Foot protection service redesign: an adaptive leadership approach

KEY WORDS
- Adaptive leadership
- Service redesign
- Podiatry
- Foot protection

The need to implement and deliver radical service redesign continues to present NHS systems and services with significant challenges. Leadership is frequently cited as being a key determinant of success in such large-scale redesign programmes. This paper describes the application of one leadership model – adaptive leadership – to the redesign of a complex set of clinical and inter-professional challenges that saw NHS Greater Glasgow and Clyde (NHSGGC) Podiatry Service take full responsibility for all foot and ankle wounds across all operating units in the Board area. The model is described, with practical, applied examples of the approach taken at each stage of the process. Qualitative and quantitative outcomes are reported, with the NHSGGC Podiatry Service now actively involved in all aspects of foot and ankle pressure damage for all patients, regardless of underlying pathology, with significant improvements delivered across all metrics, including a 56% reduction in Grade 2 and above hospital-acquired foot and ankle-tissue damage; a 55% improvement in the number of wards reporting more than 300 pressure ulcer-free days and a 107% improvement in the number of patients with diabetes receiving foot checks on admission.

If leadership involved nothing but maintaining the status quo and passing on good news, the job would be easy. However, history bears witness to the truth that asking an entire community to change its ways is frequently difficult and often dangerous. Change is challenging. Not because people resist change per se, but because people resist loss. The emotions created following significant change are similar to those experienced by bereavement *(Figure 1)* and Meaney and Pung (2008) report that only one out of three planned organisational change programmes are successful. One possible reason for this may be the lack of consensus evident across the change management literature as to what the most effective change models or processes are (Pettigrew et al, 2001; Bamford and Daniel, 2005; Jarrel, 2017).

When attempting to effect change within the working environment, therefore, the success (or failure) of that enterprise will be determined not so much by the nature of the change or the logic or rationale behind it, but by the manner in which it is implemented. Often, change is implemented via governance systems driven into operational systems by management in order to achieve targets without any real attention given to the cultural readiness of the system for embracing the proposed change. *Figure 2* shows this relationship by representing governance as a set of visible, 'above the waterline' systems implemented and administered by management processes. Cultural systems, including behaviours, quality, person-centredness and team dynamics lie beneath the visible management and governance systems but determine their sustainability and success. These are enabled or disenabled by leadership behaviours across the service or organisation.

NHSGGC has a population of 1,169,110 (21.6% of the Scottish population) and is associated with some of the poorest health outcomes, including those for lower limb amputations and foot ulceration, in the UK (Walsh et al, 2016; Hurst et al, 2020).

In 2012, NHSGGC redesigned ten separate podiatry services into a single system service with around 200 staff (155.0 whole-time equivalent [wte]) and a budget of around £6.8m.

Between 2012 and 2015, large scale changes were implemented, including the move to a clear service

DAVID A WYLIE
Head of Podiatry, NHS Greater Glasgow & Clyde, Scotland

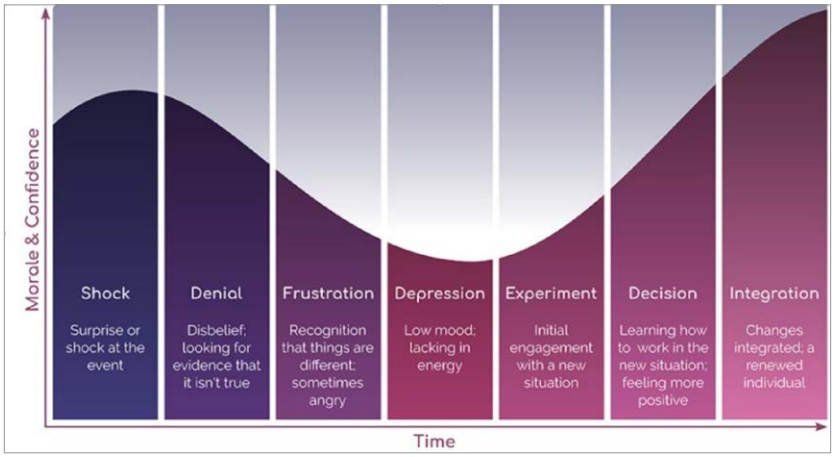

Figure 1. Kübler-Ross Change Curve™

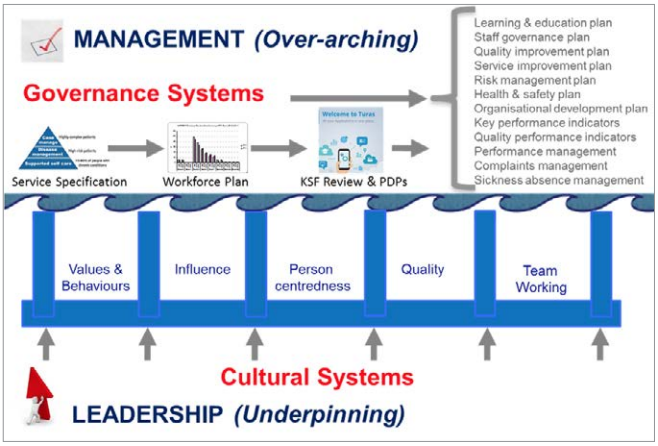

Figure 2. What lies beneath: management and leadership systems in organisations

Table 1. Technical and adaptive challenges (Heifetz and Linsky, 2002)

	What is the work?	Who does the work?
Technical (Tame)	Apply current know-how	Authority
Adaptive (Wicked)	Learn new ways	People with the problem

model and electronic records. However, as the 'tame' elements of service redesign were completed, it became apparent that not all elements of the redesign of the service would be so easy to change.

When trying to change 'the way we do things around here', an 'above-the-line' approach that simply changes governance and system processes will not work. The problems faced by services engaged in such complex redesign are not tame or technical in that they are easily changed — they are adaptive or 'wicked' in that they were generated by historic custom and practice and require an adaptive rather than an algorithmic approach *(Table 1)*.

One of the main problems facing the redesigned Podiatry Service was the provision of foot protection to individuals with foot and ankle ulceration who did not have diabetes. The historic podiatric workforce had developed specialist and advanced 'Diabetes Podiatrist' posts and whilst these clinicians provided an excellent service to individuals with diabetes, peripheral arterial disease patients were not granted access to the Podiatry Service in the same way. This was considered to be inequitable, following an Equality Impact Assessment (EQIA). Historically, Tissue Viability colleagues picked up these individuals within the inpatient population. This led to fragmented care and created inequity and lack of clarity across the system in terms of 'who did what to whom?' Many of the challenges experienced during this period of ongoing change were therefore due to who 'did' and 'did not do' certain clinical work historically. An adaptive approach was required.

THE LEADERSHIP CHALLENGE

Leadership would be a safe undertaking if organisations and communities faced problems for which they already knew the answers. For many of the day-to-day problems that people and organisations face, they already have the necessary knowledge, skills and procedures to generate solutions. These are technical problems. They can be dealt with through algorithmic solutions.

The problem faced by the Podiatry Service, in this case, was not amenable to authoritative expertise or standard operating procedures. It could not be solved by someone providing an answer from above. It was a true adaptive challenge because it required experiments, discoveries, and adjustments from numerous places across the organisation in order to achieve the necessary change. Without iteratively learning new ways and fundamentally changing attitudes, values and behaviours, individuals involved in the delivery of historic care models could not make the adaptive leap necessary to operate sustainably in a new environment. The sustainability of any change in this space, therefore, depended on the individuals who had been part of generating the historic situation being fully involved in creating and implementing the changes themselves.

Typically, at the beginning of such a process, individuals cannot see how a new situation would be

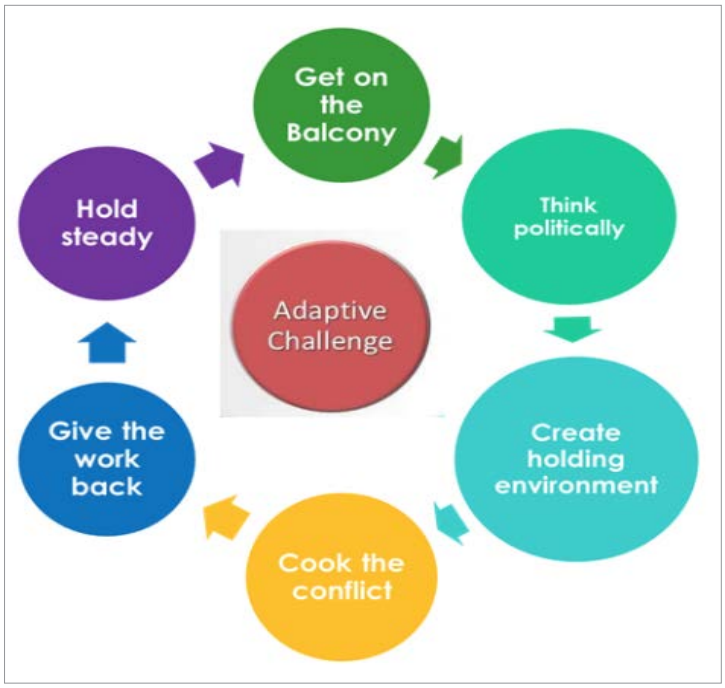

Figure 3. The Adaptive Leadership Model (Heifetz, 2003)

	Diabetes	Non-diabetes	CPR for Feet	Pressure Ulcer reporting (Avoidable/ unavoidable)
Adult Wards	Acute Podiatry	TVN	Ward Nurses (Patchy)	TVN (Non-diabetes only
Paediatric Wards	Acute Podiatry	TVN	Ward Nurses (Patchy)	TVN (Non-diabetes only
Community Nursing	Community Nursing/ Podiatry	Community Nursing/ Podiatry	Community Nursing	Community Nursing
Acute Podiatry	Acute Podiatry	Acute Podiatry (Patchy)	Patchy	No
Community Podiatry	Community Podiatry	Community Podiatry	No	No
Care Homes	Community Podiatry	CHLN/ Community Podiatry/ CH Staff	Care Home Liaison Nurses/Staff	Care Home Liaison Nurses

Figure 4. Historic NHSGGC podiatry involvement in foot and ankle wounds

any better than the current situation. What they do see is the potential for personal loss. This frequently leads to change either being delayed or not happening at all by allowing clinicians to avoiding painful adjustments or postponing them indefinitely.

It became apparent early in discussions with Nursing and Tissue Viability colleagues that the Podiatry Service redesign 'to take responsibility for all foot protection across the NHS Board area' was not solely a technical problem but a series of complex challenges that required an adaptive, collaborative approach. Rather than adopting a leadership model that 'influenced the community to follow the leader's vision,' a leadership model that 'influenced the community to face its problems' was required (Heifetz, 2003). The adaptive leadership model was therefore selected as a means by which change could be managed and achieved.

METHOD AND RATIONALE

Adaptive leadership was popularised in the 1990s by Ronald Heifetz and others (Heifetz, 1994; Heifetz and Laurie, 1997), gaining traction because of its ability to surface conflict, challenge long-held beliefs and generate new ways of working. By introducing a realistic, collaborative approach to challenging and difficult issues that are frequently left in the "too-hard-to-do" box, it enabled organisations to implement significant and sustainable changes. The steps in the adaptive leadership model are presented in *Figure 3*. The process begins by taking the stakeholders to 'the balcony.'

STEP 1— GET ON THE BALCONY

In order to fully understand the nature and the scale of the problem, it is vital to take time to 'view the dancefloor' from the 'balcony.' This requires a threefold approach:

Know yourself

Being truly reflective is not easy, but it is an essential feature of good clinical leadership (Schön, 1983). Being able to objectively look down on or into a service and how it delivers care takes time and intentional objectivity. Self-awareness is a key leadership function here. It requires the ability to clearly understand personal role and purpose, and a 360o leadership tool such as the Healthcare Leadership Model (NHS Leadership Academy, 2011) may be a useful place to begin. By focusing on these, and acknowledging a realistic operational bandwidth, an achievable set of aims can be developed that greatly increase the chances of successful completion. By adopting a 'balcony' approach to this problem, management was able to 'listen' to the organisation and take a more objective view of service provision, rather than reacting to perceived problems by implementing top-down solutions and quick fixes, which may have been the historic approach to this kind of problem.

Figure 5. NHSGGC Podiatry Service foot protection vision 2016

Know your system

From the balcony, it is also possible to view gaps, inconsistencies and inequalities in the delivery of services, and to differentiate between technical 'tame' issues and adaptive 'wicked' issues. Process mapping can help here in order to identify gaps, delays and duplication. From the balcony, it was evident that the Podiatry Service was either not involved nor actively contributing in a number of key aspects of foot and ankle wound management *(Figure 4)*. This provided a focus for the areas where most effort was going to be required in implementing the adaptive changes envisaged later.

Know your culture

The balcony also allows space to identify organisational behaviours, including personal and professional tribalism and cultural resistance. This approach helps to shape the nature and extent of engagement that is required to break through the culture web (Johnston and Scholes, 1993). The Podiatry Service measures the 'cultural temperature' of the service on an annual basis using the Humming Culture Questionnaire (Humming, 2015). It confirmed that business focus, organisational discipline and internal communications were strong enough to indicate that further change would be possible within the service to maximise skills and improve the equity of service provision by taking responsibility for all foot and ankle wounds, regardless of underlying pathology.

STEP 2 — THINK POLITICALLY

The proposed redesign was aligned with national and board-wide strategic objectives aimed at reducing pressure damage, and achieving a 2-working day podiatry response to foot wound referrals in line with Scottish Intercollegiate Guidelines Network (SIGN) and The National Institute for Health and Care Excellence (NICE) guidelines. By doing this, the service was able to present the proposed redesign as a solution that would contribute to organisational performance indicators rather than simply an isolated improvement programme within a single service.

A further driver for change within the NHS comes from patient complaints (Reader et al, 2014). Through these, it became evident that non-diabetic inpatients with foot ulceration felt disadvantaged at not being given the same access to podiatry services as those who did have diabetes. Although in no way critical or detrimentally reflective of the service provided by the relatively small Tissue Viability team, it was an unsustainable and indefensible inequity for a service which purported to offer specialist services for the foot and ankle.

These political aspects of the adaptive approach provided the framework for strategic discussions with senior nurse and service managers across the Board area, gaining organisational support.

STEP 3 — CREATE A HOLDING ENVIRONMENT

The importance of staff engagement, particularly in building a coalition of influential employees, can help signal consensus in implementing large scale system change (Kellog 2012; Bies, 2013).

The adaptive leadership model provides a space for this to take place within a safe 'holding environment' so that all stakeholders may fully contribute to the adaptive change process, and to provide a place to influence and encourage the community to face its problems and generate potential solutions. In this project, the first step in creating a 'holding environment' or an organisational safe space was generated via a stakeholder engagement event. This facilitated an honest and transparent discussion about historic perceptions, previous and current tribalism, myths, rumours, perceptions, agendas, preconceptions and misunderstandings about roles, processes and

Box 1. NHSGGC Podiatry Service vascular referral criteria

Clinical problems

Pain
- Claudication pain present Yes/No (include claudication distance)
- Rest pain present Yes/No
- Has pain level increased? Yes/No

Clinical Findings
- Wound
- Size
- Source
- Orientation
- UOT classification

Pulses
- Palpable Yes/No
- Location

Previous vascular investigations/intervention

Other information

Confirmation
- Picture uploaded to clinical portal
- Outpatient Clinical Letter has been generated

competencies. These were able to be aired and heard in order to be dealt with collaboratively.

Show the future

Within the holding environment, it is important to present a vision – or alternative visions – of an improved future state. This may take the form of a new or improved model of care already in existence and supported by an evidence base, or it may be the product of an iterative process generated from the stakeholders themselves, since a vision is more likely to be effective if it appeals to a wide range of stakeholders (Kotter, 1996).

Either way, the future state must be perceived by all stakeholders – particularly service users — as being more desirable than the status quo and indicate a clear separation from the past (Kanter et al, 1992).

Consequently, a vision emerged that enabled the Podiatry Service to make an improved offer to the system, proposing that podiatry would take responsibility for ALL foot and ankle wounds across NHSGGC, and the associated challenges *(Figure 5)*. Not least amongst these was the requirement for Podiatry to report all tissue damage to the foot and ankle in line with reporting mechanisms used by Tissue Viability and District nursing. Hitherto, this had not been done by Podiatry and represented a substantial governance gap in the organisation generated by the historic 'silo-approach.'

It is difficult to accurately predict the volume or increased demand that this new work would generate. Projections based on what is currently known about incidences of foot and ankle tissue damage in the increasing elderly population, as well as the anticipated increased volume of foot wounds from a larger population with diabetes, enabled the Podiatry Service to estimate that an adjustment to the workforce of around an additional 9.0 wte specialist podiatry posts would be required. Since no additional funding was available to deliver this redesign, the increased resource was found from an internal service redesign of the podiatry service itself – mainly from redesigning the MSK podiatry service to become far more efficient.

Furthermore, the nomenclature and scope of existing 'Diabetes Specialist' posts in the podiatry service were redesigned to become generic 'Foot Protection' posts in order to include non-diabetic patients.

STEP 4 — COOK THE CONFLICT

These change elements required a specific set of discussions with each stakeholder constituency in order to agree on a joint approach to implementing the planned future model.

Vascular

A pathway to facilitate direct access to vascular services was needed. Podiatrists and vascular surgeons created a set of referral criteria *(Box 1)* which allows critical limb ischaemia and sepsis to be fast-tracked to a vascular 'hot clinic' for same-day review with a view to admission, without having to go via GP or A&E.

Tissue Viability Nurses

A full collaboration with the Tissue Viability service was essential to transfer responsibility for inpatient foot and ankle pressure management to Podiatry. Tissue Viability Nurses (TVNs) and Podiatrists worked together to revise the Board pressure ulcer prevention policy to ensure a joint future governance approach in this area. This required the podiatry service to work closely with TVN colleagues to change its reporting processes to match those used by the TVN service to record and report inpatient tissue damage at Grade 2 or above, and to identify whether that damage was avoidable or unavoidable. The DATIX incident recording system was utilised to record and report on these data items.

Staff job descriptions

In partnership with Trades Unions, the Podiatry Service revised the 'Diabetes Specialist Podiatrist' job description with a view to replacing these posts in the workforce plan with 'Foot Protection Podiatrists.'

This involved reviewing the Podiatry Competency Framework For Integrated Diabetic Foot Care (SDFAG, 2012), which provided evidence that vascular competencies were already present in the Diabetes Podiatry workforce that would render Diabetes Specialist Podiatrists competent to assess non-diabetic individuals for critical limb ischaemia and sepsis as part of a foot protection service *(Figure 6)*.

Thus, by maximising and fully developing vascular assessment skills already present in the podiatry workforce, it was possible to create a sustainable, resilient vascular skill set across the podiatric workforce, rather than only in a few select individuals with a narrow range of skills.

Figure 6. Vascular Assessment Dimensions in Podiatry Competency Framework For Integrated Diabetic Foot Care

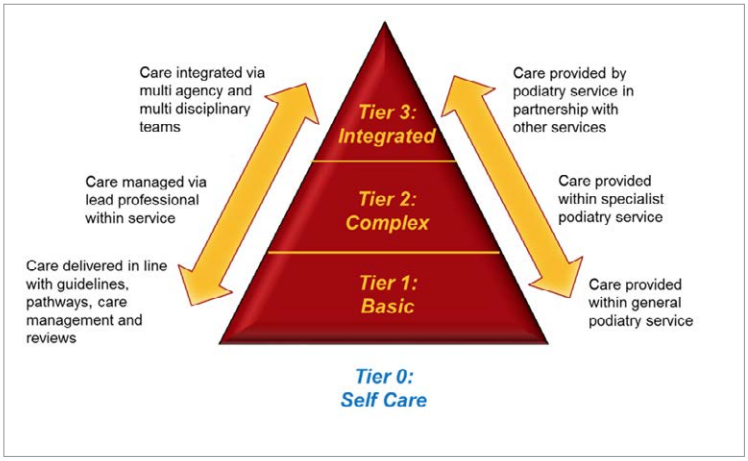

Figure 7. NHSGGC Podiatry Service Model

Maintain disciplined attention

A key aspect of managing the conflict generated by change requires those leading the change to maintain control of all work streams by using a form of project management methodology such as Prince 2. This is helpful in ensuring that every workstream remains accountable for deliverables. It is vital to remain focussed on the primary issue(s) under consideration (Stouten et al, 2018).

Consistent service model

Complete and utter clarity around the service model was required *(Figure 7)* in order to ensure that every proposed change was clearly associated with a particular stage of the patient journey enabled the redesign to stay focused.

Consistency of narrative

When the service model is clear, consistent messaging is vital to ensure that multiple versions of the 'truth' do not end up being implemented or adopted. The podiatry service rebranded the service as 'Positively Podiatry' with the strapline 'Protecting Limbs, Prolonging Lives'. This logo was incorporated into all Podiatry communications and supported with leaflets, banners, pens, mugs, pin badges, stickers and business cards. All communications were tied into this narrative, creating a consistent message across the Board area. Positively Podiatry also featured as a 'Hot Topic' on the Board intranet in order to publicise the changes widely.

STEP 5 — GIVE BACK THE WORK

Sustainable change on this scale is only possible when those who require implementing it embrace it and make it part of the way they work in the future state.

Central to achieving this is the stage in the change process where the work is 'given back' to staff themselves, with the understanding that the new way of working is actually what they should have been doing all along. The Scottish Government's Realistic Medicine paper challenges all healthcare professionals to work to the top of their capability (Scottish Government, 2016). However, in practice, this often doesn't happen in many services due to a form of skills suppression caused by more senior banded staff reaching into lower banded competencies and doing work that should be done there. Consequently, those staff then have to reach down to a band below them to find work to remain busy, thereby suppressing capability in lower bands, preventing them working at the top of their clinical licence *(Figure 8)*. By allowing lower banded staff to work at the top of their capacity, higher banded staff are then free to develop into the specialist areas and advanced pillars of practice that defined more senior roles *(Figure 9)*.

Historically, a significant volume of clinical work was being retained in tier 3 of the podiatry service that could and should have been de-escalated to Tiers 1 and 2 *(Figure 8)*. By giving Band 7 Podiatrists back the responsibility for facilitating learning and leadership as two of their pillars of advanced practice, it was possible to enable Band 5 and 6 clinicians to work at the top of their capability, thereby maximising skills across the service

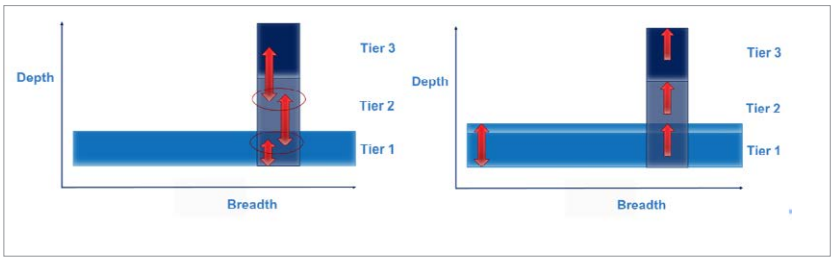

Figure 8. Skills Suppression Model

Figure 9. Skills Maximisation Model

	Diabetes	Non-diabetes	CPR for Feet	Pressure Ulcer reporting (Avoidable/ unavoidable)
Adult Wards	Podiatry (2 working days)	Podiatry (2 working days)	Ward nurses Supported by Podiatry	Podiatry (2 working days)
Paediatric Wards	Podiatry (2 working days)	Podiatry (2 working days)	Ward nurses Supported by Podiatry	Podiatry (2 working days)
Community Nursing	Community Nursing/Podiatry Shared Care (2 working days)	Community Nursing/Podiatry Shared Care (2 working days)	Community Nursing supported by Podiatry	Community Nursing/Podiatry (2 working days)
Acute Podiatry	Podiatry/ Diabetes MDT (2 working days)	Podiatry/ Vascular MDT (2 working days)	Ward nurses Supported by Podiatry	Podiatry (2 working days)
Community Podiatry	Podiatry/ Diabetes MDT (2 working days)	Podiatry/ Diabetes MDT (2 working days)	Podiatry	Podiatry (2 working days)
Care Homes	Podiatry/CHLN Shared Care (2 working days)	Podiatry/CHLN Shared Care (2 working days)	Podiatry/CHLN Shared Care	CHLN/Podiatry (2 working days)

Figure 10. Post-redesign NHSGGC podiatry involvement in foot and ankle wound management

(Figure 9). This process also ensured that Band 7 clinicians were developing their non-clinical pillars of advanced practice appropriately for the benefit of the service.

Protect the voices from below

As work was given back during the change process, it was vitally important to continue to engage with all staff and stakeholders. Ultimately, the success or failure of a major redesign project will stand or fall on the degree to which the individuals implementing it feel they have ownership. Achieving this without it appearing tokenistic is challenging and requires intentional planning and engagement.

It also requires an organisational willingness to invest in learning, education and organisational development in order to ensure that sufficient support is provided throughout the entire process and beyond. In this project, a comprehensive programme of learning and education was implemented to support the changes agreed, and an audit of competencies was carried out in 2019 to ensure that progress was being made and maintained (Wylie and Butters, 2019).

STEP 6 — HOLD STEADY

The final step in the adaptive leadership journey involves making the change and holding the line. Implementation of large-scale change always generates 'speed bumps' along the way, but it is vital not to abandon the changes when the first problems within the new way of working emerge. There will be many of these, and they require constant revisits to the balcony in order to review the 'new dancefloor'. And so the cycle of improvement continues.

RESULTS

Following the redesign, the podiatry service now contributes fully to each area of foot and ankle wound management *(Figure 10)*.

In addition, the Podiatry Service has contributed positively to a reduction in the number of avoidable Grade 2 foot and ankle wounds within the inpatient population *(Figure 11)*.

Following the implementation of the redesign to enable the Podiatry Service to take responsibility for all foot and ankle wounds, there has been a 190% increase in the number of foot and ankle wounds referred to the service. Despite this, an average of 94.4% patients with these wounds were given an appointment by the service within 2 working days *(Figure 12)*, representing a 467% improvement.

CONCLUSION

The adaptive leadership model has provided the NHSGGC podiatry service with a framework for implementing and sustaining large scale service redesign. This model has delivered improved clinical outcomes in the prevention and management of all wounds and tissue damage affecting the foot and ankle. It has also improved timeous access to podiatry services for all foot and ankle wounds despite a significant increase in demand, demonstrating the resilience and efficiency of the redesigned service model. Furthermore, the Podiatry Service is now a fully integrated partner in the provision of wound care and pressure damage prevention with Tissue Viability and General and District Nursing colleagues. WUK

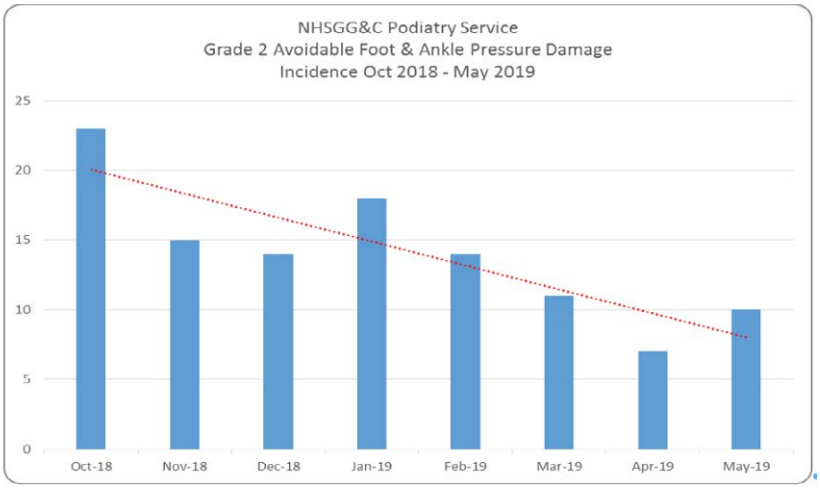

Figure 11. NHSGGC Podiatry Service: The number of avoidable inpatient Grade 2 foot and ankle wounds

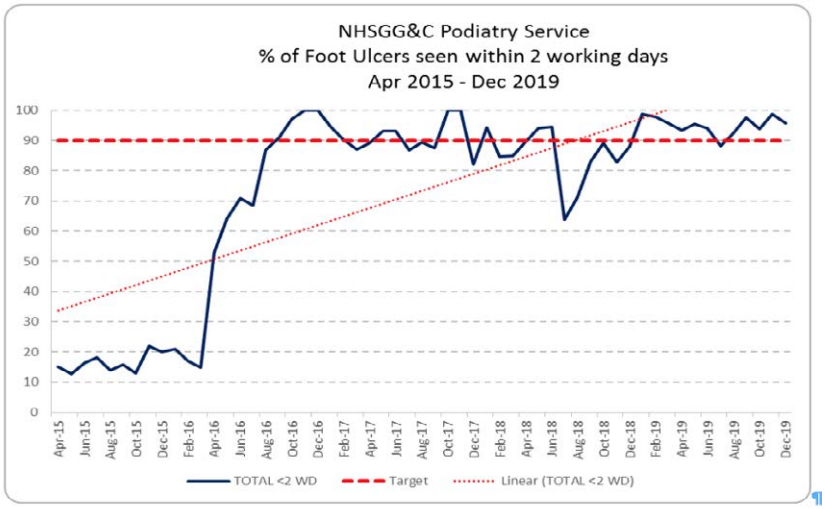

Figure 12. NHSGGC Podiatry Service: The percentage of patients with foot and ankle wounds seen within 2 working days (2015–2019)

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