TOWER HAMLETS TOGETHER

GP CARE GROUP
LOCAL PEOPLE, LOCAL HEALTH

## Patient Experience Team

# Foot Health Whole Systems Review

**Shona Davies**

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## Background and Introduction

Between May 2017 and May 2018, Healthwatch conducted a consultation on changes to eligibility for the Specialist Foot Health Service in Tower Hamlets. The Patient Experience Team (PET) had been aware of the growing number of patients and carers that had been affected by the changes, but also the number of people who had complex conditions that impacted on their foot health who were benefiting from more timely interventions following the implementation of the new criteria. The PET was therefore interested in building on the Healthwatch report through undertaking a whole systems review of Foot Health. In particular, there was awareness of the importance of preventative strategies, and the potential impact that low income. In addition to being on a low income, failure to maintain a balanced diet, wearing ill-fitting shoes and neglect of basic foot self-care can have a major the impact on wellbeing if not addressed appropriately or effectively.

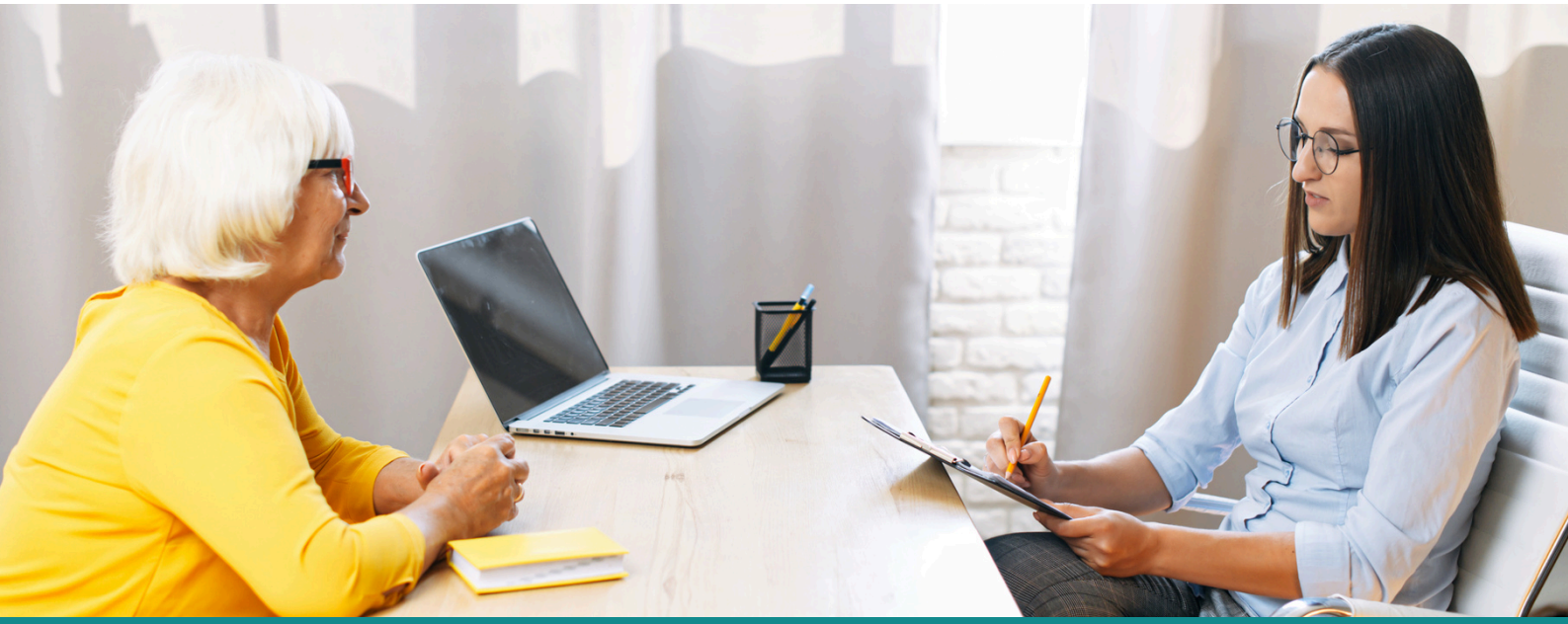
It was agreed that in addition to talking to service users and carers, it was important to talk to staff and stakeholders across the Tower Hamlets Community to find out what works well, reasons for effectiveness, what doesn't work so well, and identification of potential opportunities for improving foot health and preventing problems developing over time.

The initial consultation undertaken by Healthwatch earlier in 2018 meant it was not necessary to hold any process mapping sessions to understand the pathway, as this had already been clearly identified through their report which was published at the point that the PET work was to begin. We are most grateful to them for sharing their findings and enabling us to build upon it.

# Executive summary

The main learning themes:

- Improve prevention and awareness of how to self-care for feet at the earliest possible opportunity across the system at all points of contact, including young peoples services.
- Ensure that understanding of the criteria for eligibility is communicated in an effective way and opportunities for dialogue with specialist services is facilitated to ensure appropriate referral or alternative signposting.
- For those who fall outside the eligibility criteria for specialist foot care, but struggle to self-manage, signpost to a range of affordable and accessible local options available.
- Enable members of the community to be equipped with the knowledge, tools and skills to manage their own foot health in an effective way acknowledging that low income can have an impact on foot health.
- Investment in voluntary sector support services who may help to ensure that those assessed as being low risk are signposted or supported appropriately and in a timely way should their physical or mental health change.
- Ongoing monitoring of the impact of new model on different parts of the patient pathway and any evidence of need for capacity and demand management strategies and identifying any areas of unmet need.



# Methodology

Analysis of data relating to foot health interventions was undertaken, but the main methodology used was qualitative using discovery Interviews, which are one to one semi-structured interviews using a ‘spine’ of questions as developed by the Coronary Heart Disease Collaborative of the NHS Improvement Agency. This methodology allows people to direct the interview according to their own priorities rather than steering the interview in a directive way. There were also facilitated group discussions and process mapping sessions, and thematic analysis was used.

# Key recommendations

### Recommendation 1: Prevention

Working with schools and School Nurses to promote good self-care and provide advice and information about footwear to young people and families.

### Recommendation 2: Health promotion

That across all ages and in community settings, including facilities for homeless people, there is information available in a range of formats that demonstrate good practice around nail cutting, prevention of fungal infections, prevention of as well as available affordable treatments for common problems such as verrucas, bunions, callouses etc.

### Recommendation 3: Information regarding the new model

There is clear information available to staff and patients regarding revised eligibility criteria, and options available if ineligible for specialist services.

### Recommendation 4: Integrated approach to training

That appropriate training is delivered through CEPN (Tower Hamlets Training Provider) and/or provider organisations to ensure staff are able to assist the community in maintaining healthy feet, and to understand and agree when it is appropriate for care staff to support people requiring help with nail cutting and foot health.

### Recommendation 5: Supporting physiotherapists

That consideration be given to supporting physiotherapists to deliver support to those no longer eligible for podiatry as part of their MSK role.

### Recommendation 6: Ongoing monitoring of impact of new model on different parts of the system

e.g. pressure on GPs to refer elsewhere, increased A&E attendances, increase in falls or surgical interventions which in turn may result in increased demand on community nursing services.

### Recommendation 7: Learning from those who have maintained good foot health throughout life:

Harness the knowledge and experience of local people to influence and support others.

# Key recommendations

Recommendation 8: Create a THT wide Foot Health Champions group
Encourage partners to join a Champions Group for Foot Health to both raise awareness of prevention strategies and ensure cross organisational awareness of best practice re good foot health management. In addition to this, THT Alliance partners to seek to improve engagement with service users by working with and supporting all sectors to help promote healthy feet through education and training, to promote preventative strategies. This group could also monitor any unforeseen consequences in the longer term that may emerge as a result of the changes to access to specialist podiatry service and agree strategies to address emergent issues.
Recommendation 9: Identify resources to support prevention and management of lower risk FH conditions: The CCG might consider exploring the possibility of performing a social prescribing or commissioning function in relation to management of foot health / prevention of problems: releasing Health Budgets to enable people to access appropriate support/activities such as private podiatry to prevent issues around foot related problems. As more signposting to Voluntary Sector has been an outcome of reductions in service provision, need to better resource organisations to meet need.
Recommendation 10: Incorporate foot health and management into local PSHE syllabus at schools
That consideration is given to encouraging incorporation of Foot Health awareness to the education syllabus.
Recommendation 11: Public Health to put pressure on politicians to enter into dialogue with the fashion industry
To ensure higher priority to healthy and appropriate footwear.
Recommendation 12:
Any self-care information targeting people with Learning Disability needs to be produced in a way that would be easily understood, as would any 'rejection of referral' letters.
Recommendation 13: Foot Health to provide guidance to professionals as to how to 'frame' a referral, and guidance around what needs to be included; the correct terminology and categorisation.

# Background

The Tower Hamlets Foot Health Service was procured in 2017 as part of the Community Health Services and is managed by the East London Foundation Trust. The service underwent a review in 2017 as a part of the transformation plan. A proposal was developed, supported by the THT Alliance and approved by the CCG. The service model implemented in December 2017 included a significant change to the pathway with patients considered at lower risk e.g. those with callouses and toenail cutting needs in the absence of other risk factors excluded from accessing the service.

The local changes in eligibility and provision of specialist Foot Health Services implemented in are line with National Institute for Clinical Evidence (NICE) guidelines Diabetic foot problems: prevention and management NICE guideline [NG19] Published date: August 2015
https://www.nice.org.uk/guidance/ng19

A review of comparable services in other parts of the country was undertaken; the results demonstrated considerable variation in the eligibility criteria for specialist Foot Health intervention. There is evidence of continuing debate about the most appropriate pathway for patients with MSK conditions and the potential outcomes of managing this pathway through Orthopaedic specialist teams and how CCGs and middle managers fail to understand or value foot health: arthritis pathways and podiatry (McCulloch L et al 2018).

There was anecdotal evidence of an increase in surgical intervention in those referred via the Orthopaedic pathway compared with those managed in a specialist Foot Health service.

"If there is deformity, advice about management is useful but only has a certain amount of benefit. These would likely get referred to Orthopaedics and there will be an increased incidence of surgery – is my prediction. Podiatry services often encourage conservative care until there is sufficient pain….provision needs to be well structured and co-ordinated." (Specialist MSK Practitioner)

# Background

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A need for monitoring of potential impact on other parts of the pathway has been a theme much in evidence when talking to practitioners and stakeholders across the system. Concerns were raised around the need for a joined up or 'whole systems' approach to prevention of avoidable foot health problems, and the benefits of timely liaison with colleagues in other parts of the health and social care system have been suggested as useful to help ensure that implementation of the new criteria for eligibility in one part of the system does not adversely impact on capacity and demand elsewhere in the pathway.

https://jfootankleres.biomedcentral.com/articles/10.1186/s13047-018-0250-9 : Article on provision of orthotics

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5989380/ : Article on Podiatry /Physio and access for those with arthritis

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# Background

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Patients were accepting of changes related to the limited value of some treatments offered through Foot Health. An example of this was the implementation of changes in provision in relation to treatment of verrucae by the specialist Foot Health service. There was more resistance to changes in eligibility in the case of biomechanics, and staff described the less successful management of expectations; while feeling sure that discharge from the service was appropriate. It was however, acknowledged that there had been some potential identified advantages in some people being active on the caseload in that early diagnosis and treatment of people who mightdevelop more serious problems were identified this way.

"I think it was sometimes helpful that people attending with an MSK problem, and where something else then occurred, could be dealt with to prevent longer term problems. "Can you have a look at this while I'm here?" The next minute they're in nail surgery clinic, so it was a form of safety net for patients in that sense, even if they were medium risk, as it meant we could spot things early".

However, there was a consensus that there was not a significant risk in the system of missed opportunities for early detection. As one manager shared,

"With the MSK group I don't worry so much, because if it's genuinely that they're in pain and it's affecting their ability to do sport and their daily activities of walking, or they're in agony because it's a muscular or a tendon issue …… then I am sure they would do something proactively to get help".

# Background

The support would, however, be coming from a different part of the pathway, so the concerns expressed by MSK clinicians were about a lack of a whole systems approach, meaning that a different part of the pathway would feel the pressure:

"It is pretty clear that foot and lower limb problems are a major issue and often affect people's ability to work and remain active and thus healthy. My question would be – how well co-ordinated do Tower Hamlets feel their provision of service to this large group of patients is currently? I can only advise from experience and I simply cannot see how it will end up more cost effective".

A July 2017 research paper (Edward K et al 2017) looking at the future: direction of Podiatric services highlighted the emphasis placed on exercise as a longer term strategy for preventing future foot health problems. However, as the study pointed out, this disregards the pain and discomfort associated with poor foot care that may prevent people from engaging in exercise, and the difficulty some people may have in managing their own basic foot and nail care. The study also cited confusion over referral pathways as a barrier to accessing foot care.

# Objectives

To explore the impact of the implementation of a new model of care in the Foot Health Service on staff and patients in Tower Hamlets. To identify ways of promoting good foot health and self-care from a young age and increase awareness of effective ways of preventing, promoting and maintaining wellbeing in relation to feet.

A qualitative methodologys used in this study because of the scope it provides to engage in direct dialogue with respondents and to unpack their views. In qualitative research, the main interest lies in identifying and describing the range of issues, themes, views or experiences and the relationships between them, rather than counting or estimating their prevalence. The work is in-depth and detailed as opposed to standardised and large-scale. Sample units are thus small since there is a point of 'diminishing return' where increasing the sample size no longer contributes to the evidence. Thus the sample does not need to be large enough to support statements of prevalence or incidence since these are not the concern of qualitative research. It is also impossible to do justice to the richness of the data yielded if the sample is large-scale.

In the case of this study, a qualitative methodology was able to:

- Provide an opportunity for patients/carers to tell their stories and experiences;
- Enable an understanding of the themes from both a provider and user perspective;
- Allow an exploration and ‘unpicking’ of the different factors that have created either previous positive or negative experiences/opinions and how they might be interlinked;
- Provide a mechanism through which aspects of service provision can be explored through the perspectives of service users and carers participating in the review;
- Provide a mechanism through which aspects of service provision can be explored through the perspectives of healthcare professionals;
- Enable an understanding of the nature of the role of healthcare professionals in the process; and
- Enable an understanding of the interplay between healthcare professionals and parents/carers in relation to self-care strategies.

# Objectives

It was considered that the most suitable qualitative methodological tools for this project would be both group-based approaches and individual in-depth interviews. Group discussions most commonly referred to as focus groups bring together people who are members of established user-led groups. Focus groups have the advantage of being cost effective (more people for your money) but also have a theoretical rationale. In focus groups people's views are often stimulated and brought into sharper focus by the opinions and experiences of others and there is an opportunity to hear and see how people interact on a given subject.

Group-based methods, however, give fairly limited scope to explore in-depth the 'stories' of individual respondents – their experiences and behaviour, views and perspectives and the links between these. This usually calls for individual interviews in which topics are pursued in-depth with single respondents at a different time.

Between May and November, 415 service users and carers shared their views. Of these, 21 took part in face to face 1:1 interviews, and 49 participated in telephone interviews. A further 13 participants shared their views while in the Foot Health clinic waiting area at Mile End, and the remaining 95 contributed through facilitated discussion in the following local focus groups: Alzheimer's Carer Support Group (26), Stepney Day Centre (10) The Geezers (30), Arthritis and MS Support Groups (10 each respectively), St. Hilda's User Group (8), Sonali Gardens Group (6), Sonali Darts Group (13) TH Carers Forum (30) ELFT Working Together Group (4) Osmani Group (1) and Linkage Group at Wapping Centre (14) ELFT MH Carers Hub (9), Day Centre for people with learning Disabilities (8) Toynbee Hall Steering Group (14).

In the course of the review, 45 service providers and clinicians took part in 1:1 interviews or helped facilitate contact with user led support groups, as follows:

# Objectives

- Alzheimer's Society BAME Dementia Support Worker and Café Facilitators x 2
- Alzheimer's Society Dementia Support Manager
- Barts Health Community Dietician
- Barts Health Rheumatology Lead Clinician
- Barts Health Specialist Neuro Physiotherapist
- Barts Health Specialist Neuro Service Manager
- Barts Health Specialist Clinical Psychologist: Long Term Health Conditions and Primary Care (Tower Hamlets - Network 2)
- ELFT Care Navigator Lead
- ELFT Clinical Lead & Specialist Podiatrist
- ELFT People Participation Lead (Adults, Mental health)
- ELFT Paediatrics Podiatrist / Therapeutic Footwear
- ELFT Specialist Podiatrist Diabetes x 2
- ELFT Learning Disabilities Clinical Nurse Specialist and LD Therapies lead
- ELFT EPCT Therapies Leads x 2
- ELFT Senior Managers x 2
- ELFT GP Clinical Lead Health E1 Homeless Medical Service
- ELFT Carer Liaison Practitioner
- ELFT Re-Think Service Manager for Carers Support Service
- ELFT TH Recovery College Practitioners
- ELFT Involvement and Co-Production Manager for Health & Wellbeing
- GPCG Governance Lead
- Jewish Care Centre Coordinator
- LA Community Engagement and Preventative Services, Health, Adults & Community Services
- LA/Voluntary Sector Link Age Plus outreach services x 4
- LA Public Health x 2
- LA Provider Network Team and LA Managers x 2 (Care Homes and extra care sheltered housing)
- LA Reablement Nursing and Therapies Leads x 2,
- LA Carers and Cross-Cutting Issues Lead, Health, Adults & Community Services,
- LA Community Engagement & Quality Officer, (Health, Adults and Community Services and Children's Services)

# Objectives

- LA Strategic Commissioning Manager – Home Care, Health, Adults & Community
- Tower Hamlets Friend & Neighbour (THFN)
- Tower Hamlets Community Housing HR Team,
- Tower Hamlets Community Housing Community Development Manager,
- Former Tower Hamlets Community Housing Executive Director
- Independent Podiatrist,
- Independent Foot and nail care technician
- Voluntary Sector Service Managers x 3

## Data Collection

The Patient Experience and Discovery interview team undertook the interviews which were digitally recorded and transcribed by an external provider.

## Data Analysis

Existing research and evidence was read and analysed. Process mapping enabled identification of key issues and individuals who were then contacted, and transcripts of interviews were thematised and informed the recommendations in the report.

## Limitations

The demographic in Tower Hamlets and the limited resources of the team meant that there were some communities who were excluded from the interview process e.g. Chinese, and Vietnamese.

# Discussion: Preventative approaches

Although some clinicians have flagged up the limited value of prevention in relation to foot health, the general consensus was that an early approach to awareness raising amongst young people and parents/carers would be hugely beneficial. School Nurses may be able to identify issues with gait at an early stage, and take prompt remedial action. This awareness of the importance of gait and footwear problems being addressed as early as possible was echoed by one of the podiatrist's offering an affordable private service to Tower Hamlets residents:

"...I remember one of my lecturers said to me that if our gait was corrected at a very young age, we wouldn't end up with so many hip and knee problems in older age..... because we are walking incorrectly over time, and the wear and tear continues throughout the years, we get to a stage where there's nothing much you can do, as it needs correcting much earlier on. I think we should look into ways we can better assess children's gait, if not when very young then at least as a teenager."

PSHE education is not currently a statutory part of the curriculum. The Programme of Study offers schools a framework through which to deliver PSHE education.
Schools are encouraged to use the learning opportunities to design a PSHE curriculum which meets the needs of their students, by using student surveys, and local and national health data to find out what the key priorities are for their communities.

Many of the interviewees expressed an informed perception that many people value footwear appearance above foot health until they suffered with long term pain. One MSK specialist reflected:

"MSK problems, which are the vast majority, occur for many reasons but, once present, can be managed to maintain function and resolve many conditions. Footwear is a major issue and lots of education can be done here. However, most people are very reluctant to change footwear unless they have significant pain."

# Preventative approaches

Concerns were also raised about the current trend for fashionable 'sports' footwear. The Patient Experience team unsuccessfully attempted to engage a local HEI, who offer a respected Fashion Shoe Design post-graduate course, in contributing to this report.

A view expressed by a member of the Foot Health team was also somewhat sceptical in relation to approaches to seemingly less harmful sports orientated footwear, as fashion it seems still reigns supreme and many brands which appear more, or are advertised as 'foot friendly' are in fact very bad for feet:

"There are good shoes out there that are affordable and can better contribute to foot health. It makes me really cross when these big companies ……. are promoted as good for feet as none of them have Valgus fillers which are basically heel arch supports in them, they're completely flat inside……they haven't got a basic standard foot arch support … I think we should lobby the government as professionals to raise awareness".

One of the psychologists who contributed to this review suggested that a 'damage limitation' approach might work best with most people, where instead of being too prescriptive a checklist to minimise harm may be more effective. The guidance could include simple advice such as saving flip flops for holidays and using insoles for shoes without arch support.

# Pro-active approaches

A good example of promotion of healthy feet and prevention of future problems are evidenced in the good practice adopted by Tower Hamlets Community Housing (THCH). This organisation has a track record of innovation when it comes to caring for both its workforce and tenants. Relevant to the Foot Health review is the subsidised offer for podiatry for tenants and a staff 'wellbeing' allowance.

Tower Hamlets Local Authority was also one of the pioneers of such an approach in relation to helping the workforce access low cost podiatry, and this initiative, developed 14 years ago by an innovative manager in Social Services, was concerned about Social Work and Home Care staff travelling around the borough, and the need for maintaining healthy feet. It is understood that this on-site provision has recently changed with the outsourcing of the LA Occupational Health service. Barts Health also offer subsidised health and wellbeing opportunities and foot health is one of the services provided at a variety of sites across Tower Hamlets.

# Diet and obesity

Another area identified for discussion was the relationship between diet and foot health. Academic research has been undertaken with an emphasis on how new technological advancements in footwear design might help those with foot problems resulting from obesity (Price, C and Nester 2016).

Awareness of the potential impact of obesity on foot health and the relationship between diabetes and foot related issues illustrates the need to support people with managing their weight. Diet can also play a part in various conditions that can lead to problems with foot pain, and while NHS online support weight management support is available, people may not have access to computers or even where they do, identify the lack of personalised support and face to face contact as problematic in achieving their weight goals. Private provision of weight loss programmes which provide greater personal support may be unaffordable for some.

The Dieticians do, however, contribute to maintaining foot health in the community through their involvement in wound healing, and play a role in seeing patients with ulcers, because their nutritional requirements and their protein requirements are higher. To aid wound healing they ensure that people are getting the nutrition they need to get better. If they are on a low income and suffering from food poverty, resulting in low food intake, they may lose weight and District Nurses, or Community therapists will use a malnutrition screening tool and if appropriate will refer to dieticians to advise on diet.

An increased awareness of and adherence to a healthy diet and maintenance of an optimal weight from an early age could reduce the number of people developing type 2 diabetes, and this in turn would prevent some of the diabetes related foot health problems. As one of the Foot Health team members shared:

# Diet and obesity

"In our department, we are very focused on educating the patients. So, when they come in, I have a one to one; the relationship we develop is very important, as a good rapport with a patient means they are more likely to listen to you.When they attend their first assessment, that's when we really focus on education and the ramifications that can occur through mismanagement."

However, the difficulty that people have in managing weight was recognised as being complex and challenging, and problems associated with maintaining a healthy weight can relate to lifestyle, low income and emotional state, and just as people make unwise choices in relation to footwear, many people also make unwise choices in relation to diet and diabetes management. Although the Specialist Podiatrists are focused on people already diagnosed with diabetes, they are very successful in helping people maintain their health and prevent deterioration of their feet as a result of their diabetes and will explain whether they have a 'low risk foot', and why it's low risk or if it is 'moderate risk' or a 'high risk'. At this point they will also receive information about how they can keep their feet healthy, and signs to look out for, as well as accessing the emergency clinic.

It is currently unknown how people with low risk foot health concerns manage to maintain their wellbeing and foot health when discharged from the service.

# Homelessness and Foot Health

There are multiple factors associated with homelessness which impact on the risks for this population in relation to foot health. As one of the GPs providing access to homeless people explained:

"You need a good diet for everything; everything goes wrong if we don't eat well! Issues people often raise are access to fresh fruit and vegetables and lack of cooking facilities. …. all of our patients have a much higher incidence of all morbidities at a much earlier age: so poor diet, lack of exercise, drugs, alcohol, mental health issues. So, they get diabetes, heart diseases, COPD at a much earlier age and it usually ends up being quite severe much earlier on… the average age of death of a homeless person is 47."

The issue of proactive care was also raised by a specialist in Homeless. There were a range of issues that the GP felt were particular to supporting homeless people with maintaining foot health, and one of them was around raising the profile of the importance of pro-actively screening patients rather than waiting for them to raise an existing problem:

"… there are lots of in-reach services around the hostels, for instance, different types of screening, where the teams come in and offer it to the people there and then, or it's advertised and people are aware of it. So doing something along those lines for feet would be good because it's not something that probably (and I can speak for my colleagues as well as myself) that we would think or have time to proactively ask about. But to go in and offer a foot check to people and then appropriate treatment on the back of that would be quite useful… to go out and seek people and offer foot checks and subsequent treatment, because obviously it's not worth just having a look at their feet and then doing nothing afterwards….."

As part of this review, something as simple as raising awareness among people who wish to donate warm clothing and footwear directly to help homeless people through publicising local distribution centres could help towards promoting better foot health amongst those living on the streets:

# Homelessness and Foot Health

"... with in-reach, there isn't a central place for people to go to for socks and shoes, to get supplies of clean socks, they don't have to be new socks, just putting the information out there to make it available to people might help."

The issue of poor footwear is an important consideration for homeless people and can have a variety of contributory factors and consequences, ranging from poor hygiene to full blown trench foot, including issues around the impact of lack of available changes of footwear or socks:

"Many people don't want to take off their footwear and socks because they're too embarrassed and ashamed to do so, which means they don't then air the feet at all! Because they stay wet it gets much worse than just fungal infections... I can think of at least six or maybe even ten people I've seen who had trench foot, which is the result of chronic changes from your feet being wet all the time. It ends up fixing itself relatively quickly once they start treatment ... I would prescribe a potassium permanganate soak, but you need to put your feet in a bowl of water, that's the upshot. So that's the first thing I ask: are they engaging with a hostel or somewhere where they'll be able to get access to a bowl and hot water to be able to do that....?"

The specialist Homelessness GPs refer to the Foot Health specialists and are aware that there have been changes to eligibility criteria where issues are non- urgent or diabetic related. There is also an understanding that access to the specialist foot wear centre has changed and that the focus is on those who have a deformity or a structural functional abnormality. There was a consensus that a focus on foot health education and support for people who are homeless could have a significant impact on future health needs. It was noted that homeless shelters often had healthcare teams offering to deliver other public health initiatives such as screening and vaccinations but there was no foot health provision.

# Homelessness and Foot Health

The ELFT Manager of the Mental Health Recovery College as well as the Homeless Specialist GP both voiced similar enthusiasm about the need to capitalise on any education or training videos, and to optimise the effectiveness by including a variety of topics that could promote good self-care. The psychologist is currently working with the Mental Health Recovery College and Local Authority to devise a piece of training that can be cascaded.

This idea of a multi-topic training has been supported in principle by the Care Group Quality and Governance Lead, who suggested producing a video that is essentially visual but with voice-overs in various community languages as a potentially cost effective and practical way of delivering such training over time. This could be available in a variety of community settings, as it would be useful to others as well as people living on the streets. ELFT has made some really positive developments in relation to this that are being progressed which include a planned video film currently in production to promote good understanding and self -care of feet. It would be excellent if this could be built on by partners in THT to produce a wellbeing resource that could be shown as suggested above in Homeless shelters and in GP waiting rooms.

The psychologist has also been working with the Whitechapel Mission and a dietician to come up with some very brief guidelines around trying to improve diabetes through diet. One of the challenges of being homeless or in temporary accommodation, is the lack of choice and control over what you eat and when, through lack of cooking facilities.

This innovative approach where some small changes can prevent things from getting worse aims to have a positive outcome on foot health, as higher blood sugar levels can raise risk of complications, so this initiative could be a practical way to improve diabetes management or at least to help individuals to prioritise diet and thus minimise risk.

Another element of this might be to try to raise public awareness of the issues faced by homeless people who are living with diabetes.

# Homelessness and Foot Health

"Everything is designed to be high in carbs and fat, because it might be the only meal you have that day and actually that's not what you need for diabetes. The idea is to produce a series of leaflets, one for people living on the street, one for if you're living in a hostel, and making them available to people who work in hostels. So, if someone has diabetes, staff can support them rather than thinking someone is just being difficult".

Again, such an approach would be helpful to those people in temporary accommodation and reliant on food banks where choices are limited by low income and access to cooking facilities.

Another challenge faced on the streets is around addiction. Where someone is struggling with addiction, diet isn't often prioritised, so the psychologist and dietician are also looking at 'damage limitation' in relation to general as well as foot health and ensuring access to nourishment drinks at the very least. Addiction to alcohol is particularly challenging in relation to diabetes management, and because of the link to foot health, this can impact in a major way.

One of the over-arching issues relating to homelessness is their potential vulnerability. When the psychologist looked through the revised FH eligibility criteria, the absence of a clear definition of vulnerability particularly resonated, as did clarity around who may make the decision about the degree of vulnerability present and whether qualifying as vulnerable means they would be automatically eligible for specialist FH services. Homeless people are by definition less likely to be consistently in one locality or even borough, and this in itself means that keeping track of individuals and preventing deterioration of their health is a huge issue. While the Homeless GPs are finding creative ways of helping people to gain fast track access to, for example, retinal screening, there are other challenges associated with being unable to monitor people's health on a very regular basis. This is one of the issues raised around the management of risks associated with discharging stable diabetics and is a cause for concern in the static as well as the more mobile homeless population.

# Managing risk

There was a consensus among many of those interviewed across the system that there was a need for robust management of risk of people identified as being vulnerable. Some managers felt that existing processes were able to ensure risk was effectively managed, and felt reassured that safeguarding strategies are ensuring those at risk are in touch with or known to the appropriate teams within the health and social care system.

This view was not supported by some in the voluntary sector who voiced concerns felt that while people who are known to and in receipt of statutory services may be getting support, they may not alert service providers to issues relating to their feet if unrelated to their care package. As a Voluntary Sector Manager shared:

" A person known to us gets people coming in and a pretty comprehensive package of support . He was walking oddly, so I asked him, "When did someone last look at your feet?" He replied that nobody had, and he had just accepted that, so if we hadn't noticed..... I'm sure there are hundreds of people that don't think to ask for anyone to look at their feet ...especially if the carers don't come to help with that specifically!"

Anecdotally there are also incidences of people with significant risk factors relying on self-care with potentially serious consequences. It was noted that visual impairment was not an inclusion criterion for foot health but has the potential for significant limitations for self-care. Another issue identified was around the drive to encourage mobile patients to attend clinics instead of receiving home visits. This has caused some concern where there are issues around mobilising unaccompanied:

"If the person is eligible to get an escort, they can manage to attend a clinic, but in a lot of cases they won't be and are housebound without someone to collect them and help them downstairs and on to transport."

# Managing risk

Low income as well as complex health issues was a real concern for many of the people being visited by the Befriending and Advocacy Team, who were aware that even the affordable options that had been circulated by the Foot Health Team were not a viable option for many:

"This particular person can't read or write …. she's not very good with money, so she couldn't get to a private practice because she gets too anxious,so it would have to be somebody that comes home to do it, which she wouldn't be able to afford."

# Communication and consultation

There was a need identified from the Specialist Neurological Team, Learning Disabilities team and other services supporting those with dementia for inter-organisational multidisciplinary prior to implementation of the new model, it was widely felt that this would have improved care for this patient group. The Specialist Community Neurological Team felt timely discussion may have enabled identification of unmet need and better strategies to ensure that the patient group was able to access alternative support, prevent deterioration, manage pain and promote independence. The ineligibility of this group of patients to access some previously available specialist podiatry services is being experienced by a number within this patient group across the country. This has increased demand on the few services that remain accessible, such as Queen's Square Hospital, so there has been a significant rise in the number of people on their waiting list and long delays in accessing orthotics. One of the concerns raised by Community Neurology was how some of the patients with long term conditions are no longer eligible for the FH service under the new criteria.

"With upper motor neurone conditions, such as MS, spinal cord injury and stroke, you can get lack of control over reflexes, where you get the spasms, and that could cause pain. And one of the things that actually contribute to increased spasms is pain, and toenails that aren't cut can cause pain, as can in-growing toenails. Also, a lot of our Parkinson's patients, if their toenails are not cut, they can't get proper shoes on, so there's an increased risk of falls. So there are a lot of secondary complications. Some of our patients have got increased sensation in the feet, which can happen with neurological conditions, and become really hypersensitive, which also causes discomfort. And because these are all people who are generally not working, and on benefits, because they've got such high levels of impairment, they wouldn't be able to afford to pay privately for nail cutting or foot care."

# Communication and consultation

Using personal care budgets to pay for such services was highlighted as problematic in that a number of patients with conditions such as advanced MS, have cognitive impairment so would find it quite difficult to manage a personal budget. The Neuro Specialist team is dealing with concerns they have around some patients who do hold a personal budget but are struggling to deal with the responsibility for managing their support, as things like training of carers is the individual person's responsibility.

"REAL would be the people to help advocate and support people in managing the budgets, but their funding has also been reduced. Everywhere there has been cuts, or that's what the feedback tells us."

The Specialist Neuro Therapists talked of previously enjoying a very good relationship with Foot Health, where the different specialisms came together to provide patients with the best possible service. This is particularly relevant to orthotic provision, where the skill set of orthotics in FH focus on biomechanical specialism, and have a very different approach to the functional Neuro physiotherapists.

The issue of dementia was also raised, as although the FH specialists offered reassurance that people with dementia who required input with foot health would be seen, there was no specific mention of this cohort of patients in the eligibility criteria. The Specialist Neuro team pointed out that dementia is not a Mental Health condition, but rather a Neuro condition, so would not be under the mental health teams.

Recent eligibility criteria circulated to GPs does state that people with dementia may be eligible for support from the Foot Health service but as the service is needs based, an individual assessment would need to be undertaken to ascertain whether the person was eligible, given that a diagnosis of early stage dementia may not impact in a way that requires input from specialist Foot Health.

# Communication and consultation

The Learning Disabilities Team also felt that they and their client group had not been fully considered or consulted with and were not aware of any attempts to communicate with them about the potential impact of the new criteria. The team felt that people with a Learning Disability might struggle to understand the standardised letter sent to patients and would have expected an easy read version with visuals to enable better understanding as is accepted good practice.

It is acknowledged that due to the 60% reduction in funding to the Specialist podiatry service, the administrative capacity of the service was, as previously documented, severely reduced and the 'lead-in' timescale in which to inform local community and colleagues of the implementation of the new service model and eligibility criteria was very limited. This was an additional challenge faced by ELFT and the Foot Health team.

The eligibility criteria itself was also seen by LD colleagues as somewhat vague and while in a positive sense this could be a deliberate attempt to enable a degree of flexibility and potential for greater inclusion of vulnerable people, it can also lead to the evident confusion around whether a person can be considered for referral. From the published criteria it was not felt to be clear whether a person with a LD would be automatically ineligible for the specialist service unless they had other conditions that raised their risk factor, but anxiety management and an individual's inability to cooperate were identified as a real concern when looking at alternative options that may be available. It was felt that for most people who had an LD that was of a severity that meant they were unable to work; low income would make it almost impossible for them to access private foot health services as a viable option.

Furthermore, the issue of the particular needs of individuals with a LD were flagged up as being absent from the eligibility criteria, and it was felt that there was a need for a tailored and specific understanding and approach acknowledging the potential vulnerability of individuals with LD.

# Communication and consultation

Such challenging behaviour also means that it needs a specialist approach to providing support and assessing need in a way that reassures the person. One of the issues in relation to LD appears to be about communication rather than lack of consideration for this patient group, as a specialist podiatrist offered reassurance that the above-mentioned examples would indeed be eligible to access support from the specialist FH team. Another issue that was raised with people with LD, like any other patient group, was around encouraging appropriate footwear.

"We've a lot of clients who have got historical footwear, even transitioning from children's to adults' services… they are used to a certain kind of footwear, and then suddenly they're an adult. Also they might have been more active and doing lots of standing when they were a child, and now they're in a community setting, this can change so they may gain weight and their foot health needs change. So, we definitely … require help with this issue. You're looking at about 70% of patients with learning disabilities who actually develop foot issues over time."

It was felt that potential problems can arise without specialist input to monitor foot health, and LD specialist services reported having frequent rejection of referrals with LD patients not meeting the revised eligibility criteria.The wide spectrum of needs and age range covered by the LD Team also means that it can be challenging to encompass a set of generalised criteria around LD alone. For example, while one person with a LD may be physically very fit and well, another may live with a range of age-related conditions that make their care needs extremely complex.

"We see people from 18 until the end of life, so it's the spectrum of needs…. they might have a learning disability and then on top of that, they might have an old age-related issue and all of the other things in between. A lot of our clients would be much more at risk of being obese, developing diabetes, etc., So, there you're dealing with a higher risk group than normal, so for them not to have that contact with the specialist FH service in terms of prevention would be difficult."

# Communication and consultation

The potential for self-care with people with LD was also an issue raised, as the need for education and support can also differ when compared to those without a LD. Education about Foot Health was another concern, as some people start developing fungal infections through lack of knowledge around how to care for their feet. The consequences of ill-informed self-care can lead to problems:

"Although the GP referred him, he got rejected by Foot Health…so he sliced off the skin himself and when I saw him a few weeks later he was at risk of infection….. he said he saw it on YouTube and sliced off that calloused skin …."

It was suggested that any self-care information targeting people with LD needs to be produced in a way that would be easily understood, as would any 'rejection of referral' letters. Although LD Specialist Physiotherapists endeavour to address some of the problems that people experience, there was a feeling that their skills alone were not sufficient, and that more recently it has been harder to access appropriate Specialist FH advice regarding footwear.

This inconsistency has led to some LD Team members questioning whether the problem lies with their own lack of awareness as to how to 'frame' a referral, and a need needs to be included on the referral form and the correct terminology and categorisation. to utilise.

There are some lobbying groups and individual activists who shared their view that an acceptance of self-funded options is a further erosion of the principles embodied in the NHS. As this person shared:

"….what it's doing, which I'm totally opposed to is pushing people towards the private sector….people are scratching around to find the cheapest option and it's not a good thing at all, and I've got a nasty suspicion that if a private podiatrist doesn't get enough patients at that clinic, they'll stop doing it…."

# Criteria for eligibility

ELFT has recently updated the eligibility criteria provided to GPs (and this is particularly helpful to Locums) and it would be very helpful if this could be circulated to all potential referring agents.

There have also been significant developments with signposting to affordable local non-NHS options. The voluntary sector has taken a role in seeking out and hosting sessions for basic nail cutting and foot care, such as at the Zacchaeus and Toynbee Hall. There is now also provision of an independent podiatrist based in Wapping Health Centre, in response to local patient demand.

Mental health (MH) as a definition in itself can be problematic, as there was widely felt to be an issue with depression not being a category eligible for inclusion, when it was acknowledged that it may potentially lead to self-neglect and potentially in the longer term, avoidable foot health problems. The criteria around who might make the decision about what constitutes a Mental Health problem was also seen as lacking clarity, with questions (as raised by the Specialist Neurology team) about whether the Podiatric assessor would be able to accept a judgement by a non-specialist MH clinician that a patient suffered from a Mental Health condition without obtaining a formal psychiatric diagnosis. In the Sheffield pilot this was indeed one of the issues that was identified as a key consideration in the success of this empowerment project. The Podiatry team assessing the patient was able to identify anyone who although they may not at first appear to meet the eligibility criteria, they then assessed as likely to be vulnerable:

> "It was important to include social circumstances and mental health considerations in the assessment process before determining whether an individual can safely self-care. It was also important to understand that when it is not clear that patients can safely self-care, they should be given treatment instead."

# Criteria for eligibility

The Sheffield project was focused on self-care/empowering family members to support someone to maintain good foot health, and did not act as a means of sign-posting those unable to self- care to a private option, although this seems to be how many Podiatry services nationally have evolved since the widespread implementation of the eligibility guidelines.

Prior to the introduction of the new model, Foot Health was provided to people attending Day Centres through a mobile unit that visited on specific days. This was helpful as care staff could be on hand to support those who may need it, and in particular those with Dementia attending a specialist unit. While the mobile unit was not included in the new Contract for Community Services, ELFT are dementia and carer friendly in the way that the service is now provided, including offering domiciliary visits should these be required.

New approaches being piloted by independent podiatrists, who are providing more 'affordable' services through community groups and housing associations, but for people on very low incomes this service can still fall outside their own affordability. Prevention can be hard to address when patients have low incomes and/or a range of other medical issues that may impact on their ability to self-care:

"I've got an appointment next week because the skin on my feet is so dry, it is splitting, and last time I went she said, "You have to moisturise your feet every day." But I can't reach them because of my osteoarthritis! That is the difficult bit…and even if I could reach my feet, you have to buy the moisturiser."

Although it was felt that people with vulnerabilities should be making contact with a range of services to prevent crises occurring, it was evident that access to any voluntary sector support groups that may have been in a prime position to monitor vulnerability and make timely interventions through tackling isolation and loneliness are under pressure through volume of people needing support. These people are assessed as being low risk so ineligible for statutory services but have remained well in part through being in touch with Voluntary sector services.

# Criteria for eligibility

Concerns were voiced about people who might find it daunting to make initial contact and support to overcome the initial hurdle of joining a group or activity, in combination with pressures on local authority and voluntary sector budgets to provide key workers mean this one to one support is increasingly unlikely to be available to those assessed as being lower risk. These may prove to be the people who 'slip through the net' and over time are identified through attendance at A&E.

A key voluntary sector agency who is providing low cost podiatry services through their community centre shared the pressures that on their infrastructure that have resulted from the increased footfall through the centre while core staff numbers have remained static, causing capacity issues as a result. It was pointed out that while the main reason for the person accessing the Centre is to see a podiatrist, most people have a range of other issues and problems that they then seek help with, as well as signing up to enjoy many of the other benefits associated with membership of the community centre. The manager explained a little about the background:

"We'd already set up a nail cutting service for people who couldn't cut their own toenails and didn't have any ongoing serious health problems about two years …it wasn't aimed at people with long term conditions but was really for people that couldn't reach their feet. Here it was only £8 when it started and we saw a lot of people's toenails that had been 'hacked', as people hadn't managed to cut their toenails properly. Since the changes to FH and the new list went out advertising our service she's up to full capacity and the charge has risen to £10. I am have now negotiating for another person to provide a similar service as there is so much demand. We've seen a lot of new people coming in for toenails but then they see other things that are happening here and then that leads to other requests …"

While demand for the podiatry service provided through this Community Centre continues to rise, the knock-on effects for staff are that they are presented with challenges in terms of their capacity to respond to every patient in the manner they aspire to due to time constraints and staffing numbers. They talked about a desire to be welcoming and supportive to people, but how many people seek support with issues such as Personal Independence Payments (PIPs) which generate more work.

# A&E and Community Nursing

As part of this whole systems review, the RLH Emergency Department (ED) were approached to help examine whether there have been any changes to numbers of people who are attending with foot related problems, and this data proved interesting. Anecdotally, people were sharing in individual or group feedback that they find the physical location of the Mile End emergency clinic a challenge. If someone is having a problem with their feet but cannot afford or access a cab, the bus or tube stops that are close by to the Foot Health clinic still require a reasonably long walk when compared to the RLH Emergency Care department, so it may be a more attractive option to those who are having difficulty mobilising.

The data provided by ED covers the three year period from before the changes to Foot Health in 2016, through to the latest figures available (for October 2018).The key spikes in demand show that there has been a significant increase in episodes of people with diabetes experiencing foot problems attending the Emergency Department over the last two years, but further clarification is being sought as to whether all these patients are from Tower Hamlets.

There are also interesting seasonal spikes which suggest that there may be a link between the unusually hotter months of 2018 which may have seen more people wearing sandals and flip flops and the numbers of people suffering foot and toe problems. While it may be too early to see the impact of some of the changes in criteria on the EPCT's, if, as has been predicted by some clinicians, the changes over time may lead to more surgical interventions, this could potentially lead to greater demand for ongoing wound management support from Community Teams. As the discharges from the specialist Foot Health service have only relatively recently taken place for a large cohort of patients, it may be too early to see any impact of this type on Community Teams.

# Managing expectations amongst those assessed as lower risk

While there is an issue around encouraging and supporting people who are in the high-risk category to reduce their risk to moderate or low there is also an issue around those people assessed as being low risk deteriorating and become medium to high risk. The struggles some people have with adherence to a change in lifestyle and close monitoring of their own health, and the fact that these people were previously being monitored may now contribute to a deterioration that could have potentially been avoided if they were still being seen by Foot Health. One of the concerns raised by the FH Team was the challenge around maintaining support for people assessed as being well controlled diabetics:

"Some people have to lose a limb or a digit before they take action…..then it hits home, because there is like a school of thought that says sometimes diabetes can affect the brain, the thinking. You can say to people, "Look, you do realise your sugar is 22!"And … they'll still go and do whatever they want to do, no change in habits or lifestyle. And it's only when they've lost a toe, or they've had an amputation, bits and pieces have been cut off, it suddenly hits them…."

Another issue relates to people who have a number of complex health needs, and whether they are able to make a judgement about the urgency of their need for Foot Health input. It was acknowledged that someone has different comorbidities and are seeing someone for their heart or their kidney dialysis, they are less likely to prioritise their feet unless there's an open wound and this can lead to a deprioritisation of their feet over for example dialysis, because that would appear more important. In contrast, it is evident that some people adapt and manage their conditions well, and this is true of people with diabetes who, with support and are able to grasp the sometimes complex balance needed when 'trading' foods. Accompanying this understanding is the need to redefine or reframe how people view often less healthy foods as rewards and use terminology such as being 'bad' or 'good' in relation to food.

# Managing expectations amongst those assessed as lower risk

There is some evidence to suggest that it can be the anxiety around self-management that people find challenging, and the 'fear' around not being monitored as closely as they were previously, and this too requires a shift in mind-set and approach to self –care. As a Sonali Gardens group member explained:

"The FH clinic won't see me anymore. I have high diabetes. It's really poorly controlled. Diabetes is affecting my feet. I went to see my GP about it, but he suggested I pay to get my nails cut as Mile End won't accept referral. My wife cuts my nails and she herself has Diabetes but what can I do, I can't bend to cut my own nails…."

This suggests that despite the perception by the individual that their diabetes is poorly managed, there is no clinical evidence to support that the person is higher risk, and they clearly have difficulty in accepting this.

# Self-care

The podiatrist's role in prevention of ill health could, it might be argued, be seen in a more far-reaching context, and this was something that came up frequently as a theme in discussions with people who had been discharged from the service and felt 'rejected'. This led to consideration of the potential preventative quality of the physical contact provided by podiatrists in a 'hands on' and 'healing' way, which seems to have a particular significance when people may be experiencing isolation, loneliness, depression and a sense of feeling they are no longer valued or have any intimacy with people.

While as children, parents or caregivers rubbing a child's feet is experienced as a very comforting act, and while people often then associate having their feet rubbed as reassuring, people are less comfortable with touching a mature person's 'imperfect' feet unless qualified to do so. This may be one of the reasons that people losing the regular hands on contact provided by Foot Health is perceived as a 'loss' as this relative degree of intimacy can take on a greater and reassuring significance.

This sense of 'loss' seems at odds with the need to challenge a culture of dependency and the way that people described the feeling of being discharged from the service as punitive rather than an indicator of wellbeing was much in evidence, aspeople seemed to equate being discharged from the service with some sort of rejection or failure. As a senior manager pointed out, it would be hoped that a person who received a specialist assessment and was deemed to be well enough to manage their feet without specialist input might be expected to celebrate this fact. The reality, however, appears to be that many people experienced feelings of being somehow rejected through being discharged, and this was frequently reinforced through their emotive choice of words:

"They assess people on whether they can do this and do that, but it feels like a box ticking thing. Not an individual thing. They don't ask you personally what you feel you can manage…. they put down what they think …. So, a lot of people here have been struck off".

# Self-care

The social function of 'having one's feet done' as many people referred to the service perhaps reflects the blurring of need and perceptions of independence as an undesirable state. This seems to relate directly to that fear of loneliness and isolation, and people often describe the experience of seeing a podiatrist in a way that suggests an interaction of intimacy, significance and sociability that may otherwise be lacking in their lives.

One potential serious outcome of this feeling of resentment at being discharged is that people may unconsciously allow their foot health to deteriorate in order to qualify once more for the service. As a member of the Foot Health team explained, for some coming to the department is the only chance they get to interact. So, if they're no longer coming, they may be tempted to let themselves deteriorate and present later with a foot ulceration, because of poor self- care.

Aligned to this is the value placed on the relationship with a podiatrist that has developed over time. The relative stability of the FH workforce means that some staff have been in the department for 23 years and have developed a rapport that is greatly valued. While seeking a service from a private podiatrist can be difficult on affordability grounds, for others it is far more about loss of the familiar and trusted relationship that they fear or mourn. This can lead to neglect and self- destructive behaviour observed by FH team members.

The relationships that have been developed over time and have been so successful at enabling maintenance of wellbeing has led to the experience of discharge process of those assessed as low risk being challenging for the practitioners as well as patients. It is understandable that because of the genuine concern that the podiatrists have for the patients, it can be extremely hard to discharge patients who are feeling vulnerable. In addition to this, the impact of the reduction in number of staff members has resulted in an equally stressful challenge across the department.

# Self-care

There was also an age issue that was raised by many patients. Often someone in their 90's felt they had earned an entitlement to the FH service by virtue of their longevity alone. The emotional impact on staff was also in evidence where having to tell someone in their 90's or on occasion over 100 years of age that they no longer meet the criteria was experienced as painful for both parties.

In addition to the ineligibility of those who are low risk to receive a service, there is the challenge of reducing the numbers of home visits undertaken, staff numbers mean that it makes no sense to provide a domiciliary service to those who are mobile, but for some people maintaining their mobility is a struggle and again people felt 'punished' for trying to remain independent.

"We're trying to cut down on domiciliary visits and bring people into the clinic by transport….but it's very difficult. We only see the ones who are bed-bound on home visits; the ones that are using frames… you do an assessment … you see someone who is 90 and you're thinking, she's so frail. The domiciliary rule is she's got to be bed-ridden now. So I do home visits to assess them, then if mobile, discharge them from domiciliary and put them on the transport. I think 'what if they have a fall getting on the ambulance'? And they're saying, "Well, I can't get down the stairs!" I'm not an therapist so can't assess whether a person is going to have a fall…. but we haven't got the capacity to see people at home who are mobile….."

Some staff expressed the view that senior management do not understand or recognise the emotional impact and challenges involved in implementing the changes at grass roots level. There was also a perception among staff that those who found the process of discharging people they felt were vulnerable upsetting were in some way regarded as displaying ineptitude or weakness, and this lack of empathy was reflected in some of the comments made by the team. It was also clear that the substantive amount of Administrative function time had been lost as part of the reorganisation and felt this had impacted significantly on the work of the podiatrists. One perceived repercussion was their sense of having to juggle clinics, admin and management tasks as well as data collection and monthly reporting.

# Self-care

This was reported as resulting in low morale and a sense of being devalued, and staff also reported working over their paid hours in an effort to keep on top of the administrative tasks and there was a sense of resentment that management rather than appreciating the pressures the team experienced were more likely to be critical of time management skills.

Interestingly, one of the earliest adopters of a trial to examine the potential savings that might be achieved through educating and empowering patients (called the Empowerment Project) and informal carers to self-care was undertaken in Sheffield in 2013. This was regarded as a very successful project that helped to inform the subsequent roll out across the UK and contributed to the adoption of the current eligibility criteria. However, in Sheffield there was substantive investment in the process in terms of lead-in and dedicated staff time made available to support the change. The Empowerment Project involved dedicated podiatrists, an in-house psychologist and physiotherapist providing free training to staff working in the podiatry service and staff were diverted from normal clinical duties, trained in empowerment techniques and they offered training to other disciplines. This included a podiatrist demonstrating how to file toenails for individuals with reduced mobility.

This training linked up with the rehabilitation physiotherapy team who provide education for people who have had or who are at risk of falls. New patients were triaged. Those not at risk were invited to empowerment sessions then discharged after tuition. Advice was provided and if necessary, face-to-face assessments to confirm the decision were arranged. This lengthy lead in period allocated to ensure the safe discharge of those patients assessed as lower risk could not happen in Tower Hamlets, where the value of the Community Contract necessitated a more rapid turnaround of those to be assessed and discharged and others prioritised as high risk. Another issue that Sheffield identified was the need for the podiatrists to retain the ultimate decision regarding vulnerability, so that even if a patient did not meet the new criteria, if the clinician had real fears that the person would be unlikely to self-care, they would not be discharged.

# DNA rate

As part of the review contact was made with people who had failed to attend appointments (this peaked during the summer months but continued into Autumn) and over half of the patients said they had experienced difficulties getting through to rearrange an appointment which clashed with an existing one, or that they received letters inviting them to interview two days after the appointment date.

Other people reported that they had been seen but the system and records had not been updated to reflect this, so the recording of DNA had resulted in the inappropriate discharge of some patients. It was fortunate that the PET team worked closely with the FH Team to ensure early identification and resolution of these cases, but again lack of admin time and problems with the telephone system seem to be a significant factor in contributing to both problems with DNA rates and formal complaints.

The Foot Health Manager has since implemented a number of strategies to address the high DNA rate and to better understand, support or signpost those who failed to attend appointments. By empowering clinicians to chase up all patients who DNA'd it became evident that a number of patients genuinely forgot the date of their appointment, although memory or capacity issues were not identified as being an issue.

The introduction of an improved SMS messaging service to remind the person about their appointment has also impacted on the DNA rate. Other patients identified as potentially needing support to remember appointments and book transport has led to a process of following up enabling engagement with close family members who happily accepted a role in ensuring they support the patient in attending future appointments.

# DNA rate

Problems with the loss of the dedicated Foot Health line meant that service users, carers as well as staff found it increasingly difficult to communicate, and although the system was overhauled in the last few years, it continued to pose challenges to the smooth running of the department. The telephone line problem has since been resolved, so this too should aid the reduction of numbers of DNAs.

Recent other positive measures taken or in progress by ELFT include strategies to address some of the 'process issues' such as the above mentioned administrative and systems glitches that contributed to the high DNA rates which increased the stress levels amongst the team. A FH patient Focus Group has also recently launched, and this will hopefully result in improved levels of engagement in service improvement cycles.

# Risk aversion and changing the culture

The problem of whether the many agencies who deliver packages of support to service users and carers in their own homes would be paid to attend training unless deemed mandatory was also an issue for consideration as the independent provider organisations are profit driven, and the question of who will pay for their staff to have training remains an issue. It could be argued that toenail cutting in people with low risk feet is part of a care package and so should be part of mandatory training.

The extent to which training and risk management can be addressed and overcome by agencies is an ongoing challenge, but as part of the review, PET members attended the new revised Foot Health training, which was extremely well attended by a range of professionals and included care staff working in the community. These sessions include clarification around eligibility, demonstrations on what good foot care looks like and opportunities for questions as well as signposting to affordable local options. The Training also includes a practical element teaching nail cutting techniques, how to ascertain whether there is any problem around sensitivity as well as issues to look out for and actions to prevent poor foot health.

It was suggested that this training could be rolled out to be provided in a variety of community settings where it could reach higher numbers of paid and informal carers, service users, and relatives, with an emphasis on prevention.

"We could do training through the Carers' Centre for informal carers and the LA could support paid carers locally to attend. I don't think we need to make this into a half day complex thing, it's really more about demystifying it, providing people with common sense and the escalation point. So it would be really helpful for these people to feel that they could maybe contact somebody if they wish to talk through a concern. Also, looking at video clips, or still images of what to escalate could be helpful."

# Risk aversion and changing the culture

In relation to informal carers, a local Voluntary Sector manager who has been supporting informal carers for over 25 years voiced concern about the support network currently available:

"When we think about carers, we always think of them as able to care 100% on their own, but we know that we've got people here that have got learning disabilities, that are caring for someone that doesn't have a learning disability. We saw a man with LD who cares for his wife with really bad feet who was having problems walking so the Foot Health person here had a look at her and found her feet were in a terrible state, but the carer hadn't realised the severity. I suggested the Emergency Clinic and he said that his wife doesn't get up that early in the morning and didn't really realise the seriousness of it. The cared for person is being assessed for possible dementia, and the system wasn't picking up on what is being assessed for possible dementia, and the system wasn't picking up on what was happening as on the surface they seemed to be coping"

The Specialist Foot Health clinic provides some images on the door where the Emergency clinic is held early each weekday morning and these graphic depictions of serious foot health issues that require specialist assessment and potentially intervention have been very helpful to those uncertain about whether they need to seek help. The new training provided lots of visual aids to help attendees distinguish between foot problems that can be resolved through topical treatments or better foot hygiene and those that may require more urgent or specialist intervention.

It was also suggested that some staff might share photographic images of feet about which they may have concerns via nhs.net or EMIS with the specialist team for timely advice and that easily accessible images or video clips that service users, informal and formal carers could access would be helpful for all:

# Risk aversion and changing the culture

"You could include some of the red flags to look out for, such as 'if the foot is looking like this, then perhaps it might be time to ring Foot Health', or signpost to see the nurse at the GP practice…. give people reassurance that they can get some support, and with the visual aid of course you can put a voiceover in different languages as well, much easier, particularly with our Sylheti population and written issues off."

Signposting to nail-bars as an option for very low risk patients was suggested as a potentially pleasurable 'pampering' experience much as a visit to a hairdresser. A senior ELFT manager had experienced rolling out new criteria a number of years back in another London Borough, and as part of this process time was invested in working in partnership with beauticians and nail bars to ensure that they had adequate knowledge of what to look out for and when to refer to the Emergency FH clinic or suggest a consultation with a GP.

This might be something worth investing in locally in the future. However, some older people fed back that they felt unwelcome in the environment of a nail bar, as the average age is younger, and people said they felt self-conscious. Several people felt that the other clientele seldom seem to have common problems experienced with older age such as thickened nails or serious hard skin or bunions. A Voluntary sector worker shared some feedback from those who had been signposted to local nail bars in Tower Hamlets:

"A lot of people said they felt really upset about the expectation that they would feel comfortable in that kind of environment, because they saw their foot problems as a medical thing, and they were reassured and comfortable getting support from a professional; it's not about just having pink toenails, it's about somebody with appropriate skills doing your feet properly. There have also been bad experiences when people have gone in and had a pedicure, and they've taken too much hard skin"

# Changing the culture

It might be that if there are successful challenges to ageism and notions of bodily ideals at some point people of all ages will feel comfortable going to nail bars and beauty salons as envisaged. There was certainly widespread acknowledgement across a range of stakeholders of the need to move towards greater support for people to self-care, and help care agencies, family members and friends to be less risk averse when it comes to managing good foot health. The transition from Foot Health Specialist services for those no longer eligible to receive the service to provision of nail cutting as part of packages of care has been far from seamless.

As a Reablement nurse explained:

> "We've always had concerns around nail cutting, because we've got to support clients with their personal care, but the process has always been if you've got concerns about their nails, you speak to the GP who will refer to Foot Health. We started having discussions around whether carers could be trained to do the basic nail care, but there was a concern around indemnity insurance. These issues are yet to be resolved, as it then becomes a question of is the council going to be liable should things go wrong with the paid carers, if the carers were to cut nails".

However, there is some evidence that a change in dependency culture is beginning to happen, and a Senior Nurse within ELFT felt there is evidence of progress around risk management. At the Home Care Providers' Forum there were discussions around foot health for home carers, and in day centres and it was acknowledged that there are myths around diabetes and toenail cutting. As an ELFT Manager pointed out:

> "I was able to put forward to the home carers that if toenails look normal, then treat them as normal, and if you cut my foot, even if I don't have diabetes, I'd be very upset! These supposed risks are just not there. If you cut somebody's finger off while cutting their fingernails, it's the same risk".

# Changing the culture

In recent years the roles and tasks undertaken by care staff has changed considerably to include those once performed by Community Nursing, but which do not require specialist nursing training or skills, such as administration of eye drops, however the Reablement team felt the nail and foot care issues should be identified as being slightly different to eye drops is it can be seen as an invasive process. The team therefore carry out basic risk assessments to explore whether there is a training need to ensure safe practice. The Governance Lead for one of the THT Alliance partners pointed out the need to differentiate clearly between those who may be at risk, and the vast majority of people for whom the risk is low:

"We've got the headlines of somebody getting an infection in their foot which of course is very low risk for most people. If we are making sure that we don't put people at risk, we can actually make it again back into something that we feel we can cope with. We've sort of taken away people's ability and we've made everyone scared about doing these everyday tasks."

This risk aversion was reinforced by Reablement Team members, who were concerned about indemnity and highlighted the need for practical information, and equipment that can safely be used within a client's home. Discussions with service users, carers and staff do however suggest that if there is a shift in the way that self-care is viewed over time, it may lead to more relaxed attitudes towards helping each other out. As a Foot Health team member pointed out:

"You could give anybody a pair of clippers and say to someone, "Can you cut my toenails?" I mean your neighbour could ask you and you could do it for your neighbour, your sister, your mother, anyone, they're not going to sue you! Everybody is so concerned about risk and I completely understand, but I would just advise all of them to just have it written down that 'you are allowing me to do this'..."

# Changing the culture

A governance manager in the Alliance seeking a new approach to self-care agreed that a change in culture needs to be promoted across the board and a de-medicalisation of something which is essentially an everyday need for most people. If there is a demystification this can help address fears to the point that it becomes something that can be fulfilled by either family members or paid carers.

# Examples of good self care

Many people were delighted to be managing their own foot health. This was particularly true of cohorts of 'citizens' who were very active and connected within their local communities, such as members of the Geezers and other citizen and community led groups. These are a number of extracts from conversations with members of these groups:

"I cut my nails myself. I don't have trouble. I put them in hot water first to soften them up as they are really hard" "Well personally I soak my feet every day. That helps and stops hard skin forming."

"We wear comfortable shoes… I buy DMs and they are good … and Clarks" "Leather is good as it stretches, and your feet can breathe. I stretch them with a stretcher if they are too tight."

"I have to take someone with me now to get shoes. … I have MS and I can't feel my toes so can't tell if they fit. So, I have to have someone who can check the space at the end of the shoe. They must think I'm odd, but I have to know they will fit."

Safety concerns had led some people to seek out more expensive specialist options where they visited a private podiatrist every 3 months, while others had made arrangements for domiciliary visits. This was true of some people who attended a local MS group who assumed they would be ineligible for national health podiatry.

When the initial list of qualified podiatrists was issued, feedback suggested it would be helpful to signpost to local affordable options for simple and more complex foot care, and after feeding this back to the team, the Foot Health Specialist service responded and circulated a revised comprehensive list of local non-NHS provision with helpful guidance on cost and scope of support offered.

# Examples of good self care

Although family members may be able to physically assist, the act of providing help with toenail cutting, bathing and touching another person's feet was viewed by many as an intimate act and one they felt uncomfortable with. This issue was being touched on at the Carer's Forum, and the new Carers Services Contract being commissioned and including training for Carers may help to resolve this issue through practical tips and training in techniques for effective foot and nail care.

# Conclusions

Although the recommendations made by NICE relate to prioritising high-risk FH patients, Clinicians in Neuro Community Services, Rheumatology, Sports Medicine, LA Commissioners and Public Health, Psychology and the Voluntary sector raised whether it may be helpful to consider relaxing some of those high level recommendations locally. It was felt that it may be valuable to undertake regular reviews and consider the merits of adopting a local eligibility criterion tailored to the specific needs of the TH population. This may require a more expansive study of some of the longer term financial and health related implications resulting from the implementation of the new criteria for eligibility.

A more far reaching whole system review undertaken when the impact of the changes may have become more evident might examine whether the short term savings have resulted in more people having urgent care interventions rather than conservative management over time, and would help develop an understanding of whether there hasbeen a shift of cost pressures onto a different part of the integrated health and social care system.

# Appendix 1: links and further information

**Scholarly articles on Foot Health**

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5982038/
Article on RAPID (reduction in amputations in Diabetics) in highlands of Scotland
https://jfootankleres.biomedcentral.com/articles/10.1186/s13047-017-0232-3
**What direction for podiatry?**
https://pdfs.semanticscholar.org/eaff/9de98131f2781f974f504b9a1a38b8058ba2.pdf LD
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4342196/ LD
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5217416/ Medical grade footwear vs. custom made footwear
http://usir.salford.ac.uk/32920/1/CPrice_PHD_FINAL.pdf Biomechanical testing of walking footwear and gait
https://pdfs.semanticscholar.org/8457/1cf10d6ef0f3797a83d64a341eed5d01eb55.pdf Brazilian study on Diabetes and impact of wearing incorrect size of footwear
https://academic.oup.com/ajcn/article/80/3/752/4690556 Vitamin D and Calcium and increase in bone density/decrease in falls
https://www.everydayhealth.com/foot-health/nutrition-and-your-feet.aspx diet and foot health
http://www.oldbridgefootdr.com/index.php/featured-articles/item/287-the-relationship-between-diet-and-foot-health
https://www.everydayhealth.com/foot-health/flip-flops-the-most-dangerous-shoes-you-can-wear.aspx dangers of flip flops
http://www.scielo.br/pdf/ramb/v62n8/0104-4230-ramb-62-08-0789.pdf Older people and ill fitting footwear
https://jfootankleres.biomedcentral.com/articles/10.1186/s13047-018-0250-9: Orthotic provision across podiatry, physio and orthotists
http://eprints.leedsbeckett.ac.uk/2664/6/BridgenPerceptionsMSc_Journal_article.pdf
Overlap between physio and podiatry
Older people and extra depth footwear to address pain:
https://www.oarsijournal.com/article/S1063-4584(12)00862-X/pdf Osteoarthritis, foot surgery and footwear
http://usir.salford.ac.uk/41223/ Ageing, obesity, diabetes and foot health
https://onlinelibrary.wiley.com/doi/full/10.1002/art.24733

# Appendix 1: links and further information

Women, foot pain and footwear https://jfootankleres.biomedcentral.com/articles/10.1186/s13047-018-0265-2 Women and foot problems due to ill fitting shoes https://www.correcttoes.com/foot-help/modify-shoes-better-fit-feet/ athletic shoes and gender https://www.england.nhs.uk/wp-content/uploads/2017/01/ahp-action-transform-hlth.pdf Role of AHPs in health transformation https://onlinelibrary.wiley.com/doi/full/10.1002/acr.20582 footwear, gait and gout https://www.health.com/pain/top-ball-arch-foot-pain-causes-relief Causes of and remedies for foot pain https://www.betterhealth.vic.gov.au/health/healthyliving/childrens-feet-and-shoes Child foot health https://philmaffetone.com/kids-shoes/ Child foot health https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5989380/ : how CCGs and middle managers fail to understand or value foot health: arthritis pathways and podiatry https://jfootankleres.biomedcentral.com/articles/10.1186s13047-018-0250-9 : Provision of orthotics https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5989380/ : Podiatry /Physio and access for those with arthritishttps://www.google.co.uk/search?source=hp&ei=FXeOW-2PJMuCgAa-o7-ACw&q=scholarly+articles+on+whether+podiatry+was+undertaking+MSK+physio+tasks+prior+to+new+eligibility+criteria&oq=scholarly+articles+on+whether+podiatry+was+undertaking+MSK+physio+tasks+prior+to+new+eligibility+criteria&gs_l=psy-ab.12...3145.34420.0.36754.108.106.1.0.0.0.226.9006.76j24j1.101.0....0...1c.1.64.psy-ab..6.42.4246.0..0j35i39k1j0i131k1j0i22i30k1j0i13k1j0i13i30k1j33i21k1j33i22i29i30k1j33i160k1.0.v-ILaprH-po http://eprints.staffs.ac.uk/2256/1/BRANTHWAITE%20H%20-%20PhD%20by%20PW%20-%20final%20e-thesis%20%28Helen_Branthwaite_Complete_Phd%29.pdf Fashion vs function and child foot health

# Appendix 1: links and further information

"Females are 40% more likely to report significant foot pain than men (Hill et al., 2008). The fit and style of the shoe related to the dimensions of the wearer's foot are highlighted as being the most significant in the development of foot pain in females (Au and Goonetilleke, 2007). The difference in incidence between gender is not fully established yet fashion and styling of female shoes is often thought to be most significant. Therefore, frequent use of an irregular ill-fitting styled shoe that compresses the foot into a smaller dimension in younger females could significantly contribute to the development of related foot pathologies observed in older females. Education of footwear choices made earlier in life could alter the incidence of disabling pathologies seen in elderly patients.

**1.3 Fashion versus Function**

Fashionable footwear commenced as far back as the Roman era with reports that Julius Caesar wore boots with golden embossed soles when out parading on ceremony. The styles and trends of shoes have evolved over time but have also shown a cyclical and repetitive nature regarding what is considered fashionable. Poulaines, originally thought to be a symbol of wealth and sexuality, were worn as far back as 1300 and have been resurrected frequently throughout the ages appearing in the 1960s as the well-known Winkle Picker (McDowell, 1989). This pointed styling has often been thought to be the reason why shod communities have a higher prevalence of hallux adducto varus compared to unshod communities as the foot is persistently squashed into a smaller area (Ferrari et al., 2004). Yet, the forgotten purpose of the shoe as a protective layer between the ground and the foot is demonstrated, with 44% of women being prepared to wear painful shoes to look fashionable (Phelan, 2002). However, it is not known if all footwear choices made by women are based solely on fashion grounds or if function, comfort, purpose and cost are equally considered when buying shoes. Similarly, it is also not known what mechanical effect popular everyday footwear choices have on foot function.

Previous work has not looked at what shoes people choose and therefore footwear advice to get people to change habits has been limited. This published work assists a clinicians understanding of the influences style and image have on footwear choice and how these factors should be considered when promoting footwear changes amongst patients. From the outcomes of these 2 publications further work has already commenced to advance this questionnaire with a group of people who suffer from foot pain to assess if their choices are different. Developing a focus group prior to data collection and running a pilot study has improved the structure and content of the questionnaire and data collection. This has been implemented in further work developed by our research group.1

# Appendix 1: links and further information

**2.3 Results and Discussion**

**2.3.1 Sports Shoe Choices**

Initially it was thought that sports and exercise students would purchase the trainers they wore based on the technology promoted by the sports company. However, the emphasis for choice placed by respondents was heavily weighted towards the colour and brand of the shoe over the function and performance features marketed by the manufacturer. Findings from this questionnaire were surprising and strengthened the existing research knowledge, demonstrating the need for more detailed inquiry. The findings also drove further thoughts as to why people choose the shoes they wear and helped focus the overall aim of this thesis specifically when considering what influences people when purchasing everyday shoes. Furthermore, the results from the sports science students purchasing athletic shoes were based on image only and ignored the functional element of the shoe. This provoked thought as to whether the popular and fashionable unstable shoes were an image item or actually altered foot function The main results indicated that young females choose their shoes based on the activity they are doing and choices are strongly related to the comfort and feel of the shoe. The most popular shoe of choice for everyday wear was the flat ballet pump shoe, with a heeled shoe being worn for occasions and an UGG® boot for warmth. Footwear makes this group feel happy and cheerful and has a positive impact on self-esteem; therefore footwear plays an important role in image and positivity for young females.

**2.3.2 Everyday shoe choices**

The main results indicated that young females choose their shoes based on the activity they are doing and choices are strongly related to the comfort and feel of the shoe. The most popular shoe of choice for everyday wear was the flat ballet pump shoe, with a heeled shoe being worn for occasions and an UGG® boot for warmth. Footwear makes this group feel happy and cheerful and has a positive impact on self-esteem; therefore footwear plays an important role in image and positivity for young females. Image and fashion persistently dominate the choices made when purchasing new shoes and should be considered when clinical footwear advice is distributed. Athletic footwear designs are constantly being altered with current trends and colours, however it appears that the functional element of footwear design are mainly ignored by younger student consumers.

Footwear fit and measurement, as well as function of the shoe, was not considered as important when buying shoes. None of the subjects had a foot measurement prior to buying shoes and would often move around sizes to make an acceptable fit. Measuring feet of children is deemed as a critical job of a parent and the type of shoe worn is portrayed as essential for a good foot structure (Davies et al., 2014).

# Appendix 1: links and further information

It is unknown at what point society stop measuring children's feet, the mean age of this sample was 17 years and nobody considered foot measurement when purchasing new shoes. The lack of attention to sizing could in fact lead to the wrong size of shoe being worn for a large proportion of someone's life and could therefore be the main source of pain in older adults. It is well documented that elderly people wear a shoe that is too small for them (Frey et al., 1993, Burns et al., 2002). This could have resulted from a life time of not measuring the foot and assuming a size that was last measured in childhood. The results from this questionnaire also suggest that when buying a shoe little thought is given to the implications of wearing a shoe that is too tight, that the shoe may alter gait pattern and cause foot pathology. The choice of shoe seems only to be led by fashion and little individuality existed amongst the group with the majority of subjects choosing the same footwear styles regardless of foot size, shape and fit. This culture of image and fashion seen in younger generations who 'follow the crowd' may also play a significant role in the development of footwear-related pain in the elderly, as foot shape
and anthropometric data remain high in variance amongst populations, yet the availability of varying footwear shape and style for people to buy remains constant.

**2.3.3 Critique**

Collection of data solely by questionnaire may have limited the breadth of discussion and data collected from these studies. The structure of open and closed questions may have prohibited the expression of emotion regarding footwear choice and in-depth descriptions could have been lost in the design of the questions used. Developing further methods of data collection with interviews and focus groups could have expanded opinions and discussions relating to what influences footwear purchases.
However, the results have generated some baseline data to expand and advance research into footwear choices, because the role personal preference plays on the development of foot pathology is still thought to be significant. A recent publication on footwear choice in the elderly showed that aesthetics and comfort were still the most important factors when looking for new shoes (Davis et al., 2013). The importance of body image, even in the later years of life, should be emphasised to designers when they are making comfort, therapeutic and functional shoes for the general population to buy on the high street."

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/397429/Improving_community_services.pdf
**Healthwatch Barnet**
http://www.healthwatchbarnet.co.uk/sites/default/files/uploads/experiences_of_podiatry_services_in_barnet_23rd_january_2018_final.pdf

# GLOSSARY of Abbreviated Terms

A&E: Accident & Emergency (now known as ED or Emergency Department)
CCGs: Clinical commissioning groups are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.
COPD: Chronic Obstructive Pulmonary Disease
DI: Discovery Interviews; a qualitative method comprising one-to-one face-to-face semi-structured interviews https://www.england.nhs.uk/improvement-hub/publication/a-guide-to-using-discovery-interviews-to-improve-care/
DNA: Did not Attend
ELFT: East London Foundation Trust: Provides a wide range of community and inpatient services to children, young people, adults of working age, older adults and forensic services to the City of London, Hackney, Newham, Tower Hamlets, Bedfordshire and Luton.https://www.elft.nhs.uk/
EPCT: ELFT Tower Hamlets Enhanced Primary Care Teams
GPCG: GP Care Group
FH: Foot Health
LA: Local Authority
LD: Learning Disabilities
MH: Mental Health
MS: Multiple Sclerosis
MSK: Muscular Skeletal
NICE: National Institute for Clinical Excellence
PET: Patient Experience Team
PSHE: Personal Social Health and Economic Education
https://www.pshe-association.org.uk/campaigns
REAL: a group for disabled and non-disabled people in Tower Hamlets to make change happen www.real.org.uk
RLH: Royal London Hospital

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## Contact

**GP Care Group Patient Experience Team**

**www.gpcaregroup.org/your-health-services/patient-experience-team/**

**Contact the team:**
**thgpcg.patientexperience@nhs.net**