

***Standards of Care
for people with
Musculoskeletal
Foot Health
Problems***

YOUR VIEWS ARE REQUESTED ON THE COMPLETENESS AND ACCURACY OF THE STANDARD STATEMENTS ONLY (PAGES 1-4).

PLEASE NOTE THAT THE STANDARD STATEMENTS ARE ORIENTED TOWARDS FULFILLING PATIENT NEEDS RATHER THAN PRESCRIBING SERVICE ORGANISATION.

THE REMAINDER OF THE DOCUMENT IS IN EARLY DRAFT FORM AND IS INCLUDED FOR INFORMATION ONLY.

THANK YOU.

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GENERIC FOOT HEALTH SERVICE STANDARDS

Please let us know if there are any errors or omissions in the following 28 Service Standard Statements.

STANDARDS TO IMPROVE ACCESS TO EFFECTIVE SERVICES

Public health information

Standard 1: Health service providers should make robust and reliable information available to the public that promotes good musculoskeletal foot health.

Physical access to facilities

Standard 2: Foot health services should endeavour to provide access to health care facilities at times and locations convenient to the needs of service users, and facilitate access to people with disabilities.

Involvement of service users in service development

Standard 3: Healthcare organisations should involve people with musculoskeletal foot health problems in the planning, development and evaluation of foot health services.

Education & training of health professionals

Standard 4a: All relevant members of the primary health care team must understand the diagnosis and management of musculoskeletal foot health problems, including the mechanisms for accessing local foot health services.

Standard 4b: Foot healthcare providers must understand the consequences of systemic disease on the feet, and be able to identify the warning signs that require timely referral to specialist medical care.

STANDARDS TO IMPROVE ACCESS TO SERVICES THAT ENABLE EARLY DIAGNOSIS

Access to foot health services

Standard 5a: People with foot symptoms of musculoskeletal origin, or whose foot health needs are increased because of systemic musculoskeletal disease, should have timely access to foot health care in community or hospital settings.

Standard 5b: Clear referral pathways should be developed locally that detail indications for referral to the various professions involved in the care of foot problems and the mechanisms by which referrals are made.

Assessment of need

Standard 6a: On presentation, people should have a comprehensive assessment of their foot problems in an environment and manner that preserves privacy and dignity.

Standard 6b: Assessment should consider the need for referrals to, or communication with, other services and organisations, e.g. community care organisations and employers. The outcome of the assessment, along with any diagnosis and treatment plan, should be made available to the patient, referrer, and where indicated, the individual's GP.

Diagnosis

Standard 7a: Whenever possible, a specific diagnosis should be given. In circumstances where a firm diagnosis is not possible, symptom-based management should be provided and explained.

Standard 7b: People should be given written information about their condition and its impact to help them to contribute to a management plan which may include arrangements for further assessments or investigative procedures.

STANDARDS TO IMPROVE ACCESS TO SERVICES THAT ENABLE ONGOING MANAGEMENT

Self-management

Standard 8: People with musculoskeletal foot health problems should be supported to manage their condition appropriately. Assistance may take the form of information, training or advice.

Clinical management

Standard 9: People with foot problems should have access to safe, effective, timely care with appropriate monitoring arrangements. The health professional should ensure that the person understands management strategies, which should take into account personal circumstances both at home and at work. Agreed strategies should be in accordance with the best available evidence from national and international guidelines.

Standard 9b: Foot health professionals should gain confirmation from service users that they understand and accept the current episode of care and know what will happen next.

Individualised care plans

Standard 10: On diagnosis, an appropriate, individualised plan for ongoing care should be jointly developed by the foot health provider, the service user, carer and relevant members of the multi-disciplinary team. A printed copy of the care plan should be provided for the service user.

STANDARDS TO IMPROVE ACCESS TO SERVICES THAT ENABLE ONGOING SUPPORT

The multidisciplinary team

Standard 11a: People with chronic symptoms or complex conditions should have timely access to appropriate multidisciplinary care.

Standard 11b: Providers of foot health services should ensure that they are adequately integrated with the appropriate multidisciplinary team, preferably physically, but at least through clear lines of communication.

Prompt access to care if symptoms worsen

Standard 12: People whose condition does not respond to treatment, who experience new or worsening symptoms, or whose personal situations change, should have timely access to health professionals trained to carry out specific care or treatment, or who can refer them to other specialist care if needed. Foot health service providers should be aware of indications for urgent referrals, surgical referrals and disease red flags.

DISEASE SPECIFIC FOOT HEALTH SERVICE STANDARDS

STANDARDS OF CARE FOR PEOPLE WITH FOOT PROBLEMS & INFLAMMATORY ARTHRITIS

Assessment & management

Standard 13: Everyone with a diagnosis of an inflammatory arthritis should receive a foot health assessment within 3 months of diagnosis. This assessment need not be by a foot health professional.

Prompt access to care if symptoms change

Standard 14: Where there is a substantial change in disease activity (for better or worse) foot health implications should be reviewed.

The multidisciplinary team

Standard 15: People with IA have a particular need for access to multi-disciplinary care; including foot health services based in either the community or hospital settings. Practitioners providing foot health care for people with IA should ensure that they are adequately integrated with other parts of the multi-disciplinary team, either geographically or through excellent communication links.

Self-management

Standard 16a: People with IA and foot problems should be supported to manage their condition appropriately. Assistance may take the form of information, training or advice that emphasises the specific aspects of their condition.

Standard 16b: People with IA should receive adequate information regarding the signs and symptoms that warn of deterioration in their condition; advising them to seek prompt review by an appropriate multi-disciplinary team member.

Specialist review

Standard 17a: People with IA should be offered a comprehensive, annual specialist review that includes review of foot health needs.

Standard 17b: If foot health needs are identified, mechanisms should be in place for people with IA to receive timely and appropriate foot health care.

Surgery

Standard 18: To maximise the best possible outcome for the individual, people with IA who may require foot surgery should receive early referral for a surgical opinion from a specialist experienced in the management of inflammatory foot problems.

STANDARDS OF CARE FOR PEOPLE WITH FOOT PROBLEMS & OSTEOARTHRITIS

Self-management

Standard 19: People with OA and foot problems should be supported to manage their condition appropriately. Assistance may take the form of information, training or advice that emphasises the specific aspects of their condition.

Pain management

Standard 20: People with OA should receive education and intervention to enable them to manage their pain.

STANDARDS OF CARE FOR PEOPLE WITH FOOT PROBLEMS & CONNECTIVE TISSUE DISORDERS

Assessment & management

Standard 21a: All people with a diagnosis of a CTD should receive a foot health assessment within 3 months of diagnosis, with follow-up assessments annually. These assessments should consider the need for communication with other support services.

Standard 21b: People whose condition does not respond to treatment, who experience new or worsening symptoms, or whose personal situations change, should have timely access to a professional with specialist knowledge of CTDs. Foot health service providers should be aware of indications for urgent referrals, surgical referrals and disease red flags.

The multidisciplinary team

Standard 22: People with CTDs have a particular need for access to multi-disciplinary care; including foot health services based in either the community or hospital settings. Practitioners providing foot health care for people with CTDs should ensure that they are adequately integrated with other parts of the multi disciplinary team, either geographically or through excellent communication links.

Self-management

Standard 23: People with CTD and foot problems should be supported to manage their condition appropriately. Assistance may take the form of information, training or advice that emphasises the specific aspects of their condition.

STANDARDS OF CARE FOR PEOPLE WITH FOOT PROBLEMS & METABOLIC BONE DISEASE

Promoting bone health

Standard 24: Health service providers should make information available to the public that promotes good musculoskeletal foot health.

Diagnosis and management

Standard 25: Clear referral pathways should be developed locally that detail indications for referral to the various professions involved in the care of people with MBD and foot problems, and the mechanisms by which referrals are made.

Self-management

Standard 26: People with MBD and foot problems should be supported to manage their condition appropriately. Assistance may take the form of information, training or advice that emphasises the specific aspects of their condition.

STANDARDS OF CARE FOR PEOPLE WITH FOOT PROBLEMS & BACK PAIN

Assessment and diagnosis

Standard 27: People with foot problems and mechanical back pain may require a lower limb assessment by a health care provider with understanding of the complex interaction between the lower limbs and back pain.

Prompt access to care if symptoms worsen

Standard 28: If a person's back pain fails to respond to conservative management they should be offered further assessment by a practitioner who has the authority to refer for specialist assessment or investigation, including a surgical opinion if indicated.

Generic Foot Health Service Standards

**THE REMAINING SECTIONS ARE FOR INFORMATION ONLY.
PLEASE DO NOT COMMENT ON THESE SECTIONS JUST YET.**

<p>Standards of care for people with musculoskeletal foot health problems</p>	<p>Standards to improve access to effective services</p>
<p>Public health information <u>Standard 1:</u> Health service providers should make robust and reliable information available to the public that promotes good musculoskeletal foot health.</p> <p>Physical access to facilities <u>Standard 2:</u> Foot health services should endeavour to provide access to health care facilities at times and locations convenient to the needs of service users, and facilitate access to people with disabilities.</p> <p>Involvement of service users in service development <u>Standard 3:</u> Healthcare organisations should involve people with musculoskeletal foot health problems in the planning, development and evaluation of foot health services.</p> <p>Education & training of health professionals <u>Standard 4a:</u> All relevant members of the primary health care team must understand the diagnosis and management of musculoskeletal foot health problems, including the mechanisms for accessing local foot health services. <u>Standard 4b:</u> Foot healthcare providers must understand the consequences of systemic disease on the feet, and be able to identify the warning signs that require timely referral to specialist medical care.</p>	
<p>Rationale</p> <ul style="list-style-type: none"> • There is evidence that lifestyle changes can reduce the risk of developing foot health problems, alleviate pain and prevent disability. Foot problems may be prevented by weight reduction and by following advice about foot protection when taking part in activities that could lead to joint injury and development of osteoarthritis. Information provided to the general public that emphasises these factors, as well as promoting strengthening exercises, general (aerobic) fitness, weight reduction programmes for the overweight and obese; and appropriate footwear and use of appliances (sticks, insoles, braces) would prevent some foot problems from developing. ^{**ref} • People with musculoskeletal disorders often have mobility problems which may be exacerbated by their environment, for example, difficulty with climbing stairs, or problems may be disease specific, such as early morning joint stiffness. Corollary factors may also impact on mobility, such as the extra time taken to perform activities of daily living or fatigue associated with activity. • The involvement of people with foot problems in the planning and development of services at both local and national level can lead to imaginative solutions, improvements to healthcare services and ensure that services meet the real needs of people with musculoskeletal foot health problems. (Something about cost effectiveness (evidence?) Rachel/Ailsa/Picker Institute/NHS centre for involvement, Warwick Uni to provide statement. <p>The serious consideration by all health care practitioners of musculoskeletal disorders affecting the foot will result in better health outcomes. Spell out health care team. To enable informed referral to foot health services, all health professionals need to be aware of the scope of foot health service practice and the mechanisms by which foot health service providers are accessed. (does not really reflect statements)</p>	

Key Interventions

1. The general public should have access to evidence-based information in a variety of languages and formats that explains:

- the role of lifestyle or social choices such as physical activity, weight, footwear, footwear suitability and general hygiene on foot health
- the role of self-management in maintaining foot health
- awareness of general foot mechanisms and functions
- how to prevent occupational, leisure and sports injuries such as achilles tendonitis, plantar fasciitis and tendonopathies.
- the range of health services available to people with musculoskeletal foot health needs
- the various professions who provide foot health services, the scope of their practice, likely treatments and locations

Foot health providers should note that people recently diagnosed with a musculoskeletal condition can sometimes be overwhelmed with information pertaining to their diagnosis. Education should be introduced selectively, focussing on issues of particular relevance at any given time

2. Foot health service providers should be aware of any barriers to access to their facilities for people whose gait is unstable or who walk with assistive devices and ensure that these barriers are removed.

Foot health service providers can also improve access to facilities by providing foot health services at times and locations convenient to the patient. This may require considerable flexibility in planning and provision, and will be influenced by nationally agreed directives. Novel approaches to flexible service provision should be considered such as triage, telephone or internet assistance and flexible hours of provision.

3. People with musculoskeletal conditions are well placed to identify the difficulties which arise as a consequence of their symptoms. Healthcare provision can ideally benefit from this viewpoint in tailoring service provision to user needs. To engage service users in planning, providers of foot health services should:

- have contact with local and national user groups (see box).
- direct those who wish to be involved to these groups
- assist service users in accessing practical support to enable them to contribute actively to planning
- ensure there is user representation at service planning meetings and consult with users and user groups during service reconfiguration

4. Members of the primary health care team need to be well informed of:

- the signs and symptoms that should prompt referral to foot health services
- the mechanisms by which to refer to foot health services

Quality of life and mobility issues should also prompt clinicians to refer to foot health services.

Foot health service providers need to keep themselves well informed of:

- the signs and symptoms that point to undiagnosed musculoskeletal disease
- the red flags for each musculoskeletal disease that should prompt referral to a specialist
- the clinical management of every patient in their care and the implications for treatment
- when to communicate with other members of the MDT regarding treatment decisions

Education and training should be provided to primary care staff and foot health care providers to enable them to understand the systemic consequences of musculoskeletal disorders of the feet. Training should begin with undergraduate and postgraduate education and extend to post-registration education and continuing professional development.

<p>Standards of care for people with musculoskeletal foot health problems</p>	<p>Standards to improve access to services that enable early diagnosis</p>
<p>Access to foot health services <u>Standard 5a:</u> People with foot symptoms of musculoskeletal origin, or whose foot health needs are increased because of systemic musculoskeletal disease, should have timely access to foot health care in community or hospital settings. <u>Standard 5b:</u> Clear referral pathways should be developed locally that detail indications for referral to the various professions involved in the care of foot problems and the mechanisms by which referrals are made.</p> <p>Assessment of need <u>Standard 6a:</u> On presentation, people should have a comprehensive assessment of their foot problems in an environment and manner that preserves privacy and dignity. <u>Standard 6b:</u> Assessment should consider the need for referrals to, or communication with, other services and organisations, e.g. community care organisations and employers. The outcome of the assessment, along with any diagnosis and treatment plan, should be made available to the patient, referrer, and where indicated, the individual's GP.</p> <p>Diagnosis <u>Standard 7a:</u> Whenever possible, a specific diagnosis should be given. In circumstances where a firm diagnosis is not possible, symptom-based management should be provided and explained. <u>Standard 7b:</u> People should be given written information about their condition and its impact to help them to contribute to a management plan which may include arrangements for further assessments or investigative procedures.</p>	
<p>Rationale</p> <ul style="list-style-type: none"> • People with musculoskeletal foot health problems need ready access to foot health services. AR - differentiate between direct foot problem presentations and indirect foot involvement - high risk status of neuro-vascular problems, structural changes resulting from OA • Examination beyond the foot. Preserving the dignity of patient. Curtained areas, and the risk of not getting complete feedback from patient because of embarrassment. Mention whole body assessment • A small minority of people may need investigations, such as X-rays or other imaging, to help determine whether they need to be referred to specialist services. If so, these should be performed promptly. The vast majority of people with foot disorders, however, do not need investigations, including X-rays or hospital treatment. It is important to avoid unnecessary investigations. • Musculoskeletal foot problems can arise as a direct consequence of activity or may evolve slowly as a result of multi-system conditions, and therefore, a definitive diagnosis is not always possible. An initial diagnosis may also change as circumstances develop over time and more information is gained. Management should be fluid enough to reflect potential changes. • Written information made available for patients promotes understanding and involvement in the management process. Need something here about information also changing as required. Self determination is an important part of therapy. Information that explains the nature of the condition, its impact and preferably outlines potential investigations and treatments will result in better health outcomes. 	

Key Interventions

5. Clear guidelines, protocols and referral pathways should be developed locally with agreed eligibility criteria for access to foot health services from both primary and secondary care referrals, and also for self-referral. Referral pathways in to foot health service should make clear:

- who has access to their services (e.g. geographic location, referring agencies and organisations, children/adults, etc)
- the signs and symptoms that indicate referral
- red flags that indicate priority referral

Foot health care providers should be involved in developing service contracts developed by purchasers and commissioners to ensure that the people who need their services are provided for.

6. A musculoskeletal foot health assessment should include evaluation of:

- General health
- Foot health
- Systemic factors
- Lifestyle or social factors (workplace, leisure activities)
- Pain management
- Other assessments as required (imaging, biomechanical)

Assessments should be conducted in an environment that preserves privacy and confidentiality of information (curtained areas are inadequate for this). Physical assessments should also preserve privacy and dignity, for example, walking evaluations in public corridors are less than ideal.

At the first visit:

- a range of assessments should be completed (see Standard 7a)
- baseline measures recorded
- tailored education, information and advice provided
- appropriate referrals for other interventions considered (e.g. occupational therapy, physiotherapy and other therapies as required)

Explanation should be provided during assessment as to procedures, examinations and equipment used. Explanation should also be provided on the impact of lifestyle or social choices on presentation, symptoms and prognosis, and the possible social impact of treatments and referrals (e.g. impact on work). mention consent for referrals

7. Explanation of why certain diagnoses are considered should be provided. Understanding that diagnosis may not be possible at that time or ever, should be conveyed where appropriate, along with explanations of symptom management versus diagnosis.

Foot health providers should remember, however, that people's information needs may change over time. Information should be reviewed as part of a comprehensive annual review and written in language accessible to the patient as far as possible. Written information may be stand-alone or can take the form of advice documented in the care plan. (see standard 10)

<p>Standards of care for people with musculoskeletal foot health problems</p>	<p>Standards to improve access to services that enable ongoing management</p>
<p>Self-management <u>Standard 8:</u> People with musculoskeletal foot health problems should be supported to manage their condition appropriately. Assistance may take the form of information, training or advice.</p> <p>Clinical management <u>Standard 9:</u> People with foot problems should have access to safe, effective, timely care with appropriate monitoring arrangements. The health professional should ensure that the person understands management strategies, which should take into account personal circumstances both at home and at work. Agreed strategies should be in accordance with the best available evidence from national and international guidelines. <u>Standard 9b:</u> Foot health professionals should gain confirmation from service users that they understand and accept the current episode of care and know what will happen next.</p> <p>Individualised care plans <u>Standard 10:</u> On diagnosis, an appropriate, individualised plan for ongoing care should be jointly developed by the foot health provider, the service user, carer and relevant members of the multi-disciplinary team. A printed copy of the care plan should be provided for the service user.</p>	
<p>Rationale</p> <ul style="list-style-type: none"> • There is evidence that people who are active partners in making decisions about their care have better outcomes, are better able to engage with health services, i.e. they are better able to manage and cope, than those who do not. *ref* <p>Self management information and advice that encourages people to become well informed about their condition, empowers them to take responsibility for their foot health, and supports them to make informed choices about treatments, providers and settings for care are an aid to improved health outcomes. The extent to which an individual is empowered to take this active role will depend on their individual circumstances, including their education and cultural background.</p> <p>Self-management training is particularly important to help restore people's independence, build their skills to cope with their condition and enable them to make informed choices about treatments. There is evidence that education programmes and support groups help people to self-manage their symptoms. There needs to be wider recognition of the importance of self-management initiatives led by people with chronic conditions (see Box). Support also needs to be available for those who are not able to self-manage.</p> <ul style="list-style-type: none"> • Foot health services should be designed to: <ul style="list-style-type: none"> ○ maintain and improve the quality of life of people with musculoskeletal foot health problems ○ enable people to be as independent as possible ○ empower people to manage their condition effectively ○ limit the impact of foot problems on their work and activities of daily life ○ deliver better health outcomes and a more efficient use of resources • People with foot problems need to be offered constructive messages about how they can participate in the management of their condition. Mention increased risk of falls. 	

This includes referrals, treatments, interventions and follow-up arrangements, with acknowledgment at every stage in the assessment and care process of the patient's readiness, need and requirement for information.

- An individualised care plan can enable a person with foot problems to make informed choices about treatments, healthcare providers and services, and to have a clear understanding of what to expect. It identifies who is responsible for which aspects of care, and promotes collaboration between the patient and all the professionals involved.

Research has shown that greater involvement of the individual in understanding, monitoring, reviewing and deciding their care needs is beneficial, particularly for people living with long term conditions. People who are more involved in their care may; manage their condition more effectively, feel better, manage risks to their health more effectively, have less pain, be less depressed and use health services less. refs

Key Interventions

8. People who have musculoskeletal foot health problems should receive regular information that emphasises the importance of self management of their condition and provides support in making the necessary lifestyle and social changes to improve their overall health. This information should help people to:

- identify the factors that lead to musculoskeletal foot problems
- identify the signs & symptoms of musculoskeletal foot problems
- manage their foot health problem, including access to information on pain management, and how to prevent recurrence of symptoms (see box)
- make changes to factors such as footwear that may improve their foot health
- access appropriate equipment, e.g. assisted living devices and gadgets such as long handled shoe horns
- recognise the signs and symptoms that indicate the need for professional advice
- be aware of the health services available to people with musculoskeletal foot health needs
- be aware of the various professions who provide foot health services, the scope of their practice, likely treatments and how to access them.
- understand the mechanisms for self referral
- access appropriate self-help groups and other voluntary organisations (see box, page x)

It is vital to try to prevent foot disorders from developing into a chronic health problem. People whose foot disorders are not responding to self-management should receive timely and reliable advice and management to restore them to optimal health as quickly as possible.

9. All people with foot disorders require information to enable them to make informed choices about the range of management options available, including self management.
10. Good pain control is essential to enable people to maintain or regain function. Under-treated pain is linked to the development of persistent foot problems. Some people will need analgesics to control their pain. These should be appropriate and adequate and may initially include opioids if the pain is severe. Foot health services providers should ensure adequate pain relief is provided either through their own mechanisms or through the referral pathway.

People whose foot problems do not respond to standard support and management may benefit from other types of management, including joint injection and acupuncture, or psychosocial support, cognitive behavioural therapy and other pain management strategies. Ongoing communication with the multidisciplinary team is vital in these circumstances to ensure that people receive the services that they require.

The evidence for the effectiveness of complementary therapy is conflicting and no firm recommendations can be made.

11. Foot health professionals in primary care should have good communication links with other disciplines to ensure that patients are managed appropriately, with timely local access to diagnostic and other services as required. They should be able to refer individuals appropriately, either directly for investigations or for further opinion or other support.

Clear information should be given and documented in the care plan (see Standard 10). Tidy up communication bits

12. People with foot problems should be offered:

- personalised information about their care
- detailed care plan options, including recognised self-management programmes (see box page x)
- information on sources of reliable further information regarding interventions, treatment and prognosis
- the option of receiving copies of correspondence between services regarding their management

The care plan should give constructive messages about their condition and roles for the patient, the foot health team and other relevant parties, e.g. other healthcare professionals and employers, in the management of their condition. This care plan should draw on good clinical practice and be evidence-based. The foot health practitioner should work with the service user to identify possible triggers or causes of their condition, and to build joint solutions for the monitoring and management of their condition.

<p>Standards of care for people with musculoskeletal foot health problems</p>	<p>Standards to improve access to services that enable ongoing support</p>
<p>The multidisciplinary team <u>Standard 11a:</u> People with chronic symptoms or complex conditions should have timely access to appropriate multidisciplinary care.</p> <p><u>Standard 11b:</u> Providers of foot health services should ensure that they are adequately integrated with the appropriate multidisciplinary team, preferably physically, but at least through clear lines of communication.</p> <p>Prompt access to care if symptoms worsen <u>Standard 12:</u> People whose condition does not respond to treatment, who experience new or worsening symptoms, or whose personal situations change, should have timely access to health professionals trained to carry out specific care or treatment, or who can refer them to other specialist care if needed. Foot health service providers should be aware of indications for urgent referrals, surgical referrals and disease red flags.</p>	
<p>Rationale</p> <ul style="list-style-type: none"> <p>Musculoskeletal foot problems should not be assessed in isolation. Many systemic conditions such as Rheumatoid Arthritis can adversely affect foot health, and a multidisciplinary approach to management should be person-specific.</p> <p>Foot disorders can affect all aspects of a person’s life and development, especially when part of a systemic disease. A foot health assessment needs to include non-clinical, e.g. occupation, leisure activities and environment, as well as clinical factors.</p> <p>People with foot disorders may have complex needs. They may need to consult many different professionals from health and social care.</p> <p>Foot disorders may be associated with progressive disease or co-morbidities requiring input from multiple professions. The constituents of the multidisciplinary team will vary according to any underlying disorders and local service organisation. Foot health services provided either as part of a physical multidisciplinary team or through clear lines of communication will provide the best care to people with multiple needs, as evidence shows that services are most effective when they are delivered through a full and well-established multi-disciplinary team.</p> <p>The right intervention at the right time is the key to preventing a foot problem becoming a persistent health problem. Where a foot problem does not respond as expected, or where a person is unable to resume work or other normal activities, then referral for further opinion should not be delayed.</p> <p>Clear pathways for referral, with defined eligibility criteria, minimise delay and maximise efficiency.</p> <p>A very small percentage of people will have warning signs which need to be investigated. Foot health professionals must be aware of these warning signs, or ‘red flags’, and refer without delay to specialist services for investigation and treatment in accordance with national guidelines, such as NICE.</p> 	

Key Interventions

13. Members of the multi-disciplinary team can help individuals to access specialist services, such as orthotics, wheelchair services, assistive devices and educational advice. There should be agreed care pathways for referral in to these service as well as back to the coordinating specialist as required.

Foot health providers should ideally be fully integrated as a multidisciplinary team member. If this is not possible however, clear lines of communication should exist between the foot health service provider and identified team members. Means of communication may be verbal or written and will develop with technological internet based advances

Referral should be in accordance with locally agreed referral pathways, guidelines or protocols, and should be accompanied by information to support patient choice.

14. Foot health services should be provided by a practitioner with appropriate skills and expertise to deal effectively with the presenting symptoms. Efficient foot health service provision utilises the skills and expertise of individual practitioners most effectively by matching experienced clinicians with the most complex cases.

Similarly, complex co-morbidities may require advanced systemic (e.g. medical specialist) input. Referral should not be delayed and multidisciplinary care should be encouraged.

Training should be provided so that foot health staff can recognise 'red flags' that indicate the need for referral.

Referral pathways should be developed locally that indicate the signs and symptoms that constitute 'red flags' and make explicit the mechanisms for referral.

15. Surgery may be considered when severe symptoms persist and do not respond to conservative treatment. People with foot problems who may require specialist surgical opinion, for example those with progressive joint or tendon damage, should be referred for an orthopaedic or other relevant opinion. Some patients, e.g. those with nerve compression or tendon ruptures, may require urgent appointments, which should be provided immediately. Foot health service providers should be aware of indications for urgent surgical referrals.

Intensity and duration of joint use based upon the patient's activities and aspirations should be taken into account when considering foot surgery.

People recommended for foot surgery should be given an appropriate, timely explanation of their condition and its treatment, including medication, risks and alternative treatment options.

Further written information should also be provided on services that provide practical support and voluntary organisations that offer peer-support and information.

Disease Specific Foot Health Service Standards

<p>Standards of care for people with musculoskeletal foot health problems</p>	<p>Standards of care for people with foot problems & inflammatory arthritis</p>
<p>Inflammatory arthritis (IA) is the term used to describe a range of conditions, including rheumatoid arthritis, ankylosing spondylitis, psoriatic arthritis and juvenile idiopathic arthritis (JIA). These are autoimmune diseases, in which the body's immune system attacks the joints and causes them to become inflamed. Inflammatory arthritis can affect almost any joint: often the hands and feet, but also knees, shoulders, elbows, hips, neck and other joints. (ARMA)</p> <p>Rheumatoid Arthritis (RA) is the most common inflammatory arthritis.</p> <ul style="list-style-type: none"> • RA is a chronic, immune mediated inflammatory disease. Chronic inflammation leads to joint damage and functional impairment. Complete remission is unusual. Management goals should focus on controlling disease activity, providing symptom relief and maximising quality of life (Neale's page 214-16). The foot is affected in nearly all people with RA eventually and the prevalence and impact of foot problems is strongly associated with disease duration. • Joint pain and stiffness is the most common initial presentation, but a range of other features, including tenosynovitis, nodule formation and tarsal tunnel syndrome may also present, reflecting widespread soft-tissue involvement. <p>Involvement of the feet, even to a mild degree, is a significant marker for impaired mobility and functional incapacity. The foot contributes to difficulty with walking in about 75% of people with RA, and is the main or only cause of walking difficulty in 25%.</p>	
<p>Assessment & management <u>Standard 13:</u> Everyone with a diagnosis of an inflammatory arthritis should receive a foot health assessment within 3 months of diagnosis. This assessment need not be by a foot health professional.</p> <p>Prompt access to care if symptoms change <u>Standard 14:</u> Where there is a substantial change in disease activity (for better or worse) foot health implications should be reviewed.</p> <p>The multidisciplinary team <u>Standard 15:</u> People with IA have a particular need for access to multi-disciplinary care; including foot health services based in either the community or hospital settings. Practitioners providing foot health care for people with IA should ensure that they are adequately integrated with other parts of the multi disciplinary team, either geographically or through excellent communication links.</p> <p>Self-management <u>Standard 16a:</u> People with IA and foot problems should be supported to manage their condition appropriately. Assistance may take the form of information, training or advice that emphasises the specific aspects of their condition. <u>Standard 16b:</u> People with IA should receive adequate information regarding the signs and symptoms that warn of deterioration in their condition; advising them to seek prompt review by an appropriate multi-disciplinary team member.</p> <p>Specialist review <u>Standard 17a:</u> People with IA should be offered a comprehensive, annual specialist review that includes review of foot health needs. <u>Standard 17b:</u> If foot health needs are identified, mechanisms should be in place for people with IA to receive timely and appropriate foot health care.</p>	

Surgery

Standard 18: To maximise the best possible outcome for the individual, people with IA who may require foot surgery should receive early referral for a surgical opinion from a specialist experienced in the management of inflammatory foot problems.

Rationale

- Patients with inflammatory arthritis have an increased need for a range of basic foot care services. Up to 90% of people with RA have foot involvement. Long standing inflammation leads to structural deformity and soft tissue lesions which in turn create areas of pressure that result in callus and corn formation.

Arthritis in the hands may make foot care and hygiene tasks difficult, and spinal involvement can make bending to attend to basic foot care tasks impossible (Neale's page 213)

Regular assessments that document the rate of structural change can aid treatment decisions and improves outcomes.

Advances in the management of systemic disease and the lower limb consequences of inflammatory arthritis are significant and rapid. Providers of foot health services to this group of patient should maintain an up to date knowledge of current best evidence and good practice.

- People with IA who experience a sudden 'flare' in disease activity should have direct access to specialist advice, and be offered the option of an early review with appropriate multi-disciplinary team members, including foot health providers.

IAs are complex systemic diseases requiring the input of many health professionals.

There is a growing body of evidence that local foot problems have better outcomes when managed proactively, especially in early disease, mirroring advances in medical management of IAs.

Those involved in the care of the feet of people with IA should be aware of their medications and the implications of drug therapy. Patients with IA are twice as likely to develop infection than the general population. There is a further increase in risk in those taking DMARDS. Patients undergoing immunotherapy are particularly at risk from infection as they are susceptible to unusually rapid progression. It is essential that other disciplines liaise with the rheumatologist where there is any risk of infection, e.g. from ulceration or prior to minor surgery. (refs Neale's page 210).

Professionals other than foot health specialists should be aware of recent advances in the care of the foot in people with IAs.

- Practitioners providing foot health care for people with IA should ensure that their service is adequately integrated, either geographically or through excellent communication links, with the multi disciplinary team responsible for an individual's care.
- Foot health providers have a role to play in the general health education of people with IA, as well as in providing timely and relevant foot health specific advice and education.

People with IA often have to live with chronic pain. It is important that foot health care providers recognise the limitations of medical management and ensure that patients understand their condition and moderate their beliefs and behaviours in response to pain, and standard approaches are supplemented by information and advice on specific coping strategies,. (Neale's page 211)

People with foot problems and IA should have access to personalised education programmes to enable them to make informed choices about treatment options, including recognised self-management programmes.

- An annual musculoskeletal, vascular and neurological assessment which includes an assessment of the lower limbs and feet will help identify problems early. It is well recognised that patients are sometimes reluctant to request reviews. Routine assessment will identify problems that may otherwise have been left untreated. An annual review enables problems and emerging health issues to be identified and offers the opportunity to consider treatment options, to assess the person's wider needs, and the opportunity for referral to other specialities.

Increased systemic disease activity can accelerate changes in the foot pathology so consideration must be taken of local as well as systemic factors.

It should be noted also that worsening of foot symptoms may be an early sign of a systemic disease flare and foot health providers should be aware of the relevant signs and manage or refer appropriately.

- Referral for surgical opinion should be viewed as a priority and not be delayed until only salvage procedures can be considered.

20-25% of all surgical intervention for RA relate to manifestations in the feet, though success is only moderate. Fewer than 50% of people undergoing forefoot surgery for RA report very good or excellent outcomes and 13% undergoing foot surgery for IA require subsequent re-operation because of poor outcomes. (Neale's page 216)

However, surgical interventions, especially for the foot affected by RA, are often delayed until too late. BSR early RA guidelines and ARMA

Key Interventions

16. Assessments should include:

- measures of structure and function
- neurological and vascular factors
- lifestyle or social factors
- footwear, skin and nail assessments
- baseline and follow-up measures of foot impairment
- the impact of any previous interventions, including surgery

The musculoskeletal foot examination should include:

- observation of the arch profile
- toe deformities
- joint swelling
- pain and instability
- plantar callus
- foot ulceration.

Baseline measures of pain, function and health status are desirable.

Potential foot health needs should be established with a view to relieving pain, maintaining function and improving quality of life. Patients whose symptoms worsen or who are at risk of significant foot disease should be referred for examination by a professional with specialist knowledge of rheumatological foot disorders. Patients whose condition improves may also require a review of current treatment as risk factors alter and relevance of information changes.

People with IA can have complex coexisting presentations. People with inflammatory arthritis should receive foot health services from a person adequately trained and experienced to deal effectively with the complexity of problems as they relate to inflammatory arthritis disease stage and activity. Routine foot care in people with well

controlled IA may not need specialist intervention, whereas the care of the vasculitic foot or the foot undergoing rapid structural change associated with high levels of disease activity is likely to require more specialist intervention.

Providers of foot health services should ensure that there is an adequate skill mix within the (multidisciplinary) team to most efficiently meet that range of needs associated with IA and that care pathways exist to ensure that people with IA have access to providers of care with appropriate skills and expertise.

17. Foot health providers should ensure that they are working effectively with a range of professions. Ideally this will involve a service integrated, at least in part, into the multidisciplinary rheumatology team but where this is not feasible good communications and clear lines of (two way) referral should be developed.

18. The following specific information and advice should be provided to people with foot problems and IA:

- Weight management
- Smoking cessation
- The appropriate choices regarding footwear and insoles and direction towards appropriate retail footwear and/or provided with assistance in sourcing specialist footwear where standard retail footwear does not meet their needs
- Maintain foot hygiene
- Determine areas of self care that are not appropriate for self management (e.g. corns and hard skin removal)
- Changes in the foot that can occur and what signs and symptoms may warrant further investigation
- How to access the relevant services if foot health needs change

However, people can be overwhelmed with information at diagnosis and it may be best to introduce education selectively, focussing on issues of particular relevance at any given time (Neale's page 213).

People with IA should receive information that enables them to recognise change in disease state. It is important that people with IAs are educated to be aware of and act on (how?) the signs of increased disease activity, and that they are encouraged to recognise the cumulative effects of joint damage when inflammation is ignored.

Information should be provided on signs such as:

- increased joint stiffness, either severity or duration
- joint swelling
- changes in the foot (or other joints): structure or position.
- inflammatory flares in tendons and other soft tissue structures.
- development of nodules and bursae

19. Foot health assessments need not be provided by specialist foot health providers but can be conducted by any appropriate member of the multi-disciplinary team.

The annual foot assessment should include at least:

- observation of the lower limb
- assessment of arch profile, toe deformities, pain in the foot
- assessment of skin and nail pathologies
- identification of problems with footwear

Clear care pathways and referral guidelines should be in place to ensure that people with IA who have foot health needs have timely access to relevant care.

People who experience an IA flare-up should expect that consideration be given to the implications locally in the foot, as well as control of the systemic disease process.

Conversely non-medical foot health providers should be trained adequately to be able to

identify signs of poor disease control and/or disease flare-up and be able to liaise with medical colleagues as appropriate.

20. Providers of services that include foot health should be aware of the indications for surgical referral and should have referral pathways and guidelines developed to reflect local surgical provision.

Standards of care for people with musculoskeletal foot health problems	Standards of care for people with foot problems & osteoarthritis
<p>Osteoarthritis (OA) is the commonest form of arthritis. It affects mainly the knee, hip, hand, spine and less often, the feet. OA causes damage to cartilage and the growth of new bone in affected joints which manifests as joint damage and joint failure and presents as stiffness and pain. People with osteoarthritis may have increased foot health needs because:</p> <ul style="list-style-type: none"> • OA may affect the joints of the foot directly. The most common site for OA change in the foot being the first MTP joint, although any foot joint may be affected. Note that there are currently no formal diagnostic criteria for OA in the foot joints. • Patients may have musculoskeletal manifestations in the feet that arise secondarily to OA elsewhere. Examples include significant varus/valgus knee malalignments causing abnormal foot postures. • People with OA in joints such as hips, knees and the back may have foot problems arising from an inability to care for their own foot health. <p>Foot health support should be available to all patients in whom OA causes direct foot problems or impacts on their ability to self-care.</p>	
<p>Self-management <u>Standard 19:</u> People with OA and foot problems should be supported to manage their condition appropriately. Assistance may take the form of information, training or advice that emphasises the specific aspects of their condition.</p> <p>Pain management <u>Standard 20:</u> People with OA should receive education and intervention to enable them to manage their pain.</p>	
<p>Rationale</p> <ul style="list-style-type: none"> • Management of OA affecting the joints of the foot relates primarily to lifestyle factors, such as activity and body weight, and local factors, such as footwear. Foot health providers have a role to play in both the general health education of people with OA and in providing timely and relevant foot health specific advice and education. • People presenting with OA, or with problems arising secondarily to OA, often feel that their concerns are trivialised. The implications of OA for foot health, either directly, or indirectly through impaired ability for self-care, should be considered by all health care providers. OA is not an inevitable consequence of ageing nor is it true that nothing can be done. 	
<p>Key Interventions</p> <p>21. People with OA and foot problems should receive information, education and support to enable them to::</p> <ul style="list-style-type: none"> • Understand the impact of OA on foot health • Understand the affect of lifestyle and social factors such as weight management, exercise and footwear • Recognising signs and symptoms that may warrant further investigation. • Manage joint pain. • Understand the importance of remaining active 	

- Access the relevant services if foot health needs change.

Foot health service providers may need to liaise with the service user or with other significant figures such as employers about changes in roles or equipment, such as the provision of specialist footwear (A).

22. Assessment and treatment should consider the impact of the disease on lifestyle, social factors and work and/or education, as well as the assessment of disease process and physiological and pathological severity.

Pain relief should consider both systemic (i.e. drug-based) and local (mechanical or physical) therapies, and should be in accordance with the best available evidence and national/international guidance and guidelines, including NICE guidance and referral protocols.

Management options should support people to make informed choices by providing information on the benefits, risks and effects on lifestyle of each option.

Patients should receive positive messages about the importance of maintaining function. In particular it should be reinforced that pain in this context does not equate directly to damage and that function should be maximised.

People whose condition is not responding to treatment, or who are experiencing worsening symptoms, should be referred promptly to appropriate specialist care in accordance with agreed protocols. This should be accompanied by information to support choice.

If surgery is recommended, people with osteoarthritis should be offered a multidisciplinary pre-surgery assessment to provide information on procedures and postoperative care, to enable informed consent, and to agree an individualised discharge plan. Information should also be offered to enable an informed choice of provider.

Needs discussion – foot surgery?? Joint preserving and joint sacrificing should be considered an adjunct to conservative therapy

Needs a lot of thought- we will have to take a steer from the surgeons on this. I don't want to be prescriptive, presumably no surgeon intentionally uses sub optimal procedures so we need to seek guidance on how far we can stretch evidence-based statements.

Standards of care for people with musculoskeletal foot health problems	Standards of care for people with foot problems & connective tissues diseases
<p>Connective tissue diseases (CTD) are a group of conditions characterised by multi-organ inflammation and autoimmunity. Symptoms vary depending on the disease, but many share the common symptoms of joint aches and pains, fatigue, muscle pain and weakness, rashes, skin changes and inflammatory changes in different organ systems. The term does not encompass inherited conditions such as Marfan's disease or the Ehlers-Danlos group of inherited conditions of connective tissue.</p> <p>Inflammatory myopathies, including dermatomyositis and polymyositis, are a heterogeneous group of acquired diseases of skeletal muscle characterised by weakness and inflammation. Dermatomyositis, which includes skin involvement, is seen most often and can involve internal organs like the heart and lungs. Polymyositis mainly affects only the muscles.</p> <p>Scleroderma (systemic sclerosis) is an uncommon multi-system connective tissue disease that affects the musculoskeletal system and skin but also can involve internal organs such as the heart, lung and kidneys. It affect women much more commonly than men, can be life-threatening and has the highest mortality per case of any of the connective tissue diseases. Scleroderma comes in several forms including progressive systemic sclerosis and localised or limited sclerosis. In the Systemic form vascular lesions are also characteristic, affecting the skin and internal structures. About 1500 new case are diagnosed annually in the UK . Foot involvement (commonly Raynauds phenomenon, or vasculitis) is seen in 90% patients with systemic sclerosis.</p> <p>Sjögren's syndrome causes severe dryness of the eyes and mouth with an accompanying arthritis. Swelling of the lymph glands in the head and neck and of the parotid gland are well recognised complications, as are poor circulation, fatigue and neurological complications. It is not usually a fatal disease but is associated with a greatly increased risk (up to 40 times) of a non-Hodgkin's B cell lymphoma.</p> <p>System lupus erythematosus (SLE or sometimes known just as lupus) is an immune mediated connective tissue disease which is mostly found in women during the childbearing years. Although the skin and joints are the most commonly affected organs, lupus is a disease which can affect any organ or system.</p> <p>The systemic vasculitides (Wegener's granulomatosis, microscopic polyangiitis, Churg Strauss syndrome, Polyarteritis nodosa) are a group of uncommon conditions characterised by inflammation of blood vessels which can lead to organ failure and death. The most common organs to be involved are the skin, kidneys and nerves.</p> <p>Foot disorders specific to CTD (more needed – Mainly vascular and neurological and should be tailored to this (PH))</p>	
<p>Assessment & management</p> <p><u>Standard 21a:</u> All people with a diagnosis of a CTD should receive a foot health assessment within 3 months of diagnosis, with follow-up assessments annually. These assessments should consider the need for communication with other support services.</p> <p><u>Standard 21b:</u> People whose condition does not respond to treatment, who experience new or worsening symptoms, or whose personal situations change, should have timely access to a professional with specialist knowledge of CTDs. Foot health service providers should be aware of indications for urgent referrals, surgical referrals and disease red flags.</p> <p>The multidisciplinary team</p> <p><u>Standard 22:</u> People with CTDs have a particular need for access to multi-disciplinary care; including foot health services based in either the community or hospital settings. Practitioners providing foot health care for people with CTDs should ensure that they are adequately integrated with other parts of the multi disciplinary team, either geographically or through</p>	

excellent communication links.

Self-management

Standard 23: People with CTD and foot problems should be supported to manage their condition appropriately. Assistance may take the form of information, training or advice that emphasises the specific aspects of their condition.

Rationale

- People with CTDs, especially where the skin or vascular system is involved, are at potentially increased risk of foot ulceration. This can be compounded in some CTDs by loss of subcutaneous fat and skin fibrosis over weight bearing areas.
- We are aware that this need exists but there is little evidence etc. CTDs are complex, usually multi-system conditions. People with connective tissue diseases should experience a seamless service in the management of their condition. Foot health providers involved in the care of people with CTDs should have good links with specialist centres to ensure that foot care and medical care is appropriately integrated. Similarly medical specialists should be able to facilitate access to foot health services for patients with foot health needs arising from their CTDs.
- People with CTD and foot problems present with . . . Foot health providers have a role to play in both the general health education of people with CTDs, and in providing timely and relevant foot health specific advice and education.

Key Interventions

23. Assessments should include:

- measures of structure and function
- neurological and vascular factors
- lifestyle and social factors
- footwear, skin and nail assessments
- baseline and follow-up measures of foot impairment
- the impact of any previous interventions

Foot health professionals in primary care should be well-trained and informed about the full range of connective tissue diseases. They should recognise and be able to screen for the clinical features which may indicate connective tissue disease and know how to access appropriate secondary care services., including being able to identify people who require immediate/emergency access to secondary or specialised care.

24. People with CTDs and foot health problems need information:

- about the local and systematic consequences of connective tissue diseases
- to support to smoking cessation
- about appropriate choices regarding footwear and insoles
- that promotes foot hygiene
- on appropriate and inappropriate areas of self management, e.g. inappropriate areas of self management include corns and hard skin removal
- on local and national service user support organisations for CTDs.

<p>Standards of care for people with musculoskeletal foot health problems</p>	<p>Standards of care for people with foot problems & metabolic bone disease</p>
<p>Metabolic Bone Disease (MBD) is the term used to describe a range of conditions, including Osteoporosis, Paget’s disease, Osteomalacia and Osteogenesis Imperfecta (OI), otherwise known as brittle bone disease. These are all diseases which cause bones to become fragile and break without too much force. Common fracture sites are the wrist, hip and vertebrae but fractures may occur throughout the skeleton. People with foot disorders and MBD</p>	
<p>Promoting bone health <u>Standard 24:</u> Health service providers should make information available to the public that promotes good musculoskeletal foot health.</p> <p>Diagnosis and management <u>Standard 25:</u> Clear referral pathways should be developed locally that detail indications for referral to the various professions involved in the care of people with MBD and foot problems, and the mechanisms by which referrals are made.</p> <p>Self-management <u>Standard 26:</u> People with MBD and foot problems should be supported to manage their condition appropriately. Assistance may take the form of information, training or advice that emphasises the specific aspects of their condition.</p>	
<p>Rationale</p> <ul style="list-style-type: none"> • Foot health providers have a role to play in both the general health education of people with MBD and in providing timely and relevant foot health specific advice and education. AR to write • Manifestations in the feet might be the first signs of MBDs and foot health assessment should include consideration of MBD where other clinical signs exist. In people with MBDs major events such as fractures may occur and may also result in longer term consequence such as altered gait and deformity. • People with upper limb or spinal involvement may have difficulty with self care of their feet. Abnormal neurological signs and symptoms may be detected in the feet following spinal damage and nerve root irritation. <p>If osteoporosis is secondary to another disorder or pathology, the underlying cause may adversely affect the feet, e.g tissue viability issues resulting from steroid treatment for RA. Bone pain and tenderness that results from osteomalacia can restrict mobility. The bone remodelling of Pagets disease can result in altered biomechanical stresses within the leg and alter the mechanical stress to the foot and ankle. Bone metabolism is complex and involves organs such as the liver and kidney, damage to which has implications for podiatric management in terms of oedema and impaired tissue viability.</p> <ul style="list-style-type: none"> • People with MBD and foot health problems should receive regular information that emphasises the importance of self management of their condition, and provides support in making the necessary lifestyle and social changes to improve their overall health. 	

Key Interventions

25. The general public should be have access to evidence-based information in a variety of languages and formats on factors that promote bone health and prevent bone deterioration, such as:

- lifestyle and social choices such as physical activity, nutrition, and ?
- prevention of injuries, including occupational and leisure injuries,
- and falls in older people

26. Foot care providers should understand the lower limb consequences of metabolic bone disease and be able to identify significant developments such as stress fractures.

Foot health service providers should ensure that appropriate mechanisms and pathways are in place to enable timely access to diagnostic facilities, and where symptoms worsen, to specialist rheumatological foot health services.

People with foot specific presentations of MBDs such as recurrent stress fractures associated with osteoporosis or increasing deformity associated with Paget's disease, should be able to access ongoing foot care that addresses the musculoskeletal and other consequences of their disorder.

27. People with MBD and foot health problems should receive information on how to:

- identify the signs and symptoms of, or risk factors for, metabolic bone diseases and their manifestations in the feet
- recognise possible complications and address pain management
- provide guidance on how and when to seek professional advice.
- Identify local and national service user support organisations
- encourage an active, healthy lifestyle by quitting smoking, controlling weight, using appropriate footwear.

<p>Standards of care for people with musculoskeletal foot health problems</p>	<p>Standards of care for people with foot problems & back pain</p>
<p>There are many different causes of back pain (BP) but in most cases the cause is uncertain and the condition is referred to as ‘simple’ or ‘mechanical’ back pain. In the remaining cases, it is important to make a specific diagnosis as the underlying pathology may be serious, even life threatening, or require a specific type of treatment.. Between the ‘simple’ and serious cases are individuals with nerve root pain (also known as sciatica), which is commonly due to a disc prolapse (‘slipped disc’). The majority of people with back pain will not require anything more than conservative management, including advice, pain control and exercises. Again there is some old evidence on the use of insoles in back pain but it is not very strong and would not stand up to modern critical appraisal (PH)</p> <p>People with Back Pain may have increased foot health needs because:</p> <ul style="list-style-type: none"> • Back problems resulting from neurological change can manifest in the feet and foot health providers should be able to recognise red flags for neurological damage. • Mechanical back pain may be associated with functional imbalance in the lower limbs and therapies directed at the foot and leg may need consideration. • Foot problems may occur in conjunction with spinal symptoms in systemic disease such as the sero-negative spondyloarthropathies. Foot health providers should be aware of these associations and be able to recognise them, making appropriate referrals for further investigation. 	
<p>Assessment and diagnosis <u>Standard 27:</u> People with foot problems and mechanical back pain may require a lower limb assessment by a health care provider with understanding of the complex interaction between the lower limbs and back pain.</p> <p>Prompt access to care if symptoms worsen <u>Standard 28:</u> If a person’s back pain fails to respond to conservative management they should be offered further assessment by a practitioner who has the authority to refer for specialist assessment or investigation, including a surgical opinion if indicated.</p>	
<p>Rationale</p> <ul style="list-style-type: none"> • Back pain may arise from mechanical imbalances arising in the lower limbs. For most people with back pain however, any foot health needs will arise from an inability to reach the feet to perform functions of self-care. <p>People with back pain should have prompt access to practitioners who are able to identify warning signs of serious disease. Red flags for serious disease may manifest in the feet of people attending incidentally for foot care.</p> <ul style="list-style-type: none"> • Providers of foot health services may be involved in the direct management of mechanical back pain but should be aware of the limitations of lower limb approaches in managing chronic back pain. • An agreed pathway should exist for referring patients to more appropriate care if symptoms worsen. <p>This may be provided through a triage service which has the authority to refer for further specialist assessment or investigation, including a surgical opinion if indicated.</p>	

Key Interventions

28. Back pain may affect a person's ability to care for their feet. Consideration should be given to self-management advice, access to assistive equipment and possibly provision of basic foot care.
29. People with back pain of suspected mechanical origin should undergo an assessment that includes consideration of lower limb structure and function, neurological factors and footwear.

The foot assessment when back pain is present should include consideration of both cause (mechanical causes) and consequence (neurological or inflammatory).

Foot health service providers should be aware of these warning signs. Where these warning signs are present, practitioners should refer without delay for specialist assessment.

National guidance exists to identify warning signs and symptoms which indicate the need for further assessment both in terms of establishing cause and optimising management of symptoms.