AUTUMN 2022
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THE SMAE INSTITUTE™

THE JOURNAL OF

Podiatric Medicine

For the Private Practitioner

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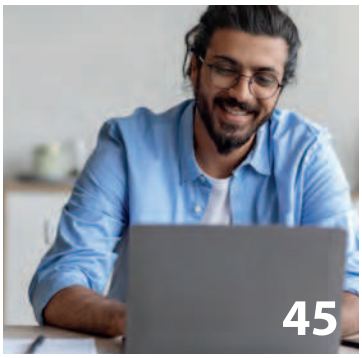

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For advertising information contact our advertising manager on:

T: 01628 621100
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Editorial Address:

The SMAE Institute
The Journal of Podiatric Medicine
The New Hall
149 Bath Road
Maidenhead
Berkshire SL6 4LA

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Editorial

THE SMAE INSTITUTE™

At the time of writing our editorial, we are deeply saddened to learn of the death of Her Majesty the Queen. Throughout her 70-year reign, her devotion and commitment were unparalleled. We offer our deepest condolences to His Majesty King Charles III and all of the Royal Family. May she rest in peace.

We have now thankfully left the extreme summer heatwaves behind us and we hope the severe heat did not affect you or your businesses too much. We are already seeing the signs of autumn, with the stunning colours of the turning of the leaves. The MET office recently shared some interesting facts on Autumn and we share some of these below:

The chemistry of colour: *Chlorophyll is the chemical which makes tree leaves green and as it declines other chemicals become more prominent in the leaves. These are responsible for the vibrant ambers, reds and yellows of autumn. The chemicals responsible are types of flavonoids, carotenoids and anthocyanins. Did you know some of these chemicals are the same ones that give carrots (beta-carotenes) and egg yolks (luteins) their colours?*

Autumn and Fall. *We typically think of 'fall' as the North American version of the word 'autumn', but it was in fact in widespread usage in England until relatively recently. Originally a shortening of the phrase fall of the leaf, the phrase was common in England in the 17th century. The word autumn entered English from the French automne and did not become common usage until the 18th century.*

If you would like to read more you can do so here: www.metoffice.gov.uk/weather/learn-about/weather/seasons/autumn/autumn-facts

We are delighted to finally be hosting our Summer School in the Fall. We look forward to seeing you there for what promises to be a great event. Full details of our 2023 events will be published in due course. We have a number of workshops running through until the end of this year, which are always well attended, especially now that there is the option to attend in person or via Zoom. This mixed method of hosting workshops has been very successful and so we plan to continue this format into 2023.

As we approach the final months of 2022, we are delighted to hear our members report good growth in their practices; it is such an enjoyable profession where you can do the work you enjoy and where patients reap the benefit of the work you provide. This is so important and personally very satisfying to us all.

A little reminder for you all – the paper £20 and £50 notes are no longer legal tender so cannot be used in shops or to pay businessess. These paper notes are being replaced with new polymer ones which are considered more durable. Many UK banks will accept these paper notes from customers and some Post Offices may also accept these paper notes as a deposit into any bank account you can access with them.

As we move into the final months of the year, we hope the weather will be kind to us all and we look forward to seeing you at our Summer School in the Fall.

Mike Batt
Joint Principal

Nicky Batt
Joint Principal

Submission of articles

Content of submitted articles should be Podiatry or Foot Health related. Please ensure you include your full name, post nominals and a photo of yourself.

Please include references to any books or papers mentioned in your article.

Mental Health

Part I – Awareness and Appreciation of Mental Health

By Tracey O'Keeffe
MA (Education), BSc (Critical Care), RN, MAFHP, MCFHP

Programme Lead - Diploma in Foot Health, The SMAE Institute

PHYSICAL HEALTH IS OFTEN VISIBLE, BETTER UNDERSTOOD AND ACCEPTED. MENTAL HEALTH, ALTHOUGH BECOMING MORE ACCEPTABLE IN SOCIETY, CAN STILL CARRY STIGMA AND CAN ALSO BE POTENTIALLY INVISIBLE TO ONLOOKERS

INTRODUCTION

This is the first paper in a short series looking at mental health. As foot health clinicians we work with individuals with all different health problems. Some may be physically well but struggle more emotionally, whereas others may battle physical co-morbidities but appear to be coping well psychologically with their conditions. It can be difficult sometimes to understand everyone's own challenges. Changes to mental health in particular can bring unique and demanding issues. Physical health is often visible, better understood and accepted. Mental health, although becoming more acceptable in society, can still carry stigma and can also be potentially invisible to onlookers. This compounds the situation for the person and, indeed, for those around them who wish to help. With mental health problems affecting around one in four people at some point in their life (Mental Health Matters 2022), it is very unlikely that we will avoid coming into close contact with someone experiencing psychological challenges, be it ourselves or others.

This series of papers aims to explore mental health to create greater understanding of how it can affect us as well as our clients. By gaining knowledge we may be better placed to help ourselves and to work clinically to support those we care for. The first paper will look at broad concepts of mental health and then the series will continue by considering specific conditions as well as progressing on to self-harm and suicide. It will finish by focusing on health coping strategies and creating a lifestyle to support positive mental health.

WHAT IS MENTAL HEALTH?

The words "mental health" can conjure up different meanings for different people as they hear them. For some, it will feel positive with an emphasis on "good" mental health and how that resonates with them. For others, the immediate reaction will be one of negativity and with a focus on mental health problems that cause distress and an inability to function day-to-day. The way we hear and perceive these words can be due to our own life experiences, our knowledge or perhaps preconceptions and misconceptions.

The World Health Organisation (2018) define mental health as a "state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community". This creates a feeling that being mentally "well" is represented by how the individual deals with the world around them and how they fit in with that environment. An earlier definition from the Department of Health (DH) (2011) states that mental health is "a positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment. Levels of mental health are influenced by the conditions people are born into, grow up in, live and work in".

Different people will view these two ideas from their own perspective, but commonalities are evident. A sense of belonging and being able to cope is shared between them, but the second one also acknowledges some of the influencing factors that can affect mental health. By understanding these there can arguably be greater acceptance of differences between people and the way they react to situations. This second quotation comes from the paper "No Health Without Mental Health" (DH 2011) which aimed to raise awareness of the importance of mental health for both psychological and physical well-being.

The first definition comes from the World Health Organisation (2018) as they tried to further build on the DH (2011) paper and improve the way mental health is viewed and how people and services respond to it. Figure 1 summarises some of the key points they emphasis as well as the definition above.

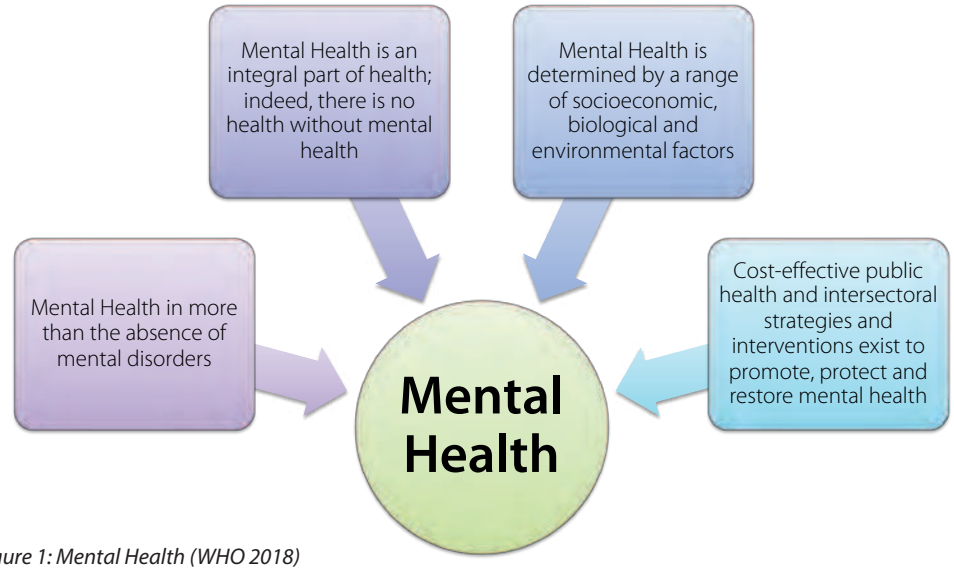

Figure 1: Mental Health (WHO 2018)

FOCAL ELEMENTS OF MENTAL WELL-BEING

In exploring mental health and what it means, it is perhaps useful to consider some focused statements and how these may be influential in terms of total well-being. Mind (2017a) suggests that having good mental health, a sense of well-being, enables us to live the life we want and to be able to react and feel in such a way to make that happen. The following five areas may be elements which enable individuals to experience mental wellness.

The ability to deal with everyday life and its demands

"Everyday life" for each person may be very different. This can fluctuate depending on circumstances and for some dramatic and life-changing events can happen, often in quick succession. As well as adjusting to those events, each individual will have a unique "package" of life around them. Influencing factors can include housing, finance, work, family and health. The ways these all fit together around the person will determine in part how their everyday life looks and feels. An ability to accept and work with those elements can perhaps impact on how someone is able to cope with their experience of life. One area to consider here is also how different people react to stress. The Stress Curve (see Figure 2) has been in existence since 1908. It demonstrates the need for stress as a stimulus for action. Often, we hear the word "stress" and think of it as negative but its actual meaning is "the non-specific responses of the body to any demand for change" (Seyle 1965). What the curve shows is how positive stress, or "eustress", enables us to reach our optimum performance levels. Becoming "distressed" however, with an overload of stress, tips us over the brow of the curve and into possible burnout. The way individuals feel and work with stress will vary.

OFTEN, WE HEAR THE WORD "STRESS" AND THINK OF IT AS NEGATIVE BUT ITS ACTUAL MEANING IS "THE NON-SPECIFIC RESPONSES OF THE BODY TO ANY DEMAND FOR CHANGE"

"Stress"

(as it is viewed by most people)

A physical, mental and emotional response to feeling threatened or under pressure in daily life.

Temporary or Ongoing

Physical effects: blood pressure, heart rate, muscle tension and insomnia

Causes: environment, relationships, workplace, finance, isolation

Figure 2: The Stress Curve

Being part of the community and society as well as forming and maintaining relationships

It is evident from the earlier two definitions of mental health that a strong emphasis is on connecting with other people and contributing to society in a way that feels meaningful to that individual. Humans have always lived with others and, although some people seem to prefer isolation and their own company, a sense of belonging can feel very supportive creating a feeling of security and being cared for. Of course, relationships of any sort can also bring complications and challenges, but it is the concept of connecting and linking which can add meaning to life. Seppala (2012) suggests that as well as being likely to have poorer physical and mental health, those with lower social connections can have a greater likelihood for increased isolation due to an inability to interact in a way that is socially acceptable. This leads into the idea of participation in society being important. Again, there may be variations in how essential this is to people, with some needing to have a working role, join groups and feel as if they are contributing whilst others may be more self-contained, achieving their personal sense of belonging from more internal recognition. The important factor is for each individual to recognise their own personal needs.

Feeling comfortable with the purpose of life and the world

The purpose of our existence is a line of philosophical enquiry that some people consider and dwell on more than others. Making sense of life can come from a religious set of beliefs but this does still not guarantee a sense of contentment or calmness about experiences that occur. A strong faith-based ideology about the world can enable some individuals to reframe their lived experience as they journey through life, but others may still struggle. This could be due to catastrophic events or personal loss, but it can also occur if life feels "flat" and pointless. Arguably for those who do not have a faith, this can be a greater potential risk as they try to understand why they exist and what the overall purpose is of life. Conversely, a lack of belief can also provide a sense of freedom to live for today and for some this can be liberating. In essence, this is so personal and every individual will be unique in how they perceive their reason for being, for living and for the way the world is around them. Interestingly, Fletcher (2004) highlights the way a shared belief can create social connections and human interactions which may also be influential in terms of mental health, rather than just the belief itself.

THE WAY WE RESPOND TO EMOTIONS CAN BE DEPENDENT ON A NUMBER OF FACTORS WHICH INCLUDE GENDER, UPBRINGING, PREVIOUS EXPERIENCES, AND EXPECTATIONS, AS WELL AS ANY INFLUENCING FORCES IN OUR LIVES AT THAT TIME.

Understand, process and express internal emotions and feelings alongside those of others

Emotions and feelings can be positive and uplifting or negative and destructive. Being able to recognise them and how they impact us can mean we are more able to respond appropriately. It may also be that we can share the joy of good feelings as well as reach out for support if the more challenging ones are overwhelming us. The way we respond to emotions can be dependent on a number of factors which include gender, upbringing, previous experiences, and expectations, as well as any influencing forces in our lives at that time. The American Psychological Association (2022) suggest that anything perceived as significant to someone can trigger a pattern of complex reactions and emotions. Indeed, the University of West Alabama (2019) suggest there is a sequence or different parts to emotions, namely subjective experiences, physiological responses, and behavioural responses. The implication here is that emotion is a very "heavily-packaged" commodity which can be difficult to confront, unravel and manage. An inability to do this can result in threats to health for some individuals.

Being able to make decisions that feel right based on clear thinking and problem-solving

This follows on naturally from the previous discussion point. An inability to understand and process emotions can make decision-making even more challenging than it potentially needs to be. Indeed, Lerner et al. (2014) suggest that emotions can be powerful to the point of being pervasive or harmful in terms of their influence on decision-making. They stress, however, that they are also at times beneficial. Similarly, a feeling of uncertainty about life and its purpose or a lack of connection with the world around can change the way an individual views problems. Consequently, being able to solve them can be thwarted by confusion and questions driven internally which cloud rational or useful thought. It is also worth noting that decisions made by different people may not always be recognised as wise or sound by others. This can also create conflict either between people or indeed trigger a myriad of emotional responses from an internal perspective as the person tries to defend the decision they feel is best for them. However, thinking clearly, solving problems and making decisions can also be supported by external support and, for some, this is a key enabling factor.

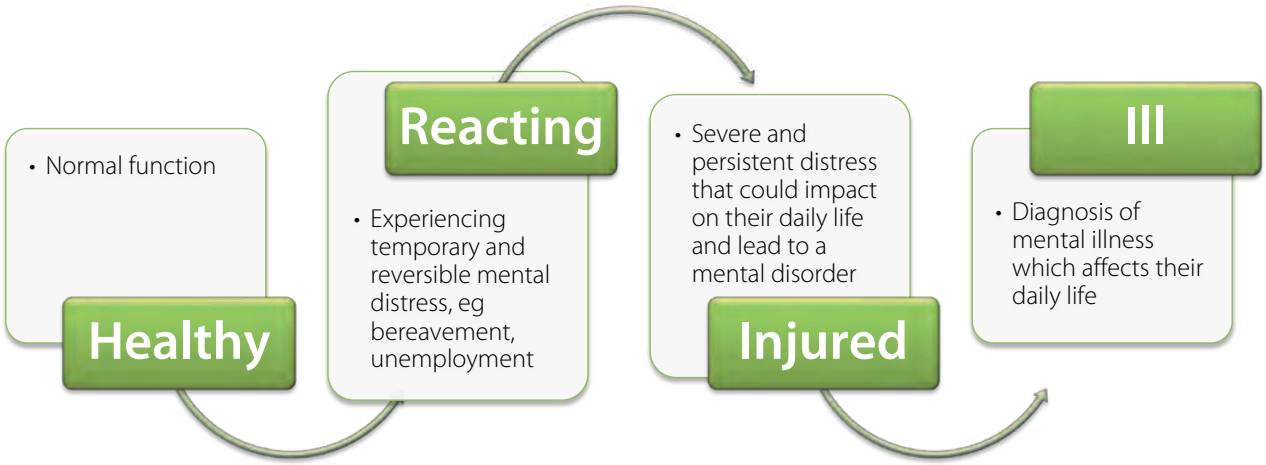

Figure 3: The Mental Health Continuum

Having touched on some of the elements of mental well-being above, it is even more evident that creating and maintaining mental health is not easy, straightforward or linear. It is complex and multifaceted with many different influencing factors.

THE MENTAL HEALTH CONTINUUM – a continuous spectrum

The experience of mental health or ill-health can be seen as a spectrum or a journey or a scale. It is known that mental health fluctuates for each individual and Mental Health Matters (2022) discuss the Mental Health Continuum (see Figure 3). This model acknowledges the variations that can occur and also that people can transition back and forth from wellness to illness. This can occur with or without a diagnosis of mental illness.

The continuum suggests that any individual may move from a state of healthy to ill during their life. The concept of "healthy" on the far left describes a person who experiences normal mood swings, feeling low at times and more positive at others. They are able to cope with challenges as they come up and they have a sense of internal confidence that allows them to function alongside others in a generally positive way. Depending on their physical health and ability, they are active as well as having a sleep pattern which gives them rest and restoration. This start point could also be considered "normal functioning".

Moving on to "reacting", an individual may be experiencing common distress. Emotions may be starting to rise, including feeling sad and nervous or impatient and irritable. They may be seeing changes to sleep patterns, often struggling to get off to sleep at night. An ability to relax is often evident. Decision-making and productivity can begin to be affected with possible procrastination and forgetfulness which may be further compounded by worrying. The worry can be triggered by intrusive thoughts which cause distraction, leading possibly to a decreased involvement in their normal social activity. One important thing to note at this point, is that the distress felt is usually reversible and can often be managed by the individual themselves or with their pre-existing social support networks.

In looking at the third section, the picture moves away from a person who is in a transient state of experiencing mental health problems. "Injured" suggests significant functional impairment. The individual may have very disturbed sleep patterns, either unable to fall asleep or indeed feeling like they want to sleep all the time as a way of avoiding reality. The emotions experienced move to a deeper level where sadness can transition to a sense of hopelessness. Episodes of tearfulness, anxiety and anger may be present and their can also be a sense of worthlessness. Processing of intrusive thoughts becomes more challenging and can leave the person preoccupied and withdrawing from social situations completely. For some, external intervention is vital as this stage is reached to avoid further movement along the continuum.

Notes:

The final element is that of "ill" which is where there is definite functional impairment and there may also be a diagnosis of a clinical disorder. The feelings experienced are persistent, severe and disabling. Anxiety levels may be high with associated panic attacks or there could extreme depression and a sense of being overwhelmed. Thought processes can alter to a point where the individual loses the ability to connect with reality and this is compounded further by sleep problems and constant fatigue. At this point, the individual may also experience suicidal ideations. This may stay as internalised thoughts or it could develop into actual self-destructive behaviours and actions. Intervention from professional services is essential at this point.

One very important concept to grasp with the regard to the Mental Health Continuum is that it is not solely based on the confirmation of a clinically diagnosed mental health disorder. An individual with a mental health disorder can spend much of their time being "healthy" if they understand their condition and if it is well-managed. A seemingly "well" person with no known history of mental illness can rapidly move from healthy to ill if they experience threats and challenges to their well-being.

RISK FACTORS FOR MENTAL HEALTH PROBLEMS

The reason people experience mental health problems is complex. There are many causes and often it is a group of factors working together which can cause someone to experience poor mental health (Mind 2017b). Figure 4 highlights some of the possible risk factors for mental health problems.

It can be seen from this that fluctuations or deterioration in mental health can stem from changes to an individual's environment and the life around them. This can be from unexpected negative, traumatic life events such as bereavement or loss, but it can also be positive experiences such as marriage or childbirth. Although often positive, these experiences can result in fundamental alterations to the person's life, the way them seem themselves and their relationships. Furthermore, early childhood journeys through adversity, also known as Adverse Childhood Experiences (ACEs), increase the risk of both psychological and physical poor health later in life (Nelson et al. 2020). Mental wellbeing can also be affected by surroundings

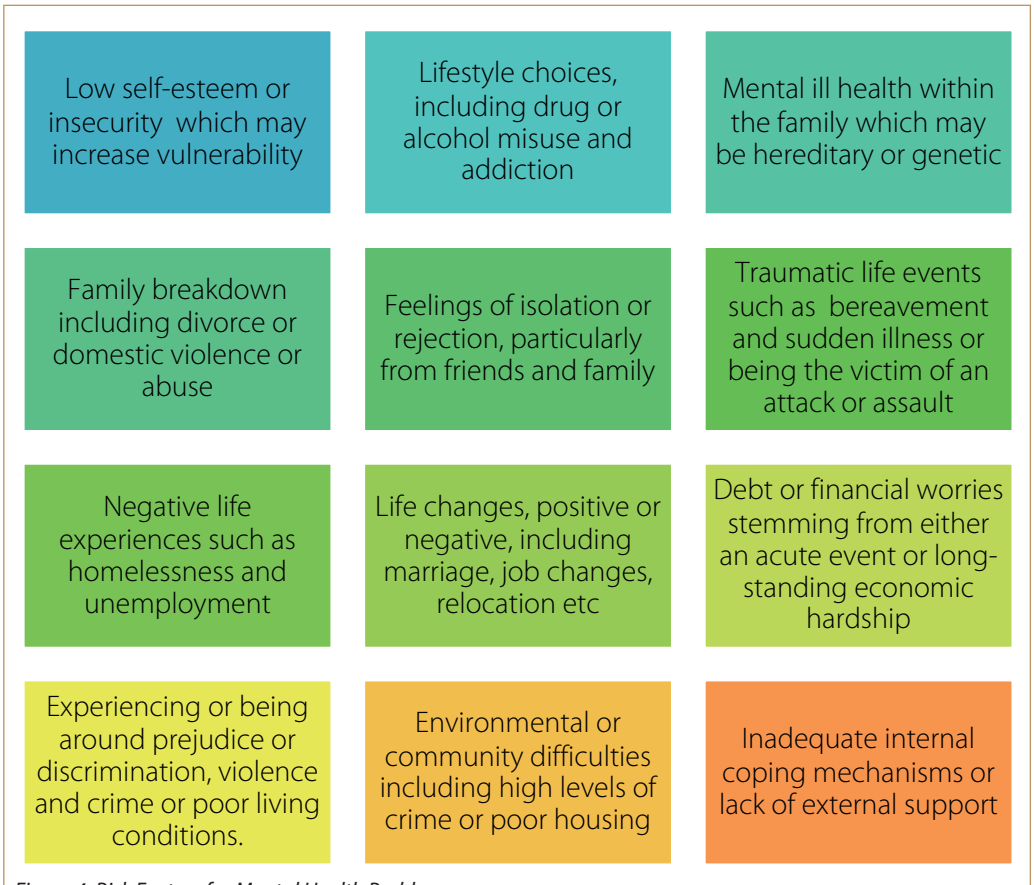

Figure 4: Risk Factors for Mental Health Problems

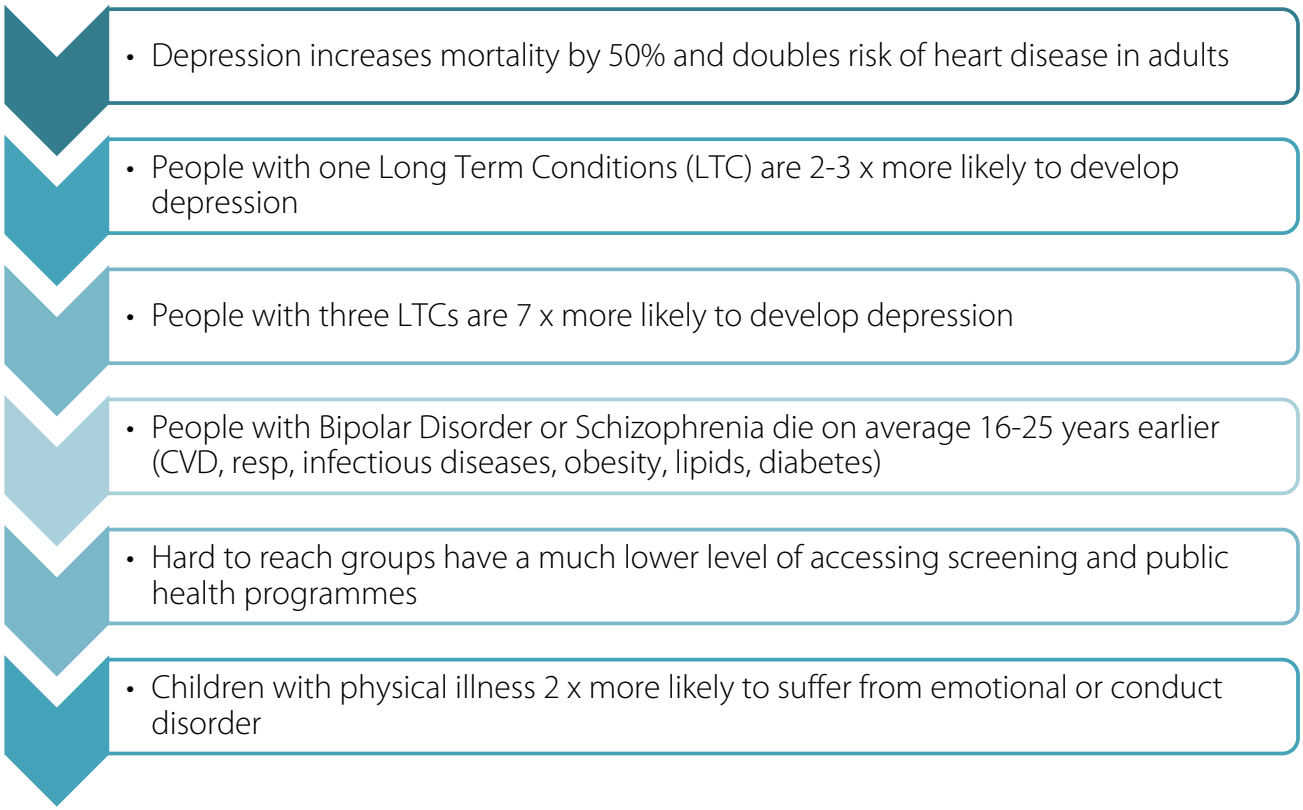

Figure 5: Connections between physical and mental health

including living in areas of deprivation or poverty, poor housing, or a sense of feeling unsafe in their living environment (Public Health England 2019). Safety can be compromised as well by any type of abuse (in any form) or indeed from uncontrollable external factors such as sudden loss of employment which can result in a feeling of insecurity, financial worry and loss of role.

There are also risk factors to consider which be inherent within each person. These include genetic elements or family history of mental illness, a poor sense of self-esteem which may be long-standing, or physical comorbidities which can impact on or go hand-in-hand with mental ill-health (explored later in this article). Mind (2017b) also highlight the risk of other physical causes such as physical trauma including head injury. As well as physical stresses, longer-term effects can be seen from psychological trauma causing post-traumatic stress disorder, such as military combat, violent crime, or any life-threatening event.

Although it is difficult to limit the possible number of risk factors, one final area of consideration is that of lifestyle choices. This can include the use of drugs and alcohol which can have a detrimental affect on mental wellbeing. By choosing this route an individual may transition into mental ill health, but it is also worth understanding that often the picture is more complex with pre-existing mental illness diagnosis being a trigger for the substance misuse and subsequent addiction. The term "dual diagnosis" indicates a situation where an individual has two or more co-occurring conditions or disorders, one of which usually being addiction. The Dual Diagnosis Hub (2022) stress that, although the two occur together, the order in which they start may vary. One of the problems with this group of individuals is that service provision does not always fit their unique needs, and this can compound the problem as they fail to successfully access the help required (Lowe and Abou-Saleh 2014). For many, there can be stigma attached particularly if the nature of addiction and substance misuse is not understood.

CONNECTIONS BETWEEN PHYSICAL AND MENTAL HEALTH

It is now well recognised that there are strong links between physical and mental health. Glew (2016) suggests that there is a bi-directional relationship implying that mental health problems can cause physical manifestations and vice versa. Naylor et al. (2016) highlight further evidence. In consideration of individuals with long-term physical ill-health, there is a high rate of mental ill-health as well. For those with severe mental illness, poor physical health runs concurrently and produces a reduced life expectancy. Naylor et al. (2016) also raise concerns about the services to support these complex individuals saying that many people with medically unexplained symptoms are poorly

Notes:

managed and that there is a reduced support for those that experience psychological impact relating to physical problems. Figure 5 outlines further statistics related to the connections.

It can be seen that different groups of individuals may access services less and this can compound other health issues. Lack of engagement with screening services can impact on early treatment for conditions such as cancer, as diagnoses can be missed. Nicolle (2022) also highlights how poor mental health can lead to unhealthy lifestyle choices in terms of diet, exercise and smoking. As well as this, The Royal College of Nursing (2022) suggests that there are possible genetic factors. Those with a severe mental illness may have changes to cholesterol levels, elevated blood glucose as well as changes to lung function. For health care clinicians, understanding the links between physical and mental wellness is vital. People need to be treated holistically to ensure all elements of their needs are acknowledged and cared for, whether that be direct intervention at that point if applicable, or onward and timely referral to appropriate specialist services. Just by recognising those needs and acting compassionately and swiftly, further deterioration may be prevented and the person helped to live a fulfilling and potentially safer life.

CONCLUSION

This first paper has just touched the surface of mental health. The subject is vast and as we progress through this series we will examine some of the clinical conditions, how they manifest and how they affect the person. We will consider how we may respond appropriately and in a helpful way to ensure we are not only working within our duty of care, but also reacting in a manner that gives the individuals concerned confidence and trust in us personally and professionally.

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Put your selected nominee forward for 'Practitioner of the Year 2022 Award'

We want to reward those members who continue to develop themselves professionally, go the extra mile, and enjoy their role within the community. The winner of "Practitioner of the Year 2022" shall receive a place at one of our 2023 CPD Events (Summer School or Annual Conference) and a certificate, along with publicity on the SMAE Institute Website and in the 2023 Quarterly Journal. The runner up shall receive a CPD of their choice, from our Workshop or CPD@Home range.

The nomination process is straightforward and can be completed easily by an involved third party (a colleague, or client). The winner will be announced in Spring 2023 Journal.

HOW THE NOMINATIONS WORK:

- Nominees should be Members of The SMAE Institute.
- A nomination will only be accepted for a named individual or individuals.
- Third-party nominations are accepted.
- Nominations must be supported by client referees prepared to provide testimony if your nomination is shortlisted.

Let us decide who the winners are - don't count yourself out of the application process - YOU could be an award winner!

Please email the following details to Jane Rhodes at jrhodes@smaeinstitute.co.uk

- Details of why you feel the nominee/nominees deserve to be rewarded
- Yours and the nominees name and address

Previous Winners

2018 Ian Mitchell
MSSCh MBChA

2019 Trish Parker
MCFHP MAFHP

2020 Lesley Tanner
MCFHP MAFHP

2021 Trish Parker
MCFHP MAFHP

2022 WINNER
THIS COULD BE YOU!

Diploma in Local Anaesthesia

www.smae-la.co.uk

The timetable for the 2023 Diploma is as follows:

Open / Registration Day (Location: The SMAE Institute)
Saturday 18th February 2023
This is a pre-requisite for those who wish to enrol

Introductory Lectures (Location: The SMAE Institute)
Friday 19th May 2023

Module 1 (Location: e-Learning)
Begins: Monday 22nd May 2023

Module 1 Assessment Submission
Friday 18th August 2023

Module 2 (Location: e-Learning)
Begins: Monday 25th September 2023

Module 2 Assessment Submission
Friday 8th December 2023

Clinical Practice
February 2024

The **Open Day for the 2023 Cohort** will be held on Saturday 18th February via Zoom. If you are interested and would like to attend please contact Gill Hawkins at **ghawkins@smaeinstitute.co.uk** . More information about this Diploma can be found at **www.smae-la.co.uk**

Please note: Those wishing to enrol onto this course must provide evidence of registration with the HCPC.

*** Instalment Option Available**

Diploma in Prescription Only Medicines

www.smae-poms.co.uk

Our next cohort begins December 2022. More information about the 2022 cohort can be found at www.smae-poms.co.uk

Open / Registration Day (Location: The SMAE Institute)
Saturday 5th November 2022
This is a pre-requisite for those who wish to enrol

Introductory Lectures (Location: The SMAE Institute)
Friday 25th November 2022

Module 1 (Location: e-Learning)
Begins: Monday 28th November 2022

Module 1 Assessment Submission
Monday 3rd April 2023

Examination (Location: The SMAE Institute)
May 2023 (tbc)

If you are interested in the 2022 POMs Cohort, please contact Gill Hawkins at **ghawkins@smaeinstitute.co.uk** for more information and to book yourself a place on the upcoming Open/Registration Day.

Please note: Those wishing to enrol onto this course must provide evidence of registration with the HCPC and demonstrate annotation in LA on the HCPC Register.

*** Instalment Option Available**

hcpc health & care professions council

hcpc health & care professions council

Connect with us

To keep in touch and up-to-date on our latest developments, follow us on social media. You can:

Tweet us @The_HCPC
Follow us on www.linkedin.com
Find us on www.facebook.com/hcpcuk
Watch us on www.youtube.com/user/HCPCuk
Visit our website on www.hcpc-uk.org

Notes:

UK applications move completely online

This summer we moved our UK applications process completely online following a successful pilot. This is the second stage in moving all HCPC applications processes online, following international applications, which moved online in Spring 2022.

UK applicants are now able to enter their details, make their declarations and upload certified documentation all in one place, making this stage of the process easier and more streamlined. We hope this will improve the experience of applicants across the board.

The new form is supported by online UK applications guidance, available via the UK applications of our website. Applicants will need to read this, as well as the standards of proficiency for their profession, the standards of conduct, performance and ethics and the standards for CPD before submitting their application.

If an applicant requires a paper form for accessibility reasons, this can be arranged on request.

HCPC updates standards of proficiency

We have updated our standards of proficiency for the first time since 2015. The crucial changes have been made following an extensive period of engagement with a wide range of stakeholders, to seek views and develop standards in line with current professional practice.

From 1 September 2023, all registrants will have to meet the standards of proficiency relevant to their scope of practice. The revised standards set clear expectations of registrants' knowledge and ability in a healthcare landscape which has changed and evolved in the wake of the COVID-19 pandemic.

Updating the standards was a crucial component in fulfilling our purpose to promote excellence in the professions we regulate, and champion high quality care that the public can access safely and with confidence.

We will be providing a host of resources and activities which will assist different stakeholder groups prepare ahead of the implementation date.

You can find out more standards of proficiency review on our website

Top tips for completing your CPD profile

Continuing professional development (CPD) is the way in which registrants continue to learn and develop throughout their careers so they keep their skills and knowledge up to date and can continue to practise safely and effectively.

If you are selected for audit and asked to submit a Continuing Professional Development (CPD) profile, it is your chance for you to show us how much work you have put in to maintaining your CPD.

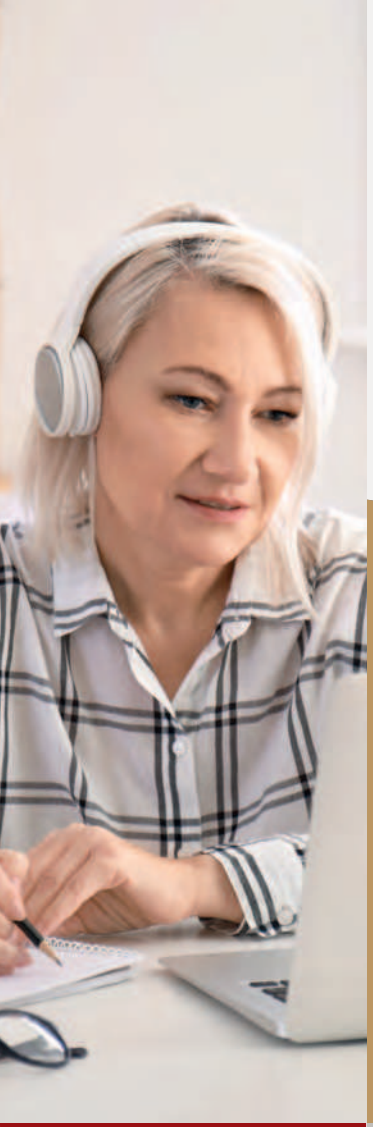
We have compiled information and guidance, along with our top tips for completing your profile CPD profile, to help make this process as smooth as possible.

You can find out more about CPD on our website

Latest updates from HCPC Chair Christine Elliott

Read the latest blogs from our Chair for updates of how the HCPC are working to reach the key decisions and initiatives.

Find out about the latest updates about the revised health and character guidance, our fitness to practise improvement programme, regulatory reform, the HCPC professional liaison service and much more on the HCPC website.



THE SMAE INSTITUTE™

BSc (Hons) PODIATRY

About the course

The SMAE Institute, in collaboration with Queen Margaret University (QMU), is proud to introduce this four-year distance based, blended elearning BSc (Hons) Podiatry course. On this course you'll gain the knowledge, practical skills and confidence that you'll need to practise as a registered podiatrist in the private sector or NHS.

This is a four-year, distance learning honours degree, at levels 7-10 on the Scottish Credit Qualification Framework (SCQF), that is designed to enable those who have successfully completed the SMAE Institute Diploma in Foot Health, which is credit rated by QMU, to progress to eligibility to apply for HCPC Registration.

Course Overview

Duration: 4 years distance learning

Start Date: September 2023

Format: Distance based, blended elearning

Fees: £3,999 per year (payment options available)

Awarding Body: QMU

Queen Margaret University
EDINBURGH
Collaborative Partner

This course will not only develop you to the standard required for eligibility to apply for HCPC registration, but will also give you the skills, attributes, clinical experience, plus personal and professional confidence to be at the forefront of the profession and to become the future influencers, managers and leaders of the profession. This course aims to develop a podiatrist who is a patient focused practitioner, reflective in all aspects of practice, and proactively engaged with learning and professional development to enhance and advance both their individual practice and their profession.

Course Structure

This course is delivered via blended e-learning, which means as a student you would be working at a distance via the internet (utilising a Virtual Learning Environment (VLE)) as well as attending lectures, practical and clinical sessions at The SMAE Institute. In addition to this, students will also attend placements in the private and third sector. Whilst most content is delivered online, lecturers will guide you through your learning and provide one-on-one and small group support throughout. Each year students will be required to attend clinical training and/or placements, and schedules.

Teaching, learning and assessment

This is a distance-based, blended e-learning course that requires dedicated hours of study commensurate with full-time learning. Each module has dedicated weekly live tutor chat sessions with the designated module leader (tutor), who is also available via personal email and telephone at scheduled times. There is also administrative support staff available online and via telephone daily. The module forums are accessible for each module to provide a virtual classroom environment and will be accessed and supported by staff and tutors alike. The assessment method varies from module to module and the majority of the course will be distance learning with some compulsory attendance. The dates of attendance required are given to students at the beginning of the course so that they can plan ahead.

Whilst The SMAE Institute is the organisation delivering your study, on this course you will be also be a student of Queen Margaret University (QMU). As such you'll be given access to their learning resources and have a QMU VLE (virtual learning environment) username and password.

Course Modules

YEAR ONE

Module Name	Module Description
Manual Handling	This module is designed to provide the student with the knowledge and skills required to develop an analytical, reflective and professional approach to implementing safe manual handling.
Clinical Studies 1	This module is designed to enable the student to acquire the knowledge and skills necessary to investigate, diagnose and manage a range of common lower limb pathologies seen in low risk patients.
Locomotory Science and Anatomy – The Foot and Ankle	This module introduces the student to the mechanical principles that underpin gait analysis and explores in detail the structural anatomy of the lower limb, with particular emphasis on the ankle and foot.
Locomotory Science and Anatomy 2 – Normal Gait	This module explores in detail the structural anatomy of the lower limb, with particular emphasis on the leg, knee and thigh as well as the gait cycle and normal developmental variants.

YEAR ONE

Module Name	Module Description
Cell Biology, Physiology and Microbiology	This module enables students to develop an understanding of the role of Podiatry and other health disciplines in the context of cell biology, physiology and microbiology. There is a focus on the structure, function and neuro-humoral regulation of the endocrine system, and its relationship to other major physiological systems as well as developing knowledge and understanding of microbial growth and survival emphasising features relevant to interactions with humans and human health.
Evidence Based Healthcare - Sourcing and selecting literature to understand and inform research	This module develops student understanding of the use of research in evidence-based health care delivery; through guided exploration of the ways in which research informs development and implementation of guidelines for clinical practice.

YEAR TWO

Module Name	Module Description
Clinical Studies 2a	This module enables a student to develop an understanding of the underlying principles of pharmacological therapy and the rationale for treatment relating to the cardiovascular, autonomic and inflammatory response. It also develops a student's theoretical knowledge and practical skills required to administer digital local analgesia (POM-A as per HCPC annotation).
Clinical Studies 2b	This module enables the student to investigate and diagnose a range of pathologies related to soft tissue and structural anomalies, and consider and demonstrate appropriate therapeutic regimes including the use of functional foot orthoses.
Pathophysiology	This module provides knowledge and understanding of the pathological processes relating to the systems covered in human physiology. It will introduce students to the concept of problem-based medicine and provide deeper understanding of physiological processes and the application to the clinical context. This module will also focus on the role of Podiatry within the broader context of multi-disciplinary care in managing patients with chronic and / or complex pathology.
Disorders and Management – Musculoskeletal conditions	The module provides the student with the necessary skills and knowledge base to diagnose and carry out effective management strategies for musculoskeletal conditions affecting the lower limb.

YEAR TWO

Professional Issues – Part 1 - Professionalism	This module prepares the student for registered practice as a Podiatrist by enabling them to critically examine and interpret the elements of professionalism within the contexts of delivering healthcare and podiatric practice. This will be considered against the backdrop of Interprofessional working,

YEAR THREE

Module Name	Module Description
Clinical Studies 3	This module develops students skills in examination, evaluation and management of the 'high risk' lower limb by developing high level psychomotor skills and by developing skills to undertake evidence based podiatric practice (in particular developing familiarity with NICE and SIGN guidelines). This module also enables students to gain experience of utilising POM-A in using digital block analgesia, and undertaking nail surgery procedures.
Locomotory Science and Anatomy 3 – The hip, pelvis, nerve supply and pathological gait	This module explores the structural anatomy of the lower limb with particular emphasis on the hip, pelvis and the motor & cutaneous nerve supply to the lower limb and helps students to develop a knowledge base and the skills required to distinguish between normal gait changes across the life cycle and pathological gait.
Disorders and Management 3	This module helps the student to develop a deep knowledge and understanding of the physical and psychosocial manifestation of systemic diseases related to Podiatric practice in association with relevant podiatric, pharmacological and surgical management through a problem based and shared learning approach. It further enables the student to critically analyse their own and other health professionals' roles, expertise and perspectives in healthcare practice in the context of lower limb pathology as well as service users' perspectives on self-care
Disorders and Management 3 – Dermatology of the lower limb	This module provides consideration of the differential diagnosis, potential impact and management of cutaneous and systemic disorders and diseases on the skin of the lower limb. It further enables the student to critically analyse their own and others' roles, expertise and perspectives in healthcare practice in the context of lower limb dermatology
Evidence-based Healthcare – Appraising the Evidence	This module enables students to develop their understanding of the importance of appraising evidence and helps them to develop their ability to constructively appraise evidence and to construct a focussed literature review.

YEAR FOUR

Module Name	Module Description
Clinical Studies 4	This module enables the student to fulfil the requirements for eligibility for HCPC registration by consolidating skills in examination, evaluation and management of the 'high risk' lower limb, to enable evidence-based practice. This module further helps the student to develop experience of new patient triage and referral, utilising POMS-S, psychomotor skills such as needling techniques, and anaesthetic techniques such as tibial block.
Disorders and Management 4 – Tissue Viability	This module enables the students to critically investigate/ study the evidence base for factors contributing to cutaneous ulceration, and the effectiveness of current management practices. It further enables the students to critically analyse their own and other health professionals' roles, expertise and perspectives in healthcare practice in the context of cutaneous ulceration.
Evidence-based healthcare – Clinical Audit	This module engages students in decision-making in the context of quality assurance, user perspectives, priorities of service delivery and practice development.
Developing Electronic Resources for Patient Education	This module enables the students to explore a topic of interest relating to patient education in Podiatry presented through electronic media for public broadcast.
Podiatric Mechanics (Elective)	This module enables the student to evaluate and apply current concepts in podiatric mechanics in the management of foot and lower limb pathology with particular reference to podiatric surgical intervention.
Medicine and Pathology (Elective)	This module enables the student to critically appreciate the clinical principles, philosophy and concepts which underpin critically relevant medical conditions and associated pathological changes in the foot.
Professional Issues – Preparation for Registration and Practice	This module provides an opportunity for students to critically consider the skills and attributes required to become an autonomous, HCPC registered private practitioner in the context of inter-professional collaborative working

Facilities / Placements

You'll consolidate your theoretical learning by working directly with patients during clinical sessions undertaken mainly at the SMAE Institute's purpose built clinic in Maidenhead, Berkshire. Some observational placements will be undertaken within specialist private practices and observational and practical placements will be undertaken in a third sector charity organisation. Academic staff will arrange and co-ordinate your placements, with the aim to be as local to the individual as possible. Where attendance is required, you will be informed of the dates at the beginning of the academic year to enable you to plan ahead.

A summary of clinical/placement attendance is detailed below, however please note that these time-frames are not specifically week blocks of time, but will be spread out across the academic year at a range of placement providers. Full details and dates are given to students at the start of the academic year.

Year One: Two weeks clinical/practical attendance

Year Two: Two weeks clinical/practical attendance

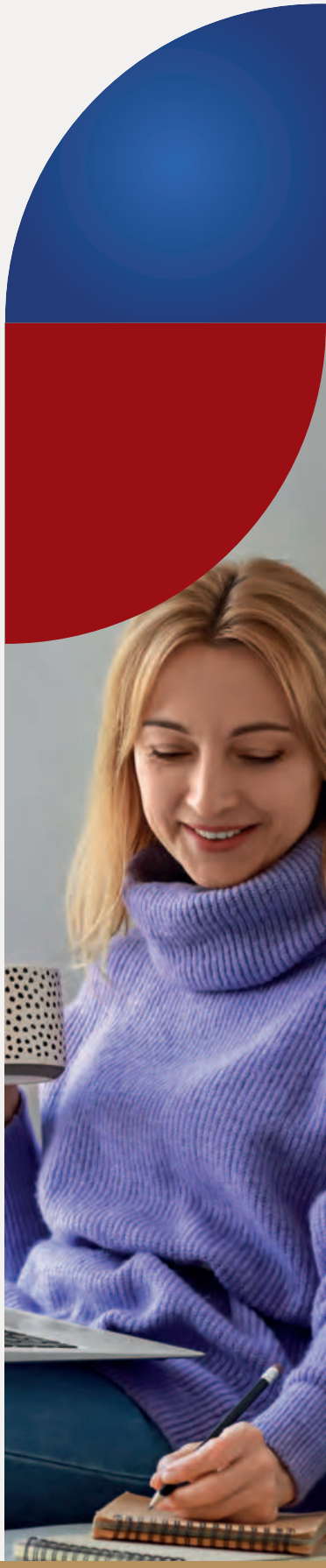
Year Three: Five weeks clinical/practical attendance

Year Four: Six weeks clinical/practical attendance

Qualification / Exit points

Successful completion of all four years will give you the award of BSc (Hons) Podiatry and eligibility to apply for HCPC registration.

In certain circumstances, a student may exit the course after completion of Year One with the award of Certificate in Higher Education (120 credits), Year Two with a Diploma in Higher Education (Assistant Practitioner – Podiatry) (240 credits) or Year Three with the award of BSc Health Studies (480 credits). Please note that by exiting the course in Year One, Two or Three, one is not eligible to register with the HCPC, only upon successful completion of Year Four and award of BSc (Hons) Podiatry entitles one to register.



Entry requirements

- The applicant has normally, within the last 5 years, completed one of the following:
  - successfully completed the SMAE Institute 60 credit diploma in foot health,
  - successfully completed the Diploma in Higher Education (Assistant Practitioner – Podiatry),
  - successfully completed the first year of a BSc (Hons) Podiatry at another University,
  - successfully completed a Foot Health course that can be mapped to the SMAE Institute's Diploma in Foot Health.
- The applicant has a current DBS certificate.
- The applicant has an up to date CPD portfolio (has attended at least one CPD event in the last 12 months and in addition can demonstrate ongoing professional development, for example, reading journal articles and applying them to practice)
- The applicant has up to date vaccination against Hep B, has had a recent eye sight test, and are encouraged to declare any disabilities (physical, mental or learning).
- The applicant has provided a suitable character reference (where the applicant is previously unknown to The SMAE Institute)
- If English is a second language the applicant has achieved an IELTS English equivalency level 6 or above (scoring above 5.5 in each section) (successful completion of the access courses outlined above would satisfy this).

Fees and funding

The course fees for this programme will be £3,999 per academic year.

Payment options (per academic year)

- A deposit of £424.00 followed by 11 monthly payments of £325.00 (0% Interest)
- A deposit of £710.00 followed by 11 monthly payments of £299.00 (0% Interest)
- One off payment (£3,999.00 per academic year)
- Sponsor (details of your sponsor would be requested)

What's included?

You may have to pay additional costs during your studies. A summary of the costs that you may be expected to pay, and what is included in your fees, while studying this course are listed here:

- DBS checks, where required, are included in the course fees.
- Access to learning resources through the virtual learning environment and the QMU library is included.
- Instruments used in clinical placements are provided by the establishment.
- Where your course includes a placement, travel costs are not included in the course fees.
- Insurance for your clinical practical placements is included.
- Clinical clothing, where required, is not included in the course fees. However, any relevant PPE will be provided to the student at placement sites.

Professional registration

This course is approved by the Health and Care Professions Council (HCPC). Successful completion enables application for registration with the Health and Care Professions Council as a Podiatrist.

Awarding body

Queen Margaret University
EDINBURGH
Collaborative Partner

Open day and admissions

If you are interested in studying this course, please contact Jane Rhodes at The SMAE Institute (degree@smaeinstitute.co.uk) who will initially send you an application form to complete to ensure eligibility. This application form will provide pre-screening questions outlining the admission criteria (set out above). If you meet the entry criteria, The SMAE Institute shall then invite you to an open day followed by an informal interview. The interview panel will consist of one of the programme co-leads, the quality assurance manager and a service user (patient). All members of the interview panel pre-agree the questions that will be asked before the interview takes place. The interview process shall consist of cross-checking the pre-screened applications to see that prospective students do indeed meet the correct entry criteria.

Following the interview the SMAE Institute shall select appropriately qualified students for offer of admission as students of the Institute/University and formally offer them a place. Should you be unable to travel to the SMAE Institute for an interview then you may be offered an online virtual interview via Zoom.

The open day for the 2023 cohort will be held virtually on 20th May 2023. To register your interest in the 2023 cohort open day please email Jane Rhodes at degree@smaeinstitute.co.uk

Motivational Interviewing: for busy clinics

"Less fuss, more trust"

By Jonathan Brocklehurst
MRCPod, BSc (Hons), DipFH, ARSM.

SMAE Lecturer

Introduction

Motivational Interviewing (MI) is a systematic and collaborative template of communication for the busy practicing clinician. The Covid-19 pandemic plus increasing demand for healthcare services equals busy clinics. The solution. MI. With loneliness (particularly in elderly demographics) on the rise and communities further isolated from regular person-to-person conversation, clinicians face increasing responsibility to facilitate for patient's interactional needs as well as their healthcare needs (Taylor et al. 2021). MI is made up of the following four approaches:

1	**Engaging**
2	**Focusing**
3	**Evoking**
4	**Planning**

Why do it?

Less fuss, more trust. That is the aim, the objective. The fluency of our appointment schedules is dependent on how we build that trust. There is no point in 'winging it' if we have a credible alternative (Barrett et al. 2018). Listening can build that trust with individuals even in a busy time schedule. The onus is on us as clinicians to ensure that we understand the best way to gage the tone and content of what the patient is saying to stencil our response. One size does not fit all. However, the underpinning principles of MI do. If we do not engage with patients, we can lose patient confidence in our services. If we also do not acknowledge and evoke patient's attitudes and thoughts from the tail of a conversation, we can risk alienating rather than motivating (Hettema et al. 2005). Momentum is vital.

THE ONUS IS ON US AS CLINICIANS TO ENSURE THAT WE UNDERSTAND THE BEST WAY TO GAUGE THE TONE AND CONTENT OF WHAT THE PATIENT IS SAYING TO STENCIL OUR RESPONSE

Patient not bothered.

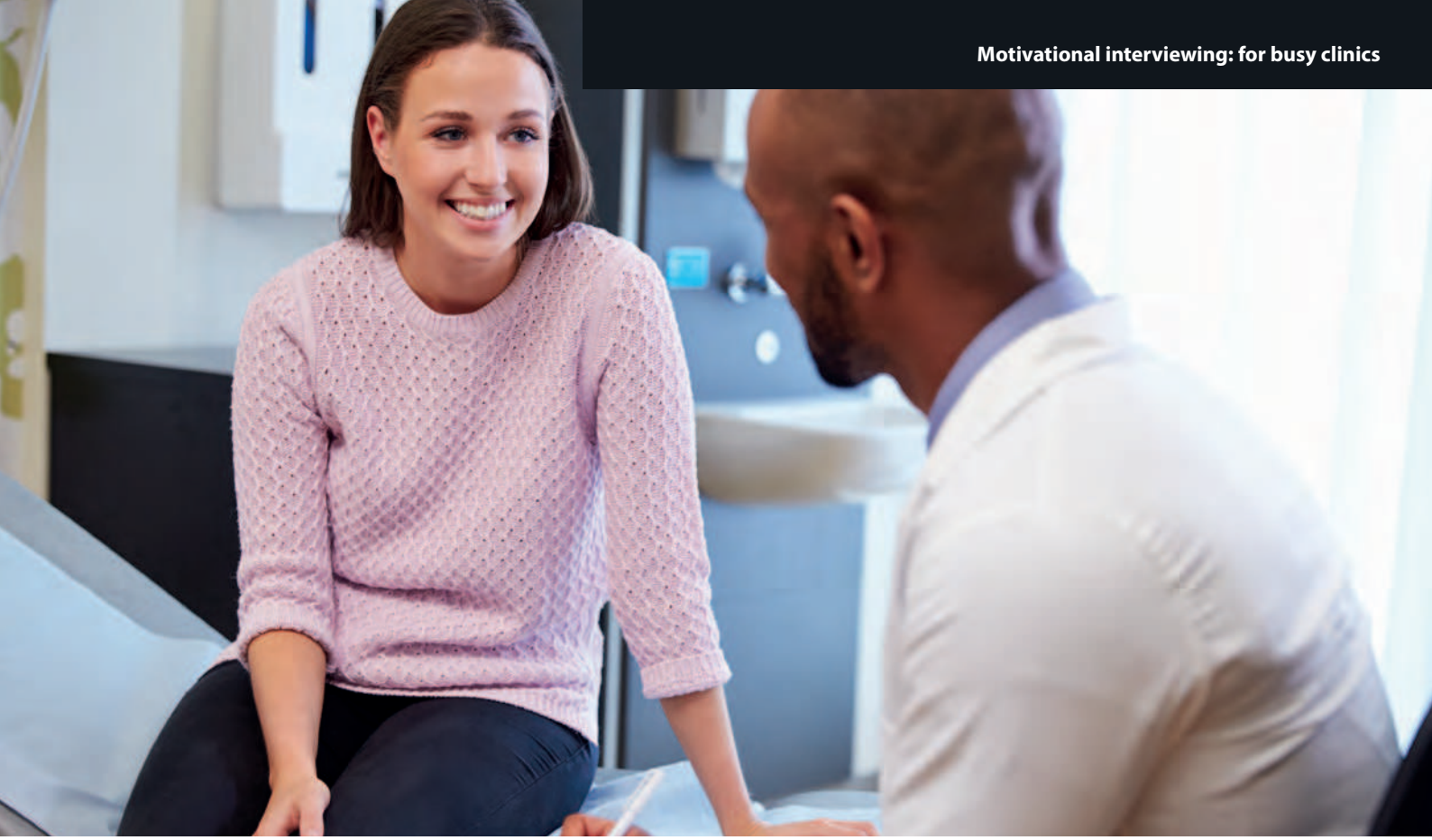
"I'm not too bothered to be honest…" tends to be the typical response of an individual disinterested in immediate conversation. This can be multi-factorial. The further a patient feels from progress in their condition, right up to palliative care, the uphill hike to progress can feel steeper than anticipated (Black and Helgason 2018). However, our cynicism can get the better of us if our response lacks accuracy. MI faces this head-on. The ability to implement MI is core to agile navigation of an individual's central views and beliefs. Let's break that down a bit.

Engaging

Engagement and disengagement are the conundrums here. Understanding the person's dilemma through listening is the next part, followed by core listening skills: OARS (see appendix) exploring a person's values and goals for their own health.

Open Questions ('O') is like opening a door for eliciting an individual's motivation or ambivalence. It also provides an opportunity for the individual to think before answering. This can result in deeper reflections, objective decisions and often adherence to evidence-based health advice (Palacio et al. 2016).

Affirmation ('A') is about emphasising the positives from an individual's reflections. Recognition and acknowledgement of the individual is key to demonstrating this. In a busy clinical environment, empathy can seem more challenging to show, especially if we are feeling exhausted, dealing with challenging personal circumstances, and conscious of waiting times for patients. However, empathy is an important measure of what is required to reduce defensiveness and increase openness (Palacio et al. 2016). By recognising the patient's key emotions and acknowledging past challenges, we as clinicians can provide a safe psychological environment for patients as well as ourselves. We as clinicians have the tools to empower the patient's self-care as well as our own treatment plan (Masterson et al. 2016).



Reflections ('R') are the interpretation of life events or feelings. Notably, an individual needs a safe environment in which to process either verbally or internally. Motivational interviewing empowers the individual to share their experiences and feelings openly with a trusted healthcare professional. Understanding their reflections is how we as clinicians can help steer the conversation forwards (Miller et al. 2017).

Summarising ('S') an individual's reflections back to them is an essential way to cohesively draw information together to demonstrate acceptance of the patient's circumstances and make the person feel they are being listened to. Summarising can also be shown through collecting key points, linking themes, and transitioning between thoughts seamlessly (Miller and Rollnick 2012).

Focusing

Why focus? Focussing encourages a collaborative approach to finding a mutually agreeable path. When goals differ, it can feel like a lengthy journey to the precipice. By that I mean, a patient and clinician not in tandem. Friction can become resident in these situations. This is particularly important when addressing sensitive issues such as an individual's alcohol consumption and smoking cessation (Foxcroft et al. 2016; Melnick et al. 2021). Both are likely to affect an individual's foot health, thus, attention to detail is key. Focusing magnifies those details and broadens our understanding of the level of a patient's motivation.

Agenda mapping enables this process to occur fluidly. This is when a clinician steps back from the conversation for a short period of time to contemplate the way ahead with the patient. This is particularly useful if the conversation can become stagnant with difficulties in changes of topic or clarification of direction (Aanesen et al. 2021). Agenda mapping aids the navigation process for a clinician, this is vital in a time-pressured environment (Resnicow and Mcmaster 2012).

Evoking

Often, ambivalence from patients is rife in clinical practice. "I want to, but I don't want to…" is a common example of ambivalence. Change Talk and Sustain Talk are the tools we as clinicians can use to aid a patient in understanding their own ambivalence and helping them reach a decision that is best for them.

Change Talk is defined as a verbal transition from one mode of thinking to another. An example of this could be a patient initially resisting the idea of treatment due to focusing on the risks and coming to the realisation of the overriding benefits. Allowing the patient to come to this conclusion is an acknowledgement of patient empowerment and self-motivation (Miller et al. 2017).

However, Sustain Talk is defined as a stagnation in an individual's verbal response to the suggestion of positive change (Miller and Rollnick 2012). This can occur particularly during topics that trigger a retrospective element to a patient's processing of trauma or anxiety.

SUMMARISING ('S') AN INDIVIDUAL'S REFLECTIONS BACK TO THEM IS AN ESSENTIAL WAY TO COHESIVELY DRAW INFORMATION TOGETHER TO DEMONSTRATE ACCEPTANCE OF THE PATIENT'S CIRCUMSTANCES AND MAKE THE PERSON FEEL THEY ARE BEING LISTENED TO

Motivational interviewing: for busy clinics

To evoke the person's own motivation in their health care plan (particularly for the long term), the following points must be raised.

Planning

The transition between evoking and planning can be seamless, stagnant, or relapse.

For a seamless transition to occur, the rapport between the clinician and patient must be cooperative and collaborative (Miller and Rollnick 2012). However, this process can be hindered through our use of tone, body language and lack of focus at key points. The treatment needs to be completed; however, a patient can also be equally enthusiastic about their need for a response to their expression of feeling or emotion. Both of which can be exhausting (on a Friday afternoon in particular). This places emphasis on the requirement for synergy between the patient's expression of behaviour attitudes and our response as clinicians (Barrett et al. 2018).

Conclusions

Engaging. Focusing. Evoking. Planning. These four concepts underpin MI. Through facilitating Change Talk, we as clinicians can facilitate a safe psychological and emotional environment for a patient who shows initial reluctance to the idea of change (Georgopoulou et al. 2016).

Therefore, by focussing on elements of a patient's Sustain Talk, we can identify the 'eye of the hurricane' and filter the patient's own motivation for the benefit of focussing on progressive dialogue (Catley et al. 2016). This in turn prompts an evocation of a patient's deeper motives behind their original views coming into an appointment. Successful rapport building with a patient can empower and enable objective, evidence-based decision making to occur. Finally, the plan for the patient going forward can be solidified through cooperative dialogue, rooted in trust not just for now, but for the future too.

Appendix

Motivational Interviewing OARS	
1.	Open Questions
2.	Affirming
3.	Reflecting
4.	Summarising

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Members' Zone

We love to hear from our Members and are excited to include this new Members' Zone within the Journal where we shall publish case studies, articles or personal reflections.

If you would like to submit something for publication, please send this to Carol O'Brien at CObrien@smaeinstitute.co.uk

The SMAE Institute reserves the right to edit or individual submissions as and when considered necessary. Opinions expressed are those of the individual author, and do not necessarily reflect the opinion of The SMAE Institute.

Do you have any achievements to share? Please send us details so we can celebrate with you!

Members' achievements

We start with congratulating Alex Hepburn, Chairman of the East Anglia BCPA Branch.

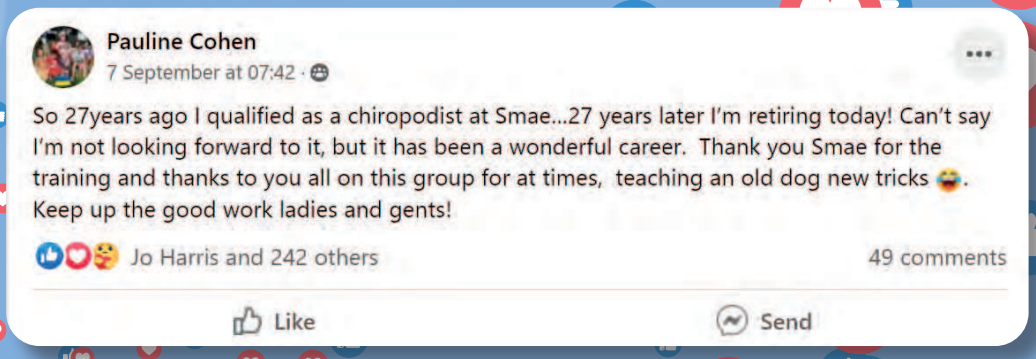
St John volunteers from Lowestoft have been recognised for their service to the charity at a prestigious event, with the awards given by Mayor of Lowestoft, Alan Green.

Their vital work, dedication, service and achievements were all honoured at the thanksgiving service in Ipswich. The Lord Lieutenant of Suffolk, Clare Countess of Euston, and the High Sherriff of Suffolk, Major Jamie Lowther-Pinkerton, witnessed the awards going to Suffolk volunteers, which amounted to an amazing 1525 volunteer years!

Awards were also given for youth achievement, as 2022 marks 100 years of the youth movement.

Congratulations Alex! (2nd in on left at the back).

SMAE FACEBOOK POSSE



Congratulations Pauline - it's wonderful to hear of your successful 27 year career. All of us at SMAE wish you a very happy retirement!

Patients Letter

"I have just returned home from my fourth appointment at the foot clinic and felt I had to put in writing my sincere thanks to you and your team for making the experience so pleasant.

I started attending your clinic some months ago because I had difficulty in cutting my toe nails as they were so deformed that I have difficulty in walking without the pain.

At my first visit I was made to feel comfortable – not ashamed of my feet – and I received the most efficient and effective treatment. Every part of my treatment was done by one of your students and scrutinised, judged and helped by supportive advice tactfully given by a tutor Deborah Rockell.

Over these last weeks my nails have become difficult again. The student tactfully asked and obtained my health issues since my previous visit, carried out the tests and questionnaire needed to fill in her report – all the time ensuring I was happy and relaxed with the procedure.

She was excellent in carrying out the work needed on my toenails, cutting and filing them back into the comfort zone while telling me at every stage what she was doing. When there were difficulties she would consult with the tutors, Deborah Rockell or Jonathan Brocklehurst, having her newly learned skills and knowledge confirmed by them.

Jonathan gave me advice to follow to help soften my nails between treatments and I shall certainly be taking the advice on board.

I just had to put on record how much I appreciate the staff and students at the Foot Clinic. Your reputation for excellence in teaching and pastoral support shows in the happy atmosphere of all the students and tutors there.

They make such a difference to all who attend. The welcoming atmosphere of Rosie at Reception and her appointment making means that we are never likely to forget our next visit. The welcome of the student who comes to take us into their comfortable cubicle for treatment, is not taken for granted but appreciated.

Sometimes the spoken praise does not seem enough as I am sure you receive many compliments on your staff. I just wanted to have mine recorded. Thank you.
Please pass on my grateful thanks to your students and give them my good wishes for the future."

Jaqueline Dudley

Whilst we receive many wonderful comments from patients in our clinics, it is rare to receive them in writing, and so we were delighted to receive Jacqueline's letter to share with those staff and students involved in her visit.

Exploring self-care behaviour in the context of ulcer-prevention in diabetes

A review of the Literature

By Andrew Hill
DHealth Candidate (University of Bath); MSc Podiatry; PGCert L&T; FFPM RCPS(Glasg); FHEA; FSSCh
Programme Lead and Senior Lecturer – BSc (Hons) Podiatry, The SMAE Institue

Foot disease in diabetes

For a person with diabetes, the lifetime incidence rate of a diabetic foot ulcer (DFU) is between 19% and 34%, with a yearly incidence rate of 2%, and they are the leading cause of non-traumatic lower extremity amputations (Bus et al., 2019). This is of more striking significance when contextualised by the fact that there is between a 60% and 80% risk of death within five years of a diabetes-related amputation (Singh et al., 2005; NICE, 2019). It has even been suggested that preventing DFU development is the single biggest way to reduce diabetes-associated mortality (Jeyaramen et al, 2019). Accordingly, ever-increasing importance is given to strategies aimed at preventing the development of DFUs – so much so that this has been identified as one of the top 10-foot health research priorities in the UK (James Lind Alliance, 2019). With appropriate disease management and effective self-care behaviours, many complications, including DFUs, are deemed to be entirely avoidable (Ren et al., 2014; Bus and van Netten, 2016; NICE, 2019; Bus et al., 2019). Whilst the role of the clinician in helping patients to effectively manage their diabetes remains a crucial aspect of diabetes care, the International Working Group on the Diabetic Foot [IWGDF] have cited good foot self-care behaviours as a key approach to prevent the development of DFUs (Bus et al., 2019). Despite this, a large integrative review identified that HCPs frequently report that foot self-care behaviours are not undertaken consistently enough by people with diabetes (Matricianni & Jones, 2015). Given the harms and costs associated with diabetic foot disease, all approaches that may help to reduce the incidence and prevalence of this require urgent investigation – not least efficacious and cost-effective measures like appropriate foot self-care behaviours.

Self-care in the context of foot disease in diabetes

With a changing landscape of public health comes a change in the way that healthcare is delivered and received. Health care decisions and practices are no longer viewed as the sole responsibility of the clinician and, indeed, these decisions relating to patient care are more equally shared with the patient (Speight et al., 2012). This initiates two premises upon which health care provision then exists – firstly, the patient must assume some control and accountability for their own health and health outcomes; and secondly, effective communication between the HCP and the patient is of crucial importance (Vranceanu et al., 2012; Beverley et al., 2016; Neuner-Jehle et al., 2017;). This is particularly relevant when it comes to the management of chronic, non-communicable diseases such as diabetes where effective self-care is a crucial aspect of optimal disease management and outcomes (Shrivastava et al., 2013).

Self-care management has been defined as the capacity of the individual in managing the symptoms associated with a chronic condition through physical activity, psychosocial approaches and lifestyle changes (Tuncay and Avci, 2020). The purpose of this is to ensure that individuals can sustain their wellness as much as possible. In diabetes, self-care is a well-established facet of achieving optimal disease management and clinical outcomes because most of the day-to-day care and management of the disease is handled by patients and/or their families (Shrivastava et al., 2013). The American Association of Diabetes Educators (2008) identified seven essential self-care behaviours in diabetes which predict good outcomes, viz.: healthy eating; being physically active; monitoring of blood sugar; compliance with medications; good problem-solving skills; healthy coping skills and risk-reduction behaviours (which includes reducing risk of foot ulceration via good foot care). All of these behaviours have been seen to positively correlate with good glycaemic control, reduction of complications and improvement in quality of life (Odegard and Capoccia, 2007; Povey and Clark-Carter, 2007; American Diabetes Association; 2009; Shrivastava et al., 2013). Diabetes self-care requires people with diabetes to make many dietary and lifestyle modifications supported by health care professionals to help them maintain a higher level of self-confidence which, in turn, facilitates sustained self-care behaviours (Dogru et al., 2019).

Foot self-care behaviours typically identified as what people with diabetes should be encouraged to undertake regularly include: daily washing and drying of the feet; daily visual foot examinations; application of skin moisturiser; avoiding walking bare-footed (even within the home); ensuring that bathing water is not too hot; attending regular professional footcare and following professional advice in relation to foot

care behaviours (McInnes et al., 2011; Fan et al., 2014; Bonner et al., 2016; Bus et al., 2016; NHS, 2018; Diabetes UK, 2021). Whilst this represents the optimal approach to self-care in the context of foot disease in diabetes, the pertinent question is to what extent these behaviours are typically undertaken and adhered to.

Adherence to self-care behaviours

Self-care is widely considered to be the most cost-effective way of managing diabetes and delaying or preventing of the development of associated complications, yet self-care is often found lacking in people with diabetes and is sometimes under-appreciated by health care professionals too (Hunter et al., 2014). Much of the evidence indicates that foot self-care behaviours, specifically, remain under-utilised in the prevention of DFUs (Perrin et al., 2009; McInnes et al., 2011; Shrivastava et al., 2013; Freitas, 2014; Matricianni and Jones, 2015; Neta et al., 2015). Mogre et al. (2019) undertook the only large systematic review to date that specifically looked at foot self-care behaviours within a range of self-care practices in diabetes to determine how well they were adhered to. Their systematic review of 72 studies included 10 that specifically looked at foot self-care behaviours in a pooled population of over 1,600. The findings of this systematic review were that only 40% of people with diabetes undertake regular foot inspections and a much lower 10% met the criteria of having "good" foot self-care practices. These numbers compared with median adherence rates of 58% for diet; 71% for medication taking and 41% for exercise behaviours, respectively. Whilst this systematic review was limited to low- and middle-income countries, the findings were largely consistent within the literature that reported on foot self-care behaviours in many different countries – including high-income ones too (Schmidt et al, 2008; Perrin et al., 2009; McInnes et al., 2011; Freitas, 2014; Neta et al., 2015). Understanding what may explain this apparent lack of regular, consistent foot self-care among people with diabetes is, thus, the focus of a literature review.

Literature Search

The databases selected to perform literature searches were: Web of Science; Scopus; The Cochrane Database; Embase; CINAHL and the Nursing and Allied Health Database. These were selected on the basis that they provided access to thousands of peer-reviewed journals and articles within the various aspects of healthcare that are concerned with the specific area of interest. These include medicine, nursing, podiatry, chronic disease, allied health, clinical care, patient education and counselling.

Various search terms were used systematically for each of the searched databases. Search terms were applied using the Khan et al. (2003) PEO (population, exposure, outcome) framework [Figure 1]. The searches were conducted to locate the exact words or phrases within the title, medical subject heading (MeSH), keywords or abstract. The search terms were selected and refined by identifying recurring key terms in relevant papers returned from preliminary searches. The initial date range was selected from 2003 to locate papers published since the implementation of NICE guidance on patient self-management and education in diabetes.

SELF-CARE IS OFTEN FOUND LACKING IN PEOPLE WITH DIABETES AND IS SOMETIMES UNDER-APPRECIATED BY HEALTH CARE PROFESSIONALS TOO

Population	Exposure	Outcome
Diabet*	concern* **OR** consider* **OR** "Patient motiv*" **OR** "motivations" **OR** barriers **OR** facilitate* **OR** enable*	"foot self-care" **OR** "Self-foot care" **OR** "self-care behav*"

Figure 1 – PEO framework search terms table

THE TERM 'HEALTH LITERACY' REFERS TO SOCIO-COGNITIVE SKILLS THAT RESULT IN THE PRESERVATION AND PROMOTION OF GOOD HEALTH

To obtain focused and relevant results that could be appropriately analysed, search filters were employed to make sure that the returned articles were full-text accessible, were original papers and/or reported original research and were peer-reviewed. No language filters were included so that potentially useful international studies were not excluded from the search results. From the articles retrieved, papers were selected or rejected according to their subject relevance and their reliability and validity in terms of research hierarchy. Papers already selected from earlier searches were excluded from the retrieved results in later searches. All papers that were used in the literature review were put through a CASP review process to judge reliability and suitability prior to inclusion (CASP UK, 2021).

Barriers and Facilitators to Foot Self-Care Behaviours

Adherence to care is a multidimensional phenomenon, determined by the interplay of several factors, including: social and economic, patient-related, health-system-related, and condition-related factors (World Health Organisation [WHO], 2003 cited by Kardas et al., 2013). Within the searched literature, each of those factors appear to be frequently captured in the context of foot self-care in diabetes. Social and economic factors often concern limited health literacy, socio-economic status and social support of patients with foot problems in diabetes (Vedhara et al., 2014; D'Souza et al., 2016; Price, 2016); patient-related factors involve the person's existing knowledge, skills, and beliefs around their illness and the benefits of care (Gale et al., 2008; Beattie et al., 2014; Guell and Unwin, 2015; Hill and Dunlop, 2015); the health-system-related factors include patient experiences of the health service and HCP interaction (Anders and Smith, 2010; Marchand et al., 2012; Delea, 2015; Coffey et al., 2019); and condition-related factors most commonly appear to be co-existing depression commonly seen in diabetes (Gonzalez et al., 2008; Gharaibeh et al., 2016). Accordingly, the following areas have been identified as the focus of the literature review around possible barriers and facilitators to foot self-care behaviours:

- **Health literacy**
- **Socio-economic status**
- **Patient knowledge / education**
- **Depression**
- **Patient beliefs**
- **Social support**
- **Patient-HCP interaction**
- **Health service experiences**

Health Literacy

The term 'health literacy' refers to socio-cognitive skills that result in the preservation and promotion of good health (Lael-Monfared et al., 2019). It is typically viewed as the ability of people to access, process and understand information and basic health services that are necessary to make appropriate health decisions (Apfel and Tsouros, 2013). Individuals with low health literacy often struggle to understand the health information provided to them and are known to have greater difficulty in managing chronic diseases and, as a consequence, are at greater risk for poor health outcomes (Hadden et al., 2019). Ferguson et al (2015) studied 280 adults with poorly controlled diabetes and found that almost 40% of them reported that they were managing to control their diabetes either 'well' or 'very well'. They concluded that this problem was due in large part to low health literacy amongst these individuals. In keeping with this, people with diabetes who have low health literacy appear to be at increased risk of developing complications such as DFUs due to poor self-management behaviours (Bailey et al., 2014; Margolis et al., 2015; Protheroe et al., 2017; Anderson et al., 2017). However, this conclusion was not reflected the systematic review of the literature by Al Sayah et al. (2013) who found that whilst good health literacy was associated with improved diabetes knowledge, there is little sufficient or consistent evidence suggesting that it is independently associated with diabetes-related outcomes.

Studies looking at health literacy specifically in the context of diabetic foot disease are few, though one of the largest was conducted by Hadden et al. (2019) who compared health literacy levels in 177 DFU-related amputees with 14,683 people in a general orthopaedic patient group and found that individuals in the amputee group were over 8 times as likely to have poor health literacy than those in the general orthopaedic group. Another was conducted by Lael-Monfared et al., (2019) who explored health literacy in the context of the foot in diabetes in a cross-sectional study of over 400 people with type II diabetes in Iran and found that those with higher levels of health literacy undertook self-care practices more consistently and had better foot health outcomes than those with poorer health literacy. The recommendations by Hadden et al. (2019) and Lael-Monfared et al., (2019) were that interventions aimed at improving health literacy should be an area of active focus to help improve foot health outcomes in diabetes through better engagement with self-care behaviours.

Whilst there is a relative scarcity of studies looking at health literacy interventions aimed specifically at improving foot self-care behaviours, Kim and Lee (2016) conducted a meta-analysis of the literature around interventions aimed at improving health literacy in general diabetes self-care. They found that these interventions were focused around four domains: written communication; spoken communication; empowerment and language/cultural consideration. They concluded that, overall, health-literacy sensitive diabetes management interventions were effective at improving patient self-care behaviours as measures by reductions in HbA1c levels. Whilst health literacy, therefore, appears to be an important factor to consider in the context of self-care, a consistent indication in the literature on this is that health literacy rarely exists in isolation and, instead, is influenced by many factors – most notably socio-economic status (Al Sayah et al., 2013; Kim and Lee, 2016; Hadden et al., 2019; Lael-Monfared et al., 2019).

Socio-economic status

Socio-economic status (SES) refers to the social and economic position that a person occupies within a given social structure and higher SES appears to be positively associated with better health outcomes (Baker, 2014). In her 2014 comprehensive literature review around the relationship between SES and health, Baker identified three common measures of SES: education, income and occupation. SES is generally thought to influence health through three avenues: (1) SES influences health through the ability to purchase health promoting resources and treatments; (2) socialisation of early health habits and continuing socialisation of health habits differs by SES; and (3) it has been posited that, rather than SES influencing health, health influences SES as less healthy individuals complete fewer years of school, miss more work, and earn lower incomes (Baker, 2014). However, Präg et al. (2016) in their multi-national cross-comparison study of SES in the context of health found that the perceived SES – not just actual SES metrics – appeared to be related to health outcomes, raising questions over the precise relationship between SES and health.

In the specific context of diabetes, it has been found in the largest systematic review and meta-analysis on the relationship between SES and type II diabetes that individuals with low SES are more likely to develop type II diabetes (Agardh et al., 2011). This finding was more pronounced in high-income countries compared to low- and middle-income countries. This has since been supported by a large cross-sectional, population-based study in Canada of over 27,000 people which found that household income was strongly and independently associated with type 2 diabetes prevalence (and its associated conditions of high blood pressure and obesity) and that these outcomes were most commonly associated with physical inactivity (Bird et al., 2015). The inference from this study was that SES appeared to play a role in self-care behaviours. This aligns with the conclusions of a large review of 191 studies by Volaco et al., (2018) which found that obesity – an independent risk factor for the development of diabetes and acceleration of diabetes complications – was strongly correlated with low SES. Reasons given for this were that there was a compounding effect of consumption of poorer quality food (higher intake of fat and simple carbohydrates and less of fruits, vegetables and whole wheat bread); and reduced physical activity being undertaken in the more disadvantaged social classes (Volaco et al., 2018).

An additional factor that may contribute to how SES contributes to poorer health outcomes in diabetes was posited by Kelly and Ismail (2015) who in their literature review of variables associated with poorer diabetes outcomes found that stress was positively associated with poor self-care and early development of diabetes complications. Furthermore, they drew inference that poor SES may be a contributor to the development of stress through concerns around social and economic security. Whilst there appears to be considerable evidence that SES may impact upon health outcomes in chronic diseases like diabetes, what is less well studied is whether specific interventions aimed at patients may help to mitigate these impacts. The only study looking at this within the retrieved literature was by Houle et al. (2016) who examined whether targeted self-care education and counselling may have a mediating effect between SES and glycaemic control in diabetes. To explore this, they recruited 295 people with diabetes and low SES and compared average HbA1c levels before and after an intensive patient education and counselling course. The intervention focused on tackling patient knowledge and treating any co-existing depression. They found that by increasing patient knowledge levels and providing counselling to those struggling to cope with stress and depression, self-care behaviours improved and

Notes:

THERE APPEARS TO BE A NEED FOR FURTHER RESEARCH IN UNDERSTANDING MECHANISMS BY WHICH SES MAY IMPACT UPON FOOT SELF-CARE BEHAVIOURS

resulted in significant reductions in HbA1c levels. Though these are just the findings of one study, they do echo two of the factors that the WHO (2003) identified as being part of a complex interplay around adherence to care – namely, patient-related factors (patient knowledge) and condition-related factors (depression). There appears to be a need for further research in understanding mechanisms by which SES may impact upon foot self-care behaviours.

Patient knowledge & education

A consistent finding within the literature is that a lack of patient knowledge is a factor in poor engagement with foot self-care behaviours and that this requires more frequent and effective foot-specific patient education to be provided to help address this deficit (Johnson et al, 2005; Anders and Smith, 2010; Lamchahab et al, 2011; Li et al., 2014; Sharoni et al, 2017). Accordingly, over the last 20 years patient education in the context of foot health has come into sharp focus as a tool to reduce the development of DFUs and amputation. The International Working Group for the Diabetic Foot (IWGDF) cite patient education as one of the key approaches to preventing the development of a DFU (Bus et al., 2019). However, despite a drive to increase diabetes patient education in the UK since the UK Prospective Diabetes Study (Evans, 1998); NICE guidance (2003; 2020) and NHS directives (2011) in parallel with guidelines from the IWGDF, the largest systematic review of the current literature found there is insufficient robust evidence that patient education alone is effective in achieving clinically-relevant reductions in DFU and amputation rates (Dorresteijin et al, 2012). A more recent systematic review by van Netten et al. (2016) concluded similarly in terms of first-time ulceration, however, did find that targeted education can reduce recurrence rates of DFUs.

The proposed conduit between targeted foot health education and any possible reduction in DFU development attributable to it is via improved foot self-care behaviours. If the strongest evidence from the aforementioned systematic reviews suggests that targeted patient education does not appear to be an independent factor that reduces the development of DFUs, this raises two possibilities – 1) the efficacy of foot self-care at reducing DFU development is the problem – not the adherence to it; or 2) there is a disconnect between targeted patient education being given and this translating into effective foot self-care behaviours. The evidence presented in this literature review suggests that foot self-care behaviours being optimally undertaken are effective at reducing the burden of diabetic foot disease and reducing the likelihood of ulceration. Thus, the inference is that the issue may well be a disconnect between targeted patient education being given and this translating into effective foot self-care behaviours. A recent systematic review appeared to support this inference as it concluded that there was insufficient evidence to suggest that targeted patient education has a positive impact on foot self-care behaviour (Goodall et al., 2020). Reasons why targeted patient education do not appear to translate into improved foot self-care behaviours may be partially explained by qualitative studies exploring the perspectives of people with diabetes about their patient education experiences. Such studies repeatedly found that patient education appears to be inconsistently delivered with non-standardised content (Anders and Smith, 2010; Hill and Dunlop, 2015) and that education recall was often sub-optimal (Basu et al, 2004). Indeed, the largest qualitative meta-analysis of patient perceptions and experiences of foot health and ulceration in diabetes highlighted limitations of patient education as one of the key barriers to effective foot self-care (Coffey et al., 2019).

Another part of the explanation surrounding the apparent disconnect between patient education delivery and adherence to foot self-care behaviours may be that the education may be ineffective if health literacy factors are not taken into account. Adarmouch et al. (2017) studied 133 people with diabetes in Morocco and compared foot self-care behaviour before and after a targeted patient education intervention. The difference between baseline foot self-care behaviours and post-intervention were analysed against health literacy metrics of individuals in the study. They found that those with high health literacy demonstrated significant positive improvements in foot self-care behaviours following the patient education intervention compared with those with low health literacy. These findings, however, are not supported by a more recent and larger study by Vandenbosche et al. (2018) in which 366 people with diabetes across nine countries were assessed via questionnaire to determine their health literacy,

self-care behaviours, problem perception, coping, perceived general health and well-being before and after participating in a diabetes self-care patient education programme. The conclusion of this study was that patient education programmes aimed at self-care have positive, short-term effects on reported patient self-care behaviours and that whilst low health literacy is associated with poorer diabetes outcomes, it did not appear to influence the likelihood of the education programme resulting in increased reported self-care behaviours (Vandenbosche et al., 2018). Studies seeking to explore these interactions are often hampered by a reliance upon self-reported self-care behaviours and perceptions of their knowledge and well-being and they can often use quite different tools to evaluate factors like health literacy and coping. Thus, the results of studies in this area need to be considered with these limitations in mind and so the interplay between health literacy and effectiveness of patient education remains unclear. This is a subject needing further investigation.

Another possible reason why foot self-care behaviours do not seem to reliably improve following targeted patient education is that the burden placed on individuals with diabetes in relation to their self-care may be too onerous (Vileikyte, 1999; Vileikyte et al, 2004). The many complications of diabetes mean that patients with this disease have to consider various aspects of their self-care regime and be vigilant for an array of symptoms and health developments that might lead to an increased risk of developing (Diabetes UK, 2016). In essence, the foot in diabetes may often be being de-prioritised by patients relative to more pressing concerns about other aspects of day-to-day management of their diabetes despite the risk that severe foot problems in diabetes may cause (Lamchahab et al., 2011; McInnes et al, 2011). Indeed, an exploratory qualitative study by Guell and Unwin (2015) seeking to understand the barriers to diabetic foot care as experienced by patients and HCPs found that patients and HCPs alike prioritised glycaemic control above all else in the context of self-care and this often eclipsed the importance given to foot care. A more recent consensus statement has picked up on this perceived dynamic that certain aspects of self-care advice are given in a more formulaic way and this can mean that patients do not have appropriate priorities set for their individual needs (van Netten et al., 2020). Accordingly, van Netten et al. (2020) suggested that patient advice and education should be tailored to the needs of the individual to reduce the burden on the patient that may come from overwhelming advice across a range of aspects of self-care. It was suggested that this would help more effectively translate advice into behaviour.

It is clear from the literature reviewed in this area that patient knowledge and education continue to be perceived as important in the wider context of self-care, but the evidence about its effectiveness at translating into appropriate foot self-care behaviours remains unclear. The large body of evidence that exists around the role of patient education in the context of DFU prevention and foot self-care behaviours point towards complex interplays between myriad factors and these have not been clearly delineated. There is clear need for further research in this area.

A LACK OF PATIENT KNOWLEDGE IS A FACTOR IN POOR ENGAGEMENT WITH FOOT SELF-CARE BEHAVIOURS

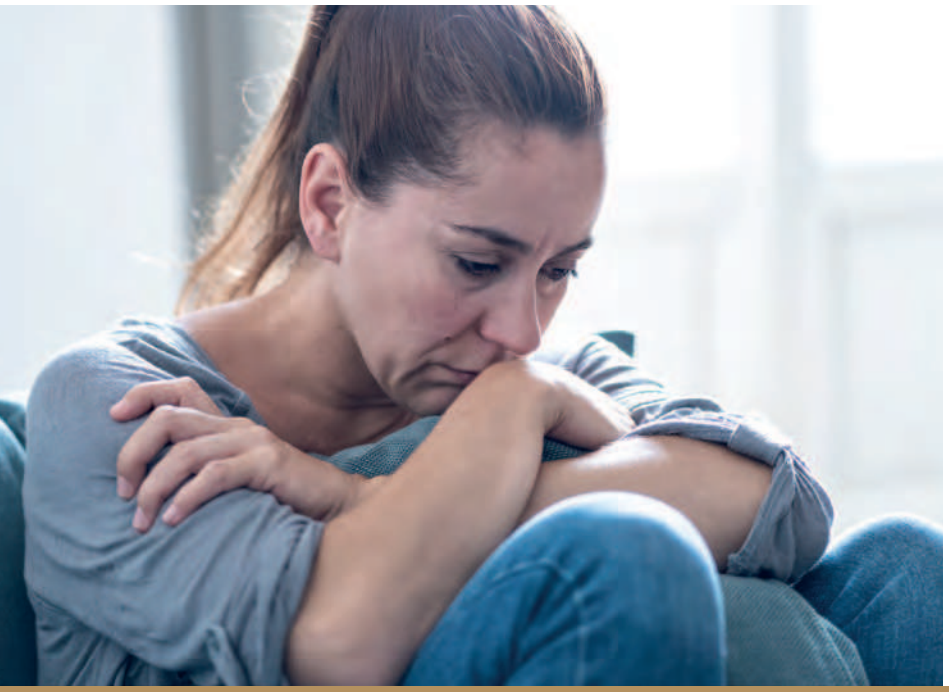
Depression

Diabetes-associated depression is well established phenomenon and the prevalence of depression amongst people with diabetes is known to be in the range of 10%-15% - which is twice the rate of people without diabetes (Lloyd et al., 2012; Bădescu et al., 2015; Semenkovich et al., 2015; Sartorius, 2018). A meta-analysis and systematic review of depression and mortality in individuals with diabetes found that not only are the outcomes of depression and diabetes worse when they appear together but that the presence of depression is linked to higher rates of complications in diabetes, to more disability and to loss of years of life (Park et al., 2013; Sartorius, 2018).

THE PREVALENCE OF DEPRESSION AMONGST PEOPLE WITH DIABETES IS KNOWN TO BE IN THE RANGE OF 10%-15% - WHICH IS TWICE THE RATE OF PEOPLE WITHOUT DIABETES

This was most clearly shown in the large, seminal study by Egede (2004) of 30,022 adults in the USA which showed that the risk of functional disability in people with diabetes was 2.42 times higher than in people who did not have diabetes; that in people with depression alone, it was 3 times higher than in people without depression; and that the risk for those who had depression and diabetes, the risk was 7.15 times higher than in people who did not have depression or diabetes.

One plausible reason that the co-existence of depression alongside diabetes is associated with poorer health outcomes in diabetes is that it may affect self-care behaviours. A meta-analysis of 47 studies looking at the link between diabetes, depression and adherence to treatment regimens found that the co-presence of depression and diabetes increases the likelihood of poor self-care (including lacking in physical exercise, non-adherence to diet, irregular intake of medications for any purpose) (Gonzalez et al., 2008). Whilst none of the studies included within that meta-analysis provided conclusive evidence that the relationship between depression in diabetes and poorer self-care is causal –plausible mechanisms have been identified that could imply causality. These are: increased likelihood of withdrawal from society (including healthcare appointments); reduced levels of motivation; reduced coping ability and lower self-efficacy (Owens-Gary et al., 2019). These factors were all identified as the likely connection between depression and an associated reduction is self-care in a systematic review and meta-analysis of behavioural determinants of glycaemic control in type II diabetes (Brown et al., 2016). Self-efficacy is an individual's beliefs about their capabilities to do what it takes to reach a specific goal (Bandura, 2010). It is activity specific and along with outcome expectation (belief that behaviour will have the desired effect), self-efficacy appears to influence behaviour (D'Souza et al., 2017; Sharoni et al., 2017). Thus, this concept emphasises not the actual state of an individuals' skills, but their judgment of what they believe they can do. Therefore, in the context of depression where beliefs in one's abilities and outcome expectations are often pessimistic, this potentially articulates part of the reason why self-care appears poorer where depression is present (Devarajooh and Chinner, 2017).



Alongside this complex interplay of factors, depression may also impact self-care through how this affects their relationships with others – especially their HCPs. Patients with increased levels of depression have been shown to report more dissatisfaction with their providers citing decreased empathy and poor patient-provider communication as well as a perceived reduction in their continuity of care (Gonzalez et al., 2008; Price, 2016; Coffey et al., 2019). The potential role of these health-system-related factors are discussed in later sections of this article.

Patient beliefs

Patient beliefs in this context may relate to those held about their health condition (health/illness beliefs); the treatment of their condition (treatment efficacy); their ability to follow a treatment regimen (self-efficacy), or all three (Alatawi et al., 2016). It has been suggested that individuals who accept their illness are more likely to appreciate how their disease impacts their life and take appropriate action to mitigate this (Besen & Esen, 2012; Sahin & Cingil, 2020). Accordingly, illness acceptance and illness beliefs appear to be closely intertwined. Vedhara et al (2014) studied 169 people with diabetes and captured their illness beliefs and self-reported self-care behaviours at baseline and then reviewed foot self-care data again at 6-, 12- and 24-week intervals. They found that patients' beliefs regarding the symptoms associated with ulceration, their beliefs around ulceration and their perceived personal control over ulceration emerged as independent determinants of foot self-care. The conclusion of Vedhara et al. (2014) was that illness beliefs may be a useful predictor for future foot self-care behaviours and they suggested that these beliefs may drive motivation to alter self-care behaviours. These findings were consistent with a systematic review of the literature which found that illness beliefs have a small but significant effect on glycaemic control in diabetes (McSharry et al., 2011) whilst the qualitative meta-synthesis of patient experiences of diabetes and ulceration by Coffey et al. (2019) identified that individuals who held more incorrect beliefs about diabetes and risks of DFUs appeared to have experienced more DFUs and amputations.

A recent qualitative study by Skidmore et al. (2021) looked at the perspective of individuals with type 2 diabetes in the UK on foot health and foot self-care practices and found that where treatment advice diverged from the beliefs that patients held about their disease and/or the efficacy of the advice, their beliefs 'trumped advice'. This is consistent with the main conclusion of Gale et al. (2008) in their widely cited qualitative study of 18 people with diabetes interviewed about their perspectives of foot complications in type II diabetes. Beliefs 'trumping advice' may well be a potentially important area of consideration when trying to understand what shapes patient behaviour and decision-making.

One final area to consider in the context of patient beliefs is that these may be shaped by the experiences of other. Multiple sources of data within the literature – including quantitative studies; qualitative studies; literature reviews and systematic reviews – have pointed to the impact of witnessing family and friends' poor health outcomes in diabetes as a factor which shapes beliefs around illness and efficacy of treatment (Scollan-Koliopoulos et al., 2010; Vedhara et al., 2014; Jaam et al., 2018; Coffey et al., 2019). A possible link between this source of belief and a translation into self-care behaviours was identified by Salamon et al. (2012) in their qualitative study exploring adolescents' concepts of Illness, adjustment and motivation to engage in self-care behaviours in diabetes. Their study found that familial experiences of adverse diabetes outcomes were the most cited source of motivation to engage in self-care behaviours. Alongside the impact on patient beliefs, this does bring into focus the possible wider impact and influence that loved ones may have in helping and supporting people in living with their diabetes.

Social Support

Social support is a strong example of one of the social factors that help to understand and explain patient adherence to care (Kardas et al., 2013). DiMatteo (2004), in his large quantitative review of factors that shape patient adherence to treatment, identified positive and significant relationships between social support and treatment adherence among patients with diabetes. Social support from family provides patients with practical help and can buffer the stresses of living with illness (Miller and DiMatteo, 2013). In the meta-synthesis of patient perceptions and experiences of foot care and ulceration by Coffey et al. (2019) they reported that family members were an important source of emotional and practical support in dealing with DFU as well as being able to take on tasks participants were no longer able to perform. They also found that many older individuals relied on community health services for ulcer management and that social support definitions should be extended to include those of professional health services rather than just being limited to close friends and loved ones. Other sources of support patients with foot problems in diabetes have described have included community workers (Gale et al., 2008; Foster and Luaver, 2014) and fellow DFU patients (Searle et al., 2005; Hjelm et al., 2009; Vedhara et al., 2012).

The association between disease management and social support has been extensively studied in the social and behavioural sciences though the precise means by which social support contributes to health outcomes is not yet completely understood. DiMatteo (2004) in his extensive literature review of this area indicated that the strongest plausible mechanisms by which social support can benefit patients' health are: by buffering stress; positively affecting emotions; increasing self-efficacy and influencing change in health behaviours. Rosland et al. (2008) in their cross-sectional study of 164 people with diabetes found that practical and emotional support received by both family and friends had a positive influence on measures of disease management (such as HbA1C) in patients with diabetes. The suggestion that social support is facilitative in improving health behaviours is supported by a more recent meta-analysis of 27 papers which found that older adults with good social support were more likely to undertake and sustain physical activity behaviours than those with poor social support (Lindsay Smith et al., 2017). Additionally, a cross-sectional study of 157 people with diabetes identified strong associations between positive family dynamics and better glycaemic control among people with diabetes (Graça Pereira et al., 2008). Positive family dynamics in this study related primarily to cohesion, in which families are described as warm, accepting, and close. In these dynamics, the odds of those studied adhering to glycaemic control advice were three times higher when compared with those in non-cohesive families (Graça Pereira et al., 2008). Thus, the evidence points towards an important contribution of social support to patients health and this includes a role in facilitating self-care behaviours.

Notes:

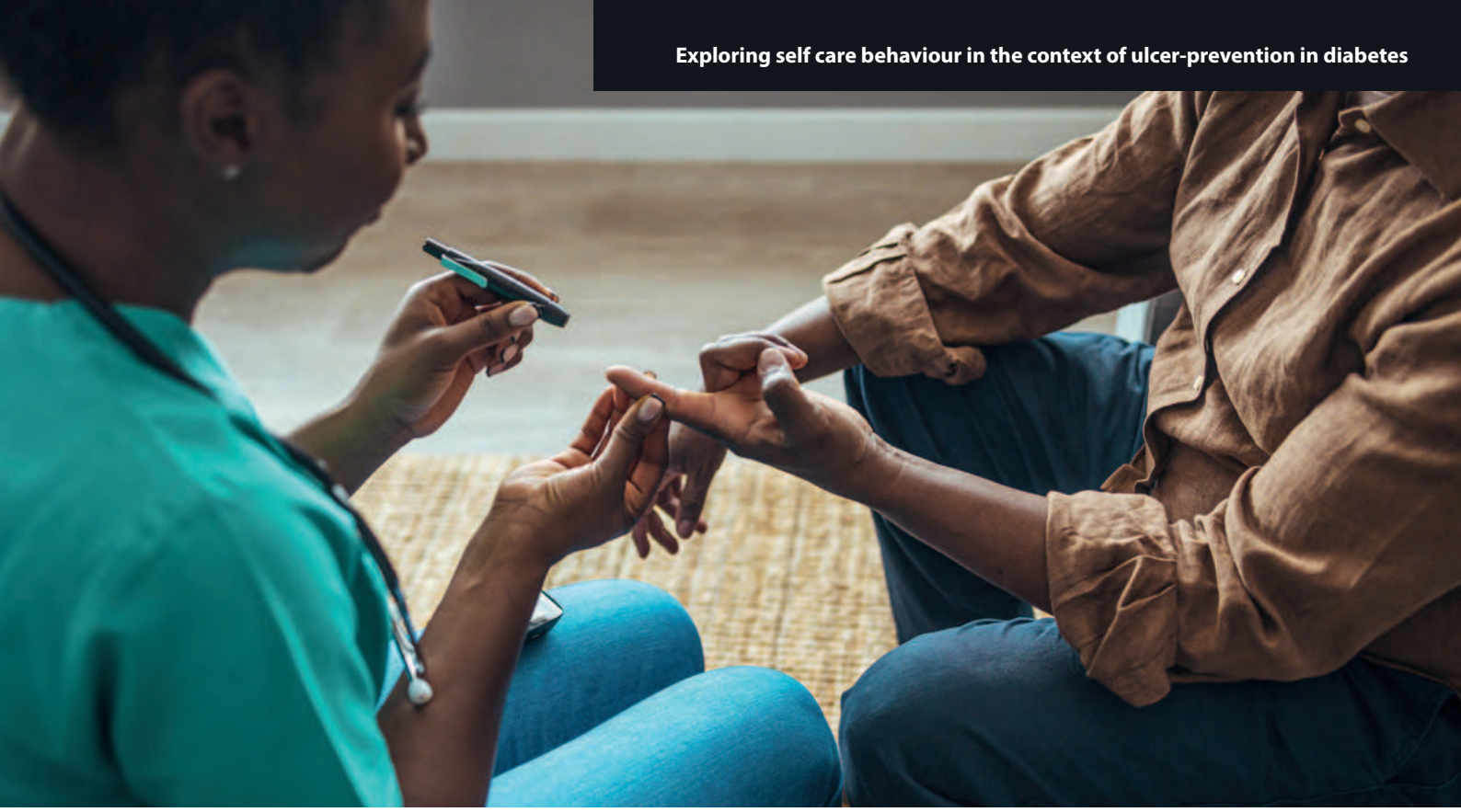
The contribution of individuals' close social circles to their health behaviours are, however, not always positive and have been linked to negative health outcomes too (Rosland et al., 2008). It has been found in several studies that patients often feel criticised, nagged and sometimes even guilty when receiving support from family and/or that competing demands (i.e. around diet) between patient and family members can act as barriers to self-management (Carter-Edwards, 2004; Gallant, 2007; Beattie et al., 2014; Coffey et al., 2019). It is also reported within qualitative studies exploring patient perspectives and experiences of living with diabetes that some people are reluctant to discuss their diabetes with loved ones due a perceived lack of support they receive from them (Foster and Luaver, 2014; Delea et al., 2015). Therefore, much like previously discussed factors that surround self-care behaviours, it appears that the role of social support is an important component that requires consideration. Understanding the precise mechanisms by which social support impacts upon self-care appears to be where further research is needed. One area where social support appears to connect social and health-system-related factors is where social support is conceptualised to encompass the relationship between patients and HCPs.

Patient-HCP interaction

As the delivery of healthcare has evolved over time, the way in which HCPs might best deliver their care as clinicians has changed as they have become encouraged to view their service users as 'health partners' rather than as a passive recipient of health care (Wade & Halligan, 2017). This evolution takes health care decisions and practices out of the sole power of the clinician and more equally shares them with the patient. This is particularly relevant when it comes to the management of chronic, non-communicable diseases like diabetes where effective self-care is a crucial aspect of optimal disease management and outcome (Shrivastava et al., 2013). It becomes an important consideration and an ever-more essential tool in the management of the foot in diabetes, as in so many other aspects of chronic disease, where contact with the physician may be time limited (Armstrong et al., 2017; Rogers et al., 2020).

Words can shape or reinforce a patient's coping strategies (Vranceanu et al., 2012) and ineffective health communication between patients and HCPs have long been argued as a contributory factor towards suboptimal care and, consequently, sub-optimal outcomes (White et al, 2015). Despite fairly wide-held beliefs to this effect, evidential proof of the direct effect of patient-practitioner communication on clinical outcomes has been hard to demonstrate. Riedl and Schüßler (2017) conducted the only systematic review which specifically looked at the influence of doctor-patient communication on health outcomes. From their review of 42 studies (17 RCT, 17 controlled studies and 8 uncontrolled studies) they concluded that doctor-patient communication had convincing subjective and objective impacts on patient health outcomes. Of particular relevance to this literature review, Riedl and Schüßler (2017) found that when information was shared effectively between doctors and patients, the patient's therapeutic compliance, engagement in self-care and quality of life were improved alongside their health status. This has been a phenomenon long recognised in clinical care across a wide array of chronic health and social care contexts and has been the foundation upon which strategies such as motivational interviewing have been developed (Frost et al., 2018). Riedl and Schüßler (2017) also identified from this systematic review that when asked about their preferences, patients rated open communication as the most important aspect of their patient-physician relationship which, itself, is based upon trust. This echoes with several qualitative patient studies in which it has been found that patient-practitioner communication which was not open and built on trust led to an underestimation of disease severity; HCPs not heeding patient concerns and, ultimately, poorer levels of care as a result of patients not feeling secure enough to discuss important lifestyle changes or enabled to undertake them (Gale et al., 2008; Searle et al., 2008; Moffat et al., 2006; Foster and Lauver, 2014; Chitambo and Frobes., 2015). Thus, it would appear that developing good and effective communication with patients is a crucial and potentially undervalued mechanism to help improve clinical outcomes within chronic health issues – not least by promoting adherence to therapeutic interventions and improved self-care behaviour.

Successful diabetes care requires teamwork between practitioners and patients which is predicated upon trust. The cornerstones of this teamwork are effective communication between both parties and shared decision-making (Beverley et al., 2016). This shared decision-making in practice resembles the patient sharing their medical, personal and lifestyle history with their physician who, in turn, processes that information into a series of therapeutic options for the patient with clear benefits and risks of each presented clearly and unbiasedly. This allows the patient to indicate their preference of option for discussion without concern or fear that their choice may be disagreeable for the practitioner (Beverley et al., 2014). Patient autonomy is key here and the ability of the practitioner to promote an environment of genuine patient autonomy is vital to the quick and robust development of trust in the relationship (Von Korff et al., 1997; Nimmon and Stenfors-Hayes, 2016). Other factors that influence a trustful and constructive relationship between patient and HCP are how the patient is treated during the consultation and how much



time they perceive that they have been afforded in the consultation (Beverley et al., 2016).

A first element to further expand upon here is how the patient is treated. Verbal communication is central to how a patient feels they have been treated (Dickinson et al., 2017). This ranges from friendly greetings and a genuine interest in them as individuals through to the specific language used to describe the patient, their behaviour and/or their condition (Dunning et al., 2017). Indeed, language is powerful and can have a strong impact on perceptions, behaviour and experiences and is the principal vehicle for the sharing of knowledge and understanding. Words are immediately shaped into meanings when people hear or read them and those meanings can affect how a person views him- or herself (Fleischman, 1999; Benedetti, 2008). The way a person views themselves and the beliefs they carry about their abilities and disease-state has been suggested to be a predictor for how they engage with their condition. Examples of how patients may feel poorly treated in consultations in this context include: insensitivity of HCPs when discussing the individuals' health status (Delea et al., 2015; Coffey et al., 2019); failing to provide emotional support (Bradbury and Price, 2011; Coffey, 2019); and HCPs not appearing to appreciate the impact of DFU and foot care demands on the everyday lives of patients (Anders and Smith, 2010; Aliasgharpour and Nayeri, 2012).

The second element that surrounds the development of a trustful and constructive relationship between patient and practitioner is that of the perception of time that a patient feels that they are afforded in the consultation (Bradbury and Price, 2011; Chitambo and Forbes, 2015; Coffey et al., 2019). Whilst a lack of perceived consultation time is a frequent frustration of patients, it is also a frequent frustration voiced by clinicians (Stuckey et al., 2015). Interestingly, however, the systematic review by Riedl and Schüβler (2017) indicated that skilfully trained clinicians in consultative techniques such as motivational interviewing did not need more time in their consultations to develop trust, rapport, meaningful conversation and, indeed, effective information exchange. This provided both clinicians and patients with the perception of seemingly longer consultation times and improved satisfaction levels for both parties.

Whilst there are a number of studies that have identified the important role of patient-HCP communication as well as its complexities in impacting health outcomes, treatment adherence and self-care behaviours, there remains much that needs to be explored in how this particular dynamic may shape and influence patient foot self-care behaviours. This appears to be an area that warrants further investigation.

Health Service Experiences

The final factor explored in this literature review relates to how the health service experiences of patients may contribute to patient adherence to treatment and foot self-care behaviours. Coffey et al. (2019) in their meta-synthesis of patient experiences of foot care and foot ulceration found that patients frequently reported frustrations about their health service experiences and often directly attributed these to any adverse foot health outcomes that ultimately befell them. Examples of these frustrations include: HCPs often neglecting to examine the feet of people with diabetes (Anders and Smith, 2010; Aliasgharpour

LANGUAGE IS POWERFUL AND CAN HAVE A STRONG IMPACT ON PERCEPTIONS, BEHAVIOUR AND EXPERIENCES AND IS THE PRINCIPAL VEHICLE FOR THE SHARING OF KNOWLEDGE AND UNDERSTANDING

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and Nayeri, 2012); HCPs failing to provide or reinforce advice on foot care – potentially limiting knowledge of appropriate behaviours and undermining their perceived importance (Gale et al., 2008; Searle et al., 2008; Marchand et al., 2012; Delea et al., 2015); inconsistencies in the foot care received from different health professionals and services which resulted from a lack of continuity in staff and poor co-ordination between services (Aliasgharpur and Nayeri, 2012; Beverley et al., 2016; Skidmore et al., 2021); and confusion over the division of responsibility for different aspects of care (Hjelm et al., 2009; Skidmore et al., 2021). With this combination of factors, it can be seen how people with diabetes could arguably be under-informed about the status of their foot health and be confused over what it is they are required to do to maintain their foot health, how often it should be done and by whom.

There are, however, health service experiences which patients have reported more positively within studies seeking to gain their perspectives around foot health in diabetes. These include: holding health professionals deemed to have expertise in foot care (i.e. Podiatrists and diabetes specialist nurses) in high regard (Bradbury and Price, 2011; Foster and Lauver, 2014; Delea et al., 2015) and that regular appointments with such individuals provided reassurance (Coffey et al., 2019). However, access to such professionals has often been reported as limited (Delea et al., 2015; Guell and Unwin, 2015; Coffey et al., 2019).

The literature relating to health service experiences in the context of the foot in diabetes typically highlights these findings within a much broader collection and summary of patient perspectives. Accordingly, whilst these do provide very useful insights, there is not much by way of in-depth analysis that specifically attempts to connect these findings within an explanatory framework and this is an area that needs further research. Furthermore, despite studies alluding to notions of mixed messaging from HCPs and subsequent confusion and frustration this causes patients, there is a scarcity of literature that seeks to understand if differing perspectives of the importance of feet and footcare in diabetes between patients and HCPs may be of relevance.

Summary

Foot ulceration is a common but serious complication of diabetes mellitus resulting in a foot or lower limb amputation every 30 seconds across the globe (Armstrong et al., 2017). There has been much focus on means to try and prevent foot ulceration in diabetes but this continues to be an increasing problem. Approaches to reduce the burden of DFUs focus evermore towards their prevention via good patient education and optimal self-care behaviours. Despite this, however, instilling good foot self-care behaviours remains a challenge. While the importance of self-care behaviours in diabetic foot care is widely acknowledged in clinical practice, conclusive research in this field remains limited. There is a much greater volume of studies that seek to understand foot self-care behaviours in individuals who have or have had foot ulceration, but much fewer studies seeking to understand these behaviours in individuals without such a history and who are currently at low- risk of developing a DFU. This is important because low-risk patients in this population often become high-risk in time. Thus, all reasonable efforts should be taken to prevent an individual from becoming high-risk for ulceration and it appears that establishing effective foot self-care behaviours early may be key to achieving that. Despite self-care being a widely studied phenomenon in the context of diabetes, there is no consistent guidance available for HCPs to help patients undertake and sustain foot self-care behaviours.

From this literature review, it appears that adherence to recommended diabetic foot ulcer self-care is limited at best, and that this is a multidimensional phenomenon. Motivating patients to initiate and maintain good foot self-care behaviours is complex and requires greater understanding of the perspectives of individuals with diabetes and HCPs involved in the management of the foot in diabetes. In particular, the complex interplay between socio-economic status, patient knowledge & education, patient beliefs, social support, HCP-patient interactions and health service experiences is where knowledge appears limited and further research is required. Therefore, there is a need to explore patient and HCP perspectives on barriers and facilitators towards patient foot self-care behaviours in adults with diabetes currently at low-risk of developing a DFU. In exploring these perspectives, a seemingly overlooked dynamic that may be of relevance is where areas of consensus and tension may exist between patient and HCP perspectives of foot self-care in diabetes and if these areas may contribute towards any perceived barriers and facilitators to this.

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Classifieds

For Sale, Wanted and Services

Advertising Deadline

Post or email your advertisements to Carol O'Brien at COBrien@smaeinstitute.co.uk by 12th December 2022

Fully equipped clinic and business for sale

Fully equipped clinic (located in a Physiotherapy practice) for sale with instruments, a work station, practice autoclave, various equipment and consumables. Further Items needed to provide domiciliary and Nursing home visits are included in the sale.

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Workshop Format

virtual (zoom) and in-house

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Whilst many have enjoyed the new virtual workshops we have put in place, there are some members that would prefer to attend workshops in-house. For this reason, we are delighted to continue offering the majority* of our workshops virtually via Zoom, or in-house - the choice is yours! When booking a place you simply need to let us know your preference of in-house or virtual and you will be booked on accordingly.

** The hands-on workshops can only be attended in-house.*

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Visit the Smae CPD website where you can find more details about our workshops, CPD@Home range and our annual CPD events!

You can also download booking forms for these events and access your online CPD subjects.

Ever considered teaching in the foot health field? If so, then we would love to hear from you!

Contact Andrew Hill at ahill@smaeinstitute.co.uk

The Institute reserves the right to postpone and reschedule lectures. Fees paid are non refundable or transferable.

SUMMER SCHOOL IN THE FALL - 7TH & 8TH OCTOBER 2022

Workshops

Workshop Format

Many of our workshops can now be attended either virtually via Zoom or in-house, the choice is yours! When booking a place you simply need to let us know your preference of in-house or virtual and you will be booked on accordingly.
** The hands-on workshops can only be attended in-house.*

virtual (zoom) and in-house

in-house only

Medical Emergency Procedures Courses

24th September FULLY BOOKED

9th October FULLY BOOKED

6th November

11th December

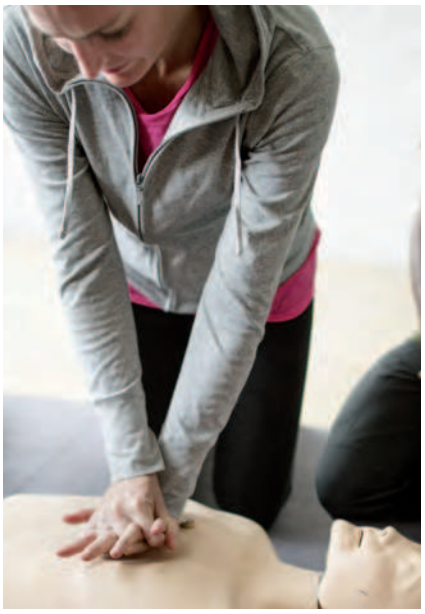
In keeping with safety in Foot Health practice, it is essential that every clinician undertakes medical emergency training every 3 years. To help facilitate this, the Institute runs an in-house bespoke training day to fulfil this requirement.

The day is fun, informative and relevant to the clinical situation. It is also a great opportunity to network with like minded professionals.

The Medical Emergency Procedures day covers amongst other things:

- Carrying out emergency procedures single handed including basic life support / CPR
- Principles of recognition of collapse, diagnosis, treatment and referral
- Coping with medical emergencies including the unconscious patient and respiratory and circulatory disorders
- A basic overview of minor injuries

Cost: £110.00
(A certificate is provided upon satisfactory completion)



Biomechanics Level 1

A Beginners Guide

18/19 January 2023

10.00am - 4.30pm

Lecturer: Andrew Hill

A 2 day introduction into the world of biomechanics including functional lower limb anatomy, common biomechanical foot complaints and how to manage them, pedorthic examination, and comprehensive assessment of the foot & ankle. Run as a Step-by-Step hands on workshop aimed at practitioners wishing to add another lucrative dimension to their clinical skills.

Cost: £289.00

Biomechanics Level 2

A Focus on Pathology

22/23 March 2023

10.00am - 4.30pm

Lecturer: Andrew Hill

A 2 day hands on workshop focused on further exploration of lower limb anatomy, biomechanics and pathomechanics including assessment of the knee and hip, leg length discrepancy, static and dynamic weight bearing examination and concepts of human motion.

NB: Successful completion of biomechanics Level 1 is a prerequisite for this course.

Cost: £289.00

Biomechanics Level 3

Therapeutic interventions & Prescription writing

17/18 May 2023

10.00am - 4.30pm

Lecturer: Andrew Hill

A 2 day hands on workshop focused on consolidating patient centred assessments of the foot, ankle, knees and hips, as well as comprehensive gait analysis. It includes interpretation of all findings in the context of insole and orthotic prescription writing; including how to take templates or casts, and how to correct any identified pathomechanics of the lower extremities. On completion, the practitioner will have the knowledge and skill to confidently incorporate biomechanics into their practice.

NB: Successful completion of biomechanics Levels 1 & 2 are a prerequisite for this course.

Cost: £289.00

What is the best way to deal with Onychocryptosis?

1st September 2022 FULLY BOOKED

MEMBERS FAVOURITE

10.00am - 4.30pm

Lecturer: Andrew Hill

This workshop provides a more in-depth look into ingrowing toenails. It will provide confidence to identify different presentations of Onychocryptosis as well as give practical experience in treating the condition. The course will outline conventional treatments as well as alternative ones (such as scalpel and beaver blade use). Referral pathways and surgical interventions will also be explored. The practical session will be practiced on prosthetic toes.

Cost: £56.00

What is that persistent pain in the ball of the foot?

Exploring Metatarsalgia

8th September 2022

10.00am - 4.30pm

Lecturer: Andrew Hill

An umbrella term used to describe generalised forefoot pain. Whilst extremely common, the causes of Metatarsalgia are extremely varied and correctly diagnosing the cause is half of the battle when looking to relieve the pain. This workshop comprehensively covers each established cause of Metatarsalgia and discusses diagnosis and management of each of them. Ideal for practitioners new and experienced alike!

Cost: £56.00

What Type Of Joint Problem Does Your Patient Have?

27th September 2022

10.00am - 4.30pm

Lecturer: Andrew Hill

The arthritides cause sufferers chronic pain and make daily tasks difficult. This workshop looks at these conditions, and how we as practitioners can provide relief to the pain that these conditions can cause the feet.

We will look at:

Rheumatoid Arthritis

- RA and pathogenesis / epidemiology
- Process of synovial inflammation and progression to erosive arthritis
- Treatment / general principles / flowchart including DMARDS
- Particular problems of RA with respect to ulceration, vascular disease and infection
- Deformities and biomechanical problems associated with RA

Other Rheumatological / Inflammatory Problems and other arthritides

- Other forms of arthritis and its management
- Metatarsalgia in more detail and its various causes (other than RA)
- Ankle and mid-tarsal problems
- Achilles tendonitis and Bursitis
- General advice with respect to exercise
- Patient advice and information sheets,useful sources e.g. ARC

Cost: £56.00

Heel Pain – is it just another case of Plantar Fasciitis?

6th October 2022

10.00am - 4.30pm

Lecturer: Andrew Hill

Heel pain is an all too common complaint for a number of people with terms like 'Policeman's heel' and 'heel spurs' being widely used by the general public. In more recent years, a greater public awareness of 'Plantar Fasciitis' has emerged meaning that not only are patients self-diagnosing (often erroneously) but also a great many practitioners are too quick to assume that any heel pain is plantar fasciitis. This workshop looks into what is occurring in the heel anatomically and how these structures can lead to pain development when they become injured or malfunction. It is hoped that this can lead to more accurate diagnosis and treatment regimes accordingly.

Cost: £56.00

Fostering Improvements in Patient Health Behaviour

9th October 2022

10.00am - 4.30pm

Lecturer: Andrew Hill

This workshop is aimed at Podiatrists and FHPs who spend time (or need to spend time) encouraging patients to consider behaviour change as a means to manage their condition(s) more optimally. Whilst this is a growing 'ask' of all health professionals to help encourage healthy and positive behaviours in patients, it is not something that they are collectively trained to do in any meaningful way. Accordingly, there is often a communication breakdown that ensues from this (well intentioned) attempt to influence a patients behaviour. This workshop is designed to help you start addressing communication in the context of promoting behaviour change in patients. It will introduce concepts related to reasons underpinning patient decision-making; ambivalence; your role as a communicator and tie all of this together in the context of motivational interviewing as a technique to improve this aspect of growing importance in clinical practice.

Cost: £56.00

The Sharp End of the Job

Scalpel Debridement & Enucleation Technique

19th October 2022

10.00am - 4.30pm

Lecturer: Andrew Hill

In this workshop we will be looking at the anatomy of the skin, epidermal and dermal tissue, and its relation to the development of callus and of various heloma formations.

This workshop will present how to assess and treat callus and helomas, focusing on scalpel debridement and introducing an effective method for heloma enucleation using the scalpel 15T blade. The morning session will be based on theory, with the afternoon being a practical session on scalpel debridement with heloma enucleation on artificial corns.

Cost: £56.00

Are you promoting evidence-based practice?

3rd November 2022

10.00am - 4.30pm

Lecturer: Andrew Hill

This workshop will look at the importance of evidenced-based practice and how this feeds into rationale and decision making in a clinical context. It will also consider the effect of dangerous claims and look at treatment myths that can have bad outcomes for you and your patients.

Cost: £56.00

Common Foot Conditions

Things that you cannot afford not to know about

15th November 2022
FULLY BOOKED

10.00am - 4.30pm

Lecturer: Andrew Hill

This workshop provides the practitioner with the general conditions that present at their practice. The conditions that will be discussed will range from various basic dermatology conditions, neurological conditions, vascular conditions and musculoskeletal disorders. It is a great refresher course and can direct the practitioner into desired fields.

Cost: £56.00

Tropical Diseases of the Foot

1st December 2022

10.00am - 4.30pm

Lecturer: Andrew Hill

Given that in today's society people can travel the world quickly and relatively easily – it is plausible that foot conditions of a curious origin could well be encountered within the UK. It also takes an interesting look at how our podiatric colleagues in different parts of the world face different challenges that we do in Western Europe.

This workshop will look at the various foot conditions that can be encountered that do not have a common domestic cause. Many conditions will be explored in how virulent bacterial strains can cause all manner of serious foot problems.

Cost: £56.00

How Would You Look After A Patient With Chronic Pain?

13th December 2022

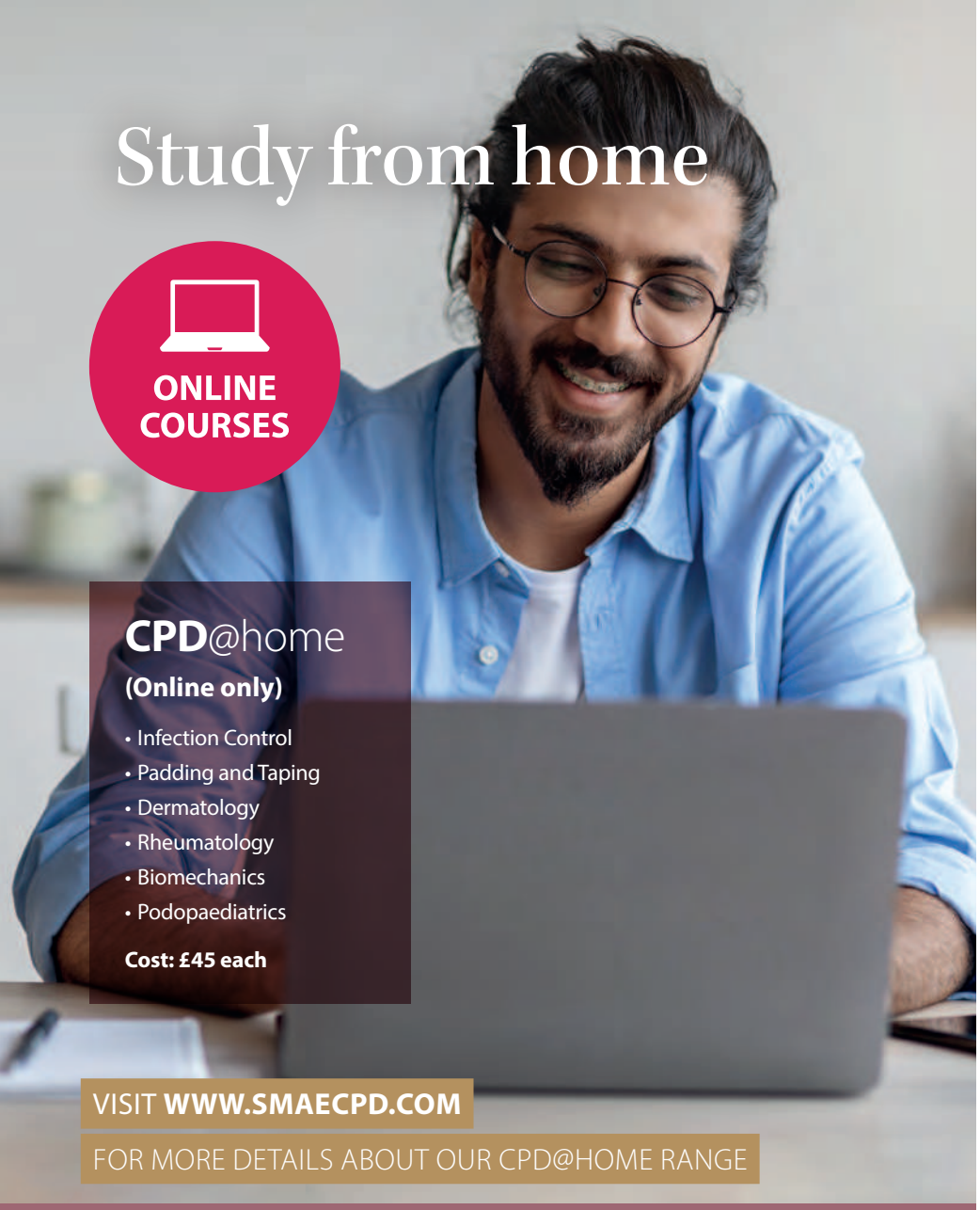
10.00am - 4.30pm

Lecturer: Andrew Hill

This workshop is designed to explore the concept of chronic pain and its management. A variety of chronic pain conditions will be discussed and differences between the types of pain will be explored.

This session will look at not only the pharmacological and alternative methods of pain relief, but also how this impacts your patient and your treatments for these patients.

Cost: £56.00



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Fostering improvements in patient health behaviour

(Online only)

With a changing landscape of public health comes a change in the way that healthcare is delivered and received. In more recent years, healthcare professional across a wide number of disciplines have been moving away from a more traditional, didactic view of the patient-practitioner relationship towards notions of concordance and equity of decision making between both parties.

This change of direction, whilst far from complete, has re-defined the way in which healthcare professionals might best deliver their care within the context of facilitating behaviour change in patients and changing the mind-set away from considering a patient as 'adherent' / 'non-adherent' or 'compliant' / 'non-compliant'. This is particularly true in the delivery of healthcare for patients with more chronic health conditions in which altered lifestyle and amended behaviours are a cornerstone of disease management. As perspectives on healthcare delivery change, the emergence of different approaches towards delivering care to the patient is a logical consequence.

This CPD aims to explore patient-practitioner relationships and how we can improve our consultation skills to best help patients to to make beneficial decisions about their health and to foster any change in behaviour for the longer term.

Cost: £45.00

The On-Going Challenge of Ulcer and Wound Management

(Online only)

Ulcers and wounds are a large problem facing many individuals who are 'at risk'. Identifying the risk factors can certainly help to reduce the incidence and impact of these debilitating lesions. This CPD looks to address what a practitioner should do when encountering a wound or ulcer and help to alleviate the apprehension and fear that a practitioner may otherwise face by arming them with information and guidance.

This CPD covers:

- Structure and function of the skin
- Concept and issues of tissue viability
- The 'high-risk' patient
- Prevention of wound development and complications
- General considerations for treating high-risk patients
- Examining the wound
- Identifying and treating infection
- Osteomyelitis
- Treating the wound
- Dressings
- Other aspects of wound management
- Conclusions

Cost: £45.00

Tackling the Nerves

(Online only)

The nerves are a crucial part of our anatomy and neurological disorders in the lower extremity result from disease processes that involve sensory, motor and autonomic nervous systems. This can follow a metabolic or hereditary process or indeed an injury or trauma which can create progressive or static deformity and be treatable or incurable. Any process which impacts on the delicate nervous tissue and its ability to process electrical signals can create significant issues within the body, not least the lower limb. This CPD looks to assess the nervous system and tackle nervous system pathologies to help practitioners in their management of patients with neurological disorders.

Cost: £45.00

Anatomy, Cell Biology and Physiology Series

The Endocrine System

(Online only)

The endocrine system is made up of a network of glands. These glands secrete hormones to regulate many bodily functions, including growth and metabolism. Endocrine diseases are common and usually occur when glands produce an incorrect amount of hormones or when the hormones cease to work effectively. Thus, when these diseases occur many –if not all- body systems can be adversely affected leading to many life-altering, and possibly life threatening, outcomes. This CPD seeks to explore the main principles and anatomy and physiology of the endocrine system with a focus on pathology and management of endocrine disorders.

Cost: £45.00

The Cardiovascular System

(Online only)

Anatomy, cell biology and physiology are key and underpinning subject areas for all health disciplines. Understanding the way that the body works on both the micro- and macro scale allows us not only understand normal physiological function, but also to understand pathology of various body systems and how medicinal approaches can remedy these pathologies. Within this series of CPD subjects, this one in particular focuses on the Cardiovascular System.

Cost: £45.00

The Respiratory System

(Online only)

The respiratory system contributes to homeostasis by facilitating the exchange of gases – oxygen (O_2) and carbon dioxide (CO_2) – between the atmospheric air, blood and tissue cells. It also plays a role in adjusting the pH of body fluids. Oxygen is the single most important substance that our body requires. Without it death would occur in minutes. Therefore, the importance of the respiratory system is evident and when it doesn't work properly there are serious health implications. This CPD covers the anatomy and physiology of the respiratory system to provide context to help explain and understand respiratory conditions and how they affect the whole body.

Cost: £45.00

What is that pain in the foot my patient is complaining of?

(Online only)

Pain across the metatarsal region of the foot is very common, yet pinning down exactly what is causing it can be tricky. The term 'metatarsalgia' is used to describe such pain but this term only describes the symptoms - pain in the metatarsal region of the foot. This CPD looks to explore this area of the foot both anatomically as well as pathologically and covers the various conditions that can given rise to pain in the ball of the foot. This CPD is ideal for new and experienced practitioners alike and will help support and direct clinical assessments and treatments of this all too common problem.

Cost: £45.00

Can you avert a potential disaster?

Managing the foot in Diabetes

(Online only)

With diabetes mellitus consuming 10% of the entire NHS budget for England and Wales and a significant portion of that amount (some £300m) being spent on managing avoidable foot-related complications, there is a considerable focus on developing tools and strategies to minimise both the individual and financial cost of this devastating disease. The role, therefore, that podiatrists and foot health professionals play in the reduction of morbidity and mortality of the disease as well as improving patients' quality of life cannot be overstated. Against this backdrop this CPD will discuss diabetes mellitus from pathophysiology through to complications and implications for practitioners.

Cost: £45.00

Treating the Persistent Verruca CPD

(Online only)

BEST SELLER

This CPD tackles the area of patient Verrucas are one of the most common conditions treated by podiatrists and FHPs. Sometimes they resolve quickly and very often spontaneously. However, there is a large number that take many months (if not years) to resolve. These lesions are what are termed 'persistent verrucas' and successful treatment of them can be elusive.

This CPD explores this condition from pathophysiology of the condition through to the treatment modalities available to the patient. This serves as a useful guide to practitioners looking to keep up to date with treatment options (standard and contemporary) as well as providing theoretical interest for those looking to broaden their understanding of this common condition.

Areas covered include:

- Overview and Background of Verruca Pedis
- Types of Verruca
- Structure and function of skin
- Clinical Features
- Treatment options:
  - Sharp debridement + occlusion
  - Caustic treatment
  - 'Natural remedies'
  - Cryotherapy
  - Laser Treatment
  - Bleomycin
  - 'Needling'
  - Surgical intervention
- Patient suitability and prognosis

Cost: £45.00

Tropical Diseases of the Foot

(Online only)

This CPD looks to introduce various pathologies that have traditionally been encountered in foot health and Podiatry clinics within tropical climates. It is the responsibility of the modern and competent practitioner to identify certain tropical diseases of the foot and at least have a rudimental understanding of them and their treatments given that more round the world travel is ever more common meaning that more and more of these conditions are being seen more frequently in temperate climates – certainly including the UK.

Cost: £45.00

Common Conditions Affecting The Elderly

BEST SELLER

(Online only)

Elderly patients make up a very large proportion of our clients. It is also this demographic of patients who tend to have more underlying pathologies and chronic foot problems. The elderly foot, therefore, can present in many different ways and provide a complex set of challenges. This CPD will discuss the symptoms and treatments of various pathologies that are commonly seen in the elderly foot.

Conditions that will be discussed include:

- Arthritis
- Parkinson's Disease
- Peripheral Vascular Disease
- Peripheral Neuropathy
- Common Biomechanical pathologies in the elderly foot
- And many, many more

Cost: £45.00

Is It Fungal Or Isn't It?

BEST SELLER

A guide to this most common of Skin and Nail Pathologies

(Online only)

The presentation of a fungal infection in the skin and / or nails is often considered easily distinguishable – however, as this CPD will explore, that is often far from the case with many fungal infections incorrectly labelled as being something else entirely, or a fungal infection going undiagnosed for long periods of time. This certainly can render treatments ineffective, which makes the already tricky task of effective treatment all the more complicated.

This CPD looks to cover all this and more:

- Structure and function of the skin
- Structure and function of the nails
- Types of fungal infection
- Fungal infection of the skin
- Fungal infection of the nails
- Prognosis and future considerations

Cost: £45.00

Are you performing vascular assessments properly?

(Online only)

Vascular assessments are a crucial part of the patient appointment, but are significantly devalued if they are not being done regularly or correctly. The aim of this CPD program is to improve the diagnostic skills of practitioners in their assessment of the vascular system.

By applying more evidence-based actions to their clinical practice, the benefits to patients are significant. This is a must-do CPD for practitioners to ensure that they are providing excellent care for their patients.

Cost: £45.00

Commonly Used Medications And Their Side Effects

BEST SELLER

(Online only)

The aim of this CPD is to educate the practitioner in the effects, both adverse and otherwise, of common medicinal interventions for equally common conditions. This CPD will go on to explore how these effects will influence the symptoms of your patients foot problems as well as the treatments that can be offered.

Cost: £45.00

Are you a Modern Practitioner?

The Growing Need for Health Promotion & Patient Education

(Online only)

This CPD tackles the area of patient education and health promotion. It is easy for health professionals to slip into an isolated view of themselves in the context of their patients' overall health and the role that they may play in improving that.

Certainly within the context of many widespread and serious health conditions such as diabetes mellitus, concepts of 'patient empowerment' and patient-led management is a recent paradigm shift. As such, modern day Podiatrists and FHPs need to take a significant role in the multidisciplinary approach to healthcare. The CPD looks to discuss this theory and provide some useful and insightful guidance on this growing and changing landscape.

Cost: £45.00

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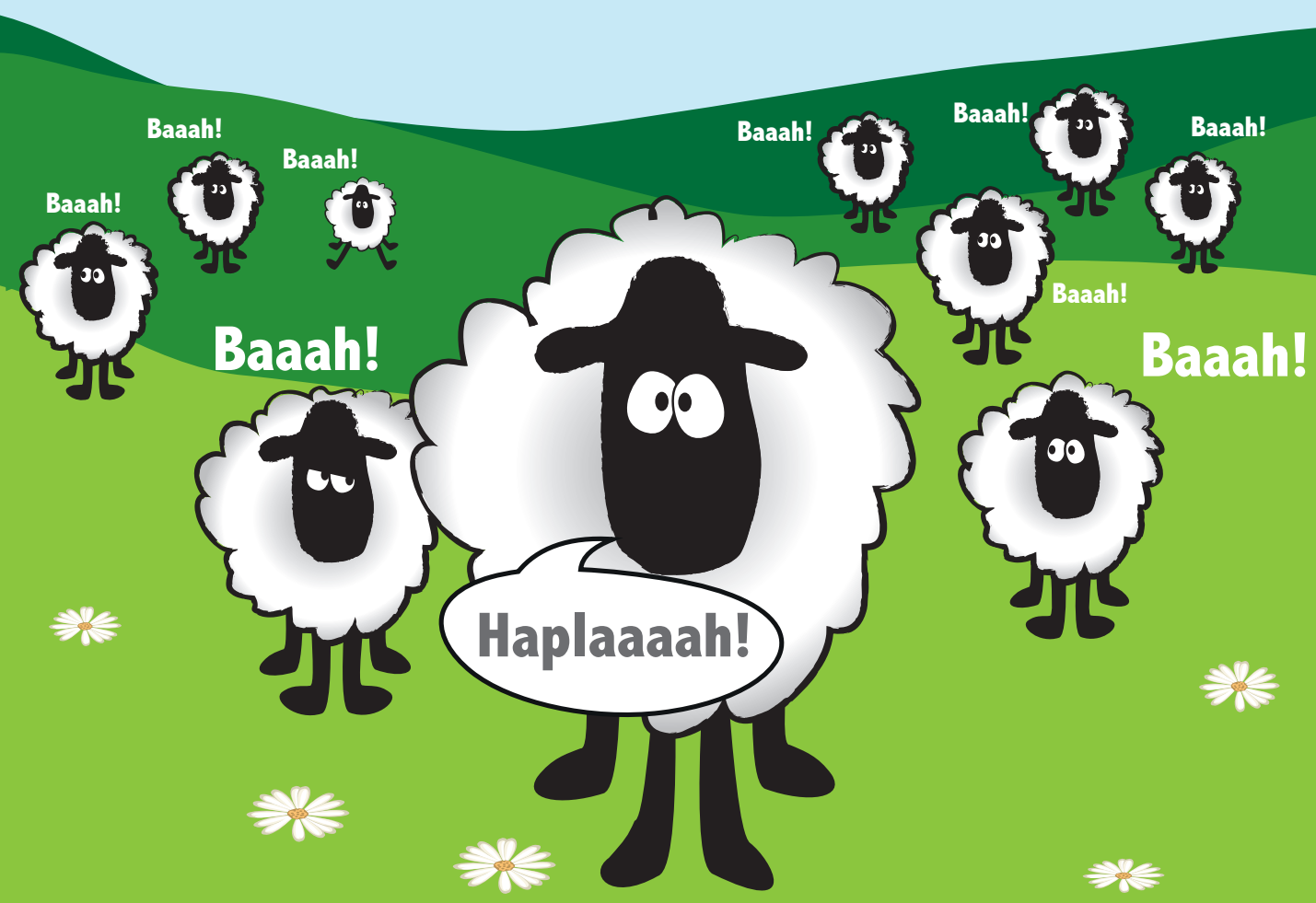

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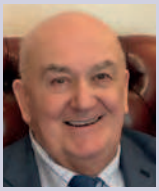

Hon. President

Michael J. Batt
info@smaeinstitute.co.uk
Tel: 01628 621100

The SMAE Institute (1919) Ltd,
The New Hall, 149 Bath Road,
Maidenhead, Berkshire SL6 4LA

Chairman of BCPA / BAFHP

Deborah Mercer FSSCh MBChA
chairman@bcpa-uk.org
Tel: 01268 741019 / 07932 928113

120 Bull Lane, Rayleigh, Essex SS6 8NQ

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alexhepburn30@hotmail.com

Treasurer: Deborah Hart
deborahhartuk@yahoo.com

Secretary: Ashleigh Smaller
ash@thefootfairy.uk

Venue: Honington and Sapiston Village Hall, Bardwell Road, Sapiston, Bury St Edmunds, Suffolk, IP31 1RU | 9am – 4pm

East Midlands Branch

Chairman: Ruth Cranmer
ruth.cranmer@feetaid.co.uk

Secretary: Carl Eary

Treasurer: Toni-Maria Walter

Venue: Wanlip Church Hall, Wanlip, Leicester, LE7 4PJ | 10am – 1pm

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deborah.mercer2@btinternet.com

Secretary: Anna Mapp
anna.mapp773@gmail.com

Treasurer: Michele Pyne
michele.pyne@btinternet.com

Venue: Bulphan Village Hall, Church Road, Bulphan, Upminster, Essex RM14 3RU
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Chairman: Emma Thorpe
emmathorpefoothealth@gmail.com

Secretary: Heather Callaghan
heathercallaghan66@gmail.com

Vice Chairman: Graham Seath
foothealthcare@yahoo.co.uk

Treasurer: Marion Chapman
marion@lyffootcare.com

Venue: Davis Estate Community Centre, Barberry Avenue, Chatham, Kent ME5 9TE
8.45am – 1pm

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Christophe0@aol.com

Secretary: John Gobin
Jgobin@hotmail.com

Minutes Secretary: Angela Fenton
angela_fenton@hotmail.co.uk

Venue: Ormskirk Civic Hall, Southport Road, Ormskirk L39 1LN
10am – 2pm

Scottish Branch

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lornastronach999@gmail.com

Secretary: Fiona Morgan
fiona.morgan22@btinternet.com

Venue: The Landmark Hotel & Leisure Club, Kingsway West, Dundee, DD2 5JT
10am – 3pm

South East Branch

Chairman: Marianne Elliott
thehappyfootcompany@icloud.com

Secretary: Verity Nicholls
veritynicholls@hotmail.co.uk

Treasurer: Kate Alexander
kate.alexander1@hotmail.co.uk

Venue:: The Crowne Plaza Felbridge Hotel, London Road, East Grinstead. RH19 2BH
9am – 4pm

South West Branch

Chairman: Jayne Chudley
jaynechudley1@gmail.com

Secretary: Katharine Hardisty
katharinehardisty@yahoo.co.uk

Venue: St. Cuthbert's Conference Centre, Buckfast Abbey, Northwood Lane, Buckfast, Devon TQ11 0EG
9am – 5pm

West Midlands Branch

Chairman: Eléna Serafinas Broom
elenapodiatry@hotmail.com

Secretary: Emma Jones
completelyfeet@hotmail.com

Venue: Aldridge Community Centre, Anchor Meadow, Middlemore Lane, Aldridge, Walsall, West Midlands WS9 8AN
12noon – 4pm

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