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MAY/JUNE 2021
VOLUME 24
NUMBER 3

The Podiatrist

THE PROFESSIONAL MAGAZINE OF THE COLLEGE OF PODIATRY

Inside stories

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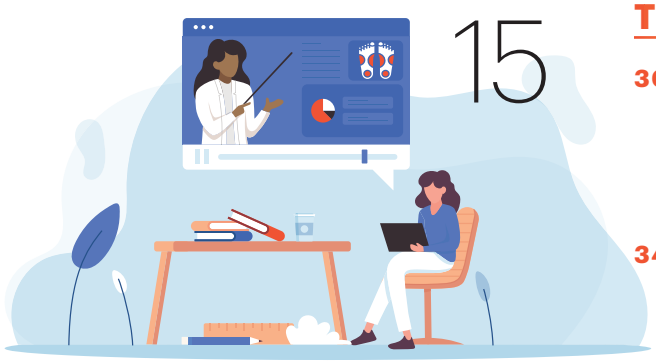

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THE END

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The Podiatrist, 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

A point of pride

As we enter the summer, there is a lot to look forward to.

Many of our members have received both Covid-19 vaccinations as frontline workers and, as restrictions ease, it seems we are on the road to recovery and some sense of normality.

Within the College, we have had a lot to be thankful for in the past few months. We have fought hard for vaccine access for our members in independent practice and fair pay for those who work in the NHS. In April, our annual foot health campaign, Foot Health Week, brought our members together to highlight the magnificent work that podiatrists do.

Of course, the big news was that Her Majesty The Queen bestowed the honour of a royal title on the College – we can now be called the Royal College of Podiatry. This has been an ambition I have held for the profession since I joined as your chief executive. For years, with our council and staff, we have worked hard to bring this to fruition, and I felt immense pride to receive the formal notification from the Cabinet Office in March.

It is not often that royal status is bestowed, and this has been granted in recognition of the amazing work that you, our members, do every day. This elevates the profession to a new level. It is a recognition of the immense contribution that podiatrists make to the welfare of the nation. It enhances both the public image of podiatry and how other professions view your role. This will help in numerous ways, not only with lobbying for more podiatry access and provision, but in attracting more people into the profession, both as patients and as students.

I know many of you are eager to start using the title straight away – so are we! Although we have been granted the right to use it, our governance requires that we put the name change to a formal AGM vote to be accepted by our members. This will be a special resolution at the AGM in June, and our voting members will soon receive details of how to participate. Please make sure you cast your vote. Upon the name change being accepted by our members, the new branding will take effect and you will all be given details on how to update your identity as a member. See more on page 8.

This good news follows a year of tumult for people across the globe. Despite the many challenges our members have faced and overcome in the past 12 months, the increased recognition that the honour of a royal title brings should give us all hope for the future of this profession and those who practise it.

I continue to wish you and your families good health.

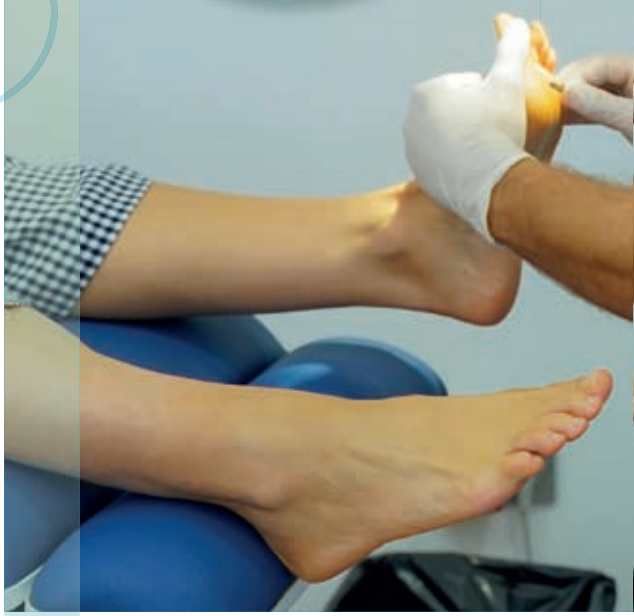
STEVE JAMIESON
Chief executive

The S&O

THE SUBJECTIVE AND OBJECTIVE

You asked, we listened

Following requests to prevent the 'naked' copies of *The Podiatrist* becoming too damaged and revealing some of the more sensitive clinical images during transit, a sticky label has been added to keep the pages closed. Hope you agree it's a welcome addition!



NHS PAY REVIEW

England NHS pay offer 'disappointing' as Scotland promised banded increase

1

The government's recommendation that NHS staff in England should receive a maximum pay increase of 1% delivered a 'massive disappointment' to the workforce, the College said.

Westminster's long-awaited evidence to the NHS Pay Review Body (PRB) in March came in spite of the Office for Budget Responsibility's forecast of a rise in inflation to 1.5% this year, meaning the recommendation represents a pay cut in real terms for NHS staff.

College chief executive Steve Jamieson said: 'This is not the way to thank our hard-working and dedicated NHS members... [particularly given] the hardships of the last 12 months and the serious burnout they are reporting.'

The PRB does not have to accept the recommendation submitted by the government. The College said it would issue a fuller response to members after taking time to absorb the evidence.

Meanwhile, negotiations between the Scottish government and NHS trade unions, including the College, have led to a formal offer being issued.

The offer states:

BANDS 1 TO 4
receive a flat uplift of **£1009**

BANDS 5 TO 7
receive at least a **4%** uplift

BAND 8A TO 8C
receive a **2%** uplift

BANDS 8D TO 9
receive a flat uplift of **£800**

What's next? A formal consultation with College members on whether to accept the offer, which opened on 6 April and ran for four weeks. Look out for the decision on the usual channels.

To read the government's evidence in full, go to **bit.ly/gov-PRB-evidence**

NEW APPOINTMENTS

Council election result announced

The College council elections were held in March, and four new members have been appointed.

The successful candidates were Martin Fox, vascular specialist podiatrist at Manchester Leg Circulation Service; Jane McAdam, director of allied and public health at the University of Salford; Adam Smith, owner and podiatrist at Adam Smith Podiatry & Healthcare; and George Dunn, former chair of council at the College.

Votes cast: 1821

Candidate with most votes: Martin Fox with 1243.

2

3

REPRESENTATION FOR WOMEN

SUPPORT OFFICER RE-ELECTED BY TUC WOMEN'S COMMITTEE

The TUC has re-elected Katie Collins, College professional support officer, to its women's committee for the third year.

The reappointment marks a significant achievement for Katie and the College, particularly as she was standing against candidates from other larger unions.

'I am proud to represent the College on the women's committee,' Katie said. 'I raise important issues that affect our members, including poor-fitting PPE, the inequitable impact of Covid-19 on women, gender-based harassment and the violence affecting women and girls both in and outside the workplace. Fighting for these issues to be raised in parliament gives members vital representation at the highest level.'

Photography: Getty

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STAYING SOCIAL

Here's what you've been saying so far about your new-look member magazine.

James Welch @Ablefeet
The latest issue of **@ThePodiatristUK** is out and it's a cracker, with great focus on paediatric podiatry and its importance #specialistnotniche. Good representation from **@CyliePaedspod @NinaDavies11 @S_Mo_15 & Simon Jones #podiatry #paediatricpodiatry #childrensfeet**

Dr Emma Cowley @EmmaCowleyPhD
I thought this edition took **@ThePodiatristUK** to the next level. I came away feeling like I had been equipped with stats, information and stories that directly added to my professional narrative ready for those 'why podiatry' challenges we get so often

Christopher Joyce @Toepher_Joyce
Thoroughly enjoyed this edition of **@ThePodiatristUK** – easy reading, in-depth topics and great variety! Eagerly awaiting the next one

Hackney Podiatry @HackneyPodiatry
I absolutely love **@ThePodiatristUK** in its new format. Always really excited to open it and have a good read! **#professionalmagazine**

Alice Twomey @a2mepod
Excellent write-up on clinical emergencies in podiatric practice including sepsis, DVT and CRPS (among others) in **@ThePodiatristUK** this month. Definitely worth a read and taking note if you've forgotten/are unfamiliar with the NEWS and Wells scores **#podiatry #weareAHPs**

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SEAL OF APPROVAL

COLLEGE GRANTED ROYAL STATUS

What? The College of Podiatry has been renamed the Royal College of Podiatry (RCPod).
Why? The change comes after Her Majesty The Queen granted the College permission to use the royal title in March.
How? The Queen acts on advice provided by her ministers before granting permission to use the royal title. It was noted that the College's long history, proud heritage and its embodiment of high standards contributed towards the decision.
When? While the Royal College of Podiatry has been able to use the new title since then, it was decided that rebranding should occur from a fixed date to ensure clarity.

Our governance is written in such a way that our Articles of Association require a special resolution to change the wording. Although the College can have a different name to that referenced in the Articles, the preference is for all of it to align. Therefore, we will not formally change any branding until after the AGM vote to be accepted by members on 26 June.

The College will advise members on the new logo and identity closer to this date. Until then, we will continue to refer to ourselves as the College of Podiatry and ask that all our members and stakeholders do the same. Watch this space for more updates!

6

PODIATRY: STILL OPEN FOR CARE

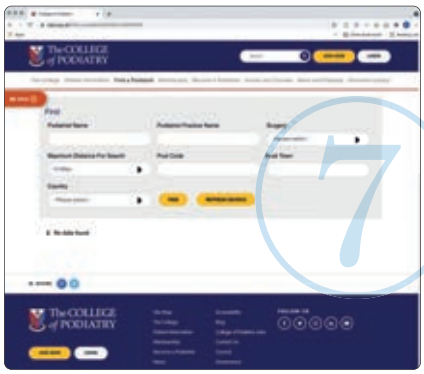
Refreshed Foot Health Week returns for virtual event

Podiatry services should remain open for care: this was a key message during April's Foot Health Week.

The College's annual campaign, which aims to raise public awareness regarding foot health, was refreshed following member and stakeholder feedback. It was also forced to take place virtually due to ongoing restrictions related to the pandemic.

Since the outbreak of Covid-19, the public has not been seeking help with their healthcare needs in the same way, so this year's campaign aimed to provide guidance on safe self-care while signposting when to seek the help of a podiatrist.

College members shared tips and promoted events using the hashtag **#UKFootHealthWeek21**



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FIND A PODIATRIST

Promote your practice

Have you listed your practice in the College's Find a Podiatrist directory?

A listing in our online searchable directory is a key benefit for members in private practice. It helps potential patients to find your practice quickly and easily when they need foot care advice.

If you haven't joined yet, watch our video to show how easy it is to list your practice: **youtu.be/WbkNd9rT3Ek**

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DIABETES ONLINE

EDFN to host first conference

The English Diabetes Footcare Network (EDFN), of which the College is a partner, will host its first national conference online.
Dates: 21 May between 12.30pm and 5pm
Discussion: The free-to-attend event will bring together leading foot care experts, multidisciplinary foot teams, foot protection teams and anyone with an interest in lower limb disease to share best practice and discuss developments in the field.
More info: Founded in 2019, the EDFN tasked itself with developing an England-wide network, which feeds into the national programme.
Book: Register at **bit.ly/attend-EDFN-conference**

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SLEEP

Restless nights

Research suggests the pandemic has had an adverse impact on the sleep of healthcare workers, leading to critically high levels of stress, anxiety, depression and burnout.

Words Steve Smethurst

Prominent US neurologists have warned that sleep deprivation among frontline healthcare workers has turned 'critical' during the Covid-19 pandemic (Peckel, 2020). As a result of long hours in close proximity to Covid-19 patients, often with limited resources, many have experienced high levels of stress, anxiety, depression, burnout and, increasingly, insomnia.

It's a view backed up by an Iranian meta-analysis, which shows that increased stress due to exposure to Covid-19 increases the prevalence of sleep disturbances in nurses and physicians (Salari et al, 2020). Furthermore, a study from China reported that 36% of hospital staff experienced insomnia during the crisis (Zhang et al, 2020). In the high-insomnia group, women and nurses were more likely to be anxious and depressed.

Dr Sara McNeillis is clinical lead consultant for the Sleep Service at the Royal National ENT and Eastman Dental Hospitals. She says that sleep issues commonly affect healthcare workers even without the added impact of a pandemic. 'The impact of shift patterns on sleep has been well recognised,' says Sara. 'A "shift-work sleep" disorder is prevalent in as much as 26% of shift workers [Drake et al, 2004] and can result in severe insomnia and sleep deprivation. Many international studies show that they suffer from more long-term health conditions as a result.'

Sleep and health

The impact of long-term insufficient sleep on our physical health is serious, being associated with increased metabolic disturbances, weight gain, obesity, hypertension, diabetes and a greater risk of heart attacks and stroke, as well as weakened immune function. As a result, long-term sleep deprivation also presents a higher risk of acquiring Covid-19.

In terms of mental health, Professor Jude Mary Cénat from the University of Ottawa's School of Psychology led a meta-analysis of more than 50 global studies involving almost 200,000 participants. The results showed that depression, anxiety and post-traumatic stress disorders (often accompanied by nightmares and disturbed sleep) had all risen significantly throughout the pandemic (Cénat et al, 2021).

Sleep loss has also been associated with reduced functional connectivity – for example, communication between the regions that normally regulate emotions. This could potentially lead to an increased tendency to view experiences from an emotionally skewed (usually negative) perspective (Peckel, 2020 – see our article on supporting mental health on page 34).

Even before Covid-19, healthcare workers who work shifts were prone to mental health issues, says Sara. 'Several studies suggest that those sleeping less than six hours per night on average can have adverse mental and physical health effects. Women undergoing shift work have also reported irregular menstrual cycles.'

Impact on podiatrists

At Swansea Bay University Health Board (UHB), David Hughes can relate to this all too well; when the pandemic took hold, as clinical lead and manager for podiatry, orthotic, MCAS and persistent pain services, he was redeployed to lead the Verification of Death and

Can't sleep?

The prevalence of sleep disturbances in physicians caring for Covid-19 patients was reported to be

41.6%

Salari et al, 2020

Insomnia symptoms were associated with:

- Worries about infection – **odds ratio 2.30**
- Perceived lack of helpfulness in terms of psychological support from news or social media with regard to Covid-19 – **odds ratio 2.10**
- Strong uncertainty regarding effective disease control – **odds ratio 3.30**

Zhang et al, 2020

Bereavement Support Service with Kath Brenton, deputy head of podiatry and orthotic services.

He says: 'We went from never having done shift-working to running a 24/7 service, and it certainly had a significant impact on my sleep. It was a huge change to the body clock, going for the first time into a 24/7 service.'

David recalls that he built up resilience quickly and it helped that it was an extremely rewarding, high-value role. 'That resilience is something we still need,' he says, 'as we face constant pressure 24/7 to accommodate Covid-19, to make sure our service and our patients aren't as affected as they could be.'

Now back in his original role, his sleep is yet to return to normal. 'I've never remembered my dreams before, but they've been very vivid since March last year. They are always work-related and quite troublesome. I often feel anxious or angry in them.'

He attributes this to the pressure to get back to 'normal'. 'I don't think there's been the potential to switch off. Our workforce is facing these challenges with various levels of resilience and we have more support demands on us than ever before.'

Kath recalls that on her deployment there was always the anticipation of a call during the night, so she took to sleeping on the sofa as she waited for the phone to ring.

She says: 'I was able to go back to sleep after calls, the challenge came with managing the lack of sleep the day after. That's been quite a hard habit to break.

'I try to self-regulate, and am very mindful of health and wellbeing for others. We have a duty of care to staff and patients, so I tend to put my own wellbeing at the end of a long list. I still get tired easily. I try to relax in the evenings but will often log back on before bed to do some work, which can make it difficult to get to sleep.'

Work/life balance

As assistant head of podiatry and orthotic services at Swansea Bay UHB, Jane Neathey works closely with David and Kath. She has been working from home while shielding during the pandemic, and her struggle has been with managing her work/life balance.

'I had sleep issues even before Covid-19, but working from home hasn't helped. Work is just too accessible. Previously, if I didn't sleep, I might get up in the night and do some work, but I'd have to find my laptop, then get it up and running. At the moment, everything is just there, permanently on, which means I have to be very strict with myself.'

Jane says that work is constantly ticking over in her head: 'I find myself lying in bed thinking, "I have to get it all done" – not just work, but all the things that need doing round the house. I wouldn't worry about it if I was out of the house at work all day – if you're not here, you can't do it. Being at home, I put added pressure on myself to do those things, which has an impact on sleep.'

She also makes the point that, in the early days of Covid, in some ways it almost felt easier. 'There was such a focus on keeping people and the team safe. What keeps me awake at night now is planning ahead – making sure everything's been done today that needs to be done and also getting things right for the future.'

How to support healthcare workers

Kath makes the point that peer and external support were both available to those working on the Verification of Death Service. 'We worked with a buddy at night, which was helpful as we had that shared experience and could talk things through. We were very well supported.'

She also stresses the need to have ongoing dialogue with staff. 'Everyone has been through a lot of change with the pandemic and we have to be mindful that staff need ongoing support for their wellbeing. Certainly, sleep deprivation and changes in sleep patterns have an impact. Our wellbeing champion has been really supportive to all members of the podiatry team from the start of the pandemic to minimise any impact.'

Sara agrees: 'Healthcare workers need supportive environments to ensure adequate rest after night shifts so they are safe to travel. I would prefer that employers monitor their healthcare workers for shift work sleep disorder and advise referral to specialists as needed.'

Sleep is 'automated and habitual', she adds. 'Protecting sleep for healthcare workers is essential to maintain good alertness during work time and adequate recovery after work.

'Highlighting and monitoring health and sleep of healthcare workers in the longer term to identify sleep disorders earlier will allow sleep clinicians to treat these effectively.'

Image: Shutterstock

Tips for shift workers

Good sleep hygiene is important to get a good night's rest. It is important to maintain regular sleep and wake timings, and aim to get seven to eight hours of sleep each night.

- Sleep onset is best when your body temperature is falling rather than rising. Having a bath is helpful before bedtime as it means your body temperature rises and then falls again.
- Try to stay on the cool side in bed. If you're too warm while asleep, there is a possibility of reducing REM or dream state sleep, which helps with memory.
- If you're wide awake in the evenings, wear dark glasses after work to minimise light input and eat a meal containing starch-based carbohydrates. Also, avoid caffeine intake three hours before planned bedtime. You may also find exercise immediately after a night shift helpful to increase the depth of sleep.

Good sleep for shift work, by Dr Sara McNeillis and Dr Hugo Selsick

References are available to view online: **membersarea.cop.org.uk/the-podiatrist**

THE MEMBERS SPEAK

We're listening!

The College's recent member survey was designed to shed light on your attitudes to membership. Here are some of the most important findings...

7%

up on the response rate to the survey by members in 2018

Respondents were split across the following groups:

89% UK practising members

4% Overseas practising members

2% Non-practising members

1% Newly qualified members (qualified in last two years)

3% Student/apprentice members

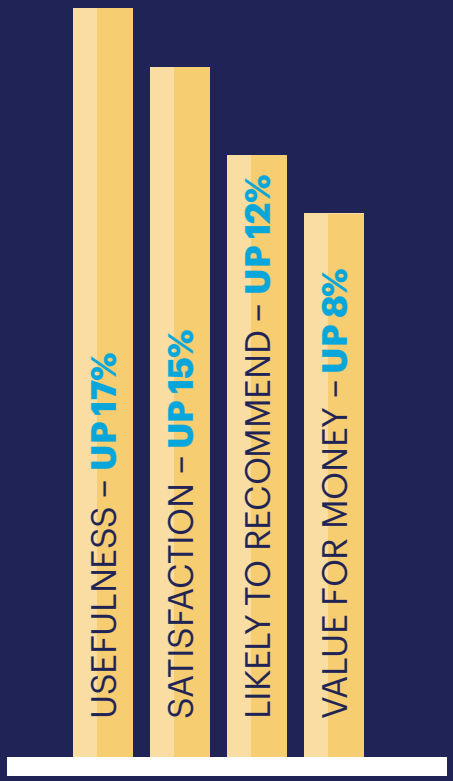
1% Associate members

For comparison with 2018 data, 'UK practising', 'overseas practising' and 'non-practising' were grouped together and classed as 'full members'

1% have used the College's new counselling support services or mentoring programme

If you feel you need help or support, please go to **membersarea.cop.org.uk/membership/membership-benefits/wellbeing-support-service**, and you can find our mentoring programme at **cop.onpld.com**

MORE THAN 1/4 ranked 'support and advice for members' as the College's most valued role



Aspects of membership whose member ratings have risen since 2018

95%

of members feel the College has been **supportive during Covid-19** and **over half** said their career goals and plans for the next two years have been influenced by factors relating to the pandemic

Most important aspects of membership:

1. Medical (malpractice) insurance
2. Access to CPD and courses
3. Access to resources, guidelines and other documentation

50 YEARS

The mean age of a full member

18 YEARS

Average length of membership

9 IN 20 MEMBERS

said they are looking to 'enhance their skill-set' over the next two years

Here is where the College can help. Go to **membersarea.cop.org.uk/cpd2/5-standards-of-cpd/college-cpd-courses**

ONLY 1 IN 20 MEMBERS

are looking to 'move into a new area of podiatry'

If you are interested in developing your career, visit **membersarea.cop.org.uk/cpd2/career-development**

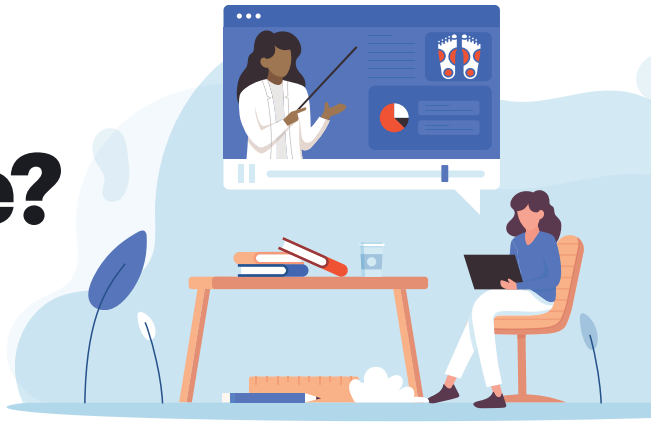
GIVING BACK

17.5% have volunteered at some time with the College. If you would like to donate your time, visit **membersarea.cop.org.uk/membership/volunteering**

The College will be reviewing the results and putting together an action plan to further develop and improve support for members

THE BIG QUESTION

Training and CPD: in person or online?



People have become accustomed to online courses over the last year. But are face-to-face sessions better?

SARAH CROOKES

Podiatrist and chiropodist at Hackney Podiatry in London

As a busy mum of three working in private practice, online training and CPD is appealing because it can fit around my family commitments. It also provides a great opportunity to show my children that I am a working mum, giving them an insight into my career as a podiatrist. I've recently attended an update on local anaesthesia, and joined the Foot and Ankle Show online and the College's digital conference in November. All had excellent content, were great value for money and were executed without any glitches. Online, I can fit more training and CPD into my spare time, which eliminates the stress of ensuring I meet my CPD requirements. Although I miss the social aspect of networking with colleagues and having a change of scene, I think a mixture of online and face-to-face events is the future of professional learning.

ALI MARBAN

Third-year student in Oldham

Both can be beneficial according to an individual's style of learning, but I prefer learning face to face. It allows for better engagement and involvement, especially in a group setting when carrying out tasks. Face-to-face settings also provide a great environment for discussions and encourage further learning and personal development. A face-to-face setting allows us to ask our peers relevant questions. This is incredibly important when trying to understand new topics and to make better practical decisions when dealing with patients on a daily basis, and how certain factors may relate to everyday podiatry work. Face-to-face settings also allow networking with other professionals, which encourages interprofessional and multidisciplinary working.

JAMES COUGHTREY

Head of education and professional development at the College

It's been really positive to embrace a wide variety of virtual methods that have allowed us to revise, train and assess our understanding of professional practice. But the core philosophy behind CPD remains the same – how do I understand the elements of my practice better so that I can enable my service users to benefit? Some of that is about deeper understanding and some is about building in novel approaches, but the opportunity to develop through these new methods is heavily reliant on that core principle. Within that, there must remain a requirement to retain the traditional approaches that rely on face-to-face or physical contact. We are a hands-on profession, after all. Good CPD should act as a bridge between both worlds, bringing together evidence-led traditional and modern views and enabling us to utilise technology's advantages alongside practical components to support us in that core approach.

ONLINE LEARNING

As part of its CPD developments the College has started populating content on its new online learning platform – TALUS (Teaching and Learning Update System) for members.

Further content and face-to-face CPD will return when it is safe to do so, but there are lots of ideas. Keep checking the usual channels for more information.

WOULD YOU LIKE TO TAKE PART IN A FUTURE BIG QUESTION?
If so, please contact *The Podiatrist* editorial team at editorial@the-podiatrist.co.uk

Remote control

Professor Sandra MacRury explains how the RAPID project is using cutting-edge communication technology to link community and specialist podiatric care and help diabetes patients in some of the most far-flung parts of Scotland.

Words Matt Lamy

The buzz phrase 'remote care' may have been around since the pandemic started, but a team of podiatry and diabetes experts in Scotland was considering how to enhance services to patients in some of the country's most isolated areas long before Covid-19's arrival. The RAPID (Reducing Amputations In People with Diabetes) project – initially a study run by the Highland Diabetes Institute in collaboration with the University of the Highlands and Islands (UHI), NHS Highland and Tactical Wireless – sought to take specialist care right into people's homes, even in areas with poor network coverage.

Its leader is Sandra MacRury, professor of clinical diabetes at UHI and a consultant endocrinologist and diabetologist at Raigmore Hospital, Inverness. She says that the need

THE RAPID PROJECT'S KEY STATS

In the latest pilot, **89% of ulcers** were healed, improved or stabilised.

Foot ulcers and amputations cost up to **£84m a year** in Scotland.

Using theoretical health economic analysis on the latest pilot, it was suggested that up to **£1.80 could be saved for every £1 invested** in RAPID.

'This is about technology-enabled care, not technology as the main care vehicle'

to improve outcomes for patients, particularly those in remote areas who were finding it hard to access normal clinical care, was clear.

'An audit found that several patients hadn't come through our multidisciplinary team before they had amputations,' Sandra recalls. 'We were concerned people weren't seeing our specialists often enough. So we asked: "Can we do more to reach them so they don't have to travel so much?"'

More than mere virtual clinics

The team had been running virtual clinics (VCs) for years, but it realised these alone wouldn't be enough to solve the problem. Instead, it proposed equipping community podiatrists with communications technology that would enable them to consult clinic-based specialists while they were visiting patients. This new approach was piloted in 2015.

During the initial feasibility trial, community podiatrists would use an iPad, some lights and a router from Tactical Wireless called an Omni-Hub to help boost the cellular network signal. 'Although the connectivity wasn't always great, we did gain a better idea of what was required,' Sandra recalls.

During the next phase of the pilot, enhancements to the router improved connectivity. By the final phase, further technological refinements had enabled the participants to start using NHS Scotland's video consultation platform, Near Me.

'We ask community staff to take photos and email them to us,' Sandra says. 'From these, we can reassure them that what they're doing is fine, recommend a VC consultation with a specialist, or decide that the patient needs to come in. That's an important facet of what we're attempting – it's to save journeys where possible, while not preventing someone from being seen in a specialist centre if that's more appropriate.'

All-round benefits

The response to the project has been 'overwhelmingly positive', according to Sandra. 'Patients like it because they don't necessarily have to travel to be seen by a specialist. They're also getting frequent visits from their community podiatrist, which they find reassuring.'

She believes that the community podiatrists like it 'partly because they are interacting far more with the specialist team than they used to'. She adds: 'They're also becoming more skilled at managing patients with complicated ulcers. It's been a chance for them to learn more about our protocols, right down to antibiotic prescribing and wound dressing.'

After the final trial phase, Sandra's team distributed five RAPID toolkits to community podiatrists in different parts of the Highlands. She reports that the initiative's benefits are becoming ever clearer.

'Although it was harder to establish than we expected because community clinics were closed for a time during the pandemic, it's now going well. We're adding slots to our diabetes foot clinics because of an increase in requests,' she says. 'For me, there is significant fulfilment in helping people with chronic diseases, but I find the teamwork aspect particularly rewarding. Our multidisciplinary approach is so important in managing diabetic foot disease.'

RAPID expansion

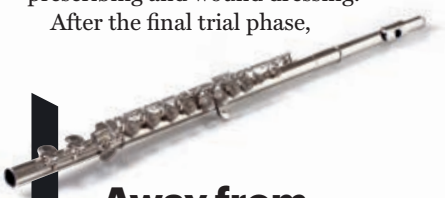
Owing to the project's success, a RAPID-style approach is being considered by other clinical departments.

'It has piqued people's interest at a time when we're looking at a lot more service digitalisation,' Sandra says. 'The good thing is people are becoming familiar with the technology. We were worried patients might not want to do VCs, but many were actually keen, having got used to video calls with relatives and friends during the lockdowns.'

Having said that, she doesn't believe the RAPID approach signals remote monitoring and/or consultation will be universally suitable.

'Our model is facilitated by someone being there with our patients,' Sandra says. 'That's important, because they have complex problems. These can entail a degree of review, debridement and dressing, along with guidance such as prescription advice.'

She continues: 'We require a mix: we must provide face-to-face contact; we have to run specialist clinics; and we need patients to see the whole team at times. This is about technology-enabled care, not technology as the main care vehicle. I hope in the long run that our approach helps to improve care while reducing costs, travel, unnecessary hospital visits – and, most crucially, amputations.'



Away from the clinic

Sandra MacRury was the first diabetes consultant appointed by NHS Highland. As well as developing and expanding the regional service across a large tract of northern Scotland, she has helped to create the Highland Diabetes Institute.

Despite the demands of her busy professional life, she does find some time to relax.

'I play the flute in a couple of local groups, including the Truly Terrible Orchestra and a small gathering of fiddlers called Slow Jam,' Sandra says. 'I'm also on a lifelong mission to improve my Gaelic language skills. At present, I'm taking an advanced course run by Scotland's Gaelic college, Sabhal Mòr Ostaig.'

Identifying the evidence

The world of forensic podiatry welcomes College members keen to become expert witnesses or help out in criminal casework.

Many years ago, as a newly qualified podiatrist, Sarah was approached by the police. 'They asked if I could assist in a criminal case where podiatry evidence was required to identify a person. At the time, I knew I didn't have the knowledge or experience, so I didn't respond,' she says.

'Since then, though, standards and codes of practice – including the Criminal Procedure Rules, Criminal Practice Directions and those set out by the Forensic Science Regulator – have been put in place for forensic podiatry expert witnesses.

'However, any podiatrist – with or without experience in forensic podiatry – could still be asked to help out in criminal casework, and find themselves in a court of law in front of a judge and jury being cross-examined. This is not a pleasant experience for the unprepared!'

The College's newly reinvigorated Forensic Podiatry Special Advisory Group (FPSAG) has at its core a team of forensic practitioners who are also members of the Chartered Society of Forensic Sciences.

It seeks to support podiatrists by familiarising them with the four areas of forensic podiatry used in criminal casework:

DR SARAH REEL is senior lecturer in podiatry at the University of Huddersfield and chair of the FPSAG

1. The use of podiatry records to assist in identification (similar to dental record identification)
2. Footprint examination (usually of those left at crime scenes)
3. Feet-in-shoes examination (footwear linked to a crime scene where ownership is disputed)
4. Forensic gait analysis (involving CCTV footage linked to a crime scene).

'Not all practitioners in this discipline are podiatrists – forensic gait analysts are a good example – but all are forensically trained and keep up to date with continuing professional development in forensic science,' Sarah says. 'If venturing into this interesting discipline, it's important to acknowledge that you are a podiatrist who has entered the forensic arena.'

Aims of the FPSAG

- Advise the College in forensic podiatry-related issues
- Support and advise members in the education, training and development of safe practice in this specialist field
- Raise internal and external awareness of forensic practice and thus the profile of podiatry.

'If you have an interest in this exciting field within the profession, you are welcome to join our meetings to chat about anything relating to forensic practice, as well as the development of education, training and research,' Sarah says.

'The FPSAG is keen to support podiatrists wishing to participate in this area of practice and we look forward to hearing from you.'

To contact Sarah and the FPSAG, email **s.m.reel@hud.ac.uk**

Image: Getty

Reaching out

New free e-learning resources will support outreach work and encourage future generations to follow an AHP career.

DAN WATSON
is the independent communications consultant for the SIHED programme

In 2020, the number of applications to study podiatry increased for the first time in several years. Work led by the College, through initiatives such as the SIHED programme (Strategic Interventions in Health Education Disciplines – funded by the Office for Students) in partnership with Health Education England (HEE) and other bodies, seems to have pushed back against the declining application rate. According to UCAS, university acceptances for allied health profession (AHP) degrees increased by 17.5% last year.

A big part of that success story was an outreach programme, run in conjunction with the I See The Difference campaign, which worked to raise awareness of AHPs among young people. The outreach programme visited hundreds of schools and, during the pandemic, ran a series of online webinars for students considering their career options.

While the I See The Difference marketing campaign continues, funding for outreach has now ended. For podiatry and other AHPs, this presents a potential problem. Young people are often unaware of some of the less well-known professions. The profile of health careers is extremely high due to the pandemic, so it remains essential to inform young people about the full range of choices available.

RESOURCES

- I See The Difference campaign: **iseethedifference.co.uk**
- Promoting careers in the AHPs (HEE E-Learning for Healthcare): **bit.ly/ELFH-promoting-careers**

Part of the family

During the final year of the three-year SIHED programme, the team overseeing the initiative developed a set of online CPD training courses focusing on outreach work with young people and career changers. The hope is that these resources – free to use and available on the HEE E-Learning for Healthcare platform – will inspire more AHPs to take part as volunteers in outreach activity.

These courses aim to promote the AHPs as a family of professions. The SIHED outreach team found that this approach proved more effective when approaching a school to ask about running outreach activity: providing information on a range of careers is a better offer to schools, and means that the information given to young people is of wider interest and value.

Of course, detailed knowledge of all 15 AHPs is a lot to ask of anyone. The online resources are designed to help outreach volunteers provide an overview and to think about ways to present the set of professions, rather than diving into great depth about each one. There are three short courses to complete that give a comprehensive grounding in outreach work for beginners, or help to make outreach work more effective for those already active in this area.

How to guides

Practical resources include support on how to approach schools, plan an engaging session, speak to different age groups, and conquer nerves in public speaking. The resources also provide access to a range of other tools developed through I See The Difference, such as slides and video content.

You can include outreach work in your CPD portfolio as a professional activity. But perhaps more importantly, it's rewarding and can make a big difference to the future of your profession.

FOR STATISTICS ON THE PODIATRY WORKFORCE IN ENGLAND, go to page 10 of the last issue (March/April 2021).

Image: iStock

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'I am eager to go into podiatric surgery, but my ultimate aim is to return to Liverpool FC as the club's podiatrist'

A league of his own

Malek Abdo, podiatrist at Salford Royal NHS Foundation Trust, explains how he went from being a prospective Liverpool FC footballer to a fully qualified podiatrist.

What set you on the path to becoming a podiatrist?

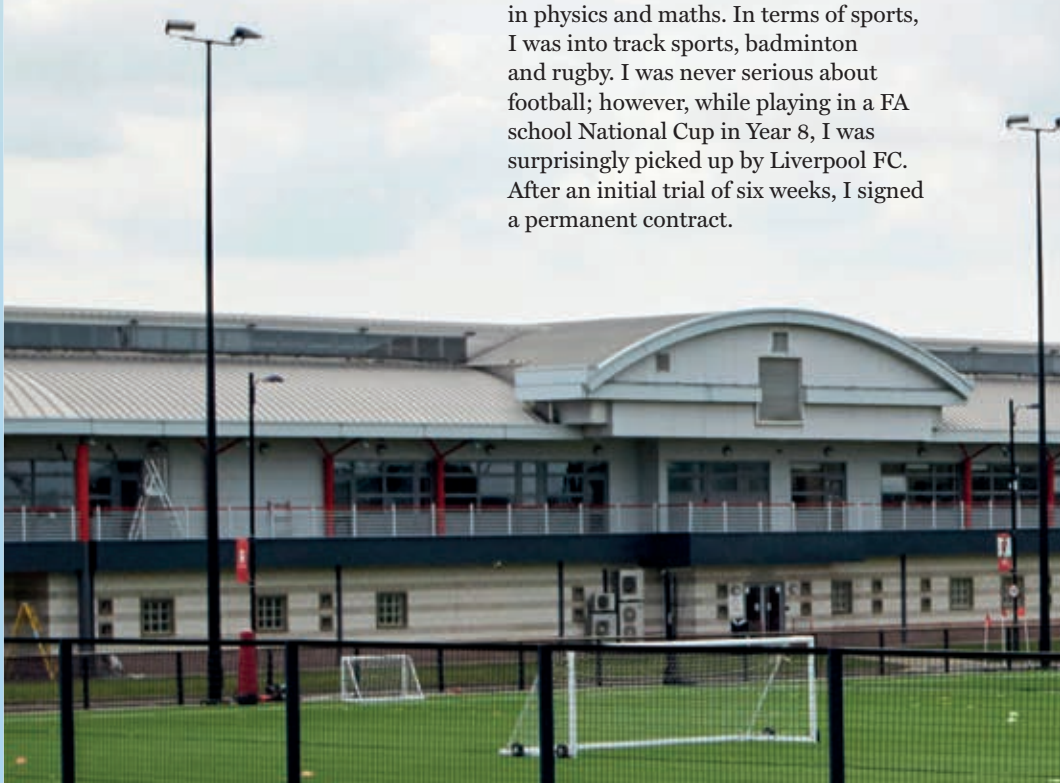
The initial spark was my college tutor telling me about how they were seeing a podiatrist for treatment. Although I had seen nothing about podiatry at careers fairs, I went to an open day at the University of Salford with some friends and saw the orthoses department and the lasers, and I was wowed by it all. On reflection, if I'd been shown routine care and wound care at that stage, I might have been massively turned off!

I was volunteering in the renal department at Salford Royal Hospital during my degree, and I persuaded the consultant to introduce me to Jane Steel, allied health professional senior manager at the trust, and Paul Chadwick, clinical director at the College. They were operational lead for podiatry and head of the multidisciplinary foot centre and allowed me to shadow the high-risk clinic.

What were you interested in at school?

I went to a fairly rough school in Salford, although it was the first academy in Manchester. I was head boy by Year 11 and a peer mentor and sports mentor as I bridged both academic and sports groups.

Academically, I was always interested in physics and maths. In terms of sports, I was into track sports, badminton and rugby. I was never serious about football; however, while playing in a FA school National Cup in Year 8, I was surprisingly picked up by Liverpool FC. After an initial trial of six weeks, I signed a permanent contract.



How did you keep up with your school work and your interests outside of football?

Although it was a once-in-a-lifetime opportunity, my time at the Liverpool FC Academy did affect my GCSE results. The academy tried to provide after-school programmes to compensate for the learning missed, but they had little success. By the end of Year 11, I was told by Liverpool that due to my repeated injuries they weren't going to offer me a scholarship. They took on eight out of 22 players – I was training at the time with Harry Wilson, who now plays for Liverpool and Wales.

Emotionally and psychologically, it hit me hard. It was a very challenging time – I had to find another club while revising for my GCSEs. My faith kept me in line. If I hadn't had my religion and my family, I think I would've struggled. I can empathise with those academy players who suffer from mental health issues, as there is very little support out there, and it is easy to get lost.

Where did you go next?

I tried to turn a fresh page with a trial at Wigan FC. They offered me a one-year scholarship contract. Because of all the intensive training from Year 8 to 11, I had suffered many groin and hamstring injuries and I was in and out of training. I took a huge gamble, but my body and mind were exhausted.

Looking back, it was one of my best decisions to stop playing. I only take positives from my time at the academy, including numerous team tours around the world, being coached by legends and playing for the best team in Europe.

Images: Alamy / Nick Taylor / Liverpool FC

What does your experience of the game bring to your clinical career?

My MSK knowledge helps me to identify injuries in athletes. We had only physios, not podiatrists, at Liverpool FC, but I know exercises and stretches to prevent injury in the lower limbs.

I was able to recommend orthoses for my younger brother, who was also playing football at a high level. A lot of my friends who play sport suffer from ingrowing toenails and trauma to the feet, so they are constantly coming to me for advice.

Liverpool manager Jürgen Klopp said last year that the Premier League was overloaded with fixtures, which leads to high injury rates. Do you agree?

Yes. The intensity of gym work, diet and training to ensure you improve your technical skills is already incredibly high.

A game a week is too much already. If you are not going to reduce the number of games, you have to reduce training hours. Perhaps a better solution is to increase the number of permitted substitutions to five.

Players might not be prepared mentally and physically. In the Premier League, tackles are hard, and people are regularly injured because there is no guidance on how hard you go in. The players have been cutting down on impact, but that still doesn't help.

How can the podiatry profession promote itself to people who were in your situation?

Youth clubs, careers fairs and social media are the obvious places. We need to emphasise the different routes an individual can go down – there is a wide scope within podiatry for personal growth, and development is possible straight after graduating.

No allied health profession has better development opportunities than podiatry. On Tuesday mornings at Salford Royal we shadow different clinics to have a greater understanding of each other's specialties. It helps to ensure people keep developing.

What are your career plans now?

My short-term goal is to continue my development at Salford Royal Hospital. I'm part of a great team and there are very skilled specialists to learn from – everyone is approachable and supportive. Another short-term goal is to expand my scope in the independent sector with Louise Kenworthy at Complete Podiatry in Stockport, where I have started recently.

Long-term, I am eager to go into podiatric surgery. Even if I don't go into surgery, I still want to do the two-year theory behind it. My ultimate aim is to return to Liverpool FC as the club's podiatrist.


INSIDE
STORIES

We speak to podiatrists who work in prisons about their experiences, the impact of Covid, and some of the unique challenges and rewards of practising behind bars.

Words Juliette Astrup

A hidden army of healthcare professionals is at work within our prisons, taking care of close to 80,000 people in England and Wales (Ministry of Justice et al, 2021). And this prison population is ageing: the number of those aged 60 or over has increased by 82% in the last decade and by 243% since 2002 (House of Commons Justice Committee, 2020).

Podiatrists are key players within prison healthcare centres, which are often run by a core team of nurses employed by a healthcare provider, with other services – including optometry, dentistry and general practice – usually commissioned externally.

The prison environment

Working in prisons requires adaptation to normal practice. There are additional risks you need to be mindful of, explains Chris Brown, senior podiatrist at Premier Physical Healthcare, one of the largest independent providers, employing 16 podiatrists across 61 prisons up and down England. 'When you go into the treatment room, you need to be aware of where the panic alarms are, how the clinic is set up, and you'll always sit nearest the door just in case you need to get out. I've never been attacked or had to press a panic button, but I've been there when a member of staff has been attacked.'

Most of the time he sees patients alone, unless a specific risk has been flagged on their notes: 'You'll get a warning on your screen, "Not to be seen alone", and an officer in the room. I've had six officers around the podiatrist's chair before.

'The tools you're working with, anything sharp, need to be kept out of arm's reach of the patient, and everything needs to be counted in and counted out; there have been incidents where the whole place has been shut down because a pair of scissors has gone missing.'

Prisons can be volatile. When an incident occurs on a wing, alarms sound and the prison – including the healthcare centre – goes into lockdown until it's resolved – a frequent occurrence in some prisons.

Chris says: 'You see fights and assaults erupt in front of you. It's not for the faint-hearted. I've seen people start a job in a prison and last a day – just going through all the security makes some people quickly realise, "This is not for me."'

But while there are risks, they are well managed, explains Pauline Kelly, a podiatrist with the Practice Plus Group, which serves patients in 47 prisons of all categories. 'I actually feel safer in prison than I have done in the community where I worked in a substance misuse clinic and with a lot of homeless people,' says Pauline. 'You always have someone around you; if someone is becoming aggressive, you shout for an officer and it's shut down straight away. You don't have to manage it as you would if that happened in a clinic in a big hospital, or a patient's home – you stand back and walk away from it.'

'I've never felt under threat in that environment, [or] felt uncomfortable,' agrees Vicky Dunstan, regional manager and senior podiatrist with Premier Physical Healthcare. She continued to work in category B, C and D prisons, even while heavily pregnant. 'I've always found the prisoners to be incredibly well behaved and respectful,' she adds.

The impact of the pandemic

Just as in the outside world, Covid has had a big impact on health and the provision of services in prisons, presenting a 'logistical headache', explains Tom Evans, a podiatrist with Kent Community Health NHS Foundation Trust, which is commissioned to provide healthcare for two prisons on the Isle of Sheppey.

Waiting lists have grown so long that he has taken the step of training prison officers to carry out low-risk non-pathological nail cutting, while healthcare assistants have been trained to assess diabetic patients' feet to prevent inappropriate referrals.

Since Covid, prisoners have remained locked up in their cells for 23 hours a day, which doubtless has an impact on their health. Chris says: 'Tendons stiffen up – I've seen more cases of plantar fasciitis in the past few weeks and months, which you can put down to prisoners being immobile. I've seen a deterioration in more elderly prisoners too.'

Tom adds: 'I've never seen pressure sores in prison until Covid, and I've

What do you need to work in a prison setting?

- Enhanced security clearance, renewed every four years
- Experience, usually a minimum of two years postgrad
- Energy and enthusiasm
- To be an autonomous practitioner
- Clinical confidence on complex needs
- Compassion
- Communication skills.

Photography: iStock / Getty

seen a few now. And for conditions like peripheral vascular disease, being sedentary is only going to speed up the associated complications.'

But while Covid has been challenging, it has also presented 'a wonderful opportunity to raise the profile of podiatry,' adds Vicky. 'Podiatrists that go into prisons are some of the best; they have to be able to do all the specialisms – diabetic foot care, MSK, nail surgery, routine work. We've worked really hard to give governors a better understanding of how important what we do is, to continue to go into these sites.'

Treatment limitations

Some treatments cannot be offered. Chris says: 'A big one is Curanail, because prisoners have used that to get some kind of high, and you can't prescribe anything with alcohol in the contents, like Lamisil Once. That can be frustrating when you're treating a patient.

'Another issue is the toenail clippers in prisons, which look like something out of a Christmas cracker. They cause a lot of the problems with chronic ingrown toenails.'

Tom adds: 'Anything in a glass bottle or an aerosol can is not allowed, which makes it difficult to treat a lot of people with fungal infection. Pregabalin, along with other pain relief medication, was banned because of its addictive properties.'

The realities of prison life have other implications for treatments too. 'You need to be aware that everything can be used as a bargaining tool in prisons,' says Tom. 'Things like trainers, so you'll have prisoners wanting you to submit a particular form, which means they can have trainers on medical grounds. Even things like emery boards can be traded.'

The prison population

Not only do the environment and considerations around safety and security have an impact on podiatry practice in prison, but so too do the patients themselves, who often have complex needs.

'We see a lot of mental health problems, drug addiction, poor lifestyle choices, and history of homelessness – so many things that impact on their health,' explains Vicky. 'When doing a surgery, for example, you need to think about individual healing rates, and how that person will be able to look after a wound in a cell with shared facilities. These podiatrists have to tune their communication and clinical skills to address challenges they see day-to-day in prison that you wouldn't often see outside. These patients really need more care.'

> 'PRISON SETTINGS REALLY SHOWCASE OUR VALUE AND THE EXTENSIVE SCOPE OF OUR SKILLS AS PODIATRISTS'
>
> **Pauline Kelly**

Chris adds: 'The problems I see have often been left for a long time, or the patients have tried to take matters into their own hands – used anything they could get their hands on, a razor blade or another piece of metal – to try to dig out an ingrown toenail, for example.

'I see podiatry ailments that stem from gunshot wounds – things you'd rarely see on the outside – where someone has been shot in the leg and ended up with one leg shorter than the other. I've seen that three or four times. There are issues related to drug use too, such as vascular problems.

'Prisoners can present with anything and their needs tend to be quite complex. You've really got to know what you're doing and you have to make decisions yourself.'

Caring for criminals

Aside from the practical considerations, does treating someone who has been convicted of a crime, especially an abhorrent one, make a difference to the job? How does it feel to >

A day in the life of a prison podiatrist

Chris Brown describes a day at work in a prison setting.

8am

I go through 'airport style' security, including a metal detector. Security guards will pat or wand me down, and check my bags for banned items, including mobile phones or recording devices.

8.10am

From one of the locked cabinets, using fingerprint recognition, I 'draw keys', which must be hooked on a key chain. They enable movement around the prison and access to treatment rooms, and they mustn't be on show to prisoners. Then I make my way over to the healthcare building, through as many as 10 locked gates and doors, making sure all have been locked securely behind me.

9am

Appointments. Patients are brought to the healthcare centre by escorting officers. Only those from the same block can attend at the same time due to Covid infection control measures. They wait in a holding cell until they're seen. Appointments last 15 to 20 minutes at normal times, but take up 30 minutes now, including clean-down time. Appointments can include anything from an initial assessment to nail surgery. At times I will follow up and review patients by visiting them in their cells, accompanied by a prison officer.

12-2pm

Prison is locked down for security reasons while staff have lunch.

2-4pm

Appointments.

4pm

I make my way out of the prison, back through all those gates and doors, return the keys to the locked box, and go through security again before exiting the prison.

care for someone with a history of harming others?

'I used to want to know what they'd done,' says Tom. 'You want to know who you're in the room with and what they might be capable of – but I don't do that now. I talk to everyone in the same way.'

Pauline works one day a week at HMP Whatton, in Nottinghamshire, a category C prison for men convicted of a sex offence. 'There is a philosophy here that a prisoner can be a victim, even though they have created a victim,' she says. 'I see so many prisoners who self-harm and have been harmed, and while of course, I do think about what they've done, there are a lot of reasons why people end up behind that wall – we're not there to judge or criticise.'

Chris, who has worked in the highest-security category A prisons, holding prisoners who have committed the most serious crimes, adds: 'It's tough at first to be in a room with them, but you have got to leave your preconceived ideas from media reports at home or in the car park before you go in. As a medical professional you're there to do a job and you have to be professional. I always say you have to treat the patient, not the crime.'

Rewarding work

While it inevitably has its challenges, the work is satisfying too, says Chris. 'I like the complexity of the work. It's unique and very interesting, and everyone you see has got a story to tell. I have access to a world that people find fascinating – there is a reason for all those fly-on-the-wall documentaries in prisons.

'And you're helping people in real need. Some people I treat have suffered for years, too ashamed to show anyone their feet.'

Being part of a close working team of professionals is another big plus, adds Pauline: 'I worked in the community for 15 years and it could be really hard to break barriers down. Here, we are all completely involved in the holistic care of these 800 prisoners. My skills as a podiatrist are well understood and respected within the team – and we share skills and train one another, working together where we can. That provides a lot of job satisfaction.'

Putting prisoners first

Julia Waldron, head of primary care for Practice Plus Group's Health in Justice division.

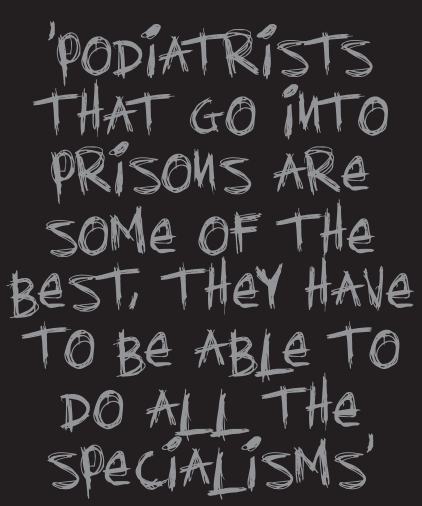
We believe in putting the patient first, regardless of the environment or their history. In prison, when there is limited access to the tools most people need to keep their feet healthy, it becomes even more of a challenge, which is where our podiatrists and partner podiatrists can help.

England has a significantly ageing prison population, and this leads to us supporting more patients with long-term conditions. For example, podiatrists are important members of the team when it comes to providing care for people with diabetes and reducing lower extremity complications, which is vital to reducing the burden on health services in the future.

As with other older people, falls can be a problem. In prisons this is compounded by the architecture, especially in prisons built in the Victorian era, or even earlier. Well-fitting footwear and healthy feet are simple ways to reduce non-complex falls in patients. Serious falls often require hospital treatment, which can impact on patients' long-term health. This also places an additional burden on hospitals and prison officers, as patients need to be transferred for hospital stays.

High-quality prison healthcare gives us the opportunity to help people return to the community in the best condition to start new lives. Working in prison has certainly been the most rewarding part of my career. So anyone who is a good podiatrist, who is patient, even-tempered and who wants to make a real difference, not just to those in prison but to the communities they return to, may want to consider a future on the other side of the wall.

FOR MORE INFORMATION, VISIT practiceplusgroup.com/our-services/health-in-justice



Vicky Dunstan

A lack of recognition?

Despite how vital this work is, it remains a 'struggle to recruit', explains Chris. 'Even with all the appreciation that has been shown to healthcare workers during Covid, there has not been one mention of healthcare workers in prisons. I don't think most people even realise healthcare professionals go into prisons and work day in and out in difficult conditions, and that's something I'd like to see change.'

Pauline adds: 'Prison settings really showcase our value and the extensive scope of our skills as podiatrists, so that lack of recognition is such a big problem.

'I would love to see us having a platform at conferences, speaking at job fairs and demystifying the world of prison healthcare.

'There is also a great opportunity to allow others to learn from that good multidisciplinary practice, and to share more widely what we do well.'

Podiatrists working in these settings 'absolutely deserve more recognition', agrees Vicky. 'To anyone considering this work I would say go for it! It's a really different, exciting opportunity.

'I have never been as challenged as I have by this role – and it surprises you, and makes you laugh sometimes. It gave me that challenge and renewed my enthusiasm for podiatry when I really needed it.'

References are available to view online: **membersarea.cop.org.uk/the-podiatrist**

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WHAT'S HAPPENING ON THE GROUND?

Get with the programme

With Covid pushing podiatry even further into the digital age, how does a practice decide which software package is right for its business and patients?

Words John Windell

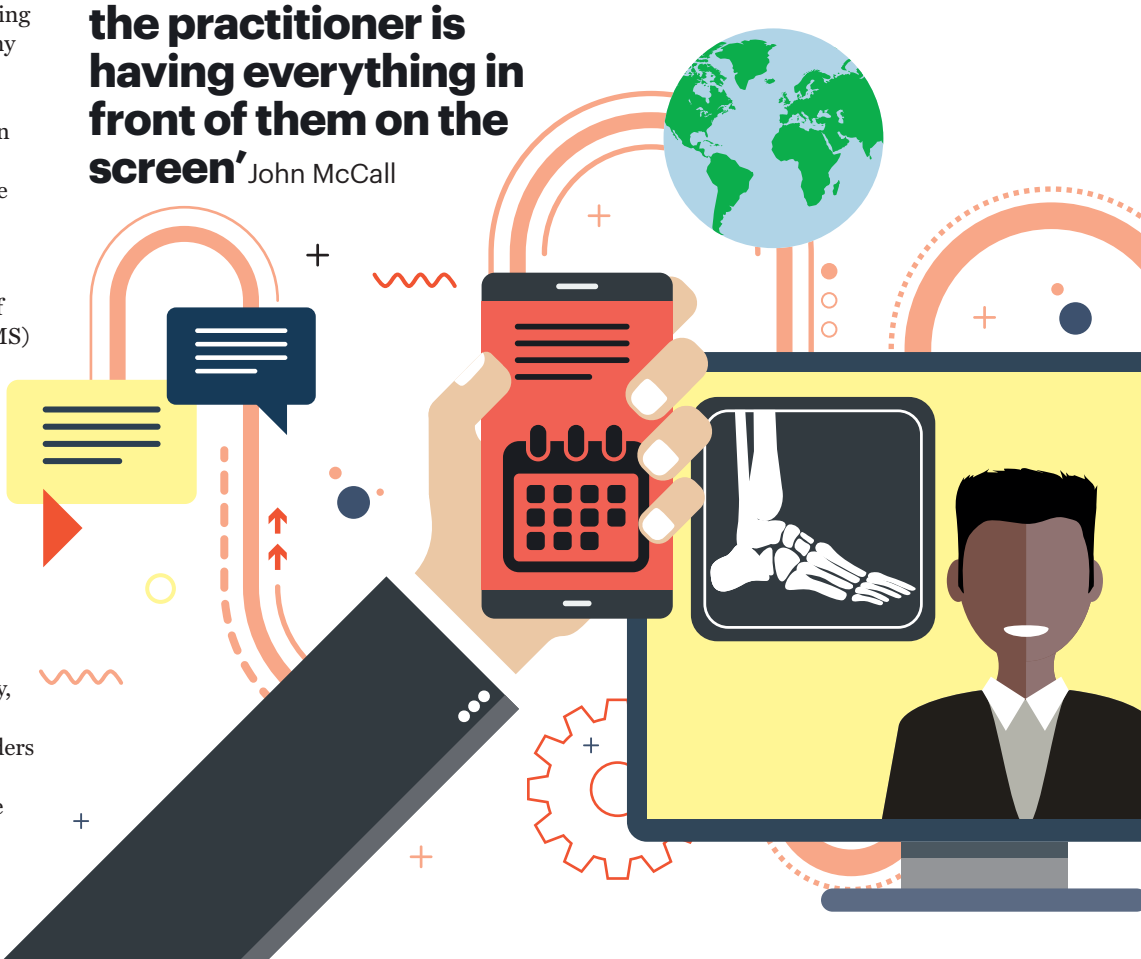
Technological innovation has made the day-to-day running of a business easier in many ways. But in others, it has made it more complex, not least when it comes to choosing between the many competing software packages and ensuring what you've chosen works as expected and provides good value for money.

Most software for podiatrists comes under the generic banner of practice management systems (PMS) or electronic medical records (EMR). Whatever the particular brand or bespoke features, the packages should all do more or less the same job: make it easier for a practice to manage its patients, their records and the overall business.

The software should possess several core functions, such as providing a simple and accessible way of managing the practice diary, registering patients, scheduling appointments, sending out reminders and making repeat bookings. It should also keep records for all the practice's patients, provide simple templates for making clinical notes, allow clinicians to add attachments such as diagrams or pictures, and keep a full case history that can be viewed at a glance.

Beyond that, the software should organise all business transactions, such as sending invoices, tracking payments and recording expenses. It should also offer a full management overview of the practice and its progress – tracking patient numbers and working hours, showing the origin of referrals, pinpointing the key marketing channels, and so on. It all adds up to something rather more than just an electronic diary.

'The convenience for the practitioner is having everything in front of them on the screen' John McCall



Convenient and efficient

'It comes down to three main elements,' says Helen Jobling, customer service manager at Tynedale Computer Systems, which supplies PPMS Podiatry software. 'It promotes effective time management, allows detailed, standardised and enhanced record-keeping, and improves efficiency. For example, you can reduce DNAs [did not attends] by sending a text reminder of an appointment, you have a standard bank of letters rather than having to type them individually, and you can visually chart a patient's recovery.'

For Michelle Geslewitz, growth marketer at Cliniko, one of the larger software providers which was recently awarded the College's Professionally Approved status, the convenience is a big selling point. 'Practitioners are always telling us that it saves time. Many are using a PMS for the first time, switching from paper, so it automatically makes everything a lot easier.'

The head of Podware, John McCall, started developing his product back in the 1990s. 'One reason I started doing this when I was still a practitioner was because we needed to have legible records.

Image: Shutterstock

Look out for the hidden costs

Most packages are available on a monthly subscription basis, or can be bought outright. But it pays to look beyond the basic price at the potential extra hidden costs of going digital or upgrading an existing system:

Hardware

Depending on the software and the services you offer, you might also need tablets or smartphones, and large hard drives or cloud storage for all your data.

Technical help, training and customer support

Will you need somebody to come in and set up your computers, the network and software? Do you need to train staff to use the software? And what sort of customer support does the software include – is this an extra monthly or annual charge?

Data transfer

Getting all the practice's data onto a new system, or off it, is seldom a simple or quick task. Make sure you have a clear idea of what's required before making any decisions.

Third-party software

A lot of software needs other software to support it, especially if it's Windows-based. For example, you may need extra licences for Microsoft Server products.

Advanced features

You may be charged extra for advanced features. Consider which ones you really need.

Text messages

Sending out automatic texts to patients is a very handy feature of most software, but are those texts costing you extra? The price will soon add up.

Time

Learning to use new software can be time-consuming – especially if you decide it's not working for you. Do your homework on the software, trial it if you can, and make sure everybody is comfortable using it.

What also grabbed me about computerisation was the ability to make administration easier and patient care better. Everything is there in the records for everyone to see, so your patients aren't coming in and having to answer the same questions again and again.'

The ease of communication has also improved the patient experience. 'Messaging patients easily through texts has become a big thing,' says John. 'The convenience for the practitioner is having everything in front of them on the screen. They can also control that, and have the right people facing the right parts of the records for the job they're doing at that time. It all ties in to having the right security and a good audit trail.'

Michelle adds that privacy and security should be key features: 'A PMS means patient data can be safeguarded. It's not 100% foolproof, but it is more secure than paper.'

Ease of use

Nick Knight heads a practice in Hampshire that runs a wide range of software, from a PMS to the tech that controls a 3D gait system. 'I'm always looking for the next thing to make life easier,' he says. 'I started with Cliniko as a PMS, then over time added things like ClinicApps, Mailchimp, Microsoft forms, even Trello for project management.'

'Software has to make the process slicker and more repeatable. If it doesn't, we don't use it' Nick Knight

How does he decide what to use? 'Trial and error. I'll play around with the software for a month, then look at how I can incorporate it into the practice. We have tried things that looked good on paper but in practical terms just didn't do what we needed. Software has to make the process slicker and more repeatable. If not, we don't use it.'

This practical approach also works for NHS Fife, where Benjamin Morrison is the specialist podiatrist/allied health professional clinical lead for digital and information. 'The main software we use for patient records is called Tiara. As well as diary management, it lets us control waiting lists. We can allocate referrals to the most appropriate clinics, and if some clinics are a bit quieter than others, patients can request a quicker appointment.'

When it comes to choosing software for a practice, where do you start? 'People need different things,' says Helen. 'A lot of packages now are cloud-based, but if you're in rural Scotland without internet access, that's no help. So think about what you really need. The most important thing is how comfortable you are with it. Try it out one feature at a time.'

Michellle echoes this point. 'It has to be easy to use, and not just for the clinician but the whole team. We find that once a practice starts using a PMS, it's hard to switch from one package to another because of all the patient data. So do that due diligence and make sure you are comfortable using it.'

Also bear in mind that software is continually being updated in line with technological advances, new legal demands and professional guidelines – ensure it will be able to keep up.

Look ahead

Covid has also changed many practices' view of software and what it can do. 'At the start of the pandemic we saw a huge influx of new customers,' says Michelle. 'I think they had been using traditional paper systems, but Covid made it impossible for that to continue.'

Software has become necessary just to keep in touch with patients online. More than that, with practitioners unable to treat patients in the flesh, they have been forced to find new ways of working. 'Telemedicine has certainly come to the fore with Covid,' says John. 'I think some high-risk patients may benefit from a quick video consultation via computer or phone.'

Nick says that his practice started offering video sessions before the pandemic, and that once it hit the practice went virtual. 'During that initial lockdown, I must have done nearly 100 video consultations. It has opened up the scope of practice. I think that's here to stay now, and the technology will get better and better.'

The NHS has also turned to video consultations. 'We're using the system to see the patients remotely via webcams,' says Benjamin. 'Clinicians use Tiara remotely on a laptop, tethering the laptop to a mobile phone to use the data for an internet connection on to the secure site. This allows the staff to have full access to clinical records.'

Software has become central to the way podiatry practices manage themselves, and as it migrates from computers to mobile phones and tablets it will get even harder to live without. It also looks to be on the verge of revolutionising the way they treat patients. Practices can ill afford to get left behind.

Dos and don'ts

DO

- ✔ Carefully consider what the most important thing is that your software needs to do – this will narrow down your initial search.
- ✔ Educate clients on the changes they could see as a result of the software implementation – for example, virtual consultations.
- ✔ Regularly monitor the benefits you're getting from the software – is it working hard enough for you?

DON'T

- ✘ Forget about software security. Is your video system secure? Does it meet the necessary data protection regulations?
- ✘ Assume one system is for life – your priorities may change and so may your software.
- ✘ Ignore feedback from colleagues and patients – they can be integral to the software system's success.

Cliniko

10 hidden costs of practice management software

On the surface, it seems easy enough to compare practice management software. But that won't always give you the true price.

Beyond the monthly fee, the actual cost of practice management software (PMS) is specific to your business – and it will be tricky to budget for if you can't figure out how much it will cost to use.

At Cliniko, we've helped thousands of practitioners switch systems. Based on our decade of experience making software for healthcare businesses, here are the 10 hidden cost considerations when choosing your practice management software.

1 Purchasing hardware

This might mean buying computers, a server and maybe tablets for your practitioners. And don't forget about the modem and router.

Are you handling backups yourself? You may need to purchase external disk drives for storage.

2 IT technical assistance

Depending on the software you choose, you may need to get a consultant to help install the program or set up your network, server and computers. And don't forget about configuring backups and security. If you do need this kind of assistance, you'll likely have both upfront and ongoing expenses.

3 Training

Choosing software that's user-friendly can help to save you money. Training can be expensive, especially if you have to hire someone to help get everything set up and get your staff trained on using the software.

There can also be ongoing training costs if there is a significant software upgrade or if you hire someone new.

4 Data transfer

Many clinic software companies will charge for transferring your existing data into their system, which can easily end up costing hundreds of pounds at a minimum. Make sure you get a quote for this in advance.

5 Customer support

Some software companies charge an additional fee for customer support. It might be a monthly or an annual charge, or you may have to 'pay per use'. However they do it, you'll need to include this ongoing cost into your budget.

6 Third-party software licensing

Depending on the system you use, you may be required to purchase additional software licensing to support your software. A good example is Microsoft Windows Server or even Microsoft SQL Server. If you use a system that requires you to have your own server in-house, this will greatly increase cost.

7 SMS credits

Most clinic software applications that offer SMS messaging will charge extra for the messages you send. Costs can reach up to 10p per SMS (plus VAT). At 10p per SMS, with 50 appointments per week, you'd be looking at more than £20 per month – per practitioner – for messages. With a busy clinic, SMS credits can cost nearly as much as the software itself. So don't underestimate the impact of SMS credit pricing.

8 Additional features

Many clinic software applications will give you basic functionality with your standard licence but charge additional fees for using advanced features. Be sure you work out what features you'll need and include any additional costs in your quote.

9 Data lock-in

With some systems, it's not always easy to get your data when you need it. This can cost you a lot of time and money if you ever decide to switch to different software.

It's very important to make sure you keep ownership of your data and can easily get it back if you decide to change systems. If not, you could be looking at a substantial cost down the track, and it might get you locked into an outdated system.

10 Your time

If your clinic software is not easy to use, you will spend extra time on each function you perform. Things can add up quickly, eventually leading to an enormous cost.

The amount of time you spend training new team members can also cost you in the long run. It's a big warning sign if you need to read a 100-page manual before getting started.

With these considerations in mind, you'll be one step closer to finding a system that is truly affordable for your business.

Cliniko could help you save on the costs listed above and more. To use our web-based app on any device, all you need is an internet connection and an up-to-date browser. Training is not necessary and unlimited free support is included if you need it. We also protect the security of patient data for you, so you can rest easy.

To start your free 90-day trial, visit **cliniko.com/cop-member**

HOW TO...

Protect your mental health

After a stressful year of restrictions and uncertainty, podiatrists are feeling the strain. We explore how best to support your own and your colleagues' mental wellbeing.

Words Emma Bennett

1 ACKNOWLEDGE YOUR FEELINGS

'Try to avoid using smiling or dismissive behaviour to cope,' says Dr Audrey Tang. 'It is important to acknowledge your feelings and accept that you are not "strange" or "being silly" – depression and anxiety are very real. It is best to seek help before the point of crisis.'

Emma Brand agrees: 'Anxiety or depression can have a holistic impact on you, from your physical health – not eating or sleeping well – to your relationships with people.'

2 TALK TO A PROFESSIONAL

Emma says that counselling and talking therapy can give you time to reflect. 'If you talk to family or a friend you might not want to tell them certain things,' she explains. 'Counselling allows you to speak freely and openly – it's a non-judgemental space so people can process their emotions at their own pace. Talking and sharing can feel empowering, even being able to say something out loud can help you feel less alone.'

Mental pain: the signs of suffering

- Change in personality – becoming more agitated or withdrawn
- Lack of focus or concentration
- Poor self-care and changes in appearance
- Seeming tired or not sleeping well
- Change to routine – e.g. working more, exercising less
- Becoming ill more often
- A change in eating or drinking habits
- Tearfulness
- A general lack of interest or 'compassion fatigue', brought about by working in stressful environments

3 FIND AN OUTLET

If you find it difficult to speak to anyone, find a different way to seek help.

Audrey says: 'Find an outlet to express your feelings – some people do it through journalling, others through poetry, dance, song, music or art. Anything that allows you a release of emotion can help free your mind enough to think more clearly.'

There are also plenty of resources to tap into, such as the College's Health Assured wellbeing app (see *Resources*, below). Emma explains: 'Mental health charity Mind is an excellent resource – really approachable and informative – and there are some useful apps, such as Calm and Headspace, that offer guided meditation.'

4 TAKE A BREAK

Switch off and go for a walk away from the glare of your computer or phone.

'Listen to what your body needs,' says Emma. 'Try breathing techniques when your wellbeing needs attention. You can't pour from an empty cup – if we're taking care of lots of other people we need to have that resilience as well. Find something that brings you joy and allow yourself to experience it.'

EMMA BRAND is a qualified counsellor and member of the British Association for Counselling and Psychotherapy. She runs a private practice in Kent, working with clients experiencing anxiety and depression
Twitter: @ELBcounselling1

DR AUDREY TANG is a counselling psychologist and a chartered member of the British Psychological Society. She lectures on personal development and mindfulness, focusing on positive psychology, mental health and wellness in leadership
Twitter: @DrAudreyT

5 STAY HEALTHY

'Eat, sleep and exercise – getting your blood pumping can help to clear your mind,' says Audrey. 'Overindulgence can result in feelings of guilt and excess weight, which can add to feelings of loneliness in lockdown. Simply getting out in the fresh air can help you get more vitamin D, which can increase feelings of happiness and counter seasonal affective disorder.'

6 FIND A WAY TO COPE

Different practices work for different people, from cognitive behavioural visualisations to various breathing techniques. Emma explains her 'magic five' strategy: 'When someone is stuck in a situation or an emotional feeling, I encourage them to think about how they would feel about it in five minutes, five hours, five days, five weeks and five months. Anxiety can be overwhelming, and this can help people to feel more in control.'

7 REACH OUT TO OTHERS

Connect and share your experiences with fellow professionals by joining a Private Practice Network or becoming a member of your local podiatry branch. This could combat feelings of loneliness and isolation.

Audrey adds: 'You may meet like-minded people who you know it will be possible to connect with.'

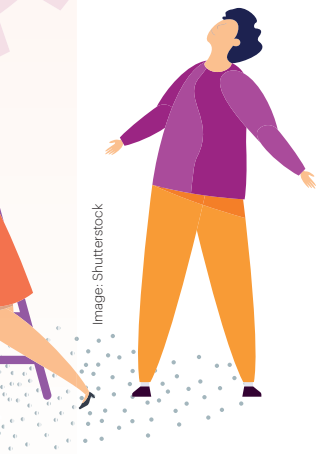


Image: Shutterstock

RESOURCES

- Mind: **mind.org.uk**
- Calm meditation app: **calm.com**
- Headspace sleep and meditation app: **headspace.com**
- Other useful apps: **bit.ly/nhs-mental-health-apps**
- NHS mental health support: **bit.ly/nhs-every-mind-matters**
- Health Assured wellbeing app: 24/7 helpline and counselling service accredited by the BACP, CBT sessions, online physical and mental health assessments: **0844 891 0354** or **enquiries@healthassured.co.uk**

WHEN LOSS HITS HARD

Stephanie Wilson, owner of WilsonGrant Podiatry in Glasgow, lost her 24-year-old brother 19 months ago in a car collision.

I've experienced loss before and always thought I was a strong person. But this was different, and I knew I had to find something or someone to help me.

I did research on coping with this type of loss and contacted various organisations – reading a lot helped. I went to the GP for some advice and have taken up playing the keyboard again, walking the dog and spending more time outside with my little one. Work has also kept me very busy, and I am in the process of opening a second clinic.

Keeping a brave face at work was hard. I felt I couldn't show my team how much I was suffering. I didn't want my problems to bring morale down. I'm very lucky to have a supportive and hard-working team, who helped run the clinic when I took time off.

I have always been motivated, and I was aware that I was slowly losing that ambition and drive. However, hard work and determination kept me going.

The support is ongoing; it probably will be for the rest of my life. I now know how important it is not to be ashamed or hide mental health and the challenges it can bring. Being caring and kind goes a long way.

RETHINKING EXAMS

In line with government guidance, the College is running its Assistant Practitioner Training Programme assessments online. It's a decision that's already proven successful for everyone involved.

JOANNE CASEY
is the podiatry project officer at the College

One of the government's biggest dilemmas throughout the Covid-19 pandemic has been finding ways to deliver education to students of all ages while minimising exposure to the virus. At the College, we have also had to rethink the way in which we deliver courses and programmes of study to keep everyone safe.

For many, remote online teaching allows flexibility in learning and often blends well with lifestyle choices. However, as with all allied health professionals, podiatrists are inherently hands-on learners, which makes delivering any clinical course online particularly challenging.

The Assistant Practitioner Training Programme is a course delivered at the College for many years with great success. It is a modular course built on reflections, assessments and practical competencies within the training manual, and requires the trainee assistant to compile a portfolio of their studies and experiences.

At the end of the course, the portfolio is submitted to an examiner and a date is set for the practical examination and portfolio review. The role of the examiner is to tease out the student's applied knowledge and assess their competence in patient care.

The new process

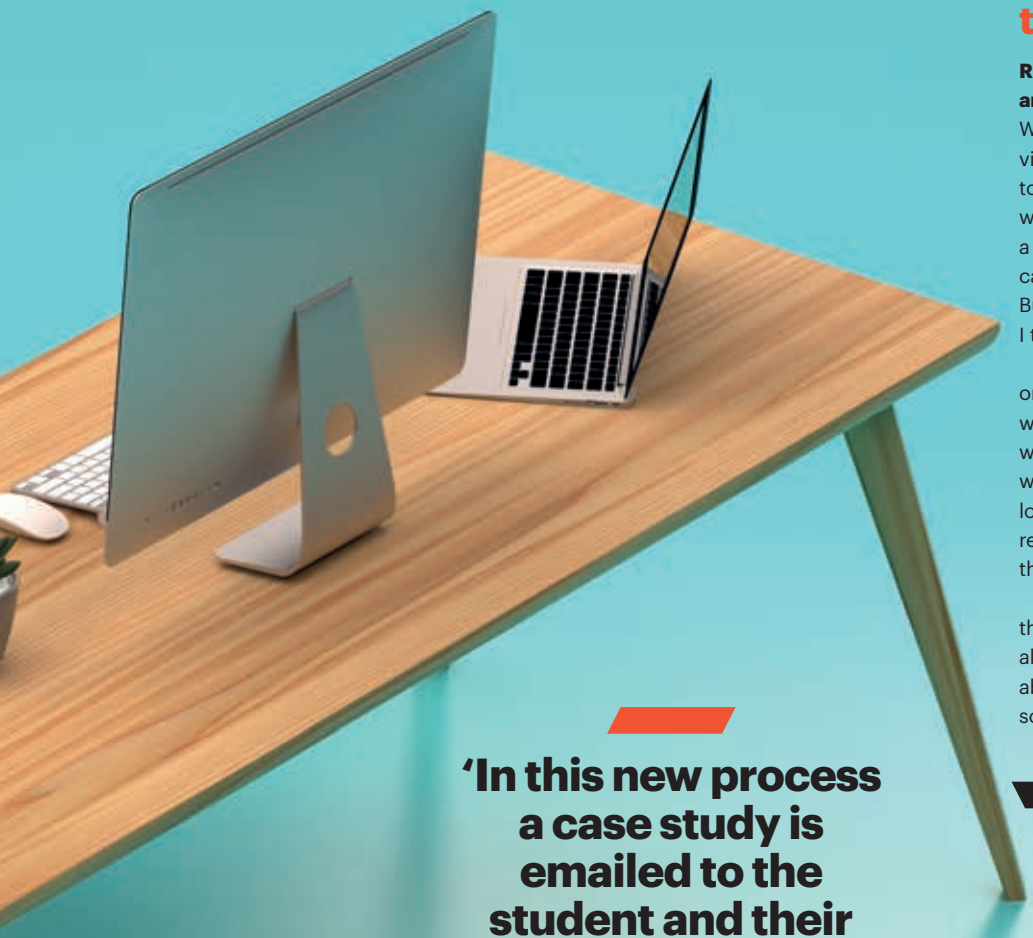
In 2020, in line with government guidance and following in the footsteps of Health Education England, the College devised a new way to assess the assistant practitioner in training. Once the supervising podiatrist had signed off all the practical competence, it was decided that the assessment would be conducted through an online viva voce exam and portfolio review.

The exam process begins with a 'pre-prep' virtual meeting between the student, their supervisor, an external examiner and a moderator from the College. The pre-prep meeting serves to reassure all those involved about delivery of the exam and, at this meeting, a future date for the exam is confirmed.

Rather than having a practical assessment where care is given to two selected patients, in this new process a case study is emailed to the student and their supervisor 24 hours prior to the exam. On the day of the examination, the student presents the case study

HOW TO GET INVOLVED

If you are interested in becoming an examiner for the Assistant Practitioner Training Programme, or would like to enrol a student into the programme, please contact the College on **assistants@cop.org.uk**



‘In this new process a case study is emailed to the student and their supervisor 24 hours prior to the exam’

Case study: ‘I thought the exam was great’

Ruth McMenemy, Belfast Health and Social Care Trust

When I was told that the exam would be done virtually, I thought, ‘I don’t know if I’m going to like this.’ I was anxious to see how it would work, thinking it would be strange to talk about a patient rather than have them in the room and carry out the assessment in front of the examiner. But now, having gone through the virtual exam, I thought it was great.

An examiner and a lady from the College were on the computer screen, and in the room there was myself and my supervisor. I thought the exam was done very well. The patient case study that we were given was very detailed and gave me a lot of information – just like having the patient’s records on the computer. Once I broke it down, there was a lot that I could talk about.

Completing the exam in this way and finishing the course means that I can work more effectively alongside the podiatrists and feel that I am now able to help them as much as I can within my scope of practice.

Case study: ‘This way allowed a bit of my personality to come through’

Rhona Whiting, Belfast Health and Social Care Trust

Despite much reassurance from the examiner, I felt apprehensive going into the exam. However, I enjoyed working through the case study, even though I felt there was a vast amount of stuff to be covered and it was difficult to know how much detail to go into.

I imagined that doing the exam this way would feel like I hadn’t done justice to all the training and prep I had done. However, on completion of the process I didn’t feel like that at all. In fact, I felt I had given a reasonable account of how I would work within a clinic situation, what my thoughts or concerns would be regarding this patient, and how I would deal with her.

I had debated if this would have felt easier as a written exam, but I concluded that this way allowed a bit of my own personality to come through. Also, to write the amount of detail that we talked about would have made for a much longer exam.

Image: iStock

to their examiner and answers any questions the examiner may have in relation to both this and their portfolio.

First-rate feedback

We have already had great comments from the students (see *Case study*, left and above). At first, on top of the usual exam day nerves, there was much apprehension about using technology. However, the students who have sat their exams this way have proven that this format of assessment can be successfully used to enable them to finish their student journey and embark on their new roles.

It remains to be seen if this type of blended examining will become embedded in future. However, if there is one thing those in the podiatry profession have always shown an aptitude for, it is in learning how to adapt.

PERFECT MATCH

How the College's online mentoring platform is bringing colleagues together to share skills and solve problems.

Words Emma Bennett

Since the College launched its online mentoring platform last spring, practitioners from across the UK have signed up to share their knowledge and expertise.

The network allows podiatrists in both private practice and the NHS, as well as in academia and research, to connect with fellow professionals. They can develop skills, seek guidance and gain support, whether they're at the beginning of their career or going through a period of change.

For mentors, it is an opportunity to pass on specialist knowledge while contributing to their own professional development.

Pay it forward

The platform works much like an online dating service. Mentees create a profile detailing their background, specialism, skills and the support they're looking for, and they are then matched with a suitable mentor.

So far, around 120 people have signed up, and 40 relationships have been created. Claire Angus, director of membership services at the College, says: 'Mentoring is really worthwhile and an opportunity to "pay it forward". We're a small profession but there's a lot of knowledge out there that we can share to support each other.

'It can be more innovative than just the traditional mentoring of younger podiatrists. Members may have a specialist skill, such as social media, or experience in a different area of podiatry.'

The mentoring platform works alongside the College's new Clinical Development Preceptorship Framework and is designed to support – from both a clinical and wellbeing perspective – colleagues who are newly qualified or who have had a career break.

Mutually beneficial

Emma McConnachie, owner of Stirling Podiatry, has been offering business mentoring to fellow professionals for years and was matched with six mentees through the College's platform.

'We're a small profession but there's a lot of knowledge out there that we can share to support each other'
Claire Angus

'Mentoring and having critical friends is integral to our development as professionals'
Emma Cowley

She says it's been a mutually beneficial relationship: 'I had a mentor when I opened my practice 16 years ago and we are still good friends. We have grown with each other because we have different skill-sets and we share those skills. It's sometimes useful to have a completely neutral viewpoint and sounding board from someone outside of your business.

'Talking things through with my mentees often gives me a fresh perspective I hadn't considered before, and it sparks ideas I can use in my own business.'

For Emma Cowley, senior teaching fellow at the University of Southampton and the owner of 4D Podiatry, mentoring is not optional.

She says: 'Mentoring and having critical friends is integral to our development as professionals. It is fundamental to build up a sense of trust and be nurturing in a challenging way – a way that shows you're on their side. Mentoring is a way to start building that culture of community and mutual development, and anybody can benefit no matter what your age or stage of career.'

Emma, who was matched with numerous mentees through the College's platform, says her experience was positive.

'The reason I started in my career as an educationalist and scholar is that I wanted to see what podiatry and podiatrists are capable of. Mentoring allows me to work with those people and revitalise their careers if they have fallen into a black hole of what to do next. While I'm there to help them understand their long-term goals and aspirations, and encourage them to find their solution, I also benefit by gaining a greater understanding of podiatry as a profession.'

Image: iStock

‘It’s incredibly rewarding to see people grow in their careers’

Debbie Delves

GET CONNECTED

To find a mentor or connect with a mentee, visit **bit.ly/CoP-mentoring-platform** (you will need to be logged in)

Once you have created a profile you can start searching for a match.

So, what are the benefits?

- Simple to use
- Online – no need for face-to-face meetings
- Nationwide – you can connect with members from across the UK
- Safe and secure – no personal details are shared
- Support – there are plenty of useful resources on the platform

DEVELOPING CONFIDENCE

The Preceptorship Framework is a structured programme for registered practitioners new to a role, designed to provide an agreed national approach to improving their confidence in practice. It will enhance clinical skills, professional behaviour and autonomous practice.

To find out further information, go to **bit.ly/CoP-preceptorship-framework**

‘It is a rare opportunity to connect, interact and build a relationship with an experienced podiatrist’

Stephanie Raley

Top tips for mentors

Don't overcommit – be realistic about the time you can devote to mentoring, and only accept matches if you can follow them through.

Use it as an opportunity to gain new ideas – your mentees may bring a fresh perspective to your own career.

Agree the parameters of your relationship – how often you will meet and what you want to achieve.

Top tips for mentees

Set specific career goals – be clear about what you would like to achieve and your expectations of the relationship.

Carefully pick your mentor – ensure it's someone you feel a rapport with and is where you want to be professionally.

Don't be afraid to question yourself – it will help you decide what you want from your career.

'Talking things through with my mentees often gives me a fresh perspective I hadn't considered before'

Emma McConnachie

Mentee: A push in the right direction

Stephanie Raley is an NHS podiatrist and private practitioner in north-west England.

Following my studies to re-register as a podiatrist after six years away, I was feeling highly motivated but slightly lost about how I could achieve my career goals. I signed up to the mentorship scheme to develop as a podiatrist and avoid the professional stagnation I had previously experienced.

I chose my mentor initially because of her biomechanics knowledge – a field I wanted to develop.

Because of Covid-19, mentorship meetings were held online. This was a great benefit to me because my mentor is located at the other end of the country. Meeting online was actually better because it gave me more choices.

My mentor encouraged me to analyse what I wanted from my career and how I could achieve it, giving me concise, actionable steps on what to do next. The support, knowledge and motivation she has provided me with has spurred me on to think about alternative career paths I never knew about.

Since my mentorship, I have gained a Band 6 specialist podiatrist position in the NHS and have interviewed for a Band 7 role. I have used various points that my mentor has shared to propel my private practice, and I have a list of goals I want to achieve in 2021, such as qualifying to perform needling, joining the Royal College of Physicians and Surgeons of Glasgow, and learning how to do steroid injections.

The only challenge I faced was the amount of deep introspection required, which I wasn't expecting. However, this has given me clarity on my strengths and weaknesses and what I really want from a career.

I would encourage anyone who is thinking of using the mentorship programme to go for it. It is a rare opportunity to connect, interact and build a relationship with an experienced podiatrist who can share their knowledge and push you in whichever direction you want to go.

Mentor: Watching them grow

Debbie Delves is clinical director at Dulwich Podiatry in London.

The platform matched me with two mentees – the first dropped off when Covid-19 hit, but the second relationship has been very positive. She was working in private practice but was feeling demotivated. She wanted some practical advice, as well as some emotional support and encouragement.

We did a couple of Zoom calls and we met in the gap between lockdowns. She had set up her new practice, so I went to look round and make sure she had ticked all the boxes she needed to – how to get clinical waste collected, for example, and I helped her set up [accounting software] Sage. She was also interested in the College's accreditation scheme and wanted to know how she could ensure she was working to those standards. I have been in private practice for 30 years, so have a lot of experience she could draw from.

If Covid-19 hadn't happened, I probably would have followed up with her more often, but she has messaged me with updates. Having the technology in place has made it very easy – we've shared screens on Zoom so I could help with cashflow forecasts. It's so much easier to give hands-on advice without being in the room.

As a mentor, it's important to listen to what your mentee is asking you and respond to that, rather than trying to push them in one direction. Talking to other mentors is also a useful way to share experiences with others and help you guide your relationships.

Mentoring is a great way to keep developing – I always learn from other people regardless of where they are in their journey. When I'm helping people there's often a click in my head where I think, 'Actually, I could be doing this in my practice'. It's also incredibly rewarding to see people grow in their careers.

HOW I GOT HERE...

Digging deep

Continuing our series following the journeys of podiatrists to Chartered Scientist (CSci) status, we speak to Ayrshire-based practice owner **Vicki Cameron**.

Applying for CSci status seemed a natural progression...

I've always believed that research and innovation are at the core of quality and professional foot care, and essential for achieving the best clinical outcomes for patients.

I applied after seeing an advert in *The Podiatrist*. I'd never heard about it, but since we were in lockdown I thought it would give me something to focus on professionally while our clinics were closed.

It's a journey...

The application took me through a challenging process of critically evaluating the various aspects of my career over the past 15 years, and how they have contributed to my learning and development as a podiatrist. The questions forced me to reflect on what I do and how I've managed clinical scenarios.

Growth can be painful...

Acknowledging the times you did not do something well can feel sore, yet it's critical to your growth as a clinician, a manager, a leader, an innovator and a person.

It's well worth the effort...

Obtaining CSci status has been very positive for me, and I can look back on lockdown with a sense of achievement.

Image: iStock

Find out more about applying for CSci status at **cop.org.uk/membership/chartered-scientist**

Vicki's podiatry career

- Graduated from Queen Margaret University, Edinburgh in 2005
- Worked as a Band 6 podiatrist for NHS Ayrshire and Arran, and as a clinical teacher and podiatrist at NHS Greater Glasgow and Clyde
- Worked as a research assistant at Stirling University's Cancer Care Research Centre
- Completed a PhD in 2010
- Started independent practice StEPS Podiatry in 2011
- Awarded an innovation grant to carry out research at the University of Strathclyde, using its 3D gait analysis equipment to identify injury risk in footballers at the Scottish Football Association
- Supervised PhD students at the Alzheimer Scotland Centre for Policy and Practice at the University of West of Scotland
- Partnered with the University of Strathclyde to look at the design and manufacture of podiatry tools, focusing on the needs of people with dementia.

I also feel proud that, as a podiatrist, I was able to showcase our skill-set as scientifically sound.

Let's raise our profile...

Much of what we study at undergraduate level is scientific, and science underpins much of what we do in practice. With the emergence of foot health professionals it seems a timely opportunity to showcase what podiatry is all about, and to challenge the traditional perception of chiropody care.

Give it a go...

I'd advise other podiatrists to seriously consider applying for CSci status. You need to dedicate time to the process, but the result is rewarding.

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The Evidence

CLINICAL UPDATE

Research round-up

A closer look at the latest reviews and trials from journals around the globe – with insight from the authors.

Are you a PhD or master's student looking at new research papers weekly or even daily? If you think one should be featured in our round-up, get in touch at **editorial@ the-podiatrist.co.uk**

1 Toe gaps and their assessment in footwear for people with diabetes: a narrative review

PUBLICATION: *Journal of Foot and Ankle Research*

BACKGROUND: Adequate footwear fit is critical in preventing diabetes-related foot ulcers. One important element is the toe gap – the difference between foot length and internal footwear length available to the foot.

AIMS: To summarise the literature on toe gaps in studies assessing footwear worn by people with diabetes and the methods used to measure both foot length and internal footwear length; to identify ambiguities that may impact on toe gap assessment in clinical practice and suggest pragmatic solutions.

FINDINGS: Toe gap ranges – as used in assessments of footwear worn by people with diabetes – vary, with a minimum of 1cm to 1.6cm and a maximum of 1.5cm to 2cm, as do methods of measuring internal footwear length. Only three published studies suggested possible measuring devices, and a gold standard device for internal footwear length measurement has yet to emerge.

A plus12med is one of a number of gauges that can be used to measure internal footwear length, and together with an individual's foot length, can determine the available toe gap in each shoe

RESEARCHERS' TAKEAWAY: 'Ill-fitting footwear can be responsible for up to one in five diabetes-related ulcers. We hope our paper will encourage experimentation with some of the internal footwear gauges used to measure toe gap in these studies. We plan to carry out further research looking at their reliability and ease of use, and to assess alternate recommended toe gap ranges upon in-shoe pressures and plantar thermal stress response. We are always interested to hear from podiatrists at Leicester Diabetes Centre.'
Petra Jones, lead author

READ THE FULL STUDY
bit.ly/JFAR-toe-gaps

WANT TO FEATURE ON THIS PAGE?
If you would like your work to be featured here, please prepare an 80- to 100-word summary of your research and its take-home messages and send it to us at **editorial@the-podiatrist.co.uk**

2 Shoe-stiffening inserts for first metatarsophalangeal joint osteoarthritis: a randomised trial

PUBLICATION: *Osteoarthritis and Cartilage*

BACKGROUND: While some evidence suggested that shoe-stiffening inserts could reduce dorsiflexion of the first metatarsophalangeal joint (first MTP joint OA) during gait, there was a need to evaluate their effectiveness for reducing pain.

AIMS: To evaluate the efficacy of carbon-fibre shoe-stiffening inserts.

FINDINGS: Following a 12-month randomised trial comparing the effectiveness of shoe-stiffening inserts with sham inserts, results showed improvements in foot pain at each follow-up in both groups. At the 12-week follow-up there was a significant between-group difference in favour of the shoe-stiffening insert.

RESEARCHERS' TAKEAWAY: 'It could be argued that shoe-stiffening inserts should be considered the non-surgical treatment of choice for first MTP joint OA.'
Hylton Menz, co-author

READ THE FULL STUDY
bit.ly/OaC-shoe-stiffening

Image: kinderfuesse.com

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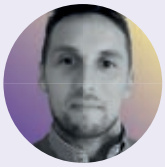
Visit **surveymonkey.co.uk/r/ThePodiatrist21** to complete the survey. The deadline is **7 June**.

Upstreaming preventative practice – are we doing enough?

Smoking, poor diet, high blood pressure, obesity – what podiatrists should know, and what they can do, about the growing burden of lifestyle-related health problems on ageing populations.



DEREK PROTHEROE
is an advanced podiatry practitioner at Hywel Dda University Health Board (UHB)

MIKE MULROY
is head of podiatry and orthotics at Hywel Dda UHB

Populations are ageing across the globe (United Nations, 2019). In 2018, 11.9 million residents in Great Britain, or 18% of the population, were aged 65 years and over (see Figure 1). It is estimated that by 2050 almost 25% of the population (17.7 million) will be aged over 65, and the number of over-85s will double to 3.6 million (5%) (Office for National Statistics, 2019). The impact of the health burden on these population groups is significant. For example, 20% of over-65s have peripheral arterial disease (PAD) and an increased risk of cardiovascular disease (CVD) and limb loss (Criqui and Aboyans, 2015).

We need to raise awareness in the general public that their health and wellbeing is within their control and is often dependent on factors outside of the NHS. The Global Burden of Disease (GBD) study has quantified and ranked the contribution of various risks that cause premature death and long-term health conditions in England (Steel et al, 2018). The top five are smoking, poor diet, high blood pressure, obesity, and alcohol and drug use. An additional significant risk factor is low physical activity. Supporting people in reducing their modifiable cardiovascular risks is well ingrained in our practice, and some education programmes established in podiatric departments can both improve and maintain a patient's ability to live a full and healthy life. Various targets have been set by the NHS in its Long Term Plan (NHS, 2019) to strengthen its contribution to upstream prevention of avoidable illnesses. The plan highlights the role of the NHS in secondary prevention by identifying disease early, thereby reducing symptoms and preventing a subsequent decline of health, leading to improved quality of life. This will contribute to the government's objective to add five years of extra life expectancy by 2035.

The NHS Long Term Plan also targets CVD as the leading cause of death worldwide, and makes it a clinical priority to prevent 150,000 heart attacks, strokes and cases of dementia in the next 10 years. The CVD prevention programme aims to improve and increase early detection and treatment of CVD to help patients live longer, healthier lives. The programme hopes to encourage people to routinely know their 'ABC': atrial fibrillation, blood pressure and cholesterol (Public Health England (PHE), 2019).

The podiatric profession and PAD

The podiatry profession is a skilled workforce, able to recognise and treat a range of lower limb pathologies. This skill mix has the potential to be enhanced and developed, which is demonstrated by the many advanced practice roles within secondary care and even primary care centres, such as musculoskeletal first contact practitioners (Health Education England, 2019). However, are we providing enough preventative measures alongside monitoring these recognised risk factors, to ensure our patients can live their longest and healthiest lives? >

Image: Getty

'The doctor of the future will give no medication but will interest his patients in the care of the human frame, diet and in the cause and prevention of disease'

Thomas Edison (1847-1931)

Podiatrists are recognised as potential key healthcare professionals with an ability to provide early PAD detection and best clinical management (Fox et al, 2015). This recognition of, and agreement to tackle, PAD has been reached between the College and the Vascular Society of Great Britain and Ireland. Therefore, our particular skill mix can be further utilised for screening our patients for other preventative contributing risk factors, as stated in the GBD study and the NHS Long Term Plan. Once risk factors are identified, the podiatrist can use several targeted interventions to modify these risks and prevent increased lower limb morbidity.

We must appreciate there are barriers to podiatrists having these conversations with patients at present and taking a lead role, such as the perception that there is not enough time or it is 'not our job', as well as the possibility of feeling underconfident or uneasy. One way to make every contact count is the use of brief motivational interviewing (MI). The concept of brief MI has been around for many years, and podiatrists have long been recognised as occupying a unique position from which to nudge their patients into behavioural changes in an attempt to improve their health (Gabbay et al, 2011).

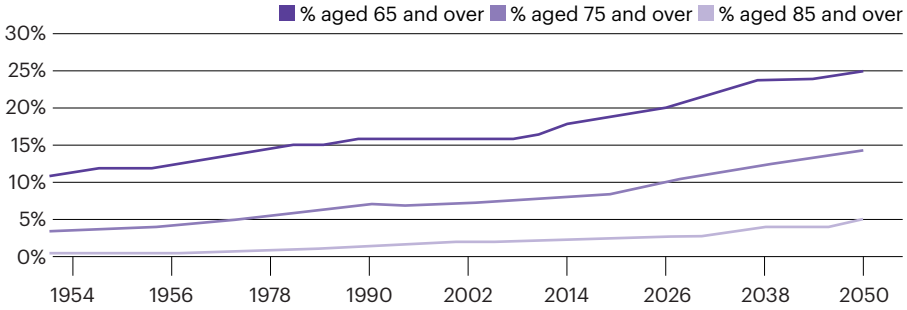
Although not recent, a multicentre randomised controlled trial conducted in South Wales investigated the effect of MI in type 1 diabetic teenagers. Sixty patients were evaluated, and the mean HbA1c (glycated haemoglobin) in the MI group was significantly lower than in the control group ($P = 0.04$). The MI group demonstrated more positive wellbeing, improved quality of life and differences in their personal models of illness (all $P < 0.01$), with some of these differences maintained for 24 months (Channon et al, 2007).

MI has been used in many other health and social care areas, including smoking cessation, medication adherence, alcohol and substance abuse, obesity, physical activity and diabetes mellitus (Frost et al, 2018).

There are even various free e-learning courses provided by NHS England to improve these concepts within the training section of their 'NHS Health Check' resource: see **bit.ly/NHS-health-check-resources**

FIGURE 1

Percentage of people aged 65 years and over, 75 years and over, and 85 years and over, 1950 to 2050, Great Britain



Office for National Statistics, 2019

Modifiable risk factors

Blood pressure and hypertension

Hypertension is the largest-known worldwide risk factor for disability and disease after poor diet, accounting for almost half of all ischaemic heart disease and CVD events worldwide (GBD 2013 Risk Factors Collaborators et al, 2015).

Atturu et al (2014) highlight hypertension as an independent risk factor for both diabetic and non-diabetic patients with PAD.

TABLE 1

Number of adults diagnosed with diabetes in the UK

Country	Number
England	2,913,538
Scotland	271,312
Wales	183,438
Northern Ireland	84,836

Modified from Diabetes.co.uk, 2019

A reduction of systolic blood pressure by 10mmHg confers a 16% decrease in lower limb amputation or death from PAD (Atturu et al, 2014).

Raised blood pressure from eating too much salt remains a leading cause, resulting in thousands of heart attacks, strokes and premature deaths. Lowering intake of salt in foods by 1g per day, for example, could prevent 1500 early deaths each year and potentially save the NHS more than £140m annually (NHS, 2019).

Podiatrists undertaking routine vascular assessment using a Doppler ultrasound and syphgmomanometer cuff can often pick up hypertension either not previously diagnosed or not medically optimised, as well as unknown arrhythmias that can be signposted to the GP (College of Podiatry, 2020).

Cholesterol and lipid levels

High cholesterol can be defined as the build-up of fatty deposits in arteries, which increase as we age. Elevated cholesterol is one of the most significant risk factors for CVD, and a third of ischaemic heart disease globally can be attibuted to it. It also accounts for 7.1% of deaths and 3.7% of disability-

adjusted life years (DALYS) in England (PHE, 2019).

De Vera et al (2014) conducted a systematic review and reported that observational studies consistently indicate an increased risk of adverse outcomes associated with poor statin adherence. Podiatrists are in a prime position, with a knowledge of brief MI, to discuss the issue with patients and support medication concordance, along with requesting potential cardiovascular medication GP reviews.

Excessive weight and obesity

Obesity rates have tripled globally since 1975, and in Europe the UK ranks among the most obese nations. Poor diet and obesity are linked with elevated blood pressure, high cholesterol, type 2 diabetes and increased risk of respiratory, musculoskeletal and liver diseases. In 2016-17, 617,000 admissions to NHS hospitals recorded obesity as a primary or secondary diagnosis (NHS, 2019).

In Wales, almost a quarter of adults self-report as obese – an estimated 600,000 adults – while one in eight Reception-age children are obese. High body mass index (BMI) is the largest identified contributor to years lived with disability, and the third leading cause of DALYs (Public Health Wales Observatory, 2019a).

Reduced cardiovascular exercise

All-cause mortality decreases by about 30% to 35% in the physically active, as opposed to inactive subjects (Reimers et al, 2012). Supervised exercise training has been shown to improve cardiovascular mortality and morbidity in patients with PAD, reporting a clinical significance (P = 0.048) when compared with cardiovascular event-free rates between patients who completed the training (Sakamoto et al, 2009). In addition, exercise programmes significantly improve the maximal walking time when compared to usual care or placebo, with improvements seen for up to two years (Lane et al, 2014).

NHS physical activity guidelines recommend at least 150 minutes of moderate-intensity activity a week, or 75 minutes of vigorous intensity activity a week, in combination with reducing time spent sitting or lying down, and breaking up long periods of not moving with some activity. The guidelines encourage people who are unable to perform moderate-intensity physical activity because of comorbidity, medical conditions or personal circumstances to exercise at their maximum safe capacity (NHS Choices, 2019).

Take-home questions

1. Are you aware of the top five risks that cause premature death and long-term illness globally?
2. Do you routinely ask your patients about their modifiable risk factors?
3. Do you feel confident in screening your patients for potential avoidable diseases that would significantly lower their mortality rate?
4. Are you aware of brief motivational interviewing?
5. Do you monitor any changes patients make to their modifiable risk factors?

Elevated glucose levels

In the UK, there are currently 3.5 million people diagnosed with diabetes (see Table 1), with a predicted 549,000 people yet to be diagnosed (Diabetes.co.uk, 2019).

HbA1c, or glycated haemoglobin, is a diagnostic biomarker for diabetes. Increased mortality is associated with higher HbA1c levels from all causes and CVD among subjects without known diabetes (Zhong et al, 2016).

Intermittent claudication is about twice as common among diabetic patients as non-diabetic, and for every 1% increase in HbA1c there is a corresponding increased risk of PAD (Norgren et al, 2007).

Smoking and nicotine use

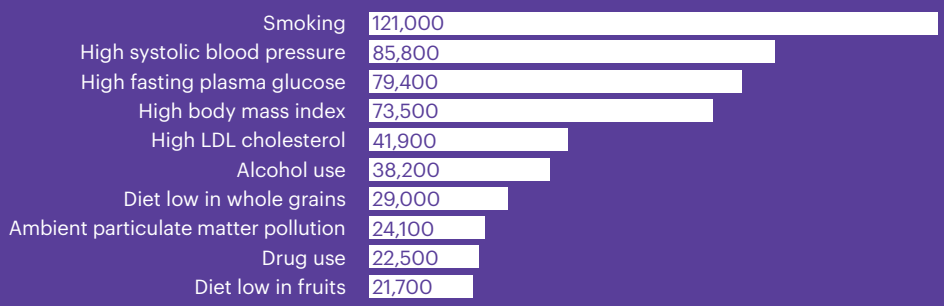
In Wales, 18.4% of adults self-report smoking, a prevalence comparable to other wealthy European countries. Smoking is the largest risk factor for DALYs in Wales, contributing to 121,000 years of healthy life lost in 2017 – see Figure 2 (Public Health Wales Observatory, 2020).

Alcohol consumption

It has been shown that 19% of adults in Wales were drinking more than the weekly guidelines during 2016-17 to 2017-18. This was more prevalent in males as opposed to females in all age groups. Within some age

FIGURE 2

Top 10 risk factors identified by the Global Burden of Disease: years of healthy life lost in Wales in 2017



Public Health Wales Observatory, 2020

groups, the difference was as much as double for males. Males aged 55 to 74 had the highest levels of drinking in Wales, with around a third drinking more than 14 units of alcohol in a usual week. Alcohol use was ranked among the top five risk factors for DALYs in Wales in 2016, and it remains a major public health challenge (Public Health Wales Observatory, 2019b).

PREVENT risk scoring system

Following the Hywel Dda University Health Board (UHB) podiatry team's seminal training with Martin Fox (a vascular podiatrist) in 2018, a proposed prevention criterion and scoring system was developed. This classification system (see Tables 2 and 3) is similar to other stratification systems currently in use, but with the added element of incorporating a perceived risk to future lower limb function. A review component has been incorporated to audit whether perceived risk increases or decreases because of the action taken. A mnemonic, PREVENT +/-, has been formulated to allow ease of use and to act as an aide-memoire.

These perceived risk factors are not new to our practice or understanding. Hywel Dda UHB is making conscious efforts to upstream these preventative measures and monitor how they could affect our patient population.

One of the main purposes of this article is to stimulate critical review of this proposal from clinicians with an interest in this area.

The PREVENT system correlates to a three-stage category system: no symptoms (C), moderate symptoms (B) and active symptoms (A). This provides a prevention risk assessment score, from a low risk and no symptoms (C0) to a high-risk score (A8). A patient may move up and down this proposed prevention risk assessment scoring system. Ultimately, it allows a red flag system of monitoring and projected comparisons on whether prevention programmes are being implemented.

Once a risk category has been recorded, the patient can be allocated to an individualised management plan, whether that be urgent onward vascular/orthopaedic opinion or one of the trust's support groups, such as smoking cessation, weight management, self-exercise programmes, an exercise referral system, diabetic education packages and GP cardiovascular medication optimisation.

At Hywel Dda UHB, we are currently in the process of developing a long-term (two- to three-year) analysis of these factors and how they may be influenced over time. As part of the outcome measures utilised, we aim to correlate these with the PASCOM-10 system endorsed by the College.

TABLE 2

PREVENT risk factors for lower limb circulation

Pressure Blood pressure (resting >140/90)	**Explanation of risk** R/8 = max R. R/0 = min R	R1
Raised blood lipids (cholesterol) Total is greater than 4 or LDL is greater than 2		R1
Elevated blood glucose (with diabetes) HbA1c is greater than 7.0 or 53 (new measure)		R1
Vascular – lack of cardiovascular (heart) exercise Less than 2.5 hours per week of light exercise		R1
Excessive weight > BMI 30kg/m^2		R1
Nicotine – smoking any tobacco/nicotine		R1
Total alcohol consumption		R1
+/- Musculoskeletal lower limb/ foot pathology		R1

TABLE 3

PREVENT risk staging system

Your foot symptom classification today		
Active symptoms (A)	**Moderate symptoms (B)**	**No symptoms (C)**
Significant neurovascular deficit/and biomechanical issue	Some neurovascular deficit/ biomechanical issue	Good neurovascular function/no biomechanical issues
Action		
To be seen in hospital/ community ulcer clinics, and risk factors addressed, monitored or referred on to T&O, vascular, endocrinology or MDT clinics if appropriate	Initiate risk reduction strategies and signpost to services. Educate and empower patient to self-care. Referral to specialist clinics if further support/ intervention needed, e.g. MSK, footwear, vascular podiatry	Educate, empower and initiate risk reduction strategies

Summary

With the knowledge of preventative healthcare practice, we can have a significant effect on a patient's awareness of these well-recognised comorbidities. We can thus empower our patients to utilise this knowledge with appropriate interventions and/or refer to allied health educational programmes. The aim is to reduce the identified risk factors and lessen/prevent PAD, ulceration and neuroarthropathy, ultimately saving limbs and lives and reducing morbidity, and attempting to reduce the inevitable overuse of an already understaffed, underfunded and strained NHS system.

References are available to view online:
membersarea.cop.org.uk/the-podiatrist

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60 SECONDS WITH...

Nina Davies

The Leeds-based children's podiatrist and clinical system pathway development lead, recently selected by the College for a coveted Diamond Award, tells us about her 20 years in podiatry.

My passion for healthcare started at a young age. I had a Lego hospital – and that's what sparked my interest. Later, during my A-levels, I did work experience sitting in with a podiatrist. This inspired me to join the profession.

Seeing immediate results attracted me to podiatry, because when you treat somebody you can make them better instantly. That appealed to me, whereas something like physiotherapy is more of a slow burn.

Practice today looks very different to 20 years ago, when we were very much defined by personal care and priority groups. We have a very different skill-set now, and it's led by a lot of research and knowledge. When I qualified [in 1999], we didn't really have the internet or mobile phones, so if you worked in a particular town, that was your podiatry network. But in the last 10 years, technology has opened everything up; we can now access journal articles and hear what everybody else is doing on Twitter.

My clinician and lecturer roles have complemented each other. I love my clinical work and I've got a real passion for developing podiatry and podiatrists' skills. You need great podiatrists to change patient care. I don't think I could just be a lecturer, because it's lovely being able to see that end point.

Children's podiatry is so important because they're underrepresented. They get pain, they get arthritis, and activity is really important to them, so when they can't participate, it means a lot more to them. The social aspect of it is important, but for

'When children can't participate, it means a lot more to them'

podiatrists, it's also recognising that if a child has pain, it can have a big impact on them.

I'm really proud of where I've managed to lead children's podiatry and of being able to make a difference. I've also got my Diamond Award through the College – that's only held by 25 people at one time.

I try and teach students the value and scope of podiatry, that we extend beyond managing conditions. It's about understanding the impact a foot condition can have on the whole person and how it makes them feel. Podiatrists aren't fully recognised, so it's important that we push the boundaries and become aligned with all the allied health professions (AHPs).

I would like to see podiatry integrate more with primary care and other AHP services, in areas such as rehabilitation and the detection of vascular diseases, and extend our scope within the profession. Integration should be across towns and cities, and include the third sector.

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