Value Chain Analysis of UK Foot Health Service Provision 1996-2020

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Angela Abbott
Head of Podiatry and Orthotics Services | Torbay and South Devon NHS Foundation Trust

David A Wylie
Head of Podiatry Service | NHS Greater Glasgow & Clyde

INDEX

Executive Summary

The interim NHS People Plan (June 2019) indicates that there is a need to address urgent workforce shortages across the whole health sector. The Allied Health Professions' (AHP) response to this situation is being led by Health Education England, in partnership with all stakeholders. This work aims to develop a sustainable solution to recruitment and retention within the AHPs.

Podiatry within the NHS has been identified as one of the small, but vital professions facing significant challenges in this area, and solutions to developing a sustainable, inclusive and integrated Foot Health workforce are needed.

This work requires steps being put in place to ensure sufficient numbers of staff trained to deliver new service models set out in the NHS Long Term Plan. This is particularly relevant to podiatry, especially in light of a number of key drivers and system challenges including:

- guidance for podiatrists to be part of multidisciplinary teams working in primary care networks
- increase in demand for podiatry services
- an aging NHS workforce
- reduction in graduate entry level numbers.

A stakeholder group, the Foot Health Education and Training Standards Core Group (FHETSCG) has been commissioned to define, clarify and develop the level of accredited learning and education underpinning clinical practice at all levels. In order to support this work, a value chain analysis was used to map the caseload complexity and commensurate training and educational requirements, across all stakeholders delivering foot health interventions in the UK.

This group has been working to standardise recommendations to maximise the knowledge and skills resident within all providers of foot care, as well as maximising value from new roles – particularly in advanced practice. This work aims to develop a richer, more varied and integrated skill mix to enable staff to perform at the top of their licence.

Foot health services are delivered by different groups of providers with differing levels of qualifications, and treating different levels of complexity. The current qualifications required to deliver foot care range from Foot Health Practitioner courses to degree level, BSc (Hons) (required for Health and Care Professions (HCPC) registration), and Masters and Doctoral postgraduate study. In the NHS, the clinical support workforce also achieve differing levels of academic and clinical skills using a variety of accredited vocational qualifications.

The national drivers including workforce challenges, increased service demand, fewer UCAS applications, increased NHS vacancies, plus an organisational requirement to evidence value for money offer a unique opportunity to strategically develop the podiatry and foot health workforce, with particular reference on agreeing and standardising the educational requirements across each tier of the workforce.

Differing levels of care require different levels of knowledge and skills, accredited by different qualification levels - in line with the Regulated Qualifications framework (RQF) or Scottish Credit and Qualifications Framework (SCQF).

Where complex clinical decision making involving the use of anaesthetics and supply of medicines is delivered, the graduate podiatrist working to the top of their scope of practice is able to deliver better value for money in terms of the return on educational investment. Where NHS services are using staff to work to the top of their licences to practice and have maximised the opportunity to skill mix they have been able to demonstrate cost effective delivery as well as improved efficiency (including reduced waiting times) and improved outcomes for patients.

Many graduate podiatrists choose to work within the independent sector delivering essential foot care to a particular cohort of patients. In some geographical areas, NHS podiatry services provide the same level of care to similar cohorts of patients. However in other geographical areas, other NHS providers are delivering podiatry care solely to patients with multiple comorbidities and extremely complex foot problems.

The paper has identified the range of activities that are delivered by differing providers and the cost effectiveness of the resources used to produce them.

NHS podiatry providers that have engaged in whole system service redesign have been able to demonstrate through the value chain that graduate podiatrists add value by maximising their clinical decision making skills (particularly relating to pharmacy only medicines (POMs)) at all levels rather than focusing solely on their technical skills. In these services, a higher percentage of treatments is delivered to patients with active foot ulcers or those at a much higher risk of developing foot ulcers and will be of a more complex nature in terms of the clinical decision making required to support the technical and practical interventions provided.

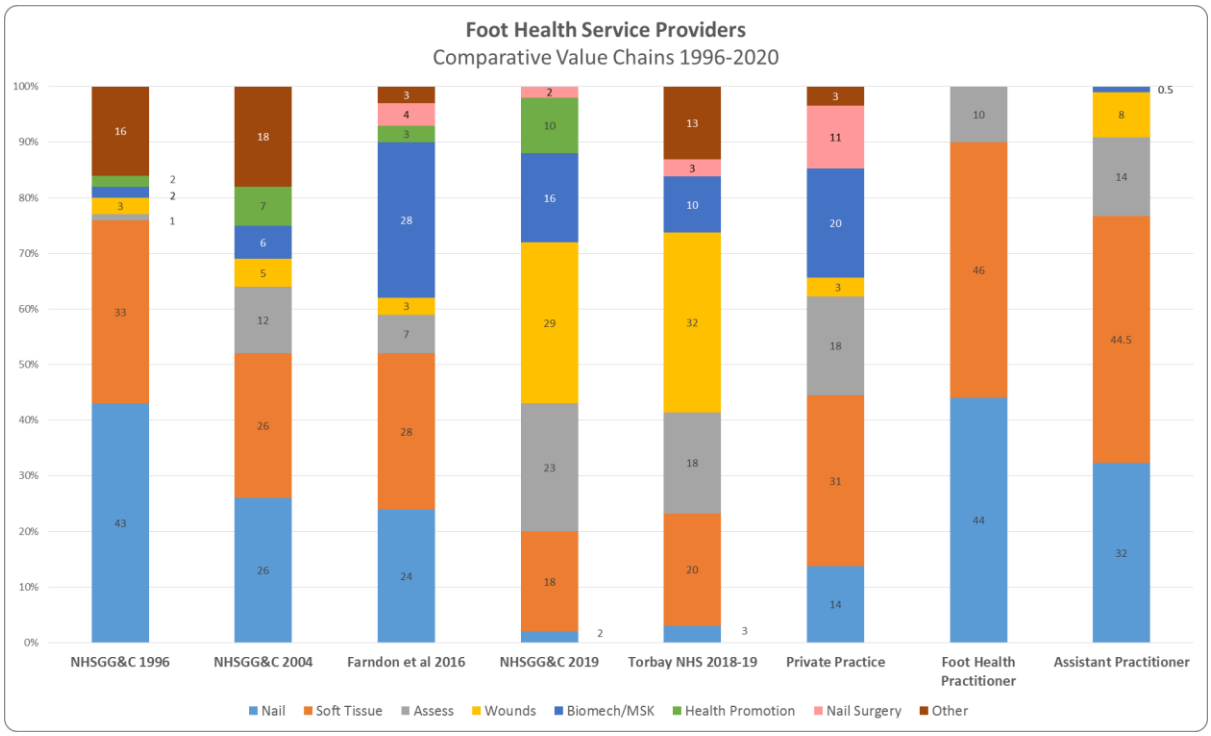
Nail care and skin care is either not provided, or provided to higher risk patients by Assistant Practitioners with varying levels of accredited academic qualifications. Follow up appointments are reduced or eliminated for lower risk individuals, thereby maximising opportunities to see those who are most vulnerable in terms of developing more serious foot pathology or mobility reduction.

In independent practice however, podiatrists and foot health practitioners each have caseload profiles that deliver smaller number of foot wound interventions, with the percentage of nail and soft tissue debridement accounting for around 45% of their activity. The independent practice caseload is similar to that within NHS podiatry services that have not undergone significant service redesign (Figure 1).

It is important to recognise, however, that all foot health providers in the independent sector – both foot health practitioners and podiatrists – frequently see self-referred acute and complex pathologies that may not immediately access community NHS podiatry services. There is also a need to enable rapid referral mechanisms between the two sectors to escalate red-flag referrals timeously into multi-disciplinary and high risk foot protection teams.

The standards of education and training required to deliver these differing levels of clinical practice vary and the cost effectiveness in terms of value for every £ spent in education and service provision is inextricably linked to this. Within NHS podiatry services, the value is not profit, but value for money and efficient, maximised use of resources in delivering services. It is therefore evident from the value chain (Figure 1) that there are significant areas of crossover in tasks undertaken by the range of foot health service providers. Value is potentially being lost across the academic tiers of service delivery, with graduate level providers retaining elements of foot health service provision that can adequately be delivered by a workforce requiring a lower level of educational investment.

Figure 1 Value chain analysis for UK foot health service provider groups 1996-2020



Summary recommendations

NHS Services

It is recommended that the NHS workforce explore how they can upskill existing footcare assistants to take on additional tasks building on their existing competency set as it is anticipated that the implementation of these new posts will contribute significantly to the long term sustainability of NHS podiatry services in the U.K.

NHS Commissioning & planning

The significant discrepancies evident in NHS podiatry service provision requires to be reduced between different service providers, in order that those potentially still delivering services commensurate with an historic service delivery model of up to 12 years old are brought into line with more radically redesigned services in order that the portfolio of interventions provided maximises NHS delivery cost.

HEE and Education providers

There is a need to ensure that NHS podiatry is delivering cost effective services in line with any consensus agreed on the appropriate levels of education required for each tier of service delivery. A detailed implementation plan is required, with respect to engagement and consensus with Higher Educational Institutions and Further Education colleges on competencies, training and mentoring.

Regulators

There is a potential requirement to discuss the potential need for protection of the public by ensuring that all interventions carried out on the foot and ankle by foot health providers is regulated appropriately at all levels.

2 Background

At the meeting of the Foot Health Education and Training Standards Core Group (FHETSCG) on 20 February 2020, a value chain analysis approach was suggested and agreed as part of the mapping process to identify the caseload complexity across all stakeholders delivering foot health interventions in the UK.

This work is envisaged as contributing to a fuller understanding of the level of accredited learning and education that underpins clinical practice at all levels.

2.1 Drivers

A number of drivers currently offer foot health service providers within the NHS and independent practice in the UK a unique opportunity to strategically develop its workforce, with particular reference to the educational requirement for each tier of the workforce. These include:

- An increasingly elderly population requiring personal foot care and toenail and callus debridement interventions that do not require the skills of a registered podiatrist
- Role development for Allied Health Professionals supported by national workforce requirements and skills maximisation models
- Further increasing demand and the need to manage waiting times, hospital admissions and an increasingly complex caseload.

2.2 Skill levels (taxonomy)

Podiatry services required to respond to caseloads with increasing complexity of comorbidities within a growing elderly population whilst improving waiting times and delivering value for money. As higher skilled roles develop across the workforce to meet these demands, the podiatry profession requires to accept that a range of less complex tasks may be safely delivered by less qualified staff[1]. No long-term workforce solution has hitherto been found to deal with the large volume of individuals not requiring the full skills of a podiatrist, but still requiring basic nail and callus debridement. Thus, a fully integrated, evidence based strategic workforce and educational planning solution is required if future foot health need and demand is to be addressed appropriately by NHS podiatry, independent podiatry and other providers of foot health interventions.

3. Value Chain Methodology

Value chain analysis is a strategy tool used to analyse activities carried out within a system. Its goal is to recognise and help identify which activities (outputs) are the most valuable, or cost effective, for the resources used to produce them[2,3]. Value chains are often used to identify differentiation advantages in business, or to

demonstrate where systems could be improved to provide competitive advantage – or in the case of foot health service provision – cost effectiveness in terms of value for every £ spent in education and service provision.

Within NHS podiatry services, the value is not profit, but value for money and efficient use of resources in delivering services. Porter's technique helps workforce planners compare relative percentages of podiatric activities between NHS and independent podiatry service models and activities and interventions carried out by other providers of foot health in order to identify where value for money in terms of educational return on investment is being created or destroyed.

This provides an objective framework upon which to base podiatric competencies, and therefore, by extension, the podiatric workforce required to deliver them.

Value chain methodology was therefore chosen to help answer the question of how foot health service providers may maximise their value within each of their offerings across NHS, independent and unregulated service provision. In times of financial and workforce constraints, it is essential that foot health inputs are translated into foot health outputs in such a way that they have a greater value than the historic or baseline costs of creating those outputs.

This challenge represents more than a dry, academic question: it is a matter of fundamental importance to the podiatry profession, because it addresses the economic logic of why podiatry exists as a profession in the first place, and why it requires to be maintained and developed as a vital health care profession, despite its relatively small size.

However, and crucially, it challenges podiatry profession to clearly articulate and describe its unique contribution to the health economy and what academic underpinning is required for each tier of the foot health burden of care across the UK.
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4. Data

A value chain comparator across professional tiers, provider groups and NHS systems over 24 years is attached in Appendix 1. This was populated using data drawn from NHS podiatry services in Scotland and England, private (independent) practice podiatry and foot health practitioner activity audits. One published paper[4] reporting referral data for 3 NHS Trusts in England is also included.

4.1 NHS podiatry value chain data

NHS podiatry data sources include activity (n=155,342) and caseload (n=37,891) analysis from NHS Greater Glasgow & Clyde Podiatry Service in NHS Scotland, Torbay and South Devon NHS Foundation Trust in NHS England (activity: n=45,000; caseload: n=7,000), and a single publication by Farndon et al (2016)[1] showing aggregated referral data to three podiatry services NHS England; South Yorkshire, Humberside and Nottinghamshire (n=635).

The classifications used in the Torbay 2019 service specification are included in Appendix 2.

4.2 Independent (private) podiatry value chain data

These data were derived from over 2,000 contacts carried out across 3 independent (private) practices in the independent sector.

4.3 NHS assistant practitioner value chain data

These data were derived from over 8,000 assistant practitioner contacts within NHS podiatry services.

4.4 Foot health practitioner value chain data

These data were derived from 3 foot health practitioner service providers.

5. Discussion

5.1 NHS Value Chain

Podiatrist Value Chain

In 1996, NHS Greater Glasgow and Clyde (NHSGG&C) podiatry service carried out an audit of the caseload being carried by its podiatrists. This provided a benchmark in terms of the types of clinical activity carried out across the service. This work revealed that at that time, around 75% of clinical activity carried out by graduate podiatrists involved non-wound related nail and callus debridement.
In 2003, the NHSGG&C podiatry service implemented a partial redesign where it moved to a self-referral service and began the process of discharging patients with personal foot care and toenail cutting foot health needs.

In 2004, a further caseload audit was carried out in partnership with Information Services Division (ISD) Scotland[5], demonstrating that lower risk, task-technical focused debridement of skin and nail tissue had reduced from consuming 76% of service resource to 52% - a 33% reduction in this activity. Consequently, the amount of time spent in more activities requiring graduate level clinical decision making activities including assessment, wound management, biomechanics/MSK and health promotion, had increased from a combined total of 8% in 1996 to 30% - a 275% increase in these activities thereby adding value to the service[6] (Sandifer & Davies, 1998). By the time a further review of NHSGG&C patients was published in 2007[7], these activities had further reduced to around 36% of registered podiatrist activity

In 2012, the NHSGG&C podiatry service became a single system service across the NHS Board area, including acute based podiatry services. Further redesign work followed, including the introduction of POM-S and Non-Medical Prescribing to the

graduate workforce and the removal of Personal Foot Care from the podiatry service specification in 2014.

The Scottish definition of Personal Foot Care was adapted from the version proposed by the Department of Health[8]. This was incorporated into The Scottish Government's Personal Foot Care Guidance document[9] which clearly states that NHS podiatry managers in Scotland agreed that the provision of personal footcare does not require the specialist skills of a podiatrist (p5).

These drivers facilitated further development of assessment and clinical decision making skills commensurate with a more complex podiatry caseload. When the NHSGG&C podiatry service re-audited in 2019, lower risk, task-technical focused debridement of skin and nail tissue had reduced further. What had consumed 52% of activity in 2004, reducing to 36% in 2007, had further reduced to 21% of activity – a further 60% reduction since 2004, and an overall reduction of 72% since 1996.

The value chain shift within NHSGG&C podiatry service over the 23 year period between 1996 - 2019 indicates that there is a strong case for selective divestment within podiatric education of teaching competencies relating to simple nail and callus debridement for individuals at negligible medical risk.

Although no historic data are available from Torbay & South Devon NHS podiatry service, their own service redesign is delivering activity ratios very similar to those in NSHGG&C. This service redesign led to the discharge of lower risk patients and delivery of long term care to a caseload that is predominantly made up of patients with multiple comorbidities, complex foot and lower limb ulcerations and short episodes of care for MSK and surgical procedures. The level of congruence between these services is remarkable, particularly in the redesign of nail and soft tissue debridement out of the NHS podiatry services in each area (Table 1).

These comparator services are of interest since they are geographically distant, and are administered by different NHS systems. NHSGG&C is an NHS Scotland Health Board service, and Torbay & South Devon NHS Foundation Trust is an NHS England Foundation Trust.

Table 1 Value chain domain comparisons between NHSGG&C and NHS Torbay

Activity Domain 2019	NHSGG&C	NHS TORBAY	DIFFERENTIAL
Nail	2%	3%	Torbay Higher by1%
Soft Tissue	18%	20%	Torbay higher by 2%
Assessment	23%	18%	NHSGGC higher by 4%
Wounds	29%	32%	Torbay higher by 3%
Biomechanics/MSK	16%	10%	NHSGGC higher by 6%
Nail Surgery	2%	3%	Torbay Higher by1%
Health Promotion	7%	n/k	Torbay higher by 6%
Other	0%	13%	

What is evident from this comparative work is that in NHS Podiatry services where radical whole system redesign has taken place the historic NHS podiatry value chain has been dramatically altered.

What is also interesting, however, is that the work published[4] using data from three NHS Trusts in England (South Yorkshire, Humberside and Nottinghamshire), shows a picture much more congruent with the NHSGG&C podiatry service position in 2004 with respect to nail and soft tissue debridement work.

Assistant Practitioner value chain

The term Assistant Practitioner is general terms for staff trained to support podiatrist in the delivery of care. These ranged from staff trained at NVQ 2,3,4 to foundation degree level. These data were derived from over 8,000 assistant practitioner contacts within NHS podiatry services. The assistant practitioner is safely able to provide a range of foot care. It is evident that within a delegated scheme of responsibility, assistant practitioners add value within the NHS value chain, by providing nail/soft tissue interventions, health education, footchecks, corn and callus debridement and wound care on complex high risk patients for patients delegated by regulated graduate NHS podiatrists. These patients may still be classified as 'higher risk' in podiatric terms, but their care is delivered within clear NHS governance standards and to an agreed service specification and workforce plan.

5.2 Independent (Private) Practice Value Chain

These data were derived from over 2,000 contacts carried out in the independent sector. The independent podiatry sector is a major player in the delivery of foot health within the UK, with upwards of 50% of College of Podiatry members declaring activity in this domain. The percentage of nail and soft tissue debridement carried out within the practices audited accounts for around 45% of their activity. The independent practice value chain therefore looks more similar to the Farndon NHS value chain from 2016 than to the radically redesigned NHS services in Torbay and Glasgow from 2019.

Independent practitioners are able to choose for themselves what services they offer to the public, and the skill set of practitioner they choose to deliver it. Many choose to deliver nail and callus debridement themselves, rather than skill mix their caseload, although – anecdotally - an increasing number of independent practitioners are employing assistants in order to maximise a more cost efficient and effective use of their own time and skills.

5.3 Foot Health Practitioner Value Chain

The foot health practitioner (FHPs) predominantly deliver care to private patients and not within the NHS. The value chain was derived from information provided by three foot health practitioner providers. Unsurprisingly, nail and callus debridement accounts for 90% of their activity.
The closest value chain match for FHPs was the pre-redesign Podiatry service in NHSGG&C in 1996, demonstrating the way in which podiatry skills have developed

over that 23 year period. In 1996, the value chain differential between a FHP and a regulated NHS podiatrist would have been negligible. In 2020, it is now significant. The main difference between FHPs and Assistant Practitioners' value chains is that Assistant Practitioners operate within the NHS and have their caseload delegated and 'supervised' by a regulated graduate podiatrist. They currently attain a level of academic study at foundation degree level. FHPs operate exclusively within the independent sector.

5.4 Value chain implications for the NHS podiatry workforce

The current workforce profile for podiatry services in Scotland demonstrates a "skills-glut" at level 6 and a significant skills-gap at level 4 (Appendix 3)[10]. The unsustainability of this situation becomes apparent when the volume of less complex nail and callus debridement carried out by, for example, the three podiatry services surveyed by Farndon et al. is taken into consideration. Value is clearly being lost if level 6 staff are being employed to carry out level 3 and 4 tasks.

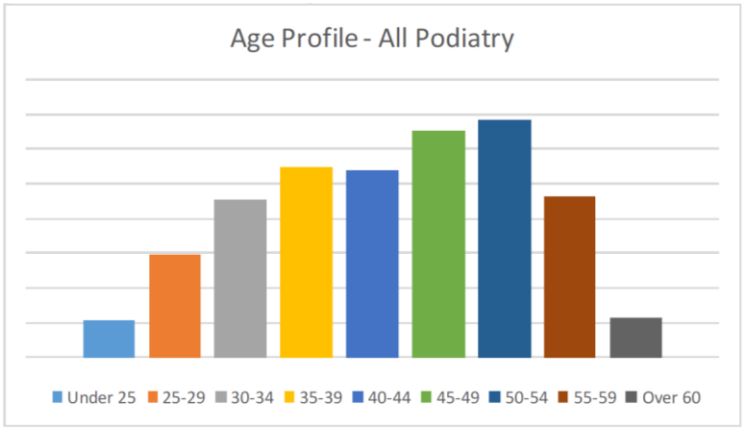
The NHSGG&C podiatry skills profile, by comparison, has a more sustainable workforce model (Appendix 4) with Band 5 staff working at the top of their graduate licence, utilising POM-S and POM-A qualifications to contribute appropriately to a more complex caseload than, for example, the Trusts described in the Farndon paper[4].

5.5 NHS podiatry workforce skills gap

Nonetheless, there remains a significant skills gap in the podiatry workforce, and to fill this new assistant practitioner posts at Band 4 require to be created. A five-year workforce projection based on competencies and anticipated caseload requirements reveals a future skills profile more commensurate with anticipated caseload requirements.

Around 32.9% the NHS podiatry workforce in NHS England will reach 60 years of age within the next ten years (Figure 1). Most of these posts are at level 6 in the career's framework.

Figure 1. NHS England Podiatry Age Profile 2017



To maintain a sustainable NHS workforce, many of these posts require to be skill-mixed as they become vacant in order to create new level 4 or 5 posts, working at the top of their competency set. There is a further emerging workforce challenge with the need for additional level 7 posts operating at the top of *their* capability to deliver an increasing volume of complex decision making interventions previously carried out by medical professionals as they struggle to maintain their own workforce numbers.

5.6 NHS service caseload complexity

The comparable England and Scotland NHS services demonstrate that they are providing services to patients with Diabetes who are at risk of developing foot ulcerations or have active Diabetic foot ulcers. Patients within the NHSGG&C have comparatively high levels of deprivation. T&SD NHSFT service has a high elderly population and many present with multiple comorbidities and long term conditions.

Table 2 NHS service caseload complexity

Caseload demographics	**NHSGG&C Active caseload (37,696)**	**NHS TORBAY Active caseload (6,989)**
Diabetes	**8,112**	**3,356**
Active ulceration	**2,318**	**322**
High Risk	**1,808**	**1,166**
Moderate Risk	**2,676**	**1,114**
Low Risk	**3,569**	**754**
Peripheral vascular disease	**7,671**	**1,215**
Neuropathy	**6,802**	**2,241**
Low risk caseload		
Nail surgery procedures	**3,410**	**1,618**
MSK	**26,750**	**2,560**

6. Conclusions & recommendations

6.1 Educational implications

It is evident from the value chain analysis that there are significant areas of crossover in tasks between foot health service providers. It therefore follows that value is potentially being lost across the academic tiers of service delivery, with graduate level providers retaining elements of foot health service provision that can adequately be delivered by a workforce requiring a lower level of educational investment.

The immediate challenge facing NHS podiatry services is the initial creation and introduction of assistant grades into services in the short term, thereby paving the way for more radical resource reallocation in future workforce plans. The implementation options distil into a choice between upskilling existing footcare assistants to take on additional tasks based on their existing competency set in order to become assistant practitioners, or to recruit from the foot health practitioner workforce or elsewhere to take up these posts, following consensus on the appropriate levels of education required for each tier.

Given that success in implementing a radical skill mix into the NHS foot health provider space will largely be dependent upon cultural factors, and that no additional funding is assumed, it is likely that a significant amount of detailed planning is required, particularly with respect to stakeholder engagement and consensus with Higher Educational Institutions and Further Education colleges on competencies, training and mentoring. Nonetheless this option offers an achievable short term implementation with minimum disruption to the existing service delivery.

6.2 NHS podiatry service implications

It seems evident therefore that there may be significant discrepancies in NHS podiatry service provision between different service providers, with some potentially still operating up to 12 years behind other more radically redesigned services in terms of the portfolio of interventions provided.

It is anticipated that the implementation of these new posts will contribute significantly to the long term sustainability of NHS podiatry services in the UK, whilst simultaneously providing a cost effective solution for the basic toenail and callus debridement needs of an increasingly elderly population that has hitherto proved so elusive.

Although, since this paper is designed to address educational redesign to support the NHS podiatry workforce, it is also submitted as evidence supporting a vision of what NHS podiatry services across the UK *should* or *could* potentially include in future service specifications, or commissioning rounds.

This will, in turn and over time, drive undergraduate educational levels, and redefine the skills required by the graduate podiatry profession, and those which can adequately and safely be divested and delegated to diplomate and certificated

cohorts of staff working, not only within the NHS, but also across the global foot heath workforce.

6.3 Professional implications

It is also evident that there is no homogenised service specification for podiatry across NHS services, leading to potential confusion in terms of defining 'who should do what?' in foot health service provision, and – at an even more fundamental existential level, no definitive answer to the basic question 'what is Podiatry?'

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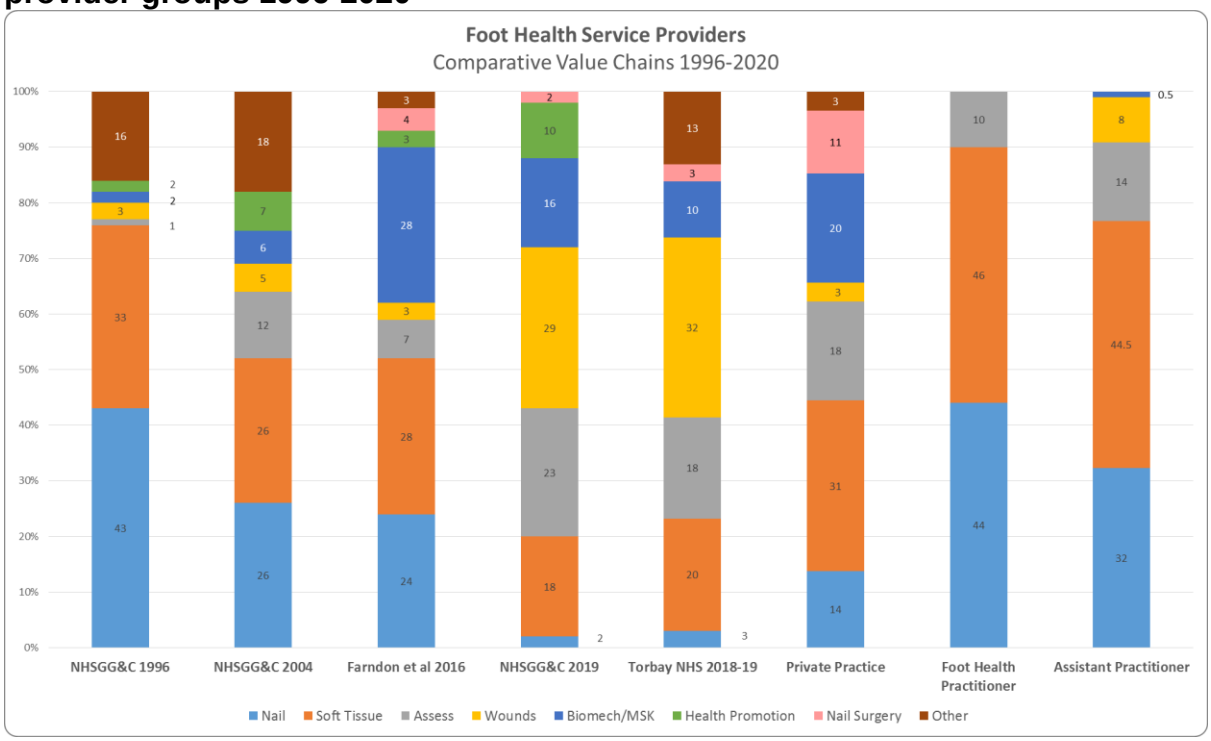
APPENDIX 1: Comparative value chain analysis for UK foot health service provider groups 1996-2020

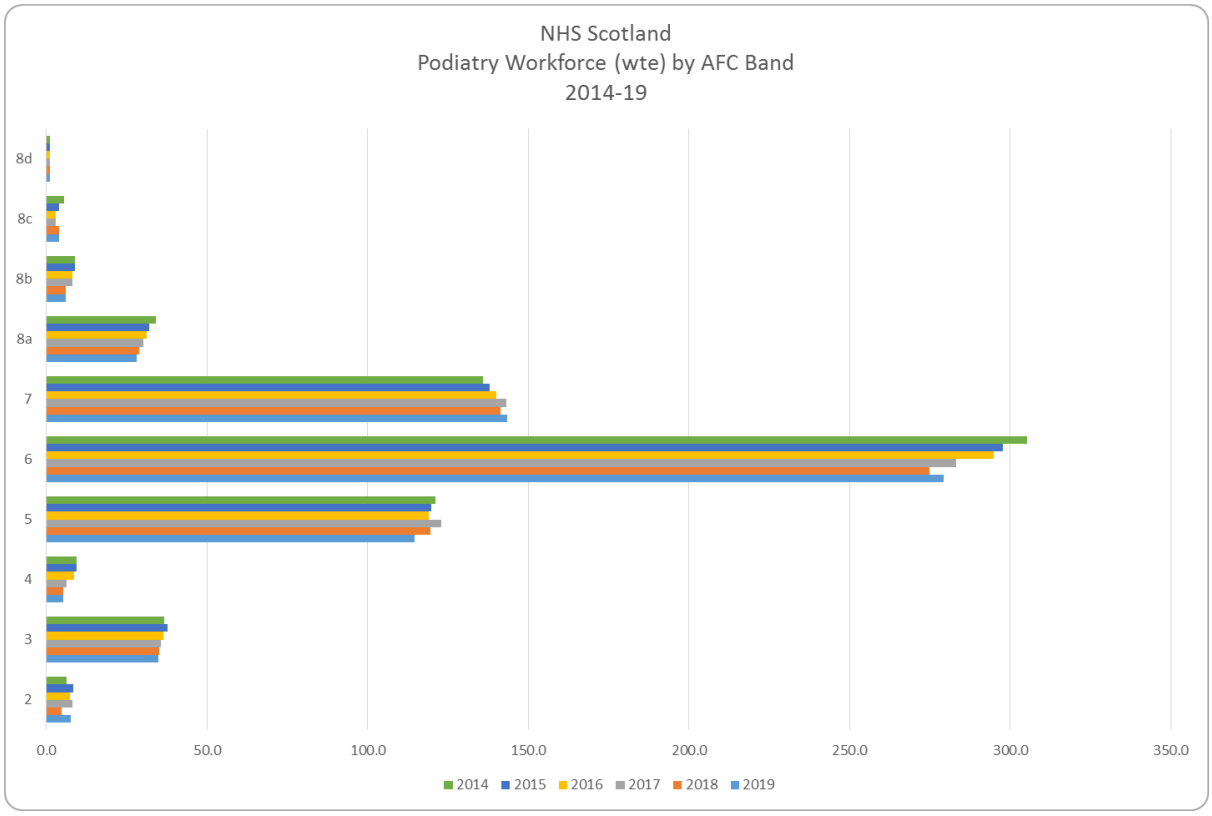


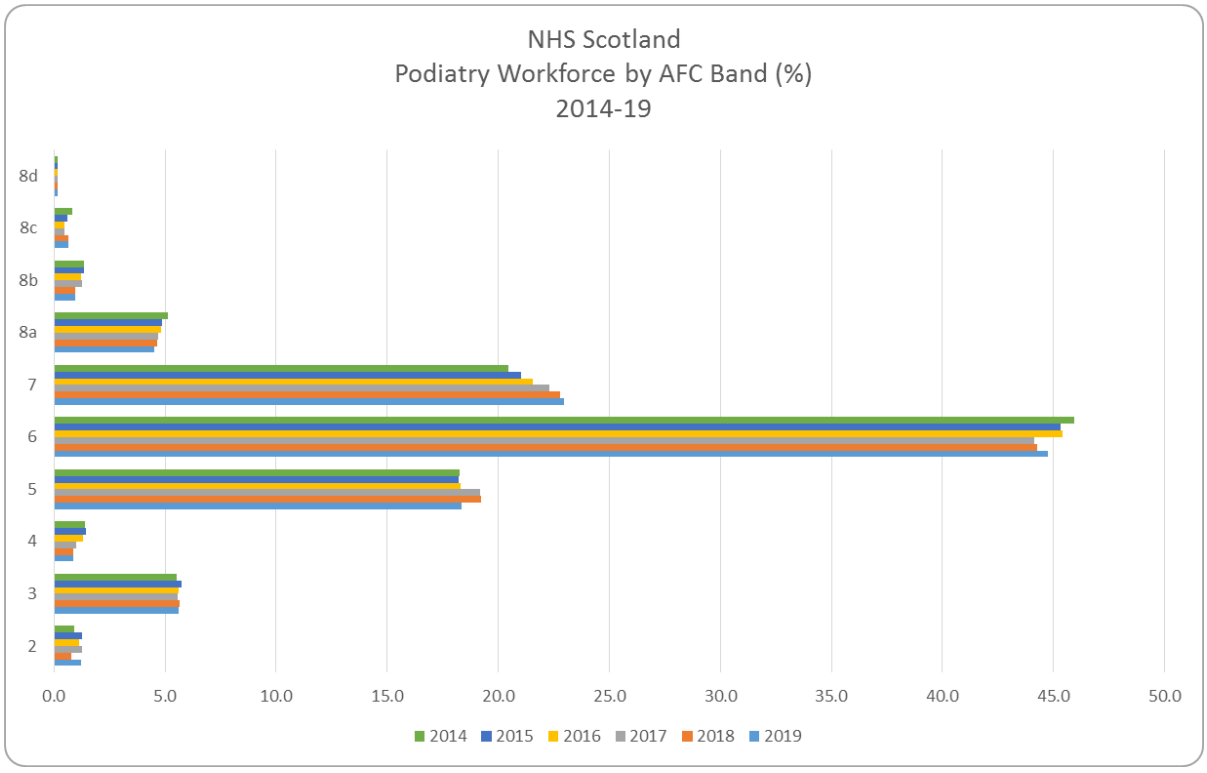
APPENDIX 2: CATEGORY DEFINITIONS for TORBAY PODIATRY

Category	What's included in the appointment	Caseload
Nail surgery	**Activity** vital signs, VTE assessment, O2 saturation, BP, video of redressing's virtual reality for needle phobic patients.	Children who are fit and well through to those with multiple comorbidities
Other	**Activity** Health education of other heath professionals, mentoring students, supervision, incident investigations, training of Assistant practitioners, Root cause analysis investigations, research clinics , non- custom stock footwear,	
MSK	Triage of interface orthopaedics referrals, shockwave therapy, ultrasound scanning, steroid injections, radiology referrals, x-ray interpretations, video referrals , insoles, casting, foot plate analysis, video analysis, MSK assessments, AFO's, prescription of footwear modification (e.g. Rocker bottom) . Sports injuries	Children and adults and incudes those with multiple co-morbidities, Post Trauma and orthopaedic surgical intervention follow ups Listing for surgery in interphase service
Wounds	Non Medical prescribing, pressure ulcers, diabetic foot ulcers, Gouty ulcers, ulceration linked to Inflammatory arthropathy , radiology referrals, x-ray interpretations, duplex requests, blood monitoring, swabs, Total Contact Casts, MDFT clinics, vac therapy, larvae therapy, video referrals, Pressure ulcer prevention with MUST , waterlow, SSKIN assessments. Post-surgical wounds. All tissue viability activity on lower limb with multilayer bandaging excluding initiation of compression bandaging. **Excluded**- nail surgery redressings	High risk patients with diabetes inflammatory conditions , palliative care vascular patients, venous foot ulceration Tier 1 **Patients on wards**
Nail care	Abnormal nails, simple nail care not provided unless ulcerated patient	One of reduction of gryphotic neglected nails then discharge unless ulcerated on any patient
Soft tissue	Non chronic ulcers with reduced healing ability due to RhA, gout, IA. Corns callus breakdown, VP tissue breakdown, **Excluded**	Increased risk of ulceration patients only due to immunocompromised, peripheral vascular disease etc

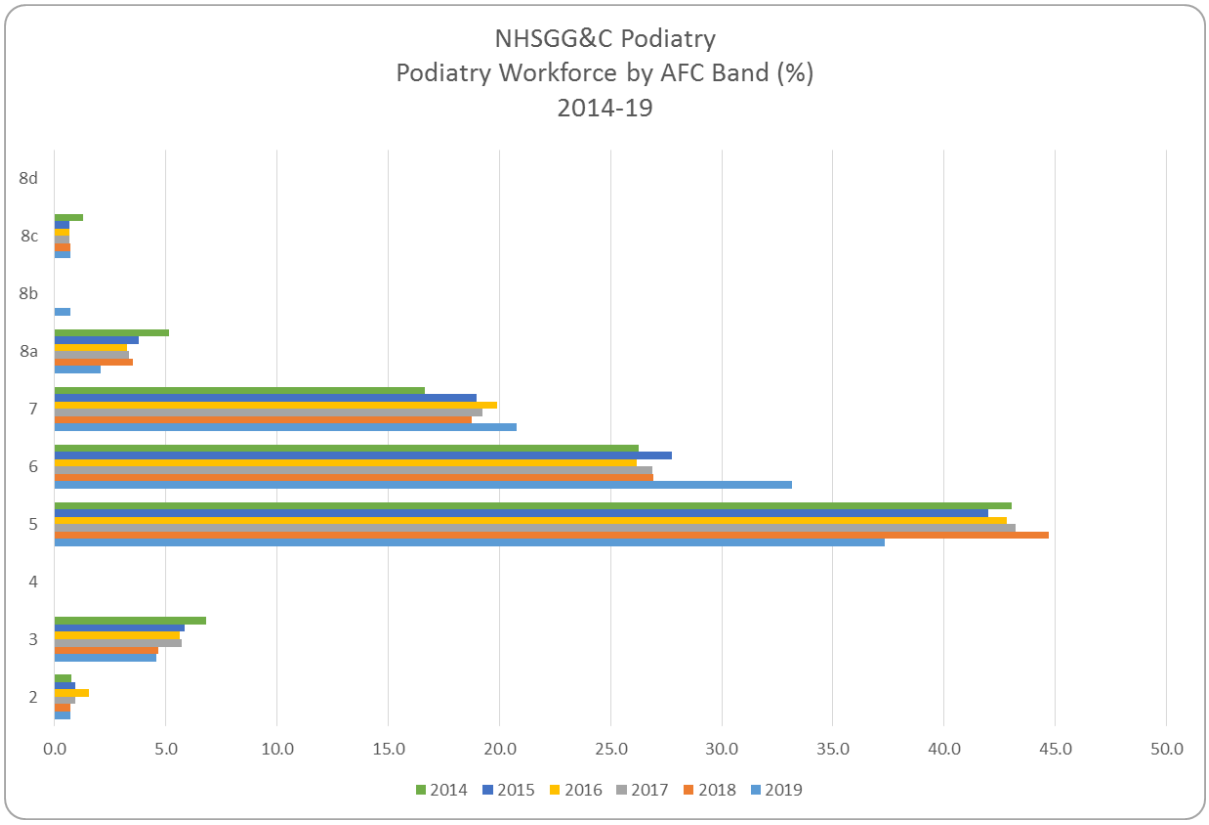
	Verrucae, corns and callus on low risk foot	
Assessments	Ankle brachial pressure index (ABPI), Toe brachial pressure index (TBPI), Doppler, monofilament, full medical history, medication review, Blood pressures (BP), Atrial Fibrillation screening, video referrals, Pressure Ulcer prevention (PUP) strategies (ordering offloading equipment), waterlow, SSKIN, MUST. Patient education on Diabetic foot risk, PUP risk. Drug and Alcohol screening/signposting . Signposting for smoking cessation, weight management.	At moderate or high risk of developing diabetic foot ulcer, immunocompromised, peripheral vascular disease.

APPENDIX 3: NHS Scotland Podiatry Workforce by AFC Band 2014-2019



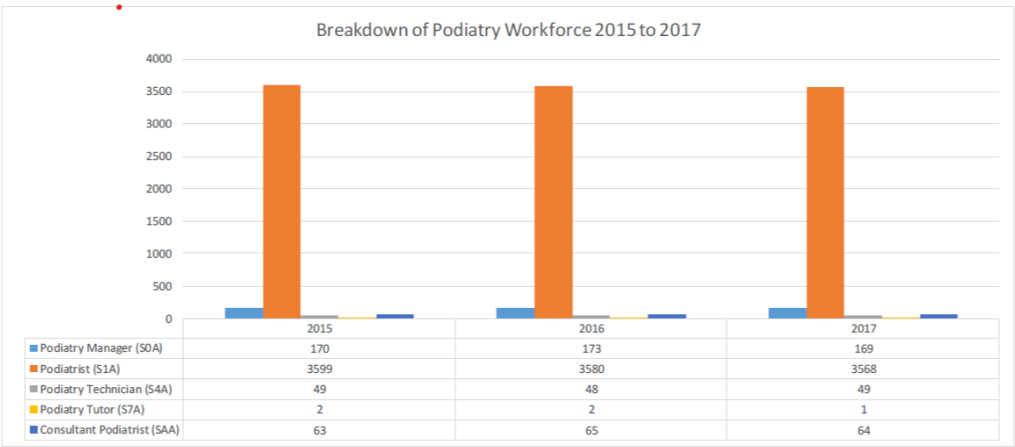


APPENDIX 4: NHS Greater Glasgow & Clyde Podiatry Workforce by AFC Band 2014-2019



APPENDIX 5: NHS Podiatry workforce 2015 to 2017

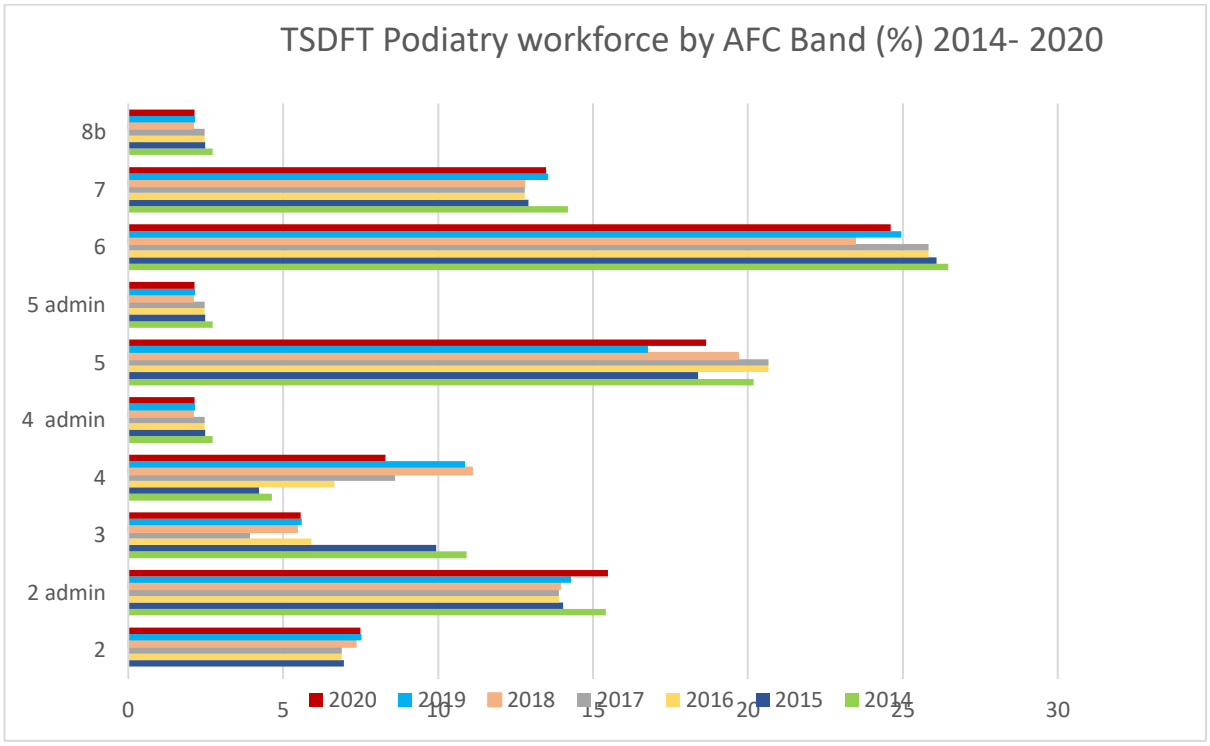
Breakdown of Podiatry Workforce - 2015 to 2017



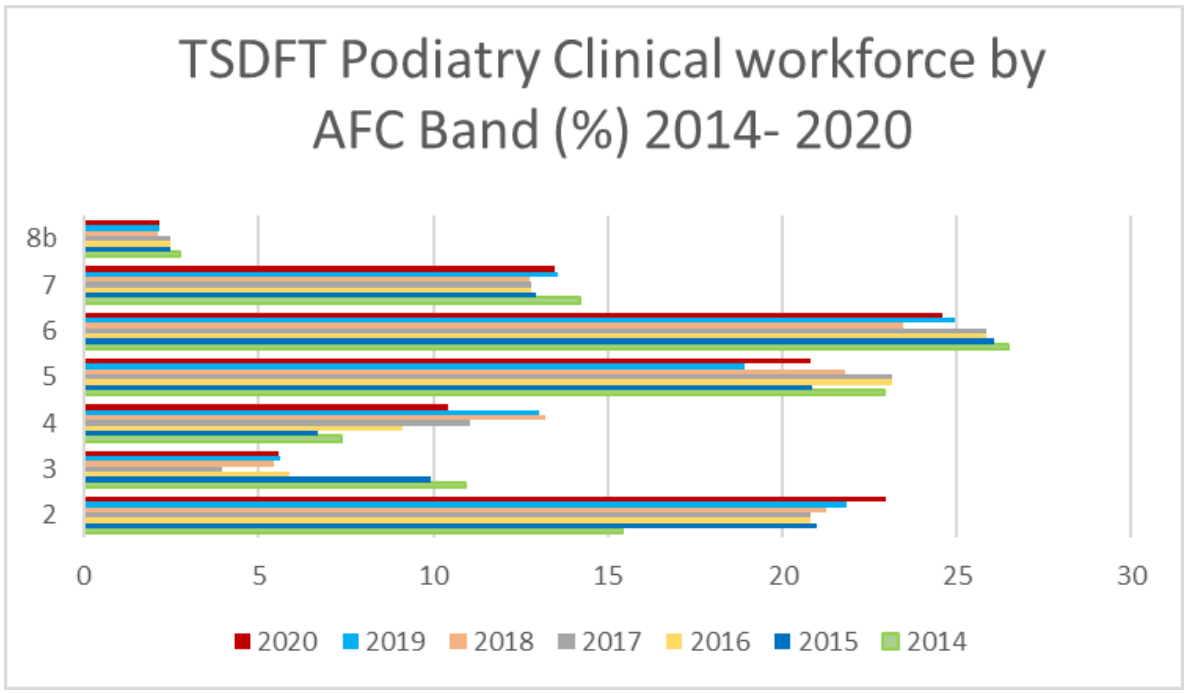
	2015	2016	2017
Podiatry Manager (SOA)	170	173	169
Podiatrist (S1A)	3599	3580	3568
Podiatry Technician (S4A)	49	48	49
Podiatry Tutor (S7A)	2	2	1
Consultant Podiatrist (SAA)	63	65	64

Source: HEE Analysis of ESR March 2017

Torbay and South Devon NHS Workforce by AFC Band 2014 -2020



Torbay and South Devon NHS Clinical Workforce by AFC Band 2014 -2020



WTE Torbay and South Devon NHS Workforce by AFC Band 2014 -2020