Department of Health

Footcare

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Footcare

1. Introduction

Footcare really matters to older people. Foot problems cause pain and discomfort that affect people's mobility and ability to manage everyday tasks. This may mean they lose their independence and self-confidence. They may be more likely to fall or harm themselves.

Early and regular footcare services can prevent more serious health problems arising and enable older people to remain mobile and pain-free as long as possible. It is therefore important that older people can easily obtain footcare services locally that meet their individual needs.

In 2006 the regulatory body, the Commission for Healthcare Audit and Inspection, called for the Department of Health to improve access to both good quality podiatry and general footcare services by requiring PCTs to commission adequate provision of services.

The Department has carried out a review of footcare services across the country to see what is available to older people. It has found plenty of good examples of services, but sometimes these are delivered in a patchy way. This may be because responsibility for providing footcare services has been unclear in the past, and there has not been a clear definition of footcare, as opposed to podiatry.[1]

The focus of this guide is on footcare services rather than NHS podiatry services. Podiatrists are highly trained professionals registered with the Health Professions Council who diagnose and treat abnormalities of the foot. They give professional advice on the prevention of foot problems and on proper care of the foot.

This guide defines footcare as a set of tasks, including toenail cutting, skincare, advice and referrals. Some of these a healthy adult will normally carry out themselves, but an older person may be unable to manage. **A full definition of footcare can be found in Figure 1**.

Local footcare services are often commissioned from the voluntary or third sector, so it is crucial to understand how good commissioning practice can be applied to this area of services, and reinforce the role of organisations such as Age Concern.

1 The terms podiatry and podiatrist are interchangeable with the terms chiropody and chiropodist

Figure 1: What is footcare?

The term footcare covers a set of tasks that a healthy adult, whatever their age, would normally do for themselves. When this becomes difficult for an older person to do for themself, their family, friends or carers may choose to do it for them.

Footcare is defined as:

Toenail cutting

- cutting and filing toenails safely, and keeping them at a length which feels comfortable.

Skincare

- smoothing and moisturising dry and rough skin
- checking for cracks and breaks in the skin and signs of inflammation
- looking for signs of infection or other obvious early problems and referring for further professional advice.

The definition of footcare also covers tasks carried out by a trained professional:

Footwear advice

- reviewing footwear to assure safety and stability
- advising on suitability and how and where to obtain appropriate socks, shoes and other footwear.

Prevention advice

- keeping feet clean, dry, mobile, comfortable and warm
- promoting good foot health advice based on each individual's lifestyle and circumstances.

Signposting

- recognising that foot conditions can change and, in the instance of pain, infection or other unreported conditions, knowing when to refer to podiatrists or other healthcare professionals
- raising other health and social care risks with appropriate professionals including health and safety issues, social exclusion and benefit rights.

Using this guide

This guide is part of the Department of Health's Prevention Package for Older People, a key component of the Government's ageing strategy. The package aims to raise the focus on older people's prevention services and encourage their use, ultimately improving older people's health, well-being and independence.

It offers commissioners of health and social care services guidance on how to deliver the footcare services older people require, with examples of good practice models that have been developed to meet footcare needs in local communities.

The guide looks at what makes a high-quality footcare service and how to deliver this in a way that suits the needs of different groups of older people locally.

There are currently no specific indicators or outcome measures around the creation of footcare services, but this guidance is based on the wealth of research evidence that exists (see **Annex**). It is also in line with World Class Commissioning competencies and the accepted commissioning pathway.

Organisations and individuals who provide footcare services may also find the guide useful in understanding what type of service they should offer, using evidence-based examples of high-quality care. Existing footcare services can benchmark themselves against the elements of a good footcare service set out in **Section 5**.

The information in this guide will also help older people understand what sort of footcare services may be available in their local area and what quality of service they can expect to receive.

2. Why footcare is important

Footcare matters to older people because it improves their quality of life by supporting independence, mobility, socialisation and associated mental well-being. Foot problems are one of the major causes of walking difficulties in older people. There is evidence that foot problems, particularly painful feet, impair balance and functional ability.

Research also suggests that foot problems increase the risk of trips and falls, especially when a person has multiple foot problems.

Figures from the General Household Survey suggest that a large proportion of the older population have difficulty cutting their own toenails.

The General Household Survey, which is carried out across the UK annually, only includes people living in private accommodation, not in institutional settings like care homes, so these figures may not give the whole picture.

Stakeholder events held as part of the Department of Health review highlighted examples of how PCT commissioners had consulted with older people. For instance, Swindon PCT developed a footcare service based on the views of its older population, who wanted footcare made a top priority locally.

Improving access to footcare services will make a difference to many older people. Good footcare leads to:

- reduced pain
- increased mobility
- increased self-esteem
- increased participation in leisure and cultural activity
- increased physical activity.

In turn, this can lead to wider positive outcomes, such as older people remaining independent and able to live at home and a reduction in the number of preventable falls.

In organisational terms, too, it makes sound financial sense to invest in relatively low-cost, low-level services in order to prevent the need to provide more costly treatments at a more acute stage.

Better footcare services can support wider service improvement by creating efficiencies in the system, eg more rapid access to clinical care.

The health and well-being of older people is especially important as they are a growing proportion of the population. Far from being a burden to the state, many older people will become carers for a wide range of dependants, including their own parents, grandchildren and great-grandchildren, and take up volunteering and employment opportunities.

The Government's 2009 strategy *Be active, be healthy: A plan for getting the nation moving* highlights the value of physical activities like walking and dancing to encourage older people to be more active. Currently only 17% of men and 13% of women aged 65 to 74 meet the Chief Medical Officer's recommendations for physical activity, and these figures drop considerably among over-75s.

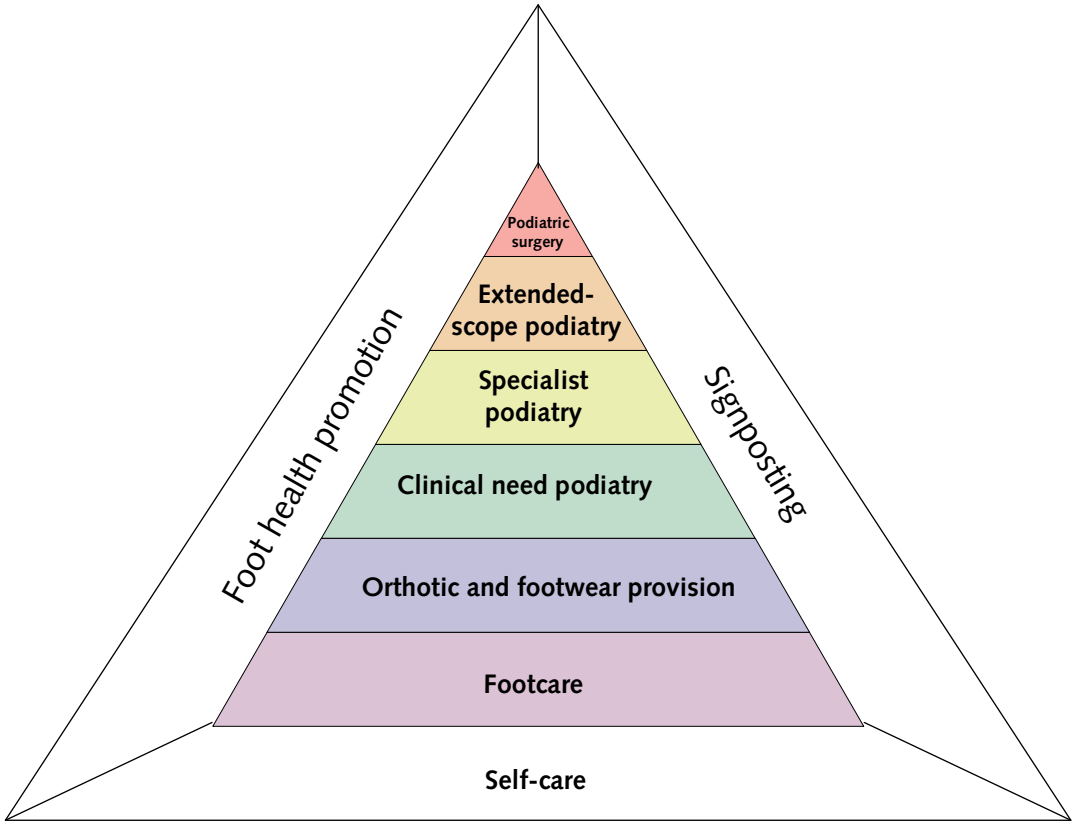
The NHS Next Stage Review points out that because people are living longer, there is a need to proactively identify and mitigate health risks. This includes supporting people to take responsibility for their own health and helping them to live independent and fulfilling lives. The review highlights the importance of more flexible services in the community providing personalised care to older people.

The significant benefits to older people of healthy feet are clear. However, the economic benefits are more difficult to quantify as this is an under-researched area but it is reasonable to suggest that good footcare could lead to a range of economic benefits particularly in relation to falls, more costly treatments and the general health gains from improved quality of life.

Older people value footcare and view it as an important service, but there is a lack of provision that is the subject of many complaints and needs to be rectified.

There is no national classification of footcare needs. The following diagram shows the foot health spectrum of care.

Figure 2: Foot health spectrum of care



Adapted from Boden (2007)

3. Providers of footcare services

Historically both footcare and services for older people have been viewed as low priority, low status and less glamorous aspects of healthcare provision.

Much footcare can be safely and effectively delivered by social care providers, the voluntary or private sector, or by carers and family members where they wish to, with podiatrist-led services limited to those with clearly defined clinical needs.

Age Concern launched its Feet for Purpose campaign in 2007 to highlight problems faced by older people in accessing footcare, including basic nail cutting services. The charity has developed footcare services in partnership with a number of NHS trusts and local authorities (see **Section 5**).

Footcare case study: Jim and Elma Bolt, Exeter

Jim and Elma Bolt (both aged 85 years) have lived at their home in Whipton in Exeter for nearly thirty years.

Both Jim and Elma had been cutting their own toenails but were having real problems doing so. Jim found bending down to reach his toes increasingly difficult and having cataracts created even more problems. Elma has arthritis in her hands and so finds it really hard to grip the clippers. They had both agreed that they would need to look into getting them done by someone else when Jim spotted a newspaper article on the Exeter footcare service and called up straight away.

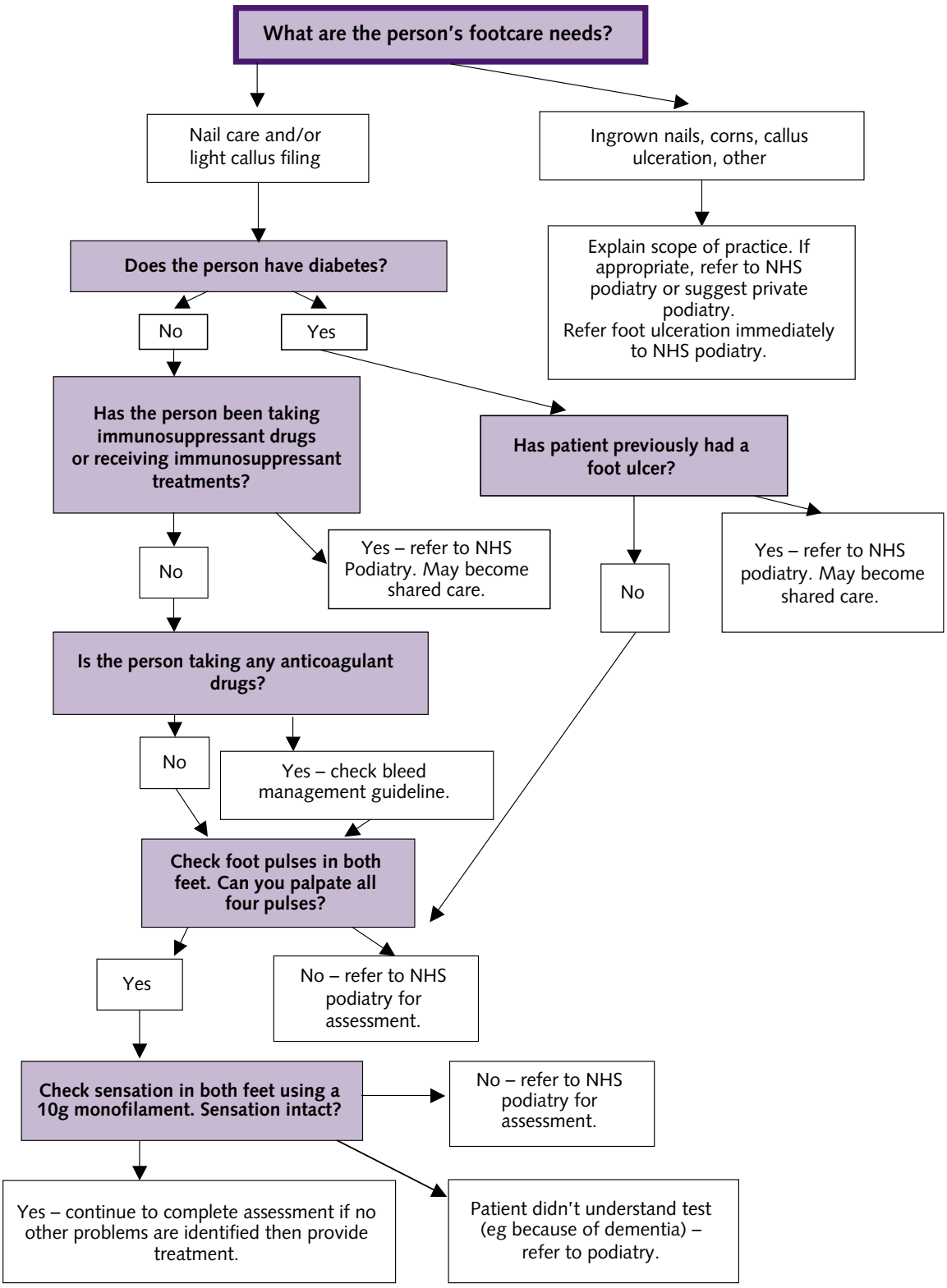
Both Jim and Elma now have their toenails cut at Countess Weir Medical Centre every six weeks and they are thrilled with the service.

Jim explained, 'I have been very impressed with the service and would recommend it to anyone who needs help cutting their toenails. This service is very necessary for older people like me as our eyesight is not as good as it was and coupled with the general problems that old age brings cutting your own toenails becomes very tricky indeed. The shape of our toenails changes and if they are not cut properly and regularly it can cause problems and difficulties. It saves a lot of bother for me and Elma.'

Elma added, 'It has been a godsend for me as the arthritis in my hands made it practically impossible for me to cut my toenails properly. Now I don't have to worry as the lovely lady at the clinic does it for me. My feet feel so much better than they did when I was struggling to cut them.'

New podiatry care pathways and innovative forms of footcare provision are emerging (see **Section 5**).

Figure 3: A footcare pathway



4. Types of footcare service

The Department of Health review has identified five potential models of safe and effective footcare service provision, outlined below. Within these five main categories there is potential for wide variation, as the case examples show, and other models are expected to evolve over time.

(i) Partnership footcare services – possibly commissioned by PCTs and local authorities, and where PCTs, local authorities or other organisations undertake a governance role.

Case example: Social services home care and podiatry

Best Foot Forward is a joint footcare initiative between Gloucester PCT's NHS podiatry service and the county council home care service. Home care assistants are trained by NHS podiatry to provide footcare in people's own homes. The initiative has the added benefit of improving job satisfaction for home care assistants, who are overseen by the podiatry service.

For details contact Chris Boden, head of Gloucestershire podiatry services, chris.boden@glos.nhs.uk

Case example: Health and social care partnership

Portsmouth City Council footcare service has been running for seven years with a caseload of over 1,500. Staff are directly employed by social care but have been trained by Portsmouth City Teaching PCT through a dedicated foot health educator, who offers ongoing support and supervision. Social care staff are invited to podiatry service training and other events and frequently work alongside podiatry in PCT premises for easy referral and advice. Local authority knowledge enables effective signposting to other social care services and information. There is an audit programme focusing on infection rates, record-keeping and user satisfaction.

For details contact Suzanne Crawford, foot health educator, suzanne.crawford@ports.nhs.uk

Case example: Age Concern and PCT partnership

The Feet First service is provided by Age Concern Surrey in partnership with Woking Borough Council and Surrey PCT to support older and disabled people in the local community. Feet First provides simple footcare which includes nail care, filing of callus, advice on self-care and guidance on suitable footwear. The remit of the service is to provide footcare to the level which a well and able adult could do for themselves, and it does not offer podiatry/chiropody treatment. The general aims are to ensure comfortable feet to help keep people mobile and independent with a reduced risk of falling and prevent, where appropriate, deterioration of foot health to a level where professional input is necessary. The success of the service has led to increased demand and extension into other areas. Staff undergo a six-week validated training programme through local NHS podiatry departments.

For details contact Runette Theunissen, theunissen@surreypct.nhs.uk

(ii) Social enterprises – where businesses are established to address footcare services, and any profits made are reinvested into community or service redevelopments. These businesses may hold contracts with PCTs to deliver footcare services.

Case example: Caremart Social Enterprise

Caremart runs a toenail cutting service for older people in the East Lancashire area, working in partnership with the East Lancashire PCT and Pendle Older People's Group, which complements the existing service provided by NHS podiatry. The service is provided by footcare assistants qualified to NVQ level 2 in health and social care, who are trained by NHS podiatrists in simple toenail cutting techniques. Target users are older people and disabled people who have problems with the risk of falling or mobility.

For details contact Steven Tomlinson, 01282 615 757 or 07813 841 067.

(iii) Training and education model – where training is provided by podiatrists to individuals, including carers and older people, for supported self-care and empowerment.

Case example: Empowerment

The Sheffield Podiatry Empowerment Project was introduced by Sheffield PCT to relieve pressure on the NHS podiatry service and manage a four-year waiting list of 2,500 patients.

It appeared that many people were using podiatry services when there was evidence that with the right support and understanding, self-care would be appropriate. The aim was to empower suitable low-risk, low-needs patients to self-care without instruments instead of automatically providing care through the podiatry service.

As a result of this approach:

- the waiting list was eliminated in four months
- access to the podiatry service has improved
- the NHS podiatry service is based on clinical justification of need
- there is improved satisfaction with the service among patients, carers and GPs
- the empowerment process is better understood, which has widened the assessment model to consider social circumstances and mental health issues as opposed to simply being focused on the medical status of the individual.

For details contact Jeremy Walker, Jeremy.Walker@sheffieldpct.nhs.uk

(iv) NHS podiatry service – where footcare services are directly commissioned by a PCT and delivered by footcare assistants within a podiatry service.

Case example: Commissioning additional podiatry services

Following a comprehensive review and options appraisal, Westminster PCT has commissioned additional footcare services from the current NHS podiatry service. The service will be delivered by trained footcare assistants who will benefit from supervision by registered podiatrists and easy access to qualified staff where clinical needs change beyond their scope of practice. Service delivery will benefit from a skills mix, internal governance and communication systems.

For details contact Mark C Brogan, 020 7316 6807 or 07771 794 045 or mark.brogan@westminster-pct.nhs.uk

Case example: Commissioning new roles

A Suffolk community healthcare staff training programme has created 100 new 'generic worker' posts to support seven areas of care, receiving training in aspects of podiatry, occupational therapy, physiotherapy, nursing, medicines management, nutrition and mental health. They undergo specific training in anatomy, physiology, common foot conditions, footwear and footcare, ending with clinical practice and a competence assessment. Generic workers can help service users manage their own footcare as much possible, offering advice on self-management and information on where to go for further care or to buy equipment, if necessary.

For details contact Simon Bamford, 01473 275215 or 07940 471778 or simon.bamford@suffolkpct.nhs.uk or Jane Benten, 01473 322143

(v) Independent podiatry practice – where people pay for services delivered by, or under the supervision of, registered podiatrists.

Case example: Independent practice skills mix

Dulwich Podiatry offers nail cutting from a podiatry assistant, supervised by a podiatrist on site, providing a lower-cost service option. All patients are assessed by a podiatrist and those at high risk are excluded from the scheme. Immediate access to a podiatrist is available if necessary.

For details contact Debbie Delves, 020 8693 6000 or Dulwichpod@aol.com

Case example: Reduced cost service

Lancashire independent practice Simply Toenails aims to help those patients who only need assistance with nail care, offering this as part of a professional range of treatments provided in the practice by registered podiatrists but at a reduced cost. Access to the service is through an initial assessment appointment. Training and governance are overseen through regulation. Many other independent practitioners have adopted this model, which is supported by the Society of Chiropodists and Podiatrists

For details contact Hilary Walker, 01282 613056 or chirohils@aol.com

5. What good footcare services should look like

Commissioners will need to build a diverse provider market that can respond to identified local needs, both on an individual and whole population level. Some services will be commissioned to respond directly to an assessed need. Some may build the capacity of other services to respond, eg the extended use of domiciliary care agencies. There is also a role for ensuring that formerly excluded groups and communities of service users have a voice that is heard by local decision-makers.

Successful models of footcare provision should have the following characteristics:

- robust governance arrangements
- the development and maintenance of individuals competent to carry out footcare activities
- robust pathways of care with clear guidance on when people access podiatry or footcare services – ie access criteria, referral policies, policy on transfer between services
- regular service reviews, including patient satisfaction surveys
- evidence of meeting infection control standards
- appropriate and safe environment for provision of footcare services
- clear information about whether this service is free at the point of use or requires a financial contribution from the individual
- relevant mandatory training, including health and safety and safeguarding.

6. What a footcare service should achieve

The table below outlines some of the outcomes that could be gained by individuals using footcare services, their local communities and wider health and social care provision. There are benefits derived from receiving support and being more informed about footcare as well as from actually having treatment.

	Universal offer of information	Footcare intervention	Support
Individual outcomes	People are in contact with services Personalised information is given to service users Mobility services are well promoted Isolation and exclusion are tackled People have a voice with local decision-makers	A clear route into and through the system Better outcomes from assessments and treatment Pain reduction Mobility improvement Support with difficulties and complaints Support with spending own resources	Less at risk of crisis or more intensive treatment Less at risk of needing podiatric surgery Sentinel services for other needs Holistic support (health, social care, household safety, footwear etc)
Area outcomes	Greater reach to excluded groups A better offer to self-funders All services more inclusive and family friendly Better informed joint strategic needs assessments	More sustainable and more independent lifestyles Ability to become more involved in community life More likely to remain active Fewer unresolved complaints	Lower take-up of costly services by people, whether living independently or in cared-for settings More effective investment in prevention and community-based services

In some areas a single agency may have a role to play in more than one of these five categories of service. This would offer potential for developing a smoother care pathway, but could also bring the risk of conflict of interest. The individual may also feel they are not being given a proper choice or do not have a route to independent advice and support. Service commissioners and providers need to be clear about what kinds of interventions are available, and what steps people can take to change their choice of provider or to complain about services.

7. Developing footcare services

Commissioning or supporting the development of footcare services

Which services deliver which footcare interventions, and how they do so, will vary greatly from area to area. There will also be different ways of reaching and supporting excluded groups.

The Department of Health's World Class Commissioning guidance states that a good commissioner routinely ensures that patients and the public can share their experiences of both health and care services and use this to inform commissioning. It is vital to support footcare services that enable commissioners to include the end-users themselves, particularly those most at risk of exclusion, in needs assessment and the commissioning process.

Each area's local involvement network (LINk), made up of patients, public and stakeholders, has a role to play in identifying local challenges and inequalities and should influence commissioning decisions. So too do local older people's forums, which were subject to independent review in 2008.[2] This found that although the number and type of forums have increased to enable more older people to influence local and central government policy, there is no single route or quick solution to effective engagement, and there are still areas where older people do not have the same opportunity to make their voices heard. The review's recommendations include ways of supporting and building on existing older people's forums.

Commissioning or supporting the development of footcare services requires engagement with the independent, education and third sectors as well as local authorities.

The Third Sector Commissioning Task Force has highlighted the need for commissioners to understand the voluntary sector's potential to add value to needs assessment, strategic planning, empowering service users and building capacity within the community, in addition to actually delivering services.

This is particularly important given the high proportion of footcare services provided by the third sector. The Government has set out a national framework,

2 Elbourne (2008)

or 'compact',[3] for conducting relationships between public sector organisations and the voluntary sector. Most local areas have developed a local compact too.

The national compact sets out general principles for commissioning from the third sector and key points to consider at each stage in the commissioning cycle.

Key actions for commissioners include discussion with providers of footcare services regarding:

- which footcare interventions are already being delivered locally
- how well these services are performing against desired outcomes and outputs
- which groups or communities are most at risk of being unable to access each intervention
- how those barriers can be overcome
- where there are gaps and under-provision
- where there is over-provision or scope for better co-ordination between services.

Phase 1: Strategic planning

(a) Needs assessment

The joint strategic needs assessment (JSNA) that local authorities and their NHS partners must undertake of their local population will inform the commissioning process. Assessments will indicate the amount and range of footcare services required to meet local need.

Commissioners will need to develop a good understanding of what services currently exist in their area. A mapping exercise of the nature, range and dispersal of services will help in planning how and where to plug any gaps in provision, possibly through market development.

Specific factors that may affect the way funding is invested in footcare and how service provision is stimulated may include the following.

The diversity of the local population. The profile of local micro and macro populations may raise some specific issues, eg cultural sensitivities about certain forms of personal care.

3 Commissioning guidance at www.thecompact.org.uk

The geography of the area. It is important to acknowledge that some rural or isolated areas are hard to serve.

The age range and gender profile of the local population. In areas where there is a higher than average percentage of vulnerable older people, or areas that typically attract retirement populations, there may be greater demand on existing services or pressure to introduce new ones.

(b) Workforce

Footcare services may be delivered by a variety of health and care workers, given appropriate training and support.

The competencies required to deliver footcare services include:

Clinical practice

Toenail cutting

- demonstrates competence in the use of nail clippers and files for the reduction of nails
- maintains client's toenails at a length which feels comfortable.

Skincare

- able to assess the viability of client's skin by checking for cracks and breaks in the skin and signs of inflammation and infection
- treats dry and rough skin by smoothing and moisturising.

Footwear advice

- understands the importance of appropriate footwear and its role in assuring safety and stability and advises accordingly.

Prevention advice

- demonstrates competence in giving prevention advice to clients, eg keeping feet clean, dry, mobile, comfortable and warm
- promotes good foot health advice based on each individual's lifestyle and circumstances.

Signposting

- demonstrates an awareness of other health and social care risks including health and safety issues, social exclusion and benefit rights and refers to appropriate health or social care professional
- recognises pain, infection or other unreported conditions that necessitate an onward referral to a podiatrist or other healthcare professionals
- acknowledges the limitation of the footcare support worker in the performance of certain tasks, and if necessary refuses to undertake the particular task.

Health and safety

- ensures the highest standards of hygiene are applied in all treatment areas regardless of the setting
- ensures a sterile environment is maintained at all times regardless of the setting (eg decontamination of instruments prior to return to client, ensuring correct disposal of clinical waste)
- complies at all times with the Health and Safety at Work Act to ensure the health and safety of all staff and clients regardless of the setting in which footcare takes place.

Dignity and respect

- assists client to and from treatment rooms and assists if necessary with shoes and hosiery
- upholds the right of clients to privacy, dignity and self-respect
- respects the customs, values and spiritual beliefs of the client
- maintains client confidentiality.

Administration

- Maintains consistent, accurate records of all client treatments and assessments.

It is the service commissioner's responsibility to ensure that the individuals they commission to deliver footcare services are competent. The models of service delivery in Section 5 identify how this may be done.

Phase 2: Specifying outcomes and procurement services

(a) Market development

A factor in how footcare services are commissioned and developed is the marketplace in which providers operate. The marketplace is more likely to flourish if the various partners within the system are willing to invest in it to support the creation and maintenance of footcare provision.

The commissioner's role is to stimulate a diverse range of services and secure them in affordable and sustainable contractual arrangements. Developing footcare services should not be at the expense of a reduction in existing NHS podiatry services.

Public sector commissioners must comply with European Union (EU) procurement law, which stipulates opening up funding arrangements to competition through open tendering. However, EU procurement law applies in full only to contracts above a certain threshold, and footcare services are likely to be subject to a less stringent regime for 'educational, health and social, recreational, cultural and sporting' services.

This means that commissioners will often have a choice about the best combination of funding arrangements to put in place, providing they adhere to the principles of non-discrimination, equal treatment, transparency, mutual recognition and proportionality in awarding contracts to providers.

New forms of provider are emerging. The home care sector and other domiciliary-based services can provide footcare services.

The use of personal budgets in line with *Putting People First* and the personalisation agenda can enable a level of self-commissioned or self-managed care.

There is an opportunity to educate the public through health promotion, raising awareness of their own responsibility to keep their feet healthy and act early to get help when they encounter problems.

It is important to provide good-quality information on available services, covering location, cost and how they may be accessed.

(b) Funding options

Treasury guidance says that funding bodies need to decide what form of funding is most likely to generate desired outcomes, and how the basis of funding chosen will best support the funded organisation. It is clear that NHS podiatry services that are delivered to those with a clinical need should not be reduced in order to develop footcare services. This may mean that commissioners will have to identify alternative sources of funding, or re-prioritise their budgets, or realign them with others in order to provide adequate funding where investment in footcare demands it.

Effectively, commissioners can choose between four approaches.

- A commissioned service free at the point of use for which they are responsible for identifying an adequate source of funding to buy enough footcare at the right quality. This option includes fully funding the whole cost of service provision including infrastructure costs and contact time.
- A commissioned service that is not free at the point of use, where the commissioners bear infrastructure costs but channel treatment costs through personal budgets so that individuals using the service are also given the means to pay for it.
- Sharing the risk of funding services by promoting the development of footcare services with other stakeholders where partners may offer 'in kind' resources (eg professional advice, use of premises) or where those partners may be prepared to share the costs.
- Facilitating the creation of non-statutorily funded services that rely on the ability and willingness of individuals to purchase using their own money

There is a strong case for practice-based commissioning to ensure that a wide range of community-based footcare services exist. Any investment case that practice-based commissioners wish to make needs to include an invest-to-save argument to persuade PCTs to release the funding to the practice-based commissioning team so that the recommendations of this guide can be implemented.

Commissioners will also want to refer to local information gathered through the JSNA and in consultation with older people to inform their investment decisions.

The evidence-base to build the business case is not well developed. However, we do know that older people place a high value on footcare services. It is also reasonable to assume that footcare services make a contribution to the reduction of falls, a decrease in pain and increased participation in physical, social and cultural activity leading to increased health and wellbeing.

Phase 3: Managing demand and performance

(a) Managing capacity and demand

As with any commissioning relationship, there will be an ongoing need to monitor demand for services in relation to the funding available and the performance of those services in achieving the outcomes specified in contractual arrangements. The joint strategic needs assessment is an iterative process and all commissioning strategies resulting from it will be capable of review, adjustment and improvement to ensure that resources are accurately targeted at identified need.

With scarce resources, commissioners of footcare services may need to specify that their funding for support is targeted at a defined group of people, or that they are prioritised for support according to their level of need.

Commissioners should consider the following in specifying target groups.

Provider organisations may have other sources of funding for their work, which carry their own target groups or outcomes. Statutory commissioners should only set targets for providers in proportion to the funding they provide.

There is a requirement on local areas to deliver a universal offer of information and advice to everyone, as well as support to those most in need.

Commissioners should consider how to incentivise providers to offer early intervention and preventive support as well as crisis support.

Commissioning relationships should encourage evidence-based approaches to support, through leaving room for re-evaluating unmet need and support methods, and learning from mistakes.

Some models of footcare provision are developed through partnership arrangements, where PCTs, local authorities or other organisations support key partners and may undertake a governance role.

(b) Evaluating services

The National Indicator set of inspection indicators for local areas does not include a specific indicator for footcare services, but it can be helpful to provide a 'crib sheet' for asking key questions that will aid assessment of people's need for preventive services.

Commissioners should recognise that reaching some excluded groups can hinge on a service being able to guarantee a level of confidentiality. They should therefore negotiate a monitoring and audit process that is proportionate and does not unnecessarily restrict the provider's ability to achieve outcomes.

Commissioners and providers should discuss what will happen should providers fail to reach or exceed their commitments. It is important to look for any perverse incentives in the original tender document.

Alongside evidence of outcomes – changes in people's lives or an area's infrastructure – it is useful to consider measures of user satisfaction, and to encourage the use of quality assurance systems. Individuals, their carers and their families should be involved in reviewing the success of services.

There is a need to promote further research into footcare services.

Annex: References

Arber S, Ginn J (1991) *Gender and Later Life, a sociological analysis of resources and constraints*, Sage Publications, London

Boden C (2007) *Older People and 'Person-Centred' Podiatry: A Critical Evaluation of Two Models of Care* (unpublished PhD thesis), University of Gloucestershire

Bowling A, Bannister D (et al) (2002) A multidimensional model of the quality of life in older age, *Aging & Mental Health*, Vol.6, No.4, pp.355–71

Bryan S, Parkin D (et al) (1991) Chiropody and the QUALY: a case study in assigning categories of disability and distress in patients, *Health Policy*, Vol. 18, No.2, pp.169–85

Campbell J, Bradley A (et al) (2000) Do 'low-risk' older people need podiatry care? Preliminary results of a follow-up study of discharged patients, *British Journal of Podiatry*, Vol.3, No.2, pp.39–45

Campbell J, Patterson A (et al) (2002) What happens when older people are discharged from NHS podiatry services? *The Foot*, Vol.12, pp.32–42

Cartwright A, Henderson G (1986) *More trouble with feet: a survey of the foot problems and chiropody needs of the elderly*, HMSO, London

Clarke M (1966) *Trouble with Feet*, Occasional Papers on Social Administration No.29, Bell, London

Department of Health Statistics Division (2005) *NHS Chiropody Services Summary information for 2004–05 England* (KT23 Return), Health and Social Care Information Centre, London

Elbourne J (2008) *Review of Older People's Engagement with Government*, www.dwp.gov.uk/resourcecentre/john-elbourne-181108.pdf

Farndon L, Vernon W (et al) (2004) Why do new patients seek NHS podiatry care? A multi-centre qualitative study, *British Journal of Podiatry*, Vol.7, No.1, pp17–20

Farndon L, Vernon W (et al) (2006) What is the evidence for the continuation of core podiatry services in the NHS? A review of foot surveys, *British Journal of Podiatry*, Vol.9, No.3, pp.89–94

Farndon L, Vernon W (et al) (2007) The Sheffield empowerment project: six years on, *British Journal of Podiatry*, Vol.10, No.9, pp.104–9

Hadbridge P (1993) *Health Care Needs in Later Life: Consumer Views*, East Anglian Regional Health Authority, Norwich

Harvey I, Frankel S (et al) (1997) Foot morbidity and exposure to chiropody: a population based study, *British Medical Journal*, Vol.315, pp.1054–5

Kemp J, Winkler J T (1983) *Problems Afoot: Need and Efficiency in Footcare*, Disabled Living Foundation, London

Lever A, Shearer J (1999) Priority criteria for podiatric referral, *Podiatry Now*, January 1999, pp.5–6

Macdonald E, Capewell S (2001) Podiatry: Cinderella specialty in search of a glass slipper? *Podiatry Now*, November 2001, pp.518–20

Menz H, Lord S (2001) Foot Pain Impairs Balance and Functional Ability in Community-Dwelling Older People, *Journal of the American Podiatric Medical Association*, Vol.91, No.5, pp.222–9

Menz H, Lord S (2005) The Contribution of Foot Problems to Mobility Impairment and Falls in Community-Dwelling Older People, *Journal of the American Geriatrics Society*, Vol.49, No.12, pp.1651–6

Menz H, Morris M (et al) (2005) Foot and Ankle Characteristics Associated with Impaired Balance and Functional Ability in Older People, *Journals of Gerontology Series A: Biological Sciences and Medical Sciences*, Vol.60, No.12, pp.1546–52

Menz H, Morris M (et al) (2006) Foot and Ankle Risk Factors for Falls in Older People: A Prospective Study, *Journals of Gerontology Series A: Biological Sciences and Medical Sciences*, Vol.61, pp.866–70

Moore M, Farndon L (et al) (2003) Patient Empowerment: A strategy to eradicate podiatry waiting lists – the Sheffield experience, *British Journal of Podiatry*, Vol.6, No. 1, pp.17–20

NHS Executive (1994) *Feet First*, EL(94)69, HMSO, London

Tippins M (1998) Re-profiling a chiropody department, *Podiatry Now*, September 1998, pp.301–2

Vernon D W, Borthwick A (et al) (2007), Expert Group Criteria for the recognition of healthy footwear, *British Journal of Podiatry*, Vol.10, No.4, pp.127–33
(for follow-up work see www.healthy-footwear-guide.com)

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