Volume 19 Number 3 | **March 2016**

PODIATRY NOW

The Society of Chiropodists and Podiatrists

ROUNDTABLE DISCUSSION:

PLANTAR HEEL PAIN

P2: THE HCPC AUDIT

P24: SOCIAL MEDIA: AN INTRODUCTION

P38: SOCIETY AWARDS 2015

Be a HERO in your practice

Don't wait until the next appointment, seek a patient's immediate relief. Formthotics heat mould to the patient's individual shoes and feet and can be **fitted in 15 minutes.**

FREE for osgo members

6 Tests™ for assessment

Learn how to assess your patients for treatment with Formthotics with no equipment using the 6 quick, simple and efficient tests.

ONLINE COURSES at osgo.co.uk

FREE for osgo members

6 Steps™ for fitting

Learn how to select the right Formthotics with the right prescription for your patients.

● save ● grow ● comply

0844 736 2278

www.osgo.co.uk

CONTENTS

PODIATRY NOW: CONTENTS

EDITORIAL

02 – It's come around again! HCPC audit

NEWS

05 – SCP News

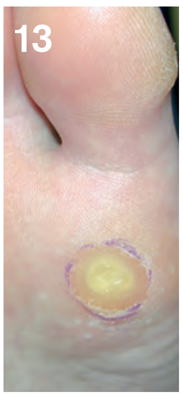
06 – MSc in Podiatry

07 – New graduate rheumatology research internships

09 – Professional practice committee and clinical abbreviations update

CLINICAL

11 – Clinical picture quiz



13 – Tibial sesamoid planing for plantar corns of the 1st MTP joint

FEATURES

18 – **Roundtable discussion:** Plantar heel pain

24 – **Upgrade your digital marketing:** Social Media: An introduction

27 – Delegate Assembly update

REPORTS

34 – One Bridgewater podiatry study day

35 – Review of lower limb pain and its clinical implications symposium

MEMBERS

37 – The Devon branch celebrate members achievements

38 – Society awards 2015

REGULARS

33 – Cosyfeet Competition

42 – Have your say

45 – Courses & Education

52 – Dates for your Diary

55 – Classified Ads

56 – Recruitment

CONTACTS

EDITORIAL CONTRIBUTIONS
podnow@scpod.org

CLASSIFIED ADVERTISEMENTS
classifieds@scpod.org

COURSES
courses@scpod.org

DIARY
diary@scpod.org

SUBSCRIPTIONS
td@scpod.org

ADVERTISING
Alex Monteith
020 7880 7613, alex.monteith@redactive.co.uk

EDITORIAL TEAM
Clare Richards 020 7234 8638, cr@scpod.org
Tina Davies 020 7234 8639, td@scpod.org
Jessica Michael 020 7234 8624, jm@scpod.org

EDITORIAL COMMITTEE
Michael Potter MSc FCPodMed MChS Chair
Matt Collison MChS
Gwen French DPodM FCPodMed MChS
Gary Gibson MChS
Peter Graham BSc(Hons) DPodM MChS
Linda Harris MChS.
Anthony Maher FCPodS
Rory O'Donaghue MChS
Michael Stephenson BSc(Hons) MChS

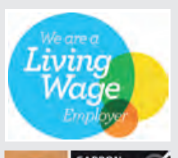
WEBSITE
www.feetforlife.org. Contributions to website@scpod.org

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*

The Editor and Council of the Society of Chiropodists and Podiatrists do not accept responsibility for opinions expressed by contributors to the journal, including advertising. While every effort is made to ensure accuracy, they cannot accept responsibility for any inaccuracies in the information provided. The Editor reserves the right to edit any material submitted for publication.



© Society of Chiropodists and Podiatrists. March 2016

IT'S COME ROUND AGAIN!

HCPC AUDIT

As part of the biannual renewal of our HCPC registration we may be called upon to provide evidence of the previous two years Continuing Professional Development (CPD) in the form of a profile.

LINDA HARRIS
LEAD PODIATRIST, PARTNERSHIP SERVICES, JOHN LEWIS PARTNERSHIP

The first audit of podiatrists took place in July 2008, by the then HPC as it was known, when 650 podiatrists were selected at random. Since 2010, the audit has represented 2.5% of registrants.

In order to be registered with the HCPC there are a number of standards that determine a registrant's 'fitness to practise'. These include character, health, proficiency, conduct, performance, education and training. However, part of the re-registration takes the form of a profession self-declaration for the first five standards; CPD has a number of elements which I will cover in this article.

CPD, according to the HCPC, is a *'range of learning activities through which professionals maintain and develop throughout their career to ensure that they retain their capacity to practise safely, effectively and legally within their evolving scope of practice'.* Put simply, CPD is the way professionals continue to learn and develop throughout their careers so they keep their skills and knowledge up to date and are able to work safely, legally and effectively.

You must, according to the HCPC:

- Maintain a continuous, up-to-date and accurate record of CPD activities.
- Demonstrate that the CPD is a mixture of learning activities relevant to current or future practice.
- Seek to ensure that the CPD has contributed to the quality of your practice and service delivery and benefits the service user.
- Finally, upon request, present a written profile as to how you have met the standards for CPD over the past two years, i.e. 'a snapshot' of your CPD.

CPD can come in various forms. On the HCPC website there are lists of examples, which are divided in to five sub groups:

Work-based learning such as case studies, clinical audit or gaining, and learning from experience.

Professional activities such as being a member of a specialist advisory group or writing an article for a journal (this could be an example for me!).

Formal/educational - the one we automatically think of – attending courses and conferences or participating in online training such as the BMJ e-learning modules - if we live in a remote area and are unable to travel to attend a course.

Self-directed learning, which would involve reading Podiatry Now (which you are doing right now by reading this editorial!) or updating your knowledge through the Internet or TV – no, watching EastEnders doesn't count unless one of the characters has a story line about their IGTN.

Other, which on the website lists voluntary work and public service.

A colleague cited attending the V&A Museum in London as an example of something she would include in her portfolio (she visited the footwear exhibition there last year), and suggested that my London Marathon participation in 2015 could be something I should include. Certainly, when patients attend my clinic and tell me they are planning to participate in such an event I can give first-hand advice about the experience and they are far more responsive when I tell them I completed it without injury or any blisters!

The HCPC states that it requires examples of at least three out of the five sub groups which will help to ensure a variety across the types of learning activities.

The next task is to evidence all this activity. Here, the HCPC has broken the evidence required into three categories:

Materials from others, for example a 'thank you' letter from a patient or a testimonial.

Materials you have produced, such as information leaflets for your patients, a business plan for the practice or training sessions you have given to colleagues or a group (back in the day I used to give talks to post-natal groups about how to care for babies' and young children's feet).

HCPC AIMS AND VISIONS

- Maintain and publish a public register of qualified members of the differing professional groups.
- Approve and uphold high standards of education and training and continuing good practice.
- Investigate complaints and take appropriate action (the one we are all aware of).
- Work in partnership with the public and professional bodies.
- Promote awareness and understanding of the HCPC.

Material showing you have reflected on and evaluated your learning and work. This is where the infamous reflective diary comes into its own or such things as a personal development plan and your thoughts about something you attended.

If selected for audit you will receive notification in May 2016 and will have until end of July to submit your CPD profile (examples are available on both the HCPC & SCP websites). This should include a simple list of CPD activities (Standard one), a summary of recent work/practice (maximum of 500 words) and your personal statement of how the standards have been met (maximum of 1500 words).

The summary should describe your role, the type of work you do and include your main responsibilities. If you have a job description you may use this as the basis, identifying the specialist areas you work in and the people you communicate and work with most. The personal statement should concentrate on how your CPD activities improve the quality of your work and the benefits to service users. You could do this by picking a number of CPD activities (three or four) undertaken in the last two years and explaining what you did, what you learnt, what you did differently as a result of the activity and, finally, who benefited.

The HCPC estimates that the average processing time for profiles will be eight to twelve weeks although it is generally much sooner than that. If you do not send in your profile, a reminder will be sent after two months and if by the end of the registration renewal period you still have not sent in your profile, your name may be removed from the register. If you send in an incomplete profile, it will be returned with a note telling you that it is not complete and what information you need to include, and this must be returned within 28 days.

If your profile does not meet or only partially meets the standards, the Registration Department may write to you with a decision allowing 'further time'. This will be a three-month period in which you can undertake further CPD activities or rewrite your profile in order for it to meet the standards. Alternatively, you may write in with any observations for the CPD assessors to consider within 14 days of receiving notification. If you are unable to provide you profile because you are on maternity leave or seriously ill, for example, you can request a deferral of the process; however, you will be called upon to carry out the process the next time the profession is being re-registered.

To reflect on this process, although it feels relative new to us, we can look to history. During the Crimean War, British medical facilities were criticised and Florence Nightingale introduced nurses to the military hospitals. On arrival at Scutari medical barracks in 1854, Florence found that the unhygienic conditions and high mortality rates meant injured soldiers were seven times more likely to die from diseases such as typhus and cholera in hospital than die on the battlefield.

Within six months she had improved hygiene, enabled the provision of fresh water, fresh fruit and vegetables and standard hospital equipment and reduced the mortality rate in the hospital by 20%. By the end of the war she had written a report that demonstrated positive outcomes from the quality of care.

To quote Florence '*I think one's feelings waste themselves in words; they ought all to be distilled into actions which bring results',* and so CPD was born. ■

THINGS TO REMEMBER

- CPD profiles must be submitted to the HCPC before the end of **July 2016**
- CPD profiles must be completed in full before they are submitted to the HCPC, as incomplete profiles will be returned
- Both personal and patient identifiable information must be removed from all correspondences submission
- Send photocopies of all supporting evidence documentation you submit with your profile as originals will not be returned!
- Both handwritten and typed profiles are acceptable as long as they are legible
- DO NOT enclose your completed CPD profile with your registration renewal form and payment; they must be sent separately
- Contact the HCPC Registration Department **NOW** to update your home address details if they have changed since July 2014

HOW WE CAN HELP

If you are selected for audit and would like some assistance through the process, please notify the College of Podiatry by logging on to the members' website and clicking the 'Contact Us' and tick the 'I've been selected for CPD Audit' box, providing a brief description of your needs in the box provided. We will then contact you within two weeks of receiving your enquiry.

Alternatively, contact the **CPD Officer** on 020 7234 8636 to make an appointment to discuss your concerns. You will be asked for your SCP membership number, contact details and a brief description of your needs or concerns so please ensure you have all of this to hand.

If your NHS Trust, Private Practice Network or Branch has a Union Learning Representative (ULR), they too will be able to give you practical help and support. If you are unsure if you have a ULR to represent you, please contact the ULR team on 020 7234 8645 or at unionlearn@scpod.org

Important Note

It is important to note that although the CPD Officer, a ULR, other colleagues, etc can offer support in producing evidence to satisfy the HCPC, it is the responsibility of the registrant themselves to do the work and record the evidence; CPD is a statutory obligation of SCP membership and integral to the way a professional works and delivers care.

Patients with extra wide or swollen feet?

try **Cosyfeet**®

Recommended by over 11,000 Health Professionals

AS ADVERTISED ON TV

Styles shown: Sandy, Paradise, Heaven, Koryl, Shelley

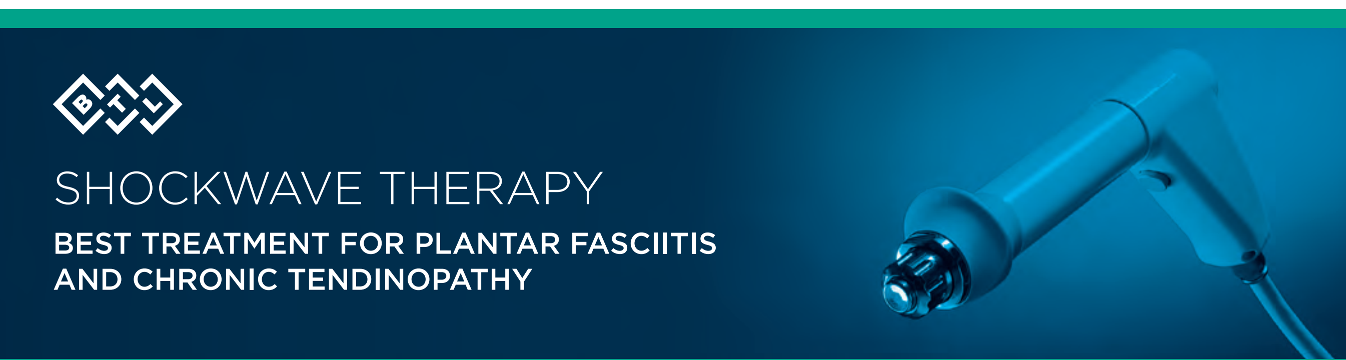
To request copies of the NEW spring catalogue or for other information

Visit: **www.Cosyfeet.com/pn**

Call: **01458 447275**

Celebrating over 30 years of Cosyfeet

NEW Styles & Colours for Spring/Summer



BTL SHOCKWAVE

- Pressure up to 5 bars and frequency up to 20 Hz
- Touch operation – intuitive operation with colour touch screen (5.7")
- Easy-to-use by any therapist – therapeutic encyclopaedia with colour anatomical images
- Ergonomic applicator – designed by users for a comfortable application
- User replaceable cartridges keep it cost effective to maintain

HIGHLY EFFECTIVE PAIN TREATMENT

- Radial extracorporeal shockwave therapy is a non-invasive effective treatment for chronic plantar fasciitis and chronic tendinopathies that can be administered to patients without anesthesia
- Improvement after the first session, over 70% of patients experience significant pain reduction and an increase in function and quality of life after just 3 sessions

TO ARRANGE A FREE SHOCKWAVE THERAPY DEMO IN YOUR CLINIC WITH NO OBLIGATION, CALL **01782561767** OR EMAIL US AT **INFO@BTLMED.CO.UK** FOR DETAILS.

Price starts from **£ 5990**

BTL Medical
Studio 1, Unit 6, Lymedale Enterprise Center, Dalewood Road, Newcastle-Under-Lyme, Staffordshire, ST5 9QH

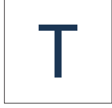
BTL Medical U.K.

BTL Medical

www.btlshockwave.co.uk

NEWS

HCPC WELCOME NEW COUNCIL MEMBER

**he Health and Care Professions Council (HCPC) welcomes new member Maureen Drake to Council. Maureen has over 20 years' experience in health and education settings including working at Coventry University, South Birmingham PCT and Leeds Community Healthcare NHS Trust.**

As well as having worked as a senior lecturer in occupational therapy, she holds an MSc in disability management and vocational rehabilitation, and has an extensive background in leadership and management positions. Currently working in Leeds, she is also a registered occupational therapist, specialising in vocational rehabilitation and neurology.

Elaine Buckley, Council Chair HCPC, commented: '*I am delighted that we have recruited Maureen to the Council and look forward to working with her this year. Maureen's background in health, social care and education alongside her leadership skills and clinical experience will benefit the Council. This is particularly important as we continue working with our stakeholders to ensure all our regulatory processes are fit for purpose.*'

SCP NEWS: OPEN MEETINGS: THE BOARD OF TRUSTEES OF THE COLLEGE OF PODIATRY

Meetings of The Board of Trustees of The College of Podiatry are now open to members of the Society. The next scheduled meeting is at 10.30am on Wednesday, 16 March 2016.

If you would like to attend, please contact the Assistant Company Secretary, Helena Basarab-Horwath, no less than two weeks in advance of the meeting.
Email hb@scpod.org

SCP NEWS: ANNUAL GENERAL MEETING 2016 CALL FOR MEMBERS RESOLUTIONS

The Society invites members to submit Resolutions to be considered at the Annual General Meeting, which will take place at 10.30am on Saturday, 25 June 2016 (venue to be advised shortly).

Resolutions should be sent to the Chief Executive at the Society by close of business on Friday, 8 April 2016. Resolutions may be accompanied by a supporting statement of not more than 500 (five hundred) words in length.

Members who are unable to attend the Annual General Meeting are encouraged to make use of their Proxy Votes. A form for Proxy Votes, along with the AGM agenda, will be sent to all members prior to the Annual General Meeting.

STAFF

CHIEF EXECUTIVE'S OFFICE

CHIEF EXECUTIVE
Joanna Brown
020 7234 8630, jb@scpod.org

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

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

POLICY OFFICER FOR NORTHERN IRELAND
Julie Williams-Nash (part-time)
07813187301, issue.island@btinternet.com

POLICY OFFICER FOR SCOTLAND
Karen Utting (Tue-Fri)
0131 226 3660, ku@scpod.org

POLICY OFFICER FOR WALES
Richard Clark (part-time)
07584 246027, rc@scpod.org

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

COLLEGE OF PODIATRY

DIRECTOR OF EDUCATION & DEVELOPMENT
Dr Wilfred Foxe
020 7234 8628, wf@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 (Mon-Wed) 020 7234 8651, sl@scpod.org

EMPLOYMENT RELATIONS & BUSINESS SERVICES

DIRECTOR OF ER & BUSINESS SERVICES
Brian Harris 07733 111692, bh@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
Arthur Richardson 07768 552462, ar@scpod.org
Steve Morse 07787 421337, sm@scpod.org

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

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

ASSISTANT TO ER & BUSINESS SERVICES
Natasha Smith 020 7234 8633, ns@scpod.org

ULF PROJECT MANAGER
Liz Salem (part time) 07827 838701, liz@scpod.org

ULF PROJECT WORKERS
Karen Reed (part-time)
07909 117743, karen@scpod.org
Anna Lunato 07827 838700, anna@scpod.org
Sandra Edwards (part time)
07827 838699, sandra@scpod.org

ULF PROJECT ADMINISTRATOR
Valerie Matheson (part time)
020 7234 8645, vm@scpod.org

MARKETING & COMMUNICATIONS

DIRECTOR OF COMMUNICATIONS & EDITOR
Clare Richards 020 7234 8638, cr@scpod.org

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

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

M&C ASSISTANT
Tina Davies 020 7234 8639, td@scpod.org

MARKETING & COMMUNICATIONS OFFICER
Jessica Michael 020 7234 8624, jm@scpod.org

FINANCE, ADMIN & MEMBERSHIP

DIRECTOR OF FINANCE & OPERATIONS
Andrew Forrester 020 7234 8623, af@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
Darren Tredgett 020 7234 8620, enq@scpod.org

NEWS

FIRST EVER UK-WIDE SURVEY OF USE OF FOOT ORTHOTICS NOW OPEN

Researchers at the University of Salford are leading the first ever survey into the use of foot orthoses in the UK. The project is being led by Professor Chris Nester and builds on previous work in the EU SMARTPIF project, during which focus groups with NHS clinicians were used to investigate current foot orthotic practices and barriers to technology adoption.

Dr Jane McAdam, Director of Prosthetics & Orthotics and Podiatry at Salford, says *'understanding which professional groups provide foot orthoses, for what patient groups and what types of devices they are using is fundamental to understanding orthotic provision with the UK. However, it is also essential to the definition of meaningful research questions related to clinical practice, and ensuring education and training are well aligned to trends in practice'.* Other areas of interest include scoping the variation between clinicians and professional groups in the use of orthoses, how skills and competencies are maintained, and how research informs orthotic practice.

A Steering group has already been formed to provide multiprofessional and trade representation so that all stakeholders have a voice in the development, implementation and interpretation of the survey.

To contact a member of the team email: **healthcare-NFOSenquiries@salford.ac.uk**

The survey is now open and can be completed at: **www.salford.onlinesurveys.ac.uk/the-national-foot-orthotics-survey-v-3**

MSc IN PODIATRY – A FIRST FOR THE UNIVERSITY OF SALFORD PODIATRY TEAM

The Directorate of Prosthetics & Orthotics and Podiatry, podiatry programme team has achieved a first in the UK. The team has developed an innovative pre-registration Masters programme in podiatry, which has been approved by the Health and Care Professions Council (HCPC) and the College of Podiatry; and is the first to be put in to operation.

Dr Anita Williams led the programme development, internal approval process and approval with the HCPC, and says *'The rationale for this development has been the number of students joining the BSc (Hons) programme who already have a degree or higher degree in related science subjects. These students apply to podiatry to gain the professional qualification in order to register with the HCPC but then add another BSc degree qualification to their CV. The Master's programme allows these students to build on their first honours degree, by developing advanced scholarship and the application of this into practice'.*

In essence, the programme allows students to gain the standards of proficiencies required to obtain HCPC registration, whilst gaining an MSc in Podiatry. Dr Jane McAdam, the Director of Prosthetics & Orthotics and Podiatry, who led the consultation with Heads of NHS Podiatry Services NW, Health Education North West and the College of Podiatry approval process, describes the clear benefits of the Pre-registration MSc podiatry programme:

'The Consultation with heads of NHS podiatry services in the NW revealed that they are supportive of this development. They felt that an MSc qualification together with the professional practice qualification would increase employability of the students and position them better for career development and promotion, potentially in leadership roles. This programme ensures that the University of Salford is providing a unique programme and hence being attractive to potential students from across the UK and the international market'.

The students will be aligned with the Foot Ankle and Knee research group within the School of Health Sciences led by Professor Chris Nester.

The programme received approval in September 2015, just in time for three students to commence their first year. The students attend the same clinics and lectures as the BSc programme, with the M level studies being driven by the assessments and tutorials with Dr Anita Williams who is the programme lead. She says *'... the students have become socially integrated into the larger cohort of BSc students and have formed friendships outside of their small group.'*

Osman Abdulrahman, Sarah Bailey and Tarun Paul have just completed their first semester and all passed their pre-clinical assessment, allowing them to treat patients in the School's podiatry clinic. They are all delighted to be treating patients whilst gaining theoretical knowledge and applying evidence into practice. As Sarah says *'Although I am gaining professional and theoretical knowledge on a daily basis, by reading research and applying this in the clinical context, it is enabling me to challenge and ask pertinent questions'.* Tarun and Osman are relishing the opportunity to assess, diagnose and treat patients so early on in their programme and are looking forward to being involved in research for their third year.

For further information please contact Anita Williams (Programme Leader) **a.e.williams1@salford.ac.uk** or Gilly Mehraban (Admissions Tutor) **g.mehraban@salford.ac.uk**

Above: Pre-registration masters students - Osman Abdulrahman, Sarah Baily and Tarun Paul

ANITA WILLIAMS
POST GRADUATE RESEARCH STUDIES DIRECTOR, SCHOOL OF HEALTH SCIENCE

JANE McADAM
DIRECTOR OF PROSTHETICS & ORTHOTICS AND PODIATRY AT UNIVERSITY OF SALFORD

RECRUITMENT OPENS FOR NEW GRADUATE RHEUMATOLOGY RESEARCH INTERNSHIPS

Recruitment has opened for a new Arthritis Research UK-funded graduate internship programme to help develop the research careers of graduate nurses and allied health professionals (AHPs) in the field of rheumatology.

The governance of the £120,000 programme will be overseen by Dr Catherine Bowen at the University of Southampton, who is joined by colleagues from a network of universities including Leeds, Salford, Oxford, and University of the West of England, Bristol. It aims to identify and introduce outstanding graduate nurses and AHPs to clinical academic careers in rheumatology, for the benefit of people with arthritis and related musculoskeletal conditions.

The internship provides new graduates of podiatry, nursing, occupational health and physiotherapy the opportunity to be a part of leading research into musculoskeletal health, underpinned by principles in health promotion and public health.

It includes an intensive four-day research training programme, eight-week research placement, a final dissemination day and post internship mentoring. Each year group is also encouraged to develop a peer network, which helps form collaborations for future careers. Although unpaid, interns will receive £1,000 towards costs.

Jade Pullen, engagement and education manager at Arthritis Research UK, said: '*We aim to create a trained, effective clinical academic workforce who are able to give people with arthritis the best care and advice to self-manage a range of different musculoskeletal health needs.*

'This is a great opportunity for participants to be exposed at an early stage of their clinical careers to world-leading professors, PhD students and experienced clinical academics. We want to encourage graduate AHPs and nurses to establish their own research skills, feel confident and inspired to work in a rheumatology setting, and join us in ensuring direct patient benefit from this flow of knowledge.'

Twitter: www.twitter.com/arthritisRUK

Facebook: www.facebook.com/arthritisresearchuk

Dr Bowen was involved in setting up the Arthritis Research UK podiatry graduate internships in 2006. Since that time students from the early internships have progressed significantly in their careers, taking on roles such as post-doctoral fellowships, chair positions, and even presidencies including that of the British Health Professionals in Rheumatology.

Building on her experience, Dr Bowen has expanded Southampton's programme, making it multi-professional and multi-institutional. The internships are targeted towards projects that are specific to the promotion of musculoskeletal health and will be closely aligned to the strategic aims of Arthritis Research UK.

Dr Bowen, podiatrist and Health Sciences Associate Professor, said: *'With this grant from Arthritis Research UK we want to attract a new generation of young graduate stars, from the wider health professions, who will be right at the patient interface and be able to translate academic research into clinical practice.'*

Recent intern, Louis Mamode, said: *'The internship provided me with the opportunity to experience first-hand what being a research career would entail. Networking with top researchers within different healthcare professions was an invaluable experience for me. The internship presented different pathways that I had not previously encountered as a career path.'*

Applications close on Friday 11th March 2016 at 5pm.

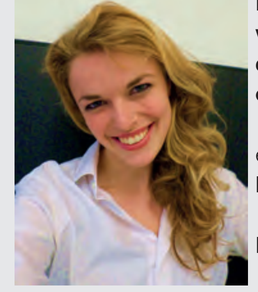
For more information and how to apply please contact Mary Fry (MSc) Programme Co-ordinator M.L.Fry@soton.ac.uk or call 02380 594023.

Interview dates will commence on Thursday 21st April 2016. The scheme will run from 4th July 2016 to 26th August 2016.

For more information about Arthritis Research UK please visit the link below, or the twitter and facebook pages listed in the column.

WWW.ARTHRITISRESEARCHUK.ORG

APPLICATIONS INVITED FOR THE 10TH COSYFEET PODIATRY AWARD



Now in its 10th year, the £1000 Cosyfeet Podiatry Award is open to any podiatrist or podiatry student planning voluntary work, a work placement or research, whether in the UK or abroad. The winner's application should demonstrate that their chosen project will develop their professional knowledge and skills while benefitting others.

Former winners have undertaken a wide range of initiatives including those relating to preventative foot care in the elderly and the podiatric needs of the homeless. Others have travelled to Asia, Africa, South America or Eastern Europe to help with conditions resulting from diseases such as Diabetes and Leprosy.

Sophie Brewer (pictured), Cosyfeet's 2015 winner, used the award to finance her voluntary work with the Life Foundation in Romania.

'Going to Romania, meeting the people and experiencing the reality of social care available there, has been one of the most profound experiences of my life,' says Sophie. *'I highly recommend this placement to anyone seeking a professional and personal challenge.'* The winner will be requested to submit a report and photographs of their experience, and to be included in Cosyfeet publicity relating to the award. If you would like to apply for the award, visit **www.cosyfeet.com/award** for further information and to enter online before the closing date of April 22nd 2016.

NEWS

IF THE SHOE FITS...

ENABLING PATIENT-CENTRED PODIATRY THROUGH SOCIAL SCIENCE METHODOLOGIES

A recent study carried out by Dr Lisa Farndon (Podiatric Development Facilitator at Sheffield Teaching Hospitals NHS Foundation Trust), Dr Vicki Robinson and Dr Emily Nicholls (sociologists from Sheffield University) used a social science approach to investigate the broader contribution of footwear to patients' sense of themselves to get the right 'fit'.

By carrying out interviews with podiatrists and people with foot problems they identified four distinct themes that were barriers when selecting appropriate footwear. These were: practicalities, personal, purpose and pressures. There can be conflict in what podiatrists and the people that they support and treat look for in a shoe, with many service users raising the importance of the visual appearance of footwear and links between footwear, occasion and identity.

These themes were combined to form an online toolkit to support podiatrists when discussing footwear with their patients. It is hoped that this will help to identify and address patients' barriers to making healthier shoe choices enabling more positive, long-term and sustainable footwear changes to be made. For further details of the toolkit please visit the below link:

RECONCEPTUALISING 'FIT'

PRACTICALITIES *(Physical Fit)*	PERSONAL *(Mental Fit)*
▪ Cost ▪ Knowing what to Look For ▪ Challenges of Shoe Shopping	▪ Identity & Wellbeing ▪ Image & 'Look' ▪ Habit & Familiarity
PURPOSE *(Fit for Purpose)*	**PRESSURES (SOCIAL)** *(Social Fit)*
▪ Hobbies & Lifestyle ▪ Special Occasions ▪ Occupation	▪ Friends & Family ▪ Fashion ▪ Social Norms

WWW.SHEFFIELD.AC.UK/PODIATRYTOOLKIT

PROFESSIONAL PRACTICE COMMITTEE AND CLINICAL ABBREVIATIONS UPDATE

Professional Practice Committee Meeting Highlights 8th October 2015

Discussed Practice accreditation scheme and had launch at the Conference in Harrogate.

Approved SCP guidelines for Clinical abbreviations (right) and Child protection policies and updated others, available on the website.

Taken part into HCPC review to be published in Jan 2016.

General terminology

B/F Both Feet
C/O Patient complains of
O/E On examination
R/ Right
L/ Left
ID Interdigital area e.g. ID1/2
GHG General health good
F/ Feet
H Haemorrhage
A/ Apex, e.g. A/2 = apex of 2nd toe

Anatomical Terminology

Ant Anterior
Post Posterior
Superi Superior
Inf Inferior
Med Medial – towards the midline of the body or a structure e.g. the leg
Lat Lateral – away from the midline
Pl Plantar
Dor Dorsal
J Joint
MTPJ Metatarso-phalangeal joint
IPJ Interphalangeal joint
Met Head Metatarsal head
STJt Sub talar joint
Dist Distal
Prox Proximal

Nails

O/H Corn under the nail plate
O/C Onychocryptosis
O/G Onychogryphosis
O/X Onychauxis
O/P Onychophosis
PNA Partial nail avulsion
TNA Total nail avulsion
Sub Ung Subungual

Skin Pathologies

VP Verucca pedis
HD Hard corn
H Mill Seed corn
H Molle Soft corn
H Vasc Vascular corn
HNV Neuro-vascular corn
PP Pressure point
PMA Plantar metatarsal area
CPMA Callus plantar metatarsal area
PD Plantar digital area
CPD Callus plantar digital area e.g. CPD1 of first toe
PCA Plantar calcaneal area
CPCA Callus plantar calcaneal area

PROFESSIONALOFFICER@SCPOD.ORG

Padding

SCF Semi-compressed felt
SR Sponge rubber
FW Fleecy web
PMP Plantar metatarsal pad
Pl Cush Plantar cushion
TG Tube gauze
TF Tube foam
OCP Oval Capacity pad
IDW Interdigital wedge
Cres Crescent cut out

Biomechanical terms

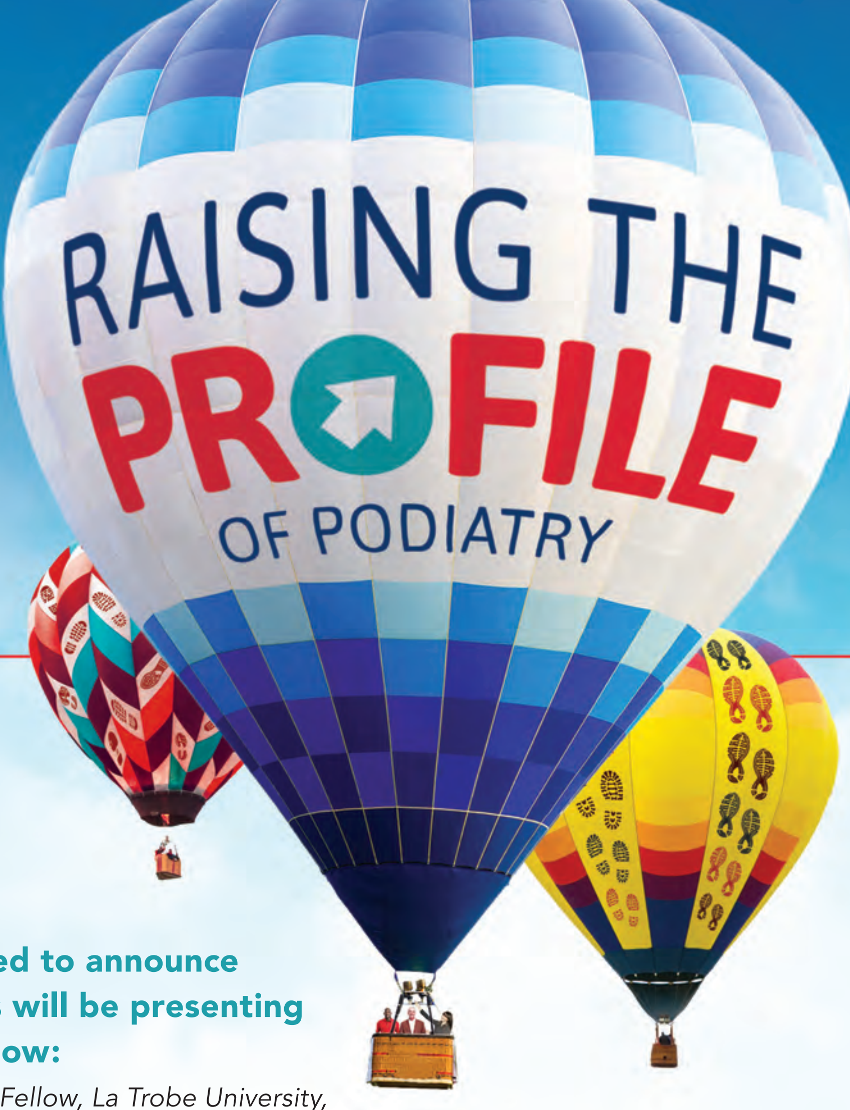
AB Abduction
AD Adduction
IN Inversion
E Eversion
LLd Limb length difference
INT Internal
EXT External
NORM Normal
POSn Position
Var Varum
Val Valgum
RECUv Recurvatum
Tib Tibia
Fib Fibula
MTJ Mid tarsal joint
ROM Range of Motion
QOM Quality of Motion
MLA (ILA) Medial (inner) longitudinal arch
RCSP Relaxed calcaneal stance position
NCSP Neutral calcaneal stance position
Met Metatarsal
Calc Calcaneus
PTTD Posterior tibial tendon dysfunction
AAFF Adult acquired flat foot

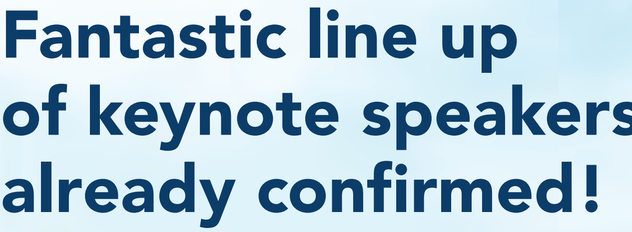
Miscellaneous

HG Hyper-granulation tissue
OA Osteoarthritis
RhA Rheumatoid arthritis
TYPE1 Type 1 diabetes mellitus – insulin dependent
TYPE2 Type 2 diabetes mellitus – medication/insulin dependent
MODY Maturity onset diabetes in the young
HAV Hallux abductovalgus
HL Hallux limitus
HR Hallux rigidus
Appt Appointment
bd Twice a day
BP Blood pressure
CPR Cardio pulmonary resuscitation
CT Scan Computer Tomography
CVA Cerebral Vascular Accident (Stroke)
Dept. Department
DM Diabetes Mellitus
DNA Did Not Attend
DOB Date of Birth
DVT Deep Vein Thrombosis
ECG Electro Cardio Graph
EEG Electro Encephalo Graph
Fracture
FV Failed Visit
FTA Failed to Attend
SR Self Referral
PTC Patient to Contact
Hep Hepatitis
HIV Human Immunodeficiency Virus
Hx History of
IV Intravenous
MI Myocardial Infarction
MRSA Methicillin-resistant *Staphylococcus aureus*
MRI Magnetic Resonance Imaging
N/A Not applicable
NAD No abnormality detected
od Once daily
OPD Out Patient Department
POP Plaster of Paris
PR Per rectum
PRN As required
Px Prescribed
qds 4 times per day
RTA Road Traffic Accident
RTI Road Traffic Incident
Rx Treatment
SC or
Sub Cut. Sub cutaneous
tds Three times daily
Temp Temperature
Yr Year

Professions

A+E Accident and Emergency
CPN Community Psychiatric Nurse
DN District Nurse
FCA Foot Care Assistant
GP General Practitioner
HV Health Visitor
HCA Health Care Assistant
OOH Out of Hours service
OT Occupational Therapist
PA Podiatry Assistant
Physio Physiotherapist
PN Practice Nurse
SALT Speech and Language Therapist
SHN School Health Nurse
SN Staff Nurse
SR Sister
SS Social Services
SW Social Worker





SECC GLASGOW

17-19 NOVEMBER 2016

Fantastic line up of keynote speakers already confirmed!

The Conference Committee are delighted to announce that the following high profile speakers will be presenting at the 2016 Annual Conference in Glasgow:

- **Professor Hylton Menz,** *NHMRC Senior Research Fellow, La Trobe University, Melbourne, Australia*
- **Professor Keith Harding CBE,** *Head of Wound Healing Unit, Cardiff University*
- **Dr Ed Roddy,** *Clinical Senior Lecturer in Rheumatology and Honorary Consultant Rheumatologist, Keele University*
- **John Lees,** *Business Speaker, Vionic Group*
- **Professor Josh Burns,** *Professor of Paediatric Neuromuscular Rehabilitation, University of Sydney*
- **Dr Brian Kennon,** *Consultant Diabetologist, Southern General Hospital, Glasgow*
- **Dr Chris Bower,** *Consultant Dermatologist, Royal Devon and Exeter NHS Foundation Trust*
- **Dr Mike Arden-Jones,** *Associate Professor, Dermatologist, University of Southampton*
- **Dr Matthew Young,** *Consultant Diabetologist, Royal Infirmary of Edinburgh*
- **Stephen Hartman,** *President, Canadian Federation of Podiatric Medicine*
- **Professor Mark Tagoe,** *Consultant Podiatric Surgeon, West Middlesex University Hospital*
- **Dr Cathy Bowen,** *Associate Professor, University of Southampton*
- **Professor Tony Redmond,** *Head of Clinical Biomechanics and Physical Medicine, NIHR Leeds Musculoskeletal Biomedical Research Unit and Leeds Institute of Rheumatic and Musculoskeletal Medicine*

Call for Papers

Don't miss the opportunity to join the stage and present your work alongside renowned industry speakers to the largest audience of podiatrists in the UK. Submissions of scientific research, case studies or general practice for oral or poster presentation are welcomed from all areas of podiatric practice.

Papers will be anonymously peer reviewed and prizes will be awarded for the best oral and best poster. The highest scoring paper will have the prestige of being presented on the main stage.

SUBMISSION DEADLINES: Oral presentations – **24 April 2016** Poster presentations – **4 September 2016**

For further information and submission guidelines please visit **www.podiatryconference.org**, call **+44(0)20 3725 5840** or email **cop@profileproductions.co.uk**

Principal sponsor:

CLINICAL PICTURE QUIZ

FOREFOOT AMPUTATION

QUESTIONS

1. What is this skin condition?
2. Where does this condition usually present?
3. What are some of the pathogenic factors?
4. What are some of the differential diagnoses for this condition?

NATALIE TANG
PODIATRIST, SINGAPORE GENERAL HOSPITAL

Answers and further discussion can be found overleaf.

For further information on this topic please contact the author via the email address below.

If you would like to submit a picture quiz please email podnow@scpod.org with your photograph, questions, answers and discussion.

NATALIE.TANG.Z.M@SGH.COM.SG

ANSWERS

1. What is this skin condition?

Verrucous hyperplasia.

2. Where does this condition usually present?

At the distal portion of an amputation stump.

3. What are some of the pathogenic factors?

- Poor prosthetic fit
- Frictional and shearing forces
- Poor hygiene
- Impaired lymphatic outflow

4. What are some of the differential diagnoses for this condition?

- Verruca vulgaris
- Verrucous carcinoma
- Chromoblastomycosis
- Tuberculosis verrucosa cutis

DISCUSSION

Verrucous hyperplasia is a skin condition that typically occurs over amputation sites in patients with diabetes and neuropathy, presenting as a wart-like thickening of the skin at the distal portion of an amputation stump. It can become fissured, macerated and produce malodorous exudate. It is sometimes also known as lymphostatic or stasis papillomatosis.

Whilst the condition has not been well documented in the literature, various factors have been thought to contribute to the pathogenesis of verrucous hyperplasia. These include friction, poor prosthetic fit and alignment, impaired lymphatic flow, poor hygiene and bacterial infection.[1] These factors cause an increase of pressure at the proximal stump over the distal stump, leading to a poor pressure gradient, resulting in oedema and the development of verrucous hyperplasia.[2]

The diagnosis of verrucous hyperplasia can be confirmed through histopathology and some differential diagnoses include verruca vulgaris, verrucous carcinoma and chromoblastomycosis.[3]

The treatment for verrucous hyperplasia mainly involves external compression, reduction of shearing forces, good hygiene and oral or topical antibiotics to control any bacterial infection if present.[4]

REFERENCES

1. Scheinfeld N, Yu T, Lee J. Verrucous hyperplasia of the great toe: A case and a review of the literature. *Dermatol Surg* 2004; 30: 215-217.

2. Levy SW. Skin problems of the leg amputee. *Prosthet Orthot Int* 1980; 4: 37–44.

3. Dhawan AK, Grover C, Bisherwal K, Arora VK, Tomar R. Verrucous hyperplasia of amputation stump. *Indian J Dermatopathol Diagn Dermatol* 2015; 2: 23-24.

4. Meulenbelt HE, Geertzen JH, Dijkstra PU, Jonkman MF. Skin problems in lower limb amputees: An overview by case reports. *J Eur Acad Dermatol Venereol* 2007; 21: 147-155.

TIBIAL SESAMOID PLANING FOR PLANTAR CORNS OF THE 1st MTP JOINT

Level of Evidence
Level IV. Case series

Keywords
corns, keratosis,
tibial sesamoid,
planing

Figure 1. Sub-tibial sesamoid intractable plantar keratosis

This study is a retrospective audit of the tibial sesamoid planing procedure in patients who presented with long-standing painful corns that had been present for at least seven years and had not responded to conservative care.

Intractable plantar keratosis under the tibial sesamoid is a common and often chronic complaint that may be only partially relieved by conservative treatment.

Surgical excision of the sesamoid carries significant risk of neuritis-type symptoms under the first metatarsal head, iatrogenic hallux valgus and transfer of pressure to the fibular sesamoid. Partially reducing the bulk of the sesamoid may however reduce risk of these complications, maintain sesamoid function and reduce the tendency for overloading and keratosis.

The study is a retrospective audit of the tibial sesamoid planing procedure in patients who presented with long-standing painful corns under the tibial sesamoid that had been present for at least seven years and had not responded to conservative care. Between May 1996 and September 2009, 46 patients underwent tibial sesamoid planing. Fourteen patients were available for review (nine females and five males). The mean follow up period was 55 months (range, 11-121).

At final review, recurrence of some level of keratosis occurred in three cases (21%), 93% of the study participants were however completely satisfied with the outcome of tibial sesamoid planing, 7% were satisfied with reservations. No participant was dissatisfied. All participants stated they would undergo surgery again in the same circumstances.

Tibial sesamoid planing is a moderately effective treatment for painful plantar keratosis under the tibial sesamoid which, apart from failure to resolve pain or keratosis, carries minimal risk.

E KANNEGIETER FCPoDS MSc & TE KILMARTIN FCPoDS PhD
DEPARTMENT OF PODIATRIC SURGERY, ILKESTON HOSPITAL, UNIVERSITY OF ULSTER, DEPARTMENT OF PODIATRY, SCHOOL OF HEALTH SCIENCES

INTRODUCTION

Corns and callus on the plantar surface of the foot are a significant cause of pain and activity restriction.[1] Patterns of callus formation are well

documented and can be conveniently divided into lesions affecting the central three metatarsals and lesions affecting the plantar surface of the 1st and 5th metatarsals. While conservative care including debridement, padding, and orthotic insoles may palliate and sometimes improve or resolve the complaint, surgery can also be considered in an attempt to cure the problem. Plantar keratosis unresponsive to conservative treatment is however a challenge to the foot surgeon. The evidence base for surgical outcomes is limited and those studies that have been conducted indicate disappointing results with a relatively high incidence of complications.

Finney et al[2] in a study of a dorsiflexory distal metatarsal osteotomy (Schwartz) for the treatment of plantar keratosis under the 3rd or 4th metatarsophalangeal (MTP) joint found that, in 27 cases, complete resolution was achieved in 44%, with complete recurrence in 24% and transfer of the lesion to an adjacent metatarsal head in 30%. Floating toes also occurred in 20% of participants. Gibbard & Kilmartin reviewed 33 cases who underwent a single Weil osteotomy of either the 2nd, 3rd or 4th metatarsal for the treatment of a painful plantar corn.[3] Prior to surgery, 97% required regular callus debridement. Final review was performed at an average 42 months post op. At review, 27% of the corns remained, with 56% still requiring regular callus debridement. Transfer metatarsalgia developed in 12% (four feet). Three cases required a Weil or Schwartz osteotomy of the adjacent metatarsal where the lesion had transferred. Revision surgery was performed on 21% of the group (seven feet) because of lesion recurrence. Revision was successful in three cases. Floating toes occurred in 36% though in no case did this cause patient dissatisfaction.

Lesions under the central three metatarsals may be related to a short first metatarsal, leading to transfer of weight to the 2nd metatarsal head, long 2nd, 3rd, 4th metatarsals or dorsally elevated 1st and 5th metatarsals.[1] Lesions of the 1st metatarsal may be related to hypertrophy of the tibial sesamoid, which can be associated with multipartite sesamoid as it increases the volume of the osseous structure. Rigid plantarflexed first ray commonly associated with pes cavus due to uncompensated forefoot valgus may also present with isolated lesions under the tibial sesamoid, though in such cases the callus will often be more diffuse covering the entire surface of the first MTP joint.[1] Lesions under the 5th metatarsal head may be related to Tailor's bunion or plantarflexed 5th ray, again related to a cavoid foot type with partially compensated rearfoot varus and forefoot valgus. In a study of rotation scarf osteotomy for the treatment of Tailor's bunion, Maher and Kilmartin reported that, in a series of 28 patients, 44% (12 patients) underwent surgery for the treatment of painful plantar keratosis under the 5th metatarsal head.[4] Unfortunately the keratosis recurred in seven patients and was symptomatic in five (41% of the keratosis subset).

Clearly the outcome of surgery to lesions under the central three metatarsals and the 5th metatarsal is disappointing with a high risk of complication. Is it possible that outcomes could be better with lesions under the tibial sesamoid where the bulk of the sesamoid can be reduced, relieving weight bearing on that particularly discreet area?

The sesamoid bones of the first MTP joint are embedded in the tendons of flexor hallucis brevis (FHB). They protect the flexor hallucis longus (FHL) tendon during push-off and increase the fulcrum of the FHB to increase its mechanical advantage across the first MTP joint. The sesamoids transmit about 50% of body weight during standing and this increases to 300% during push off phase of gait.[5] Significantly, the inter-sesamoidal plane is not horizontal but is inclined medially, which places the tibial sesamoid more plantar than the fibular sesamoid.[5] More weight is applied through the tibial sesamoid, which may explain why it is frequently a cause of pathology.

Patients presenting with a sub-tibial sesamoid keratoses (Figure 1), complain of unrelenting pain over a period of many years, often accompanied by swelling plantar to the tibial sesamoid. The patient may report the feeling of walking on a marble. They may also alter their gait with lateral offloading and the inability to push off through the 1st ray. Supinating the foot in this manner may lead to overload of the 5th ray and the development of a Tailor's bunion and or keratosis under the 5th metatarsal head. It is certainly our experience that lesions sub 1 and 5 MPT joint commonly co-exist.

The literature is sparse on the surgical treatment of painful plantar keratosis of the tibial sesamoid. Graham et al,[6] in their study of tibial sesamoid planing in 23 cases, reported complete resolution of the painful keratosis in 20 cases. Mann and Wapner reported on tibial sesamoid shaving in 14 cases, 16 feet.[7] Ten patients were available for review and outcomes were rated as excellent in five cases. In four patients there was recurrence of the callus but nevertheless their outcome was rated as good. One patient continued to require conservative debridement of the callus and rated their outcome as fair. No complications or iatrogenic problems were recorded.

In the following study we describe the approach taken for tibial sesamoid planing, and review the effectiveness of sesamoid planing in a small group of patients. Because the development of secondary problems is such an issue in the surgical management of plantar keratosis elsewhere in the foot, special attention was given to recording any adverse outcomes.

We also reviewed the study participants' smoking habits at the time of surgery and at the final review. It is our observation that tobacco smoking may be a contributory factor in painful plantar keratosis. Smoking is known to have a deleterious effect on the quality of skin through changes in cutaneous blood flow, collagen and elastin content,[8] It will reduce skin elasticity and collagen deposition, which may reduce the resilience of the skin on the plantar surface of the foot to the physical forces that can induce keratosis formation.

PATIENTS AND METHODS

The senior author's surgical database was searched for patients who underwent tibial sesamoid planing

> “”
>
> ***PATIENTS PRESENTING WITH A SUB-TIBIAL SESAMOID KERATOSES COMPLAIN OF UNRELENTING PAIN FOR MANY YEARS, OFTEN WITH SWELLING PLANTAR TO TIBIAL SESAMOID***

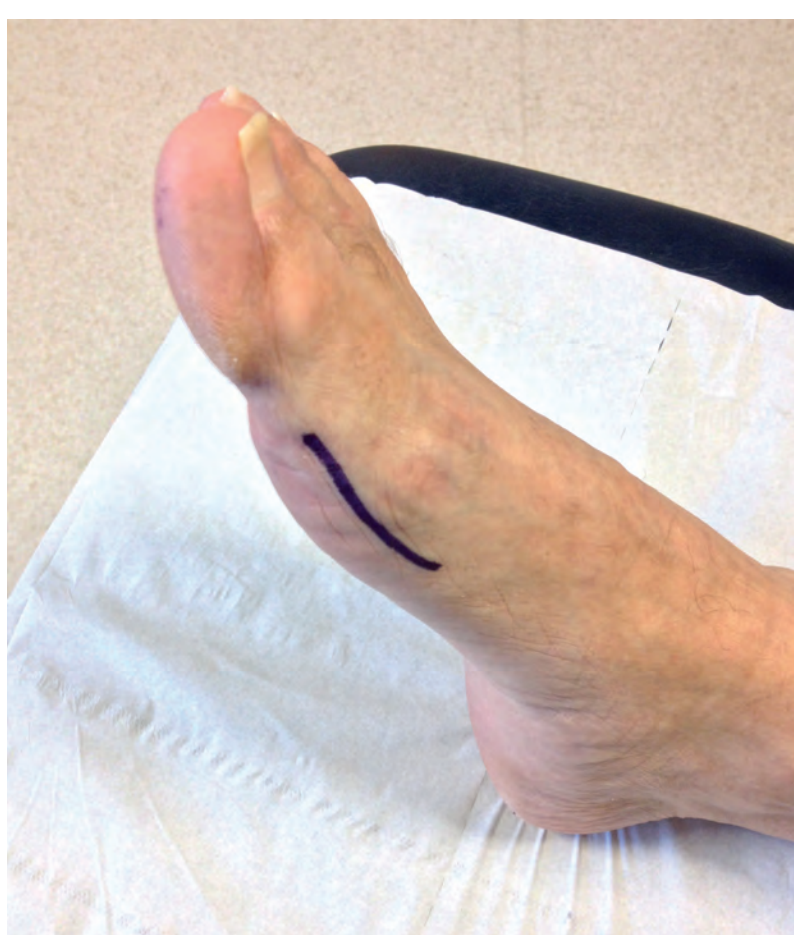


Figure 2. Incision line planing

between 1996 and 2009. A total of 45 patients were identified. At the time of follow up, 16 patients had their notes destroyed and were therefore lost to follow up. The remaining 29 were invited to return for review of which 14 attended.

Of the 14 participants reviewed, nine were female. The average age at the time of surgery was 56.5 years old (range 32-86; S.D. 16.9). Follow-up was at an average of 55 months (4.5 years) following surgery (range 11-121; S.D. 38.7). The audit included radiograph assessment measuring the pre-operative first to second inter-metatarsal angle and the position of the tibial sesamoid relative to the first metatarsal head. This evaluation sought to establish any link between first-second inter-metatarsal angle and keratosis formation. The audit also included assessment of the range of motion of the 1st MTP joint, record of adjunctive procedures, presence of transfer lesions or pain, keratosis recurrence, and the incidence of hallux valgus development post-operatively.

American Orthopaedic Foot and Ankle Score (AOFAS) scores taken during the audit appointment with the lead author, were compared to the available pre-operative scores. Patient-focused questions provided insight into the reason for surgery and which conservative measures had previously been tried and failed.

Surgical Technique

A 5cm medial longitudinal incision was made, just inferior to the midline of the first metatarsal head and superior to the medial plantar nerve (Figure 2). Dissecting through the deeper layers, the medial plantar nerve was reflected and protected. The FHB tendon and joint capsule was identified and incised longitudinally exposing the tibial sesamoid. **A 12mm wide sagittal saw blade was used to resect 50% of the height or bulk of the sesamoid (Figure 3)** excising the plantar portion, while protecting the FHL tendon. The FHL integrity was inspected following excision of the fragment. Deep layers were closed with a 2-0 absorbable vicryl suture with special attention paid to securing the flexor brevis tightly so the effect on its function could be minimised by preserving its lever arm on the hallux. The skin was closed with single interrupted 4-0 prolene sutures. The foot was dressed with a silicone dressing to the skin, gauze and bandage; this was changed and reduced at one week and removed along with sutures at two weeks post op.

All data collected were analysed using Microsoft Excel™ software. The small scale of the study prevented estimation of statistical significance.

RESULTS

The mean time from tibial sesamoid planing to final review was 55 months (range 11-121).

Prior to surgery, all participants complained of pain from a painful keratosis under the tibial sesamoid. The history of painful symptoms ranged from seven to 40 years (mean 15.4 years). Treatment received prior to surgery included callus debridement (n=11, 78%), ranging from weekly debridement to a maximum length of six weeks between treatments, and 71% received insoles to cushion and deflect pressure from the area. One participant underwent a single cortisone injection for associated pain and swelling around the tibial sesamoid, and all participants self-treated at home to relieve their symptoms by reducing the bulk of the callus over the area.

All participants reported avoiding loading through the 1st ray in gait and all 14 cases complained of failure of conservative care to adequately relieve their symptoms. Two participants had undergone previous surgery to the 1st ray for hallux valgus, in one case this was a fusion and the other a Scarf osteotomy. One participant had a family history of keratosis in an identical location. Pre-operatively 13 participants (93% of the group) expected surgery to provide a sustainable improvement of their pain symptoms, while one participant expected complete cure of their symptoms.

A total of 36% of participants (5/14) underwent adjunctive surgery, all undergoing 5th metatarsal procedures. Four participants underwent a 5th metatarsal Scarf osteotomy and one case a 5th metatarsal plantar condylectomy.

Post-operatively there was no evidence of transfer lesions, although one participant did describe the presence of transfer pain to the 2-4th MTP joint area. Three cases (21%) had some degree of symptomatic recurrence of their keratosis but two no longer sought conservative treatment. One participant who stated that he was satisfied with reservations with the outcome of surgery noted recurrence of the lesion within 6 months of surgery, and he required continued debridement of the keratosis in the area.

Four participants (29%) said that they were aware of stiffness in the 1st MTP joint (one had a previous

PUBLICATION SECTION

1st MTP joint fusion), although all were pain free. The total mean range of motion of the 1st MTP joint measured with a digital goniometer was 56.5 degrees. No participants developed hallux valgus as a consequence of planing the tibial sesamoid. Radiographic review highlighted four (29%) cases that presented with a bipartite tibial sesamoid prior to surgery. Prior to surgery, the mean first to second intermetatarsal angle was 10 degrees (7-18 degrees), indicating a range of metatarsus primus adductus from normal to severely increased. The position of the medial edge of the tibial sesamoid was measured from the medial side of the first metatarsal head and was found to be on average 3.6mm, laterally displaced prior to surgery. There is no obvious correlation between first-second intermetatarsal angle and keratosis under the tibial sesamoid. X-rays were not routinely taken post-operatively following tibial sesamoid planing but we would recommend radiographic assessment pre-operatively in order to assess for multipartite sesamoid, which will have implications for surgical technique.

The pre-operative mean AOFAS was 47 (n=3, range 45-52) and post-operative score was 85 (n=14, range 68-95). All 14 participants stated they would undergo the same surgery again under the same circumstances. Thirteen participants were completely satisfied with the results of their surgery and one case was satisfied with reservations. All participants stated their foot had improved as a result of the surgery.

In our pre-operative assessment we noted that ten cases (71% of participants) stated they had been smokers at some point prior to their surgery, six (67%) were smokers at the time of surgery and continued to smoke at the time of review. Of the three participants who complained of some recurrence of their keratosis, all were previous smokers and two were active smokers. The one participant who was satisfied with reservations smoked 20 cigarettes a day and had done so since his late teens and was now aged 58.

DISCUSSION

Chronic pain from plantar keratosis and dissatisfaction with the outcome of conservative treatment will often drive patients into seeking surgical treatment. Lesser metatarsal osteotomy that seeks to elevate or shorten a metatarsal would appear to be a logical approach to reduce loading over discreet areas of the plantar forefoot and hence reduce callus formation, but the outcomes of surgery of the 2nd to 5th metatarsals is disappointing with a high incidence of the development of secondary problems. This would suggest that our understanding of plantar keratosis formation is due for re-consideration. Lesions under the first MTP joint are however different in that they may form directly over the tibial sesamoid, which is a discrete ossicle that lies on a level inferior to the adjacent fibular sesamoid.[5] Reduction of the bulk of the tibial sesamoid may deflect pressure more equally across both sesamoids.

Complete excision of the tibial sesamoid may have a significant effect on 1st MTP joint function. The sesamoids allow the first metatarsal to remain in contact with the ground as the heel lifts and the foot supinates ready for propulsion.[9] Removal of the tibial sesamoid will transfer load to the adjacent fibular sesamoid or 2nd metatarsal head, leaving the foot at risk of transfer metatarsalgia. Detachment of the FHB with excision of the sesamoid may also have the effect of reducing the ability of FHB to restrain hyperextension of the hallux proximal phalanx as the FHL contracts at its insertion in the distal phalanx, causing the interphalangeal joint to flex.[10] Even if meticulous dissection prevents detachment of the medial head of FHB, the lever arm of the tendon will be reduced with removal of the sesamoid.[11,12,13]

Possibly the most significant complication however is the development of iatrogenic hallux valgus. Saxena described the results of 26 tibial or fibular sesamoidectomies in 20 patients.[14] There was a 19% complication rate, with two cases of iatrogenic hallux valgus and one hallux varus and two cases of neuroma-type symptoms on the plantar metatarsal head area. With removal of either sesamoid, muscle equilibrium around the first MTP joint is lost, with detachment or reduction of the lever arm of either the abductor or adductor hallucis tendon. With excision of the tibial sesamoid, the adductor hallucis will begin to dominate and pull the hallux into valgus. With excision of the fibular sesamoid, function of adductor hallucis is compromised and the hallux can slip into hallux varus. However Lee et al performed isolated tibial sesamoidectomy in 32 patients. Twenty one percent of patients had transfer metatarsalgia or plantar cutaneous neuritis but no cases of hallux valgus.[15] These inherent risks and potential need for further surgery are to be

Figure 3. Removing 50% plantar portion of the tibial sesamoid

TIBIAL SESAMOID PLANING IS A STRAIGHT FORWARD, MODERATELY EFFECTIVE AND SAFE PROCEDURE FOR TIBIAL SESAMOID PAIN DUE TO INTRACTABLE PLANTAR KERATOSIS

considered when planning full excision of the sesamoid. However Tagoe et al reported on total sesamoid excision for the treatment of hallux rigidus in 27 feet, where no metatarsalgia or iatrogenic deformity was reported at 2-4 year follow up.[16]

Certainly the findings of this study suggest that removing the plantar 50% of the tibial sesamoid is moderately effective in treating plantar keratosis in this area whilst minimising the risk of hallux valgus or transfer metatarsalgia and avoiding detachment of the FHB.

One cause of concern however is the risk of damaging the blood supply to the sesamoid. Pretterklieber described the patterns of vascular supply to the sesamoid and found that arterial supply was derived from the plantar arch and medial plantar artery. In all cases, the blood supply entered via the proximal pole of the sesamoid.[17] Sesamoid planing could effectively eradicate this supply. However, we have never encountered avascular necrosis of the sesamoid and nor are there any cases described in the literature reviewed. Damage to the medial plantar nerve is also a potential risk that may lead to neuritis, though it was not encountered in this series.

We believe this often intractable problem is more likely after complete sesamoid excision when there is no sesamoid fragment left to prevent the first metatarsal head compressing the medial plantar nerve against the weightbearing surface. This hypothesis does, however, require further comparative review of sesamoid planing versus complete excision.

At an average of 55 months following surgery, the results of the study suggest tibial sesamoid planing is a moderately effective procedure for treating intractable sub-tibial sesamoid keratosis. This is supported by all 14 participants stating they were better off as a result of their surgery - 13 patients were completely satisfied, and one was satisfied with reservations. No participants reported being dissatisfied with their outcome. Though not completely successful, these are much better outcomes than those reported for keratosis under the 2nd to 5th metatarsals and are helpful for informing patient expectations. However, tibial sesamoid planing is far from a panacea for this complaint, as simply reducing the bony bulk of the sesamoid will not reverse the dermatological changes associated with the complaint or address the abnormal position or function of the first ray, which may explain the 21% failure rate in this case series.

All 14 participants in this study received conservative care prior to surgery, with 78% having a minimum of nine podiatry appointments a year for conservative callus debridement. A total of 71% of the study group also had insoles provided, although all patients still required self-treatment, highlighting a need to review the timeliness of referring for surgical intervention in these cases. All patients had suffered with pain from the intractable corn for at least seven years prior to undergoing surgery. The cost of years of conservative care, the pain suffered and the restriction of activities must now surely warrant earlier consideration of surgery in such cases of sub-tibial sesamoid keratosis.

The possible link between smoking and plantar callus formation is worthy of further investigation but will require a large epidemiological study to confirm the link. Our observation of a high incidence of smoking in this group of participants has led us to advise candidates for tibial sesamoid planing to consider smoking cessation on the basis of our observation that recurrence of the painful keratosis appeared to be more common in smokers.

The major limitation of this study is the number of cases lost to follow up (32 patients, 69%) leaving only a small group of 14 cases available for review. This is however the greatest disadvantage of long follow up periods. In this study the mean follow up period was 4.5 years. Shorter follow up may provide greater number of participants for review but unfortunately will reduce the validity and strength of any findings.

CONCLUSION

Tibial sesamoid planing is a straightforward, moderately effective and safe procedure for tibial sesamoid pain due to intractable plantar keratosis. Results from this study are encouraging; range of motion is maintained at the 1st MTP joint, iatrogenic hallux valgus did not develop in any case, and a high long-term AOFAS score (85/100) was achieved at on average 55 month follow up. High levels of patient satisfaction were reported, with 93% completely satisfied and 7% satisfied with reservations; none were dissatisfied. In this series there was a 21% recurrence rate of the plantar keratosis under the tibial sesamoid area. ■

REFERENCES

1. Mann, R A, Mann J A, Keratotic disorders of the plantar skin. In Mann, R A, and Coughlin, M J (Eds) *Surgery of the Foot and Ankle.* Saltzman CL. St Louis, Mosby, 2007: pp. 465-470.
2. Finney SJ, Kilmartin TE. Flintham C. The modified Schwartz procedure in the management of intractable plantar keratoses: a retrospective review. *The Foot* 2003; 13: 108-111.
3. Gibbard KW, Kilmartin TE. The Weil osteotomy for the treatment of painful plantar keratoses. *The Foot* 2003; 13:199-203.
4. Maher AJ. Kilmartin TE. Scarf osteotomy for correction of Tailor's bunion: Mid to long term follow up with a rotation scarf osteotomy. *Foot Ankle Int* 2010; 31(8): 676-682.
5. Tan J, Lau JTC. Metatarso-sesamoid osteoarthritis as a cause of pain after first metatarsalphalangeal joint fusion: case report. *Foot Ankle Int* 2011; 32: 822-825.
6. Graham RB, Baldwin E, Bailey P. Tibial sesamoid planing. *British Journal of Podiatric Medicine and Surgery* 1992; 4(3): 2-3.
7. Mann RA, Wapner KL. Tibial sesamoid shaving for treatment of intractable plantar keratosis. *Foot Ankle* 1992; 13: 196-198.
6. Smith JB, Elston DM. Cutaneous Manifestations of Smoking. www.emedicine.medscape.com/article/1075039-overview#aw2aab6b3
7. Root M, Orien W, Weed JH. Observations of the foot during gait. In *Normal and Abnormal Function of the Foot.* pp131-143 Clinical Biomechanics Corporation. Los Angeles, 1977
8. Kadakia AR, Molloy A. Current concepts review: Traumatic disorders of the first metatarsophalangeal joint and sesamoid complex. *Foot Ankle Int* 2011; 32: 834-839.
9. Kaiman ME, Picora R. Tibial sesamoidectomy a review of the literature and retrospective study. *J Foot Surgery* 1983; 22: 286-289.
10. Mann RA. Sesamoidectomy of the great toe. *Orthop Trans* 1985; 9: 62-63.
11. Fabeck LG, Zekhini C, Farrokh D. Traumatic hallux valgus following rupture of the medial collateral ligament of the first metatarsophalangeal joint. A case report *J. Foot Ankle Surgery* 2002; 41: 125-128.
12. Saxena A, Krisdakumtorn. Return to activity after sesamoidectomy in athlectically active individuals. *Foot Ankle Int* 2003; 24: 415-419.
13. Lee S, Janes WC, Cohen BE. Evaluation of hallux alignment and functional outcome after isolated tibial sesamoidectomy. *Foot Ankle Int* 2005; 26: 803-809.
14. Tagoe M, Brown HA, Rees SM. Total sesamoidectomy for painful hallux rigidus: a medium term outcome study. *Foot Ankle Int* 2009; 30: 640-646.
15. Pretterklieber M, Wanivenhaus A. The arterial supply of the bones of the hallux. *Foot Ankle* 1992; 13: 135-140.
16. Tagoe M, Brown HA, Rees SM. Total sesamoidectomy for painful hallux rigidus: a medium term outcome study. *Foot Ankle Int* 2009; 30: 640-646.
17. Pretterklieber M, Wanivenhaus A. The arterial supply of the bones of the hallux. *Foot Ankle* 1992; 13: 135-140.

KILMARTIN@FOOTSURGERYSERVICES.COM

ROUNDTABLE DISCUSSION: PLANTAR HEEL PAIN

In a new regular discussion series for *Podiatry Now*, we bring together a group of leading podiatrists to discuss common and sometimes challenging conditions that will be familiar to all practising podiatrists. We pose a series of questions to the panel and their responses provide a valuable insight into the current knowledge base. In the first of these series, our experts share their knowledge on the clinical assessment and management of plantar heel pain.

Is the term plantar fasciitis still relevant?

TP. Given that histology has demonstrated degeneration rather than inflammation, there is a move away from the term fasciitis to fasciosis. In my opinion, plantar heel pain or plantar heel pain syndrome would be a better term prior to confirmation of the underlying pathology as this tends to be a spectrum of conditions rather than a specific condition.

KR. The term plantar fasciitis is used frequently in the clinical and research setting. However, the term chronic plantar heel pain, heel spur and plantar fasciosis have also been reported. The lack of inflammatory markers adds further to the argument that chronic plantar heel pain should be used instead of plantar fasciitis, because the suffix 'itis' denotes an underlying inflammatory process.

EC. Whilst recent trends have favoured the umbrella term plantar fasciopathy to encompass both acute and chronic stages of the condition, plantar fasciitis and plantar fasciosis fall under this umbrella so the answer would be 'yes', plantar fasciitis is still a relevant clinical term as it is a description of the (albeit possibly fleeting) inflammatory stages or elements of mechanical origin plantar fasciopathy. If in doubt… plantar heel pain is a better term to begin with until a firm involvement of the plantar fascia has been confirmed with sensitive imaging / clinical tests.

NP. No, as it is largely not an inflammatory condition, as the term would imply, better terminology would be plantar fasciopathy, in the same way as Achilles tendonitis was dropped for Achilles tendinopathy.

What are the features of plantar heel pain you see routinely in clinic?

TP. History, as always, is a large proportion of the diagnosis with the classic features of early morning and first step pain, with symptoms easing on activity only to get worse with continued load.

Although the question relates to plantar heel pain, I will also assess along the course of the fascia with both palpation and passive stretch. Interestingly and anecdotally in my clinics, I find far fewer patients are symptomatic on passive stretch. It is rare for it to be asymptomatic on palpation. I will also make an assessment of the degree of fat pad present. The key is pain on palpation of the plantar heel in concert with a good history.

KR. Clinical palpation and previous and current history give an indication of the commonly described features. Clinically, the condition is quite easily recognised by site of pain and first step pain, which contrasts with the uncertainty surrounding risk factors, underlying pathology or cause and the best course of treatment.

EC. By far the most common complaint is what we term 'rest-to-rise pain' or pain (often with a high pain score) that is experienced upon weight-bearing after prolonged rest. This is typically first thing in the morning when the person gets out of bed and puts their foot to the floor but can be after a period of sitting such as standing up after a meal. Rest-to-rise pain quickly dissipates after a few steps of walking but can return insidiously throughout the day if standing or walking forms part of the daily activity.

Due to the sheer number of possible diagnoses associated with plantar heel pain – and the varying prognoses among them – it is vital to take a detailed history of symptomatology including onset, duration, pattern, progression, severity at best and worst, characteristics (pain is a term used for anything from deep bone pain to neuralgia and inflammation and everything in-between!), location of pain and any radiation.

NP. The classical clinical features of plantar fasciopathy include:

1. Worst pain is weight bearing first thing in the morning after waking up.
2. Same pain also experienced after a variable period of non-weight bearing or rest. Initial pain reduces with activity.
3. Pain during the day, i.e. walking and standing, may vary, i.e. dull ache or discomfort.
4. There is no obvious swelling, paraesthesia, numbness, colour or temperature change.
5. The worst pain is classically at the site of medial plantar fascia attachment to the medial calcaneus tubercle (Figure.1).

Is assessment of foot posture or function relevant and if so what associations do you look for?

TP. This is an area of big debate at present. There is definitely evidence to indicate that our traditional postural assessments have poor scientific basis with a move towards relieving stress to the tissue (tissue stress theory). However, the underlying structure is a component I assess combined with the degree of mobility of the foot. Combining this assessment with a dynamic assessment then helps me to

FASCILITATED BY ANTHONY MAHER
PODIATRIC SURGEON AT NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST

TREVOR PRIOR, BSc(Hons), FCPods
CONSULTANT PODIATRIC SURGEON, HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST

PROFESSOR KEITH ROME, PhD, MSc, BSc(Hons) FPodM
CO-DIRECTOR, AUCKLAND UNIVERSITY OF TECHNOLOGY, HEALTH AND REHABILITATION RESEARCH CENTRE

EMMA COWLEY, BSc(Hons) MSc
LECTURER IN PODIATRY AT PLYMOUTH UNIVERSITY

DR NAT PADHIAR, MSc PhD FCPodS
CONSULTANT PODIATRIC SURGEON & HONORARY SENIOR LECTURER, QMUL

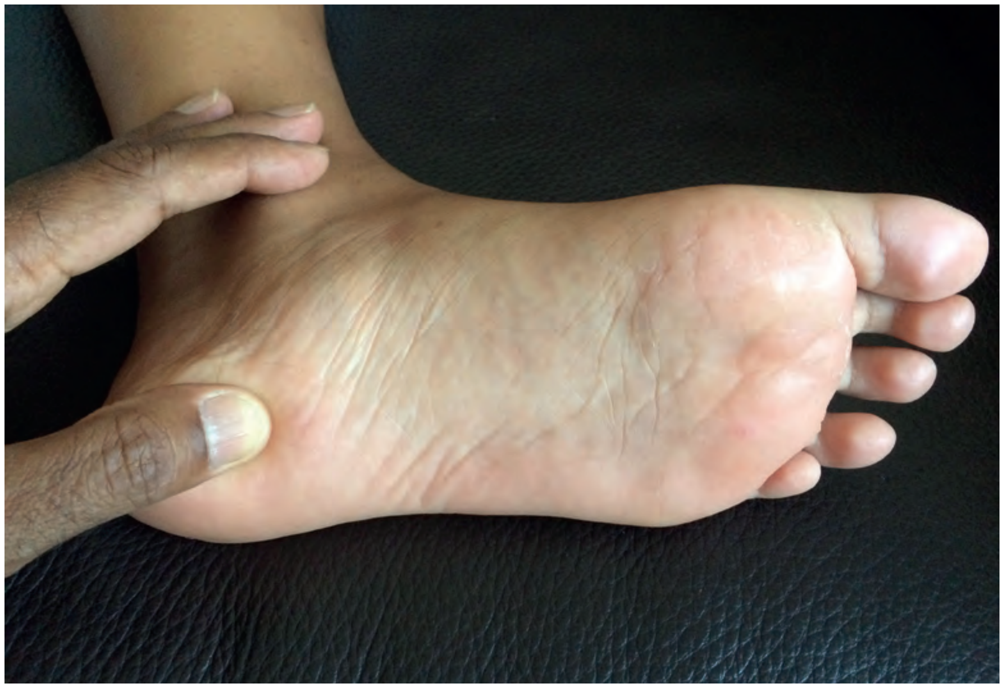


Figure 1. The worst pain is classically at the site of medial plantar fascia attachment to the medial calcaneus tubercle

determine if there are factors proximal to the foot that may be causing increased load through the fascia.

KR. A wide range of physical factors and functional characteristics of the ankle, foot and lower limb have been evaluated in terms of their relationship to chronic plantar heel pain. Ankle and foot posture, notably excessive foot pronation, is often clinically regarded as a related impairment, though it is difficult to find definitive evidence for foot posture impairments in plantar heel pain. Ankle range of motion is routinely examined in clinical evaluation of a patient with plantar heel pain. From a clinical perspective, the limiting factor to dorsiflexion could influence the impairment-based treatment techniques that are selected (e.g. ankle joint manipulation or soleus versus gastrocnemius muscle stretches). Tightness of the hamstring muscles has also been associated with plantar heel pain.

EC. Foot posture is often a helpful tool in podiatric evaluation. If the plantar fascia had ruptured it is likely that a sudden but negligible lowering of the medial longitudinal arch might be detectable clinically using the navicular height test[1] or even the foot posture index (FPI-6) tool.[2]

A change in foot posture, however, can be found in many different foot conditions and is not sensitive or specific for diagnosing any particular clinical condition. Like all clinical tests where a lack of sensitivity and specificity is frequently the case, finding agreement in numerous partly sensitive and specific tests can lead to agreement in findings and a more confident clinical impression.

NP. Yes, but this should not simply be focused on the foot as the aetiology of plantar fasciopathy is multi-factorial and poorly understood. Assessment of both historical and clinical factors is vital in order to identify aetiological and pre-disposing factors.

Risk factors for the development of plantar fasciopathy are just as important. Some of the common factors are listed below:

- Obesity or, a sudden gain in body weight, e.g. pregnancy.
- Increase in physical activity, such as walking and running.
- Increase in intensity of physical activity.
- Change in surface, e.g. training on AstroTurf and playing on grass.
- Poor shock absorbing footwear. High heeled shoes.
- Occupation that involves prolonged walking or standing, e.g. military personnel.
- Sedentary lifestyle.

Lower-limb biomechanical and functional factors may contribute to plantar fasciopathy and are as follows:

- Factors that may affect the 'windlass mechanism'.
- Excessive pronation.
- Pes cavus.
- Leg-length discrepancy.
- Reduced ankle joint dorsiflexion, e.g. ankle equinus.
- Tightness or inflexibility in the calf muscle and Achilles tendon; plantar fascia is continuation of these structures.

When assessing plantar heel pain what conditions are on your differential diagnosis short list?

TP. This falls into two camps; factors that commonly occur with plantar heel pain syndrome and specific differential diagnoses. The factors I see occurring with plantar heel pain syndrome include:

- Thickening of the fascia with or without intra-substance high signal.
- Fascial tear.
- Fat pad oedema.
- Intrinsic muscle oedema / fatty infiltration.
- Bone oedema.
- Calcaneal spur – whilst I have included this, I rarely place much weight on the presence of a spur.

In terms of a more general differential diagnosis, the more common factors would be: plantar fibroma, Referred neural component (local nerve entrapment, tarsal tunnel syndrome, spinal) or stress fracture. Of course, there are a whole range of conditions that can be considered which include inflammatory, metabolic and infectious and should be considered based on the history and response to intervention.

KR. A diagnosis of plantar fasciitis is frequently made on clinical signs and symptoms. The list of conditions is exhaustive, but clinicians should be aware of the main conditions. Goff and Crawford[3] wrote an excellent article relating to the diagnosis and treatment of plantar fasciitis. The authors stated that neurological conditions may include: medial calcaneal nerve entrapment, neuropathies, tarsal tunnel syndrome. Skeletal conditions include: Acute calcaneal fracture, calcaneal apophysitis/ Sever's disease, calcaneal stress fracture, calcaneal tumour, inflammatory arthritis that includes rheumatoid arthritis, Reiter syndrome, and psoriatic arthritis. Soft-tissue conditions may include: Achilles tendinitis, heel contusion, plantar fascia rupture, posterior tibial tendinitis, and retrocalcaneal bursitis.

EC. Differential diagnoses for plantar heel pain are many! Since pain reporting is often vague the catalogue of conditions under consideration at the commencement of assessment is broad and can only be reduced following elimination based on their hallmark and unique characteristics. But I do keep in mind that not many hens have teeth and to go looking for them is a long and usually unnecessary search.

My first port of call in any assessment for a patient is to identify any red flags that require immediate medical

intervention. As such I will always begin by questioning my patients and looking for signs of infection, deep bone pain (especially night-time and progressive), bleeding (not a frequent finding in the podiatry MSK clinic thankfully) and ischaemia and spinal symptoms such as loss of bladder or bowel control (thankfully rare and I have yet to see a cauda equina syndrome on my watch). Some of the conditions I may have in mind to rule out include bone conditions such as stress fracture, unicameral or other (malignant or benign) type of cyst or tumour, fat-pad atrophy or fat-pad contusion, Baxter's nerve entrapment, heel spurs, spondyloarthropathy, tarsal tunnel syndrome, insertional Achilles tendinosis (with or without deep retrocalcaneal bursopathy), tear or rupture of the plantar fascia, sural nerve trauma, tibialis posterior tendinopathy, referred pain from a radiculopathy (L5/S1 spinal nerve root tethering / entrapment / compression / trauma), foreign body, superficial lesion, e.g. VP, peripheral neuropathy, and local nerve trauma (post-surgical or traumatic) to name but a few.

NP. Systemic conditions need to be considered when patients present with bilateral heel pain or have recalcitrant plantar fasciopathy not responsive to treatment or the history is not quite classical for plantar fasciopathy. History taking becomes very important. Consider Paget's disease, Reiter's syndrome, rheumatoid arthritis, Systemic lupus erythematosus, ankylosing spondylitis and, generally, seronegative arthrotides. Differential diagnoses local to the foot include:

- Plantar fascia tear.
- Stress fracture of the calcaneum.
- Fat-pad contusion/atrophy.
- Bursitis.
- Medial calcaneal nerve entrapment.
- Tarsal tunnel syndrome.

Is there a role for diagnostic imaging in the investigation of plantar heel pain?

TP. In my opinion, MRI is the investigation of choice. Whilst an ultrasound scan is quick and cost effective, it is not sensitive enough to identify the range of pathology that may be present. I will consider an MRI scan in patients who have had a long-standing problem or are proving resistant to standard interventions.

KR. There is a role for diagnostic imaging but it must be used in conjunction with a clinical examination and current-history for a clinical diagnosis. Ultrasonography and MRI are not commonly required to make the diagnosis, though in recalcitrant cases it would be prudent to undertake such examinations in order to rule out other likely causes of the symptoms. The presence of calcaneal spurs visible on X-ray are sometimes the focus of attention by patients and clinicians, though their relationship to plantar fasciitis or stress of the fascia has been recently questioned. The ultrasound for diagnosis of soft-tissue problems has been commonly reported.

EC. Without a doubt diagnostic imaging is useful in diagnosing some conditions presenting with plantar heel pain. It is important to note that the Ottawa Rules apply to imaging involving exposure to ionising radiation (plain film X-ray, fluoroscopy and CT for example) and do not indicate X-ray imaging for heel pain in acute presentations where trauma is the primary history. In chronic presentations such as plantar heel pain, where a history of continuous and progressing deep bone pain was taken, ruling out a tumour with X-ray plain films may be justified.

Ultrasound scanning can enable measurement of the thickness of the plantar fascia associated with fibroblast activity and production of ground substance in chronic healing of degenerative tissue, as well as identifying loss of integrity (rupture). The risks with use of ultrasound by inexperienced and improperly trained clinicians, however, are false positives and negatives. For this reason, it is important to undertake CASE accredited ultrasound scan training and maintain a portfolio of regular imaging opportunities to ensure ultrasound scanning is a real benefit your clinical assessment.

NP. Yes. I use an ultrasound scan on a regular basis to assess the thickness of the plantar fascia, any obvious erosion at the enthesis, presence of neo-vascularity and any other obvious bone pathology. Presence of calcaneal spur, in my opinion, does not always cause plantar fascia pain. Literature suggests a plain X-ray to rule out the presence of any primary or secondary tumours.

Are blood tests relevant to the diagnosis or management of heel pain?

TP. I request blood tests much less frequently and tend to consider these only if I feel there are factors within the history and examination that may indicate one of the differential diagnoses (i.e. inflammatory, metabolic, infection etc).

KR. Unless a clinician suspects an inflammatory arthritic condition, such as rheumatoid arthritis, spondyloarthropathies or an infection, then blood tests are not essential. If suspecting an inflammatory arthritic condition, then a full blood count (anaemia can cause pain due to poor vascular supply) and ESR (as marker of inflammation) is required.

EC. A resounding yes… some of the time! If I was seeing a person presenting with bilateral heel pain and, on further examination, noted psoriatic skin plaques or sacroiliac joint dysfunction pain I would request an ESR for inflammation, HLA-B27 to rule out, possibly a serum urate test if I suspected gout.

NP. Yes, but not as a routine. There has to be either an element of suspicion, failed treatment or the history simply does not fit the mechanical nature of plantar fasciopathy.

What is your typical treatment regime for mechanical plantar heel pain?

TP. I have some standard interventions that I use for most cases which include: footwear advice – good fitting laced shoes with some cushioning of the sole if possible; modified low-dye taping; calf stretches; local ice massage; and orthoses. I tend to start with pre-formed (off-the-shelf) orthoses in the first instance depending upon foot type. I use custom orthoses where indicated for the more chronic resistant cases. Night splints – this is a consideration, particularly for early morning pain, although a number of patients cannot sleep properly with night splints. In these cases, I try to educate them to introduce these on a lower tension over a few nights. My next stage would be to consider further investigation with a view to injection therapy or extracorporeal shock wave therapy (ESWT). Other emerging interventions are a form of eccentric strengthening / stretching regime and platelet-rich plasma injections but I feel further evidence is required.

KR. There is no typical regime for plantar fasciitis. Heel pain is a substantial topic and one in which there is an extensive amount of research. General medical management of this condition tends to have three levels. First self-treatments, such as activity modification (including complete rest if required), ice, oral analgesics and stretching are trialled. If there is no change over several weeks then the second level of interventions would include physical therapy, foot orthoses, night-splinting and steroid injections. There is an expectation that 90% of patients would respond to these, but should the pain be recalcitrant after six or more months, then the third level would involve ESWT or plantar fasciotomy. It would seem that

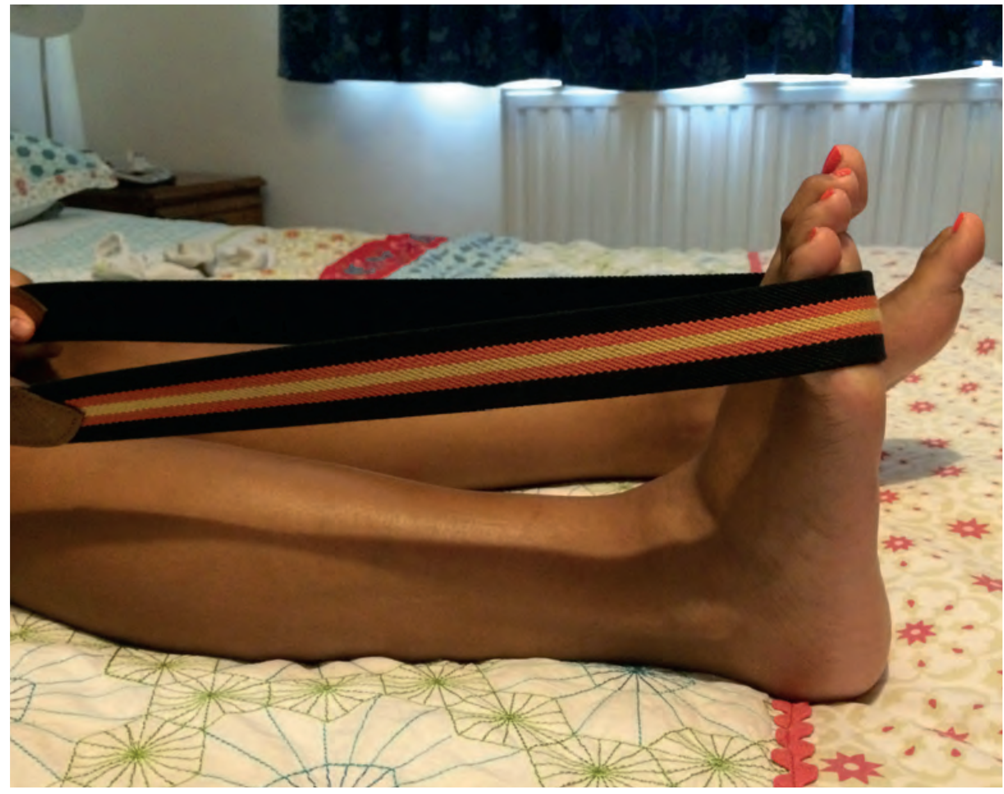


Figure 2. Patients should perform calf stretches in the bed before they get up and also during the day.

orthoses (custom made or prefabricated) have most evidence in support of a likely beneficial effect. Corticosteroid injections are commonly prescribed in general practice and the use of ultrasound-guided injections has been increasingly advocated.

EC. Treatment evolves from the assessment; without a sound assessment the treatment will be a case of trying something and hoping for the best. You should always have a rationale for the objectives of any therapy otherwise you don't know what you are trying to change and if you managed it – did it work?

I don't 'treat patients' I work with people, and there is a difference. It means engagement with and ownership of the problem on both sides. Trust, education (me and them) and rapport is gained and a contract, however loose, to do our bit is fostered. I hate paternalistic medical models – dignity in care always.

Often, the triceps and Achilles are implicated since we are a nation of stiff and short posterior muscles and the Achilles load transmits directly to plantar fascia strain.[4] Diabetes, ankle sprain history, age and smoking are among the factors that will stiffen the foot and ankle collagen and so if I don't think a simple eccentric heel drop programme will cut it, I'll add some deep friction work as necessary. I will maybe start intrinsic strengthening as well as offering passive support with orthoses or taping, etc.

NP. I use the 'hypothetical functional model' as part of my assessment but more so for treatment. Biomechanical factors are addressed with foot orthoses, usually 'off-the-shelf' products, but sometimes customised orthoses. Sometimes I also use an ankle brace that has 'air cell' technology in the heel area to provide better ankle control and reduce the stress through the heel during gait. In addition, patients should also perform calf stretches in the bed before they get up (Figure 2) and also during the day.

Does your treatment differ for acute or chronic plantar heel pain?

TP. Not particularly other than perhaps considering NSAIDs in the acute stage. I like to ensure that patients have followed a structured plan as, all too often, they have tried one thing, then another, etc. In my experience, they need to be very disciplined. I may investigate or advance to further treatments more quickly in chronic cases and would be hopeful of an increased likelihood of a quick response in the more acute cases but it is rare for me to see acute cases.

KR. In general, the longer the duration of symptoms, the longer it takes for the patient to obtain complete pain relief. Various modalities of treatment are available, and patient education is important to improve the understanding of the condition and to obtain compliance with various treatment regimens. The important aims of the treatment are to limit impact stresses on the heel, to alleviate inflammation, and to stretch the triceps surae muscle. If the pain persists for longer than two months then the following modalities could be considered: casting, corticosteroids, low-level laser therapy and ESWT. However, the evidence base is limited.

EC. If less than three months duration has passed since the onset of pain or clinically detectable changes I will assume an inflammatory component caused by tissue damage and apply (most of) a POLICE based regimen: Protection, Optimal Loading, Ice, Compression and Elevation.

If mechanical force is causing the inflammation as a result of tissue damage, I would reduce this with modification of activity, taping and or footwear / orthoses addressing any pathomechanics in the foot. Having protected the plantar fascia from further damage and, finding the Goldilocks zone of applied optimal loading to encourage healthy healing, I can now seek to reduce residual symptoms associated with inflammatory metabolites by applying local cooling compression if oedema is present and just a little elevation when resting to reduce blood pressure in the heel without bringing on ischaemic pain or neural tension.

If the condition is chronic and non-inflammatory (confirmed clinically by poor responses to oral NSAIDs or corticosteroid injection usually performed by the GP prior to seeing me), I would consider inducing an acute inflammation with deep friction massage (needling will also work but penetrates skin so I prefer the former) to accelerate healing. Once healing has moved into the proliferation stages (identified by the absence of inflammatory signs and symptoms) I can begin a graded approach to reloading the fascia in accordance with the EdUReP model.

NP. Yes. In acute cases where there is an obvious limp and the patient is struggling to walk, the patient is usually immobilised in a walking boot for two weeks after which they are treated in the same way as above.

Extra Corporeal Shock Wave Therapy (ESWT) is an emerging treatment for plantar heel pain, particularly in the private sector. Is there a place for this type of treatment in the NHS?

TP. In my opinion, this is one of the single most useful adjunctive treatments that has emerged over recent years. Despite a lack of firm understanding of

the mechanism of action, there is good evidence in terms of symptom relief. I have had consistently good responses with this treatment and it is a service we offer in our NHS service. NHS patients often pass from pillar to post and having defined management pathways can help to reduce the number of consultations and unnecessary delay for the patient.

One must consider that the standard treatment is once per week for three weeks and then review at 12 weeks. If this is provided in conjunction with the other management options, this takes the patient four months further down the management pathway and may be a contributing benefit to the beneficial outcome. However, this is an almost risk free treatment and I would have no hesitation having this treatment myself for this condition.

KR. The effectiveness of ESWT in the treatment of plantar fasciitis is controversial. Cost is always an important component. However, one of the issues has been that it is likely that there will be different levels of clinical efficacy with different dosing regimens. A recent clinical trial reported the clinically relevant effect size of focused ESWT without local anaesthesia in the treatment of recalcitrant plantar fasciitis, with success rates between 50% and 65%.[5]

EC. Yes, especially if there is a high number of refractory plantar fasciopathy cases. Increasingly, however, I am hearing of this being introduced as a first-line therapy given that machines are cheaper and more portable now. ESWT is a NICE recommended (National Institute for Health and Clinical Excellence - IPG 311, 2009) intervention for plantar fasciopathy although as a secondary intervention following failure of conservative intervention for three months.

To me, the trouble is that if the underlying mechanics have not been addressed the problem may return and the patient could end up with repeated doses of shockwave therapy and ongoing fascial degeneration as long-term recurrence is as high as 55% following ESWT.[6]

NP. ESWT is an effective and safe modality for the treatment of plantar fasciopathy. There is however a lack of real evidence to support the fact that it is better than other conventional treatment modalities utilised for this common problem. Yes it should be available in the NHS.

What are your thoughts on the role surgery may play in managing plantar heel pain?

TP. I feel this remains controversial. There are several levels at which surgery can be considered. Topaz is a form of electrical needling of the fascia and, whilst not strictly surgery, requires anaesthetic and sterile precautions. It is popular in the US but less so in this country.

Despite some reports of plantar fascia release (either open or endoscopic) providing high levels of success, the results still appear to be mixed generally. There are some more recent reports of better outcomes with release of the fascia, debridement of any spur and drilling of the subchondral bone but, in my opinion, further evidence is required before this becomes more common place.

As a rule, surgery is not required for this condition and, in my opinion, should be reserved for the most chronic unresponsive cases as the risk of failure remains relatively high. There is a lack of level 1 evidence to provide support for regular surgical intervention although this could be argued for many of our interventions.

KR. Surgery is always the last resort and should only be considered when all conservative strategies have been exhausted and are usually reserved for those with persistent pain of over six months duration, which have failed conservative management.

EC. I have never referred a patient for a fasciotomy possibly because I got lucky with my self-limiting patients, possibly because my clinical reasoning and therapeutic armoury has been sufficient so far. As a last resort fasciotomy can be performed although outcomes vary and the option is not usually popular due to the recovery time and general anaesthetic risk. Furthermore, the procedure has variable pain outcomes, with some reporting total pain relief, others reporting partial relief and still others reporting an increase in pain. The division of the plantar fascia seems rather therapeutically-dubious with these outcomes but also because function of the foot is intrinsically linked to an intact fascia. The remaining structures supporting the arch will have to withstand full bodyweight in the absence of the fascia and may become painful over time if activity levels and bodyweight increase.

NP. Surgery, as is the case with a lot of other recalcitrant conditions that do not respond to conservative non-surgical treatments, has a part to play in plantar fasciopathy. ■

“ ”

THERE IS NO TYPICAL REGIME FOR PLANTAR FASCIITIS. HEEL PAIN IS A SUBSTANTIAL TOPIC AND ONE IN WHICH THERE IS AN EXTENSIVE AMOUNT OF RESEARCH.

- PROFESSOR KEITH ROME

REFERENCES

1. Vinicombe, A, Raspovic, A and Menz, H B. Reliability of navicular displacement measurement as a clinical indicator of foot posture. *J Am Podiatr Med Assoc* 2001; 91(5): 262–268, [online] Available from: http://www.ncbi.nlm.nih.gov/pubmed/11359892.
2. Redmond, A. The Foot Posture Index: Easy quantification of standing foot posture. *Six item version USER GUIDE AND MANUAL*, 1998: 1–19.
3. Goff JD, Crawford R. Diagnosis and treatment of plantar fasciitis. *Am Fam Physician* 2011; 84: 676-682.
4. Cheung, JT and Zhang, M. Effect of Achilles tendon loading on plantar fascia tension in the standing foot. *Clin Biomech* 2006; 21: 194–203.
5. Gollwitzer H, Saxena A, DiDomenico LA et al. Clinically relevant effectiveness of focused extracorporeal shock wave therapy in the treatment of chronic plantar fasciitis: a randomized, controlled multicentre study. *J Bone Joint Surg Am* 2015; 97: 701-708.
6. Wang, C, Wang, F and Yang, K D. Long-term results of extracorporeal shockwave treatment for plantar fasciitis. *Am J Sports Med* 2006; 34(4): 592–596.

PART 3
SOCIAL MEDIA: AN INTRODUCTION

Social media is now a huge part of modern culture, and as a result many businesses including medical practices have jumped on board. For some it has been a complete waste of time (largely because they did not understand how to use it) but for others it has opened up a whole new channel of communication with potential and existing patients, referrers, suppliers and local community contacts.

What is it?

Social Media is pretty much what it says on the tin. A media channel through which to be social. In other words a digital communication tool. There are hundreds of social media platforms all operating in slightly different ways.

On most of them you can:

- Connect with people and organisations
- Share your ideas and knowledge
- Have fun
- Grow your network
- Build relationships
- Sell your services
- Promote events
- Help people
- Build your reputation
- Ask questions and do market research
- Listen and learn from others
- Link to your website and digital content

JILL WOODS

Jill is an ex-podiatrist, published author, and marketing enthusiast. She now has her own business helping health professionals to market their practices.

I could go on, but I'm hoping you get the idea that it isn't just a bunch of teenagers talking about what they had for breakfast. Social media is far more powerful than that if you know how to use it.

How does it work?

The functionality of all of the different platforms is too big to cover in this small column, but I want you to understand how it works from a marketing perspective. With marketing now being largely about building relationships and drawing people to you, social media fits perfectly. By sharing content from your website, answering questions etc. you can build your reputation and relationships, but don't think of it as a funnel for new patients. Remember, more efficient marketing comes from connecting with people who already have the eyes and ears of your ideal patients, not connecting one at a time with potential patients, so look for connections with referrers, clubs, associations, sheltered accommodation etc.

A bit about the main ones

Firstly they are all free to use (some have premium paid options), BUT they will suck up your time (which is costly) if you let them.

Twitter – is a micro blogging tool. It helps you find, connect and communicate with people and organisations. You can build relationships, have conversations, share valuable material, ask questions and have fun all in bursts of 140 characters or less.

Facebook – is a more complex social platform. You can still find and connect with people, have conversations, share information and generally reach out to the world. But you can do this using much bigger blocks of text, videos & images. You can find specific groups of people and set up events and private groups.

Linkedin – is a more formal platform, often used for job seeking and building professional networks. You can connect with people, set up private groups, share your content (serious and fun) and grow your network and your credibility.

Instagram – is based entirely around uploading, editing and sharing images or videos with associated text. It's grown in popularity massively recently appealing to organisations with visual stories to tell.

Which one to use

For social media to be effective you have to use it, so primarily use the platform you enjoy using. Secondly you need to know which platform the people you want to connect with are using the most. If the two are the same – BINGO. If not you have a decision to make as I recommend you choose one to start with, get proficient at using it before you start with a second one.

Next time we are going to be looking at how you use social media to grow your reputation and your reach. ■

Got a question? Get in touch via my website ***www.jillwoods.com*** *or via* ***@JillBWoods*** *on Twitter*

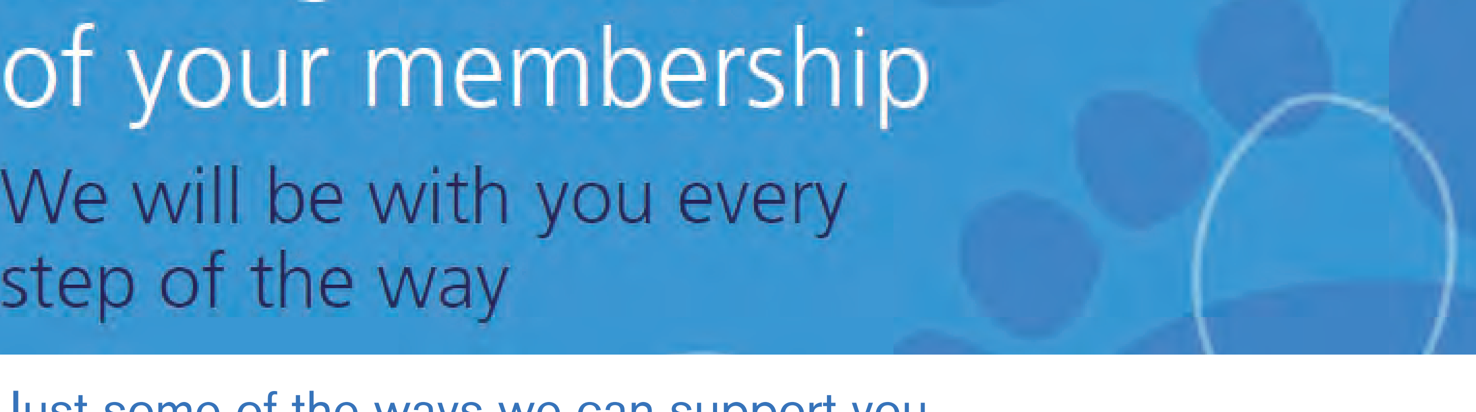
WANTED

CASE STUDIES

Would you like to submit a case study to ***Podiatry Now*** to share with other members? We are interested in all subjects including dermatology, diabetes, rheumatology and surgery.

Please contact Tina Davies on podnow@scpod.org

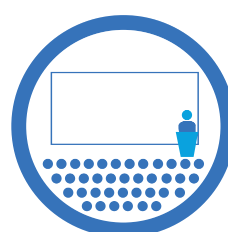
PODIATRYNOW



Making the most of your membership

We will be with you every step of the way

Just some of the ways we can support you



Keeping you at the top of your game

Lifelong learning and CPD are pivotal to the development of all podiatrists. The Society has been instrumental in providing you with the tools to stay up to date.

Numerous online CPD learning courses ▪ Comprehensive best practice documents ▪ Network of union learning representatives ▪ Nationwide branch network of podiatrists ▪ Full library of resources on our members-only website ▪ News bulletins delivered straight to your email and through social media channels ▪ Clinical articles and news in Podiatry Now ▪ The largest annual podiatry conference and exhibition in Europe: www.podiatryconference.org

Promoting the profession and campaigning on behalf of members

Keeping podiatry on the political agenda and influencing Government is one of the Society's highest priorities: we lobby for the better provision and standards of podiatric services and campaign for better employment conditions for all our members.

Promotion of podiatry through extensive PR campaigns, such as Feet for Life Month and Fair Pay Fortnight ▪ Representation at the Department of Health, the NHS Staff Council, the NHS Pay Review Body, NHS Social Partnership Forum within England, Scotland, Wales and Northern Ireland ▪ Regular contact with the HCPC on registration and professional issues ▪ Representation in Europe and internationally through Federation of International Podiatrists (FIP) and the European Federation of Public Sector Unions (EPSU) ▪ Influencing the European Parliament through the TUC and EPSU ▪ Successful campaigning for independent prescribing for podiatrists ▪ Engaging with other Allied Health Professions to promote the profession.

Keeping you updated throughout your career

We are committed to promoting high standards of education and development to keep you clinically up to date.

CPD courses run by both the Society and local branches ▪ Student and new graduate support ▪ Links with affiliated organisations and special interest groups covering every aspect of podiatry ▪ Continual research and development projects in many areas of podiatry ▪ Regular postgraduate education meetings and courses ▪ Access to Fellowship programmes leading to advanced practice, including podiatric surgery ▪ Access to a range of learning resources through the Society's Union Learning Fund ▪ Over 100 speakers at the College of Podiatry annual conference ▪ 50% discount on e-learning modules via the Society website ▪ Education quality assurance ▪ Regular CPD in Podiatry Now, and peer-review articles in the Journal of Foot and Ankle Research (JFAR).

Marketing and supporting our members

Whichever area of podiatry you work in, promoting yourself is important on a personal and business level. The Society has as a range of resources designed specifically to help you.

Network of 50 Society branches: great for local support and networking ▪ Courses and conferences: keeping you updated on latest thinking and trends ▪ The private practice handbook: the bible on running your podiatry business ▪ Support throughout your working life: we are here to advise you what ever your query ▪ Free "Find a Podiatrist" listing on www.feetforlife.org: we will promote your practice to the general public ▪ Private practice support: need help running your business? Then look no further, we have a wide range of resources including a comprehensive area on the website ▪ Practice accreditation: promote your practice as being the gold standard ▪ Peer-to-peer networks: we have dozens of specialist groups that cover all aspects of podiatry ensuring what ever your interest there are like minded individuals out there to help you.

Delegate Assembly update

Jilly Frisch, Branches and Delegate Assembly Coordinator

COUNCIL'S FURTHER RESPONSES TO 2015 DELEGATE ASSEMBLY MOTION

Council met on 4 December 2015 and agreed a second tranche of responses to the 2015 Delegate Assembly motions – these specifically relate to the following motions – 2, 4, 5,6, 10, 11, 18, 19, 25, 29, 30, 31, and composite motions 2 and 3.
The full set of Assembly motions, with Council's responses, including this second tranche, is on the Delegate Assembly page on the Society's website **www.scpod.org/assets/da2015-2**

SUPPORT TO MEMBERS	
Motion 2 **Warwickshire** **Gary Denby**	This Delegate Assembly: ▪ **Notes** that Society members often have to work alone in domiciliary settings, within the NHS and within private practice as mobile podiatrists; frequent attention is paid to the working environment and how this may impinge upon the practitioner's physical well-being; however, little consideration is given to personal safety in these situations; ▪ **Believes** that members' awareness should be increased, of **'Personal safety in work-alone situations'**: Dynamic Risk Assessment such as PET, Risk Reduction Strategies and Lone Worker systems; by ensuring his or her personal safety, the podiatrist facilitates ongoing care for all their patients; ▪ **Recommends** that the Society liaise with organizations such as the Suzy Lamplugh Trust www.suzylamplugh.org to draw up modern guidelines for safer, work-alone practices for podiatrists; and, for example, that Suzy Lamplugh Trust speakers are invited to regional and national meetings/conferences.
	The Assembly decided that this motion should go to the AGM, the following text was agreed with the Branch Ordinary Resolution 3 based on the Delegate Assembly's Motion 2 That the Society liaise with organisations such as the Suzy Lamplugh Trust (www.suzylamplugh.org) to draw up modern guidelines for safer, work-alone practices for podiatrists and that the Society increases its members' awareness of personal safety by, for example, inviting relevant speakers including from the Suzy Lamplugh Trust to regional and national meetings/conferences.
	Council's further response – *This motion was adopted by the AGM. The Health and Safety Panel have published guidance on 'Lone Working' which is available to members on the Society's website. A session at the 2015 Conference was devoted to explaining the document.*
Motion 4 **London** **Stephen Childs**	This Delegate Assembly: ▪ **Welcomes** that the '10 Key Points' document', which calls for good partnership working between the NHS and the Private Practice sectors, has been produced and available for reference; ▪ **Is concerned** that this agreement doesn't appear to be promoted or monitored by any one Directorate to ensure the desired partnership working outcomes outlined in this agreement: including, for example, sharing patient information if care is shared between both parties, service managers inviting PPs to in-house training, service managers advising PPs on how to refer urgent cases to their service such as ulcerations. ▪ **Requests** that the Directorates of Private and Independent Practice and Public Sector Management work together to revive and promote this agreement and make members aware of it's importance, particularly as the profession needs to be viewed as being united while lobbying various stakeholders.
	Council response – *The '10 Key Point Document' has been converted into a new document entitled 'Shared Care: Concurrent and Subsequent Treatment'. It is currently being reviewed by the Directorate of Public Sector Management and the Committee of Private Practice and will be published shortly.*
	Council's further response – The 'Shared Care: Concurrent and Subsequent Treatment' document has now been published and is available to members on the Society's website.

Motion 5
South Essex
Matthew Bland

This Delegate Assembly:

- **Requests** that the Society should produce a written protocol and guidelines to enable members to take appropriate actions against misleading or alleged false claims made by foot health practitioners – at the discretion of Council this may be through individuals, branches, or Regions.

Council response to motions 5, 18, 25 and Composite motion 3 –

All these motions concern foot health practitioners (FHPs) and protection of title. Council understands how strongly members feel about FHPs, and is keen to support members in differentiating themselves and forging successful practices despite the proximity of FHPs.

There is no question of permitting FHPs to join the Society (motion 25). The motion states that the Society might be considering allowing them to become members. This is simply not the case.

Council will also, as requested by Motion 5, produce a written protocol for members to take action against misleading or false claims made by FHPs. It is recognised that some FHPs try to mislead the public by implying that they are chiropodists or are statutorily registered, and it is important that members are able counteract such claims in an appropriate way. The Society is also working with other AHPs to press the HCPC to carry out its obligations within the current legal framework more effectively. The HCPC puts far too much onus on individual registrants to investigate misleading claims made by FHPs and other 'therapists', and this is something the Society has consistently complained about.

However, Council does not believe that a campaign against FHPs, as suggested by Composite 3 and Motion 18, is likely to be successful. The Law Commission report into health regulation included a recommendation that the health departments should carry out a review of protected titles and functions. This recommendation was subsequently rejected by the health departments, and the wider Law Commission recommendations did not appear in the Queen's Speech following the general election.

In summary, despite the best efforts of the Society, we have not been able to invoke Government interest in this issue. Trying to run an effective campaign would be an uphill struggle in a crowded political agenda, and a questionable use of resources. Even if such a campaign succeeded, the Government's remedy would not necessarily be to limit the function of FHPs. The Government could instead decide that FHPs should be registered with the HCPC in order to protect the public, which would increase their credibility. So even if the external environment was more favourable, this would be a risky strategy.

Council feels that it is far more worthwhile, and in the long-term interests of members, to run positive public campaigns about the benefits of seeing a chiropodist/podiatrist, such as the recent publicity around foot health month, and the public information videos that are being produced. Council will also provide more materials and advice to support individual members in promoting their practices and explaining how they are trained and what they do. Council firmly believes that this is the best way of counteracting FHPs and protecting the public.

Council's further response to motions 5, 18, 25, Composite motion 3 –

We have been actively pursuing these issues over recent months. Marc Seale, HCPC Chief Executive and Elaine Buckley, the new HCPC Chair, met with the Society Council in October. Copies of the Delegate Assembly motions were sent to Marc and Elaine before the meeting. Council members expressed very clearly to Marc and Elaine our members' concerns about foot health practitioners, and in particular the fact that it is difficult for members of the public to distinguish between HCPC registration and the register for FHPs accredited by the Professional Standards Authority (PSA).

Marc and Elaine understood this, but stressed that their remit only extends to HCPC registrants, not to commenting on the education or competencies of other groups. However they did agree to run a campaign jointly with the Society to educate and inform the public about HCPC registered chiropodists and podiatrists – a meeting has been arranged with them to take this forward.

This is a very positive development, and work is now under way to set up the campaign.

We are also now seeking a meeting with the PSA to discuss our concerns about the way that accredited registers are presented.

With regard to the wider issues about the Law Commission report, we understand that the Department of Health is considering presenting a "slimmed down" version of the draft legislation produced by the Law Commission. We also understand that the Health Select Committee will undertake a short enquiry about health regulation next spring. This will provide us with opportunities to raise our concerns publicly in the political arena, in addition to private discussions with various MPs and peers.

Council shares members' frustration, and fully understands why many members feel that protection of function is the answer to these problems. However Council wishes to emphasise that the main objective is to close the loopholes that exist around protection of title - not to pursue protection of function. There are various reasons for not pursuing protection of function at this time, both philosophical and practical.

Fundamentally, Council believes that defining functions in law could stifle the development of the profession. Looking back over history it is possible that use of local anaesthesia and POMs, independent prescribing and podiatric surgery would not have been achieved under a protection of function regime.

Podiatry is a graduate, and increasingly a postgraduate, profession which is as much about thinking as doing. The ability to assess and diagnose, and often to delegate and supervise the "doing", is the key to the professional status of podiatrists.

It is also worth bearing in mind that if the Society pursued protection of function it would be unlikely to have the support of the HCPC or the other AHP professional bodies. Any campaign needs allies in order to be successful and lack of support makes success less likely.

Council is aware that some members have instigated their own campaigns on social media and have written to their MPs. It is heartening that there is this level of activism to protect the profession and the public, but Council does ask those members who have been pressing for protection of function to be aware of the possible ramifications that unilateral action may have.

Finally, guidelines on how to take appropriate action against misleading claims has been published.

Motion 6
Staffordshire
Hazel Gibson

This Delegate Assembly:

- **Notes** that changes to terms and conditions within the NHS and the state have increased the normal age of retirement to 68 years;
- **Believes** that due to the nature of the profession this poses a risk to practitioners due to the associated effects on health, e.g. repetitive strain injury (RSI), spinal pathology and visual deterioration.
- **Requests** that the Society moves to evaluate and advise upon the suspected deterioration of health and the possible effect on a member's ability to carry out safe practice.

Council response –

This motion is the basis of one of the Society motions to the TUC Congress which takes place in Brighton, 13-16 September 2015. The TUC motion has been submitted to Council for approval at their meeting on 10 July 2015. A further report on the progress of this motion at TUC Congress will follow.

Council's further response –

This motion was adopted by the September 2105 TUC, and now forms part of the TUC's policy on 'working longer and the effects on health'.

BRANCHES

Composite Motion 2
Highlands and Cornwall

This Delegate Assembly:

- **Recalls** Composite motion 5/2013 regarding the difficulties faced by geographically remote branches in accessing CPD opportunities; and Council's response to motion 13 adopted at the 2013 Assembly, that, in spite of limited funds,
  (1) "Council is looking at a number of proposals to try to help redress the balance between those branches that have, and those that do not", and,
  (2) "Regional Branch funds might be used in special cases, but it would be up to each Regional Branch Committee to take these decisions"; and
- **Aware** that while the Cornwall branch made strenuous efforts to organise training to access extended scope prescribing, (an important part of modern professional podiatric practice), it proved impossible to secure tutors with appropriate programmes to come to Cornwall to give training to a relatively small number of members; and, cost-wise and time-wise it is prohibitive for Cornish members to travel further afield to access similar training, as establishments within reach were unable to assist;
- **Recommends** that Regions are requested to direct their funds towards those remote and rural branches, such as the Highlands Branch, who are continually struggling to fund CPD events for their widespread membership;
- **Requests** that Council renew its efforts to also assist these remote and rural branches, by considering funding of technological equipment and IT support to provide interactive video conferencing and web seminars, which would allow members to share the CPD events of other branches who meet more frequently and easily;
- **Requests also** that Council, in conjunction with educators, works to develop and deliver a distance learning package and / or peripatetic teaching programme to enable members of isolated branches to work towards gaining extended scope prescribing rights.

Council response –

The response remains much the same as the reply in 2013. Over £400,000 is held by branches, and each year a further £100,000 is paid via the levy. While this level of funding exists it is difficult to justify diverting more of the Society's central funds to some of the remote branches.

What is required is for branches to consider a collective approach to support colleagues in smaller and more remote branches. If funds were more evenly distributed, branches in areas such as Cornwall and the Highlands would be better placed to help deliver CPD, etc. to members in their area.

In the past any suggestion that Council would withhold the levy centrally and redistribute it in a different way has been met with strong and aggressive resistance so it needs branches to help find the solution. At Branches Day, on the basis of this motion, we will try to persuade branches that from 2016 the total pot from the levy be distributed equally across all branches regardless of the number of members in a branch. This would equal approximately £2,000 per branch. (The Regional funding is distributed according to this formula.)

Council has also received advice from the Medicines & Medical Devices Committee (MMDC) that all training leading to either supplementary or independent prescriber status is governed by criteria which dictates that those aspects of the motion cannot be fulfilled under present circumstances. However, the College of Podiatry, through the Directorate of Podiatric Medicine, continues to explore additional ways to make post-registration education and training available in all areas. Additionally, the Committee of that Directorate has encouraged some universities to offer training for the Prescription Only Medicines (POMs) annotation on the HCPC Register to be made available in areas of the UK which do not have a nearby University able to offer such programmes. Such activities will continue as required.

Council's further response –

The challenge with this composite motion is getting branches to agree to change how they are funded. The motion was opened up to discussion at branches day and some alternative funding options considered. There were also discussions around supporting branches in other ways .e.g. branch twinning, rather than just direct financial support.
Branches were recently surveyed (survey monkey) with the following question:
Would you like to see a change in the way Branches are funded? Yes / No

The vote was in favour 46 to 26 for a change. Future branch funding will be reviewed by a group led by the Chair Elect with a representative from each of the regions and supported by the Director of Finance & Operations. The group will be tasked with making a recommendation to the June F&E before seeking approval from Council in July 2016. The new process for branch funding should be in place for 1 January 2017.

Motion 10
Overseas
Simone McConnie, Barbados
Daniel Weitz, Israel

Overseas Observers
Pauline Wilson, Ireland
Heidi Corcoran, Hong Kong

This Delegate Assembly:

- **Notes** that many Overseas branches would benefit from greater support and integration;
- **Believes** therefore that there is a need for bringing overseas practising and national branches closer together, so that they might benefit, for example, from assistance with lobbying for the profession, reporting on local activities and CPD, and possible cooperative activities which promote the profession and raise awareness of the profession to the general public;
- **Encourages** active interface between overseas branches annually, with dedicated resources, and financial resources (recognising that overseas branches are usually small with limited fund raising possibilities), as well as administrative support;
- **Asks** the Society to look at ways to support and assist overseas branches and members to become more effective in communicating with each other and with the general public.

Council response –

Overseas Delegates and Alternate Delegates (four members) at the Assembly have, since the Assembly, formed themselves into a Working Group, and hope to become a hybrid International Members Branch (IMB). Such a branch will not really be able to operate as a typical UK branch, but the Society is working with the Working Group to help them establish a branch, and has, meanwhile, contacted all overseas members for the Working Group. If established, the IMB plan to use their branch page on the Society's website as the means of communicating with overseas members.

A separate Council paper has been drafted giving more background on the setting up of an IMB, which includes completed Annex A2 from the Branches Handbook.

If Council agrees to the setting up of an IMB, the branch officials would be happy for the Society to hold the branch levy, with amounts being reimbursed against receipts, for such items as funding part of travel expenses for attending Society events, printing a leaflet that overseas members could use to introduce themselves locally as members of the Society, etc.

Council's further response –

The International Members Branch has appointed the following officers, who met during the Conference on 19 November 2015:
Heidi Corcoran, Hong Kong – Chair
Simone McConnie, Barbados – Vice-Chair
Daniel Wiesz, Israel – Treasurer
Pauline Wilson, Republic of Ireland – Secretary
They are in the process of organizing how the Branch will operate, and plan to be in contact with International Members.

CPD

Motion 11
Hampshire & District
Rosa Morato
Rhoda Volpe

This Delegate Assembly:

- notes that business skills have never featured prominently in podiatry training;
- proposes therefore that the Society develop a 'member friendly' post registration training package which could be completed by members on a part-time basis thereby equipping them to be business savvy for podiatry practice in the twenty-first century;
- requests that the package be developed and available to members as soon as possible.

The Assembly decided that this motion should go to the AGM – the following text was agreed with the branch, and was adopted by the AGM
Ordinary Resolution 4 based on Assembly Motion 11
That the Society develop a 'member friendly' post registration training package which can be completed by members of the Society on a part-time basis thereby equipping them to be business aware for podiatry practice in the twenty-first century and that such a package be developed and available to members as soon as reasonably possible.

Motion 12
Orthotic Technicians
Phil Glover

This Delegate Assembly:

- **Notes** that podiatrists are frequently asked to measure and supply footwear and footwear adaptations;
- **Believes** therefore that orthotic technicians should have appropriate training in this field to meet these demands; and,
- **Requests** the Society to take steps to arrange such training

Council response –

Council is sensitive to the training needs of technicians and will request that the Practice Development Forum (PDF) looks into this request. At present, there is no section of the College of Podiatry set aside for technicians and/or assistant practitioners. Council will ask the Board of College Trustees to consider establishing such an area.

Council's further response –

This motion was adopted by the AGM. A business development manager will be appointed shortly, either on a fixed term contract, or as a consultant. The content of this motion will be part of the remit of this person.

PROTECTION OF FUNCTION/TITLE

Composite Motion 3
East Riding of Yorkshire, Teesside and Wiltshire
Helen Keough, Evelyn Rodger, and Ken Lacey

This Delegate Assembly:

- **Aware** of the requirement for podiatrists to register with the HCPC, and to prove their competence to practice when audited;
- **Notes** that foot health practitioners offer foot health without any requirement to prove standards or competence, which, of course, affords no protection for the public;
- **Notes also** that while the HCPC have stated their intention to protect the public, they are seen by many to be failing on this very issue;
- **Requests** the Society, in view of the recent Law Commission findings on protection of function, to review the outcome of these findings and look closely at protection of function.

The Council response to this motion is the same as for Motions 5, 18, and 25.

The Council's further response to this motion is the same as for motions 5, 18, and 25.

Motion 18
Bournemouth & District
Christine Powell

This Delegate Assembly:

- **Notes** that the Society has already had substantial discussions at Council level regarding the need to push for a parliamentary review to achieve a closure of the professional function of the podiatrist / chiropodist;
- **Believes** that the Council should continue to take notice of the depth of feeling of members who continue to be concerned that the current legislation is not protecting the public as the legislation was originally designed;
- **Believes** that Protection of function is essential for a series of tasks that may only be performed or tasked only by a current degree qualified podiatrist or a grand-parented registered podiatrist; protection of function should include at least the use of scalpel for debridement and the administration of local anaesthetic and nail surgery as a minimum;
- **Requests** that the Council launch a membership project to collect substantive evidence to demonstrate that the current position of protection of title only is not protecting the public and that there needs to be parliamentary review of this situation.

The Council response to this motion is the same as for Motions 5, 25, and Composite Motion 3.

The Council's further response to this motion is the same as for motions 5, 25, and Composite motion 3.

MARKETING

Motion 19
Glasgow
Laura McGuire
Michael Stephenson

This Delegate Assembly:

- **Notes** that in November 2012, the Prime Minister insisted that the first police and crime commissioners had a mandate to oversee the delivery of law and order despite being elected on an average valid voter turnout of 14.7%;
- **Furthermore notes** that the coalition Government and their supporters have a completely different opinion when it comes to ballots for industrial action:
- The Mayor of London has proposed that any ballot in which fewer than half of those eligible to vote do so should be ruled invalid; and,
- The Confederation of British Industry has proposed a threshold for triggering a strike be set at 40% of the unionised workforce voting in favour.
- **Calls** on the Society's Council to lead a campaign to highlight political hypocrisy regarding the validity of union ballots for industrial action.

Council response –

This motion forms the basis of one of the Society's motions which will be submitted to the 2015 TUC Conference.

Council's further response –

This motion was incorporated into a composite motion which covered the entirety of the Trades Union Bill. The motion was adopted and our suggestion to modernize ballots is now an integral part of the TUC Campaign opposing the Trades Union Bill.

ASSISTANT PRACTITIONERS

Motion 25
Leicestershire
Hilary Holmes

This Delegate Assembly:

- **Is aware** that the Society is always looking at ways of increasing membership, which is to be applauded, understands, however, that the Society might be considering allowing foot health practitioners to become members or associates;
- **Opposes** the inclusion of foot health practitioners as members or associates of the Society, as allowing unregulated persons into membership would have a detrimental effect on both membership of our Society and our public standing;
- **Requests** Delegates to support the motion that the members of the Society do not agree with allowing foot health practitioners to join our Society at any level of membership, as allowing unregulated foot health practitioners and persons who do not meet minimum standards for HCPC registration to join the Society would give an extremely clear picture to the HCPC and the government bodies of our thoughts and beliefs, which would not be in our best interests;
- **Believes** that allowing foot health practitioners into membership would lead many members to consider if they wish to remain members of Society.

The Council response to this motion is the same as for Motions 5, 18, and Composite motion 3.

The Council's further response to this motion is the same as for motions 5, 18, and Composite motion 3.

BENEVOLENT FUND

Motion 29
Lancashire
Catherine Yates

This Delegate Assembly:

- **Believes** that the Benevolent Fund Trustees should communicate the role of the Benevolent Fund more effectively by regularly highlighting the work carried out by the Trustees, and by explaining how members in need can access financial support;
- **Believes also** that it is time to reform aspects of the Benevolent Fund, particularly fundraising, and asks our professional body to expedite this action;
- **Proposes** that as a part of the reformation this Delegate Assembly requests that our Trustees explore the possibility of raising funds by collecting an optional contribution via the membership renewal.

Council response –

The work of the Fund is promoted in Podiatry Now and the Annual Report.
Council will, however, suggest to the Benevolent Fund Trustees that this motion is discussed at their next meeting – feedback after this will be provided.
Raising funds at renewal time has been considered in the past but as the majority of members pay their membership renewal by direct debit this is more challenging.

Council's further response –

The Benevolent Fund is administered according to the Trust Deed and current charity legislation. It is accountable to the Charity Commission and the Custodian Trustee, i.e. the Society via Council. All the Fund's records, including case files, are audited each year by the Society's Auditors. All cases considered by the Trustees are dealt with in the strictest confidence.
Since April 2012, the Trustees have carried out a substantial overhaul of the Benevolent Fund. Initially, the Trustees concentrated on structural improvements to the administration of the Fund and Board meetings. More recently, the Trustees have turned their attention to publicising the Fund to members.

Publicity about the Fund
Since the Autumn of 2014, the Trustees have provided the following information to members:
- *A dedicated page on the members' website, including electronic information leaflets and an application pack, including signposting to other sources of help*
- *An article in November 2014 issue of Podiatry Now*
- *Printed information leaflets which were distributed to members at the Annual Conference in 2014, at the Delegate Assembly and Branches Day in 2015.*

The Fund has, hitherto, provided a report and audited accounts to all members in the Annual General Meetings brochure and also available on the Society's website.

The Future
The Board of Trustees is committed to modernising the Fund and raising its profile within the membership of the Society.
Notices about the Fund will be published from time to time in Podiatry Now, in the e-newsletter sent to members, on Facebook and in twitter-feeds. Articles will be published occasionally in Podiatry Now about the work of the Fund (note: at the time of finalising this response, this is already in train).
The Trustees, mindful of the fact that the funds at their disposal have been donated by members, are eager to remain accountable to members. They will, therefore, be holding information meetings each year at suitable events as time and resources allow.

Fund-raising
The Trustees are extremely grateful to individual members and Branches that contribute towards its work. Acknowledgement letters and receipts are sent.
Raising funds at renewal time has been considered in the past but as the majority of members pay their membership renewal by Direct Debit this is more challenging.
Trustees are conscious of the need to fundraise. The resources the Fund has at its disposal (in terms of time, manpower, and money) for fundraising are relatively small. However, the Trustees will be addressing this matter in the coming months.

DELEGATE ASSEMBLY

Motion 30
Manchester & District
Sheila Jennings-Brown
Mark Simmons

This Delegate Assembly:

- **Questions** the merits of holding the biennial Delegate Assembly in its present form;
- **Appreciates** the value of face to face contact with fellow members and acknowledges that this is democracy in action in allowing members to express their concerns with the College/Society;
- **Notes** the improved and more transparent process of following up motions which have been passed, nonetheless, it is further noted that drawing up and engaging branch members in drafting motions is difficult to achieve;
- **Argues** that that the process involved in preparing to get motions to the position where they are voted upon, is simply historical and outdated;
- **Proposes** that branches arrive at their motions in any manner they wish, then after being submitted to the Society for scrutiny and possible composition, are incorporated into an Internet Survey programme such as 'Survey Monkey' for **all** members to vote upon, not just those who attend local branch meetings;
- **Recognising** that although survey responses are generally poor, at least **all** members are consulted and not just those able to attend branch meetings;
- **Requests** therefore that the Society investigates the benefits of using current technology and communication techniques to promote a more inclusive voice amongst Society members.

Council response –

The Delegate Assembly was reviewed and restructured in 2012, which resulted in it moving from an annual event to a biennial event. The constituencies for selecting delegates were also redesigned and aligned to the Society's branches structure in order to promote a more inclusive and participative process that culminates into the Assembly.
The motion will be discussed by the Standing Orders Committee at their next meeting (during the Conference). They will consider further changes that might develop the Assembly process into a more representative and inclusive event involving more members at the grass roots level.

Council's further response –

At it's meeting during the 2015 Conference the Standing Orders Committee discussed this motion and will be bringing forward suggestions on altering the format and processes for the 2017 Assembly, including consulting Branch Officials at the June 2016 Branches Day.

SOCIETY AWARDS

Motion 32 North Yorkshire Tony Carter	This Delegate Assembly: ▪ **Requests** that in the interests of democracy and transparency, the mechanism of deciding on various Society awards is achieved through a ballot; this would allow the membership to choose their favoured candidate to be honoured from a list of nominees. ▪ **Further requests** that a list of nominees and the reason for nomination is made available on the Society's website and a mechanism introduced to allow members to cast votes electronically; ▪ **Also requests** that the Society expands the scope of honorary awards to include awards that acknowledge those individuals committed to Quality and Innovation in both the public and private sectors.
	Council response – *The Awards Committee is currently reviewing the Society awards system, and will take on board the request in the motion as part of the review. However the committee only meets once per year and there is a long lead in time for the awards programme each year, so any change would realistically not be implemented until 2017.*
	Council's further response – *Council has considered the suggestions for the Society Awards programme. Council does not feel that it would be appropriate or practical for all Society awards to be decided on the basis of a membership ballot. However Council has decided to introduce this system for the 'Alf Morris Award', which recognises members who have given services to disadvantaged individuals or communities.* *Council believes that there are many 'unsung heroes' in the profession who provide vital podiatric care in difficult environments, and opening up this award to a membership ballot will shine a new light on their achievements.* *The practicalities are still being worked on, but the new system should be ready for the next round of awards (nominations in 2016, presentation in 2017).* *The motion also called for the awards to acknowledge quality and innovation in the public and private sectors. The award categories are being simplified, again for the 2016/17 round, and this will be taken into account.*

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:

If called for audit by the HCPC, when must you submit your CPD profile by the end of?

The answer can be found somewhere in this issue.

The winner of the January competition is Mrs Patricia Pearson from Sutherland.

Q - On average, how many Diabetes related amputations take place in England each week?
A - 135

To enter please go to www.cosyfeet.com/PNCOMP72

Cosyfeet Perfect for swollen feet

ONE BRIDGEWATER PODIATRY STUDY DAY - 3RD OCTOBER 2015

The second 'One Bridgewater Podiatry study day', held in October 2015, was attended by 66 podiatrists and podiatry assistants from across the whole of Bridgewater NHS Foundation Trust.

The opening address was given by John Prince, Lead Bridgewater Governor, who is also one of our own podiatry patients. John spoke about how grateful he was to the NHS, whose service he has used over many years due to some long-term conditions that have and continue to impact on his daily life. He feels that his work as a Lead Governor gives something back to the employees and patients at the Bridgewater Foundation Trust.

A full and varied programme continued with five other sessions. Sandra Edwards, SCP Union Learning Fund Project worker for the North of England, spoke about the Union Learning Fund Project and conducted the ice breaker.

Hitesh Chandarana, Head of Service Experience, and Val Harper, Complaints Manager, spoke about customer care and complaints - specifically in relation to our podiatry service.

Julie Allen, podiatrist and Leigh locality Team Leader, who specialises in biomechanics, spoke about the prescription and manufacture of orthotics (insoles) and footwear, and Dr Rachel Hilton, GP in the Bridgewater area spoke about dermatology,

Adie Richards, one of the Practice Education Facilitators (PEFs) and Michelle Cullen, Lecturer at the Directorate of Podiatry, Salford University, who organises student placements, spoke about the Multi-Supporting Learning in Assessment Practice update that is available for all staff to attend if they have students on placement and Michelle outlined the types of placement undertaken by students at Salford University.

It was a busy day, made possible with assistance from the medical reps and the Bridgewater Training department. We held a quiz on the day and the prize, a day at the Diabetes U.K. conference with an overnight stay, was won by Christine Hall (ULR for Pennine Acute Trust) who was an invited delegate along with other SCP ULRs from the North West.

Study days are always evaluated as this forms the basis for future training. Plans for next year are underway, with help from Julie Griffiths, the Clinical Lead for the One Bridgewater Podiatry department, Trish Schooling, ULR from Halton, and the five locality team leaders.

It is important that we receive CPD relevant to podiatry in addition to the mandatory training that all NHS employees have to complete each year.

As professionals, treatments are emerging and changing all the time and we need to be providing the best treatment possible to our patients. Time to start thinking about 2016!

NICOLA SKITT
ULR FOR BRIDGEWATER NHS FOUNDATION TRUST

Above: From Left to Right:

Adie Richards, Practice Education Facilitator, Nicola Skitt, podiatrist at Leigh Health centre and ULR John Prince, Lead Bridgewater Governor, Michelle Cullen, Lecturer Directorate of Podiatry, University of Salford and placement co-ordinator, Julie Griffiths, Clinical Lead of One Bridgewater Podiatry Department (Ashton, Leigh & Wigan, Halton and Warrington), Trish Schooling, Halton, podiatrist & ULR.

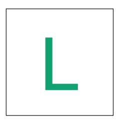
Michelle Cullen, Nicola Skitt and Adie Richards

Phyllis and Kay

REVIEW OF LOWER LIMB PAIN AND ITS CLINICAL IMPLICATIONS SYMPOSIUM

OCTOBER 16TH 2015, BIRMINGHAM MEDICAL INSTITUTE

BENJAMIN JONES, BIRMINGHAM MEDICAL INSTITUTE ON BEHALF OF THE ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW (RCPSG)



Led by Professor Stuart Baird and hosted at the Birmingham Medical Institute the day was a superb event, which made use out of every minute and kept the pace of delivery strong, but balanced. The quantitative data-led presentations delivered compelling evidence-based healthcare with a high focus on pharmacology and neurophysiology, and these together with softer qualitative lectures were spot on.

Professor Jon Raphael, Consultant Pain Physician of Russell's Hall Hospital, Dudley, began by delivering a strong revision of the ascending and descending pathways of the nervous system and the associated brain regions. What was particularly interesting was Professor Raphael's focus on the use of Local Anaesthetics (LA) in both pre and post-operative care. Practical implications of using LA prior to any work that might be perceived as highly painful may seem obvious from an immediate pain reduction perspective, but it also has long-term implications in preventing regions from becoming hyper-sensitised through repeat trauma.

Furthermore, Professor Raphael noted that the LA could be considered as part of a treatment plan and indeed the logic would appear sound, that through reducing the presence of receptors on the cells' surface, the pain sensitivity responsiveness also reduces, allowing the patient to tolerate pain better. However it was not discussed whether a repeat period of administered LA would need to be delivered, i.e. every two weeks for a period of four months etc. Potentially an excellent start of a research project for podiatry to investigate.

Professor Raphael was also keen to point out that although the pharmacological intervention was useful there was a huge level of psychology involved. He said that Cognitive Behaviour Therapy (CBT) had its place alongside the standard treatments and should be considered as part of the wider treatment plan. In podiatry it could be that, for our patients with chronic pain, we approach the problem using both qualitative and quantitative methods in a manner to cover both pain and its effect upon the patient.

Simon Biggs, a patient and former teacher, then recounted his first-hand experience with neuralgic pain. His repeat diagnosis of sciatica combined with reoccurring delays ultimately culminated in a frustrated and pain ridden patient. His story was particularly poignant as he highlighted small, but productive, methods to improving the delivery of care we provide. Namely: Reading notes before the patient enters and getting 'clued up' before the patient enters; Spending the time enquiring not just to the direct pain or problem but the implications pain itself, i.e. how does it affect your day-to-day life, specifically, and of course the often repeated request from patients, quite rightly so, to be treated as a human, not a condition, and certainly not a number.

Dr Alifia Tameem, Locum Consultant in Anaesthesia and Pain Management, was highly supportive of Professor Raphael's work, further expanding on the LA and magnesium infusion treatments and reporting reasonable success when they are administered as an epidural when dealing with spinal radiculopathies. He questioned practitioners' overuse and reliance on the pain questionnaires LANSS (The Leeds Assessment of Neuropathic Pain Symptoms and Signs) and DN4 (Douleur Neuropathique 4) – neither of which I was presently aware of nor using in a clinical setting, but this did highlight an area that, when combined with triage, could allow for better assessments comparatively and overall.

Matthew Fitzpatrick, MSK Specialist Podiatrist and Managing Director of A&E and Acute Medicine for North Middlesex Hospital, London, re-enforced

what had gone before, but with more podiatric focus.

Suggestions included speaking to GPs and engaging them by asking their opinion in cases where we are at a loss clinically and to use this method to build rapport and mutual respect. He also emphasised the need to address any pain with the patient and make this a priority. Mr Fitzpatrick was keen to remind us that, ultimately, it is what matters to the patient that should guide our clinical priorities. Whilst this can include pain reduction, it also includes helping them cope with ongoing chronic neuralgic pain and the effects on their lifestyle. Mr Fitzpatrick built upon the concept of Professor Raphael's view that pain was a disease. The persuasive case made by both Mr Fitzpatrick and Professor Raphael developed the concept further that the pain itself is only half the problem and that, especially with chronic pain, the 'implications of pain' – like any long-term condition – normally force a patient to alter their lifestyle to accommodate the condition.

Dr Benjamin Newton, Day Service & Volunteers Co-ordinator, Headway Black Country, was the key qualitative speaker of the day. As medical-based professionals we tend to give credence to quantitative data because of its rigour and substance and yet we must naturally recognise the need to embrace qualitative data readily when dealing with neuropathic pain. It is subjective in nature and personal and this restriction in its understanding and comprehensions will never be truly navigated; the closest we can aspire to understand someone's pain is through sympathy having undergone similar pain.

Dr Newton pointed out that when discussing pain with a patient we are able to use this dialogue to build rapport and more meaningful and deeper ways to better serve a treatment pathway. Indeed a patient is likely to only admit real pain and chronic pain if they trust the clinician present before them. This can be achieved by taking the patient reports more seriously, but also by conducting further tests to support or expand their pain descriptions.

> "MR FITZPATRICK WAS KEEN TO REMIND US THAT, ULTIMATELY, IT IS WHAT MATTERS TO THE PATIENT THAT SHOULD GUIDE OUR CLINICAL PRIORITIES"

Professor Steve Jeffery, Consultant Plastic Surgeon UBH, Birmingham, is a serving Colonel with the British Army and was the Keynote speaker of the event with his subject topic: amputations. Looking at the extensive injuries to service personnel when activating IEDs (Improvised Explosive Devices) it is testament to the progress of medicine that such patients recover from some of the most horrific wounds. Professor Jeffery lectured us well how it was now possible for patients to survive three major amputations and, whilst these were life changing events, the challenge of keeping them alive after surgery, post-op infection and failure to heal are still very much real events, even with today's advance technological progress.

Naturally, the mention of painkillers via cannulation was a prime focus as the pain of these injuries would be unimaginable. With shrapnel, bullets, sand and dirt all lodged within the wound it is humbling to think we usually only have sweaty feet, sock fluff, fungal infections and nail spicules to deal with, and our patients are usually able to walk out relatively unharmed from their experience. Whereas Colonel Jeffery knows that if these patients walk again, even with prosthetics, they have done well, as post-operative infection is near impossible to avoid and the recovery is slow and hard.

Post-operative pain management is paramount at Defence Medical Rehabilitation Centre Headley Court and it is a constant battle to keep pain at bay without creating a dependency on the drugs for patients. Alongside pain management, the rehabilitation process is not easy, as it is fraught with emotional highs and lows for both clinician and patient. We should take great pride in the work delivered by the NHS and serving personnel, both in the field and in the recovery and rehabilitation phase of care.

Martin Fox, Vascular Specialist Podiatrist of Penine Acute Hospitals Trust, Manchester, finished the day with a highly targeted presentation of vascular pain from the podiatric perspective. Mr Fox was a strong advocate for the podiatrist in the role diminishing pain from vascular complications and a proponent for the ideology of: 'If it is My Diagnosis, it is my Job!'

Mr Fox is a great believer of podiatrists at all levels taking on greater levels of responsibility, even in the community setting. Mr Fox advocated leading the way and working with GP practices and hospitals to create better screening and assessments in the community. His own role came from the need to reduce referrals to the hospital setting, which had managed to drop around 75% of all referrals to surgery and improve patient care overall because of podiatric intervention. The main reduction was through the increasing level and frequency of assessments by Mr Fox and his team using the Ankle Brachial Pressure Index (ABPI) and reporting findings to GPs, alongside lifestyle advice and regular one-to-one talks with patients over their life choices and implications this would have to their limbs.

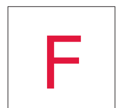
The realities of NHS politics were also raised; the funding issues and complexities of Clinical Commission Groups and service scope and breath of practice were also not without their challengers. Mr Fox was able to navigate some of these and advocated encouraging shifting patients to community-based assessments with podiatrists with appropriate training. Getting the funding to follow this change was not easy, but not impossible, and (as the results mentioned above show) he highlighted that, with the correct set-up, great gains could be obtained.

Mr Fox provided an excellent rounding off for the symposium. As clinicians we can tend to home in on neurological pain or pain in general as the main problem, which is right to address, but it is important to analyse the vascular systems with just as much focus.

I would like to thank everyone who helped host the event, especially Caity Ryan, Educational Events Co-ordinator for the RCPSG, the unsung hero of the day organising passes and providing the lectures to the attendees for us to review at our leisure, and Dr Abd Tehran, whose lecture on 'The diagnosis and management of painful diabetic neuropathy: A diabetologist prospective' was excellent (sadly I lost the notes I made on the day). I would also thank the catering team at the event; the endless coffee supply with cakes and sandwiches never goes unnoticed by any clinician -especially a hungry one! ■

THE DEVON BRANCH CELEBRATE MEMBERS ACHIEVEMENTS

The Devon Branch held a meeting on Thursday 7th January 2016 at the Royal Devon and Exeter Hospital. During the first part of the meeting they were delighted to welcome Karen Reed, ULF project worker, to speak about the forthcoming HCPC audit. Karen also spent time talking about reflective practice, which is an essential element to CPD



Following the CPD element of the meeting the Branch Secretary, Cathryn Clayden, presented the Branch Shield, which is an annual achievement award for branch members.

This year the shield was awarded to David Piper (Devon Branch Chairman) as recognition for his outstanding achievement whilst representing Great Britain at the World Dragon Boat Racing Championships in Canada in 2014, during which he won three bronze medals. Karen Reed presented this prestigious award to David as an official representative of the Society.

Last year the Shield went to Fiona Rimmer (Devon Branch DA representative) for her selfless volunteer work in Uganda. ■

CATHRYN CLAYDEN, SECRETARY, DEVON BRANCH

Above: Karen Reed with award winner David Piper

Devon Branch Secretary, Cathryn Clayden kate@mypodiatrist.co.uk

FURTHER INFORMATION ON HCPC AUDIT

Registrants chosen for audit must:
Send a written profile (which must be their own work and supported by evidence) which explains how the CPD they have done meets the HCPC standards.
CPD profiles are assessed by CPD assessors from the professions regulated by the HCPC, who decide if the profile meets the CPD standards.
Putting your CPD profile together, the main parts of your CPD profile will be:

- **a summary of your practice history for the last two years (up to 500 words);**
- **a statement of how you have met the HCPC standards of CPD (up to 1500 words); and**
- **evidence to support your statement.**

See p2 for more details.

SOCIETY AWARDS 2015

LONG SERVICE AWARD

Awarded to members who have served a branch, or committee of the regions or devolved countries for a substantial number of years; or to staff who have served the Society for a substantial number of years.

CLAIRE BLAND
DPodM POMS MChS

Claire Bland has been secretary of the South Essex Branch since its inception. She organises branch meetings with interesting talks together with an excellent CPD programme; CPD courses covering a variety of speakers and subjects with the aid of the Branch Committee, as well as organising networking evenings two to three times a year, which are also very successful.

She is a key member of the Branch Committee handling correspondence from podiatrists in South Essex and relaying HCPC and Society information to branch members. Claire and the Branch Committee offer and provide help for branch members who have been asked to provide a portfolio for HCPC registration and she has been available for problem solving and sympathy when branch members need help.

She has also helped advise newly qualified podiatrists and foot care assistants, helping them gain experience and confidence in their skill.

MATTHEW BLAND
BSc (Hons) MChS

Matthew Bland has held the post of Chairman of the South Essex Branch. He has represented the branch at the Delegate Assembly for some years as the elected official and has raised many important motions. He is a valued link between branch members and the Society. He is held in high regard professionally by branch members and by local GPs, having represented the Society speaking to groups of GPs about our profession and what we are capable of.

The South Essex Branch committee under his lead organises CPD programmes and networking evenings, which are always fully booked.

Matthew and the Branch Committee have offered and provided help for branch members who have been asked to provide a portfolio for HCPC registration, and has been available for problem solving and sympathy when any of the branch members have needed help.

KIM BRYAN

Kim Bryan joined the Society from the St John Ambulance organisation as Postgraduate Education Officer in March 2000. She is now employed in this capacity by The College of Podiatry.

During her time at the Society and College Kim has held a variety of responsibilities. These include supporting the Faculty (now Directorate) of Podiatric Surgery, co-ordinating the Fellowship training programmes, organising examinations, advising members on CPD and assisting with the annual conference.

Latterly Kim has assumed secretariat responsibility for the Research and Development Committee and Chartered Scientist Committee, and she is actively involved in Science Council working groups.

Kim is loyal and conscientious, and has an invaluable eye for

detail. She is very highly thought of by the officers with whom she works and her colleagues at Fellmongers Path.

PHILIPPA BRYANS

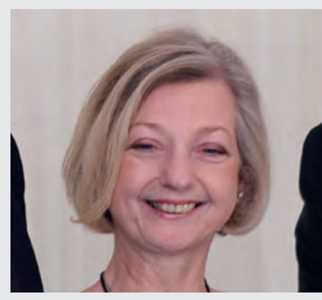
FChS CSci MChS

Philippa (Pippa) Bryans was a member of Council from 2003 to 2014. During that time she served on the Employment Relations and Professional Conduct Committees, and she acted as the Society representative to Age UK.

As a podiatry Head of Service up until 2008, Pippa was active in the then Faculty of Management, and she also represented the Society on the National Institute for Clinical Excellence Falls Prevention Group.

Pippa is currently a member of The College of Podiatry Quality Assurance Committee as the Chief Examiner for assistant practitioners. In this capacity she leads the training of new examiners, she has updated and rewritten the examination paperwork, and she is developing CPD courses for the examiners and assistants.

Over many years, both on and off Council, Pippa has consistently and enthusiastically promoted the professional development and employment rights of members.

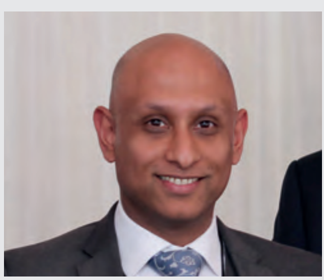


CLAIRE GIBSON

DPodM MChS

Claire Gibson graduated in 1982 and has been a central figure in the Glasgow Branch for the last 29 years. She has been a member of the Branch Committee for 25 years and has worked tirelessly on behalf of the Society, the branch and its members. Claire has worked in the NHS all her career and devoted her working life to promoting podiatry and the Society. She has helped to encourage members to attend branch meetings as well as delivering CPD through a variety of branch events. Additionally, she served as a Committee member of the Glasgow Branch when it hosted a very successful Scottish one-day conference in 2002.

She has been the Glasgow Branch Representative to the Scottish Regional Committee (SRC) since 1987 and took over as Treasurer in 2000. She played an influential role on this Committee in organising events such as presentation skills for those attending the Delegate Assembly, training for treasurers and record-keeping courses. When the SRC hosted a very successful Scottish one-day conference in 2014, Claire was on the Conference Committee both as organiser and treasurer of this event.



AKBAL RANDHAWA

BSc (Hons) POMS ACC MChS

Akbal Randhawa has served on the Committee of the Kent Branch for more than 10 years. He has served in a number of official roles over the years: Branch Secretary, Union Learning Representative, Delegate Assembly Representative, and recently South East Regional Committee Representative.

Over the years, Akbal has organised one-day courses and frequently arranged speakers for the branch monthly meetings. He is also the co-founder of the first private practice network in Kent.

More recently during the changes within the NHS wrought by the Health and Social Care Act, he has been engaging on behalf of the branch with local commissioners in Kent and the Health and Well Being Boards trying to raise the profile of podiatry as a profession, and to ensure that the benefits of podiatric care for the public have been highlighted.

PAUL SAVAGE

BSc DPodM MChS

Paul Savage has been an active and committed member of the Society since 1981, when he qualified from New College Durham. For 14 years Paul has served as Chairman of the Newcastle-upon-Tyne Branch of the Society. Throughout that time he has guided the branch and the membership numbers have grown, due mainly to the development of regular CPD courses, which continue to be well attended.

Paul contributed to the development of the new website for the Newcastle-upon-Tyne branch, which is designed to help keep branch members up to date and to encourage their input at meetings.

Paul's keen and continuing interest in the Society's work prompted him to stand for Council, to which he was elected in 2009. He continues to be active at his local branch and was recently re-elected as Chair of that branch.

CITATION

(OVERLEAF)

Awarded to members or Fellows who have demonstrated that they deserve public recognition by contributing to the development of the profession in the spheres of research, new practice systems or other areas.

RICHARD MACKENZIE

BSc MChS

Richard Mackenzie qualified from Edinburgh in 1978 and has been a member of the Fife Post-graduate Group since 2000 as well as treasurer since 2002. The Fife Post Graduate Group is the foremost provider of post-graduate education in Scotland.

Within his voluntary role spanning 13 years, Richard has always shown dedication and he continually reinforces the importance of presenting CPD courses that are clinically relevant to our podiatry profession. He provides the group with excellent structured financial guidance and information on income and expenses from the courses, without which the branch would not be able to continue delivering its high-quality courses.

MERITORIOUS AWARD

Awards to members who have given significant and devoted service to the Society through a sustained contribution to a particular sphere of practice or for service of 10 years or more.

FRANK GALLAGHER

MChS

Frank Gallagher has been a Trade Union representative for the Society for over 20 years. In this role he has provided local support both from a trade union and professional perspective on many occasions.

From 1998 until 2014, he was the Society's Northern Ireland convenor. During this extended period he guided and supported the region's Trade Union representatives through periods of change and challenging times, including the introduction of the NHS Pay system, Agenda for Change, and other organisational changes across the NHS in Northern Ireland. Indeed prior to the introduction of Agenda for Change, he oversaw a very successful regional, Whitley based upgrade of many of his fellow professionals. He also acted as the Northern Ireland Representative to the Employment Relations Committee of the Society for 16 years. He has always been supportive of the committee and the work that it does to promote the Society's and members' interests. Frank also served two terms as a delegate to the Delegate Assembly in its formative years.

He has also been a dedicated member of the Society, promoting it where possible and has been of great support and guidance for members in the UK. Through his own endeavours, he has raised the profile of the Society and podiatry amongst allied health professions, other unions and the wider NHS service in Northern Ireland, where he is held in high regard.

DR TARIQ KHAN

PhD BSc (Hons) BSc (PodMed) FCPodMed FFHom (Pod) FFPM RCPS (Glasg) MChS

Dr Tariq Khan has worked to not only raise the profile of our profession internationally but also to provide an evidence base for homeopathic podiatry, particularly Marigold Therapy. He has been running the Marigold Clinic at the Royal London Hospital for Integrated Medicine for 21 years. This is the only department in the NHS providing integrated medicine and has led to many members providing Marigold Therapy in their clinics. He has also been appointed Consultant Podiatrist in the Dermatology departments at Bart's Health NHS Trust and King George's Hospitals London specialising in wart treatments. He has also been specialising in a rare genetic skin disorder epidermolysis bullosa at Great Ormond Street, Hospital for Sick Children since 1997.

Tariq has completed a doctoral research in phytochemical, biological investigation of thuja occidentalis and its clinical treatment of viral warts and verruca pedis at the University of London. In addition to publishing research papers and running accredited courses on the subject, he has an international lecturing profile, including at the Society's conferences

He also lectures and holds research positions in University College London Hospitals, Fellow in Dermatology at the Faculty of Medicine, University of New South Wales, Australia, and Clinical Professor in the Department of Podiatric Medicine and Orthopaedics, Temple University, USA.

ANTHONY MAHER

BSc(Hons) FCPodS MChS

Anthony Maher has, since his earlier days as a member, supported the profession in podiatric surgery with a major emphasis on research quality. In a field where numbers with good academic reflection are few, he has sustained an ethos of high standards when conducting studies. His work on the Society's

website came at a time when it required significant revamping. He worked tirelessly with the Society to improve the 'face' of podiatry and podiatric surgery.

He did not just produce one piece of work, but has been highly instrumental in building standards for the database audit system – PASCOM-10. Although this was launched in 2010, from 2012 to date he has reshaped the image for the public and members and applied high expectations of image that reflects how we are perceived. As a 'reporter' he has produced reports as well as contributing quality research papers to journals.

PROFESSOR ANTHONY REDMOND

PhD MSc FCPodMed MChS

Professor Anthony Redmond recently became the first podiatrist in the UK to be appointed as a full Research Professor in the Faculty of Medicine at a Russell Group University - a significant achievement reflecting the extent to which he has raised the profile and reputation of the profession. His appointment as Professor of Clinical Biomechanics at the Leeds Institute of Rheumatic and Musculoskeletal Medicine at the University of Leeds, in 2013, constitutes the most prestigious position in research achieved by a British podiatrist. He has served as Chair of the Research and Development Committee of The College of Podiatry since 2012, initiating the 'core podiatry' research project on behalf of the College of Podiatry, which will provide essential evidence in support of commissioning and in shaping the health policy agenda for the profession.

He presently chairs the European League against Rheumatism Health Professionals Standing Committee, the Joint Replacement Technologies Group of the National Institute for Health Research Leeds Biomedical Research Unit, and is immediate past chair of the UK musculoskeletal umbrella organisation the Arthritis and Musculoskeletal Alliance.

Throughout his career, he has championed the new promising graduate podiatrists developing research and clinical academic careers. The most notable example of this is the highly successful Arthritis Research UK graduate podiatry internship scheme that was shortlisted for the Department of Health advancing clinical practice awards in 2010. The scheme has since been adopted nationally by Arthritis Research UK to include all allied health professionals and nurses, and also adopted by the National Institute for Health Research UK.

He has published extensively in the field of musculoskeletal medicine, podiatry and clinical biomechanics, and is internationally renowned as an academic and leader in the profession. He has been active in establishing evidence-based standards, care pathways, and the integration of foot health services in both primary and secondary care. He is an active member of The Society of Chiropodists and Podiatrists, and a Fellow of The College of Podiatry in Podiatric Medicine.

FURTHER INFORMATION

Each year, the Society makes awards to its members and those outside the professon who have given particular service to the profession.

The Awards Committee will be meeting in the Autumn this year to consider nominations for Awards to be presented in 2017. A notice will be posted in Podiatry Now when nominations are open

HONORARY VICE-PRESIDENT (NEXT COLUMN)

Awarded to retiring members of Council, or Retired Members of the Society, who have given meritorious and distinguished service to the Society.

PETER GRAHAM

BSc (Hons) FCPodMed MChS

Peter Graham was a member of Council from 1989 to 2005, and 2006 to 2015. During that time he served the Society in an enormous range of capacities, most significantly as Chairman from 2001 to 2003. He was a Vice- President from 1995 to 1998, Vice-Chairman from 1999 to 2001, and representative to the Federation Internationale des Podologues from 1998 to 2004.

During his tenure on Council, Peter served on a number of committees, including Finance and Establishment, Professional Conduct, Editorial, Employment Relations and Awards.

Peter has also been very active at branch level, serving as Branch Secretary to Portsmouth and District Branch and Chairman of Kingston and South London Branch, as well as a representative to the South East Regional Committee. He is also a member of the Hospital Podiatrists Panel and a Trustee of the Society's Benevolent Fund.

On behalf of the Society he served on two Ministerial Working Parties concerning the delivery of NHS podiatry services and represented the Society on the Department of Health Information Technology and NVQ mapping working groups. More recently he was appointed by the HCPC as Registrant Assessor to the team for grandparenting, International Registration applications, Fitness to Practice and CPD assessment roles, which he undertook from 2004 to 2015.

Peter was originally appointed as an Honorary Vice-President in 2005 when he left Council for a year, and the award has now been reinstated upon his final retirement after a remarkable period of service to the Society.

FEEDBACK

HAVE YOUR SAY

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

Email us:
podnow@scpod.org

@SCP_PodiatryUK

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

The Editor reserves the right to refuse and to edit responses.

My January journal landed on the mat this morning. I glanced at the cover and noticed there was a piece on Alex Catto, so instead of tossing it to one side for later reading I tore off the cover straight away, as I knew I'd find it entertaining and I wasn't disappointed: 'Time to leave (NHS) when I had thoughts of killing my line manager!'. How??

It's great to see the Society recognise the importance of 'generalist' podiatrists like Alex. His conference lectures were an eye opener to me and I owe my success to his business ethos message and the understanding that everyday conditions are at the core of us providing benefits to patients.

I turned the page to the leading letter from Liz Humble Thomas about 'Mr X', a story that underpinned the message that 'generalist' podiatry intervention can make a life-changing difference to someone.

It didn't take 'advanced skills' to make that profound difference, but it did take advanced understanding, patience, team work and persistence, characteristics at the core of our profession, which we should be proud to promote amidst the 'glamour' of prescribing and advanced practices.

Thanks for some great content.

Dianne Ashcroft,
Generalist podiatrist (and proud of it)

TRIBUTE TO LESLIE KLENERMAN

I wish to echo the recent tribute to the late Professor Leslie Klenerman and remember these words from his book, which I often displayed in Power Point when talking to nurses and doctors about the diabetic foot.

'Eventually this deep ulcer either tracks to the skin and becomes open or the ulcer is discovered when the callosity is pared.

It can then be difficult to explain to the patient that the ulcer was already there and not caused by a careless chiropodist.'[1]

Reference

1. Professor Leslie Klenerman, The Foot and its Disorders, 3rd Edition. Blackwell Science, 1991: p141.

Peter Evans

THE WORD ON THE WEB

Joanna Brown *@CEOSCP* tweeted:

#AHPNI congratulations to young podiatrist Carmel Fitzpatrick one of this year's rising star awardees @ WeAHPs @SCP_PodiatryUK

SOCAP *@SCP_PodiatryUK* tweeted:

Images from the 2015 CoP Conference in Harrogate now on Flickr: http://buff.ly/1nWiXny

CLINICAL PICTURE QUIZZES

We would like members to send us short Clinical Picture Quizzes for Podiatry Now.

Please email podnow@scpod.org

PODIATRYNOW

BE THE CHANGE YOU WANT TO SEE

I enjoyed the editorial in the January edition of Podiatry Now written by Jill Woods who asked us all to 'Be the Change You Want to See!'

It was a thought-provoking editorial and led me to question what change I did want to see. I have been guilty of an apathetic attitude to professional matters throughout my career having never become involved within the Society structure apart from being a branch member and private practice network attendee. I do attend the annual conference on a regular basis, an event I enjoy and get a lot of personal satisfaction from as well as appreciating the opportunity for continued professional development. I see the Society stand taking central place in the trade show but have never felt compelled to chat to the staff. I suspect a lot of my colleagues take a similar attitude and hurry by just in case we are collared and asked for an opinion.

I have been successful in my career, and my profession has given me a standard of life above that of the national average and has allowed me, on a local level, to influence the delivery of healthcare in a fundamental manner and change it for ever. So I ask myself why have I not felt empowered to contribute to change within the Society and as a result change within the nation? What could the Society do to inspire me to engage with the organisation, to be a part of change, indeed drive change and support initiatives with action and determination? Better still, how do I and others become the instigators of change? A tough challenge indeed.

To get engagement we need to have a sense of value in our relationship. Gaining a sense of worth from those who wish to engage us requires trust that they will work in our best interests, support us, help us develop as individuals and acknowledge our efforts. Unless we feel this value from the Society, we will never become engaged.

We must also ask ourselves, do I want to be a part of this organisation and the change it feels it needs? Does it represent my views and conform to my values and standards or is it just a convenient flag through which I am able to get the essentials to practice such as insurance and continued professional development? Does my organisation only have an interest in the small number of members pursuing a limited field of practice thus alienating the majority? Conversely, does it wish to disengage a small but possibly creative section of its membership and primarily look after the interests of the majority?

I feel that the Society has changed and has a much more even view of the multiple sides of practice, which is all to its credit. However if there is a perception that certain areas are more favoured than others then alienation and disengagement will result. It is imperative therefore for the Society to ensure that its message and values are broadcast loudly and clearly to the membership at large for individual members to feel they are valued and begin to contribute.

Finally, I need to know that my organisation is changing in a way that leads to a tangible end result. Is my Society's mission compelling and inspired and does it fit with my personal beliefs both professional and personal? For me, the Society has to work tirelessly to elevate the podiatry profession to a status where it is recognised by all - whether other professionals or the public, as the go to profession for all things foot health related. Seeing my Society working towards this aim would inspire me.

So my challenge to the Society is to show us, its members, that we are able to become a part of the winning team and to prove that each of us is a valued member of that team.

Lyndon Jones

We Use TM2

"TM2 is by far the best overall management system on the market because of the attention to detail and functionality built into it. Great system and support makes for a happy practice".

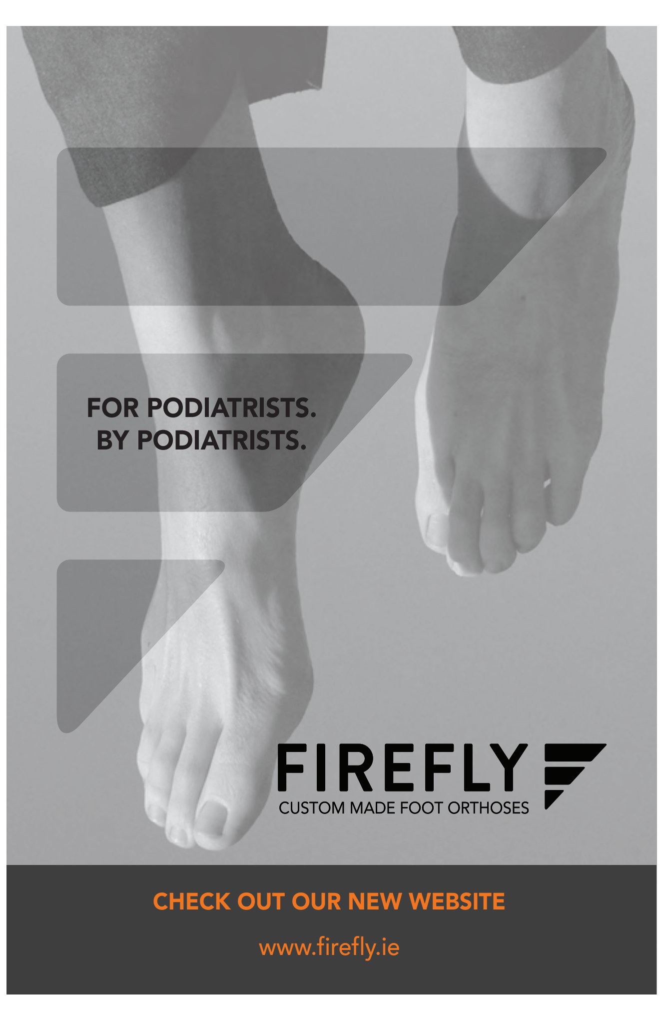
Paul Barrett
Director of Feet 24/7 Ltd

TM2, the perfect practice management software that allows you to build a better business. Call us today on 033 33 442 600 or visit www.insideTM2.com to find out why TM2 is loved by practitioners worldwide.

TM2

Your Practice Made Perfect

Created by bluezinc



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

APRIL 2016 DEADLINE: MIDDAY 19 FEBRUARY 2016

2016 DEADLINES

Issue	Deadline	Publication date
APRIL	19 FEBRUARY	19 MARCH
MAY	18 MARCH	22 APRIL
JUNE	22 APRIL	20 MAY

CATEGORIES

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

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 tel: 020 7234 8639.

Title	Venue	Date	Cost	CPD Points	Contact
Basic Life Support					
★ Basic Life Support	The Bell Surgery, Manchester	18 June 2016	£80	5	Nigel and Morag Bell, The Bell Surgery Ltd, 453 Barlow Moor Road, Chorlton, Manchester M21 8AU Tel.: 0161 881 2128 Email: information@thebellsurgery.com
Chronic Wounds/Wound Healing					
Wound Healing & Tissue Viability	Ye Olde Plough House, Brentwood Road, Bulphan. Essex RM14 3SR	4 March 2016	£70	5	Claire Bland on 01268 416603 Email: claire.bland@btconnect.com
★ Dimension in a Day - Essential Wound Care in the Diabetic Foot	College of Podiatry, London	22 April 2016	£65	8	Booking can be made via Eventbrite or contact pjdimensions@hotmail.com
★ 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	Edinburgh Marriott Hotel	4-5 March 2016	£750 early bird until 29th Jan 16 then £800 after *Please add VAT to above prices	26	Jamie Parr, Customer Services (Algeos UK) Tel.: +44 (0) 151 448 1228 F: +44 (0) 151 448 1008 Email: sales@algeos.com
★ Practical Acupuncture for Podiatrists including dry needling	Matthew Boulton College, Birmingham	9-11 March 2016	£750 early bird until 29th Jan 16 then £800 after *Please add VAT to above prices	26	Jamie Parr, Customer Services (Algeos UK) Tel.: +44 (0) 151 448 1228 F: +44 (0) 151 448 1008 Email: sales@algeos.com
Foundation in Acupuncture Course	London	7-8 May 2016 18-19 June 2016	£395	80	Steve Bailey The School of Biomechanics, Sports and Remedial Therapies, 76 Derby Road, Long Eaton, Nottingham NG10 4LB Tel.: 0115 983 5780 Email: enquiries@sobsart.com
Reflexology Certificate Course	The Holistic Coach House, Carrick House, 2 The High Street, Garstang, Preston PR3 1FA	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: 01524 791126/07411018541
Diabetes					
Diabetes Foot Module March 2016	Wellcome Foundation Euston Road, London	14 -18 March 2016	£750 (£50 deposit to secure a place)	30	Christopher Hunt Email: Christopher@huntassociates.fsnet.co.uk Tel. 0125456991 For application or information please email DrFVjackson@aol.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 extention 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
★ Dimension in a Day - Essential Wound Care in the Diabetic Foot	SCP Offices, London	22 April 2016	£65	8	Bookings can be made via Eventbrite: Contact: pjdimensions@hotmail.com
Local Analgesia					
★ Local Analgesia Update Course	The Bell Surgery, Manchester	21 May 2016	£80	5	Nigel and Morag Bell, The Bell Surgery Ltd, 453 Barlow Moor Road, Chorlton, Manchester M21 8AU Tel.: 0161 881 2128 Email: information@thebellsurgery.com
Mobilisation/Manipulation					
★ Soft Tissue Mobilisation	Edinburgh - Marriott Hotel	5-6 March 2016	£399.95 (incl. VAT, pre-reading material, course manual, lunch & refreshments)	36 CPD Points (+5 hours reading)	Courses delivered by Ian Linane To book, ring Algeos: Tel: 0151 448 1228 or book online at Algeos website: www.ALG-academy.com
★ Manipulation of the Foot and Ankle	Queen Margaret University, Edinburgh	19-20 March 2016	£399	50 CPD Points	David Cashley on tel: 07917 220099 Email: dgcashley@gmail.com
★ Foot Mobilisation	Edinburgh - Marriott Hotel	21-22 May 2016	£399.95 (incl. VAT, pre-reading material, course manual, lunch & refreshments, and videos of techiniques)	36 CPD Points (+5 hours reading)	Courses delivered by Ian Linane To book, ring Algeos: Tel: 0151 448 1228 or book online at Algeos website: www.ALG-academy.com
★ Foot Mobilisation	Cardiff - Marriott Hotel	11-12 June 2016	£399.95 (incl. VAT, pre-reading material, course manual, lunch & refreshments, and videos of techniques)	36 CPD Points (+5 hours reading)	Courses delivered by Ian Linane To book, ring Algeos: Tel: 0151 448 1228 or book online at Algeos website: www.ALG-academy.com
★ Foot Mobilisation	Derby - Marriott Breasdale Priory	16-17 July 2016	£399.95 (incl. VAT, pre-reading material, course manual, lunch & refreshments, and videos of techniques)	36 CPD Points (+5 hours reading)	Courses delivered by Ian Linane To book, ring Algeos: Tel: 0151 448 1228 or book online at Algeos website: www.ALG-academy.com
★ Soft tissue mobilisation	Bristol - Marriott Bristol Royal	10-11 Sept 2016	£399.95 (incl. VAT, pre-reading material, course manual, lunch & refreshments)	36 CPD Points (+5 hours reading)	Courses delivered by Ian Linane To book, ring Algeos: Tel: 0151 448 1228 or book online at Algeos website: www.ALG-academy.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 extention 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
☆ Ankle Mobilisation	Manchester Centre - Marriott Renaissance	24-25 Sept 2016	£399.95 (incl. VAT, pre-reading material, course manual, lunch & refreshments, and videos of techniques)	36 CPD Points (+5 hours reading)	Courses delivered by Ian Linane To book, ring Algeos: Tel: 0151 448 1228 or book online at Algeos website: www.ALG-academy.com
☆ Ankle mobilisation	Glasgow - Marriott	8-9 October 2016	£399.95 (incl. VAT, pre-reading material, course manual, lunch & refreshments, and videos of techniques)	36 CPD Points (+5 hours reading)	Courses delivered by Ian Linane To book, ring Algeos: Tel: 0151 448 1228 or book online at Algeos website: www.ALG-academy.com
☆ Ankle Mobilisation	Portsmouth - Marriott	15-16 October 2016	£399.95 (incl. VAT, pre-reading material, course manual, lunch & refreshments, and videos of techniques)	36 CPD Points (+5 hours reading)	Courses delivered by Ian Linane To book, ring Algeos: Tel: 0151 448 1228 or book online at Algeos website: www.ALG-academy.com
Pharmacology					
☆ Pharmacology Update	The Bell Surgery, Manchester	5 November 2016	£80	5	Nigel and Morag Bell, The Bell Surgery Ltd, 453 Barlow Moor Road, Chorlton, Manchester M21 8AU Tel.: 0161 881 2128 Email: information@thebellsurgery.com
Vascular Assessment					
☆ Dimension in a Day Lower Limb Vascular Assessment	Royal College of Physicians and Surgeons, Glasgow	5 March 2016	£230	8	Booking can be made via Eventbrite or contact pjdimensions@hotmail.com
☆ Dimension in a Day - Vascular Skills Training; Helping you to protect more limbs and save lives	Scotland (venue tbc)	21 April 2016	£220	8	Dr Joanne McCardle Diabetes Podiatry Research Fellow Royal Infirmary Edinburgh Tel: 07919 925539 @: pjdimensions@hotmail.com Bookings: tbc
Other					
☆ Record Keeping, SCP & Thompsons	TBC	24 March 2016	£70 per delegate from non-SCP accredited practice £60 per delegate from SCP accredited practice		Sharon Gray: Professional & Private Practice Officer, SCP www.bit.ly/1NH6k9H
☆ Low Level Laser Update Course	London	8 April 2016	£75 SCP members £60 accredited practices £90 non SCP members	7	Jessica Nelson, Omega Laser Ltd (c/o Natasha Smith, SCP) Tel.: Natasha Smith 0845 450 3733 or Email: ns@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 extention 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.

KINGSTON & SOUTH LONDON BRANCH

BIOMECHANICS UPDATE STUDY DAY

WITH ROBERT ISAACS

Saturday 23rd April 2016

MSK assessment and diagnostic techniques
Application of SALRE technique and vector mechanics
Kinetic chain theory and Lower back pain
This one day Biomechanics study day is aimed at Podiatrists with an interest in MSK at all levels. The sessions will be interactive with time for discussion and debate. Increase your knowledge base with practical advice relevant to your patients. Robert Isaacs has over ten years' experience working in a specialist NHS clinic.

Venue: Post Graduate Medical Centre, St Helier Hospital, Carshalton, SM5 1AA

Cost: £55 Refreshments provided (Lunch at cost in hospital restaurant)

Course duration: 9.00 - 16.00
Registration: 8.30 - 9.00

To book contact secretary@kslbranch.co.uk for a registration form
Closing date 16th April 2016

MANCHESTER & DISTRICT BRANCH

DIABETIC FOOT STUDIES DAY

Saturday 23rd April 2016, Village Hotel, Cheadle SK8 1HW

Programme

08.30 – Registration & Coffee
09.00 – Welcome and Housekeeping
09.05 – Overview of the Diabetic Foot – Dr Paul Chadwick, Consultant Podiatrist, Salford Royal
09.45 – Surgical Management of the Diabetic Foot – Frank Webb, Consultant Podiatric Surgeon, Buxton Hospital
10:30 – Break, Tea, Coffee & Snacks
11.00 – Management of infection in the Diabetic Foot – Prof. Frances Game, Consultant Endocrinologist,, Derby Royal Hospital
11:45 – PAD in the Diabetic Foot: Identification, Management and reducing Cardiovascular death – Susan Matthews, Vascular Podiatrist, Pennine Acute / Pam Smith, Vascular Podiatrist, Salford Royal
12:30 – Expect Panel Q&A – All Speakers
13.15 – Lunch - 2 course hot & cold buffet lunch
14.15 & 15.15 – Concurrent Workshops. Delegates can choose 2 of the following 4 workshops:*
1. Vascular Assessments – From Pedal to Pelvic and Positive Identification of Critical Limb Ischaemia, Susan Matthews & Pam Smith
2. Introduction to non-removable Total Contact Casting. Saul Hill
3. Managing Foot Emergencies in Private Practice and where to send them, Graham Holt
4. Neurological assessment TBA
16:15 – Summary and Close

**Workshops are limited to 15 per session but if demand is sufficient, extra sessions may be added. Workshops may be available as stand-alone sessions. If you have any dietary requirements please contact branch. For any other information contact Branch Secretary, Mark Simmons:- scpmanchesterbranch@gmail.com*

Book via Eventbrite. Earlybird ticket: £55+booking fee (if booked before 1/3/16)

MID SUSSEX BRANCH

RECORD KEEPING

WEDNESDAY 18 MAY
7PM FOR 7.30PM START

Venue:
Haywards Heath Town Hall,
Boltro Road,
Haywards Heath

Record keeping.
Speaker; Caroline Godfrey (Solicitor from Mayo Wynn Baxter Solicitors)

Please confirm your attendance by email midsussex.socap@gmail.com

MANCHESTER PODIATY PRIVATE PRACTICE NETWORK

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

2nd March 16 - Peripheral Arterial Disease (PAD) with Lisa Smith

5th April 16 - Skin Cancer and Suspicious Lesions with Dr Vindy Ghura

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

SOUTH YORKSHIRE BRANCH MEETING/EDUCATION

Venue:
The Holiday Inn, High Road, Warmsworth, Doncaster, DN4 9UX

6th June 2016 – Vascular Assessment Update By Jean Mooney
9.15-9.45am Registration/Refreshments,
10am-4pm Educational Session.

5th September 2016 – Neurological Update By Jean Mooney
9.15-9.45am Registration/Refreshments,
10am-4am Educational Session.

3rd October 2016 – Intermediate Level – Cardiopulmonary Resuscitation CPR/Automated External Defibrilation/ Anaphylaxis

Course 1 Refreshments and Registration 9.15-9.30am,
Course 9.30am-12.30am
Course 2 Refreshments/Registration 1.15-1.30am,
Course 1.30-4.30am.

£60.00 To pay for cost of training. Cheques to be made payable in full name of the Society of Chiropodists and Podiatrists South Yorkshire Branch.

Contact: Janet Cawthorne, Jane Senior
Email: Greensidepod@Hotmail.co.uk
Tel No: 01226 388622/384135

MANCHESTER BRANCH

PREPARING FOR RETIREMENT WORKSHOP

HOUGH END CENTRE, CHORLTON MANCHESTER

SATURDAY 30th APRIL 2016
9.30am – 2.30pm

Refreshments & lunch provided

The Manchester Branch will host this event next spring for NHS or private practitioners who are within TWO years of retirement. Partners welcome to attend. There will be a small fee of £20 per person to cover branch costs. The workshop will cover finance, pensions, and preparing for retirement itself.

If you would like to go on the list of attendees, please contact the branch secretary at the address below. Further information will be available nearer the time & the secretary will contact those on the list with full details.

Contact:
Mark Simmons
Manchester Branch Secretary
scpmanchesterbranch@gmail.com

NORTH YORKSHIRE BRANCH

AN UPDATE ON THE FOOT AND ANKLE IN RHEUMATOLOGY & OSTEOARTHRITIS

Presented by
Dr Mike Backhouse and Dr Jill Halstead

SATURDAY 16th APRIL 2016
9.15am to 4.30pm
Registration 9.30am

Venue:
The Hilton Hotel, Tower Street,
York, YO1 9WD

The course fee is £60.00 and includes refreshments, lunch and course materials.

For further information and to request a booking form please e-mail
beckyhargreaves@hotmail.com

Organised by SOCAP South East Wales Branch

Friday 8th April 2016 and Saturday 9th April 2016

Mercure Holland House, Cardiff

Speakers include... Professor Jim Woodburn, Dr Jean Mooney, Professor Nachi Chockalingam, Mr Anthony Perera, Professor Caroline McIntosh, Dr Ivan Bristow, Mandy Abbott, Professor Robert Ashford ...*and more*

Topics to include... Diabetes, rheumatology, chronic foot instability, 3D printing of orthoses, Special Olympics and Paralympics, dermatology, neurology, gait analysis...*and more*

- ***Early Bird Rates** (Till 20th February 2016):* Delegate: £125.00
  Student: £65.00 (limited places)
- ***Normal Rates** (From 21st February 2016):* Delegate: £145.00
  Student: £65.00 (limited places)

Conference Chair: Dr Sarah Curran

Website for More Information and to Book Your Place: http://walespodconf.co.uk/

"....Supporting Your Clinical Development...."

OMEGA LASER TRAINING 2016 - WORTH 7 CPD POINTS

Region	Date	Time	Venue
London	Friday 8 April 2016	9.30am-5.00pm	SCP Offices

Further dates to follow in due course.

Prices £75 - SCP Members , £60 - Accredited Practices, £90 - Non-SCP Members

To book yourself on to one of these courses, or to receive more information please contact Natasha Smith on **ns@scpod.org** or **020 7234 8633**

CALL FOR DELEGATES FOR TUC CONFERENCES IN 2016

We are looking for two delegates to attend each of the following TUC Conferences:

Conference	Date	Venue
TUC Young Workers Conference (Under 27's)	9-10 April 2016	Congress House, London
TUC Black Workers Conference	15-17 April 2016	Congress House, London
TUC Disabled Workers Conference	19-20 May 2016	Congress House, London
TUC LGBT Conference	23-24 June 2016	Congress House, London

Your role as a delegate will be to listen to the debates and represent the Society for your time at the conference and if possible form a motion to put to the Conference. The Society will also pay for expenses and organise any hotel accommodation.

If you are interested and would like to be considered, please contact Natasha Smith in the Employment Relations Department on **020 7234 8633** or **ns@scpod.org**

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. Due to space constraints, events are usually publicised no more than three months ahead. Email: diary@scpod.org with your diary dates

FEBRUARY 2016

23 – GUILDFORD BRANCH
Branch AGM - This is the members' chance to discuss the branch CPD presentations for the future. Venue: Oak Room at the Mandolay Hotel, 36-40 London Rd, Guildford GU1 2AE. 7.30pm for a prompt 8pm start. Open to non-members £15. For information, please contact Sally Hodgkins at socapguildford@gmail.com

24 – MID SUSSEX BRANCH
Haywards Heath Town Hall, Baltro Road, Haywards Heath. Time: 7pm for 7.30pm. Basic Life Support with anaphylaxis update with Lynn Watts. Please confirm your attendance by emailing Flo Paul / Karen Burrett on Email midsussex.socap@gmail.com

25 – THE SOCIETY OF CHIROPODISTS & PODIATRISTS
PR Committee meeting. Contact Tina Davies on 020 7234 8639.

26 – THE COLLEGE OF PODIATRY
Committee of the Directorate of Podiatric Medicine. Contact Debra Barlatt-Browne on 020 7234 8636 .

27 – GUILDFORD BRANCH
SCP Branch CPD Day - Robert Isaacs - CPD day - 'Biomechanics for the Terrified' Putting theory into practice. The day will include up-to-date knowledge with practical hands on practice. Venue: Woodhatch Community Centre, Whitebeam Drive, Reigate, RH2 7LS. 9am-4:00pm. Cost: £65.00. For more information please contact socapguildford@gmail.com

27 – THE COLLEGE OF PODIATRY
Committee of Private Practice and Directorate of Independent Practice. Contact Brian Harris on 020 7234 8634.

MARCH 2016

2 – GLASGOW BRANCH
AGM, topic and speaker tbc. All meetings will be held at the Students Association, Glasgow Caledonian University, Cowcaddens Road, Glasgow, G4 0BA with a start time of 7.15pm. For further details please contact glasgowbranchsecretary@googlemail.com

2 – GREATER MANCHESTER PRIVATE PRACTICE NETWORK
All podiatrists are welcome to attend. Topic: Peripheral Arterial Disease (PAD) with Lisa Smith. 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 on to www.manchesterpodppn.eventbrite.co.uk

2 – MANCHESTER AND DISTRICT BRANCH
Notice of Annual General Meeting of the Manchester & District Branch: 7.30pm Hough End Centre, Board Room. (Open to any members wishing to attend.) Contact Mark Simmons, Branch Secretary email: scpmanchesterbranch@gmail.com

2 – LONDON DISTRICT BRANCH
Sophie Roberts, Private Practitioner - Hypermobility Syndrome Affecting the Lower Limb. 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.scp@gmail.com or 07846764394 or register on Eventbrite at www.eventbrite.co.uk/e/ldb-evening-meeting-tickets-15190965587. Please also visit our Facebook page 'London District'

4 – THE COLLEGE OF PODIATRY
The College of Podiatry Academic Board. Contact Wilfred Foxe on 020 7234 8628.

7 – BRENT NETWORK PRIVATE PRACTICE
Discussion on audit profiles at The Preston Pub, 161 Preston Road, Wembley, HA9 8NG. Meetings start at 7.30pm. All podiatrists welcome. Email diana_ayres@hotmail.com or tel.: 0780 641 9940.

9 – AYRSHIRE BRANCH
Start time 7.30pm. Speaker Connie le Maitre. Lymphoedema Specialist Physiotherapist + AGM. Seminar Room, Lister Centre, Crosshouse Hospital, Kilmarnock. Please e-mail ayrbranchpodiatry@gmail.com to book a place or for further details. See us on FACEBOOK - Ayrshire Branch Society of Chiropodists and Podiatrists.

10 – KINGSTON & SOUTH LONDON BRANCH
Record keeping and Practice Accreditation. by Sharon Gray (The Society's Professional and Private Practice Officer) 8pm. Venue: Post Graduate Medical Centre, St Helier Hospital, Carshalton, SM5 1AA. Contact: secretary@kslbranch.co.uk

10 – THE SOCIETY OF CHIROPODISTS & PODIATRISTS
Time: 1.30pm. The Board of Trustees of The Benevolent Fund of The Society of Chiropodists, Contact Helena Basarab-Horwath on 020 7234 8635.

12 – EAST ANGLIAN BRANCH
Vascular Assessment for Podiatrists. 9am and AGM at 1.30pm. Further information is available on Eventbrite: www.bit.ly/1MMPIZY

15 – KINGSTON & SOUTH LONDON BRANCH

APRIL DEADLINE: MIDDAY 26 FEBRUARY

Branch AGM 8pm Post Graduate Medical Centre, St Helier Hospital, Carshalton, SM5 1AA. Contact: secretary@kslbranch.co.uk

16 – HAMPSHIRE BRANCH
AGM and presentation by Ivan Bristow on microwave therapy for skin and also Clearanail. Holiday Inn Express, West End at 19:30. For an Event Brite invitation to book your free place please contact hants.branch.scp@live.co.uk

16 – THE COLLEGE OF PODIATRY
10.30 am. The Board of Trustees of The College of Podiatry. Contact Helena Basarab-Horwath on 020 7234 8635.

16 – MANCHESTER & DISTRICT BRANCH
CPD: Introduction to Steroid Injections With Ian Reilly. 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. Trade support: ALGEOS. No need to book, just turn up. Contact Mark Simmons, Branch Secretary email: scpmanchesterbranch@gmail.com

16 – MID SUSSEX BRANCH
7pm for 7.30pm start at Haywards Heath Town Hall, Boltro Road, Haywards Heath. Red Flags. Speaker - Richard Cruse. Confirm your attendance to midsussex.socap@gmail.com

29 – GUILDFORD BRANCH
Guy Hirst - Humans as Heros and Hazards. Guy is coming to speak on risk awareness mainly regarding surgery/medical treatments, not a subject to miss to safe guard your patients, staff and yourselves. Venue: Oak Room at the Mandolay Hotel, 36-40 London Rd, Guildford GU1 2AE. Time: 7.30pm for a prompt 8pm start. Open to non-members £15. For information please contact Sally Hodgkins at socapguildford@gmail.com

30 – MANCHESTER AND DISTRICT BRANCH
Forthcoming Events (Booking & Payment required). CPR/Anaphylaxis/Adrenaline annual updates. 6.30pm (Approx 2 hrs.) Tea/coffee provided. Venue: Hough End Centre, Mauldeth Road West, Chorlton M21 7SX. Cost: £25 + booking fee. Book via Eventbrite (further update will run in May 2016). Contact email: scpmanchester@gmail.com

APRIL 2016

5 – GREATER MANCHESTER PRIVATE PRACTICE NETWORK
All podiatrists are welcome to attend. Topic: Skin Cancer and Suspicious Lesions with Dr Vindy Ghura. Venue: Manchester Maccabi Community & Sports Club, Brooklands, Bury Old Road, Prestwich, M25 0EG at 7.30pm.

PLEASE ALLOW 4 WEEKS BEFORE EVENT

YOU CAN ADVERTISE DATES UP TO 4 MONTHS IN ADVANCE

3 FREE 1/4 PAGE DISPLAY ADVERTS PER YEAR!

Contact: Lindsey 07575285815. Booking Essential. Early bird price available. To book log on-to www.manchesterpodppn.eventbrite.co.uk

5 – NEWCASTLE UPON TYNE BRANCH
"Undefeeted" by Diabetes 7.30pm. Tina Allton will present the rationale behind the book and supporting material that she hopes will assist podiatrists to reduce the incidence of diabetic foot problems and their complications. The Trinity Centre, Gosforth, Newcastle upon Tyne NE3 4AG. Further information contact Sue Emmett , Branch secretary, email susan_emmett@yahoo.co.uk

6 – LONDON DISTRICT BRANCH
Belinda Longhurst, Private Practitioner. Vertical needling. Arrive from 7pm 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.scp@gmail.com or 07846764394 or register on Eventbrite at www.eventbrite.co.uk/e/ldb-evening-meeting-tickets-15190965587. Also visit our Facebook page 'London District'

7 – THE SOCIETY OF CHIROPODISTS & PODIATRISTS
Council Meeting. (Cardiff). Contact Helena Basarab-Horwath on 020 7234 8635.

10 – LONDON DISTRICT BRANCH
Time: 9-4.30pm HIVE Podiatry business/marketing workshop. Cost TBC but will be nominal. Arrive from 7pm for 7.30pm start. Lectures held at Park Crescent Conference Centre, Great Portland St opp Great Portland St tube station. Refreshments provided. For further details please contact Steven Childs on londondistrictbranch.scp@gmail.com or 07846764394 or register on Eventbrite at www.eventbrite.co.uk/e/ldb-evening-meeting-tickets-15190965587. Please also visit our Facebook page 'London District'

12 – KINGSTON & SOUTH LONDON BRANCH
New advances in the treatment of the Diabetic Foot by Dr Steven Hyer MA MD FCRP MBA (Consultant Endocrinologist) 8pm. Post Graduate Medical Centre, St Helier Hospital, Carshalton, SM5 1AA. Contact: secretary@kslbranch.co.uk

14 – FIFE BRANCH
Venue and time TBC. Speaker TBC. Email: fifebranch@gmail.com

16 – NORTH YORKSHIRE BRANCH
An update on the foot and ankle in Rheumatology & Osteoarthritis. Presented by Dr Mike Backhouse and Dr Jill Halstead. Time: 9.45am to 4.30pm. Registration 9.30am. Venue: The Hilton Hotel, Tower Street, York YO1 9WD. The course fee is £60.00 (Early bird fee is £50.00 if booked before 31st January 2016) and includes refreshments, lunch and course material. For further information and to request a booking form please e-mail: beckyhargreaves@hotmail.com

18 – MID SUSSEX BRANCH
Neurological assessment of the lower limb. Speaker: Kieran Barnard (Specialist Physiotherapist - NHS). 7pm for 7.30pm start at Haywards Heath Town Hall, Boltro Road, Haywards Heath. Please confirm your attendance by email midsussex.socap@gmail.com

20 – MANCHESTER & DISTRICT BRANCH
CPD: Verrucae Dry Needling Technique. With Robert Morley. 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. Trade support: TBA No need to book, just turn up. Contact Mark Simmons, Branch Secretary email: scpmanchesterbranch@gmail.com

21 – NORTHERN IRELAND CONFERENCE
Annual Northern Ireland Branch Conference 2016 held in the beautiful luxurious surroundings of Lough Erne Resort & Spa, Co Fermanagh, Northern Ireland. Mark it in your diaries and plan to enjoy possibly the friendliest conference for everyone. Outline includes Thursday - Golf Competition and pre-conference dinner: Friday - Conference then Saturday - 'Bartold Biomechanics Day'. Quality keynote speakers in a fine resort which staged the G8 World Summit 2013. Contact: Alan.McCague@westerntrust.hscni.net

23 – MANCHESTER AND DISTRICT BRANCH
Diabetes Day. 9am-4pm. Cheadle Village Hotel, Cheadle Road, Cheadle, Stockport, Greater Manchester SK8 1HW. AM – Presentations: Paul Chadwick, Frances Game, Frank Webb & Martin Fox. PM – Choice of 2 of 4 workshops. Lunch & refreshments included. Free parking. Full details will be advertised/emailed out to local members. Booking available via Eventbrite. Earlybird tickets before 1/3/16 - £55 + booking fee. Email: scpmanchesterbranch@gmail.com

26 – GUILDFORD BRANCH
June Ewart, Tissue Viability Specialist. (TVS) - Tissue viability & practical wound care management. Venue: Oak Room, Mandolay Hotel, 36-40 London Rd, Guildford, GU1 2AE. 7.30pm for a prompt 8pm start. Open to non-members £15. For information please contact socapguildford@gmail.com

30 – MANCHESTER AND DISTRICT BRANCH

Preparing for Retirement Workshop 9.30am – 2.30pm. Hough End Centre, Chorlton, Manchester. Refreshments & lunch provided. This event is for NHS or private practitioners who are within TWO years of retirement. Partners welcome to attend. There is a small fee of £20 per person to cover branch costs. The workshop will cover finance, pensions, and preparing for retirement itself. If you would like to attend, please contact the branch secretary. Further information will be available nearer the time & the secretary will contact those on the list with full details. Further information contact: Mark Simmons, Manchester Branch Secretary, scpmanchesterbranch@gmail.com

MAY 2016

4 – GLASGOW BRANCH

Topic and speaker tbc. All meetings will be held at the Students Association, Glasgow Caledonian University, Cowcaddens Road, Glasgow, G4 0BA with a start time of 7.15pm. For further details please contact glasgowbranchsecretary@googlemail.com

4 – LONDON DISTRICT BRANCH

Speaker and topic TBC. 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.scp@gmail.com or 07846764394 or register on Eventbrite at www.eventbrite.co.uk/e/ldb-evening-meeting-tickets-15190965587. Please also visit our Facebook page 'London District'

11 – GREATER MANCHESTER PRIVATE PRACTICE NETWORK

Neurology Talk with Alison Edmonds-Nicholson from Manchester Neurotherapy Centre (MNC). To book log on-to www.manchesterpodppn.eventbrite.co.uk

12 – KINGSTON & SOUTH LONDON BRANCH

Swift – New Microwave treatment of verrucae By Jonathon Williams 8pm. Venue: Post Graduate Medical Centre, St Helier Hospital, Carshalton, SM5 1AA. Contact: secretary@kslbranch.co.uk

18 – MID SUSSEX BRANCH

7pm for 7.30pm start at Haywards Heath Town Hall, Boltro Road, Haywards Heath. Record keeping. Speaker, Caroline Godfrey (solicitor from Mayo Wynn Baxter Solicitors). Please confirm your attendance by email: mid-sussex.socap@gmail.com

31 – GUILDFORD BRANCH

Jonathan Williamson, Director, Strategy & Marketing Microwave Emblation SWIFT Presentation on An Introduction to Swift: Microwave Therapy for Skin. Venue: Oak Room at the Mandolay Hotel, 36-40 London Rd, Guildford GU1 2AE. 7.30pm for a prompt 8pm start. Open to non-members £15. For information, please contact socapguildford@gmail.com

JUNE 2016

1 – LONDON DISTRICT

Ina Farrelly, podiatrist. Talk on Lymphoedema. Nail Surgery CPD Update planned for September 2016. 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.scp@gmail.com or 07846764394 or register on Eventbrite at www.eventbrite.co.uk/e/ldb-evening-meeting-tickets-15190965587. Please also visit our Facebook page 'London District'

6 – BRENT PRIVATE PRACTICE NETWORK

Sterilisation and decontamination by Margaret Johns. Venue: Preston Pub, 161 Preston Road, Wembley HA9 8NG. Meetings start at 7.30pm. All podiatrists welcome. Email diana_ayres@hotmail.com or tel: 0780 641 9940.

7 – GREATER MANCHESTER PRIVATE PRACTICE NETWORK

Pharmacology Talk with Mr A.L. Murphy (Consultant Podiatry Surgeon). To book log on to www.manchesterpodppn.eventbrite.co.uk

14 – KINGSTON & SOUTH LONDON BRANCH

TBA. Contact secretary@kslbranch.co.uk

15 – MID SUSSEX BRANCH

7pm for 7.30pm start at Haywards Heath Town Hall, Boltro Road, Haywards Heath. TBC. Please confirm your attendance by email midsussex.socap@gmail.com

28 – GUILDFORD BRANCH

Paul Halliwell, Orthopaedic Surgeon. Presentation on Chronic ankle injuries and what to do about them. Venue: Oak Room at the Mandolay Hotel, 36-40 London Rd, Guildford GU1 2AE. Time: 7.30pm for a prompt 8pm start. Open to non-members. £15. For information, please contact socapguildford@gmail.com

Scottish One Day Conference

Saturday 14th May 2016

Craigmonie Hotel. Inverness

Delegate price: £85, student: £40
Lunch & refreshments included.

The COLLEGE of PODIATRY

Hosted by Highlands & Islands Branch

CONFIRMED SPEAKERS

Prof David G Armstrong (via video link) – USA Podiatric Diabetes Specialist
Mr Allan Thomson – Use of Ultrasound
Mr Ivan Bristow - Dermatology
Mr Alan Borthwick – Topic to be confirmed
Mr Martin Fox – Vascular Podiatrist
Mr James Beastall - Orthopaedic Surgeon, foot & ankle specialist

We are also offering:
First Aid / Basic Life Support on Friday 13th May, Evening.
Conference attendees: £10
Non attendees: £30
~
Friday night - free pub quiz (teams of 4)
~
Social Event / Ceilidh on Saturday 14th May, Evening £10

For more Information & Booking
www.Scottishpodiatryconference2016.com
Email: podconference2016@gmail.com
Podiatry SODC 2016

CLASSIFIED ADVERTISEMENTS

SITUATIONS VACANT

MACCLESFIELD, CHESHIRE
Experienced HPC registered podiatrist required for well-established private practice. Hours and days to be discussed. Please send your CV to enquiries@thefootcareclinic.co.uk

NR. IPSWICH Long established RSscan Lab UK Clinic near Ipswich requires motivated and forward thinking HCPC registered podiatrist for a full time role. Training with all biomechanical equipment given. Excellent interpersonal and clinical skills essential. Please email paul@footfunctioncentre.com for further details.

NORTH SOMERSET A well established, growing practice in North Somerset seeks a p/t podiatrist. This position offers a flexible 16hr/wk. contract on a fee sharing basis. Must be HCPC registered and have own transport. Please send CV and covering letter to chris@dalypodiatry.co.uk'

WARE HERTS / LOUGHTON ESSEX
Self-employed part time podiatrist welcomed to join busy multidisciplinary practice with existing client base and podiatry resources. Private practice experience desirable but not essential, with special interest in biomechanics. Email: admin@halephysio.co.uk or visit www.halephysio.co.uk

AMERSHAM / CHESHAM BUCKINGHAMSHIRE Are you passionate about feet? Do you strive to be the best podiatrist you can be? Do you love caring for your patients and healing their foot complaints? Are you committed to CPD? If you said yes, this is the job for you! We are looking for a full time employed podiatrist to join our team. Please email your CV to: enquiries@walkthiswaypodiatry.co.uk

CARLISLE Friendly Associate HCPC Qualified Podiatrist wanted for expanding busy town centre private practice. The position is on a part-time, fee-sharing, self-employed basis with the future prospect of full time. Must have high clinical standards, excellent communication skills and be reliable. Graduates welcome. For more information call 01228 523761 or email familyfootclinic@hotmail.co.uk

KENILWORTH, WARWICKSHIRE
Podiatrist required on a part-time basis to join a small, but very busy foot care practice. Would suit newly qualified or more experienced podiatrist. Excellent people skills essential. Email Kate Harrison at hello@courtyardfootcare.co.uk for more information. www.courtyardfootcare.co.uk

CHICHESTER, WEST SUSSEX New multi-disciplinary clinic looking for confident & professional HCPC registered podiatrist. Biomechanics specialism a bonus. Hours negotiable. Must have insurance, registration to professional body and present qualifications. Essential to work as team member. Send cv to iwanttowork@theboxgrove.com

WEYBRIDGE, SURREY The Footcare Centre - Are seeking a new podiatrist to join our team. If you are the podiatrist we are looking for ... you will be friendly, charming, enthusiastic and professional. You will have high standards and be described as courteous, mature and an involved team player. You will have the desire to offer complete foot-health solutions to your patients, with skills to develop thorough treatment plans, provide comprehensive advice, offer biomechanical assessment, perform nail surgery and prescribe quality orthoses or train to use the 'Richie Brace'. You will be an energetic member of our fun team and your communications skills and general commercial acumen will ensure your success! You are well presented, trustworthy, punctual and love delivering quality! If you are eager to take this opportunity to learn, grow and be challenged we have a position in our practice. If you are ready to rise to the challenge, call Jayne now on 01932849373 or email jayne@thefootcarecentre.co.uk for further details.

BUCKS/OXFORD Premier Physical Healthcare Ltd require a qualified podiatrist for up to 7 x 1/2 days a month in the Bucks/ Oxford Region. This role will involve working in a pressured environment, including clinics in secure locations. DBS checks are required alongside additional security screening. Requirements: 3+ year experience, HCPC registered & car driver essential. Email: accounts@premiertherapy.co.uk

COULSDON, SURREY CR5 2NF
Enthusiastic, skilled, part-time HCPC registered podiatrist/s required to cover an existing caseload. Days, hours, and terms negotiable. Friendly, supportive and busy practice. For further information phone 020 8660 0349. Please email CV to thefoothealthcentre@gmail.com.

PRACTICES FOR SALE

FERNDOWN, DORSET Hit the ground running. Established, successful fully equipped single chair practice in busy town centre for sale. Literally, walk in and start treating. Continuous passing foot-fall with excellent reputation and massive potential. Turnover last 3 years on part time basis £45,000+. Owner leaving to concentrate on doms, therefore clinic side of business available to capitalise on huge local demand. Goodwill only or with low rent on existing first floor, large, light room in reputable beauty premises. £15,000 for quick sale. For detailed information please contact debbie.haynes@hotmail.co.uk

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 APRIL MUST BE RECEIVED BY MIDDAY 26 FEBRUARY

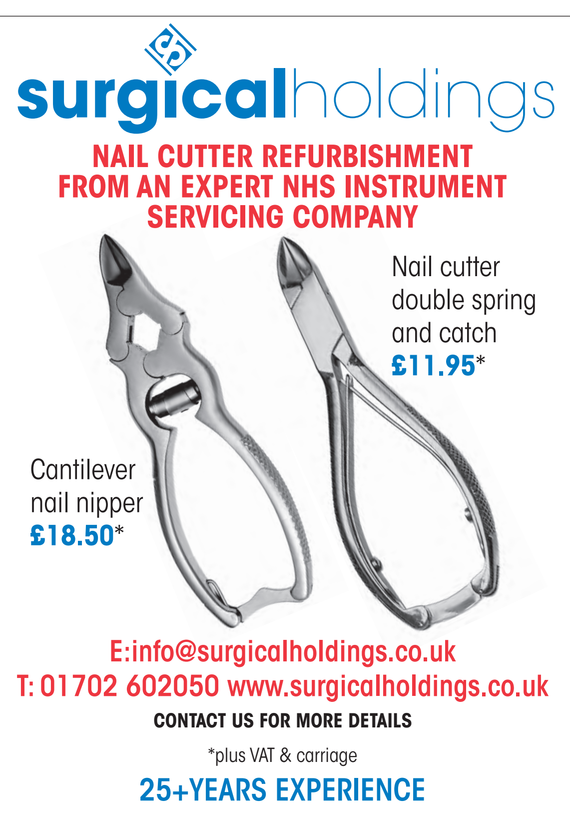
ARTICLES FOR SALE

SURREY For sale Lemy chair, mid blue, in excellent working order. Electrically operated. Folds flat to form examination couch. £400. Buyer collects. 02089795890 Surrey.

PREMISES AVAILABLE

WARLINGHAM, SURREY Treatment Room available immediately. Reasonable rates, electric included. Newly decorated. Alternatively we will pay a daily salary. Please phone Julie 07889 368923 or email greenjulie@btinternet.com Suit part-time podiatrist/ foot care specialist, days/ hours to suit you.

REPAIRS



RECRUITMENT

Contact:
Alex Montieth

Tel:
020 7880 7613

Email:
alex.monteith@redactive.co.uk

Booking deadline for APRIL is midday,26 FEB 2016
Despatch date for APRIL is 19 MARCH 2016

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

2015 DEADLINES

Month	Booking	Mailing
April	1 March	18 March
May	24 March	22 April
June	29 April	20 May

THE BEST RESOURCE
ON THE WEB FOR PODIATRY JOBS!
www.feetforlife.org

You insure everything you care about

Shouldn't that include your income?

mutual
Income Protection Plus

For an instant quote

0800 146 307

www.pgmutual.co.uk

Income protection for professionals

EXCLUSIVE MEMBER DISCOUNT
2YEARS
15%
DISCOUNT
CODE
"OSGO"

PG Mutual is the trading name of Pharmaceutical and General Provident Society Ltd. Registered office: 11 Parkway, Porters Wood, St Albans, Hertfordshire AL3 6PA. Incorporated in the United Kingdom under the Friendly Societies Act 1992, Registered Number 462F. **Authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority, Firm Reference Number 110023**

Join The Private Podiatry Buying Group

Don't face the challenges of private practice alone, give your practice the advantage it needs.
Osgo is here to help **SAVE** you money and time, **GROW** your practice, and **COMPLY** with regulations.

Access Membership ANNUAL FEE £30 (£37.50 including Vat)

- Access to member's only prices in our online shop
- Access to exclusive online CPD
- Free medical emergencies desktop guide
- Free online biomechanics course
- Free policies and procedures templates
- Access to member only deals with our partners

Compliance Membership ANNUAL FEE £95 (£118.75 including Vat)

Access Membership Benefits PLUS...

- Local Anaesthetic CPD Online course
- Access to Medicines CPD online course
- Customer Service Training CPD
- Health & Safety Template package, helping you keep compliant with all your regulatory health & safety requirements.

Osgo negotiate deals with nationwide companies to **save YOU money!**

visit: **www.osgo.co.uk** or call: **0844 736 2278**

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

Designed together with some of the world's leading biomechanics experts; the Vasyli Think Tank, Vasyli Medical introduced custom heat-moldable orthotics. Easily customisable in clinic, Vasyli has revolutionised medical orthotics for professionals who treat lower-limb disorders.

Vasyli Medical adds value to your practice with prescription heat-moldable orthotics. Vasyli's pioneering products achieve superior outcomes for patients - repeatedly documented by research.

Vasyli Dananberg Orthotic

HOWARD DANANBERG

Named among the most influential podiatrists in America by Podiatry Management magazine. Howard is renowned for his work in the development of the concepts associated with Functional Hallux Limitus. His published articles on Sagittal Plane Biomechanics, his patented kinetic wedge and work on gait related back pain is recognised worldwide.

FREE PAIR OF ORTHOTICS

when you book a Vasyli Orthotic product demonstration with your Canonbury Business Development Manager*

FREE DELIVERY ON ALL VASYLI MEDICAL ORTHOTICS

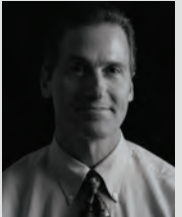
INTRODUCING THE VASYLI THINK TANK

DAVID ARMSTRONG

Professor of Surgery, Director of Lower Extremity Research and Southern Arizona Limb Salvage Alliance (SALSA) at the University of Arizona, Tucson USA. He has produced more than 230 peer reviewed research papers and is co-editor of the American Diabetes Association (ADA) Clinical Care of the Diabetic Foot.

TOM MCPOIL

Tom McPoil is a professor in the School of Physical Therapy at Regis University in Denver, Colorado. He has specialised in the evaluation and management of foot and ankle disorders since 1979. His scholarly contributions have systemically examined foot and ankle function from both scientific and clinical perspectives.



BRIAN HOKE

Co-owner and director of Atlantic Physical Therapy, a private Physical Therapist practice in Virginia Beach, Virginia, USA. Brian's clinical experience has been specialised to the realm of orthopaedic and sports physical therapy, with a particular focus upon the biomechanical basis for lower extremity rehabilitation.

TREVOR PRIOR

Trevor's areas of speciality include foot surgery, sports injuries, biomechanics and gait analysis, orthoses and diabetic foot complications. Trevor has worked extensively with elite sports men and women from a wide range of disciplines.

VIEW THE FULL RANGE ONLINE

01280 706661 | canonbury.com

*One free pair of orthotics per practice, when you book a product demonstration with your Canonbury Business Development Manager. Offer valid until 30/6/2016.