From: pang Kalson
Sent: Monday, July 03, 2017 4:51 PM
To: Office of Prof Hon Joseph LEE Kok Long
Subject: Re: 衞生事務委員會特別會議: 就「醫療人力規劃和專業發展策略檢討報告」發表意見

To:Office of Prof Hon Joseph K L Lee, PhD, RN, SBS, JP
Legislative Councillor, Health Services Constituency
3rd Jul 2017
Dear Prof Hon Joseph Lee:

Re: 醫療人力規劃和專業發展策略檢討報告」發表意見

Dear Councillor, with respect to the captioned report, our association have few concerns on the sustainable development of Podiatry to meet the demand of the public health in Hong Kong .

Background :

Work of Podiatrist includes promoting and maintaining feet health for the public and prevent high risk patient such as diabetic population to develop further foot complicaton such as cellulitis , ulceration and prevent unnecessary hospitalisation and amputation.

1. The work force of podiatrists serving in Hong Kong cannot cope with the increasing medical demand in the public sector.

2. According to College of Podiatry UK , there are around 13000podiatrist in UK serving 3000000 diabetic patient (1:230) while there are around 60 podiatrists in Hong Kong and around 10%of HK polupation is diabetic (1:11666).

3.podiatry is a bachelor degree course , however there is lack of local institution provide local training,current podiatrist supply rely on oversea scholarship offered by hospital authority. Which the resouces allocation do not allow enough supply to cope with the demand.

Thank you for your attention

Best regards
Kalson Pang
Vice-chairman HKPODA

Podiatry Workforce paper MT (1).pdf

Developing a Sustainable Podiatry Workforce for the UK Towards 2030

Rationale for report

This document has been commissioned by the Society of Chiropodists and Podiatrists as evidence to inform and influence organisations responsible for health workforce strategy, funding of under and post graduate education and service provision for Podiatry.

This is required so that Governments are able to identify and meet the needs of its population across the four United Kingdom countries.

This document may also have value within the profession and inform wider campaign strategies.

Mike Townson
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The Society of Chiropodists and Podiatrists
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The author recognises that there are four organisations planning health strategy across the UK. There is an emphasis on England because most of the concern and data is generated relating to that country and because of its significant, relative size. No offence is intended by frequent reference to the health care system in England. Scotland, Wales and Northern Ireland Health Boards all have huge contributions to make in this professional workforce debate.

Summary
The current UK population is 63.8 million (1) and growing faster than any other European Union country (2). Diabetes has reached 3.6m (3) and consuming 10% of the total NHS budget (4). The number of people aged over 85 will double by 2030 (5) and the increase in mental health illness, particularly dementia will require high quality professional behaviours. Changes to the national retirement age and the value of pensions will require people to work later into life. To ensure the UK workforce is a net contributor to fund the additional health and social care needed it must be mobile and healthy.

Good foot health and improved mobility can enable independence; the podiatry profession, led by the Society of Chiropodists and Podiatrists governs quality and safety, promoting a career profession to ensure appropriate skills are maintained to the UK population. However, funding adequate training and employment of graduate podiatrists is dependent on the national strategic and local decision making of public bodies.

The national workforce report for podiatry in England, 2012 (6) stated;
'We accept that service reconfiguration and skill mix are likely to alter future demand, so future modelling can be adapted as we know more about these changes. According to the SCP's estimate of demand – based on the increase in diabetes-related foot problems, population growth and related co-morbidity – there may already be a gap between supply and demand. There is a risk that this gap may widen over time if the incidence of diabetes continues to increase, which raises uncertainty about the ability of the profession to meet future demand.

However, prevention and healthy living initiatives as well as service reconfiguration or skill mix changes may reduce the incidence of diabetes and thus reduce the increase in demand.

The report concluded;
"There is currently no reported shortage of chiropodists/podiatrists and a low vacancy rate within the NHS. However, it is important that services providers and education commissioners are aware of potential demand changes in the future"

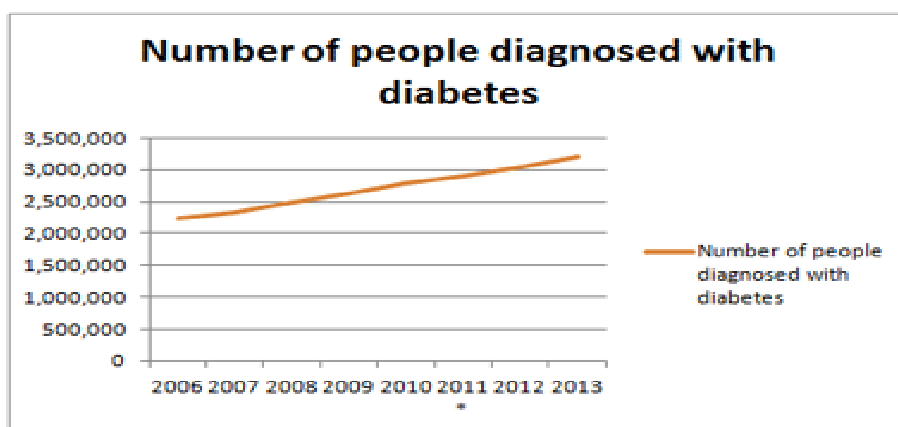
The 13% growth in undergraduate commissions stated within that report has not transpired and the 2014 workforce strategy (7) has specified a 0% growth in new podiatry student commissions.

A mobile and independent population will require the skills associated with a modern and developing podiatry profession. The economic benefit of podiatrists in reducing amputations has been demonstrated (8) and the Diabetes UK; Putting Feet First Campaign (9) reinforced this in 2013.

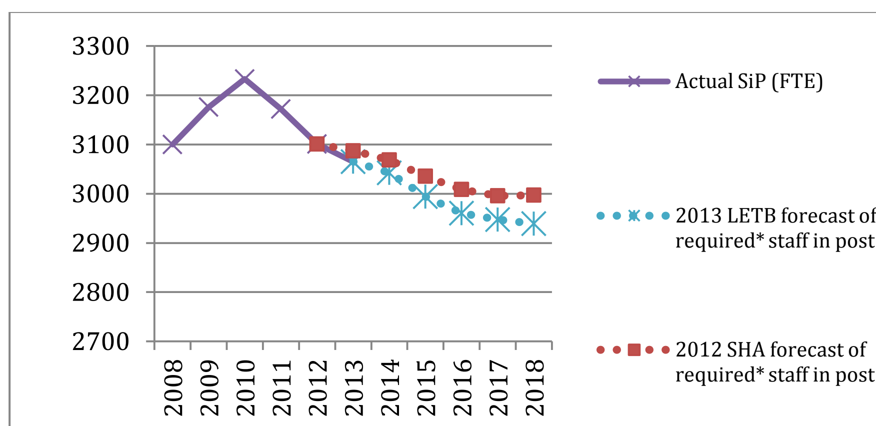
The podiatry profession, if supported with an appropriate national workforce and education strategy can respond to the needs and aspirations of a pressurised UK healthcare system. The emphasis of health promotion,

empowerment and prevention which are intrinsic to podiatric care will add further public health value both in patient outcomes and cost effectiveness of high quality care.

The demand and supply graphs below highlight a significant concern that adequate foot care will be available to meet the growing demand of diabetes. This workforce gap needs to be acknowledged by those who are planning and funding safe and effective care for this vulnerable group.



Source: Diabetes UK website



Source: Investing in People,2014/15 HEE Workforce Plan for England

In England NHS commissioners require podiatry activity to focus on patients with complex foot problems and specialist interventions, it may not be surprising therefore that the amount of activity generated by the podiatry workforce has halved since the 8m contacts in 2001 (25).

This paper identifies some of the policy and public health issues associated with podiatry and foot health, which can be used for workforce planning and professional development.

Following several high profile incidents the population and external reviewers have challenged the quality and caring nature of the NHS. Safety and professional behaviours have been placed back at the top of the NHS agenda. Changes to professional accountability, regulation and legislation

have followed, reinforced within and updated NHS Constitution (10) in 2013 emphasising the principles, rights, values, responsibilities and pledges of the health service in England and Wales.

Diabetes UK highlight that 80% of the 120 lower extremity amputations (LEA'S) each week in England are preventable, (8). The English Government has made a commitment in legislation and policy to provide safe care (10). This statistic is more unpalatable because of a ten fold variation in lower limb amputation across the country (11).

The Health Act 2012 (12) places high quality care at the centre of the NHS and transformation from hospital to community as a mechanism for sustained affordability of this treasured national resource.

The qualities of the workforce, cultures of organisations and professions, which led to the failings of health service delivery, have been rightly identified and challenged by the Francis, 2012 (13) and Berwick 2013 (14) reports from which the National Advisory Committee stated the following;

- Place the quality and safety of patient care above all other aims for the NHS. (This, by the way, is your safest and best route to lower cost).
- Engage, empower, and hear patients and carers throughout the entire system, and at all times.
-

A revised national workforce planning process in England, 2014 (15) embeds the requirement for a caring culture and behaviours within its strategy. The intention of the workforce plan is to provide safe and effective care for the population. This strategy has not recognised however the implications of increased foot ulceration and amputation within an increasing population of people with diabetes.

Capacity and Needs for Podiatry

The UK workforce of 13,000 HCPC (16) registered podiatrists is spread across public, independent, commercial, charitable and academic sectors. Foot health is relevant to the whole population and podiatrists have caseloads covering every age spectrum. The indication from this report is, that numbers of podiatrists are critically insufficient to meet the complex and growing foot health needs of our current and future population.

Podiatrists have a vital role across a range of health and social care pathways. A House of Commons debate, 2013) (17) identified that the failure to invest and support high quality podiatry services had weakened integrated care with particular emphasis on NICE Clinical Guideline 10 (18), leading to increased patient harm, hospitalisation and major cost implications.

This paper recommends the following:

1. Robust reporting to each of the UK countries NHS workforce planning strategies as a priority.
2. Invest in having a better understanding of the impact of podiatry on the UK population through both qualitative and quantitative evidence.

3. Generate public support for the profession
4. Implement workforce options to meet the current supply – need gap.

A. Key impact areas for podiatry

It is well understood that older people commonly have painful foot conditions (19) that lead to an increased risk of falling (20) reduced mobility and independence and increased risk of infection (21) and healthcare costs identified by the House of Lords Select Committee report 2013 (22).

What is Podiatry?

Podiatrists are regulated by the Health Care Professions Council (HCPC) and governed predominantly by the Society of Chiropodists and Podiatrists (SCP). Podiatry is a small but dynamic profession with a diverse skill set working with most care groups across the UK. Areas of the profession are increasingly supporting practice previously undertaken by medical surgeons or physicians. Podiatric surgery is delivering good outcomes and should become established as the primary route for most elective 'orthopaedic' foot and ankle procedures.

Independent prescribing will enable more timely and responsive care for patients particularly associated with limb threatening foot infection. Podiatrists are established clinical leaders in wound debridement, management and prevention, the need of which is increasing (23). Local anaesthesia is part of everyday practice, used to ensure patients can have disabling conditions remedied, without pain. Diagnostic ultrasound and injection procedures used with biomechanic diagnostics are effective therapies used to improve any musculo-skeletal function caused by trauma or disease.

Prevention, education and self care are at the heart of national policy and of good podiatry practice, critical within a population increasing in age and numbers with long term conditions. People who have reached a dependent stage should be supported with dignity and respect; foot health is an important element of this, which must be considered.

Key podiatry impact areas:

Podiatry can support the wellbeing of the UK population in the following areas;

A. Older People including Dementia and Falls;
B. Long Term Conditions; particularly diabetes but not exclusively and
C. Public Health and Disease Prevention

This paper should be read with an understanding of the commitment to quality emphasised within the following influential Government (England) documents;

1. Investing in People; The Workforce Plan for England 2014-15
2. Putting Patients First – The NHS England Business Plan for 2014-15
3. Hard Truths-The Journey to Putting Patients First Volumes 1 & 2
4. A promise to learn, a commitment to act. The National Advisory Group Report on improving the safety of patients in England, (August 2013)
5. NHS Education for Scotland Workforce Plan 2013-14

6. Healthcare Improvement Scotland; Driving Improvement in Healthcare, our strategy 2014-2020 (Nov 2013)
7. NHS Wales Standard 26: Workforce Training and Organisational Development
8. NHS Wales; Achieving Excellence. The Quality Delivery Plan of the NHS in Wales 2012-16 (May 2012)
9. Health and Social Care Northern Ireland; Transforming your care, Strategic Implementation Plan (October 2013)
10. Health, Social Services and Public Safety; Improving Health & Well-being through partnership. A strategy for Allied Health Professionals in Northern Ireland 2012-17

A. Older People including Dementia and Falls

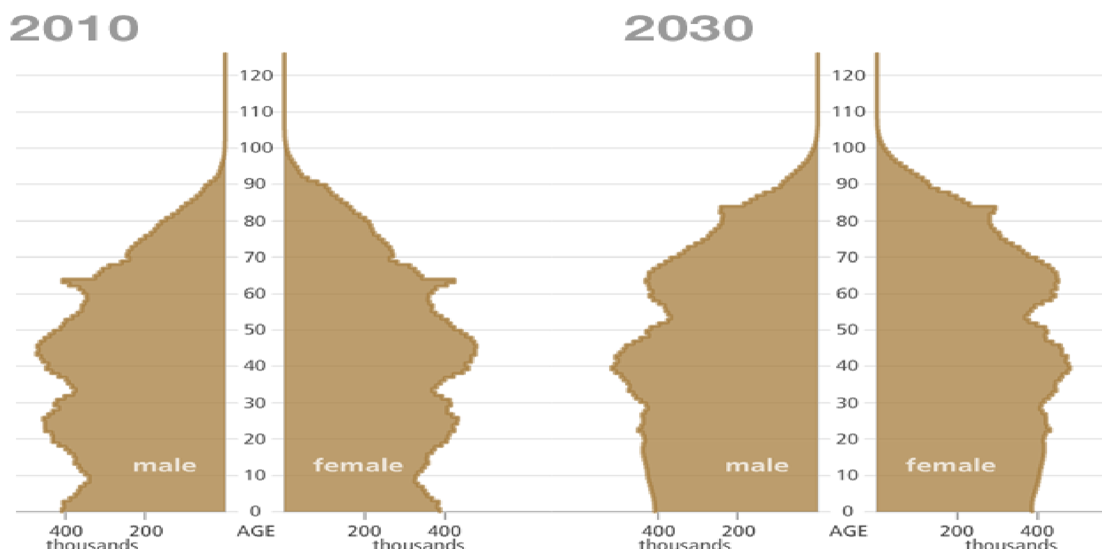
The demographic challenge has been described within the 2013 House of Lords report ‘Ready for Ageing?’ (23).

The report identifies the physical harm caused by loneliness, which is as bad for us as smoking 15 cigarettes a day. It also increases the risk of heart disease, puts people at greater risk of blood clots and dementia, and makes them more likely to exercise less and drink more. Socially isolated and lonely adults are also more likely to undergo early admission into residential or nursing care. Podiatrists are actively involved within communities, regularly visiting people within their own homes.

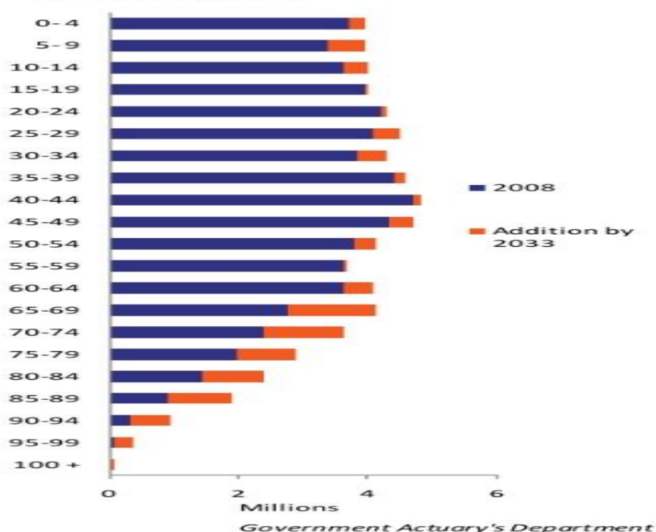
The report concluded that The UK is "woefully underprepared" for the social and economic challenges presented by an ageing society. It adds that "the gift of longer life" could lead to "a series of crises" in public service provision.

The Government response, ‘Right Care, Right Place, Right Times – How we can improve health and care for vulnerable older people (24) is a commitment to support older people. Setting out the ambition of making this country one of the best places to grow old in. ‘*A country where older people get excellent care and support when they need it, where people are supported to live independently*”. The role of foot health and podiatry could and need to form an important part of this commitment.

The following graphical presentations further emphasises the major issues of longer lives across the UK.



Source: Office for National Statistics forecasts



Source: Office for National Statistics (ONS), Pension Trends - Chapter 2: Population change, February 2012, data for figure 2.5.

Living longer lives presents a range of additional challenges, increased mental health conditions is one that will require particular attention from health and social care providers, commissioners and professions who must ensure that the needs of the whole population are considered.

Public spending and older people

Much of today's public spending on benefits is focussed on elderly people, 65% of Department for Work and Pensions benefit expenditure goes to those over working age, equivalent to £100 billion in 2010/11 or one-seventh of public expenditure. Continuing to provide state benefits and pensions at

today's average would mean additional spending of £10 billion a year for every additional one million people over working age (23).
The Department of Health estimates that the average cost of providing hospital and community health services for a person aged 85 years or more is around three times greater than for a person aged 65 to 74 years.

Workforce Implications for foot health and podiatry workforce
The evidence of foot care need in older people has been well documented over many years and summarised in a review, Farndon (2005). Older persons campaign groups have produced reports identifying unmet need, Age Concern (2007) and Help the Aged (2005). Reduced provision, particularly for the older population has made high profile news, however little has changed regarding growth in the podiatry workforce. The podiatry profession has recognised the need for high volume low risk personal foot care provision and supported national initiatives in England, Foot care Services for Older People: a resource pack for commissioners and service providers (2009) and NHS Scotland Foot care Guidance (2013).
A recognised tool to identify workforce ratios for podiatry staffing for a population of older people does not exist because of the diversity of need and disease within that age group. A generalized approach has been used below to provide an idea assuming minimal foot care input.

Population	Need	Foot Health Workload
9.4m aged 65-85.	30% need care = 3m	Quarterly appointments *12m appointments pa*
1.4m 85+	50% need care = 700,000	Bi-monthly appointments 4.2m *appointments* pa
By 2030 the 65-85 age group will have increased by 50% And the 85+ group by 100%	30% need care = 4.5m 50% need care = 1.5m	Quarterly appointments *18m appointments* Bi-monthly appointments 9m *appointments pa*
This table assumes a homogenous older population with lower level foot health need. This is not reality and many with diabetes and other long-term conditions will have acute foot health needs complicated by their age, which will require intensive care. The data could not be used for workforce planning as it is not community or disease specific. This data is an indication of a minimal baseline figure of foot health need associated with older people.		

The table above indicates that by the year 2030, a minimum of six million older people will have foot problem which will require a professional workforce able to deliver 27 million foot care/podiatry appointments a year. Currently as much as 58% of older peoples foot care need is met within the private sector.

It cannot be misunderstood that the foot health care of older people in the UK is significant and an appropriately trained workforce is needed to manage this vulnerable population with complex needs. The podiatry and foot health workforce has the opportunity to work in collaboration with other agencies to

ensure our older people live in safety and comfort. For these reasons workforce strategies and Local Education Training Boards (LETB) must engage with the whole podiatry profession through the Society of Chiropodists and Podiatrists.

Falls

Older adults at risk of falls should incorporate physical activity to improve balance and coordination on at least two days a week

Menz (2001) reported that foot problems are common in older people. Eighty-seven per cent of a 135 sample from a community dwelling of older people had at least one-foot problem. Women had a significantly higher foot problem score than did men. The foot problem score was significantly associated with stability and the risk of falling. These findings provide further evidence that foot problems are a falls risk factor. Women had a higher prevalence than men of foot pain, hallux valgus, plantar hyperkeratosis, lesser digital deformity, and digital lesions.

The study concluded that foot and leg problems are important determinants of functional status in community dwelling older people. As foot pain is amenable to treatment, podiatric intervention has the potential to improve mobility and independence in older people

B. Long Term Conditions

In England, more than 15 million people have a long-term condition, defined as a health problem that can't be cured but can be controlled by medication or other therapies. This figure is set to increase over the next 10 years, particularly those people with 3 or more conditions at once. Diabetes is the most relevant disease area for the podiatry workforce however rheumatoid arthritis, osteo-arthritis, stroke and Parkinson's disease will also have direct impact on foot health, mobility and independence. Multiple comorbidities make care and patient management more complex particularly when associated with mental health conditions such as dementia or depression.

Long term conditions can affect many parts of a person's life, from their ability to work and have relationships to housing and education opportunities. Care of people with long-term conditions accounts for 70% of the money we spend on health and social care in England.

Policy driver:
Department of Health (2012). Report. Long-term conditions compendium of Information: 3rd edition

Diabetes

Policy drivers and clinical guidelines

- Action for Diabetes (2014)
- Diabetes National Clinical Guidelines, CG10 Foot Care and CG119 Diabetic foot problems - inpatient management
- NICE Quality Standard 6 Diabetes Mellitus and Quality Statements 8, 10,11 and 12

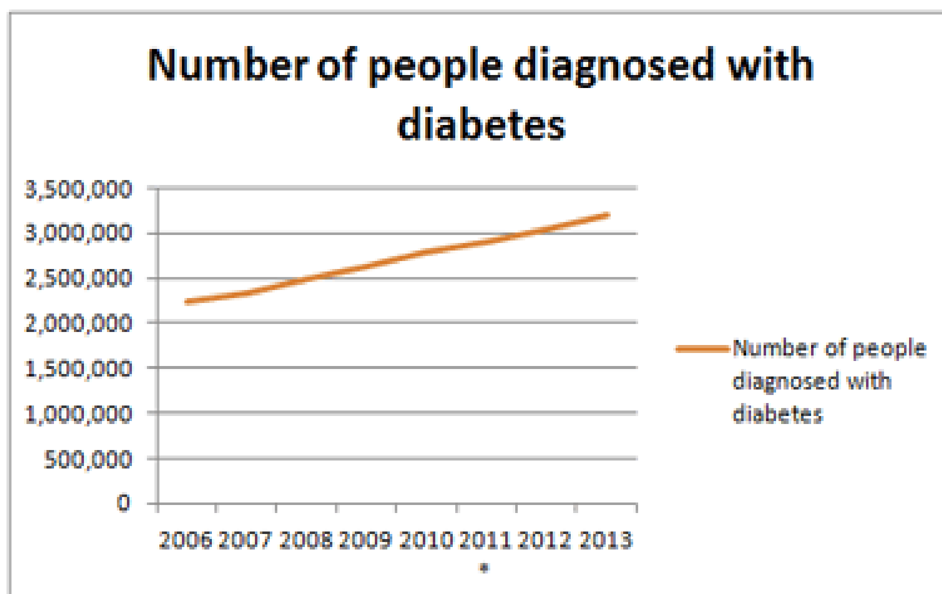
- NHS Diabetes/Diabetes UK Foot care for people with Diabetes: The Economic Case for Change (2011)

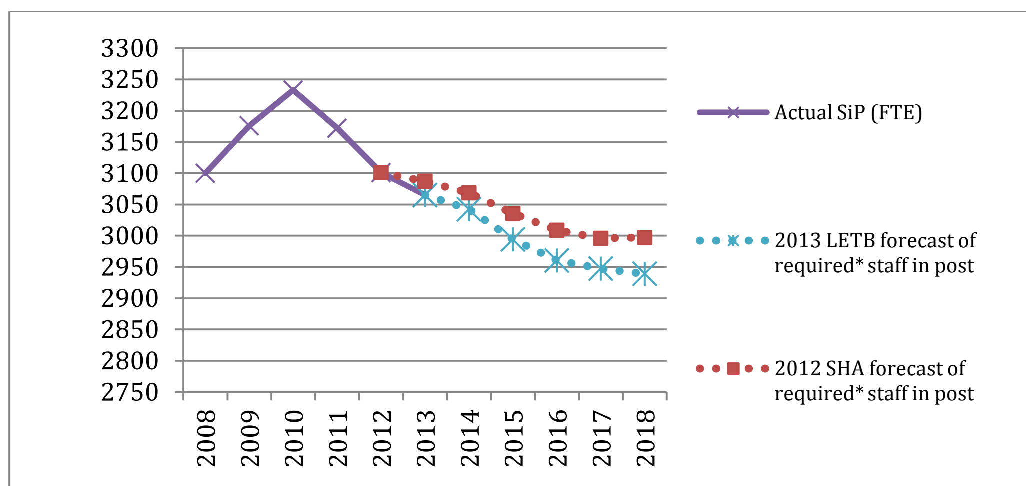
The number of people diagnosed with diabetes in the UK has increased to more than 3.2 million, (Diabetes UK Feb 2014), an increase of more than 163,000 compared to 2012. This is the biggest increase in a single year since 2008 and it means six per cent of UK adults are now diagnosed with diabetes (this does not include the hundreds of thousands of people with undiagnosed Type 2 diabetes). The UK distribution national position for 2012 is reflected below;

Country	Prevalence	Number of people
England	5.8 %	2,566,436
Northern Ireland	4.0 %	75,837
Scotland	4.4 %	234,871
Wales	5.3 %	167,537

Currently over 60,000 people with diabetes in England have a foot ulcer and over 400,000 hospital bed stays are primarily for foot disease in diabetes. Ulceration and amputation both substantially reduce quality of life, and are associated with high mortality.

In England around 6,000 people will undergo diabetes related lower extremity amputation each year (120 per week). It is estimated that up to 80% of these are preventable and people are losing limbs purely through ignorance. The prevalence of diabetes and the provision of podiatry are heading in opposite directions, which must be of great concern to anyone with diabetes.





According to the Association of Public Health Observatories Diabetes Prevalence model, this number will increase by 23% between 2010 and 2020 and will have reached 6m by 2030

In 2012 NHS Diabetes commissioned the health economist Marion Kerr of Insight Health Economics to write the report *Foot Care for People with Diabetes: The Economic Case for Change*. This report looked at the cost effectiveness of diabetic foot interventions and the impact of multidisciplinary foot care on patient outcomes and NHS costs.

In this report, Kerr highlights the importance of diagnostic tests, early referral to specialist care, the use of multidisciplinary foot care teams (MDFTs) and cardiovascular screening in reducing amputation and mortality rates. Podiatrists are pivotal within secondary care MDFTs which also ideally have input from a Diabetologist, Vascular, Orthopaedic and Plastic surgeons, Microbiologists, Diagnostic and Interventional Radiologists, Diabetes specialist nurses and Orthotists.

Outcomes from the MDFT that prevent admission, surgery or amputation are dependent on timely and appropriate referral from primary care and specifically the local Foot Protection Team a requirement of the NICE CG10 pathway. Local FPT's are predominantly the coordinated management of increased and high-risk diabetic foot disease provided by the specialist community podiatry service. The FPT works to prevent ulceration and infection, refers to the MFFT and after the acute phase the patient is returned to the FPT for long term management either with a healed ulcer or an amputation

Kerr cites a number of studies, which evidence how MDFTs can reduce the rate of amputations. Including an 11-year study at Ipswich Hospital, which found that the incidence of major amputation per 10,000 people with diabetes fell by 82% following the introduction of an inpatient MDFT. After the introduction of an MDFT lower-extremity amputation rates (major and minor combined) at James Cook University Hospital, Middlesbrough fell by two-thirds and annual net savings of £217,000
were generated.

The College of Podiatry, together with Diabetes UK and NHS Diabetes, promoted the commissioning of an integrated foot care pathway through the launch of the Putting Feet First campaign in October 2012. The pathway ensures that in the event of a foot ulcer or infection failing to heal, those people with diabetes who are at increased risk of foot problems are identified and fast-tracked to an MDFT that can expertly assess and treat them.

Implications for podiatry workforce

The development of a podiatry workforce tool for the safe and effective management of diabetic foot disease should be possible to establish, as NICE guidelines are quite prescriptive regarding the frequency and type of care required. There is also a significant evidence base identifying how to good outcomes are achieved. Podiatrists are pivotal to good outcomes as the Kerr report (2012) describes.

The table below gives an idea of the UK wide challenge of keeping feet on people with diabetes and keeping with diabetes on their feet. The national policy and legislation regarding quality and safety will be tested in this area unless there is a real understanding of the challenge and implications ahead for people with diabetes who have reduced blood supply, poor sensation and foot deformities.

Risk Type	% Diabetes population *(Leese et al 2011)*	National guideline standard of care *(NICE CG10 2004)*	2013 3m *(Diabetes UK)*	2030 4.5m+ *(Action for Diabetes 2014)*
Active Disease -Ulcerated	1-4% (3%)	Weekly appointments	**4,500,000** 90,000 people	**6,750,000** 135,000 people
High Risk of Ulceration	4-8% (7%)	Monthly appointments	**2,520,000** 210,000 people	**3,780,000** 315,000 people
Increased risk of ulceration	20%	Quarterly appointments	**2,400,000** 600,000 people	**3,600,000** 900,000
Total Appointments based on NICE CG 10 guidance			**9,420,000** 360,000 people	**14,130,000** 1,350,000 people
Low current risk of ulceration	70%	Education and personal foot care	2,100,000 people	3,150000 people

More than half of the current HCPC registered podiatry profession of 13,000 operate as independent practitioners and diabetes is not all publicly funded podiatry provision.

Reduced training commissions and failure to fund adequate integrated foot pathways or use the whole of the trained professional resource are creating a latent risk and cost for the UK population and Government.

Safe and effective levels of podiatry staffing per 10,000 diabetes population could be established utilising this tool. Local variations will apply and adjustments needed for rural, older or ethnic populations. Podiatry workforce levels and skill mix can be identified using the TRIEPodD-UK diabetic foot competency framework.

Other long-term conditions
One quarter of the population,15 million people, with a long term condition. Treating those with long term conditions, many of whom are older people, accounts for 70% of the total health and care budget, over £70 billion every year.

Rheumatoid Arthritis
Rheumatoid arthritis (RA) is a chronic, erosive inflammatory arthritis thought to affect approximately 1% of the UK adult population
NICE clinical guideline 79 The management of rheumatoid arthritis in adults (2013) identifies the following foot care standards;

- All people with RA and foot problems should have access to a podiatrist for assessment and periodic review of their foot health needs
- Functional insoles and therapeutic footwear should be available for all people with RA if indicated.

The foot is often the first area of the body to be systematically affected by rheumatoid arthritis (RA)

Upon diagnosis, approximately 16% of patients with RA have foot involvement In 15% of cases the forefoot is the first area of the body to become symptomatic

Virtually 100% of patients report foot problems within 10 years of RA onset

Stroke
NICE Guideline 162 Stroke Rehabilitation (2013)

- Identifies Mobility, Walking, Ankle-Foot Orthosis, Pressure Ulcer, Lower Limb weakness and soft tissue weakness as areas of care.

Parkinson's Disease
NICE Clinical Guideline 35 Parkinsons Disease, Diagnosis and Management

Arthritis

Osteoarthritis NICE clinical guideline 59
Arthritis of the foot is a common and disabling problem, and affects the lives of 10% - more than 3.5 million people of people aged over 60 years
OA accounts for 15% of all musculoskeletal consultations in those aged 45 years and over in primary care.

It has a major impact on quality of life, locomotor function, social participation and economic productivity
Source :Arthritis Research UK Primary Care Centre at Keele University (January 2014)

Key facts disability & rehabilitation
There are around 11.6 million disabled people (limiting long standing illness) in Great Britain, of whom 5.7 million are adults of working age, 5.1 million are over state pension age and 0.8 million are children. This is equivalent to 20 % of the population 11 million disabled adults, this includes.
Source: UK Office of Disability 2014

http://odi.dwp.gov.uk/disability-statistics-and-research/disability-facts-and-figures.php#gd

B. Public Health and Disease Prevention
The government has said supporting people in later life was a priority. There is a clear causal relationship between the amount of physical activity people do and all-cause mortality. This is reinforced within Start Active, Stay Active: A report on physical activity from the four home countries' Chief Medical Officers

Darren et al (2006) provides irrefutable evidence of the effectiveness of regular physical activity in the primary and secondary prevention of several chronic diseases (e.g. cardiovascular disease, diabetes, cancer, hypertension, obesity, depression and osteoporosis) and premature death.

Walking is simple, free and one of the easiest ways to get more active, lose weight and become healthier. It is underrated as a form of exercise but walking is ideal for people of all ages and fitness levels who want to be more active.

Regular walking has been shown to reduce the risk of chronic illnesses, such as heart disease, type 2 diabetes, asthma, stroke and some cancers. (NHS Choices)
The connection between walking either to exercise or for independence and healthy, functional, pain free feet should not need a research base but it does need a profession to promote, educate and deliver care.

The recognition of walking as a healthy lifestyle is promoted in all UK countries one example is; Getting Ireland Active
http://www.getirelandactive.ie/content/wp-content/uploads/2011/12/Get-Ireland-Active-Guidelines-GIA.pdf

Evidence of need

The NHS England Commissioning Board Strategy (2013) reports that the prevalence of obesity in England is one of the highest in the European Union. In England just over a quarter of adults (26% of both men and women aged 16 or over) were classified as obese in 2010 (Body Mass Index (BMI) 30kg/m2 or over).

Using both BMI and waist circumference to assess risk of health problems, 22% of men were estimated to be at increased risk; 12% at high risk and 23% at very high risk in 2010. Equivalent figures for women were: 14%, 19% and 25%. There has been a marked increase in the proportion (doubling) that are obese, a proportion that has gradually increased over the period from 13.2% in 1993 to 26.2% in 2010 for men and from 16.4% to 26.1% for women.

Obesity is associated with increased prevalence of long-term conditions and Tannamas (2012) has associated with increased weight and fat mass with increased foot pain.

Future Service Models

Podiatry caseloads are most commonly provided to the elderly, people with long-term conditions and delivering care that would otherwise be undertaken in hospital including podiatric surgery.

This report recognises the context of increasing public demand and rising costs of health services within a period of significant financial constraint. Professions and services have been challenged to work with the QIPP initiative to increase productivity and reduce costs. Podiatry has continually demonstrated innovative practice and advancing professional roles that could provide economic benefits to the traditional medical model of the NHS.

The RCN have identified, through their Front Line First report 2013 the real loss of the nursing workforce. The report states that officially almost 4,000 posts have been lost since 2010 an equivalent of 6,500 people however the profession, through extensive membership research estimate the real figure to be closer to 20,000 jobs and 40,000 individuals. The front line first report makes 5 recommendations, which are relevant to all health professions;

1. A mandatory legislated requirement for safe staffing
2. The mandatory use of validated workforce planning tools
3. Robust systems of review, supported by reliable workforce data
4. An end to boom and bust workforce planning
5. Investment in the current workforce

Podiatry service delivery models have always been flexible

1. **Care delivered in and closer to homes**. This may be a personal home, residential care or a prison; podiatrists have always adapted to any environment and know how to deliver safe and effective care away from clinical settings. With an increasingly frail elderly population this is a resource that can be utilised for a wide range of public health issues

such as safeguarding, monitoring wellbeing and nutrition and even involved with domestic telehealth technology.

2. **Multi disciplinary service models**. Podiatrists have always worked as part of teams and pathways. Feedback on care and referral escalation are requirements of practice whether this is in a primary care setting or as a member of a secondary care multidisciplinary foot team.
3. **Integrated care**. Foot health covers all people and all needs and is important to whichever sector they work in. Working across and within either social care or health care is immaterial to podiatrists who are comfortable liaising with relevant services, which may include organising to have some adaptive equipment fitted or referral to a vascular surgeon. Podiatrists work with and for voluntary organisations and the need for foot health is well understood by the Third Sector.
4. **Less care in hospitals.** Podiatrists have demonstrated how they can support orthopaedics by bring foot and ankle surgery into the community and also to significantly reduce referrals to secondary care by working in well coordinated and highly skilled community musculoskeletal teams. All health care planners should be commissioning community based service built around podiatrists and physiotherapy as recommended in the Musculo-Skeletal Framework (2006) Advanced sharp debridement and other bio or hydrosurgical techniques with wound management systems such as topical negative pressure are commonly led within the community by podiatrists. Previously surgical debridement would have required operating theatre time. Independent prescribing will only enable more care to be coordinated and managed under a podiatrist's clinical leadership.

Podiatric Surgery

Based on a small podiatric survey service a conservative estimate is for 60,000 procedures per annum undertaken by the podiatry profession covering only the following procedures;

H11 - simple toe exostectomy, excision of ganglion of foot
H12 - metatarso phalangeal (MTP) fusion or replacement, osteotomy of multiple metatarsals, hallux valgus
H17 – tarsal tunnel release, curettage of lesion of bone

These services would in additional save of at least 120,000 consultant led outpatient assessment and follow up appointments.

Source: Portsmouth CCG contract with NHS Solent podiatry provider. National projection based on Portsmouth population of 200,000 and 200 procedures annually

Seven day working

For half of the podiatry profession this is nothing new as they have been delivering care when and where the patient needs it for many years. There is an opportunity to maximise this resource. There are some examples of extended hours working within NHS podiatry delivery. CCG's do need to review this as many fail to provide rapid access to diabetes MDfT and at

weekends this may just be A&E department. In December 2012, Everyone Counts: Planning for Patients 2013/14 set out the initial step towards identifying how there might be better access to services seven days a week. NICE clinical guideline 119 identifies acute diabetic foot referrals are to be made to the multidisciplinary foot care team within 24 hours of the initial examination of the patient's feet. The responsibility of care s transferred to a consultant member of the multidisciplinary foot care team if a diabetic foot problem is the dominant clinical factor for inpatient care. Podiatrists are essential members of the MDT. The podiatry profession is prepared and able to meet this challenge.

The addition of independent prescribing will only enhance the professions ability to take on more clinical responsibility and support national goals and the transformation agenda's.

National Leadership

The report is written at a time of suspended growth in workforce and reduced career development. Podiatry as a profession may not look attractive to intelligent young students, or those wishing to change career. NHS recruitment is low, a national commitment to increasing the podiatry workforce is not evident and the mentorship and business support opportunities for graduates unable to find employment is recognised by the national government's, leaving this fledgling, skilled workforce to struggle alone with the risk of losing it altogether

Future Workforce Models

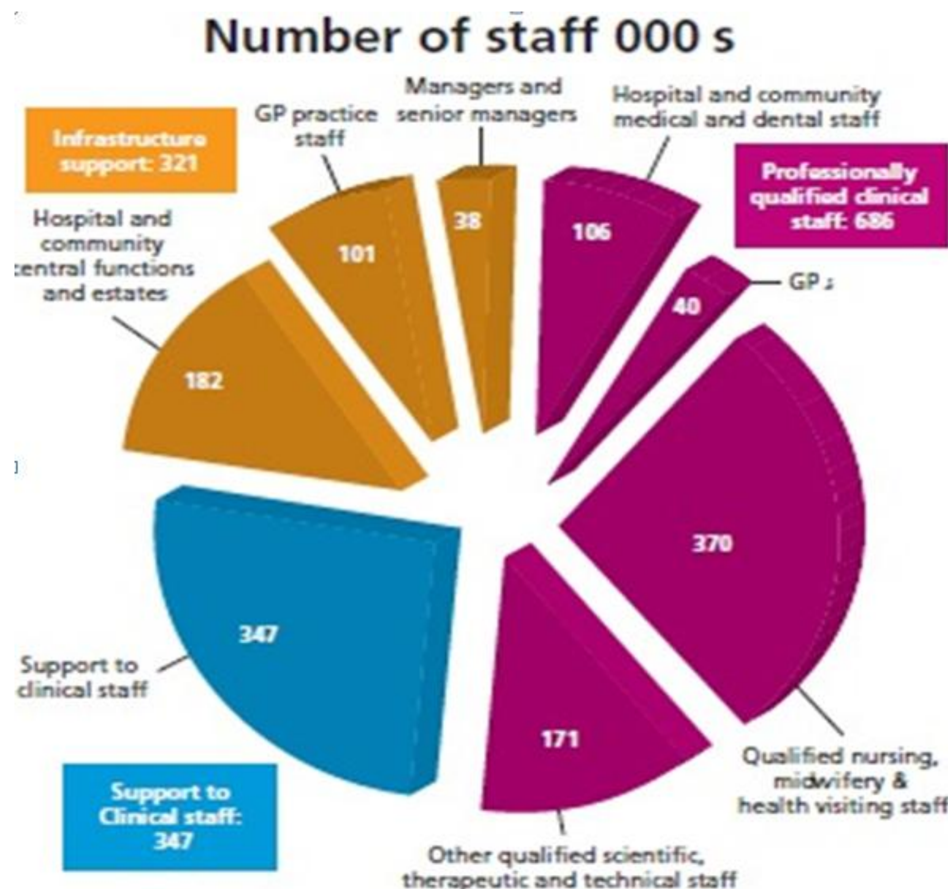
Recognising the need for profound change in the health and care system, the Secretary of State for Health has set out a number of key priorities. They require professions and organisations to demonstrate that quality of care is considered as important as quality of treatment, through more accountability, better training, tougher inspections and more attention paid to what patients say. A good experience is where people are treated with compassion, dignity and respect by skilled staff who are engaged and have time to care.

Embedding this culture throughout professions and orgnanisations in the face of the changing needs of the population and the pressure of operating in increasingly tight financial constraints will require enhanced leadership behaviours at all levels to achieving change.

The Nursing 6 C's of compassion, caring, communication, courage, competence and commitment are transferable to all professions. Two additional 'c' include the need to change the conversations we have with each other as professionals and with patients and families and to include more challenge to our colleagues, our patients and ourselves. Building this values and behavioural skill set in with the knowledge and clinical skills is certainly a challenge throughout every area of professional and employment organisations.

To safeguard its future the NHS needs to change to meet the challenges it faces – only by modernising can the NHS tackle the problems of today and avoid a crisis tomorrow.

With over 1.3 million staff performing over 300 different types of jobs across more than a 1000 different employers, the NHS requires a robust workforce planning process to ensure we have staff in the right numbers and in the right places. Examples of oversupply have demonstrated where a balance is needed in planning.
Podiatry already has an assistant grade and this can be developed with associate practitioners and utilising the wider workforce. With over 50% of the profession in independent practice it is wise to utilise that skilled workforce that has been trained and funded.



Forecast of future supply and demand

In 2012/13 podiatry services provided over 4m community contacts and 1 m outpatient contacts. A significant difference from 2001-2 where the SE of England alone provided over 840,000 initial contacts and 2,300,000 follow first contacts. As the need for foot health has grown there has been a constant under resourcing of the care provided and we have poor outcomes and high costs associated with foot disease.

2012 Supply projections

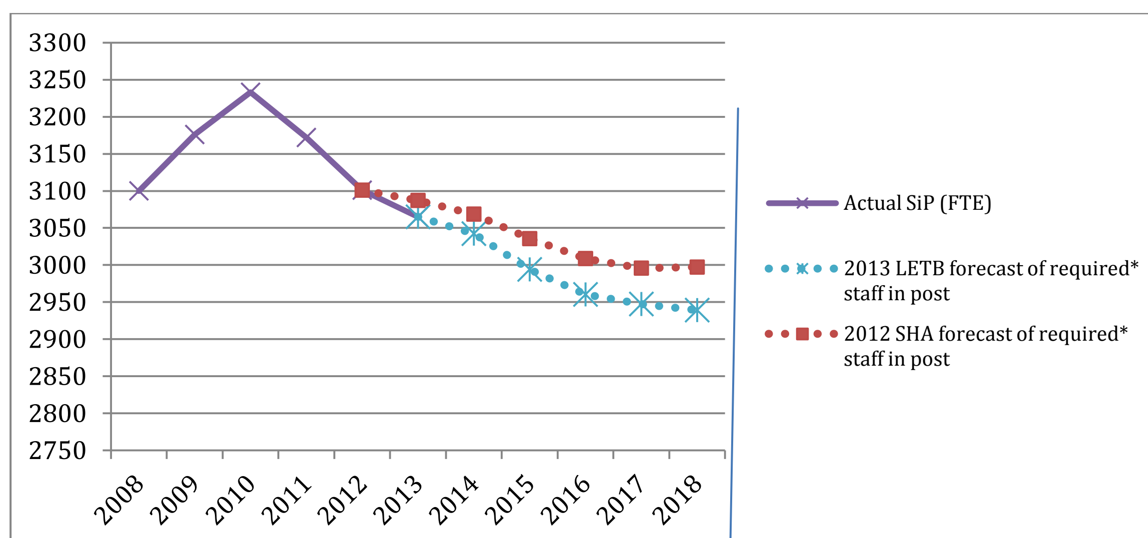
The NHS workforce remained broadly constant in size from 2005 to 2010 with a 2010 headcount of 3870 practitioners. The HPC data for England (HPC

2011) shows an additional 5729 chiropodists and podiatrists registered. The SCP (2011) reports that these chiropodists/podiatrists are likely to be working in the private sector.

Identifying local area variation for workforce priorities
Workforce planning will be influenced by the health and social care needs and priorities of each area. Knowledge of local area performance against national average can be found on the health profiles website.
http://www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES

CfWI
The supply of podiatrists in England is forecast to increase to 10,883 HC (8978 FTE) in 2016, an increase of 13 per cent from 2010.

2013 Supply Projections – England



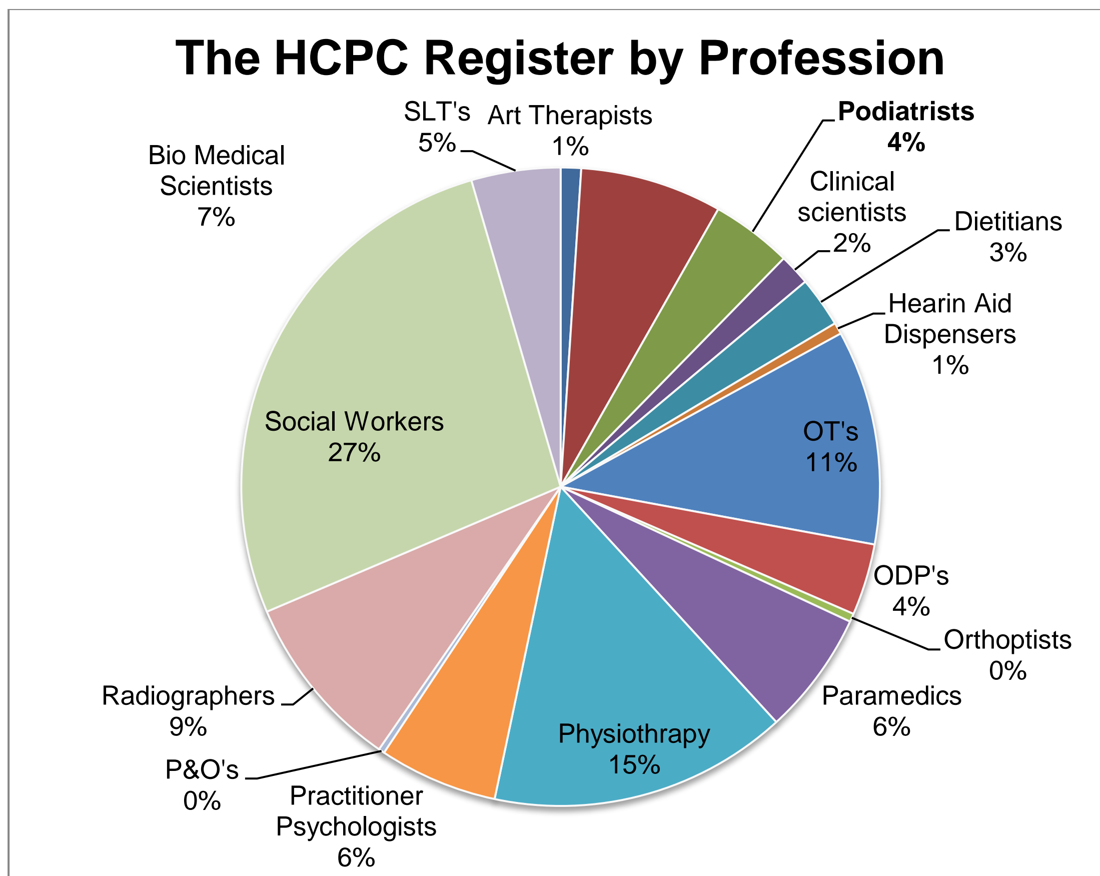
The percentage decline in AHP workforce figures since 2009-10 has been dramatic for the profession and uniquely so from all other AHP's with only Occupational Therapy showing any sort of decline.

Mapping this planned forecast of public availability to appropriately trained, skilled and regulated podiatrists, against age and disease profiling should cause people painful or disabling foot conditions, the podiatry workforce, campaign groups such as Age UK and Diabetes UK and organisations responsible for providing high quality pathways of care extreme concern. If it does not then those who are responsible for funding care are not listening to the population and professionals.

Podiatry Vacancies (29.1.14)
There are currently 13 podiatry posts are currently being advertised on NHS Jobs England website;

Band 5 – Six including one Bank and one Fixed Term Temporary
Band 6 – Two

Band 6/7 (depending on experience) - One
Band 7 – Four



Skill Mix

QIPP measures have required all NHS providers to review staff skill mix and recruitment. NHS podiatry services report an enforced band dip within the last 18 months to provide savings and maintain quality and activity. Higher proportions of Band 5 entry grade level podiatrists have substantive contracts at this level without a plan to move to a Band 6. It is possible that some podiatrists will remain at this level throughout their working career. Developments in clinical accountability and responsibility associated with independent prescribing, acute and inflammatory foot disease may rest with more junior staff, which is not in anyone's best interests.

UK Podiatry establishments outside of England have not been affected so badly and broader areas of service provision are still publicly funded.

NHS England is very aware that health care workers are developing portfolio careers, which differ from the historic 'job for life' model. The transition around public sector clinician, academic, independent sector, career break, third

sector is complex and requires better understanding by professions and workforce planners. Some examples in appendix A are available.

AHP Education Commission Figures for 2013/14 and 2014/15 – England

Profession	Education Commissions 2013/14	Education Commissions 2014/15	Current HCPC membership
Dietetics	324	336	8,342
OT	1538	1523	33,803
Physio	1488	1490	48,875
Podiatry	**362**	**362**	**13,058**
SLT	657	644	13,944
Diagnostic Rad	1051	1059	
Therapeutic Rad	369	371	29,050
Paramedics	659	853	19,960
Orthoptist	77	77	1,312
Prosthetists & Orthotists	30	30	944

Year	Numbers of commissioned student Podiatry places UK
2009-10	550
2010-11	519
2011-12	493
2012-13	479

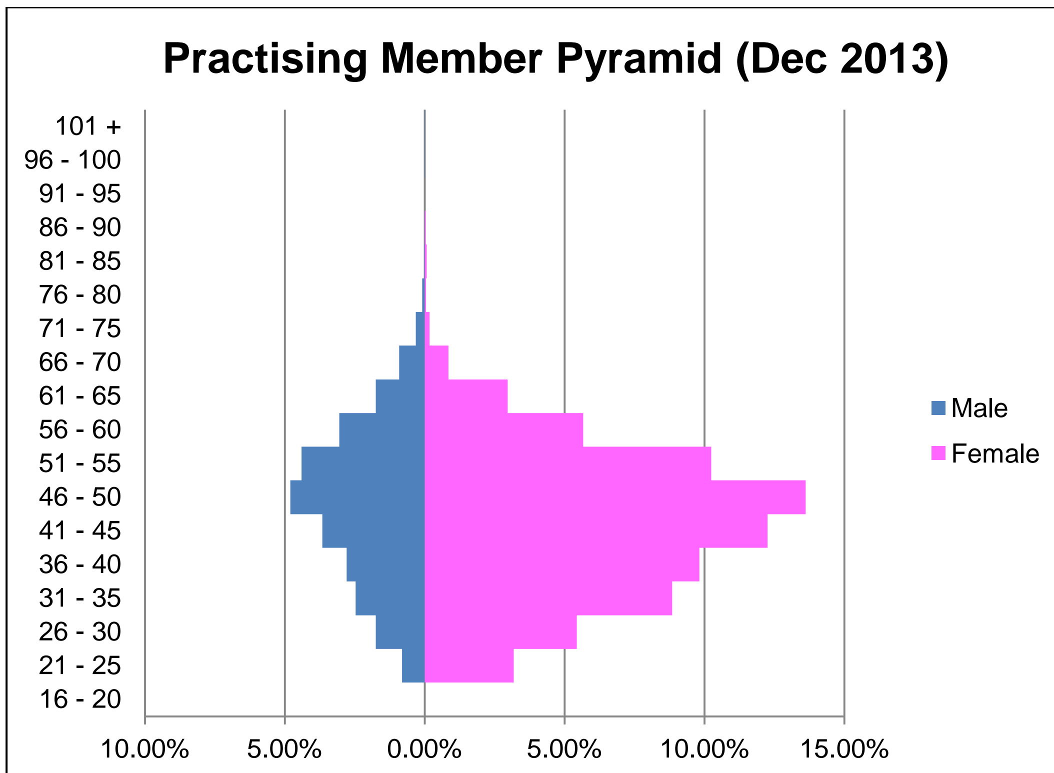
Forecast Supply –Turnover

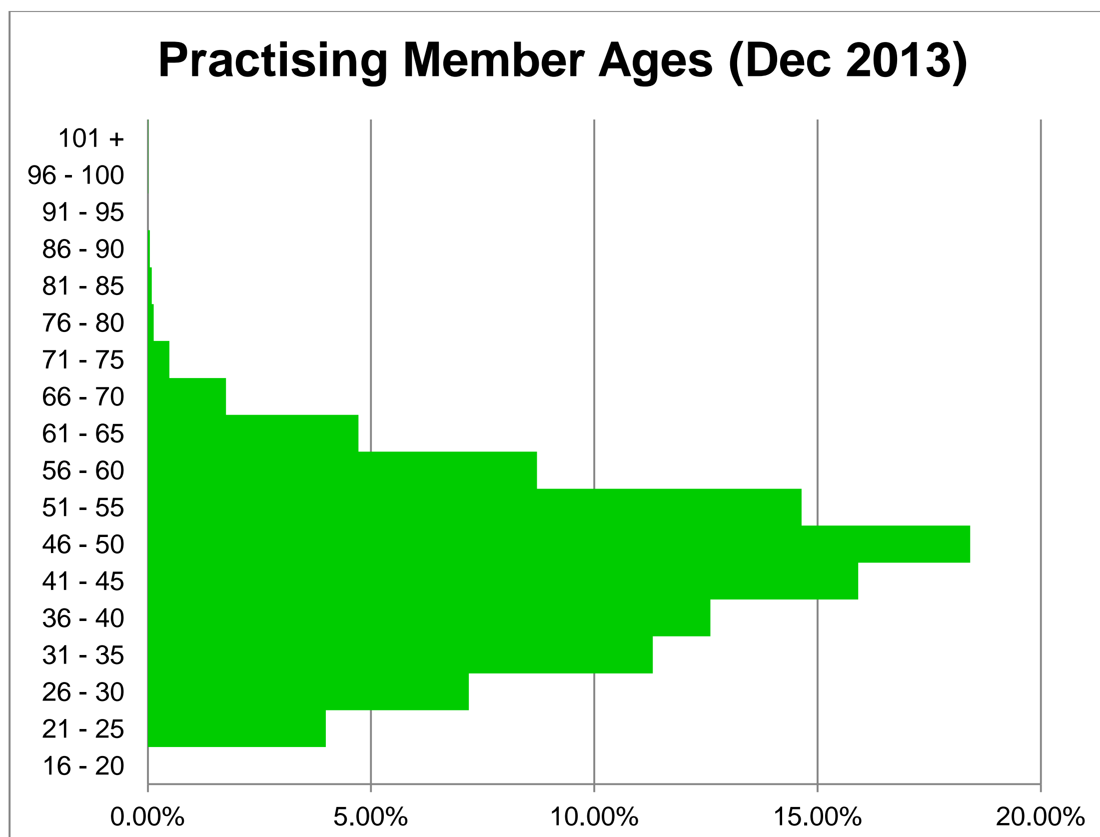
Podiatry as a career
Although the profession has undertaken a significant transformation with diverse roles and careers that can be most rewarding. Stimulating and maintaining an adequate level of interest in podiatry as a career will be of vital importance as this will be framed within increasing knowledge, skills and accountability and reduced career progression and reward.

Podiatry as a second career
With a more mobile and changing workforce second or third careers are not uncomion particularly where redundancies are associated with changing workforce patters, increased use of technology, robotics etc. People coming to the profession later in life may indicate shorter working careers however there is insufficient evidence to suggest this as younger graduates may not remain in the profession throughout their working career.

Retirement
Approximately 30% of practicing members of the Society of Chiropodists and Podiatrists are over 50 years of age. There is no age limit to cease work and

an independent practice may well be an option for members retiring from a health service career. The only reasonable view that can be made is that people over retirement age are less likely to be working full time or working with complex acute and inflammatory caseloads or undertaking podiatric surgery.





To/from the international labour market

It is not surprising that foot health is of vital global importance. The international impact of diabetes is recognised particular in the Middle East and Asian sub continent. Charities and services are developing beyond infancy into mature and professional services where Singapore is a good example. These emerging countries may well offer career opportunities for podiatrists where none exist locally. With the exception of the US and parts of Canada, a UK-trained podiatrist is insured to work anywhere in the world. Where there is local legislation impacting upon scope of practice, the law of the land holds. Hence, podiatrists cannot supply certain medicines in, for example, the Republic of Ireland even if they are appropriately trained to use them. This may impact on longer term workforce availability.

Warning regarding projections

There is a range of uncertainty about projecting population, as it rests on assumptions about future demographic behaviour. The recent rise in UK fertility could be maintained, perhaps because of the influence of high levels of net migration; life expectancy might stagnate because of increasing obesity levels; net migration may fall back to levels more typical of the UK's history if economic conditions change or more restrictive policies are introduced.

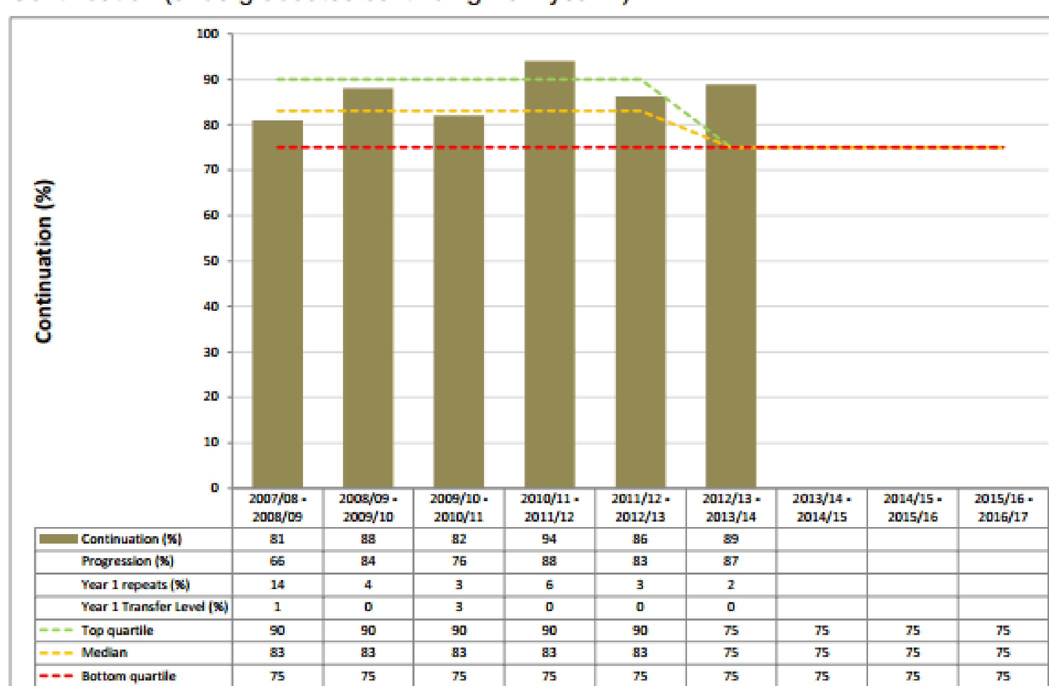
Population projections have a mixed record. They do, however, provide a common basis of framework for planning the future across the range of public policy area.

Annexe A
Podiatry Universities Undergraduate Programme feedback

BSc (Hons) Podiatry – The University of Salford
Commissioned Numbers

Academic Year	Route	Commissioned Number	Total recruited	Route	Commissioned Number	Total recruited
2011/12	Full time	58	57	Part time	23	21
2012/13	Full time	57	55	Part time	23	21
2013/14	Full time	57	56	Part time	23	19

Continuation (undergraduates continuing from year 1)



Key (Measures 1.1 to 1.7)
Top quartile
Second quartile
Third quartile
Bottom quartile

Commissioning figures for Southampton:

2010/11	33
2011/12	30
2012/13	30
2013/14	30

Attrition figures average 12% over the last three years.
Final destination information: 90% of podiatry students in work or study 6 months after qualification.

University of Brighton
2013-14
workforce commissions: 30
attrition to date: 0%

2012-13
workforce commissions: 31
attrition: 11.4%

first destination: unofficial figures: of 32 who graduated, 5 working in the NHS, 14 working in PP.

2 are not working in health, 3 are job seeking, 2 are unemployed but not job seeking.

We don't know about 6.

2011-12
workforce commissions: 32
attrition: 13.5%

The First Destination data for 2011-12 confirms that of the thirty one students who qualified in the summer of 2012, 73% were in employment: 50% in full time and 23% in part time work. 6% were about to start work at the time of publishing the destination statistics, but 12% were still looking. 9% of students are not known about.

2010-11
workforce commissions: 34
attrition: 14.2%

The First Destination data for 2010-11 confirms that of the twenty six students who qualified in the summer of 2011, 20 (77%) of these were in employment: 16 (62%) in Private Practice, and 4 (15%) in NHS employment. 5 (19%) are still looking for work, with a further 1 (4%) un-employed but not actively looking for work of any kind.

University of East London

Year	Commissions	Intake at 10 weeks	Leavers/withdrawn/ graduate with less than BSc	graduated	still here
2009/10	55	61	40	17	4
2010/11	55	69	28	27	14
2011/12	50	52	13	1 (APL)	38
2012/13	50	42	7	0	35

Employability amongst graduates differs depending on what time of the year you contact students and how many actually report back but generally it is around the 85 – 90 % of graduates within 6 months

Plymouth Progression and Retention

Cohort	Academic Year	Statistics
September 2013	2013-2013	35 students enrolled on year one including 2 repeats/transfer in

Cohort	Academic Year	Statistics
September 2012	2012-2013	33 students enrolled on year one including 7 repeats/transfer in
		4 students incomplete
		2 students fail
		27 students progressed to year two

Cohort	Academic Year	Statistics
September 2011	2011-2012	37 students enrolled on year one including four repeats/transfer
		5 students incomplete
		3 students withdrawn
		29 students progressed to year two
	2012-2013	33 students enrolled on year two including one direct entry student
		5 students incomplete
		2 students withdrawn
		1 student awarded a Diploma of Higher Education
		25 students progressed to year three

Cohort	Academic Year	Statistics
September 2010	2010-2011	34 students enrolled on year one including one repeat/transfer
		4 students incomplete
		5 students withdrawn
		25 students progressed to year two
	2011-2012	25 students enrolled on year two
		1 student incomplete
		3 students other
		21 students progressed to year three
	2012-2013	**23 students enrolled on year three**
		2 students incomplete
		21 students awarded Degrees

First destinations with data from previous 3 years

	2009/2010 (September 2007 cohort)				**2010/2011 (September 2008 cohort)**			
Destinations of Leavers from Higher Education Survey 2009/2010	**No**	**%**	**F/T Study**	**P/T Study**	**No**	**%**	**F/T Study**	**P/T Study**
Employed in full-time paid work	11	35.5	0	1	7	38.9	0	1
Employed in part-time paid work	5	16.1	0	0	5	27.8	0	0
Self-employed/freelance	9	29.0	0	0	5	27.8	0	0
Voluntary/Unpaid Work	0	0	0	0	1	5.6	0	0
Permanently Unable to Work/Retired	0	0	0	0	0	0	0	0
Temporarily Sick or Unable to Work/Looking after the home or family	1	3.2	0	0	0	0	0	0
Taking time out in order to travel	0	0	0	0	0	0	0	0
Due to start a job within the next month	0	0	0	0	0	0	0	0
Unemployed and looking for employment, further study or training	3	9.7	0	0	0	0	0	0
Unemployed and NOT looking for employment, further study or training	1	3.2	1	0	0	0	0	0

	2009/2010 (September 2007 cohort)				**2010/2011 (September 2008 cohort)**			
Doing Something else, including full time study	0	0	0	0	0	0	0	0
Questions not answered	1	3.2	0	0	0	0	0	0
Total	31	100	1	1	18	100	0	1

		2011/2012 (September 2009 cohort)	
Numbered Answers	**Destinations of Leavers from Higher Education Survey**	**No**	**%**
1	Working full time	16	69.57%
2	Working part-time	2	8.70%
4	Due to start a job in the next month	1	4.35%
5	Engage in full-time further study, training or research	2	8.70%
7	Taking time out in order to travel	1	4.35%
8	Something else	1	4.35%
	Total	**23**	**100%**

Annexe B

Population statistics

Area	Total Population millions	Median Age	65 + as % of total pop	DDA/Work limited disability as % of total	Density of people per square mile
UK	63,705	39.7	17	12.2	
Scotland	5,313	41.5	17.4	14	68
Wales	3,074	41.7	19.1	14.3	148
Northern Ireland	1,823	37.6	15	13.7	134
England	53,493	39.5	16.9	11.8	411
North East	2,602	41.5	18	14.4	304
North West	7,084	40.3	17.2	13.4	502
York & Humber	5,316	40.8	17.2	12.9	345
East Mids.	4,567	41	17.8	13.2	293
West Mids.	5,642	39.7	17.4	13	434
East	5,907	41	18.2	10.7	309
London	8,308	34	11.3	13.8	5,285
South East	8,724	41.3	17.9	9.7	458
South West	5,339	42.9	20.3	11.6	224

UK Population Statistics mid 2012 reported 19.12.13

In England the **largest rises in over-65s by 2030**

1. Milton Keynes - 108.1%
2. South Northamptonshire - 86.8%
3. Daventry - 86.6%
4. Bracknell Forest - 83.9%
5. City of London - 83.3%

Annexe C
Demographic/Epidemiological Statistics

Key Facts – Longer Lives
There are 10.8 million people aged 65 or over in the UK
Over 1.4 million people are aged 85 or over
The proportion of people aged 65+ will rise from 17.2% currently to 22.4% in 2032 to approximately 20 million

There are currently three million people aged more than 80 years and this is projected to almost double by 2030 .

Every year, 30,000 people (all ages) in the UK die of the cold (27,000 in England and Wales)

60% of older people in the UK agree that age discrimination exists in the daily lives of older people

About 3.8 million older people live alone, 70% of these are women

An estimated 4 million older people in the UK (36% of people aged 65-74 and 47% of those aged 75+) have a life limiting longstanding illness. This equates to 40% of all people aged 65+

Black and minority ethnic groups make up 16% of the England population but 8% of the population aged over 60

People aged 75-plus are much less likely to report taking the minimum levels of physical activity necessary to achieve health benefits
Foot Care

Up to 86% of elderly people have some form of foot health need.

56% of all NHS podiatry patients are over 65 (2009)

At age 65 22% of men and 36% of women are unable to manage their personal foot care. At 85+ this increases to 52% of men and 64% of women
There has been a substantial fall in new episodes of foot care in NHS England over the past 10 years while demand has increased

Of the older people surveyed who said they needed foot care, 58% get private care, 35% NHS and 1% 3rd Sector

Source; Age UK, Later Life in the United Kingdom (December 2013). Unless otherwise stated, the term “older” is used here for people aged 65 and over

Key facts about dementia
There are now 800,000 people with dementia in the UK, projected to be over 1.25 million by 2030

It is estimated that up to 500,000 older people in the UK are abused each year (roughly 5% of the older population)
Dementia represents a major challenge to the health and social care system. There is urgent need for careful planning to ensure that the right care and support is available in the future.
Over 17,000 younger people (65 years of age or below) have dementia and at least 11,000 people from black and minority ethnic groups have the condition.
The proportion of people with dementia doubles for every 5-year age group.
One third of people over 95 have dementia.
Source : Alzheimer's Society
http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=341

Key facts on falls
About a third of all people aged over 65 fall each year (which is equivalent to over 3 million).
Hip fractures are the most expensive osteoporosis fracture with estimated costs per patient ranging from £12,000 (1998 figure)130 to £25,424 (2000 figure). The latter figure is now routinely updated to £28,000 by some falls teams to reflect increased costs over the past 10 years.
Falls account for 10 – 25% of ambulance all-outs for people aged 65+, costing £115 per call- out.
The combined cost of hospitalisation and social care for hip fractures (most of which are due to falls) is £2 billion a year or £6 million a day
Falls represent over half of hospital admissions for accidental injury.
Half of those with hip fracture never regain their former level of function and one in five dies within three months.
Falls are common after strokes, especially among people who are unstable and have poor upper limb strength at hospital
A falls prevention strategy could reduce the number of falls by 15 – 30%.
Source; Age UK, Later Life in the United Kingdom (December 2013)

Annexe D
Diabetes Data

Key Facts about Diabetes
Diabetes UK : Putting Feet First
Putting feet first: Diabetes UK position on preventing amputations and improving foot care for people with diabetes
There is evidence that where effective services are in place for people with diabetes who have foot problems they are at much lower risk of amputation. There should be a structured foot care service between primary and specialist care, coordinated by someone with identified responsibility. There should be trained staff in foot protection services in the community with speedy access to multidisciplinary specialist teams for people who have a foot problem; people with ulcers or foot infections should be see by a member of the specialist multi-disciplinary foot care team (MDT) within 24 hours.

The roles, skill sets and organisation of these teams is set out in Putting Feet First (22) and recommended by NICE, but nearly 40% of hospitals did not have an MDT in 2010. This has improved to 30% hospitals without a multi-disciplinary foot care team by 2012 (23), but is still not good enough.

People with diabetes in hospital should have their feet checked. In 2012 only a third (35.1%) people in England had their feet examined at any time during an admission to hospital. Six per cent of hospitals have no access to a specialist podiatrist (25). In Wales, in 2012, over half of the hospitals (52.9%) did not have a multi-disciplinary team and less than a quarter (21.7%) had their feet examined at any time during their hospital stay (though this was a large increase on the previous year). However, the overall percentage of inpatients with diabetes in England and Wales that developed a foot lesion whilst in hospital fell significantly from 2.2% in 2010 to 1.6 per cent in 2012 (24).

Complications of diabetes happen because of raised blood glucose and blood pressure levels, smoking and high cholesterol over a long period of time. Good diabetes management and support for self management is important for the prevention of all complications of diabetes including foot problems. It is essential that the NHS delivers best practice guidance and person centred care planning as set out in the Year of Care programme.

There is a need for improved education and training for staff working in primary care; that all healthcare professionals looking after people with diabetes know how to carry out foot checks and inform people about their risk status and know how to refer appropriately.

Standards of care should be monitored nationally, and the impact on amputation rates should be measured. All staff should be encouraged to participate in diabetes audits.

Diabetes UK calls to action or Recommendations

People with diabetes should be involved more in their own care – they should know how to look after their feet, what risk they have of developing a complication, and what care they should get from the health service. A 'touch the toes test' guide has been developed so people can get another person to check their feet.

An integrated footcare pathway should be delivered across primary, community and acute health services
– that means providing the right treatment at the right time and in the right place for all people with diabetes:
Set up referral within 24 hours for those with ulcers to a multidisciplinary specialist footcare team

Ensure appropriate referral to a foot protection team which has specialist expertise in assessment and management of disease of the foot
Create local diabetes networks to join up and improve foot care for people with diabetes

For recommendations to clinical commissioning groups (CCGs) in England see:

Fast Track for a foot attack http://www.diabetes.org.uk/About_us/What-we-say/Improving-services--standards/Putting-Feet-First-Fast-Track-For-A-Foot-Attack/

Healthcare professionals should understand the risk of diabetic foot disease, talk about this with people with diabetes, provide annual foot checks by trained health care professionals and ensure that people with diabetes have their feet checked when they are in hospital and refer quickly to specialists when necessary.

There should be national and local diabetes action plans. And all of diabetes care should be monitored as part of a national framework – foot care as well as general care.

Conclusion

Diabetes UK's foot campaign "Putting Feet First" aims to improve foot care services for people with diabetes and reduce amputations. Raising awareness of the importance of good foot care amongst people with diabetes and all those who are involved in their care is crucial. It is also important to raise awareness of the services that should be provided and ensure that these are in place in all localities.

Further information

For more information about the Diabetes UK foot campaign visit
www.diabetes.org.uk/putting-feet-first

For more about the Year of Care NHS Diabetes, visit
www.diabetes.nhs.uk/year_of_care

For more information about NHS Diabetes Foot care networks go to
www.diabetes.nhs.uk/networks/footcare_network/

NICE Guidance

Type 1 Diabetes in Children, young people and adults NICE Clinical Guideline 15 http://www.nice.org.uk/CG015NICEguideline

Type 2 Diabetes: Prevention and management of foot problems Clinical Guideline 10 http://guidance.nice.org.uk/CG10 (currently being reviewed)

Diabetic Foot Problems - Inpatient Management NICE Clinical Guideline 119 http://guidance.nice.org.uk/CG119 (currently being reviewed)

For more information about the minimum skills framework: Putting Feet First: National minimum skills framework, Diabetes UK and NHS Diabetes, 2011 www.diabetes.nhs.uk/publications_and_resources/reports_and_guidance/

For recommendations to CCGs see http://www.diabetes.org.uk/About_us/What-we-say/Improving-services--standards/Putting-Feet-First-Fast-Track-For-A-Foot-Attack/

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