from other organisations to which the Duchess gives patronage. The reception was also attended by friends, family, former Royal household staff, and a number of celebrities and VIPs.

Podiatrist Tariq Khan attended, as our Patron's podiatrist, along with other people who provide medical and other services. ■

Above Left to right: The Duchess of Cornwall, Chair of Council Debbie Delves and Podiatrist Tariq Khan

Left to right: The Prince of Wales, Chair of Council Debbie Delves and Podiatrist Tariq Khan

OPTOGAIT

Advance your practice, increase your revenue & raise your profile

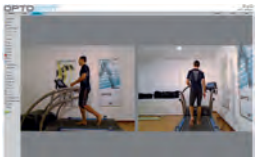
OptoGait is an innovative video gait analysis system and software package using high-resolution infrared technology. OptoGait is portable, quick to set up, easy to use and can be used for the movement analysis and functional assessment of patients with normal or pathological conditions.

Visit stand 54-63 at the College of Podiatry Conference in Liverpool to see a live demonstration of OptoGait and collect a FREE OptoGait information pack.

Laptop and treadmill not included.

OptoGait offers effective biomechanical evaluation as easy as:

1. TEST	2. ANALYSE	3. REPORT



To find out more please visit the online OptoGait Hub **www.algeos.com/optogait**

Revenue Generator
Attract new patients and increase patient spend.

PMI Recognised
Services offered using this product are reimbursed by the main PMI providers.

Available on NHS Supply Chain
For your convenience.

Education Available
Training courses and educational support available.

Financing Available
Spread the cost of the investment to improve your cash flow.

ALGEOS

+44 (0)151 448 1228
algeos.com
info@algeos.com

WORKING TOGETHER TO DEVELOP OUR STRATEGIC PLAN

It hardly seems possible that it has been a year since we first talked together about our new strategic plan. Throughout the process it has been vital that our members have had the chance to influence and input into the direction and development of the strategy.

So firstly I would like to say thank you to all who took part in our Members' survey in September 2016; thank you to those who provided input at the Delegate Assembly workshop; thank you to all who participated in our Facebook live event in July this year and thank you to those who took part in branch discussions over the summer or responded to the consultation survey in September. Your input, along with that of staff and Council, will ensure that our new strategic plan will be one we can all be proud of, sign up to and work together to achieve.The strategy will set out our commitment to achieving our vision for attaining the professional standing, influence and recognition that the profession deserves.

DEBBIE DELVES, SOCIETY CHAIR

What happens now?

We are now reviewing and compiling all your feedback and this will be incorporated into the next version of the strategy, which will go to Council in October.

The final strategic plan will be launched at Conference in November 2017 and we will develop the long-term plans that will deliver it over the next five years – setting and delivering to 'success measures' that will ensure we implement the strategy and make our ambitious plans a reality. ■

PODIATRIST BECOMES CLINICAL CHAMPION FOR DIABETES UK

Podiatrist Jennifer Madden

Twenty healthcare professionals, including consultants, nurses, GPs, dietitians, podiatrists and pharmacists have been appointed as Clinical Champions for Diabetes UK. Podiatrist, The award-winning Clinical Champions programme supports healthcare professionals to become strong local leaders, working to address the significant variation in patient care and treatment for people living with diabetes in the UK.

The new cohort of Champions have been selected based on their skills, clinical expertise and a demonstrable passion for transforming care for people with diabetes. They will be supported by Diabetes UK with two years of training alongside their clinical work, to help them identify improvements and drive vital change in diabetes services in their local areas.

Podiatrist Jennifer Madden, Advanced Podiatrist in Elderly Care for Belfast Health and Social Care Trust, who is one of the newly appointed Clinical Champions, said: 'The Diabetes UK Clinical Champion role will empower me to improve my influence and maximise my skills in delivering a vital quality improvement project for patients admitted to hospital with diabetes. I aim to conduct a pilot of an already standardised foot check pathway that will be measurable, provide preventive strategies and demonstrate an improvement in patient care, which can then be spread across Northern Ireland. I'm also looking forward to maximising my skills around advocacy for patients living with diabetes and in particular foot disease and actively engaging with patients admitted to hospital about education and awareness of the risks to their feet.'

The Clinical Champions programme was launched by Diabetes UK in 2014, in partnership with Novo Nordisk. There are now 65 Clinical Champions across the UK, with access to a network of like-minded clinicians, with whom they can share the challenges they encounter, and the solutions they discover.

Podiatrists who are already Clinical Champions include Rosalyn Thomas, Swansea Deputy Head of Podiatry, Abertawe Bro Morganwg University Health Board (Wales); Scott Cawley, Professional Lead Podiatrist, Cardiff And Vale University Health Board (Wales); Dr Julia Shaw, Assistant Podiatry Manager, Belfast Health and Social Care Trust (Northern Ireland); Daina Walton, Podiatrist, King's College Hospital (London); and Fiona Main, Podiatrist, NHS Highland (Scotland).

Chris Askew, Chief Executive of Diabetes UK, said: 'Our Clinical Champions play a critical role in leading improvements to the care people living with diabetes receive, and contribute enormously to our aim of creating a world where diabetes can do no harm.'

Adam Burt, Director of Market Access and Public Affairs at Novo Nordisk UK, said: 'It is wonderful to be working with Diabetes UK on this ambitious initiative aimed at empowering a growing network of Clinical Champions.'

If you are interested in becoming a Diabetes UK Clinical Champion for the 2018-2020 intake please contact clinicalchampions@diabetes.org.uk or call 020 7424 1896. ■

PODIATRY GRADUATE IS AWARDED A PRESTIGIOUS CARNEGIE SCHOLARSHIP TO STUDY PHD

Podiatry graduate Benedictine Yen Chen Khor has been awarded a prestigious Carnegie Scholarship to return to Glasgow Caledonian University (GCU) to work on a PhD.

Khor, from Singapore, has been working as a podiatrist for NHS Dumfries and Galloway since graduating from GCU last year, and was nominated for the scholarship by the University's Dr Ruth Barn, Professor Jim Woodburn and Dr Lisa Newcombe.

She said: 'It feels unreal to have been awarded a PhD scholarship by The Carnegie Trust as it is such a competitive and prestigious scheme. I am incredibly grateful and I wouldn't have been aware of or have been given this opportunity if not for my prospective supervisors at GCU. This award also wouldn't have been possible without the extraordinary efforts and dedication of everyone who guided me throughout my undergraduate training.' Khor's PhD will explore diabetic foot ulceration.

Dr Barn said: "This study is of vital importance to advance our understanding of the causes of foot ulceration and addresses important features affecting ulceration including tissue stiffness, tissue stress and deformity. If the findings of the study identify altered tissue properties as a risk factor for ulceration then new targeted treatment opportunities will emerge. This is a fantastic achievement for Khor and a great success for the School of Health and Life Sciences."

The prestigious Carnegie PhD Scholarship scheme supports a limited number of academically outstanding graduates through PhD studies at Scottish universities.

Khor will begin her PhD in autumn 2018. ■

Khor has been awarded a prestigious Carnegie Scholarship to continue her studies

FOOTWORKS

THE MISSION OF FOOT WORKS CHARITY IS TO ESTABLISH A REGULAR FOOT HEALTH PROGRAMME FOR HOMELESS AND MINORITY GROUPS

What is Foot Works?

Last year podiatrist Richard Cooper set out to establish a regular foot health programme for homeless and minority groups in London that provided all-year-round access. The result was Foot Works, a registered charity providing a free integrated podiatry and foot care service for homeless men and women.

Homeless men and women typically walk miles each day to access support, services and to fulfil basic needs. Foot health is often overlooked, with people wearing pre-worn, poor quality and ill-fitting shoes with limited opportunity to remove socks and shoes to enable feet to dry, heal and recuperate, resulting in sores, infection, pain and discomfort. In addition, there is limited NHS provision and private podiatry consultations are unaffordable to homeless people. Foot Works fills this important gap.

What does Foot Works provide?

Said Richard, 'Foot Works provides free podiatry consultations through a dedicated team of volunteer qualified podiatrists. We can also provide patients with a pathway to local mainstream NHS services when necessary.

'Through the generous support of our partners we can also provide brand new high-quality shoes and socks when needed.

'Homeless men and women can access the Foot Works service by attending one of the day centre clinics. We do not operate an appointments system, and most patients are treated within an hour.'

Achievements to date:

Foot Works was established in November 2016. In the eight months to 30 June 2017 Foot Works has:

* Built a team of six volunteer podiatrists
* Held 35 clinics within three established homelessness organisations
* Treated 135 individuals patients with 186 consultations
* Provided 35 pairs of new brand new high quality leather shoes

Foot Works would not exist without the commitment of:

* Our team of dedicated volunteers
* Key homelessness stakeholders: including Webber Street/London City Mission, ASLAN, Housing Justice, Pathways, Crisis Skylight, Glass Door, Hill Song
* London Branch of the Society of Chiropodists and Podiatrists
* Shoe, sock and consumables suppliers: Clarks Shoes, Jollie Socks, Gandys Orphans for Orphans, Algeos, Dave Dicker (MES) Cornerstone grant funders: Stephen Clark Trust, London Catalyst
* Countless individuals: including teams at Webber Street Day Centre and ASLAN, Okoye (Kate) Nwamaka, Eloise Whitaker, Jonny Noon

RICHARD COOPER
PODIATRIST

FOOT WORKS FOOT HEALTH CHARITY

How can you help?

There are many practical ways you can support Foot Works, including:

* Raising awareness of Foot Works with homeless men and women, podiatry professionals, medical and social care professionals, established homelessness organisations
* Signing up to receive our newsletter and following us on Facebook and Twitter
* Volunteering with Foot Works. We are currently looking for qualified podiatrists and Care & Connect volunteers (providing support for our podiatrists during the weekly clinic). We are also specifically looking for female volunteers to run a women-specific clinic in Central London
* Providing specialist support. At the moment we are looking for help with a clinical lead to initiate pathways to NHS services.
* Making introductions to funders and potential partners, such as materials suppliers

Contacts

Richard Cooper
07710 367 667 - crichard829@icloud.com
Alan Morton
07766 262 806 - alandmorton@yahoo.co.uk

Facebook: www.facebook.com/groups/FootWorksUK

VOLUNTEER WITH CRISIS

Cosyfeet have teamed up with Crisis at Christmas in an urgent call for volunteer podiatrists in London, Newcastle and Edinburgh this Christmas. Could you work a few shifts from 24th to 29th December this year?

Crisis welcomed a total of 3,911 guests in 2016, all of whom have much less opportunity for foot care than the rest of the population and yet have far greater demands on their feet. The results can be debilitating and painful. A total of 375 of those guests benefited from the Crisis Podiatry service, which was run by just 53 volunteers. This year, Crisis are hoping to attract even more volunteers, to treat even more people in need. They are seeking qualified podiatrists to treat their guests, and podiatry students or assistant practitioners (podiatry) to help run the service by welcoming guests and preparing them for treatment.

The Crisis Podiatry Service provides a range of treatments and foot care advice for guests, mainly treating corns and calluses, mycotic and gryphotic nails, blistering and maceration.

London volunteers meet at the Crisis Hub at the start of each shift to be briefed and assigned to a team. Transport is provided to and from treatment centres between 24 and 29 December. Shift times are 9.00am to 6.00pm. Clinics run from 10am to 5.00pm. Volunteers are also required in Edinburgh and Newcastle on Christmas Day and Boxing Day.

For further information, contact the Crisis at Christmas Services Team by emailing ccservices@crisis.org.uk or call 0300 636 1000.

Cosyfeet supports Crisis each year by donating socks to users of the volunteer podiatry service, and by appealing for volunteers from the podiatry community.

MEMBER WINS AHP AWARD

Vascular Specialist Podiatrist Martin Fox from the Manchester Leg Circulation Service has won a national Allied Health Professional award for demonstrating workforce transformation leadership

Martin Fox was presented with his national Allied Health Professional (AHP) award at the 2017 Chief Allied Health Professional Officer Conference in recognition of the transformational leadership work around the early diagnosis and best clinical treatment of peripheral arterial disease (PAD), which Martin and colleagues from North Manchester have pioneered. The award acknowledged the impact the team has made on raising awareness of this common and deadly disease and the transformational changes they have influenced locally, regionally and nationally, with podiatrists and other clinicians who assess and treat lower-limb conditions.

Over the last 8 years Martin and his colleagues Louise Stuart, Lisa Smith-Burgess, Susan Matthews, Debbie Ruff and Michelle Proudman, have helped shift the paradigm with PAD, from a reactive, late-diagnosis and crisis-management approach, to a proactive, early diagnosis, patient-empowerment model. The emerging clinical partnerships and co-operation they have nurtured between podiatry, vascular and diabetes stakeholders have been instrumental in ensuring successful service redesign, commissioning and strong clinical governance – fuelled by a shared vision to save more lives and limbs of people with PAD. The Manchester Leg Circulation Service has presented at professional conferences in the UK, Europe and India and has received interested clinicians – podiatrists, physiotherapists and nurses - from the UK and as far afield as Hong Kong, to look at how they are doing things differently with PAD. The team has also provided many PAD-related study days, CPD and training throughout the UK and in Ireland.

Martin Fox receiving his award from Suzanne Rastrick Chief AHP Officer, NHS England

> *'THE REAL CHALLENGE HOWEVER, WHICH I HOPE THE EXPOSURE FROM THIS AWARD WILL HELP WITH, IS TO ENGAGE AND SUPPORT INTERESTED CLINICIANS IN ALL CCGS / NHS ORGANISATIONS, TO INVEST IN MAKING THEIR NEXT STEPS TOWARDS LOWER-LIMB SERVICE TRANSFORMATION AND REDESIGN*

> *WITH OVER 7000 AMPUTATIONS A YEAR IN PEOPLE WITH PADIN ENGLAND ALONE, THE DRIVERS FOR TRANSFORMATIONAL CHANGE ARE OBVIOUS*

The Manchester Leg Circulation Service transformation initiatives include:

* Working with fellow clinicians locally, nationally and internationally to promote early detection, assessment and action, using key arterial disease indicators such as non-palpable foot pulses, monophasic Doppler signals and calf pain during exercise, relieved by rest.
* Facilitating the first agreement between the Vascular Society and the College of Podiatry about partnership working between podiatrists and vascular teams around the theme of early diagnosis and best clinical management of PAD
* Forming partnerships with supervised exercise programmes in community settings, to provide easy access for people with PAD, to this most effective treatment intervention
* Redesigning patient information posters and leaflets, locally and nationally, to better inform people with diabetes-related foot disease or PAD of their very real risks of heart attack, stroke, early death and amputation and help empower them to consider effective changes.
* Promoting proactive redesign of podiatry workforce models, regionally, nationally and internationally, to ensure opportunities for early clinical diagnosis and aggressive treatment of PAD and critical limb ischaemia are maximised, to help save more lives and limbs.
* Setting up informal professional clinical discussion and networking forums, to support other podiatrists and nurses working with PAD throughout the UK and abroad, using a Facebook Private Group platform.
*

The pioneering work of the service has been recognised by NICE and Martin has acted as a topic expert on their Guideline Development and Review committees.

Reflecting back on the journey so far Martin says, '10 years ago, working as a Clinical Lead Podiatrist with chronic lower-limb wound management, I realised that none of the best foot protection teams around the UK had developed clinically proactive and sustainable services for early diagnosis and treatment of PAD – which was underlying many of the chronic wounds, amputations and early deaths we were (and still are) overseeing. We had a culture of 'gold standard firefighting' with no effective early intervention strategy. Foot crisis management had become our accepted norm in the NHS.

'A 'call to arms' in 2007 from a diabetes and vascular journal to tackle the late diagnosis and under-treatment of PAD, was my tipping point. Having recognised the need for a change in the status quo and with an understanding that we as high-risk limb podiatrists were perfectly equipped with the potential knowledge and skills to help fill the PAD 'abyss', the only valid thing to do was to throw myself into it. Over the last 8 years in North Manchester with the support of other AHPs (podiatrists, orthotists and physiotherapists) and key vascular nurses and surgeons, we have developed one of the few NHS PAD services to actually deliver the best practice defined in the 2012 NICE Guidance (CG147) and the subsequent 2014 Quality Standard (QS52).

'We have collaborated with specialist podiatrists in three other NHS Trusts to help them ensure their populations can also receive the best clinical and cost-effective diagnosis and treatment defined in NICE. We have also collaborated with podiatrists and nurses in over 20 other NHS organisations around the UK, to help influence and support their high-risk lower-limb service transformation and redesign changes.

'The real challenge however, which I hope the exposure from this award will help with, is to engage and support interested clinicians in all CCGs / NHS organisations, to invest in making their next steps towards lower-limb service transformation and redesign. With associated modifiable mortality rates of 30–50% at 5 years in people with PAD and over 7000 amputations a year in England alone, the drivers for transformational change are obvious. Until PAD early diagnosis and treatment services match the best of those for other comparable serious, life-limiting conditions such as cardiac disease and cancer – we will have a huge job to do!

'The beauty of our Manchester PAD service model is that it is potentially simple to implement and sustain, in any NHS organisation where there are interested podiatrists and vascular teams already in place. When implemented, it saves NHS organisations money, improves use of valuable hospital vascular resources and will help save more lives and limbs from arterial disease. It is a real example of a 'win-win' opportunity, for all you potential lower limb clinical transformation leaders out there.'

A summary of the Salford podiatry-led PAD service model can be downloaded at::
https://www.scpod.org/news/podiatry-led-pad-programme-endorsed-by-nice/

Contact:

Martin Fox, Vascular Podiatrist, Pennine Acute Hospitals NHS Trust. Email: martin.fox@pat.nhs.uk

CONSENSUS ON PUBLIC HEALTH CONTENT OF AHP CURRICULA

We know a radical upgrade in prevention is needed to ensure the sustainability of the health and social care system and improve the public's health and wellbeing. Two thirds of early deaths are preventable, which is why there is a call to action to all health care professionals to deliver more proactive and meaningful prevention discussions and interventions. By acting collectively we can all be a force for change in building a culture of health and wellbeing in our society.

Allied Health Professionals (AHPs) are recognised as having the skills, opportunity and enthusiasm to be an integral part of the public health workforce. There are some excellent examples of AHP-led public health initiatives, from exercise prescriptions to preventing falls in older adults.

We need to maintain this momentum and spread good practice throughout the professions so this approach to prevention and population health becomes the norm.

One of the best ways of keeping up the momentum is to ensure the future AHP workforce is equipped with the skills, knowledge and attributes required to take a population health approach. There is consensus across the education system for AHPs that further embedding of public health into curricula is the right thing to do - in fact many universities, which train AHPs, have already taken steps to strengthen the public health component of their courses, and professional bodies are reviewing their curriculum guidance.

The education of the future workforce is influenced by many stakeholders, including professional bodies, universities, regulators and NHS providers. These organisations and others have come together to develop collective guidance on the public health component of AHP pre-registration curricula.

We are delighted that public health colleagues including those from the Faculty of Public Health and the Royal Society for Public Health have supported us in this.

The Guidance: *Public Health Content within the Pre-Registration Curricula for Allied Health Professions* is a supportive document to help shape individual professions curricula and support universities to review and develop their courses.

It is intentionally short and references other relevant work.

The guidance has 12 recommendations including:

1. All AHP pre-registration courses should include prevention and public health content.
2. Prevention and public health is threaded throughout curricula rather than as a stand-alone module.
3. The curricula should aim to address the following components of public health: understanding prevention, population health and public health data; the wider determinants of health; health improvement; health protection; public health in healthcare; enabling health, wellbeing and independence; health and wellbeing across the life-course and place-based approaches.
4. The 'All Our Health Framework' is used as a tool to inform course content.
5. Behaviour change skills are incorporated based on the Framework to promote person-centred approaches in healthcare.
6. Curricula and courses include evidence-based approaches and practices in relation to public health.
7. Interdisciplinary training opportunities are created where possible to support learners to understand a collaborative and whole system approach to prevention and population health.
8. Opportunities to build on public health knowledge and skills are created during practice placements.
9. Learners are encouraged to demonstrate leadership and act as change agents to influence learning in practice within the current workforce.
10. Professional bodies develop and provide specific guidance on the public health knowledge and skills required for their own professional context.
11. Learning around prevention and population health is assessed as part of existing quality review and assessment processes.
12. In England in particular, the HEE Public Health Quality Assurance Framework is used to assess the public health content of curricula and support action planning to further embed public health and prevention.

LINDA HINDLE

LEAD ALLIED HEALTH PROFESSIONAL AND NATIONAL ENGAGEMENT LEAD FOR POLICE AND FIRE SERVICES, PUBLIC HEALTH ENGLAND

We hope this guidance is useful to professional bodies as they review their curriculum and universities that are updating their courses. It is only through collective actions such as these that a culture of health and wellbeing can become a reality. ■

Links

1. https://councilofdeans.org.uk/wp-content/uploads/2015/10/Embracing-the-challenge_2lowres.pdf
2. https://www.gov.uk/government/collections/all-our-health-personalised-care-and-population-health
3. http://www.skillsforhealth.org.uk/news/latest-news/item/576-new-framework-to-promote-person-centred-approaches-in-healthcare
4. https://www.hee.nhs.uk/hee-your-area/north-west/news-events/news/quality-assuring-health-wellbeing-content-healthcare-education-curricula-%E2%80%93-innovative-approach

Figure 1:
Radiograph of 68-year old female.

CLINICAL PICTURE QUIZ

SAUL HILL, DIABETES RESEARCH PODIATRIST & STAFF PODIATRIST1

RENA FRANCIS, PODIATRIC SURGICAL TRAINEE2

ANDREW COUTTS, SPECIALIST REGISTRAR IN PODIATRIC SURGERY3

1,2,3 DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST

QUESTIONS

1. This 68-year old female twisted her foot on leaving the house. This resulted in a sharp pain on the lateral border of her foot with immediate swelling. She was unable to weightbear due to pain. The radiograph was taken the same day. What pathology can you see in Figure 1?

2. What classification systems could be used to grade this injury? Why are these important? How does the anatomy affect healing?

3. How would this injury be managed?

4. With regards to forces and foot position, what is the mechanism responsible for this type of injury?

5. What rules govern radiographs for suspected midfoot and ankle injuries? Why do you think these were introduced?

ANSWERS

1. This 68-year old female twisted her foot on leaving the house. This resulted in a sharp pain on the lateral border of her foot with immediate swelling. She was unable to weightbear due to pain. This radiograph was taken the same day. What pathology can you see in Figure 1?

There is an undisplaced transverse fracture at the base of the fifth metatarsal (Figure 2). This type of fracture is referred to as a Jones fracture, first described in 1902 by Sir Robert Jones.[1,2] A transverse fracture must occur 1.5 to 3cm distal to the tuberosity of the fifth metatarsal at the metadiaphyseal junction, without distal extension, to be classified as a Jones fracture (Figure 3).[3,4] If a fracture of the proximal fifth metatarsal reaches the articular surface of the metatarsocuboid joint, this is termed a Pseudo-Jones fracture.[2]

2. What classification systems could be used to grade this injury? Why are these important? How does anatomy affect healing?

Whilst the majority of proximal fifth metatarsal fractures heal uneventfully with little intervention, a small subgroup has been recognised to have an increased frequency of delayed or non-union.[2,5,6] To aid in prognosis and management, a number of classification systems have been described in the literature.[2,5-8] Tables 1, 2 and 3 describe the Stewart, Dameron and Torg classification systems respectively.[2,5-8] Figure 4 shows the fracture zones initially described by Dameron and later by Lawrence & Botte superimposed over our fracture;[4,8,9] our fracture can clearly be seen in Zone 2. Our fracture would be classed as a Torg type I (acute fracture). Smith *et al* reviewed 10 cadaver specimens to study the blood supply to the fifth metatarsal, and found that a watershed area of poor perfusion exists between the blood supply from the nutrient artery and the metaphyseal perforators, which corresponds to the proximal area of poor fracture healing.[2,10]

3. How would this injury be managed?

Initial management of proximal fifth metatarsal fractures is primarily determined by the location and type of facture.[2-8,11] Non-displaced fractures in Zone 1 often heel with a period of immobilisation and protected weightbearing in a below-knee cast or removable cast walker (RCW).[2,11] A knee-high device or cast should be used in order to prevent traction on the tuberosity from the peroneus brevis, which attaches at this point. A period of 4 to 12-weeks is usually sufficient.[2,3,11] Patients should be returned to full weightbearing when symptoms allow.[11] Research has shown that functional treatments for avulsion fractures with early weightbearing provide improved functional outcomes and earlier return to work than management in a short leg cast with non-weightbearing.[11] Non-displaced fractures in Zone 2 and 3 should be immobilised in a short cast or RCW, with the patient non-weightbearing for around 6 to 8-weeks.[2,3,11]

This patient was managed in a short RCW for 6-weeks non-weightbearing until union was confirmed on radiographs. Serial radiographs should be done at 4-week (+/- 1 week) intervals to assess for fracture union in all zones.[3,11] Surgical intervention may be required if fracture displacement is greater than 2-4mm in a dorsal or plantar direction or if dorsal/plantar angulation exceeds 10 degrees.[2,12] If non-union occurs, surgical intervention may consist of intramedullary screws, crossed K-wire fixation and tension band constructs.[2,3] Extracorporeal shock wave therapy has been shown to be effective and safe for the treatment of non-union and delayed healing of proximal metatarsal fractures in Zone 2.[13]

The National Institute for Health and Care Excellence recommends the use of the EXOGEN ultrasound bone healing system for long-bone fractures with non-union or delayed healing.[14] This delivers targeted low-intensity pulsed ultrasound waves to aid in the stimulation of bone healing.[14,15] Sarmah *et al* conducted a retrospective study on 292 patients who received EXOGEN treatment for delayed and non-union of fractures, including 38 fifth metatarsal fractures.[15] Union was achieved in 72.3% of cases.[15] Smoking was identified as a negative predictor of bone healing with and without therapy.[15] Healing time of fractures is dependent on several patient factors both intrinsic and extrinsic, however fifth metatarsal fractures generally heal in 3 to 12 weeks.[2,16] Delayed union is defined as failure to heal after 6 months whilst non-union is defined as a failure to heal after 9 months with no indications of progression radiologically for the past three consecutive months.[10,17] A venous thromboembolism risk assessment should be performed on patients who are immobilised in a cast and appropriate chemical prophylaxis prescribed based on risk factors and local casting guidelines.

4. With regards to forces and foot position, what is the mechanism responsible for this type of injury?

Usually an acute fracture to the fifth metatarsal is due to an indirect force secondary to foot plantarflexion and inversion.[2,18] It has been reported that individuals with a varus hindfoot are more susceptible to a fracture of the fifth metatarsal whilst Jones fractures have been reported to be more common in those with a metatarsus adductus due to an already overloaded lateral column.[2,18]

5. What rules govern radiographs for suspected midfoot and ankle injuries? Why do you think these were introduced?

It is estimated that foot and ankle injuries account for 6-12% of visits to emergency departments.[19] Of these, 80-98% will undergo radiography as part of their evaluation to exclude a midfoot and/or ankle fracture.[20] However less than 15% of patients are reported to have a fracture following radiographs.[19,20] Thus not only are the vast majority of foot and ankle radiographs unnecessary, they also result in a significant undue healthcare cost, increased waiting times and unnecessary radiation exposure.[19,20] To combat this, Stiell *et al* introduced the Ottawa Ankle Rules (OAR) in 1992 as a guideline to clinical decision making by setting out specific presenting features that must (or must not) be present in order to request radiographs for midfoot and ankle injuries in the non-athletic adult population.[19,20] Stiell *et al* recommended that radiographs should be performed on those with suspected midfoot and ankle injuries who are 55-years of age or older and/or unable to bear weight for four steps or more both immediately after the injury and at the time of assessment.[19,20] If bone tenderness/pain is experienced at the posterior edge of the fibular (distal 6cm) or inferior tip of the lateral malleolus, or bone tenderness/pain is experienced at the posterior edge of the tibia or inferior tip of the medial malleolus, ankle radiographs should be performed.[19,20] Radiography of the midfoot is recommended if patients experience tenderness/pain at the base of the fifth metatarsal, cuboid or navicular.[19,20]

Individuals with peripheral neuropathy of the foot, irrespective of the cause, should receive radiographs following reported trauma or in the presence of either erythema, oedema or a temperature difference when compared to the contralateral foot due to possible Charcot neuroarthropathy or neuropathic fractures even if pain is absent or minimal.[21,22] The OAR do not apply to those who have received head injuries or isolated injuries to the area (lacerations and burns), are intoxicated, have a chronic injury of 10-days or more, are pregnant or under 18-years of age.[19,20] Research supports the clinical use of the OAR as an aid to ruling out fractures of the midfoot and ankle due to a sensitivity of 96.4 to 99.0% and a modest specificity.[20]

A slight modification to the OAR is the Buffalo Rule, which was implemented to increase diagnostic accuracy.[20] The Buffalo Rule requires that, when palpating, the malleoli specific ligament attachments are avoided (particularly the anterior talofibular ligament, calcaneofibular ligament, posterior talofibular ligament) to avoid the likelihood of palpating over an injured ligament, which is likely to be traumatised following an inversion ankle sprain.[20]

Figure 2: Jones fracture (red arrows).

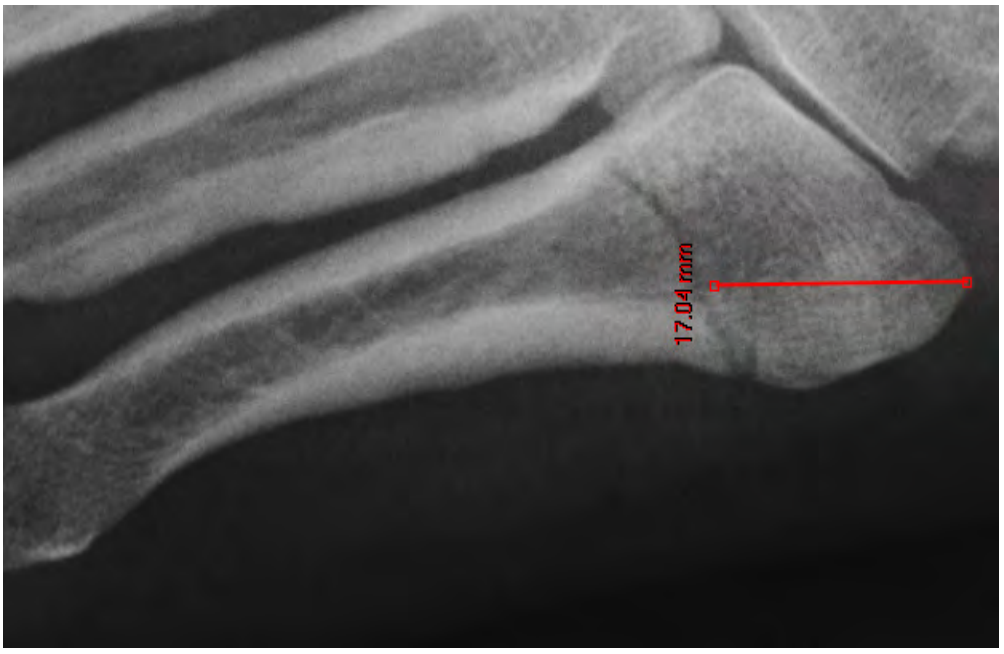
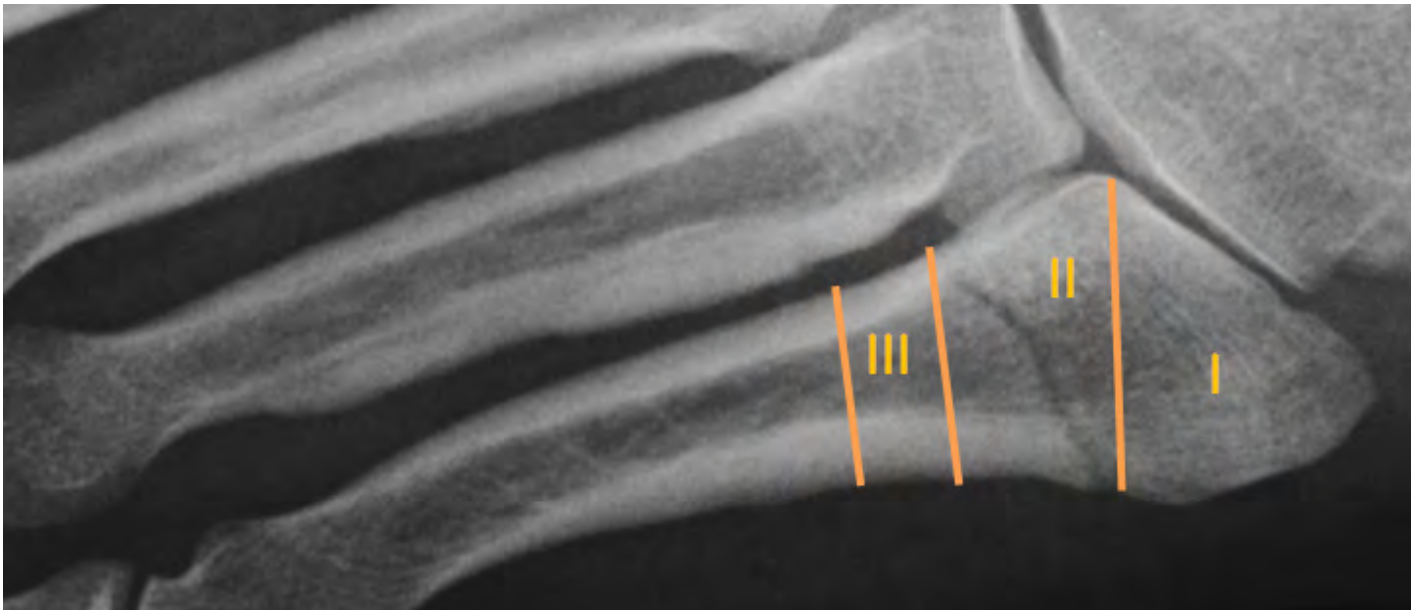


Figure 3: A Jones fracture occurs 1.5 to 3cm distal to the tuberosity of the fifth metatarsal at the metadiaphyseal junction.

Figure 4 (below): Proximal fifth metatarsal fracture classification as described initially by Dameron superimposed over radiograph.



REFERENCES

1. Jones R. Fracture of the base of the fifth metatarsal bone by indirect violence. *Ann Surg* 1902; 35(6): 697-700.
2. Ding BC, Weatherall JM, Mroczek KJ, Sheskier SC. Fractures of the proximal fifth metatarsal: keeping up with the Joneses. *Bull NYU Hosp Jt Dis* 2012; 70(1): 49-55.
3. Kolodin E, Vitale TD. Foot Disorders. In: Delisa J, Gans BM, Walsh NE *et al* (Eds). *Physical Medicine & Rehabilitation: Principles and Practice* (4th Ed). Philadelphia: Lippincott Williams & Wilkins. 2005: pp 873-894.
4. Kirchwehm WW. Fractures of the fifth metatarsal. In: BL Scurran (Ed) *Foot and Ankle Trauma* (2nd Ed). New York: Churchill Livingstone. 1996; pp 419-435.
5. Dameron TB Jr. Fractures and anatomical variations of the proximal portion of the fifth metatarsal. *J Bone Joint Surg Am* 1975; 57(6): 788-792
6. Torg JS, Balduini FC, Zelko RR, et al. Fractures of the base of the fifth metatarsal distal to the tuberosity. Classification and guidelines for non-surgical and surgical management. *J Bone Joint Surg Am* 1984; 66(2): 209-214.
7. Stewart IM. Jones's fracture: fracture of base of fifth metatarsal. *Clin Orthop* 1960; 16: 190-198.
8. Lawrence SJ, Botte MJ. Jones' fractures and related fractures of the proximal fifth metatarsal. *Foot Ankle* 1993; 14(6): 358-365.
9. Nagar M, Forrest N, Maceachern C. Utility of follow-up radiographs in conservatively managed acute fifth metatarsal fractures. *The Foot* 2014; 24(1): 17-20.
10. Smith JW, Arnoczky SP, Hersh A. The interosseous blood supply of the fifth metatarsal: implications for proximal fracture healing. *Foot Ankle* 1992; 13(3): 143-152.
11. Cheung CH, Lui TH. Proximal fifth metatarsal fractures: Anatomy, classification, treatment and complications. *Arch Trauma Res* 2016; 5(4): 1-7.
12. Hatch RL, Alsobrook JA, Clugston JR. Diagnosis and management of metatarsal fractures. *American Family Physician* 2007; 76(6): 817-826
13. Alvarez RG, Cincere B, Channappa C, Langerman R et al. Extracorporeal shock wave treatment of non- or delayed union of proximal metatarsal fractures. *Foot Ankle Int* 2011; 32(8): 746-754.
14. National Institute for Health and Care Excellence (NICE). EXOGEN ultrasound bone healing system for long bone fractures with non-union or delayed healing, MTG 12. 2003. Available from: https://www.nice.org.uk/search?q=mtg+12
15. Sarmah SS, Fenton C, Raman R, Gopal S, Roy N, Sharma HK. The role of EXOGEN bone stimulator in delayed and non-unions. *Orthopaedic Proceedings* 2013; 95(3).
16. Staheli LT. *Fundamentals of Pediatric Orthopedics.* (3rd Ed). Philadelphia: Lippincott Williams & Wilkins. 2003.
17. Somford MP. van den Bekerom MPJ, Kloen P. Operative treatment for femoral shaft non-unions, a systemic review of the literature. *Strategies Trauma Limb Reconstr* 2013; 8(2): 77-88.
18. Le M, Anderson R. Zone II and III fifth metatarsal fractures in athletes. *Curr Rev Musculoskelet Med* 2017; 10(1): 86-93.
19. Wang X, Chang S, Yu GR, Rao Z. Clinical value of the Ottawa ankle rules for diagnosis of fractures in acute ankle injuries. *PLoS One* 2013; 8(4): 1-4.
20. Jenkins M, Sitler MR, Kelly JD. Clinical usefulness of the Ottawa ankle rules for detecting fractures of the ankle and midfoot. *J ATHL Train* 2010; 45(5): 480-482.
21. Rogers LC, Frykberg RG, Armstrong DG, Boulton AJM, Edmonds M, Van HG, et al. The Charcot foot in diabetes. *Diabetes Care* 2011; 34(9): 2123-2129.
22. Milne TE, Rogers JR, Kinnear EM, Martin HV, Lazzarini PA, et al. Developing an evidence-based clinical pathway for the assessment, diagnoses and management of acute Charcot Neuro-Arthropathy: a systematic review. *Journal of Foot and Ankle Research* 2013; 30(6): doi: 10.1186/1757-1146-6-30.

Table 1: Stewart classification system based on morphology and fracture site.[2,7]

Type I – Extra-articular fracture between the metatarsal base and diaphysis
Type II – Intra-articular fracture of the metatarsal base
Type III – Avulsion fracture of the base
Type IV – Comminuted fracture with intra-articular extension
Type V – Partial avulsion of the metatarsal base with or without a fracture

Table 1: Dameron classification system based on fracture site and risk of delayed or non-union.[2,5,8]

Site of fracture	Prognosis
Zone 1 – Tuberosity avulsion (pseudo-Jones fracture site)	Good with conservative treatment
Zone 2 – Metaphyseal–diaphyseal junction (Jones fracture)	Risk of delayed or non-union
Zone 3 – Proximal diaphyseal stress fracture	Risk of delayed or non-union

Lawrence & Botte contributed to the Dameron classification system.8

Table 1: Stewart classification system based on morphology and fracture site.[2,7]

Type I – Extra-articular fracture between the metatarsal base and diaphysis
Type II – Intra-articular fracture of the metatarsal base
Type III – Avulsion fracture of the base

The COLLEGE of PODIATRY

The SOCIETY of CHIROPODISTS & PODIATRISTS

ANNUAL CONFERENCE AND EXHIBITION

Are you ready for Liverpool 2017?

Over 1,100 members are registered to attend this year's Annual Conference & Exhibition in Liverpool

Register now to make sure you can experience a fantastic line up of presentations from international and UK podiatry experts, interactive workshops, live product demonstrations, essential networking and the chance to meet with over 80 exhibitors.

Exhibitor hosted sessions

The live demonstration zone in the exhibition hall will feature a range of product demonstrations, tips and techniques, training, research and other innovations from exhibitors offering new learning opportunities and skills to take back to the workplace.

NEW for 2017 - Business Zone

Delegates will be able to book one-to-one advice slots with a range of professionals in our new Business Zone in the exhibition. If you need to talk to an expert about legal issues, marketing, insurance, HR, finance or social media, the Business Zone can help. Further details coming soon!

View the latest programme and register online at

www.podiatryconference.org

Principal sponsor

algeos www.algeos.com ALGEOS Exceeding Expectations

DIAGNOSIS AND MANAGEMENT OF **VENOUS FOOT ULCERS**

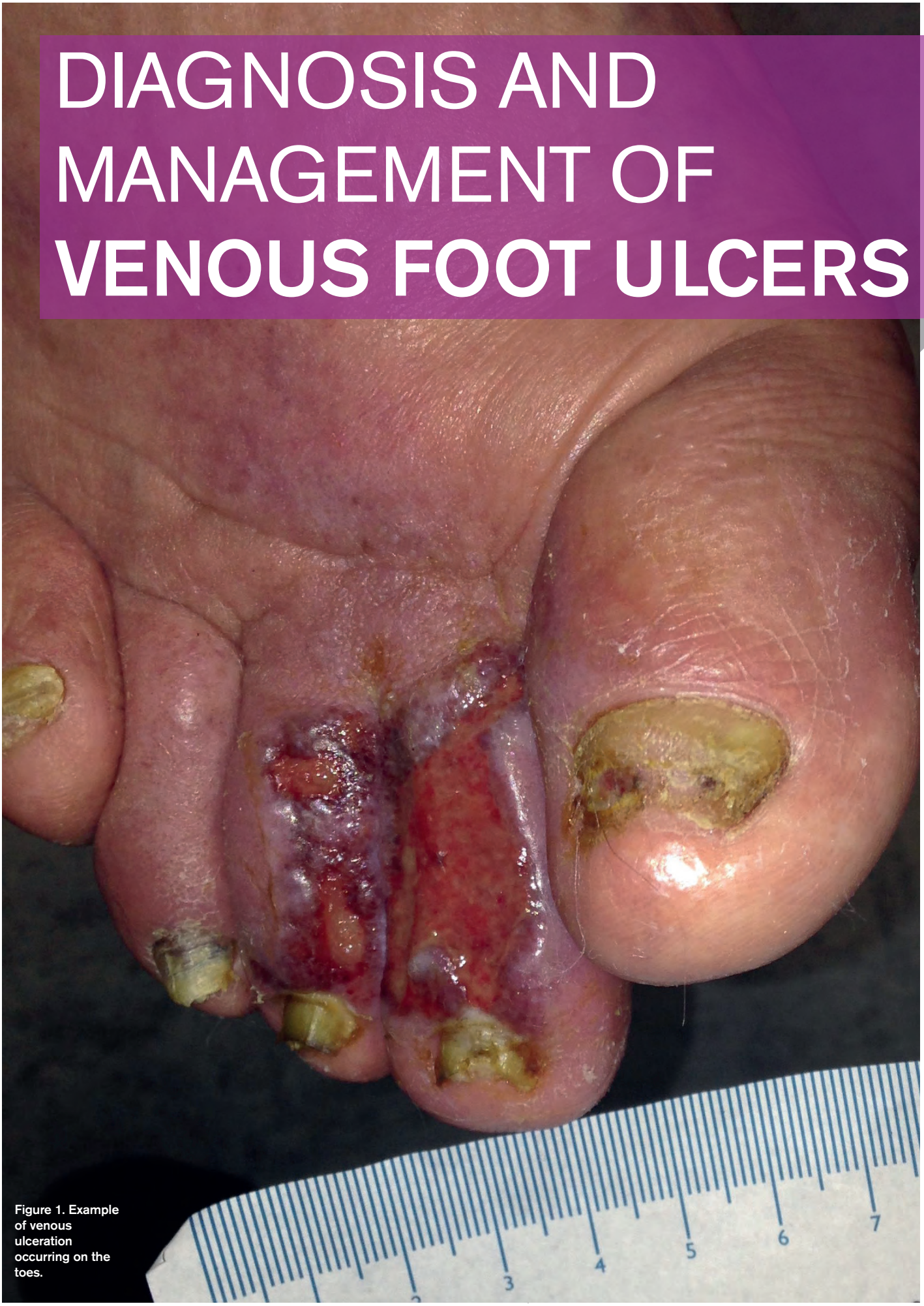


Figure 1. Example of venous ulceration occurring on the toes.

Sustained venous hypertension as a result of venous insufficiency can cause oedema of the lower limb and sub sequential breakdown of the skin/venous ulceration.[1,2] It is well-known that venous ulceration affects the lower limb, mainly the leg, but it is less well documented that this type of ulceration can also affect the foot including the toes.[1,3]

The SIGN (120) guideline [4] gives comprehensive information about the management of chronic venous leg ulceration and covers those wounds occurring between the knee and the ankle. In the absence of a guideline that includes the foot, management of venous foot ulceration is often overlooked.

Venous insufficiency occurs when the valves in the veins of the lower limb become incompetent.[2] This incompetency can occur in deep or superficial veins. The return of deoxygenated blood back to the heart and lungs slows down (venous pooling).[1,2] This increases the pressure in the superficial veins, which in turn causes dilation and elongation of these vessels, increasing their permeability,[1] and there is accumulation of lymph fluid (oedema) in the superficial tissues.[1,2] Oedema will push capillaries apart so that distances between them become wider, impeding the transport of nutrients. Surrounding tissue cells can become malnourished.

The dorsum of the foot and toes can be affected by oedema. Skin can become thickened and lymphangiomas can form. The skin can break down and ulcerate, as it would on the leg.[6] Lymphorrhea (leaking of lymph from the skin) can commence. Lymph fluid is caustic to skin and can cause it to ulcerate further.[7] The constant wetness makes the area more prone to bacterial and fungal infections.[2,8] As with all foot wounds there is a risk of developing more serious complications such as cellulitis and osteomyelitis.[2,9]

RECOGNISING A VENOUS FOOT ULCER

Duplex ultrasound is the only 100% accurate way of being sure of diagnosis.[1] However, as it is not feasible to scan every patient, clinical and physiological signs assist diagnosis. Clinicians would be sensible to gather this information and determine a likely or dominating cause. Table 1 shows some of the common features to distinguish between a venous and non-venous wound.

MANAGEMENT

Where venous hypertension is the dominating aetiology, reversal of venous pressure and reduction in oedema are key. Compression therapy is the recognised first-line treatment for venous leg ulceration.[10,11] The objective of compression therapy is to provide graded external compression to the leg and oppose the hydrostatic forces of venous hypertension.[12] The majority of compression incorporates the foot and compresses to just below the knee as a minimum. When toe ulceration is present, toe bandaging has been used effectively but requires great skill and monitoring. Stump bandaging using compression bandages can be effective at reducing toe oedema or 'toe caps,' a type of glove for the foot, provides a safer alternative to toe bandaging and can be used on top of dressings (Figure 3).[8] Additionally, hosiery kits have also been developed to treat ulceration. The development of Velcro wraps is useful for those with mobility and dexterity problems. These wraps often come with a separate foot piece, which is optional to use.

Compression therapy must be carried out by a trained professional and in most cases does not fall within a podiatrist's scope of practice. It is therefore imperative that the podiatrist recognises the wound aetiology as venous and refers the patient on appropriately to the specialist service delivering

	Venous foot ulcer	Non-venous foot ulcer (ischaemic, neuropathic, neuroischaemic, pressure)
Location	Frequently where oedema presents - on the dorsum of the foot and toes, malleoli and surrounding areas.	Usually occurs more proximally, at sites of bony prominences and weight bearing areas.
Wound description	Often heavily exuding, lymphorrhea, rolled or sloping edges, varying depth to base, mixture of slough and granulation tissue, 'buds' of granulation and epithelialisation giving a bobbly appearance, very little or no callus to debride from peri-wound, build-up of dried exudate instead (Figure 1).	Varying levels of exudate depending on aetiology, wound margins well demarcated or may have a 'punched out' appearance, granulating and/or sloughy tissue, necrotic tissue where ischaemia is present. Callus to peri-wound requiring debridement.
Clinical features	Pitting oedema, haemosiderin staining to skin, venous eczema (scaling, weeping, itching skin) visible varicose veins, atrophie blanche, lipodermatosclerosis (Figure 2).	Depending on aetiology: presence of abnormal pedal pulses, evidence of peripheral neuropathy, evidence of prolonged pressure or intermittent pressure/shearing
Other factors	History of venous leg ulcers.	

Table developed using references from 1,2,5,8

Table 1. Some of the common features to distinguish between a venous and non-venous wound

JUSTINE TANSLEY[1] BSC (HONS)
SPECIALIST PODIATRIST IN DIABETES AND WOUND MANAGEMENT, PODIATRIST FOR THE LOWER LIMB THERAPY SERVICE (SPECIALIST LEG ULCER SERVICE)

RICHARD COLLINGS[1,2] BSC(HONS), MSC
TEAM LEAD PODIATRIST, NIHR CLINICAL DOCTORAL FELLOW

1. TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST

2. UNIVERSITY OF PLYMOUTH

Figure 2. Example of skin changes associated with venous disease.

Figure 3

Figure 4

Figure 3. Microfine toe caps, used for gentle compression of the toes.

Figure 4. Case study: Skin condition at day 1 of 14 day treatment.

Figure 5. Case study: Skin condition at day 7.

Figure 5

compression therapy (tissue viability, specialist leg ulcer service, lymphoedema service, practice nurse or community nurse) according to local guidelines.

It is also important when considering a referral for specialist advice that other causative factors are reported. Guidance suggests that, in cases of diabetes, neuropathy, peripheral arterial disease (ABPI <0.8) and foot deformity, a specialist should take these factors into account at assessment.[2,4,5] Although each of these may be an additional challenge, none of them are contraindicated in compression therapy. The advantage of bandaging and shaping materials is that they may be adapted to suit individual needs [14] and the level of compression and monitoring can be adjusted accordingly.[2,4,5]

Where there is moderate-to-severe peripheral arterial disease compression may still be used, but vascular review may be appropriate in the first instance. It is suggested that compression could actually enhance arterial circulation in those with mixed venous-arterial disease (ABPI 0.5–0.8), reducing venous pressure increases filtration through capillaries. Compression therapy is only contraindicated in critical limb ischaemia.[5]

It is thought that peripheral neuropathy may exacerbate the effects of oedema. In a healthy individual, an axon-reflex exists between the venous and arterial system, causing constriction of arterioles and protecting the limb from developing dependent oedema on standing. This response is inhibited in those with neuropathy. Peripheral neuropathy is not contraindicated in compression therapy unless it is painful. Compression therapy would be contraindicated in cases of severe painful sensitive neuropathy.[5]

Podiatrists can play a positive role in educating patients with venous ulceration. Patients should be encouraged to elevate their legs for short periods during the day [4,9] and to sleep in bed at night rather than in a chair. Elevation will help to reduce venous hypertension and aid venous return.[4] Patients should be encouraged to avoid sitting or standing still for long periods of time [2] and take mild exercise, which can be helpful in aiding venous return.[12] Activity levels will vary according to individual mobility but could start with moving the feet up and down to pump the calf muscle or rotating the ankles.2 However, the role of the foot in assisting venous return is potentially understated and misunderstood.[13]

CASE STUDY

This case study involves a morbidly obese 50-year-old female without diabetes or peripheral vascular disease. She has a sedentary lifestyle and gross lower-limb oedema. In October 2016 she sustained a single blunt trauma to her right 2nd toe resulting in a full thickness wound. Lymphorrhea commenced quickly following the trauma. The patient was referred to podiatry. However weekly dressings in a community ulcer clinic could not manage the problem of lymphorrhea as dressings became saturated within hours of being applied.

By November 2016, bacterial and fungal infections were evident on the skin to all adjacent toes and the dorsum of the foot. The patient reported excruciating pain and the lymphorrhea was out of control with her bandaging becoming saturated within hours of application. (Figure 4). Oral antibiotics

Figure 6. Case Study: Skin condition at day 14.

did not improve the infection or the condition of the skin. Eventually the patient was admitted to hospital with cellulitis and suspected osteomyelitis of the 2nd toe. The patient stayed in hospital for a total of 10 days and IV antibiotics addressed the infection.

From January 2017 the specialist leg ulcer service agreed to manage the oedema in an attempt to help heal the foot wounds with advice from the lymphoedema specialist nurse and assistance from the community nursing team. The patient was seen daily for a 14-day period. Her foot was bathed in potassium permanganate, an astringent/antimicrobial, and any loose slough removed using gauze or a monofilament debridement pad. Dressings were applied that contained a high amount of zinc paste to help dry and manage the exudate and soothe the skin. Stump compression bandaging was applied from toes to below knee until the lymphorrhea stopped (Figure 5 & 6).

The patient was encouraged to elevate her legs whenever possible during the day and to start sleeping in her bed again at night. She was also encouraged to increase her activity levels again, beginning with a few steps at a time walking from her chair to the bathroom, for example, and build up gradually. The benefits of weight loss to her vascular system and venous return were also discussed.

After 14 days the skin to the foot was dry and pain was at a tolerable level. Due to the patient's ongoing mobility issues it was decided a Velcro wrap for her leg and a separate foot piece would be best suited. The patient also now wears 'toe caps' to manage the oedema in her toes.

REFERENCES

1. Brem H, Kirsner R, Falanga V; Protocol for the successful treatment of venous ulcers. *The American Journal of Surgery* (Suppl to July 2004); 188: 1S–8S.
2. Grey J, Enoch S, Harding K G; Venous and arterial leg ulcers. *British Medical Journal* 2006; 332(11): 347-350.
3. Bergqvist D, Lindholm C, Nelzén O; Chronic leg ulcers: The impact of venous disease. *Journal of Vascular Surgery* 1999; 29: 752-755.
4. Scottish Intercollegiate guidelines network (SIGN) 120 Management of chronic venous leg ulcers. *A National Clinical Guide* (2010).
5. Standards of Practices for Lymphoedema Services; Best Practice for the management of lymphoedema: Position document; 2nd Edition. *Lymphoedema Framework Journal* 2003; 10-18.
6. Close G; Microfine glove and toe caps and their use in lymphoedema management. *British Journal of Community Nursing* 2010; 15(10).
7. Boulton Z, Price J; Oedema management in a diabetic patient with foot ulceration and peripheral vascular disease: a case study. *The Diabetic Foot Journal* 2016; 19: 38–42.
8. Elwell R, Wig J; Microfine toe caps: an innovative and cost-saving solution. *British Journal of Community Nursing* 2015; 20(4).
9. Collins L, Seraj S; Diagnosis and management of venous ulcers. *American Family Physician* 2010; 81(8): 989-996.
10. Vowden K, Vowden P; Effective compression therapy. *Wound Essentials - Wounds UK Supplement* 2012; 7(2).
11. Wounds UK; Best Practice Statement: Holistic management of venous leg ulceration. Wounds UK; 2016; Available to download from: www.wounds-uk.com.
12. Eberhardt R & Raffetto J; Chronic venous insufficiency. *Contemporary Reviews in Cardiovascular Medicine* 2014; 130: 333-346.
13. Ricci S, Moro L, Incalzi R; The foot venous system: Anatomy, physiology and relevance to clinical practice. *Dermatologic Surgery* 2014; 40(3): 225-233.

Inversion Sprain & the Effects of Forefoot Valgus

FIG. 1: INVERSION SPRAIN

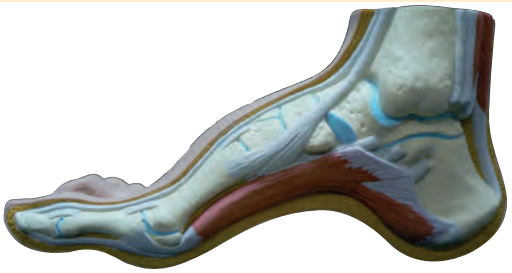
Orthopedic terminology describes inversion as a frontal plane movement of the foot, where the plantar surface is tilted to face the midline of the body or the medial sagittal plane, the axis of motion lies on the sagittal and transverse planes, a fixed inverted position is referred to as a varus deformity.

Inversion sprains are probably the most common foot sprain condition and they are often associated with pes cavus feet or a high forefoot valgus in relation to foot mechanics. The treatment of this type of condition will involve a combination of different modalities including orthotic therapy to stabilize the foot mechanics.

The most commonly injured site on the foot is the lateral ankle complex, which is composed of the anterior talofibular, calcaneofibular and posterior talofibular ligaments.

This article will focus on lateral sprain and pain associated with a pes cavus foot structure and a forefoot valgus deformity. Repetitive lateral ankle sprain or lateral knee pain (or even lateral shin splints) is often diagnosed as 'idiopathic', closer examination of the biomechanical relevance needs to be pursued. The term 'idiopathic' is often used in this area as there seems no reason for the pain occurrence. Pes cavus foot (high arch) structures (Fig. 2) may have a predisposition to lateral ankle sprains and present as a rigid structure and a supinated foot structure.

FIG. 2: PES CAVUS FOOT STRUCTURE.



Patients with this foot structure will often complain that their joints are painful and when they walk without shoes on hard floors.

This type of structure will usually exhibit a forefoot valgus deformity meaning that, 'the plantar plane of the forefoot remains everted relative to the plantar plane of the rearfoot when the subtalar joint is in neutral.'

This deformity will have an impact on the patient in heel strike, mid-stance and toe-off phases of gait.

The patient who exhibits a pes cavus foot structure will often present with a forefoot valgus (FFVL) greater than 10° and also often exhibit a plantar flexed 1st metatarsal (Boyd & Bogdan, 1993) - encouraging the foot to strike laterally and eliciting pressure on the lateral aspect of the hip joint.

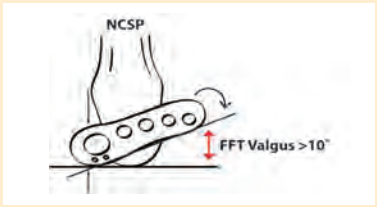
If the forefoot valgus deformity is greater than 10°, the foot will often continue to supinate through the cycle, having a 'jarring' effect on the upper structure, putting additional strain on the lateral aspect.

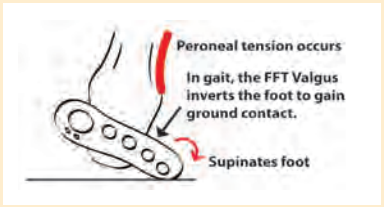
FIG. 3: USE AN ICB PROTRACTOR TOASSIST IN MEASUREMENT OF FOREFOOT VALGUS.

When the foot is supinated it often exerts stress on the peroneals and may cause elongation of the muscles and tendons, thus weakening the retinaculum and lengthening the peroneals, often causing the tendon to sublux off the lateral aspect of the malleolar.

The forefoot valgus deformity (in gait) encourages the foot to invert the foot, propulsion is delayed causing lateral instability and results in tension and tearing of the peroneal muscles, causing inflammation and tenderness, and difficulty walking. Lateral ankle sprains are more common than medial due to the fact that ligaments are weaker on the lateral side.

FIG. 4: EFFECTS OF FOREFOOT VALGUS DURING GAIT.





Hence the lack of lateral stability can be caused by uncompensated or partially compensated rearfoot, a flexible forefoot valgus or osseous forefoot valgus (Boyd & Bogdan, 1993; Hollis et al, 1995; Shapiro et al 1994).

There are also certain biomechanical foot deformities that make some patients more susceptible to inversion sprains, such as, neurological deficits and supinated foot types which exhibit or function with a supinated calcaneus (Valmassy, 1996).

In summary, if a patient presents with lateral hip pain, knee pain, ankle strain or repetitive lateral inversion sprain, always check for a forefoot valgus deformity.

If a forefoot valgus if present, add an appropriate size ICB Forefoot Valgus wedge (available in 4° & 6°) to the selected ICB Orthotics using the 3M tape provided.

Next, heat mould the ICB Orthotics to the patient's Neutral Calcaneal Stance Position. Being made from 100% EVA, ICB Orthotics can easily be heated and moulded to suit high arch foot structures.

PRESCRIBING ICB ORTHOTICS.

ICB Heat Moulding Orthotics can be prescribed to assist in the treatment of excessive pronation and supination, and resultant biomechanical conditions. With 5 densities, 5 styles & 11 sizes, there is an ICB Orthotic to suit all footwear styles, patient ages and activity levels.

Soft Density - White (<65kg) *Designed for :*
- Mild pronation
- Diabetics
- Patients weighing less than 65kg

Mid Density - Blue (65kg-75kg) *Designed for :*
- Medium pronation
- General use
- Patients weighing 65kg - 75kg

Firm Density Green (>75kg) *Designed for :*
- Severe pronation
- Athletes
- Patients weighing over 75kg

Designed for :
- Active patients involved in high performance sporting activities
- General use when the patient requires more support in the heel and arch

PRICES START FROM £18.85

To enable quick and easy orthotic customisation in the clinic setting, ICB Orthotic Additions are also available, including: Forefoot & Rearfoot wedges, Heel Lifts, Metatarsal domes, medial flanges, medial arch infills and more.

View the full ICB Orthotic range:
www.dltpodiatry.co.uk

‘INCREASINGLY COMPLEX BIOMECHANICAL THEORIES’ AND ‘PODIATRIC BIOMECHANICS’

An opinion on the importance of understanding the value of research, models and theories in science: A critical debate on an article in *Podiatry Now* and why podiatry is not yet scientific

ANDY HORWOOD

MD PODIATRIC INNOVATIONS LIMITED

VISITING FELLOW STAFFORDSHIRE UNIVERSITY

The podiatry profession often uses a range of scientific and engineering terms without clarity of meaning, particularly in relation to orthoses and biomechanics. The careful use of terms, both in mechanics and science in general, is of paramount importance, and at the very least, requires that terminology should be applied with rigorous precision.

Adherence to such a strategy will go far in demonstrating that podiatry is knowledgeable and thus qualified to be classed as a science-based profession. Furthermore, careful reflection on the research methodology used before publication is advised for those podiatrists who wish to competently present their views on clinical-based subjects, which if referenced would better support the arguments presented.

The recent article in the June edition of *Podiatry Now* by David Hallowell [‘Why custom orthotic inserts don’t work’. 21(6): p16-20] is a good example of the misunderstanding of terminology that is pervasive within the podiatry profession, and of a failure to support views with references. While certainly well meant and an interesting article per se (raising as it does issues regarding past educational standards in biomechanics at podiatry schools, arguments around prescription techniques in foot orthoses, and the debate about what is custom), it is its misuse of the scientific language and a lack of reflection on research papers that generate a cause for concern. In the defence of Mr Hallowell, he is far from alone, and the criticism presented here should not distract from the clinical experience and honesty of opinion that Mr Hallowell holds.

It is from the article’s third paragraph onwards that issues begin to arise. The article states:

‘These outcomes are occurring against a backdrop of technological advances such as dynamic foot pressure

systems, video gait analysis, and 3D foot scanning, which have facilitated greater understanding of the foot's movements and have led to ever more complex biomechanical theories and concepts emerging. One would think that these advancements in biomechanical technology would lead to an improvement in orthotic management outcomes but this doesn't appear to be the case. So where might we be going wrong?'

Where the profession may be going wrong is that the knowledge base of what biomechanics is, and what research using gait technologies has shown, does appear unacceptably low. There is a general lack of experience among podiatrists in these subjects. Certainly, among post-graduate students arriving to take modules at Staffordshire University, most report having had no experience or very limited experience in the clinical use of gait analysis technologies. Understanding what information each of these gait systems can and cannot give seems unknown to the majority of the profession.

This is a disastrous dereliction in pre- and post-graduate education and has led to gait analysis equipment sitting in cupboards doing nothing, or being considered unnecessary in the practice of podiatry except to dazzle patients. There is no support within Mr Hallowell's article for the statement that outcomes do not appear to have improved with the use of biomechanical data from technology, but if a profession does not use or understand the technology, there are unlikely to be improvements, as one might assume to be the case.

Foot pressure data, dynamic or otherwise, will only give you force over area. It can also give a crude force-time curve, but it is unable to distinguish orthogonal direction of the force; unlike a force plate, which can provide separate data for vertical, anterior/posterior and medial/lateral data. Pressure and force-time curves only furnish kinetic data, and it is the interpretation of the data and the understanding of its relevance to gait that is the clinical skill. Video analysis supplies qualitative data in 2D on motion. This gives us data to study kinesiology, but no information on the biomechanics. There are no quantitative biomechanical data, unless we draw lines on the video screen, which can then yield up crude joint angles. But this, just like 3D video systems, is dependent on marker placement, and data are only as good as the marker placement.

Researchers work hard to improve their data-capture techniques and protocols in research labs, and much has improved, especially with bone pins. As we cannot usually attach markers to bones in clinic, the surface markers at best represent the motion of the segment, not the bones. Therefore, the kinematic data still need to be used with caution, especially when taken in a clinical environment. However, technologies present opportunities to study kinematic data such as angle of gait, stride length, and velocity of inter-segmental motion, even in clinic, which provides useful information.

There is no gait technology that tells us everything. Even the best 3D systems in research units will not give kinetic data. Most research units have supplementary systems to provide this, and tend not to rely on one technology alone. This does not make the systems valueless in isolation, but you need skill and experience to adapt the information gathered by a single technology to achieve clinically relevant information. As for 3D foot scanning, this produces an image of the foot in 3D. Nothing more. 3D foot scanning is not a biomechanical tool. It provides no kinematic or kinetic data, just a shape of the foot in the position it was captured. This is unlikely to help our knowledge of foot function (biomechanics) or pathomechanics.

Knowing what technology cannot tell you is as important as what it can tell you. Much of the research undertaken using motion capture technologies has been used to disprove ideas, as much as add new information. Yet much of the research displays serious design flaws, and we must remember that research funding itself drives a huge industry, which has its own objectives outside the best interests of patients and clinicians.

Have these technologies and the data they have provided us with made no difference to practice, as Mr Hallowell's article suggests? In answer to this, I would at the very least hope that they have exerted a positive effect, because if podiatry practice has failed to change in the face of the vast amount of research undertaken and published each year, then those podiatrists unresponsive to research should seriously consider their fitness to practise. The point of CPD has been utterly lost on them.

Returning to the paper, the statement that gait technologies have *' led to ever more complex biomechanical theories'* needs some reflection on whether the laws of biomechanics can become more complex. The following quote raises the same issues of terminology regarding the science of biomechanics and the use of the term 'theory':

'The science of podiatric biomechanics has become complex and at times baffling. Has podiatry as a profession created a science of biomechanics that has become divorced from the devices we ultimately ask patients to wear? Much of our approach today relates more closely to orthopaedic work by people like GK Rose in the 1950s than to the theories put forward by Roote, [sic] Weed and Orion [sic]. These became the foundation of podiatric biomechanics and despite being superseded by more recent concepts they still permeate much of podiatry orthotic control theory.

'Here are just a few of the concepts that often stimulate debate:

- *Neutral calcaneal stance*
- *Criteria for normalcy*
- *The Root classification scheme*
- *Planal dominance preferred movement pathway theory*
- *Joint axis location & rotational equilibrium theory*
- *Tissue stress theory*
- *Sagittal plane facilitation theory*
- *Beam theory '*

Perhaps we should start with the term 'podiatric biomechanics'. This term should refer to biomechanics in the context of foot treatment only. Podiatric biomechanics has not become a science divorced from creating foot orthoses, because it is not a science at all. The science of 'biomechanics' exists (it was not created by podiatrists) and has the two subjects of kinematics and kinetics within it (1). In biomechanics, kinematics is the study of quantitative motion, such as linear or angular momentum, eversion velocities and degrees of flexion (1). Kinetics is the study of the forces used to generate motion or produced by structures, such as vertical forces, ground reaction forces, and pressure (1). Biomechanics is a 'scientific theory' based on 'Newtonian mechanics' and how it relates to biological materials. Podiatric biomechanics should be the 'science' applied to the foot therapy.

True, tissue stress (how biological materials behave under load) is also a scientific theory, which is absolutely tied into biomechanics, as it brings engineering principles to biology. The research into tissue behaviour under load is considerable, and a brief look at journals such as the *Journal of Biomechanics* will give podiatrists extensive information on tissue behaviour; although if seeking expert tuition on the subject, podiatrists need look no further than some of the modules run at Universities for them.

This is not quite the same 'tissue stress model' as proposed by Eric Fuller (2). Beam theory or beam analysis includes Elementary Beam Theory, Euler-Bernoulli or Engineers Beam Theory (which explains load carrying and deflection

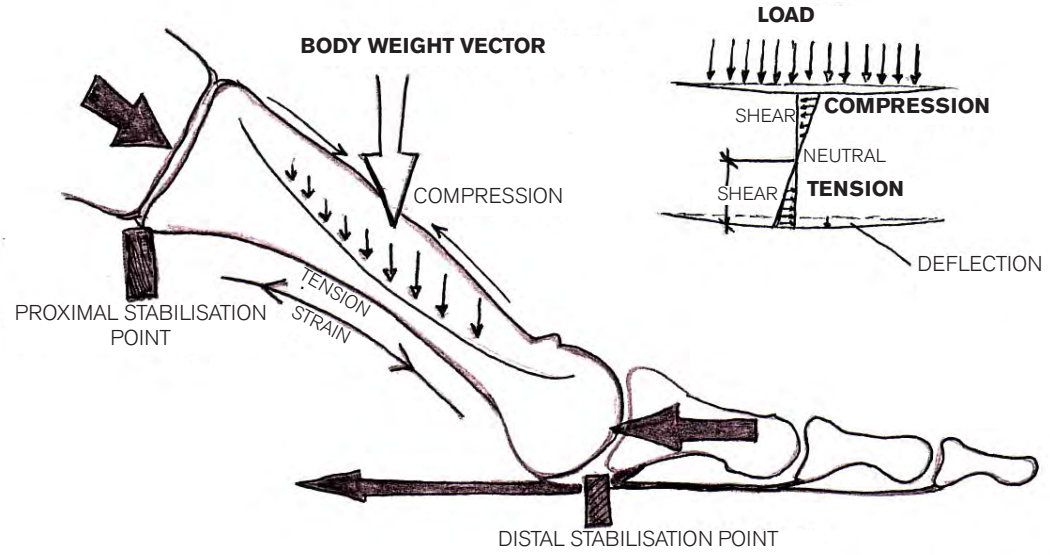


Figure 1. The mechanics of beam theory can be applied as law of engineering to a long bone under load to explain tissue stress. In the foot in stance phase the dorsal osseous surface is put under compression, and the plantar surface under strain, from the body weight vector above. During mid-stance phase the metatarsal is fixed proximally and distally by compressive forces generated in the plantar extrinsic and intrinsic muscles, completing a pathway for beam mechanics. The forces generated are reflected in the architecture of a metatarsal. This is an application of a scientific law to explain tissue behaviour under load. By knowing the physical properties of bone or other body tissues and their behaviour under a particular load, the pathomechanics can often be unravelled in the clinic. This should lead to a coherent treatment plan for individual patients based on physics not models.

characteristics) and Timoshenko Beam Theory (which explains shear deformation and torsional bending effects). These theories spell out in detail the mechanics on different types of beams under difference stress, and they are scientific theories.

It is essential that the profession understand the difference in meaning between the word 'theory' as used in science and as used in common everyday English. Furthermore, it is vital that it also comprehends the distinction between a model and a paradigm. Beam theory is a scientific theory, as it explains the behaviour of forces acting around a beam (Figure 1), but the 'foot-based beam theory' is a 'model' used to explain foot function and behaviour; although, true beam theory is certainly applicable to long bones acting as beams under load during gait.

How the term 'theory' is used is critical in science. When a proposed event is researched and contradictions to the proposed model cannot be found, it becomes a 'theory' or 'scientific law'. This is as near as science comes to saying something is true, but of course should new facts come to light that challenge the theory, then the theory can fail. That rarely happens today because science tests models to the limit before it accepts a proposed model as fact. Sadly the authors of models are often all too keen to claim they have discovered truth long before the evidence supports the model fully.

Therefore, the term 'theory' is a precious one in science, reserved for such phenomena as gravity, plate tectonics, evolution, Newtonian mechanics, biomechanics, tissue stresses, and beam mechanics, for example. The term 'theory' here is synonymous with law. Most of the terms used on Mr Hallowell's list are models and have only a few references to support the model, and those cited in the papers on the models are often references from the original author. The Root, Orien & Weed model of foot function made good sense in the light of the research they had in the 1960s, based on research in orthopaedics in the 1930s and 40s (3). Neutral Calcaneal Stance Position and the criteria of normalcy are no longer viable models, as they are disproven (4,5,6,7), while Root's classification scheme, ironically, was not his own, as it was first described by Hiss's foot classification and expanded upon by Root (2). Root can perhaps claim 'forefoot supinatus' as his own, and appended proper definitions to his foot classification system (2). No podiatrist should be working to the neutral positioned subtalar joint Root model of foot function anymore. The other 'theories' mentioned on Mr Hallowell's list are not theories in a scientific sense, but rather scientific 'models'.

McQuail & Windahl (8) describe models thus: 'we consider a model as a consciously simplified description in graphic form of a piece of reality. A model seeks to show the main elements of any structure or process and the relationships between these elements.' Models are indispensable for understanding more complex processes, and present a form of selection and abstraction. Models help explain information in a simplified way that would otherwise be complicated or ambiguous. A successful model organises concepts, explains processes, and predicts outcomes. Models therefore, allow the student to understand a principle or concept, but may not represent absolute truth (Figure 2).

Pomeroy (9) cites Kuhn as describing a paradigm as: 'a set of beliefs, values, techniques, which are shared by members of a scientific community and which act as a guide or map dictating the kinds of problems scientists should address and the types of explanation that are acceptable'. Certainly, each of the authors and followers of a particular foot function model are trying to direct the profession into accepting their preferred model as a paradigm for the profession. This is unfortunate as it can blinker practitioners to events or research that contradicts the paradigm. It is why some people still choose to ignore all the facts regarding the laws of evolution, because it contradicts their paradigm.

The retort of course is that evolution is only a theory, without realising in science that such is high praise of truth indeed. But sadly, in common quotidian English, it means an idea. Known as 'conceptualising theory', this is where a general idea is not based on any particular real physical reality, but a hypothesis. I think it would be unfair for those who have developed their foot function models to claim that their ideas are only conceptual

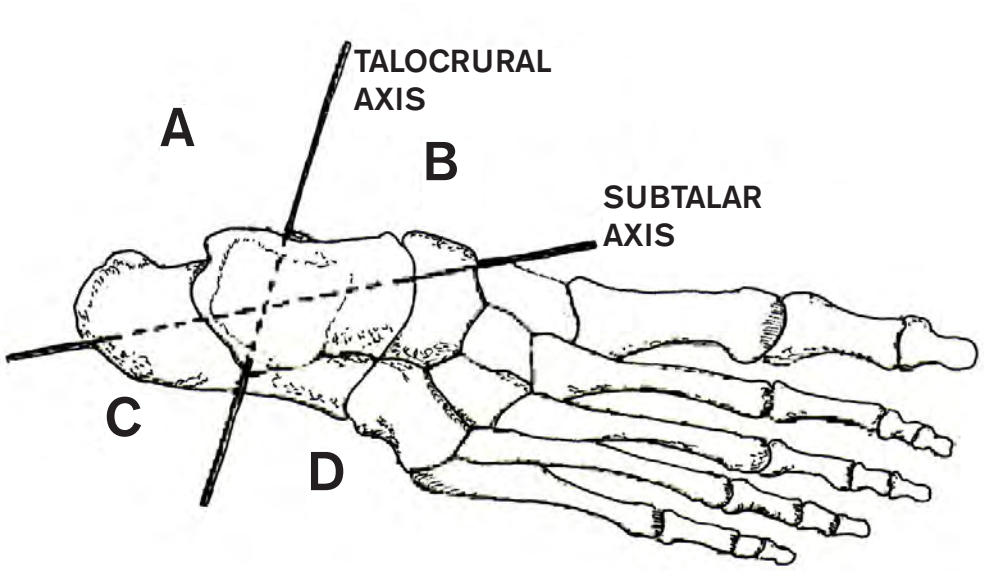


Figure 2. Models based on joint axis location & rotation equilibrium use ground reaction forces in creating angular momentum around those axes. Such models show ground reaction forces acting on the skeletal foot in quadrant (A) produce plantar flexion, inversion and adduction moments around the talocrural & subtalar axis, while in quadrant (B) they would produce, dorsiflexion, inversion and adduction moments on the foot. In quadrants C & D eversion and abduction would occur with a ground reaction force, while in C plantar flexion and D dorsiflexion would accompany those motions in the sagittal plane. However the reality does not match the model because the axes are not fixed but are instantaneous, moving throughout the gait cycle. The body weight vectors above the foot will also influence the direction of moments around these joints, as will where the primary moment of inertia is positioned in regards to the axis. Whichever segments of the foot are in open and closed chain also influences motion, as will the muscle-firing pattern of the individual, soft tissue deformation and joint stability. A model simplifies a concept but does not necessarily reflect truth.

theories, in that they are not supported enough by research to be scientific theories. They are only 'models'. It is essential that the podiatry profession understand this present situation of models vying for dominance in a period of professional uncertainty (2).

So, the dilemma for podiatry is whether we should use models that try to make a complex subject, like the function, dysfunction and pathomechanics of the foot and lower limb, easier to understand. The risk in doing so is that we are creating a paradigm that practitioners follow slavishly. Do we therefore keep lower limb biomechanics and function as a complex thing to unravel? The answer must be a simple yes and no. For biomechanics is 'The Science' and possesses all the requisite qualifications to provide truth and provide all the answers we need as clinicians; but it is a big subject. Nevertheless, it can be simply broken down into easy-to-learn segments that can be applied to the living world of patients. We do not need to try and find new paradigms within conflicting models.

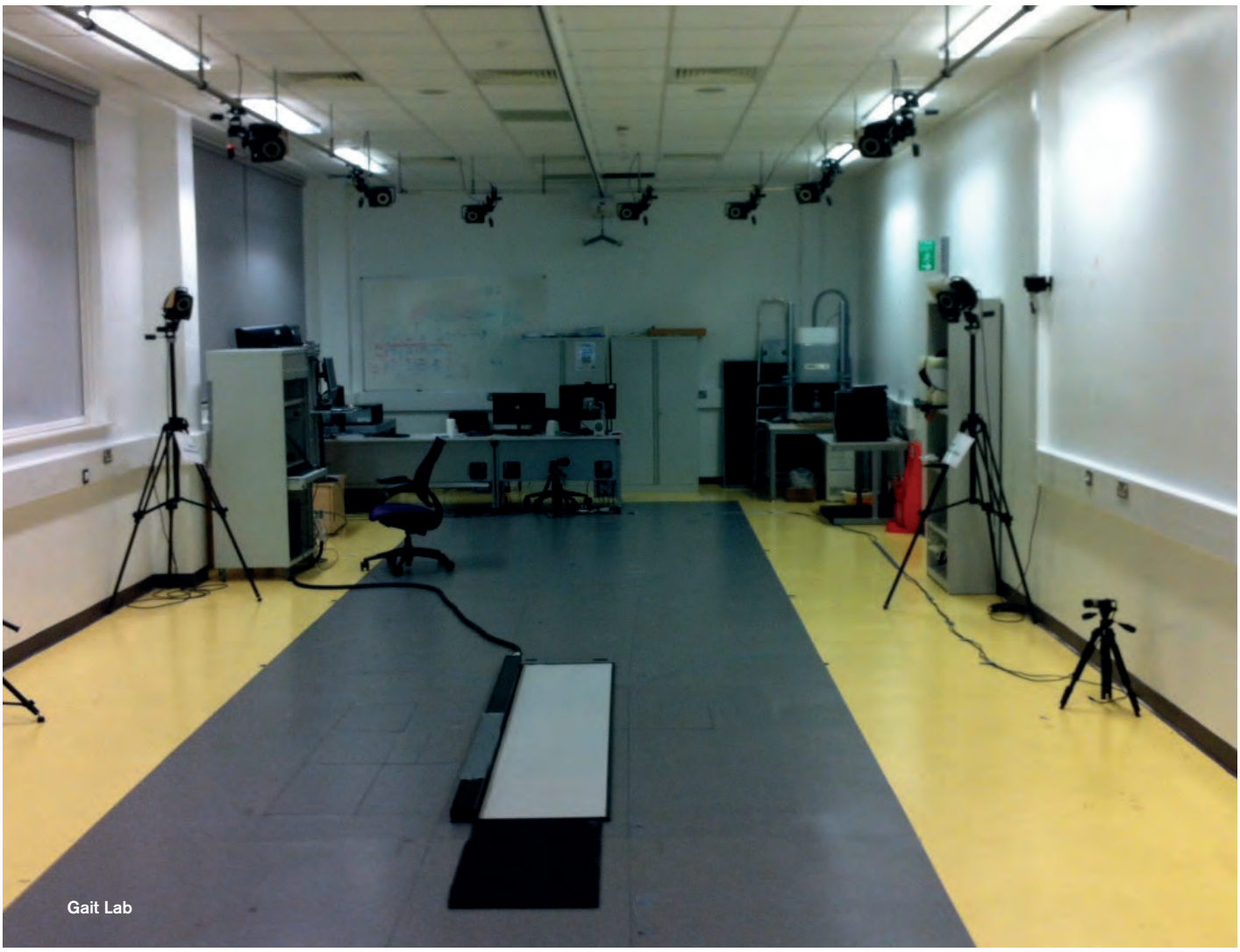
As far as biomechanics is concerned, we can start with understanding the building blocks of mechanical principles such as Newton's three laws, the centre of mass of the body and its segments, lever arms in relation to joint function, stress and strain of tendons, compression and tension on long bones, pressure and force on the plantar foot, linear and angular momentum, and velocity of body and limb segments. To me, these are very simple subjects that podiatrists should know like the back of their hand. This prevents biomechanics becoming seemingly complex and avoids reliance on models. Models can then be used as a back up to aid understanding.

From these simple concepts, we should learn how biological tissues behave under load, understand anisotropy and beam mechanics acting on long bones, etc, and how joints tie into the laws of motion and engineering mechanics. Finally how this all joins together to the functional anatomy is essential to allowing the science to become clinical. Only then can you understand gait, gait dysfunction and pathology. And it is here that models may have a role in aiding students to grasp complex concepts simply. However, your treatment programme should not be based around a model that helps you understand one feature of functional anatomy. It is the fundamental background knowledge of mechanics that should drive therapy.

Biomechanical therapy should involve biomechanics and the things that affect biomechanics, namely the biological tissue's strength and appropriate loading patterns, and force application with reference to location, duration, direction and loading rate. Mr Hallowell again quite rightly points out that just using orthoses is not enough. Shoe choice and rehabilitation have to be at least partners in biomechanical therapies involving orthoses. Any treatment plan must be based on the pathology and trying to return the patient to normal function (for them), which does not require our intervention in the long run, whenever that is possible.

Much of Mr Hallowell's comments on foot orthoses suggests that podiatry has a severe lack of knowledge of the research that has been undertaken trying to establish suitable protocols for using orthoses, as well as how they work. There is good evidence that a multitude of techniques of manufacture will give you an orthosis that works. This is in relation to manufacture protocols for custom devices and for semi-custom devices together. Semi-custom devices have even been shown to change pathology on MRI (10). So the debate over whether they do or do not do anything should be coming to an end, and be moving to how and for whom they work.

Logic suggests that taking something out of a packet has less chance of working than a well-designed prescription protocol. But don't be fooled by what that statement implies. A badly designed protocol, whether custom or semi-custom, can be less effective than some devices extracted from a packet. It is what the device changes biomechanically, in regard to changing the damaged tissues stresses causing the symptomatology, that dictates success. An injury caused by fatigued muscle action resulting through tissue vibration dampening is unlikely to be helped by a rigid orthosis, just as Morton's neuromas are indicated not to be helped by hindfoot posting (11). Such prescriptions fail to acknowledge the



Gait Lab

underlying tissue stress. Future research has started to target which therapies work for which pathologies and which patient groups. In time, we may even be able to answer the question as to why a patient does or does not respond to a specific intervention.

Reliance on models can cause the production of contradictory prescription protocols and unnecessary patient discomfort; easily unavoidable if everyone could just stick to considering the mechanics of their prescription design. Any podiatrist who says there is 'no evidence' that custom devices produce better results than 'off-the-shelf devices', as Mr Hallowell reports of a colleague's unspecified article, is wrong; but for the right reasons. There are lots of papers that claim custom devices are better! Most can be critiqued to the point of ridicule, not least in failing to specify what 'better' means. But they exist. Articles also exist which demonstrate that off-the-shelf devices, picked by pressure analysis data alone, can change kinematics and kinetics (12), so off the shelf should not be disregarded.

Only papers that compare fully custom-generated devices and semi-custom devices made to the same prescriptions and the same materials are good science, as they compare like with like, and these demonstrate little difference in kinematic effects or comfort (13,14). The bulk of comparison papers comparing off-the-shelf/pre-form versus custom, tend to test a pre-form fabricated out of a soft material with a custom device manufactured out of a rigid material, and show that different materials and different prescriptions work differently. Who knew!

The difference between custom and semi-custom has been blurred, as suggested by Mr Hallowell. Custom devices should mean starting from a representation of the foot only and then building from scratch, and should not be a meaningless term. It would, however, be better if we concentrated on the resulting prescription and material selection rather than on how the device is made. The research alone suggests much time has been wasted on this question.

Mr Hallowell's article raises another common issue, and suggests most orthoses are provided to reduce the effects of '*abnormal pronation*'. This term is a problem in itself. Until recently, no one had actually given a definition as to what 'excessive' or 'hyper-pronation' was (15). 'Abnormal pronation' opens another can of worms, as abnormal could mean 'under' or 'hypo-pronation', as much as 'hyper-pronation', or something else entirely. Without a definition, the term abnormal pronation is meaningless. Mr Hallowell's article also states that modern orthoses' heel cups are '*circular in cross section*'. Really? Perhaps semi-circular might be a better term?

While I agree that having a tick box that allows labs to manufacture devices at the laboratory's discretion is a paradox, yet another paradox would be abnormal subtalar pronation occurring at the talo-navicular joint as Mr Hallowell suggests. Abnormal pronation at the subtalar joint would occur at the subtalar joint. Abnormal pronation of the talo-navicular joint occurs at the talo-navicular joint, but I suspect what is inferred is that motion at the talo-navicular joint is mistaken for subtalar joint pronation. Research suggests that little calcaneal eversion occurs at the subtalar joint (16), and what we as clinicians see in the hindfoot is motion in gait occurring in the talo-crural/subtalar complex and the mid-tarsal articulations. What we

perceive as movement in the hindfoot is indeed movement of the hindfoot made from a multiple of joint motions, or lack thereof (16).

Mr Hallowell's article further states that:

'If most of the movement in an over-pronating foot takes place at the talo-navicular joint it seems reasonable that this is the best place to effect change'.

This seems a dramatic and unreferenced leap of faith, and leaps of faith are something that the podiatry profession seems very happy to make without demonstrating a more scientific, and therefore sceptical approach. That the talo-navicular joint tends to influence other joint motions more than other foot joints has some support (17), but the talo-navicular joint should not be viewed as being the new subtalar joint, as in a 'master joint' of foot motion. If the pathology such as talo-navicular joint arthritis is linked to navicular drift and drop, then certainly, consider supporting it (10). But to say most orthoses fail because they do not support the talo-navicular joint is too big a leap of faith. What about a patient with medial compartment degenerative joint disease of the knee or plantar plate dysfunctional metatarsalgia? The research suggests that other prescription choices in these conditions are more important than inadequate talo-navicular support (18, 19, 20, 21, 22), although the addition of arch support may alter the effects (23,24).

Terms like '*invertory ground reaction forces*', and '*pronatory impulse/force*' used by Mr Hallowell in his article are a problem when no explanation as to what they are supposed to mean is presented. They are pseudo-science terms. There are ground reaction forces that cause resultant forces that can generate angular momentum around a joint. These moments of force can invert the foot depending on the location of the moment of inertia in relation to the instantaneous joint axis in the frontal plane. This could be what is meant.

As stated earlier, podiatry needs to be very precise in the use of mechanical terminology. Impulses can be positive or negative reflecting increases or decreases in momentum, but impulses are also a reflection of a change in velocity and/or mass. Pronation (the foot becoming more prone) can have momentum by changing mass or velocity in motion that is producing a more prone, compliant foot posture, but the impulse would only reflect a change in this rate of momentum; not the amount of pronation. Clarity is important. '*Invertory ground reaction forces*' and '*pronatory impulses'* do not exist as terms in mechanics or biomechanics.

The leaders and educators in this profession wish to see students continue to choose podiatry as a career. Publishing inaccuracies by well-meaning authors is the responsibility of the editorial committee and reviewers chosen for Podiatry Now. Publishing material that can mislead the profession can also risk putting off potential students with a basic level of physics knowledge. It is not the example we should be setting, especially as we need students with good physics qualifications to enter this profession.

So far, no profession has grasped clinical biomechanics as a therapy, but it is certainly up for grabs, and other professions will happily take over if we fail to meet the standards required to provide the therapeutic quality that lower-limb biomechanics requires. Other professions may evict podiatrists from the NHS, but chiropractors, physiotherapists and other therapists too, will take over from poorly trained private practitioners. If you are a good salesperson, you will probably survive. But getting patients better with skill and knowledge based on a scientific grounding, will beat blind luck in the long run. This profession will be found out and found wanting if it does not take education/research seriously.

REFERENCES

1. Hamill J, Knutzen KM. *Biomechanical Basis of Human Movement*. 3rd Edn. Lippincott Williams & Wilkins, Baltimore MD 2009: 3-8.
2. Fuller EA. Center of pressure and its theoretical relationship to foot pathology. *Journal of the American Podiatric Medical Association* 1999; 89(6): 278-291.
3. Lee WE. Podiatric biomechanics: An historical appraisal and discussion of the Root model as a clinical system of approach in the present context of theoretical uncertainty. *Clinics Podiatric Medicine & Surgery* 2001; 18(4): 555-684,
4. Hamill J, Bates BT, Knutzen KM, *et al.* Relationship between selected static and dynamic lower extremity measurements. *Clinical Biomechanics* 1989; 4(4): 217-225,
5. McPoil TG, Cornwall MW. Relationship between neutral subtalar joint position and pattern of rearfoot motion during walking. *Foot & Ankle* 1994; 15(3):141-145.
6. McPoil TG, Cornwall MW. The relationship between static lower extremity measurements and rearfoot motion during walking. *J Orthopaedic & Sports Physical Therapy* 1996; 22(5): 381-388
7. Javis HL, Nester CJ, Bowden PD, Jones RK. Challenging the foundations of the clinical model of foot function: further evidence that the Root model assessments fail to appropriately classify foot function. *Journal of Foot and Ankle Research* 2017; 10:7 DOI 10.1 186/s 13047-017-0189-2,
8. McQuail D, Windahl S, *Communication Models: for the Study of Mass Communications* 2nd Ed. London, Routledge; Taylor & Francis Group, 1993: 2.
9. Pomeroy D. Implications of teachers' beliefs about the nature of science: comparisons of the belief of scientists, secondary science teachers and elementary teacher. *Science Education* 1993; 77(3): 261-278.
10. Halstead J, Chapman GJ, Gray JC *et al.* Foot orthoses in the treatment of symptomatic midfoot osteoarthritis using clinical and biomechanical outcomes: a randomised feasibility study. *Clinical Rheumatology* 2016; 35(4): 987-996.
11. Kilmartin TE, Wallace WA. Effect of pronation and supination on Morton's neuroma and lower extremity function. *Foot Ankle International* 1994; 15(5): 256-262.
12. Dixon SJ, McNally K. Influence of orthotic devices prescribed using pressure data on lower extremity kinematics and pressure beneath the shoe during running. *Clinical Biomechanics* 2008; 23(5): 593-600.
13. Davis IS, Zifchock RA, DeLeo AT. A comparison of rearfoot motion control and comfort between custom and semicustom foot orthotic devices. *Journal of the American Podiatric Medical Association* 2008; 98(5): 394-403.
14. Short L, Chockalingham N. Kinematic comparison of functional foot orthoses produced to three different manufacturing protocols: An exploratory study. *OA Musculoskeletal Medicine* 2014; Jul 10;2(2):14.
15. Horwood AM, Chockalingham N. Defining excessive, over or hyper-pronation: a quandary. *The Foot* 2017; 31(June): 49-55.
16. Hunt AE, Smith RM, Torode M, Keenan A-M. Inter-segmental foot motion and ground reaction forces over the stance phase of walking. *Clinical Biomechanics* 2001; 16(7): 592-600.
17. Savory KM, Wulker N, Srukenborg C, Alfke D. Biomechanics of the hindfoot joints in response to degenerative hindfoot arthrodesis. *Clinical Biomechanics* 1998; 13(1): 62-70.
18. Kerrigan, DC, Lelas, JL, Goggins, J, Merriman, J, *et al.* Effectiveness of a lateral-wedge insole on knee varus torque in patients with knee osteoarthritis. *Archives of Physical Medicine and Rehabilitation* 2002; 83(7): 889-893.
19. Kakihana, W, Akai, M, Yamasaki, N, *et al.* Changes of joint moments in the gait of normal subjects wearing laterally wedged insoles. *American Journal of Physical Medicine Rehabilitation* 2004; 83(4): 273-278.
20. Fukuchi, C, Worobets, J, Wannop, JW, Stefanyshyn, D. A small integrated lateral wedge does not alter knee joint moments during walking. *Footwear Science* 2012: 49(3): 207-212.
21. Brodtkorb T-H, Kogler GF, Arndt A. The influence of metatarsal support height and longitudinal axis position on plantar foot loading. *Clinical Biomechanics* 2008; 23(5): 640-647.
22. Hsi WL, Kang JH, Lee XX. Optimum position of metatarsal pad in metatarsalgia for pressure relief. *American Journal of Physical Medicine and Rehabilitation* 2005; 84(7): 514-520.
23. Nakajima K, Kakihana W, Nakagawa T, *et al.* Addition of an arch support improves the biomechanical effect of a laterally wedges insole. *Gait & Posture* 2009; 29(2): 208-213.
24. Hinman RS, Bowles, KA, Metcalf BB, *et al.* Lateral Wedge insoles for medial knee osteoarthritis: effects on lower limb frontal plane biomechanics. *Clinical Biomechanics* 2012; 27(1): 27-33.

AWARENESS RIDE FOR THE 140-PER-WEEK DIABETIC FOOT AMPUTATIONS

The team departs from the annual Wounds UK summer conference at the Motorcycle Museum in Birmingham. From left to right: Tom Delpierre, Specialist Podiatrist, Solent NHS Trust; Rob Clarke, Trainee Advance Clinical Practitioner, Acute Medicine, Shrewsbury and Telford Hospital NHS Trust; Deb Wingrove (Support Driver) Derma Sciences; Mark Allatt, Sales and marketing manager, Derma Sciences Europe; Rob Yates, Joint Manager OmniaMed; Graham Bowen, Podiatry Clinical Lead, Solent NHS Trust; Paul Saunders, Senior Global Market Manager, Vancive Medical.

Reprint. First printed in Wounds UK 2017; 13(3): 7-8.

There are an estimated 4.5 million people living with diabetes in the UK. As a consequence of long-term diabetes, people are at risk of developing foot ulcers — in the UK alone around 86,000 people have a foot ulcer.

Foot ulceration is the most common cause of lower limb amputations, with 90% of amputations preceded by a least a single foot ulcer. The current rate in England is 140 amputations a week or 20 a day amongst people with diabetes. This figure continues to rise — it was 130 in 2014 and 135 in 2015. Further complications are associated with foot ulceration and amputation, which results in almost a 50% 5-year mortality rate for people undergoing an amputation. However, with effective treatment 80% of amputations are avoidable

The impact on the NHS of foot ulceration continues to put further financial pressures on an already stretch service. The cost of foot ulceration in 2015 was £1.13 billion and represents £1 in every £140 spent by the NHS.

To increase awareness of the 140 amputation per week in England, a group of clinicians, plus Mark Allatt from Derma Sciences, Rob Yates from the OmniaMed and Paul Saunders from Vancive Medical rode 140 (sic!) miles over two days from a Wounds UK conference in Birmingham to the Annual Sugar Fall Charity ball in Southampton. The ride is in its 3rd year and aims to increase the awareness of diabetes foot disease across the NHS and diabetes patients to ensure they get the access to the best possible treatment and care to reduce foot ulceration and to minimise the risk of amputation.

GRAHAM BOWEN

PODIATRY CLINICAL LEAD, SOLENT NHS TRUST

READY, SET, GO

Thursday 6th July

The ride departed from the annual Wounds UK summer conference held at the Motorcycle Museum in Birmingham.. The finish line is Southampton in time for the annual Sugar Fall Charity Ball (a fundraising event at the University Hospital Southampton NHS Foundation Trust University Hospital which raises money to purchase specialist equipment and educational resources to help with the care of adult patients with diabetes).

For once the good old English weather was sunny and warm with no wind. It wasn't quite the Grand Depart of the Tour de France, but the team of six did get a very appreciative and kind send off from the delegates at the conference.

Target for Day 1 was Newbury, over 90 miles away, leaving a steady 50 miles for aching legs the following day.

The team was led by me, map reader extraordinaire, whose priority was to keep everyone safely off the M42 and find a route that was quiet with as few hills as possible. This was achieved by finding a small gap off the NEC/M42/A45

roundabout, which had certain 'Narnia' feel about it and we were off! My diligent preparation had even involved driving the route the previous week. This I recalled confidently to all as I did not need a map, 'Don't worry lads, I know the route like the back of my hand'.

After navigating the beautiful lanes and villages of Warwickshire, we reached our first target of a smashing pub in Shipston on Stour for a well-earned lunch and chance to rehydrate (at this point, the temperature was 32ºC) and update the newly created Facebook 'Diabetic Foot Amputation Awareness Cycle Ride' account with progress on route. This attracted quite a bit of attention, which is exactly what the whole event was about.

After lunch we entered the Cotswolds with its rolling hills. The villages came and went and the temperature rose. We reached our next target of Witney for well-deserved late afternoon coffee stop. The pace was starting to take its toll on some of the group. This was not helped by the need to cross the Ridgeway hill, which separated us from our stopover location in Newbury. As time went on, the group splintered and the rescue van called to save some tired legs.

At this point somebody mentioned that, mechanically, we had experienced no issues and nobody had fallen off. One mile from our overnight stop location, 'Boom' Paul suffered a blow-out. Rob, who was more concerned about his saddle soreness, duly provided a spare tube and the team were back on route again.

So Day 1 finished. A truly memorable day, but as part of the group had missed 20 miles, the map reader had to add 20 extra miles for day 2 to make it a true 140 miles ride.

Friday 7th July

Day 2 greeted us with another perfect glorious morning. With mainly flat routes to our finish line, the eagle-eyed map reader had found those essential 20 extra miles to get to our target. Lunch was at the picturesque Hampshire village of Wherwell, with its perfect country pub and fantastic food. At the coffee stop in Whitney number of the cycle team appeared keen to remain there for the remainder of the day, but common sense prevailed and onto the final leg as we had the Sugar Fall ball starting at 7pm to get to and to get out of our Lycra® and into our dinner suits.

On reflection, the key to the success of the ride was due to the fact that the longer ride had been done on Day 1, leaving a relaxing short ride on Day 2. During the ride, spirits were sky high and banter a plenty and the miles clicked by on the way down to Southampton. The annual Sugar Fall Charity Ball provided the ideal place to share our stories of the past two days and connect with clinicians and patients to continue our awareness message.

CONCLUSION

The shocking statistics around diabetes, the long-term complications and outcomes of diabetic foot ulcers are worrying. The amputation rate is growing year on year, and with 80% of them avoidable, raising awareness of these issues is key, so that both patients can have access to the best pathways and treatment is essential.

There is growing interest in the annual Diabetic Foot Amputation Awareness Bike Ride and I welcome others to join us next year. Over the past three years, we have covered many counties and miles and spoken to many people about diabetic foot disease and amputations. The goal of the team is to make this a yearly event and link it where possible to diabetes educational events; so that the team can continue to raise awareness. Hopefully this will, in some small way, help to contribute to improving outcomes for patients with diabetes.

Day one: Coffee stop in Whitney

Day Two: The finish

To register your interest, you may email me at: Graham.Bowen@ solent.nhs.uk.

DO YOU HAVE ENOUGH INSURANCE?

Insurance should be top of any podiatrist's risk management list. Practising members of the Society have the benefit of Third Party Indemnity insurance included in their membership (podiatric surgeons have additional separate insurance). The Society's insurance cover is valid overseas (dependent on that countries scope of practice) as well as in the UK, the only exceptions being USA and Canada.

As a Registrant on the Health and Care Professions Council Register it is a condition that you have adequate cover for potential claims arising out of the provision of podiatric treatments.

Society membership automatically provides you with £15 million medical malpractice and public liability insurance, although you may potentially be liable for the first £1,000 in each and every claim if either you or your practice does not comply with Society guidelines, including continuing professional development requirements. Medical malpractice insurance offers cover for legal liability for professional errors and omissions made while treating patients. Society membership also automatically provides product liability arising from claims against you for bodily injury or damage to property by items or products supplied by you as part of a treatment. This however, will not cover products that you sell that are not part of assessed treatments, for example, if you start a mail order company to sell products or provide insoles to third party organisations.

KATIE COLLINS, PROFESSIONAL AND PRIVATE PRACTICE OFFICER SCP

That is all the insurance you may need if you are an employee. However if you are a Practice owner there are extra insurances you may need to consider or indeed that may be compulsory. Your practice is likely be the main source of income for you and your dependants. Protecting your business by having adequate insurance cover therefore not only makes sense, but in many circumstances is essential. What would you do if your practice had a fire or flood tomorrow? Or if you or one of your employees could not work?

Below we will discuss the main insurances you should consider but it is highly advisable that you consult a reputable insurance broker that will assess your risks and advise accordingly, ensuring that you have cost-effective cover in place for each eventuality.

COMPULSORY INSURANCE

Employers' Liability

As soon as you have employees, other than your immediate family, you are legally required to take out an employers' liability insurance to insure against any claims they may make against you. This protects you against claims from employees that arise from injuries sustained at work or in the course of their employment.

Pressure vessel insurance

If you own a steam steriliser of any type you are legally required to have the autoclave maintained and validated on an annual basis. This is normally done via some type of Pressure Vessel insurance scheme or maintenance contract.

This insurance covers you for the servicing and validation and can also include breakdown and repair of the machine.

It should be noted that the Society's insurance covers third party injury if the autoclave injures a patient, i.e. sudden escape of steam causing a burn. However, it does not cover for damage to property, i.e. if it exploded, therefore you should make sure this is covered by the pressure vessel insurance, practice insurance or building/contents insurance.

Motor insurance

Current legislation specifies that you must have, as a minimum, third-party liability; however company vehicles that are an asset really ought to be covered by comprehensive insurance.

You need to advise your insurers of a change of use from domestic to

business, especially if you are using the vehicle for domiciliary purposes or for travel between surgeries.

NON-COMPULSORY BUT STRONGLY RECOMMENDED

Buildings and contents insurance

If you own the premises in which you work it will probably need to be insured. If you work from home you will need to check that this does not invalidate the household buildings insurance or see if the household insurance cover can be extended to protect your practice.
If you lease the premises, check with your landlord that buildings insurance is part of the rent. Find out whose responsibility it is to arrange insurance cover, and make sure that you are covered.
Regardless of whether you need buildings insurance, you will almost certainly require contents insurance. The value of your contents is often surprising. In order to assess the amount of cover that you need, make a list of the contents of each room in the practice and the replacement value. Do not forget the floor coverings.

Practice insurance

When you are in private practice you should get Practice/Business insurance. This would cover you for things such as:

* Property Damage – cover for contents, computers, buildings and stock
* Business Interruption – cover for loss of gross profit or revenue following loss or damage
* Book Debts – covers debit balances
* Loss of Money – following theft or attempted theft of money
* Goods in Transit
* Specified All Risks – damage to specified items anywhere in the UK, EU or Worldwide
* Employers' Liability
* Personal Accident – arising from any accident in work or leisure time
* Theft by Employee

Allianz has a scheme tailor made for Society members. For details please ring: 0800 294 7729 (other companies are available).

NON-COMPULSORY BUT DESIRABLE

Private healthcare

Private healthcare policies are designed to provide fast access to quality medical treatment, usually with the choice of specialist and hospital for you or any employees.

Absenteeism and presenteeism are words that are becoming synonymous with cost. In their Absence Management Annual Survey, the Chartered Institute of Personnel and Development (CIPD) estimated that in 2012 the average number of days an employee took off due to illness was 6.8. This puts the average cost of absenteeism at £600 per employee per year. In addition to this, there is an increase in employees turning up for work when they really should be at home recuperating, with estimates from the Centre of Mental health suggesting presenteeism has a negative impact on the economy of over £15bn.

Benefits for you as an employer:

* Access to fast private treatment
* Reduce the risk of a key person being unable to work
* Improved employee engagement
* Improved ability to help manage sickness absence, particularly if incorporated with other wellbeing services
* Ability to attract//retain quality staff
* Improved morale, motivation and productivity

For any employees:

* Comfort in knowing their employer cares
* Fast access to quality care
* A highly valued benefit

Income protection

This provides a regular income to employees if they become unable to work as a result of illness or injury; while providing you with the support that you need for your employees to return to work as soon as feasible. We work with employers to promote procedures that encourage early notification of absence, so that if your employees are injured or fall ill, they receive proactive help with a speedy recovery.

Human Resources insurance

HR insurance usually supports small businesses by providing expert advice and resources that help minimise the legal risk of employing people. The insurance is usually designed to keep you up-to-date and help you stay on top of changes in human resource and health and safety legislation, as well as providing templates and guidance. It may also include representation at, and assistance with, employment tribunals.

Tax investigation insurance

Your accountant may advise you to take separate insurance policy to cover the cost of his/her time, should the Inland Revenue decide to investigate you. Although the risks may be low, you could be faced with a significant bill from your accountant if you need their assistance to answer the Inland Revenue's questions. Most accountants will be happy to arrange this cover, but you can also obtain cover from the Federation of Small businesses.

Goods in transit

Motor vehicle policies do not normally cover goods in a vehicle. This type of policy would do so.

Loss of profits

This will protect your income in the event that your business premises are unusable as a result of an insured peril, for example a fire. It ensures that the income of the business will be maintained as if the disaster had not occurred. It may be worth noting that, unfortunately, a number of practices have been affected by fire and flood in recent years. Could you manage if you income was limited due to such an event? If not then it may be worth pay to cover this eventuality.

Expert witness insurance

The Society's insurers refuse to cover medico-legal work, because of the potential for a conflict of interest should you be involved in a claim against another member. Therefore if you are involved in medico-legal work, you will need to organise separate cover.

Critical illness insurance

As the name implies, the purpose is to provide a financial buffer should you contract a critical illness. Critical illness insurance is worth considering but read the small print as pre-existing conditions may not be covered.

SUMMARY

These are a list of insurances you may need to consider when practising podiatry and/or running a business. The Society Insurers have a brokerage arm called Jelf who are able to help members with Insurance, Employee Benefits and Financial Planning (other brokers are available.

For assistance in the area of insurance please contact:

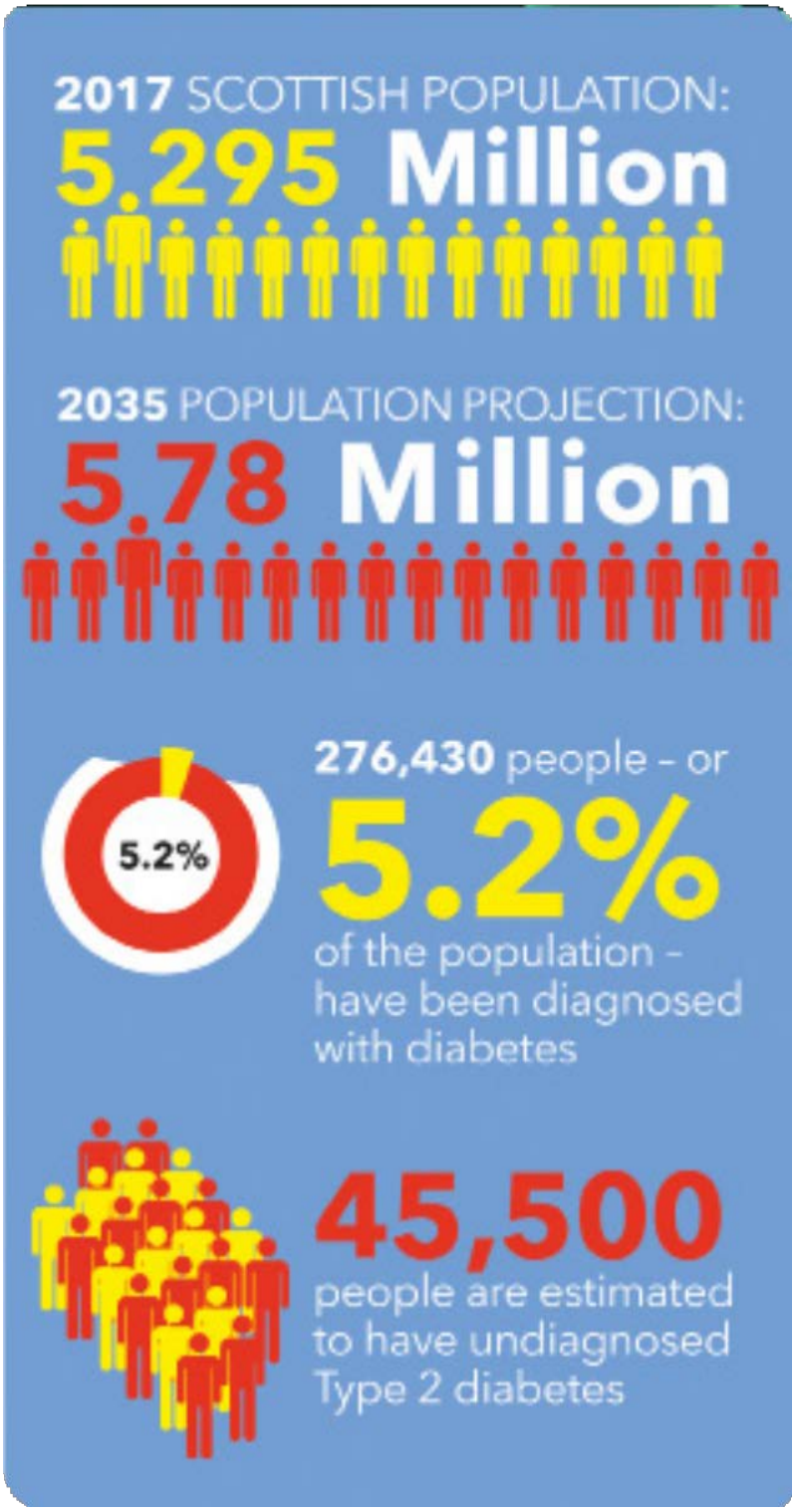
Andrew Brunton, Jelf Consultant
Email:
Andrew.brunton@jelfgroup.com
Tel Mob: 07825 383629

FEATURE

HEALTHCARE NEEDS ASSESSMENT FOR SCOTTISH NHS PODIATRY SERVICES

PODIATRY: A POSITIVE IMPACT ON PATIENT CARE THROUGH REDESIGN

The Scottish Public Health Network (ScotPHN) approached the Scottish Podiatry Managers Group to take part in a workshop in an attempt to identify the role of podiatry within the Scottish healthcare system. The first Scottish Healthcare Needs Assessment (HCNA) for NHS Specialist Podiatry Services is the result



Podiatry services in the NHS have been involved in major service redesign as part of the modernisation process, focusing on core podiatry provision especially specialist podiatry services.

The HCNA aims to assist NHS boards by providing an analysis to inform further local service development to meet the current and future needs of people with foot pathologies. The epidemiological element of the document was to use the quality of the data provided to estimate the size and composition of the population requiring generic and specialist podiatry.

It provides examples of best practice where podiatrists are an integral part of the multi-disciplinary team and the value of their intervention in making a positive impact on the quality of life for individuals as well as on the wider health system.

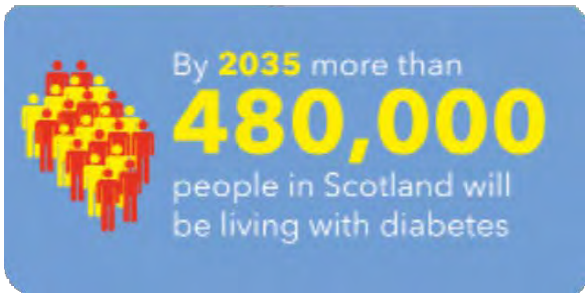
The document lists a number of

REBECCA WALTON (LEAD AUTHOR), ALISON MCCANN, ANN CONACHER, ALLISTER KELLY, ROBERT PEAT, CHERYL EASTON, PHIL MACKIE, JOHN MCCONWAY, LYNN BAIRD

IN CONJUNCTION WITH THE SCOTTISH PODIATRY MANAGERS' GROUP

EMAIL: NHS.HEALTHSCOTLAND-SCOT- PHN@NHS.NET

WEBSITE: WWW.SCOTPHN.NET
TWITTER: @NHS_SCOTPHN



recommendations to be taken forward and these will be progressed through the Scottish Podiatry Managers Group. The HCNA been shared with all CEOs and Directors of Workforce in NHS Scotland Health Boards as well as colleagues within Scottish Government.

By undertaking early interventions to identify and mitigate the impact of future foot health demands, podiatry plays a key role in the prevention of lower-limb problems through a programme of triage, screening, assessment, diagnosis, treatment and foot health education to patients with a lower-limb or systemic conditions that affects the lower limb. The service is needs-led and person-centred to support and enable self-care where possible to relieve pain, keep the public mobile, and sustain and promote active living.

Patients can have systemic acute or chronic long-term conditions, including diabetes, vascular and or neurological conditions, which give rise to further complications of feet and lower limbs.

The Allied Health Professions workforce, including podiatrists, will be expected to play a critical role in meeting the challenges facing the health and social care systems.

BACKGROUND

The Scottish Government's National Clinical Strategy (2016) & The Modern Outpatient: A Collaborative Approach (2017-2020) make proposals for how clinical services need to change in order to provide sustainable health and social care services for the future.

NHS podiatry services are delivering on this agenda and have been involved in major service redesign as part of this modernisation process, working with partners in health, social care, independent and 3rd sector organisations.

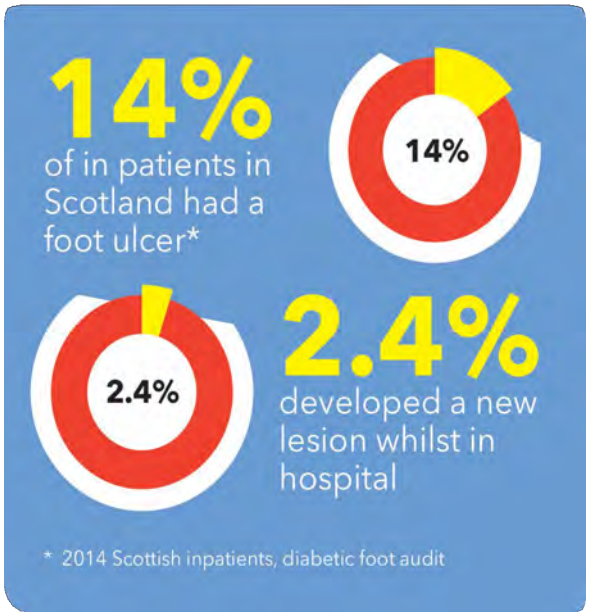
Scotland's Chief Medical Officer reinvigorated the conversation with health professionals about the shape of future practice, how people (as patients) and professionals can combine their expertise to focus on outcomes that matter to individuals, how unwarranted variation in clinical practice can be reduced to achieve optimal outcomes for patients, and how value for public money and prevention of waste can be ensured.

The philosophy of 'realistic medicine' is permeating through to all areas of healthcare, including podiatry.

NHS podiatry services are delivering on this and have been involved in major service redesign as part of this modernisation process. NHS podiatry services focus on core podiatry provision and specialist podiatry services. Specialist musculoskeletal conditions (MSK) podiatry services have engaged with The Trauma and Orthopaedics ACCESS programme (Addressing Core Capacity Everywhere in Scotland Sustainably).

This Health Care Needs Assessment (HCNA) aims to assist NHS Boards by providing analysis to inform further local service development to meet the current and future needs of people with foot disease.

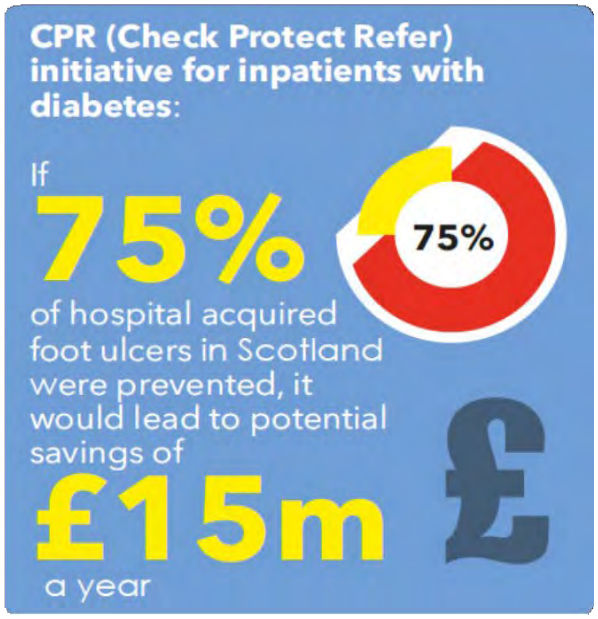
The epidemiological component for the HCNA focuses on the need for generic core podiatry and specialist podiatry services provided by the NHS Scotland.



The purpose of the epidemiological element of this HCNA was to use quantitative data to estimate the size and composition of the population requiring generic podiatry and specialist podiatry. However, the broad scope and range of service delivery for those with multiple pathologies included within the provision of NHS podiatry meant that the review could not capture the entire scope of podiatric need.

The epidemiology describing the need for diabetic foot care in Scotland is outlined in the National Diabetes Audit datasets. Estimates suggest that over 250 people per 100,000 population will have active foot ulceration or will be at high risk of developing ulceration, requiring regular care from the specialist NHS podiatry services.

Measures to assess whether the need for care is being met include structure, process and outcome measures. Some of these indicators are collated as part of the Scottish dataset, including endpoints such as presence of foot ulceration and amputation.



FINDINGS

- The percentage of patients with type 1 diabetes who have ever had a foot ulcer is 8.4% (n=2,537), with 1.2% (n=352) having had a lower-limb amputation.
- Audit data for the in-patient population in England (2015) found that 5% of all in-patients with diabetes were admitted to hospital because of foot disease.
- A total of 8.9% of in-patients included in the audit had active diabetic foot disease on admission.
- Of the patients admitted for management of their diabetes and complications, 49.5% were admitted due to active foot disease.
- The Scottish in-patient diabetic foot audit (2014) found that 14% of all in-patients with diabetes had a current foot ulcer.
- A total of 2.4% of the in-patients with diabetes developed a new foot lesion during their hospital admission.
- In 2014 the Scottish Diabetes Foot Action Group introduced a national in-patient foot care campaign called 'CPR for Diabetic Feet'. Evaluation of the impact of this initiative is planned.
- The percentage of patients with type 2 diabetes who have ever had a foot ulcer is 4.3% (n=10,903), with 0.7% (n=1,740) having had a lower-limb amputation.
-

The assessment of the contribution that podiatry makes to care is not directly measured from existing data, as it is an integral part of multidisciplinary care.

Work by the Scottish Diabetes Survey to develop their assessment of the care processes and outcomes may provide an opportunity to gain a better understanding of gaps in services provided to these patients.

Local audits may also be valuable to help improve the quality of care offered to diabetic patients with foot disease.

Complex foot wounds in non-diabetic patients have not been subject to such a strategic approach. There is little available data to describe current activity. We had access to analysis of activity undertaken by two NHS boards, and presented these as case studies.

- One NHS Board found that there were 19,209 patient contacts with specialist wound care podiatry (including diabetic patients) a crude rate of 2,940 contacts per 100,000 population in 2015-16.
- An analysis of two weeks' activity at another NHS Board found that there were 146 non-diabetic patients accessing podiatry wound services, a crude rate of 40 patients per 100,00 for the two week period.

Local analyses such as these will help inform local service planning but further developments in data collection are required to allow more detailed analysis and interpretation.

The role of NHS podiatry is less clearly defined for the care of patients with non-diabetic wounds compared to diabetic wounds. Neither SIGN nor NICE Guidelines discuss the need for multidisciplinary teams or identify specific professional groups that should be involved in the care of patients with pressure ulcers or peripheral arterial disease.

The lack of recognition of an important role for podiatry may be due to insufficient research to provide a strong evidence-base.

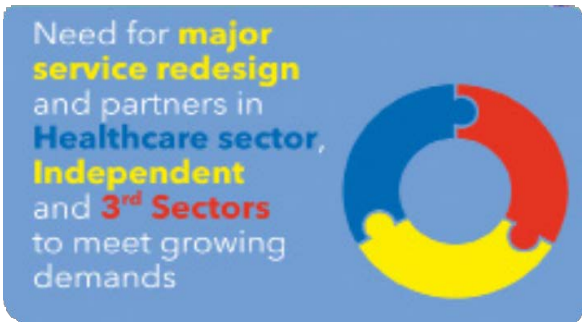
Our review of rheumatoid arthritis as a tracer condition suggests that within a synthesised NHS Board population of 100,000 people, there are estimated to be 40 patients with newly diagnosed rheumatoid arthritis. Evidence-based clinical guidelines advocate for early access to podiatry services for this group of patients..

Whilst we do not have data to assess the current situation, we have examples of best practice where podiatrists are an integral part of the multidisciplinary team.

Despite focussing on specialist NHS podiatry, the literature was found to have a lack of agreed definitions around complex wounds and MSK conditions. This HCNA experienced difficulty sourcing good quality data to describe extensive service redesign.

The development of practice improvement should be explored, with in-service training developed to support staff to participate fully in redesigning models of care and practice improvement. These should be reflected in the implementation of the Everyone Matters: 2020 Workforce Vision.

This resonates with the findings of a report by The Health Foundation and Nuffield Trust, which focussed on the quality of care provided by Allied Health Professionals in England. They commented that 'across AHPs there is very little consistent in England information about either the volume or the quality of care provided'.



The role of NHS podiatry in the provision of anticipatory care should be explored to assess the impact on quality of life for individuals and the cost effectiveness for service providers.

CONCLUSION

Meeting the specialist podiatric health care needs of people in Scotland is an essential part of achieving a sustainable health and social care system. NHS specialist podiatry services have been undergoing the sort of service redesign that is totally in line with the vision set out in *A National Clinical Strategy for Scotland* and as Scotland has progressed the separation of personal foot care from NHS specialist podiatry services, the link to *Realising Realistic Medicine* is clear.

View or download a full copy of the report here:
http://bit.ly/2tDFxJb/0001

Published: April 2017 Last updated: July 2017

RECOMMENDATIONS
There needs to be increased awareness of:
Changes in personal foot care provision
The role of specialist podiatry, particularly in relation to complex wound management and musculoskeletal conditions (MSK)
The contribution that podiatry services make to the care of older people including maintaining mobility, enabling people to remain active, as well as contributing to falls prevention
The contribution that podiatry services can make to prevent ill health and improve health and wellbeing, including signposting for smoking cessation advice for people with peripheral vascular disease.
Develop a better understanding about whether risk stratification, triage and timely podiatric intervention for patients with diabetic foot disease can improve outcomes for patients and reduce the number of patients requiring admission to hospital
Effective approaches to managing anticipatory care across the specialist podiatry services should be established and maintained.

THE SOCIETY OF CHIROPODISTS AND PODIATRISTS' BUSINESS MASTERCLASSES WITH PODIATRY HIVE PRESENTS:

Do You Own A Podiatry Practice … Or Does Your Practice Own You?
Get a grip on your podiatry practice once and for all and regain CONTROL
There are certain areas you can take control of on the business side of your practice that help to remove the stress of running a podiatry business.

The College of Podiatry

Session outcomes - increase your ability to measure, assess and adjust results in your practice with these five key levers:

1. How to communicate what you do and why you do it
2. How to optimise your patient booking system
3. How to implement practice systems, to ensure patients get the optimal treatment at the right frequency
4. How to set your pricing so it accurately reflects the value you are delivering to patients
5. Discover how and why your profit margin is the key indicator to your practice's overall health

The Podiatry hive
PRACTICES made PERFECT

Remember … Better Business Management Equals Better Patient Outcomes
Join our in-depth Business Masterclasses in partnership with The Podiatry Hive for September and October 2017 in the UK. To register for the event please go to:
Glasgow: Monday 25 September 2017 18:00 – 21:00
https://www.eventbrite.co.uk/e/business-masterclasses-tickets-36225610777
Manchester: Wednesday 27 September 2017 18:00 – 21:00
https://www.eventbrite.co.uk/e/business-materclasses-tickets-36226010974
Birmingham -Solihull: Thursday 5 October 2017 18:00 – 21:00
https://www.eventbrite.co.uk/e/business-masterclasses-tickets-36226846473

Ticket fee for the three-hour training session: £45.19 per event

Cosyfeet Competition

Enter and you could win a £50 Amazon Voucher to spend on whatever you like!

It's easy! Just answer the following question:

Which three people influenced Emma Cowley as a student?

The answer can be found somewhere in this issue.

The winner for the August competition is Adam Constable from Stourbridge, West Midlands.

Q - When will the new CEO for The Society and College of Podiatry start?
A - September

To enter please go to www.cosyfeet.com/www.cosyfeet.com/PNCOMP91

Cosyfeet Perfect for swollen feet

Figure 1

RELOCATION, RELOCATION, RELOCATION: OUR NEW SOCIETY OFFICES

Figure 2

To conclude my historical overview of the premises used by the Society – this article takes a brief look at our new Society Headquarters at Quartz House and its environs

The Society offices are currently housed on the first floor of a modern converted warehouse. We share this building with the Society of Radiographers. Although the area in which the Society office is now located has been re-developed and modernised, it was for many years one of the filthiest and most poverty stricken areas in London.

If you approach the Society headquarters via the South Bank it is necessary to cross a tidal inlet by way of a metal bridge. This is outfall of the River Neckinger; one of the lost rivers of London. Its name is believed to mean 'Devils' Neckcloth'. Allegedly, any pirates caught in the Thames were hung at the mouth of the Neckinger and their bodies displayed as a warning to others. However, this inlet is more commonly known as St Saviours Dock. It takes its name from the Patron Saint of Bermondsey Abbey. The Abbey owned the land in this area during the medieval period. Mill Lane (on which the new headquarters is located) is named after the site of the Abbey's water mill. Even after the Abbey fell into disuse, a water mill in the same area provided power to produce items as varied as gunpowder, paper and lead.

Subsequently, however, the area slid into extreme deprivation and decay. The region was criss-crossed with fetid streams and waterways and become infamously known as 'Jacob's Island.' In 1849, the social commentator and reformer Henry Mayhew wrote a letter to the Morning Chronicle lamenting the parlous state of this part of London. He stated 'On entering the precincts of the pest island, the air has literally the smell of a graveyard'. He also commented on the 'rotting bridges over the reeking ditch'.

SUE HARDIMAN MA

Figure 1
Quartz House, 207 Providence Square

Figure 2
Folly Ditch at Mill Lane c 1840

Figure 3 (right)
Plaque located at Mill Street

The waterway he was referring to was known locally 'Folly Ditch' and ran alongside Mill Lane. It was a ferment of filth and squalor and consequently the local population suffered terribly from the cholera outbreaks of the 1840s and 50s.

Charles Dickens also made several reference to 'Jacob's Island' both in his general observations and in his novel 'Oliver Twist', published in 1838. In Chapter 50, Dickens observes 'dirt-besmeared walls and decaying foundations; every repulsive lineament of poverty, every loathsome indication of filth, rot, and garbage; all these ornament the banks of Folly Ditch.' It was also the last refuge of one of his most infamous villains - Bill Sikes. Despite this, the area is currently the site of renewal and re-generation. Little evidence remains of its notorious past and there is no doubt that when visiting the Society Headquarters it will be safe to drink the water!

6TH PODIATRIC SPORTS MEDICINE CONFERENCE

In Association with European College of Sports and Exercise Physicians

The Royal College of Physicians, 13 & 14 July 2017

TIM CHESHIRE, 3RD YEAR STUDENT

SOUTHAMPTON UNIVERSITY

The Directorate of Podiatric Medicine, College of Podiatry, presented the 6th Podiatric Sports Medicine Conference in Association with European College of Sports and Exercise Physicians.

This was a two-day conference hosted by Chairman, Dr Nat Padhiar, Co-leader for Podiatric Sports Medicine and Module leader in the centre for Sports and Exercise Medicine, and Dr Nikos Malliaropoulos, Consultant (Hon) Physician in Sport and Exercise Medicine at Bart's and the Mile End Hospital, London. The conference started with an excellent presentation by Prof Bruce Kidd on the mechanisms of pain and inflammation. Prof Kidd explained that the strategies for chronic and acute pain are different due to the underlying complexity of mechanisms and that biological, psychological and societal factors must be taken into account. Next up was Mr Goodier, who expertly presented on 'Knee Anatomy and Associated Problems in Sport and Examination of the Sporting Knee', which can be surmised as effective history taking and interpretation of MRI means that many conditions can be treated conservatively.

Prof Heinz Lohrer followed, and interestingly he concluded that in the 'Use of Bracing in Knee and Ankle Problems' there is a gap between frequent use of knee braces and scientific background for their effectiveness.

'Review of USS Anatomy of the Knee. Ultrasound Scan, Clinician's Stethoscope and Guidance System' was presented by Dr Muaaze Ahmed and Dr Susan Cross. The objectives were to review the anatomy and recognise sonographic appearance, develop a structured approach, and recognise pathologies using ultrasound. Matt Fitzpatrick then hosted a workshop on ultrasound use and findings. I think that the majority of students understood the benefits of ultrasound in a clinical setting and will take a suitable qualification post qualification. However, I believe that, as with prescribing, this will become a module within the undergraduate podiatry degree programme.

Middlesex County Cricket Club p hysiotherapist David Bartlett and Coach Alan Coleman superbly presented on the 'Importance of Working alongside Coaches in the Prevention and Rehabilitation of Injuries in Professional Cricket – A Model for All Sports?' They discussed the importance of biomechanics retraining following injury, a topic that I believe we could have heard more about.

'Gut Dysbiosis and MSK Problems' was the presented by Dr Ese Stacey. Published research suggests gut microbiota have an influence on metabolism and a likely effect in performance and MSK disorders. To paraphrase - we should be taking Vitamin D to promote calcium absorption and Vitamin K2 to suppress inflammation together with a probiotic. A recent talk to Southampton Football Club inferred the same.

Other presentations included: Prof Stephan Becker 'Does PRP Have a Role in the Management of OA Knee', Dr Jonathan Williams 'Injuries in Professional Rugby and Multidisciplinary Management', Dr Sajid Butt 'Usefulness of Positron Emission Tomography (PET) Scan in Foot and Ankle Pathology', D Nat Padhiar 'Use of EOS Scan in Assessment of LLD and Standing Posture' and Dr Amir Pakraven 'Fighting Inactivity and Obesity – Who is Winning?

This was an excellent conference and one that I would recommend all podiatry students. Notably, students are able to attend free, to further their knowledge outside of the University learning environment. It also enabled existing relationships to be fortified and new ones formed with peers, an essential aspect for all aspiring podiatrists. I very much look forward to attending in 2018.

As with all conferences we are grateful to all the sponsors: EMS, Firefly, Arthrex, Dan Grobler Biokinetics, GDR Medical, TRB Chemedica (UK) Ltd, Podfo and Sonosite.

Image above: University of Southampton Students with Matt Fitzpatrick, Consultant Podiatrist and Provost, College of Podiatry

PODOPAEDIATRIC SPECIAL ADVISORY GROUP CONFERENCE ON NEUROLOGY

BIRMINGHAM, FRIDAY 30TH JUNE 2017

JO MUGAN BSC PROPODIATRY

STEPHANIE OWEN MSC SO PODIATRY

It would appear that this year's conference had been eagerly anticipated by many, as it drew a record number of attendees and attracted a bigger than ever paediatric-specific trade presence. The topic this year was 'Neurology – let's look at it, assess it, and discuss where we go with it'.

Following a warm welcome, Nina Davies, Biomechanics Specialist Lead Podiatrist in Leeds and Visiting Lecturer at Staffordshire University, described how her role had changed over recent years, reminding us all that with ever-growing pressure on the NHS and subsequent demand on paediatric services, podiatrists are seeing an increasing proportion of children with neurological conditions in their clinics. As a result, podiatrists both in the NHS and private practice require a greater knowledge in recognising, assessing and treating these children and their families and managing their onward referral.

The first speaker of the day was Sarah Haggas, Paediatric Occupational Therapist from Leeds Community Healthcare NHS Trust, who spoke about Developmental Coordination Disorder (DCD). This affects 5-6% of school-aged children and is more common in boys. Sarah went on to describe the children most likely to be affected by DCD, diagnostic criteria, associated risk factors and interventions. It is worth noting that children suspected as having DCD are most appropriately referred after the age of 5 years and, whilst DCD results in motor difficulties that will always remain despite intervention, a child's ability to perform a task can improve with intervention.

The conference was then treated to presentation by Cylie Williams, Senior Research Fellow, Credentialed Paediatric Podiatrist, who spoke on the complex subject of sensory processing and idiopathic toe-walking (ITW)via live video link from Australia. Cylie's presentation explained what sensory processing is, what Sensory Processing Disorder (SPD) is, how SPD presents and is diagnosed, and finally the link between SPD and ITW. Cylie went on to look at the evidence related to ITW treatments and the need for agreed outcome measures and more longitudinal evidence.

After a splendid lunch and visit to the trade stands, which had various samples of orthoses and footwear for the paediatric patient, the afternoon kicked off with Simon Dickinson, Orthotist at Talar made. He discussed how to treat the child with neurological disorders and emphasised the difficulties in management of their gait and the observations of toe walking and the complexities of treating cerebral palsy. The use of excellent videos brought together theories of practice and treatment outcomes. The presentation discussed the way each case is managed on its own merits, and the various treatment goals individual to each patient.

A wonderful breakout session followed with Nina Davies and Matthew Hill discussing the observation and clinical testing of the neurological child, a lot of new and thought provoking and clinical questioning to improve practice. Emphasis was made of the pGALS (paediatric Gait, Arms, Legs and Spine - a simple, quick and validated musculoskeletal screening tool for use in the assessment of the school-aged child) assessment and the testing of upper and lower limb coordination, strength and reflexes. The clinical value of this reminded us to assess the whole child along with their sensitivities and not just the lower limb. Matthew made special reference to the spinal issues that lead to lower-limb disturbances, e.g. tethered spinal cord (TCS) syndrome. Referral pathways of the child to specialty teams concurred with previous speakers earlier in the day.

The whole day was filled with enthusiasm and motivation to be better clinicians for our paediatric patient. This conference is a must for everyone it is a reminder of how fast the pace of clinical practice changes. We loved it!

LEADING MEMBER OF THE PROFESSION: EMMA COWLEY

Emma worked as an NHS podiatrist in general practice before gaining a Senior 1 role specialising in musculoskeletal podiatry. During this time, she undertook a Masters degree in Clinical Podiatric Biomechanics. Having enjoyed mentoring students on placement, she decided a career in education was her next step. Emma gained postgraduate qualifications in learning and teaching and corticosteroid injection therapy, and extended scope skills in manual therapy and gait analysis, and is currently writing up her PhD thesis on Applied Biomechanics. Emma has been awarded fellowships from the Higher Education Academy, the College of Podiatry and the Royal College of Physicians and Surgeons of Glasgow (both in podiatric medicine) and Chartered Scientist status from the Science Council

1. In what year and at what School of Podiatry did you qualify?

I graduated in 1995 from the Wessex School of Podiatry, the University of Southampton.

2. What made you choose podiatry as a career?

My next door neighbour, Alison Rowlands, was a podiatrist and I went round to see her during the holidays as she had just had a baby boy. We got chatting about careers and she had a clinic in her annex that she showed me. I was hooked! I think she saw the look in my eyes because she went out of her way to arrange a day for me to shadow Marjorie Maddocks in podiatric surgery and then, after she returned to work from maternity leave, invited me on her domiciliary rounds for a day. I honestly can't thank her enough – she was a truly inspirational podiatrist to me.

3. Who influenced you professionally when you were a student?

Wow where to begin! I so enjoyed my time studying podiatry at undergraduate level because we had such enthusiastic and knowledgeable lecturers across the board. Three people stand out though: Neil Baker, Steve Urry and Alan Borthwick. My time in Neil's diabetes clinics (I volunteered over the summers too) was invaluable experience and I still draw on the skills and knowledge I learned from him today. To set me up for the medicines I needed in clinic, Alan's lectures, were superb – just packed with podiatric wisdom and so interesting. But the person who ultimately set me up to take on the path I have followed to specialist level is Steve Urry. He had us working out the co-efficient of friction at heel strike and toe off in our second year, and I still have all my university notes – nuff said!

EMMA COWLEY MSC, FCPM, FFPM RCPS (GLASG) FHEA CSCI

4. What has been the highlight of your career?

I have had a wonderful career with many high points for which I am truly grateful. The most meaningful times, however, have been when I have gained insight into the impact of podiatry service provision in communities abroad. In 1995-6, after the Chernobyl disaster, I joined a team of doctors and dentists traveling out to Ukraine on a humanitarian tour to help address the problems associated with already poor communities having to evacuate outside the radiation zone. We visited a number of rural regions where congenital disorders were beginning to present after the radiation fall out. In addition, due to the local vegetation being contaminated, the increase in refined carbohydrate in the Ukrainian diet (and the culture for vodka drinking among many) had led to a sharp rise in the incidence of diabetic complications. There was very little knowledge or care provision for diabetes in these communities, and we spent a lot of time simply educating people about glycaemic control and raising awareness of hygiene, dental and wound care and monitoring for new problems.

Referring was of no use as people often did not have transport and the annual budget for health provision was not distributed across the financial year so, for six months of the year, only emergency care was offered in the local hospitals. It was a valiant attempt at making a difference and we saw genuine enthusiasm to see improvement among the people we saw, but we all knew the problem was huge and multi-factorial. Field-working in this way offered my first real lesson in how podiatric conditions are seldom isolated problems and that working in a multi-disciplinary team in a well-resourced society is the only effective way to ensure the complex problems we see are managed effectively. I returned to the UK incredibly humbled by our NHS, so often taken for granted.

5. Are there any particular fun anecdotes or memorable times/ events that stand out that you would like to share with other members?

Oh who doesn't? Being a podiatrist ensures one gains insight into the full gamut of the British public. I recall a frail and elderly gentleman I saw many moons ago who had complained of arch pain to his doctor and been referred to me. Upon entry to the clinic room I got chatting to him and he said he felt a fraud as his pain had eased since seeing the doctor. I noted that the gentlemen was clearly not coping with the upkeep of his laundry from the condition of his clothes but was not prepared for what I saw next. Upon removal of his shoes a compacted dry stool appeared nestled in the talo-navicular region of his foot, adhered to

his sock. On the face of it, the arch in-fill had provided the reduction in pronation moments required to reduce the tissue stress in his medial arch structures. What else could I do but try and emulate the prescription… with a foot orthosis of course, which he was delighted with. I saved his dignity and did not tell him what I'd found but reassured him that I was confident the therapy would keep him comfortable. I then arranged a visit from social services to help him with his daily activities so he did not accidentally increase the supination moment again.

6. Can you outline your career pathway and what led you down your chosen path?

After qualification in 1995 I began work as a Senior 2 Podiatrist in the Isle of Wight Healthcare NHS Trust, and after a couple of years was promoted to Senior 1 Podiatrist in biomechanics. This was a fantastic opportunity to broaden my horizons as I worked closely with prosthetists, orthotists, physiotherapists and some incredibly skilled technicians. I began my Masters degree in clinical podiatric biomechanics at Staffordshire University in 2001 and decided to venture into private practice shortly after. Around the same time, however, Staffordshire University offered me a job as a lecturer / research assistant and I jumped at the chance to work in higher education.

I was working on my Masters programmes at Staffordshire and quickly got the bug for education but missed clinical practice, so when a post came up for a clinical academic role (50:50 band 7 podiatrist / podiatry lecturer) at the University of Plymouth, I grabbed it! I began working at Plymouth in 2003 and it's now 2017. In that time education in podiatry has changed enormously and my role as a lecturer is very different from the one I started in, and this is one of the reasons I have stayed. My colleague describes the job as being like 'The Apprentice' with no two days being the same. Working in my current role has even led me to working with external organisations (to the University) including the College of Podiatry, the Royal College of Physicians and Surgeons of Glasgow, the Arthritis and Musculoskeletal Alliance and, of course, MSK:UK with Dr Jill Halstead.

7. Who or what were the key influences on your career?

We have some real super-stars in our profession, both in the UK and worldwide. These people have demonstrated how training as a podiatrist can set the foundations to excel at the highest level by global standards. Our podiatric professoriate are the first group of people I would say have paved the way to show us what is possible. Professors Jim Woodburn, Chris Nester, Anthony Redmond in the UK and Hylton Menz, Joshua Burns, Karl Landorf and others abroad; but the shining lights for me are Professors Anne-Marie Keenan (University of Leeds), Cathy Bowen (University of Southampton), Caroline McIntosh (University of Galway) and Kate Springett (University of Canterbury). These podiatrists have role modelled for all the women in our profession how dedication, focus and sacrifice (almost inevitable in an academic career) can reap the rewards due to them. The culture in academia could, and has in the past, disadvantaged women who may take career breaks to start a family or who simply don't put themselves forward for promotion in a very intense and competitive environment. Both Anne-Marie and Cathy have shown how to smash the glass ceiling to professor level and are key influences on my career and hopefully others too. I am equally impressed by many clinicians (too many to mention) and NHS managers who have modernised podiatry services and made the best of our scope of practice to offer superb footcare to the public (whilst enjoying the technology we get to use).

8. What piece of advice would you share with colleagues?

Be honest with yourself about what makes your heart sing (in a podiatric sense!) and work hard for it. Podiatry has such potential as a career and the sky is the limit but you have to work for it. Oh and when you set your fees in private practice, charge for every night spent studying, every exam you lost sleep over, and every day spent honing your expertise.

9. What changes in the profession have you noticed over the course of your career?

I started training in 1992 and so 25 years have gone by (and I now feel ancient). In that time the Internet appeared and suddenly CPD was available everywhere, forums rose up and we could converse daily with Dr Kevin Kirby on Podiatry Arena, and see evidence-based (informed) practice happening as the dissemination of articles moved from CD-Rom to the online PubMed we know today. The latest most notable change I would say I have seen is the social / professional cohesion of the UK podiatry profession through social media groups such as UK Podiatry, MSK:UK and so many others on Facebook, etc. The culture has changed from annual conferences or quarterly meetings to daily dialogue and dissemination. Every day I get Tweets from professors, lecturers, leading clinicians, podiatry suppliers, students, colleagues from other professions and more, alerting me to the latest, greatest new running shoe, article hot off the press in JFAR, or new pieces of tech arriving on the scene. I can't imagine a more connected, vibrant profession than now!

10. If you were starting over again, would you have a different ambition within podiatry or would you choose podiatry as a career at all, or are you happy where you have ended up?

Absolutely yes to choosing podiatry. It has given me a career I never dreamt of and I am less than halfway through. I am very happy problem-solving the human locomotor system and the day I say I'm bored you can tell me I'm not doing it right! As John Wildsmith allegedly once said 'you are either in your bed or in your shoes so you'd better invest in both'. Based on that I would say that podiatry is a pretty smart choice given the number of complaints we help address in populations whose footwear choices, when combined with their life-style or occupation, cause pain and pathology.

11. What would you say to encourage others to take up podiatry?

Two things. Firstly, podiatry recruitment is an increasing challenge due to, I believe, lack of awareness of podiatry, and poor perception of podiatry in those who are aware of it. In addition, the Universities have seen a reduction in applications this year due to the loss of bursaries and we simply cannot be everywhere, all the time, to advertise the merits of a career in podiatry. Being a small profession EVERY one of us counts. If we are to see our profession grow in number (not shrink as it is going to with reduced trainees coming through), we need every single podiatrist to be thinking like Alison Rowlands did when she introduced me to podiatry. Alison, like so many of our gems from that era, is now retired so it is up to you, me and our ambassadors like the College of Podiatry to seize opportunities to create interest in the profession. Contact the College about the PASS project, order some leaflets for your waiting room, or help out at your local University Open Day. If we don't we may all regret it.

Secondly, audit. The second must-do action for us all is to demonstrate that we manage foot and ankle conditions better, cheaper, faster than other professions. The reasons are twofold:

- We may think we do this, but we don't so we need to upskill. If we are better than other professions, then we need to get that message out to the public and referral channels such as GPs to be sure that we are THE first choice for foot health services.
- We also need to demonstrate that we are the best, so you need to be able to show how you address conditions, how good you are resolving the conditions, and how much you charge. It may be that you charge more for an assessment and treatment but patients are pain free after one or two sessions instead of six sessions with another profession. I am not devaluing other professions – we all have our strengths, but I am very protective of what podiatry has to offer over and above other professions for many people with foot pain.

> *BE HONEST WITH YOURSELF ABOUT WHAT MAKES YOUR HEART SING (IN A PODIATRIC SENSE!) AND WORK HARD FOR IT. PODIATRY HAS SUCH POTENTIAL AS A CAREER AND THE SKY IS THE LIMIT BUT YOU HAVE TO WORK FOR IT. OH AND WHEN YOU SET YOUR FEES IN PRIVATE PRACTICE, CHARGE FOR EVERY NIGHT SPENT STUDYING, EVERY EXAM YOU LOST SLEEP OVER, AND EVERY DAY SPENT HONING YOUR EXPERTISE.*

SPOTLIGHT ON BRANCHES

HISTORY OF THE LONDON DISTRICT BRANCH – 1961 TO PRESENT

As Treasurer of The London District Branch I was handed a small brown briefcase at a meeting last year by another member. It contains the most fascinating insight into the branch history and the lecturers they delivered at meetings.

The Past

The meetings date back from 1960 being held at The Chelsea School of Chiropody with an occasional meeting held at Caxton Hall, SW1 with a variety of topics such as 'wear marks on shoes', 'Rigidity of the foot' to 'the cult of the serpent and it's probable origin' Unfortunately I couldn't find the attendance numbers for that lecture so not sure how much of a crowd raiser that was!

In 1968 one of the topics was 'Diabetes in the community' and in 1971 topics included 'Medical hypnosis' , 'Uses and abuses of antibiotics' and 'Forensic medicine; 1975 ' Acupuncture and 1976 'Cryotherapy'.

By 1977 'Surgical arthrodesis in hallux valgus; Long-term problems and chiropodial management' and 'Nail dust inhalation and *Trichophyton rubrum* antibodies in chiropodists' were some of the featured topics.

In 1984 the subject title 'Showing of video tapes 'x" has me wondering what exactly the x tapes were about! Perhaps the 21 members who attended that evening on the 18th January can enlighten me if they have not been sworn to secrecy!

In 1986 'Diagnostic radiography in chiropody and podiatry' by Ron Laxton and 'Biomechanics without tears' were popular.

The lectures were all well attended with as many as 45 members to some and a large number of students also attending.

The annual subscription was £1.50 in 1973 and refreshments costs for the year were £14.30!

There was a break after 1987 but in 2005 the branch reformed after Maire Murphy was persuaded by Ralph Graham that London needed a branch!

In 2012 we organised the Podiatric Sports Medicine Conference to coincide with London hosting the Olympics that year. It took a lot of effort by the committee but was very successful and is now being run by Nat Padhiar and has grown into a Specialist Advisory Group of the Society.

Sheena Anderson

Treasurer, London District Branch

The Present

Here we are in 2017 with a large membership and a wide variety of lectures and courses.

Our room hire and refreshments costs may be considerably more these days at our venue in the Park Crescent Conference Centre in Regent's Park but we still have a good attendance, with 130 members on our mailing list and a keen, stable committee with a fantastic secretary/ course organiser Steve Childs who is 'stepping down' this year.
We run 10 evening meetings a year in a variety of topics and run 3-4 courses a year.

We aim to promote postgraduate education for our members and help them with any work-related issues and act as a conduit between the members and the Society.

To find out more email the London Branch secretary: londondistrictbranch.scp@gmail.com

PODIATRISTS REUNITE

CHELSEA REUNION 14 JUNE 2017

The 'Class of '1967' at Chelsea School of Chiropody reunited on the King's Road in June to celebrate the 50th anniversary of our graduation.

Eight of us had a tour of part of the former college before retiring to our old watering hole, the Six Bells (now an Ivy restaurant) for a splendid lunch to reminisce about Chelsea in the 'Swinging Sixties' and our lives since then.

We have resolved to repeat this very enjoyable event and endeavour to include more of our fellow students (email valerie.fowler144@btinternet.com).

Pictured on the steps of the college are (from the left): David (Jerry) Chambers, Sue Nickson (Weir), Valerie Fowler (Dilks), Mike Norris, Pam Peters (Skeels), John Marlor, Beri Bush (Crowe) and Marilyn Moy (Boughey).

MANCHESTER FOOT HOSPITAL OVERSEAS REUNION

From the Manchester Foot Hospital (MFH) class of 1964-67; 50 years on, two overseas members Andrew Clarke and Penelope (Penny) Brown (nee Jackson) are still in practice, in South Africa.

Andrew was a lecturer at MFH and the Salford College before moving to South Africa in 1977 as the first lecturer in podiatry and Head of School of Podiatry at what is now The University of Johannesburg. In 1995 he left academia and was a founding member of the first Centre for Diabetes in Johannesburg. From 2001 to 2013 Andrew practised in Johannesburg before moving to Cape Town where he is in now private practice.

Penny had a varied career in both private and NHS practice in UK and Cyprus prior to moving to South Africa with her podiatric surgeon husband Brian in 2012. Both are semi-retired as partners in their Eastern Cape practice and as Associates with Andrew in Cape Town.

Pictured from left to right: Andrew Clarke and Penelope Brown on a rainy night in Capetown

If any former MFH classmates would like to get in touch please email us: baypods@gmail.com or andrewclarke@iafrica.com

BOOK REVIEW

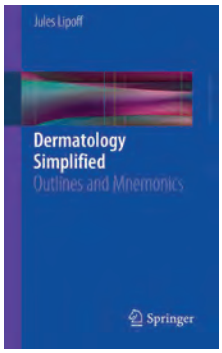
DERMATOLOGY SIMPLIFIED: OUTLINES AND MNEMONICS:

Author:
Jules Lipoff

Pages:
561

Publisher:
Springer

ISBN:
978-3-319-19731-9



Dermatology is a vast subject area with over 2000 recognised skin disorders and so it is no surprise that learning such an extensive subject can be daunting for the beginner. Therefore, any text that aims to demystify the subject and make it easier for the student to learn is very welcome. To that end, the author has taken a different approach to the subject than many other books in this market. Acknowledging the expanse of the subject, he has attempted to present the subject in a less traditional format, which may help make the subject easier to learn.

The book is split into four sections:

- Introduction
- Medical Dermatology
- Lists & Mnemonics
- High-yield topics

The introduction is the shortest and is labelled as the 'Starter Kit' for dermatology. It briefly looks at study techniques and explains how the book is laid out before looking at the skin assessment process. Dermatological terminology can be intimidating for the uninitiated and this section contains all the main terms with concise meanings of each – along with advice on their proper use (and misuse). The latter end of the chapter contains some detail on histopathological terms, which is helpful to explain the words often used and read in pathology reports that can be very jargon heavy. The chapter itself is one of the most concise I have seen, yet rich in useful clinical detail.

The following 14 chapters group the spectrum of skin conditions by their visual or morphological presentation such as papulosquamous, eczematous, vesiculobullous, keratotic, dermal and neoplastic conditions. Each chapter is set out starting with the most common conditions and their presentation followed by their differential diagnoses. Every condition is described briefly and accompanied with lists of essential information relevant to the diagnostic process. Having similar conditions concisely laid out next to each other reminds the reader of the importance of alternative and differential diagnoses as many dermatological conditions can look the same to the beginner.

The third section is difficult to describe briefly as it covers 'lists and mnemonics'. This is where you can find quick reference details on a wealth of dermatological conditions and their management. For example, one section entitled 'triads' contains numerous listings of three common conditions that may present with a specific feature such as trachyonychia, for example. Another lists skin tumours that are painful, risk factors for melanoma, important acronyms and so on. Suffice to say they are extensive and good for revision as they are short and easy to learn.

REVIEWED BY:
IVAN BRISTOW,
UNIVERSITY OF
SOUTHAMPTON

The book then moves onto regional dermatology and highlights the common conditions affecting a specific area: 15 common conditions of the foot for the dermatologist to be aware of, 16 for the shins and 6 for the knees. Cross referring each of these back to the earlier chapters fills in the clinical diagnostic details. In a similar vein, the book then lists treatments for conditions as well as commonly used acronyms and lists of things you need to know including different sub-types of disease, and basic skin cell science. The final section is intriguingly named 'high yield topics' and can only be described as essential lecture notes on important topics such as dermatological drugs, procedures and skin science.

When I first received this book to review I was a little daunted by its size, at 561 pages, but as the author points out in the introduction, the book was inspired by his own training as a student – to put together a system that allows him to cover the broad range of dermatology, not missing essential diagnoses but also not being bogged down in the extraneous detail – which is something that can be explored elsewhere, after a diagnosis is secured.

Having read through the book, there are a few things to mention. This is not a book for the visual learner. With only 10 illustrations amongst the 550 plus pages and no images of any clinical conditions – it is very text heavy. Moreover, the basic typesetting is not the most aesthetically pleasing but that should not detract from the value of this text. I would describe it as an essential facts and quick reference book for dermatology. Admittedly, it is not a book to sit and read in the clinic when a patient misses an appointment but more of a quick and accurate guide to be consulted with the patient in front of you when looking for a diagnosis and treatment.

Moreover, this may not be the first book to pick up if you are relatively new to dermatology – it is aimed more at the improver. The book itself is a perfect accompaniment to the more traditional colour atlases in this field as it can concisely add the important detail with little searching. For the podiatrist in practice this book is not for the beginner but is extremely helpful to move knowledge to the next level for those serious about the subject, being much broader than just the foot and ankle.

HAVE YOUR SAY

If you would like to have your say, please contact us

Email us:
podnow@scpod.org

Follow us:
@SCP_PodiatryUK
@feetforlife

Add and Like us on Facebook
'The Society of Chiropodists and Podiatrists'

Write to us:
The Editor,
The Society of Chiropodists & Podiatrists,
Quartz House, 207 Providence Square,
Mill Street, London
SE1 2EW

ROUNDTABLE DISCUSSION

I read with interest the round table discussion reported by Karen Reed on the future of private practice and it raised a couple of issues for me.

I would agree with much of what was reported and the issues of NHS funding etc. I would consider this to be one of the important issues the public maybe are not aware of, and the impact it will have on vital services like podiatry, the impact on care provision and patient eligibility. If this was highlighted more openly then it would assist private practitioners in advertising their businesses more effectively.

The concept of a tiered membership or profession depending on a practitioner's qualifications is an interesting one and I wonder how this would work in practice and how this would be publicised given the difficulty in understanding the public has with our current change of title (chiropodist to podiatrist) never mind those accredited with a higher range of skills or training. Would the concept be to include NHS experience and knowledge, as in my experience this dramatically increases a podiatrist's knowledge of conditions and pathologies that private practice rarely encounter?

A very interesting discussion which has also informed me of the impending HMRC changes to practice accounts that I was unaware of, and I suspect a number of members may not be aware of YET!

Gary Eden

THE WORD ON THE WEB

PublicHealthEngland (@PHE_uk) tweeted:

We've highlighted eight cost-effective ways for local areas to prevent mental ill health: http://bit.ly/2whGDKe

Charlotte Wåhlin (@CSWahlin) tweeted:

Nice to be active in a community promoting #PhysicalActivity and #Nature @exerciseworks @WeAHPs #WeActiveChallenge #AHPsActive #GlobalPT

COURSES & EDUCATION

➔ Cost: £50 per course per month, with discounts for bookings for six consecutive months or more. Entries are free of charge to SCP Branches and recognised Special Advisory Groups.

For more information contact Tina Davies on 020 7234 8639 or Email: courses@scpod.org for a course form

NOVEMBER DEADLINE: MIDDAY 27 SEPTEMBER 2017

DEADLINES

Issue	Deadline	Publication date
NOVEMBER	27 SEPTEMBER	20 OCTOBER
DECEMBER	25 OCTOBER	17 NOVEMBER
JANUARY 2018	15 NOVEMBER	8 DECEMBER

CATEGORIES

- Basic Life Support
- Biomechanics
- Chronic Wounds / Wound Healing
- Clinical Education
- Complementary Therapy
- Dermatology
- Diabetes
- Diagnostic Imaging
- Infection Control
- Injection Therapy
- Local Analgesia
- Manipulation
- Mobilisation
- Musculoskeletal
- Neurology
- Pharmacology
- Podopaediatrics
- Rheumatology
- Surgery
- Vascular Assessment
- Other

If you would like your course(s) or forthcoming event(s) to be advertised in *Podiatry Now*, please complete this form and return to the SCP. Ideally, please send in your details at least four months before the event to ensure that it appears in at least two journal issues.

➔ Title: .....

.....

➔ Venue: .....

➔ Date(s): .....

➔ Cost: .....

➔ Duration (Hours): .....

➔ CPD Points: .....(1 hour of lecture time equals 1 CPD Point)

➔ Category (see list below): .....

➔ Contact Name: .....

➔ Contact Address: .....

.....

➔ Contact Telephone: .....

➔ Contact Fax: .....

➔ Contact Email: .....

➔ Name (in block capitals): .....

.....

➔ Date: .....

Please return this form, together with payment and a copy of your course programme, to The Marketing and Communications Assistant, The Society of Chiropodists and Podiatrists, Quartz House, 207 Providence Square, Mill Street, London SE1 2EW or email to: courses@scpod.org

Title	Venue	Date	Cost	CPD Points	Contact
Biomechanics					
Theories in Podiatric Biomechanics	V-Webinar (9.30-12.00)	31 October 2017	£20	2	Steve Bailey, The School of Biomechanics, Sports and Remedial Therapies, 76 Derby Road, Long Eaton, Nottingham NG10 4LB Tel: 0115 972 1111 Email: enquiries@sobsart.com
Intermediate Biomechanical Assessment & Prescription writing course	Red Cow Moran Hotel, Naas Road, Dublin 22	10 & 11th November 2017	€325 earlybird before 10th Oct, €350 after.	14	Sarah Fox, PPL Biomechanics, Tramore Commercial Park, Tramore Road, Cork Tel: 00353-214320277
Lower Limb alignment & associated injuries	V-Webinar (9.30-12.00)	21 November 2017	£20	2	Steve Bailey, The School of Biomechanics, Sports and Remedial Therapies, 76 Derby Road, Long Eaton, Nottingham NG10 4LB Tel: 0115 972 1111 Email: enquiries@sobsart.com
Chronic Wounds/Wound Healing					
★ Wound and Larval Debridement Therapy e-Learning courses	Online	Online	FREE	5	To access course materials, visit www.larvalacademy.com/demo/ For any issues contact Kris Flynn (Biomonde) on: kflinn@biomonde.com
Complementary Therapy					
★ Practical Acupuncture for Podiatrists including dry needling Awaiting approval	NUI Galway	30 Sep to 2 October 2017	tbc		Shane Toohey, Acupuncture in Podiatry, 31 Cornfield Place, Hillarys, WA 6025 Australia Email: shane@acupunctureinpodiatry.com www.acupunctureinpodiatry.com
★ Practical Acupuncture for Podiatrists including dry needling Awaiting approval	Matthew Boulton College, Birmingham	18-20 October 2017	tbc		Shane Toohey, Acupuncture in Podiatry, 31 Cornfield Place, Hillarys, WA 6025 Australia Email: shane@acupunctureinpodiatry.com www.acupunctureinpodiatry.com
★ Podiatric Medical Acupuncture Level 1 (Foundation) Awaiting approval	Nottingham	tbc	£495	30 hours taught, 50 hours self directed	Mary Ellis, Course Organiser Tel: 0115 972 1111 Email: enquiries@sobsart.com

Disclaimer: Society accredited courses are denoted by ★. Members who undertake and successfully complete these are covered by the Society's insurance scheme for the extension to their scope of practice. Courses of general interest and those covering advances or modifications of recognised podiatric practice do not require formal accreditation. Members practising any techniques acquired during study of other courses which significantly extend their scope of practice may fall outside the insurance cover. In such cases, members are advised to ensure that they have made alternative arrangements for insurance cover before extending their scope of practice. For queries regarding courses or events please contact course organiser directly.

Title	Venue	Date	Cost	CPD Points	Contact
★ Practical Acupuncture for Podiatrists including dry needling Awaiting approval	Matthew Boulton College, Birmingham	23-25 October 2017	tbc		Shane Toohey, Acupuncture in Podiatry, 31 Cornfield Place, Hillarys, WA 6025 Australia Email: shane@acupunctureinpodiatry.com www.acupunctureinpodiatry.com
Reflexology Certificate Course	The Holistic Coach House, Carrick House, 2 The High Street, Garstang, Preston	Various held over 3/4 days	£450	24 plus min 30 post course	Jillian Edmundson Carrick House, 2 The High Street, Garstang, Preston PR3 1FA Tel: 0152 479 1126 or 0741 101 8541
Diabetes					
★ Foot in Diabetes Module	SCP Offices, London	25-29 September 2017	£695		College of Podiatry Course Please book via Eventbrite or email the CPD Officer: db@scpod.org
Diagnostic Imaging					
★ Foot and Ankle Imaging Course	University of Salford	tbc	£499 +VAT	20	Dr Jane McAdam, Unversity of Salford To register web: www.salford.ac.uk/onecpd Tel: 0800 298 2460
Injection Therapy					
★ Introduction to Corticosteroid injection Therapy	Cripps Post Graduate Medical Centre, Northampton General Hospital	23-24 September 2017	£395		Ian Reilly, BMI Three Shires Hospital, The Avenue, Cliftonville, Northampton NN1 5DR Tel: 07952 051886 Info@podsurgeon.co.uk
★ Injection Therapy (Theory) of the Foot and Ankle. MSc Module Awaiting approval	University of Huddersfield	Dec/Jan	£850	15	Matthew Rothwell, Division of Podiatry, Department of Health Sciences, The University of Huddersfield, Queensgate, Huddersfield HD1 3DH Tel: 01484 472561 Fax: 01484 472380 Email: m.j.rothwell@hud.ac.uk www.hud.ac.uk
Mobilisation					
★ Soft Tissue Mobilisation	Queen Margaret University, Edinburgh	23-24 September 2017	£399.95	54	Courses delivered by Ian Linane. For course details and to book, go to www.infigoeducation.co.uk.

Disclaimer: Society accredited courses are denoted by ★ Members who undertake and successfully complete these are covered by the Society's insurance scheme for the extension to their scope of practice. Courses of general interest and those covering advances or modifications of recognised podiatric practice do not require formal accreditation. Members practising any techniques acquired during study of other courses which significantly extend their scope of practice may fall outside the insurance cover. In such cases, members are advised to ensure that they have made alternative arrangements for insurance cover before extending their scope of practice. For queries regarding courses or events please contact course organiser directly.

Title	Venue	Date	Cost	CPD Points	Contact
★ Soft Tissue Mobilisation	York St John, York	7-8 October 2017	£399.95	54	Courses delivered by Ian Linane. For course details and to book, go to www.infigoeducation.co.uk.
Musculoskeletal					
★ Manual Therapies for MSK conditions of the Foot and Ankle Awaiting approval	tbc	tbc	£897	tbc	Ted Jedynak, 20 Melbourne Street, North Adelaide, SA 5006 Email: ted@footmobilisation.com Tel: +61 418 240 506 www.footmobilisation.com
Other					
Social Media Content Factory	Premier Meetings Manchester Trafford Centre, Old Park Lane M17 8PG	23 September 2017	£185 Plus VAT	7	Course delivered by Tony Gavin. Email enquiries@osgo.co.uk or call 0161 714 4114
★ Low Level Laser Therapy Course	SCP Offices, London	29 September 2017	£75 - SCP members £60 - SCP Accredited practices £90 - Non SCP members		College of Podiatry Course Please book via Eventbrite or email the CPD Officer: db@scpod.org
Social Media Content Factory	Premier Meetings Edinburgh Park, 1 Lochside Court, Edinburgh, Midlothian EH12 9FX	30 September 2017	£185 Plus VAT	7	Course delivered by Tony Gavin. Email e 1 714 4114
Orthotic Management & Exercise Rehabilitation	V- Webinar (9.30-12.00)	12 December 2017	£20	2	Steve Bailey, The School of Biomechanics, Sports and Remedial Therapies, 76 Derby Road, Long Eaton, Nottingham NG10 4LB Tel: 0115 972 1111 Email: enquiries@sobsart.com
Prescription Writing	V- Webinar (9.30-12.00)	23 January 2018	£20	2	Steve Bailey, The School of Biomechanics, Sports and Remedial Therapies, 76 Derby Road, Long Eaton, Nottingham NG10 4LB Tel: 0115 972 1111 Email: enquiries@sobsart.com
★ Low Level Laser Therapy Course	SCP Offices, London	23 February 2018	£75 - SCP members £60 - SCP Accredited practices £90 - Non SCP members		College of Podiatry Course Please book via Eventbrite or email the CPD Officer: db@scpod.org

Disclaimer: Society accredited courses are denoted by ★ Members who undertake and successfully complete these are covered by the Society's insurance scheme for the extension to their scope of practice. Courses of general interest and those covering advances or modifications of recognised podiatric practice do not require formal accreditation. Members practising any techniques acquired during study of other courses which significantly extend their scope of practice may fall outside the insurance cover. In such cases, members are advised to ensure that they have made alternative arrangements for insurance cover before extending their scope of practice. For queries regarding courses or events please contact course organiser directly.

Title	Venue	Date	Cost	CPD Points	Contact
✯ Low Level Laser Therapy Course	Manchester tbc	April 2018 (tbc)	£75 - SCP members £60 - SCP Accredited practices £90 - Non SCP members		College of Podiatry Course Please book via Eventbrite or email the CPD Officer: db@scpod.org
Rheumatology					
A study of Rheumatoid Arthritis & Autoimmune conditions - Lecturer Alexander Izod	Ye Old Plough House, Brentwood Road (A128), Bulphan, Essex RM14 3SR	29 September 2017	£70	5	Book via scp-seb.yapsody.com

Disclaimer: Society accredited courses are denoted by ✯ Members who undertake and successfully complete these are covered by the Society's insurance scheme for the extension to their scope of practice. Courses of general interest and those covering advances or modifications of recognised podiatric practice do not require formal accreditation. Members practising any techniques acquired during study of other courses which significantly extend their scope of practice may fall outside the insurance cover. In such cases, members are advised to ensure that they have made alternative arrangements for insurance cover before extending their scope of practice. For queries regarding courses or events please contact course organiser directly.

Leading Members of the Podiatry Profession!

Is there someone you know who is worthy of the title 'Leading member'?
Is there someone you know that has previously made or is making a big impact in the podiatry world?
Is there someone you think has a great career story to tell?
Is there a student who you feel is a rising star in the podiatry world?
Does your teacher inspire you and others and has made a mark in the world of teaching and deserves to be included?
If you answer yes to any of these questions please get in touch and let us know your nomination for the leading member's series.

Please contact td@scpod.org for further information.

MID SUSSEX BRANCH

Wednesday 29th November date subject

to conference dates

AGM plus The Deteriorating Patient

(including sepsis) - at the Town Hall, 40

Boltro Road, Haywards Heath, RH16 1BA

7pm for 7.30pm start. Please confirm

your attendance by emailing midsussex.

socap@gmail.com

NORTH YORKSHIRE BRANCH

Record Keeping Study Day

In association with Thompson Solicitors and the Society of Chiropodists and Podiatrists

Date: Saturday 21st October 2017
Time: 10am-3pm (registration and coffee from 9.30am)
Venue: Novotel, York Centre, YO10 4FD (free car parking available)
Cost: £50 per delegate (lunch, refreshments and course material included).

For further information and to request a booking form contact:
Becky Hargreaves
beckyhargreaves@hotmail.com

NEWCASTLE BRANCH

28TH OCTOBER 2017 AT 9.30PM

Novotel, Ponteland Road,
Kenton, Newcastle Upon Tyne, NE3 3HZ,

Michael Ratcliffe presents an update on the functional anatomy of the tarsal joints and spring ligament, including clinical treatment and strapping technique workshops

Cost, £55, including booking fee, light lunch, course notes and CPD certification. Booking via Eventbrite. Booking closing date, 13th October, strictly 50 places available

7TH NOVEMBER 2017 AT 7PM

CPR and AED update held at Newcastle Ambulance Service, West Denton Fire Station NE5 2RB

Cost £45, including booking fee and CPD certification. Booking via Eventbrite, strictly 12 places available

28TH NOVEMBER 2017 AT 6.30PM

CPR, AED and anaphylaxis update held at Newcastle Ambulance Service, West Denton Fire Station NE5 2RB

Cost £55, including booking fee and CPD certification. **Booking via Eventbrite, strictly 24 places available**

WALES PODIATRIC MEDICINE CONFERENCE 2018

'With You In Mind'
South East Wales Branch SCP
The SSE SWALEC
Glamorgan County Cricket Club
Cardiff
23rd & 24th March 2018

Email:
espodiatryconference@gmail.com
Facebook.com/PodMedConfWales/

DATES FOR YOUR DIARY

➔ Entries into these pages are free of charge to Society branches and groups. Please submit entries as far ahead as possible, giving date, group, basic details and a contact name and phone number. Any amendments/new dates to be highlighted clearly. Due to space constraints, events are usually publicised no more than three months ahead. Email: diary@scpod.org with your diary dates

SEPTEMBER 2017

20 — MANCHESTER & DISTRICT BRANCH
CPD: Dupuytren's disease with George Flanagan (Sponsored by Trycare). Time: 7.30pm at Hough End Centre, Mauldeth Road West, Chorlton, M21 7SX. Free to Society members/students - PLEASE bring proof of Society membership/student card. Tea/coffee provided. No need to book. Contact Manchester Branch for details: scpmanchesterbranch@gmail.com

20 — HAMPSHIRE BRANCH
Lyndon Jones, Podiatric Surgeon. Held at Hampshire Branch - Holiday Inn Express, Botley Road, West End SO30 3XA. Eventbrite invitation via hants.branch.scp@live.co.uk

22 — MID SUSSEX BRANCH
Simon Otter - Study Day Hot Topics in Rheumatology at the Town Hall, 40 Boltro Road, Haywards Heath, RH16 1BA times to be confirmed. Please confirm your attendance by emailing midsussex.socap@gmail.com

27 — MANCHESTER & DISTRICT BRANCH
CPR/Anaphylaxis/Adrenaline annual update with Mike Harrison-Blount. Time 6.30pm at Hough End Centre, Mauldeth Road West, Chorlton, M21 7SX. BOOKING ESSENTIAL – via 'Eventbrite – Manchester events -27/9/17'. Cost £40 + booking fee. Tea/coffee provided. Contact Manchester Branch for details: scpmanchesterbranch@gmail.com

27 **— WEST YORKSHIRE BRANCH**
Branch meeting: Speaker: Tony Gavin from Osgo. Venue: Kaberry Lecture Theatre, Leeds General Infirmary LS1 3EX, 7.15pm for 7.30pm start. For further details email: socapwyb@gmail.com

30 — GUILDFORD BRANCH
Podopaediatrics covering musculoskeletal, neurological and rheumatology with Matthew Hill & Nina Davies, University of Staffs. Full CPD day at the Woodhatch Centre, Reigate. Please make a diary note. Booking details to follow. Contact socapguildford@gmail.com

OCTOBER 2017

2 — SOUTH YORKSHIRE BRANCH
Intermediate level – Cardiopulmonary Resuscitation CPR / Automated External Defibrillation / Anaphylaxis. Course 1: Refreshments (lunch not provided) and Registration 9.15-9.30am. Course 9.30am-12.30pm. Course 2: Refreshments (lunch not provided), Registration 1.15-1.30pm, Course 1.30-4.30pm. £60.00 to pay for cost of each training session. Cheques to be made payable in full name of Society of Chiropodists and Podiatrists, South Yorkshire Branch. CONTACT: Janet Cawthorne or Jane Senior. Email: greensidepod@hotmail.co.uk; tel no: 01226 388622/384135.

4 — LONDON DISTRICT BRANCH
Mr Ian Beech, Consultant Podiatric Surgeon. Overview of 1st MTPJ implants for hallux limitus. Arrive from 7pm onwards for 7.30pm start. Venue: Park Crescent Conference Centre, Great Portland Street, opposite Great Portland St tube station. Refreshments provided. For further details please contact Steven Childs on londondistrictbranch@gmail.com or 07846764394 or register on Eventbrite at https://www.eventbrite.co.uk/e/ldb-evening-meeting-tickets-15190808116

5 — THE SOCIETY OF CHIROPODISTS AND PODIATRISTS
Council Strategy Planning Day. Contact Stephanie Boyce on 020 7234 8635.

NOVEMBER DEADLINE: MIDDAY 29 SEPTEMBER

6 — THE SOCIETY OF CHIROPODISTS AND PODIATRISTS
Council Meeting. Contact Stephanie Boyce on 020 7234 8635.

7 — COVENTRY & WARWICKSHIRE BRANCH
Neurology update. An all day course with doctor Jean Mooney at Stoneleigh near Coventry. For full details contact warksbranchsocap@gmail.com or telephone Sue 01926 885220.

10 — KINGSTON & SOUTH LONDON BRANCH
Parkinson's or Leprosy Speaker TBC. Enquiries to Karen Peake, email secretary@kslbranch.co.uk

10 — COLLEGE OF PODIATRY
Research & Development Committee meeting. Contact Kim Bryan, email kb@scpod.org

12 — DEVON BRANCH
Emma Cowley: Prescribing Foot Orthoses. Faculty of Health and Human Sciences, Plymouth University, Peninsula Allied Health Centre, Derriford Rd, Plymouth, PL6 8BH. Contact Branch Secretary Cathryn Clayden on kate@mypodiatrist.co.uk

13 — THE SOCIETY OF CHIROPODISTS AND PODIATRISTS
Northern Ireland Forum. Knockbreda Health Centre, Belfast. Contact Graham Pirie, email gp@scpod.org

14 — COLLEGE OF PODIATRY
Committee of Private Practice meeting and Committee of Directorate of Private and Independent Practice meeting. Contact Maureen Jonas, email mj@scpod.org.

14 — HAMPSHIRE BRANCH
Strapping techniques with Cuxson Gerrard. At Hampshire Branch - Holiday Inn Express, Botley Road, West End, SO30 3XA.Eventbrite invitation via hants.branch.scp@live.co.uk

14 — LANCASHIRE BRANCH
Rheumatoid Arthritis in Podiatry (full day)

held at Leyland Hotel, Leyland. Time 9am - 3:30pm. For more information please contact: scplancashirebranch@gmail.com

14 — MERSEYSIDE BRANCH
Vascular Update with Judith Barbaro-Brown, York St John University. These meetings will be held at 9.30am in the Education centre, Arrowe Park Hospital, Wirral. This has a purpose built lecture theatre seating 160 (please encourage your colleagues to come), lovely dining room and shopping mall at the entrance to the hospital. Travel details will follow, close to junction 3 of the M53. Contact Pauline pauline@paulinebarnes.com

14 — WARWICKSHIRE BRANCH
Neurology update an all day course with doctor Jean Moonie at Stoneleigh near Coventry. For full details contact warksbranchsocap@gmail.com or telephone Sue 01926 885220.

17 — GREATER MANCHESTER PRIVATE PRACTICE NETWORK
All podiatrists are welcome to attend. Topic: What Every Private Practice Needs In The Cupboard To Treat Infection with Mr Frank Webb (Consultant Podiatric Surgeon). Venue: Manchester Maccabi Community & Sports Club, Brooklands, Bury Old Road, Prestwich, M25 0EG at 7.30pm. Contact: Lindsey 07575285815. Booking Essential. Early bird price available. To book log onto www.manchesterpodppn.eventbrite.co.uk

18 — MID SUSSEX BRANCH
James Coughtrey - subject TBC at the Town Hall, 40 Boltro Road, Haywards Heath, RH16 1BA. 7pm for 7.30pm start. Please confirm your attendance by emailing midsussex.socap@gmail.com

18 — MANCHESTER & DISTRICT BRANCH
Padding & Strapping with Cuxson & Gerard. Time 7.30pm at Hough End Centre, Mauldeth Road West, Chorlton, M21 7SX. Free to Society members/students - PLEASE bring proof of Society membership/student card. Tea/coffee provided. No need to book, just turn up. Contact Manchester Branch for details: scpmanchesterbranch@gmail.com

19 —THE COLLEGE OF PODIATRY
Committee of the Directorate of Podiatric Surgery meeting. Please contact Kim Bryan on 020 7234 8627.

24 — GUILDFORD BRANCH
Basic Life support training - John Sions from RAMC Ltd. Free to those who have paid an annual CPD membership to Guildford branch, £40 to all others. For information contact socapguildford@gmail.com

25 — WEST YORKSHIRE BRANCH
Branch meeting: Rheumatology. Speakers: Dominic Bryer and Linda Bailey, Specialist Biologic Nurses. Venue: Kaberry Lecture Theatre, Leeds General Infirmary LS1 3EX, 7.15pm for 7.30pm start. For further details email: socapwyb@gmail.com.

30 — SOUTH ESSEX BRANCH
Roundtable discussion. Topics TBA. Venue: Ye Olde Plough House, Brentwood Road, (A128), Bulphan, Essex RM14 3SR. Time 19.30 – 21.30. Drinks available at the bar. Cost – FREE. Book through scp-seb.yapsody.com by 25th October 2017.

NOVEMBER 2017

1 — LONDON DISTRICT BRANCH
Alison Gardner, Specialist Podiatrist, CLCH. Podiatry Access for Vulnerable Patient Groups. Arrive from 7pm onwards for 7.30pm start. Venue: Park Crescent Conference Centre, Great Portland Street, opposite Great Portland St tube station. Refreshments provided. For further details please contact Steven Childs on londondistrictbranch@gmail.com or 07846764394 or register on Eventbrite at https://www.eventbrite.co.uk/e/ldb-evening-meeting-tickets-15190808116

2 — THE SOCIETY OF CHIROPODISTS AND PODIATRISTS
The Board of Trustees of the Benevolent Fund of The Society of Chiropodists and Podiatrists meeting. Contact Helena Basarab Horwath on 020 7234 8635.

7 — DEVON BRANCH
Steve McGowan: Emtrix and Flexitol. Lower East, Hannahs at Seale Hayne, Howton Lane, Newton Abbot TQ12 6NQ. Contact Branch Secretary Cathryn Clayden on kate@mypodiatrist.co.uk

9 — KINGSTON & SOUTH LONDON BRANCH
Robert Isaacs Biomechanics/anatomy. Enquiries to Karen Peake, email secretary@kslbranch.co.uk.

14 — GREATER MANCHESTER PRIVATE PRACTICE NETWORK
All podiatrists are welcome to attend. Topic: CPR with Anaphylaxis Defibrillation, CPR Adult and Paediatrics and Medical Emergencies. Venue: Manchester Maccabi Community & Sports Club, Brooklands, Bury Old Road, Prestwich, M25 0EG at 7.00pm. Contact: Lindsey 07575285815. Booking Essential. Early bird price available. To book log onto www.manchesterpodppn.eventbrite.co.uk

16-18 — COLLEGE OF PODIATRY
Annual Conference. Please contact Profile Productions at www.podiatryconference.org; tel: +44(0)20 3725 5840. email: cop@profileproductions.co.uk

22 — HAMPSHIRE BRANCH
Paul Harradine - Tibial Tendon dysfunction. At Hampshire Branch - Holiday Inn Express, Botley Road, West End SO30 3XA. Eventbrite invitation via hants.branch.scp@live.co.uk

22 — MANCHESTER & DISTRICT BRANCH
CPD: The effects of drug abuse on the lower limb with Claire Priestly – tissue viability nurse. Time 7.30pm at Hough End Centre, Mauldeth Road West, Chorlton, M21 7SX. Free to Society members/students - PLEASE bring proof of Society membership/student card. Tea/coffee provided. No need to book, just turn up. Contact Manchester Branch for details: scpmanchesterbranch@gmail.com

24 — THE COLLEGE OF PODIATRY
The Board of Trustees of The College of Podiatry meeting. Please contact Contact Helena Basarab Horwath on 020 7234 8635.

28 — GUILDFORD BRANCH
Basic Life support training - John Sions from RAMC Ltd. Free to those who have paid an annual CPD membership to Guildford branch, £40 to all others. For information contact socapguildford@gmail.com

28 — MANCHESTER & DISTRICT BRANCH
Heel Pain Workshop: Causes & Treatment with Julie Froggatt Bailey (Sponsored by Bailey Instruments). Tues 28th NOVEMBER 7.00PM at Hough End Centre, Mauldeth Road West, Chorlton, M21 7SX BOOKING ESSENTIAL – via 'Eventbrite – Manchester events -28/11/17' Cost £50 + booking fee. Tea/coffee provided.. Contact Manchester Branch for details: scpmanchesterbranch@gmail.com

29 — MANCHESTER & DISTRICT BRANCH
CPR/Anaphylaxis/Adrenaline annual update with Mike Harrison-Blount. Time 6.30pm at Hough End Centre, Mauldeth Road West, Chorlton, M21 7SX. BOOKING ESSENTIAL – via 'Eventbrite – Manchester events -29/11/17' Cost £40 + booking fee. Tea/coffee provided. Contact Manchester Branch for details: scpmanchesterbranch@gmail.com

29 — WEST YORKSHIRE BRANCH
Branch meeting: Counselling. Speaker: Helen McDonald, Counsellor. Venue: Kaberry Lecture Theatre, Leeds General Infirmary LS1 3EX, 7.15pm for 7.30pm start. For further details email: socapwyb@gmail.com.

29 — MID SUSSEX BRANCH
Date subject to conference dates - AGM plus The Deteriorating Patient (including sepsis) - at the Town Hall, 40 Boltro Road, Haywards Heath, RH16 1BA 7pm for 7.30pm start. Please confirm your attendance by emailing midsussex.socap@gmail.com

29 — LANCASHIRE BRANCH
Verrucae Needling Therapy. Time 6:30pm - 9pm. For more information please contact: scplancashirebranch@gmail.com

DECEMBER 2017

5 — THE SOCIETY OF CHIROPODISTS AND PODIATRISTS
Editorial committee meeting. Time 11am. Contact Tina Davies on td@scpod.org

5 — KINGSTON & SOUTH LONDON BRANCH
Radiology of The foot and Ankle. Susan Francis, James Kirkwood Radiographers (Kings College Hosp). Enquiries to Karen Peake, email secretary@kslbranch.co.uk.

6 — LONDON DISTRICT BRANCH
Dr Nat Padhiar, Consultant Podiatric Surgeon - Management of Achilles Tendinopathy. Please arrive from 7pm onwards for 7.30pm start. All lectures held at Park Crescent Conference Centre, Great Portland Street, opposite Great Portland St tube station. Refreshments provided. For further details please contact Steven Childs on londondistrictbranch@gmail.com or 07846764394 or register on Eventbrite at https://www.eventbrite.co.uk/e/ldb-evening-meeting-tickets-15190808116

7 — THE SOCIETY OF CHIROPODISTS AND PODIATRISTS
Council meeting at 10.15am. Contact Helena Basarab Horwath on 020 7234 8635.

11 — BRENT PRIVATE PRACTICE NETWORK
End of Year Social at 'The Preston' Pub, 161 Preston Road, Wembley, HA9 8NG, starting at 7.30 pm. All podiatrists welcome. For more information please email: diana_ayres@hotmail.com or tel: 0780 6419940.

12 — NOTTINGHAMSHIRE AND DERBYSHIRE BRANCH
Start time 7pm. Speaker tbc. Venue The Nottingham Belfry Hotel NG8 6PY. Enquiries scpbranch@Yahoo.co.uk

JANUARY 2018

17 — THE COLLEGE OF PODIATRY
Medicines and Medical Devices Committee meeting. Contact Sally Lock on sl@scpod.org

17 — MANCHESTER & DISTRICT BRANCH
JANUARY CPD: Gout with Hayley Edginton - Sponsored by DLT. Time 7.30pm at Hough End Centre, Mauldeth Road West, Chorlton, M21 7SX Free to Society members/students - PLEASE bring proof of society membership/student card. Tea/coffee provided. No need to book, just turn up

19 — THE COLLEGE OF PODIATRY
Committee of the Directorate of Podiatric Surgery meeting. Contact Kim Bryan on kb@scpod.org

23 — THE SOCIETY OF CHIROPODISTS AND PODIATRISTS
Employment Relations Committee meeting. Contact Maureen Jonas on mj@scpod.org

24 — THE SOCIETY OF CHIROPODISTS AND PODIATRISTS
England Forum meeting. Contact Lawrence Ambrose on la@scpod.org.

30 — COLLEGE OF PODIATRY
Research and Development Committee meeting. Contact Kim Bryan on kb@scpod.org

31— WEST YORKSHIRE BRANCH
Branch meeting: Hypermobility Syndrome and the work of the Hypermobility Association. Speaker: Donna Wick, Hypermobility Association. Venue: Kaberry Lecture Theatre, Leeds General Infirmary LS1 3EX, 7.15pm for 7.30pm start. For further details email: socapwyb@gmail.com.

FEBRUARY 2018

28 — WEST YORKSHIRE BRANCH
Branch meeting: AGM Meeting and DLT. Venue: Kaberry Lecture Theatre, Leeds General Infirmary LS1 3EX, 7.15pm for 7.30pm start. For further details email: socapwyb@gmail.com

DIARY AND EVENTS

FOR ALL YOUR ADVERTISING NEEDS ANY EVENTS FOR HELD BY YOUR BRANCH.

PLEASE EMAIL YOUR DATES AND DETAILS OF YOUR EVENTS TO DIARY@SCPOD.ORG

IF YOU WOULD LIKE DETAILS OF WHERE YOUR LOCAL BRANCH IS PLEASE EMAIL JILLY FRISCH JF@SCPOD.ORG

ARGYLL AND BUTE BRANCH LECTURE

Topic
Foot and Ankle Surgery
+
Update Ankle Block Sites

Lecturer
Alan Thomson MSc FHEA FFPM RCPS
Venue
Large Class Room
Vale of Leven Hospital
Alexandria (near Dumbarton)

Date; Sat. 7th October 2017
Registration; 10am - Finish 1pm
Cost £25
Contact dg.feet@virgin.net

GUILDFORD & DISTRICT BRANCH PODOPAEDIATRICS CPD STUDY DAY

Date: Saturday 30th September 2017
Time: 8.30 registration for 9.00am til 3.30pm
Venue: Woodhatch Centre, Reigate, Surrey RH2 7LS
Cost: £80 includes notes and Lunch

Speakers:
Matthew Hill MSc, BSc (Hons), FFPM RCPS (Glasg)
MSK Podiatrist, Staffordshire and Stoke on Trent Partnership Trust.
Visiting Lecturer, Staffordshire University and University of Malta.

Nina Davies MSc, BSc (Hons)
Paediatric Lead Podiatrist, Leeds Community Healthcare NHS Trust.
Visiting Lecturer, Staffordshire University.

Following the paediatric podiatry national clinical framework, the day will cover ontogeny, history taking, screening, lower limb assessment and interventions.

For application form and payment details
Contact socapguildford@gmail.com

SOUTH YORKSHIRE BRANCH

VENUE: THE HOLIDAY INN, HIGH ROAD, WARMSWORTH, DONCASTER DN4 9UX

2 October 2017 – Intermediate level – Cardiopulmonary Resuscitation CPR / Automated External Defibrillation / Anaphylaxis

Course 1: Refreshments (Lunch not provided) and Registration 9.15-9.30am, Course: 9.30am-12.30pm

Course 2: Refreshments (Lunch not provided) and Registration 1.15-1.30pm, Course 1.30-4.30pm.

£60.00 to pay for cost of each training session, cheques to be made payable in full name of 'Society of Chiropodists and Podiatrists South Yorkshire Branch'.

Janet Cawthorne or Jane Senior.
Email: greensidepod@hotmail.co.uk or
Tel No: 0122 638 8622/38 4135

MANCHESTER PODIATRY PRIVATE PRACTICE NETWORK

VENUE
Manchester Maccabi Community & Sports Club, Brooklands, Bury Old Road, Prestwich M25 0EG

All Podiatrists Welcome

BOOK EARLYBIRD TICKETS TO SAVE AND GUARANTEE YOUR PLACE AT
www.mppn.eventbrite.co.uk

16th Oct 17: What Every Private Practice Needs In The Cupboard To Treat Infection with Mr Frank Webb (Consultant Podiatric Surgeon)

14th Nov 17: CPR with Anaphylaxis (Adults and paediatric), Defibrillation and Medical Emergencies

CLASSIFIED ADVERTISEMENTS

SITUATIONS VACANT

CAMPBELTOWN, WEST of SCOTLAND
Are you looking for a lifestyle change? Come and live and work in a beautiful rural location. Full time, permanent position for highly motivated HCPC registered Podiatrist, who has great clinical and interpersonal skills, enthusiastic, confident and courteous, able to deliver high quality podiatry treatment to broad range of patients. Excellent remuneration, salary (equivalent band 5 and above) or fee-share if preferred. Generous relocation assistance available. Car driver/owner essential. **Enquiries regarding further information to info@campbeltownpodiatry.co.uk new graduates welcome to apply.**

HESWALL CHIROPODY LTD

Well established and flourishing practice seeks a HCPC registered podiatrist. We are looking for an enthusiastic individual to join our clinic on the Wirral. We require a reliable, well presented person who can work as part of a long established team. Initially one or two days per week rising to full time if wanted. Above average rates of pay (on a self-employed basis).

Telephone 0151 342 9665.

WILTSHIRE/BERKSHIRE BORDER
Brilliant opportunity for degree qualified Podiatrist to join well established practice with high standards and quality reputation. Excellent clinical and interpersonal skills are required, with attention to detail in all aspects of podiatry. Initially 1-2 days/week, with a view to possible future business opportunity. Experience of private practice is preferred however new graduates may apply if happy to be mentored. Self-employed, fee share basis. Car owner as occasional domiciliary work. CV and covering letter to podiatryvacancy2017@gmail.com

DORSET Wanted State Registered Podiatrist to work up to three days per week on a Self Employed basis at Christchurch Medical Centre, Dorset treating an eclectic mix of NHS patients. Please contact Anthony Cheshire for further details. Email: arcpodiatry@virginmedia.com or Tel: 07711990056.

STAFFORDSHIRE Established podiatry practice with several sites is looking for an enthusiastic HCPC registered podiatrist. Opportunity to develop within the practices. Latest techniques including Clearanail fungal nail and Swift microwave verrucae treatments. The position can be full or part time with some flexibility of days. We are happy to consider all levels of experience. Please contact r.davies@dslmail.co.uk

BOURNEMOUTH Podiatrist required for friendly surgery at Westbourne. At least 3 years' experience required. For more information please telephone Lynn on 07773 884321 at your earliest convenience.

INVERNESS Great opportunity for ambitious, enthusiastic degree trained podiatrist with excellent clinical and interpersonal skills to join modern well established practice located in Inverness and Elgin. Both practices are based in multidisciplinary clinics, with physiotherapists, osteopath and visiting medical specialists. The practice has a high proportion of MSK patients and works with both Scottish League football teams in Highland, so an interest in biomechanics would be an advantage, mentorship will be provided. We also offer Swift and Clearanail treatments in our clinics. The position is full time on a 50-50 fee share basis with OTE approximately £250/day. So if you enjoy the outdoors, mountain biking, road cycling (great country roads with very few cars and no pot holes), hill walking, climbing, skiing, the reason I moved here in 1976, then get in touch, new graduates will be considered. Email: lindsaymckerrow@hotmail.co.uk or call me 07734602314.

BARRY, VALE OF GLAMORGAN
An associate Podiatrist is required on a self-employed/fee sharing basis. Initially 3 days per week but full time hours available for the right candidate. Must be HCPC registered, have good clinical skills and a friendly personality. Recent graduates considered. Email CV to janec_jones@yahoo.co.uk. For more info call Jane 07894 389756.

NEWTONABBEY, COUNTY ANTRIM
We are looking for a part time HCPC Registered Podiatrist to join our busy clinic. Home visit and clinical work with general podiatry and nail surgery interest, fee sharing basis. Contact info@activefeetpodiatry.co.uk for full information.

SHOREHAM-BY-SEA Experienced podiatrist required for our clinic in Shoreham-by-Sea. This is on a fee sharing self-employed associate basis, initially working every Friday with the possibility of increasing to include Thursdays. There is no reception cover on Fridays, therefore we run a 'closed door' policy. Training on our practice software will be given. For more information or to apply please contact us by email or apply direct by sending your CV and a covering letter to; Karen Burrett email@firstfootclinic.co.uk

SE LONDON Podiatrist required in combined podiatry/physiotherapy Practice in S.E. London on Saturdays plus one other day a week (flexible days). Interested parties should be motivated with good interpersonal skills and happy to work independently. A good understanding of

To place an advert Email classifieds@scpod.org or Tel: 020 7234 8639
Advertisements must be posted to the Society address for the attention of Tina Davies or emailed to classifieds@scpod.org, along with credit card details to cover the appropriate payment. Emails are only accepted if payment is received before closing date. Adverts are not accepted over the phone and are to be paid at the time of placing the advert.

PRICING:
Members up to 40 words: £35. Each additional 10 words: £5
Non members up to 40 words: £60. Each additional 10 words: £10
Boxed adverts: £60 members and £80 non members. (Wording limited to 50 words.)
All prices inclusive of VAT.
Payment to be made via credit/debit card.
All adverts will be posted on our website within 2 working days.

Box number replies cost £2.50. Confidentiality will be maintained. Replies to c/o the Society of Chiropodists and Podiatrists, Quartz House, 207 Providence Square, Mill Street, London SE1 2EW

ENTRIES FOR AUGUST MUST BE RECEIVED BY MIDDAY 23 JUNE

biomechanical principles, prescription writing and good therapeutic skills and philosophy essential. Apply with CV to paul.studart@gmail.com

MORDEN, LONDON /SURREY Podiatrist vacancy available on Thursdays. Must be able to work until 7:00pm though start time can be flexible. Ideally with experience in private practice, routine, verruca, biomechanics, nail surgery. For more details email info@thefootspace.com

UNITED ARAB EMIRATES Interested in a move in your career location to an excellent tax- free work environment in UAE? An established Podiatry Clinic in UAE invites experienced Podiatrists and Orthotic/Prosthetic Professionals to share their CVs to hratabudhabi@gmail.com

BUCKS General Podiatrist required immediately in friendly Multi-disciplinary centre in Bucks HP16. Thursdays 9-2pm, potentially other days. Needs to be caring and highly professional. Please contact Phil at pmallen@btconnect.com for details and see www.prestwoodnaturalhealth.co.uk

BELFAST BT6 Busy Accredited practice seeking associate Podiatrist(s) for routine/dom clinics. Variety of opportunities and hours available. Driver & HCPC registration essential. Email info@proudfoots.co.uk to enquire and/or discuss options.

COLCHESTER Anglian Podiatry is a busy, expanding multi-clinic, based in Colchester. An opportunity has arisen for another Podiatrist and a Podiatry Assistant to join our team of 6 Pods. Work will mostly be based at our Colchester clinic, but may entail stints at one of our 5 outreach clinics. We are ' Accredited', with a wide scope of practice and would welcome another member to the team who can demonstrate commitment to excellent patient care. Please contact Sue Summers on 01206 854300.

PRACTICES FOR SALE

HERTFORDSHIRE long established domiciliary practice for sale. At present worked three busy days per week. Plenty of scope for expansion. Reason for sale retirement. Contact on 01438227220.

NORTH STAFFORDSHIRE Well established general podiatry practice with excellent reputation based in a north midlands town for sale. Comprising of freehold property, three fully equipped consulting rooms, separate office, sterilising and workshop rooms, goodwill and all equipment fixtures and fittings. This practice is lively, well known for MSK and with good links to physios GPs etc. Suitable for a partnership this practice is currently seeing in excess of 4000 contacts per year with a turnover of over £115K per year. Please email your interest to td@scpod.org with ref no: 001.

BIRSTALL, LEICESTERSHIRE Busy practice for sale. Established over 11 years. Fully updated and very well equipped. Turnover over 82k and still increasing yearly Asking price 60k with everything included. Owner moving. Email Rasminder or phone. Happysoles@footmedics.co.uk or 07921 866 026.

LOTHIAN REGION, SCOTLAND Busy clinic for sale, town centre location. Ground floor premises with disabled access, comprising of three treatment rooms, reception area, bathroom and sterilising room. Low rent and overheads. Turnover 31k (part-time) would suit practitioner/s able to work full time. Excellent reputation. Huge scope for expansion. Sale includes all equipment and goodwill. Genuine reason for sale. Please contact midlothianfootcare@yahoo.co.uk

ASHBY DE LA ZOUCH, LEICESTERSHIRE Long established practice for sale in centre of thriving market town. Leasehold ground floor premises, low rent and overheads. Fully equipped, sale includes goodwill. Retirement sale. Turnover 31k pa over 4 days (by choice). Great potential for expansion. Contact beryl.stephens@ashbydlz.co.uk or 07776 379401.

READING suburb and area nearby. Good opportunity. Well established (17 years) routine chiropody practice. Loyal, repeat patients. Ground floor, freehold premises in good condition with low overheads and easy parking. Turnover £53,000 from 4 days per week with scope for expansion. Sale comprises either (a) the premises, goodwill and equipment - £89,900 ono. Or (b) goodwill and equipment only, with option for buyer to rent the premises - £49,900 ono. May suit newly qualified. Practitioner planning to relocate to Midlands. Email: abdm@talktalk.net or text 07746 472781 .

ARTICLES FOR SALE

ULTRASONIC CLEANER PODOPRO, unused still boxed. £85.00. Ultrasonic Cleaner Podopro, used but perfect working order £45.00. SES Little Sister Autoclave serviced November 2016. Complete with spare door seal and printer rolls. Well used but works well. £500.00. Cryopen X only 2 years old complete with nine 16g cartridges £825.00. Total £1455 if all purchased together £1380.00. Seen Chelmsford Essex. Buyer collects. Phone 01245 441745.

8 RECEPTION CHAIRS with blue upholstery and chrome frames (some marks on seat pads) £40. Lockable medicines trolley - useful for sharps, needles and all items that need to be secured £20. Akron electro-hydraulic treatment couch - 4 section - some marks on upholstery of legs. Old but fully functioning - £150.00. Please contact Sue Summers on 01206 854300.

REPAIRS AND ORTHOTICS

BOLTON BROTHERS LTD
EXPERT SHOEMAKERS
ORTHOPAEDIC DEVICES

- **Over 120 yrs Experience.**
- **Bespoke & Semi Bespoke Insoles.**
- **Any Type of Footwear Adaption/Repair.**
- **Bespoke Footwear Manufacturer.**
- **Safety Footwear Manufacturer.**
- **Klaveness Modular Footwear.**
- **Technical Support and Clinic Rooms.**
- **Quality Service at Competitive prices.**

T: 01912732012
E: phil.glover@bolton-bros.co.uk
W: www.bolton-bros.co.uk

SVTS CHIROPODY DRILL REPAIR AND SALES

We offer an excellent competitive and efficient repair service for all makes of podiatry/ chiropody drills

Berchtold, Hadewe, Suda, Footman, Podiacare, Podo Tronic and Podo Pro EVO-30, 40, 50 drills

WE ALSO BUY YOUR UNWANTED DRILLS

Unit 239 Stratford Workshops
Burford Road
London E15 2SP

Contact us on 02085190044
or www.chiropodydrillrepair.co.uk

Are you are a small business who would like a cost-effective way to promote your products and services?

If so, place an advert in our
Repairs and Orthotics section

Contact Tina Davies on 020 7234 8639 for more information.

PodiatryNOW

RECRUITMENT

Contact:
Joanne Rose
Tel:
020 7880 6231
Email:
joanne.rose@
redactive.co.uk

Booking deadline for November is **midday, 3 October 2017**
Despatch date for November is **20 October 2017**

RECRUITMENT ADVERTISING RATES

Size	Dimensions (mm)	Rate
Full page	264(h) x186(w)	£4,700
Half page vertical	264(h) x 93(w)	£2,350
Half page horizontal	132(h) x 186(w)	£2,350
Quarter page	132(h) x 93(w)	£1,175

DEADLINES

Month	Booking	Mailing
November	3 October	20 October
December		
January		

FDUK
www.footindiabetes.org

Wounds UK

13TH MASTERCLASS ON THE FOOT IN DIABETES

UNDER PRESSURE

The diabetic foot

14 November 2017

Harrogate International Centre

Book online at www.diabetesonthenet.com/events

VASYLI®
MEDICAL

DRIVEN BY INNOVATION. GROUNDED IN SCIENCE. BACKED BY EVIDENCE.

Vasyli Custom Orthotics feature 6° rearfoot control, and are available in low, medium and high density to offer a truly customisable solution for patients with different weight and activity levels.

Vasyli Orthotics feature Triplanar Motion Control™, providing the ability to control foot function in all 3 cardinal planes: Frontal, Transverse and Sagittal.

Green Custom Orthotics
Low Density

Blue Custom Orthotics
Medium Density

Red Custom Orthotics
High Density

¾ Easyfit Orthotic
with lateral cutaway

Metatarsal raise – assists function of the metatarsals 'transverse arch'

1st ray plantarflexor – assists function of the 1st ray, a major stabilising influence on the forefoot

Newly designed high performance top cover

6 degree rearfoot correction to provide biomechanical support and control

Deep heel cup to stabilise the heel position and maximise control

Heat mouldable and customisable with wedges

Sorbon shock dot – designed to dissipate force along the angle of strike

HEAT MOULDABLE

TRI-PLAN3R MOTION CONTROL

Full Length	£24.99
¾ Length	£23.99

canonbury HEALTHCARE
WITH YOU EVERY STEP

FREE Pair of Custom Orthotics
when you book a Vasyli Orthotic product demonstration with your Canonbury Business Development Manager*

01280 706661 | canonbury.com

*One free pair of orthotics per practice.