Conference Report: Shoes Made for Walking?

Delegates enjoy the Conference exhibition over coffee

More multidisciplinary working, more skills and professional training, more Centres of Excellence, and more direct contact between patients and the technicians and craftspeople making their shoes.

These were the key messages from seventy clinicians, academics, manufacturers and patients who attended the CPD4 Health Innovation one-day conference ‘Shoes Made for Walking?’ at the University of Leeds on April 5, 2011.
Set in the University’s Weetwood Hall Conference and Hotel facility, delegates worked together to tackle the Conference’s central task of improving the development of specialist footwear services that meet the needs of patients both in terms of functionality and style.

Delegates had the opportunity to see for themselves what is currently on offer from orthopaedic footwear makers through a busy and well attended exhibition, which show-cased the best of made-to-measure and stock footwear, some produced by large manufacturers and others made by specialist craftspeople.

Keynote speakers at the Conference included Professor John Hutton, director of the York Health Economics Consortium (YHEC) and Professor of Health Economics at the University of York, and Professor Anthony Redmond, Senior Lecturer in the Section of Musculoskeletal Diseases at the University of Leeds’ Institute for Molecular Biology, and Professor of Clinical Biomechanics at Staffordshire University.

The NHS was represented by Anne Bontoft, who manages the Orthotics Service for Northern Lincolnshire and Goole Hospitals NHS Trust, and who is also a qualified occupational therapist with a particular interest in Rheumatology, and who maintains a specialist clinical caseload, ‘to keep her feet on the ground.’
Evidence that the Conference’s central objective of improving the orthotic services provided by the NHS is achievable came from Philip Taylor, who trades as The Cordwainer, a bespoke and orthopaedic shoe maker with 40 years’ experience of making footwear that both works, and looks good.

Two orthopaedic shoe wearers, Sheila Kendall-Edgecombe and Melvyn Flacks, shared their unique insight into the reality of using NHS orthotic services with other delegates, and a design team from the University Conference Speaker

Philip Taylor

Shoe maker Philip Taylor had polio as a child, and must wear either his own shoes, or shoes that he’s had made for him.

As such, Philip has the perspective of both a provider and a user of specialist, made-to-measure footwear. The reasons why some patients experience discomfort from NHS supplied footwear are straightforward in Philip’s view: “Quality, fit, function,” he said.
of Leeds, led by Professor Tom Cassidy, described their development of a universal, built-in orthopaedic rocker bar for people who suffer from Gout-related foot disorders.

Improving Orthotic Service provision

Most delegates at the Conference, whether service users, clinicians or academics, agreed that the orthotic services offered by the NHS needed to improve.

An orthosis is a device fitted to an existing body part to support, correct or compensate for an anatomical deformity or weakness, and footwear provides the largest area for which orthotic services are required. Service users at the Conference included arthritis and polio sufferers, and some patients who have particular footwear needs because of chronic wounds such as leg ulceration.

After an introduction to the day from Elaine McNichol, Director of CDP4 Health Innovation at the University of Leeds, Professor John Hutton described his review of orthotic services, which was undertaken with the
support of the British Health Trades Association (BHTA), and which led to a report in 2009, ‘Orthotic Services in the NHS: Improving Service Provision.’

Through this project, Professor Hutton and his colleague and co-author Manjusha Hurry, reviewed the policy landscape of the NHS, and summarised the various previous studies and reports on orthotic services that have been produced since 2000. They confirmed that little progress has been made since then through a survey of the six Pathfinder Pilot Trusts.

Professor Hutton explained how improving orthotic services could save the NHS a great deal of money. He gave some examples to underline this point.

Although keen to see orthotic services improve through more education, Frank Crewdson, who is the Orthotic Development Manager for Trulife, the US-based niche medical products manufacturer, feels that there is probably far greater satisfaction with orthotic services than people realise.
Diabetic foot ulcers, for instance, can be prevented through the provision of specialist footwear and proper monitoring, which costs something in the region of £300 a year for every patient, Professor Hutton said. An ulcer, however, will cost between £3,000 and £7,500 to heal properly once it occurs; in the unfortunate event that amputation is necessary, that cost can rocket to over £50,000 per patient.

In other cases, Professor Hutton pointed out, GP referral directly to orthotists can also save a lot of money, and in the case of a common condition called Plantar Fasciitis, can reduce the patient pathway from 10 visits over 51 weeks to 4 or 5 visits over 26 weeks. The relative cost of GP direct orthotic referral would be £115, Professor Hutton said, rather than the £1,015 cost of the current pathway.

Altogether, Professor Hutton calculated that every pound spent on Orthotics could save the NHS four pounds on other costs. There is therefore a powerful economic argument, he said, that underpins the quality of life gains that patients will make from improved orthotic services.

Professor Hutton’s review of orthotic services made a number of recommendations, including:

- The profile of Orthotics should be raised with commissioners and both national and local managers, perhaps through a national commissioning body.

- There should be specific funding for orthotic interventions within the PbR (Payment by Results) Tariff.

- There should be a new model of service that recognises that orthotic products are not commodities, but are individually tailored prescriptions tailored to patient needs.

- The orthotist should be involved at an early stage in the patient’s pathway.
Professor Tony Redmond, who is a Senior Lecturer in the Section of Musculoskeletal Diseases at the University of Leeds’ Institute for Molecular Biology, and Professor of Clinical Biomechanics at Staffordshire University, believes that communication between clinical researchers and consumers could be much better than it is.

“We’re very good at sitting in silos, generating new knowledge, new information, and then hoping that it goes out into the world and has a life of its own,” he said, “I don’t think we do as good a job as we might have at engaging with the public, about getting the information across in an accessible way.”

Professor Redmond believes that informed choice is essential if things are going to improve. “In my lecture I mentioned the three prongs of choice, which is about having something different people can choose from, a system in which people can make informed choices, the information that allows people, be they clinicians, commissioners of service, providers of service, to know what’s out there, what’s best,” he said, “and then design to make sure that what you’re producing is actually fit for purpose. I think all three of those need to be brought together.”
Orthotics and musculoskeletal disease

Professor Anthony Redmond, whose professional background is in podiatry and who represents the Allied Health Professionals in a range of roles within the National Institute for Health and Clinical Excellence (NICE), Arthritis Research UK, British Health Professionals in Rheumatology (BHPR) and the Arthritis and Musculoskeletal Alliance (ARMA), presented some of the evidence for the benefits of the use of different kinds of footwear and orthoses for musculoskeletal conditions.

Putting the evidence in the context of an upcoming report, commissioned by Arthritis Research UK, which examines some of the problems that exist with the supply of footwear and orthoses for people with arthritis, Professor Redmond described the pyramidal nature of the footwear that was available to patients, with commercially produced footwear at the bottom, and bespoke at the top.

Early intervention with functional orthoses in rheumatoid arthritis brings tangible benefits, he pointed out, including a reduction in pain, and a potential for minimising future joint damage.

Despite the central importance of these orthoses, Professor Redmond was able to outline a series of shortcomings in current provision. These included the fact that the funding for orthoses and footwear was organised through various and sometimes competing directorates within hospital trusts, PCTs and through commercial contracting, and that orthotic practice is often uncoordinated and incoherent. The level of effectiveness and satisfaction amongst rheumatoid arthritis sufferers receiving orthotic interventions varied, as did the practice itself.

Professor Redmond finished by highlighting criticism of orthotic services by Audit Commission reports in 2000 and 2002. There was, he said, a potential for a waste of resources on a significant scale. There were clear needs for improvement in the choices and information available to patients, and in the design of footwear and orthoses. “We can and must do better,” he told delegates.

Bespoke and orthopaedic shoe making

Before hearing the Conference’s guest orthotic service users speak, delegates were given a guided tour of the work of specialist and orthopaedic shoe maker Philip Taylor’s work. Philip contracted polio at the age of
Design and designers clearly have an important part to play if patients’ needs for greater choice in footwear styles are to be met.

Fiona Candy is a Senior Lecturer in Textiles in the School of Art, Design and Performance at the University of Central Lancashire (UCLAN) in Preston, and sees designers adopting a mediating role in a partnership approach to creating new objects. “We’ve got some skills, we’ve got some craftsmanship, we’ve got these sorts of abilities,” she said, “we can enable a group of people who don’t have that expertise to work together on a common product.”

There had been a design project at UCLAN, sponsored by the Royal College of Art and Arthritis Research UK, in which podiatrists, designers, orthotists and patients came together over two days to brainstorm new ideas. The most valuable aspect of the project for her was the way that the design process was able to liberate the knowledge that was held in the different skills bases. “The shoes that people were trying to design became a vessel for all of that knowledge to pass through,” she said.
two, and needs to wear the kind of footwear he himself makes, so was able to share a unique insight as both a service provider and a service user with the Conference.

Only one in ten of the 150 or so pairs of shoes Philip makes each year are paid for directly by the NHS; the rest are paid for personally by people who cannot get the footwear they need through the service, he said.

People choose not to use the footwear supplied by the NHS for a variety of reasons, he explained, including because they fit poorly, they don’t work well, they look ungainly, and there is little choice of style.

The NHS is a major player in the bespoke footwear industry, he pointed out, and approximately 75% of all made-to-measure boots and shoes in the UK are manufactured by companies contracted to the health service.

Some estimates suggest only roughly 5% of all bespoke footwear is not used or is thrown away, Philip said, whereas the figure for NHS bespoke footwear is between 35% and 40%.
Studies such as the 1999 British Society of Rehabilitation Medicine report ‘From Surgical Appliances to Orthotics – Towards an Effective Service’, Philip felt, have highlighted some key shortfalls in orthotic services. These include:

- Prescribers, including orthotists, are not always appropriately trained, and staff without clinical qualifications are sometimes involved in measuring and fitting orthoses or footwear.

- The management of orthotic services, including record keeping, patient reviews and audit outcome, is often poor and inefficient.

- Orthotists frequently work with inappropriate facilities and support to provide a service to patients with complex needs.

The report recommended that different levels of orthotic provision should be given according to the clinical problem, that where they both existed, orthotic services should be located and managed with prosthetic services, and that a ‘hub and spoke’ approach should be taken to the supply of orthotic services, orthotist development and patient support.

In short, Philip Taylor believed, the report supported the need for specialist orthotic centres or Centres of Excellence to deal with the more complex patient needs.

Things will need to change before orthotic services improve, Philip Taylor said, and those changes need to include:

- **Commissioning for footwear**, where the current system offers little incentive for companies to invest in training or employ the most skilled shoe makers, and where contracts are often awarded – and rolled over – on the basis of cost rather than quality of service.

- **Evaluation of suppliers**, particularly to see how the needs that cannot be met by existing contracted suppliers could be met by smaller companies, who can’t compete for large tenders.

- **Structure of clinics** using a ‘hub and spoke’ approach, where patients with complex needs would be treated by regional Centres of Excellence that brought together orthotists and student orthotists, physiotherapists, rehabilitation specialists, a gait analysis clinic and a specialist shoe maker.

- **Improved orthotic training**. Only two universities are involved in training orthotists, Salford and Strathclyde. Students often encounter complex problems for the first time with little or no experience or support.

- **Patient choice and participation**, which could be through a footwear voucher scheme, charges for footwear equivalent to normal shoe prices, and service level agreements.
• **Personal healthcare budgets.** If once they are introduced, personal healthcare budgets include a choice over where to go for footwear services this might revolutionise the whole industry.

• **Training for shoe makers.** Past attempts by the Learning and Skills Council to design an NVQ for shoe makers failed after the funding was axed. Without funding for training and changes to commissioning, Philip Taylor felt, there would be few skilled shoe makers in the future.

The consequences of not improving the Service could be expensive, Philip pointed out, suggesting that about £3.3 million of the £10 million the NHS spends annually on orthopaedic footwear is spent on shoes that are either never worn or discarded after very little use.

Using specialist shoe makers could save the NHS about 30% of its costs, Philip Taylor felt, and if people consider the estimate that every pound spent on orthotic services should save four pounds on other costs, a calculation referred to earlier by Professor Hutton, discarded or barely worn footwear could be a missed opportunity to save up to a further £13 million annually.

None of this, of course, considers the quality of life costs for the people forced to make do with painful and ill-fitting footwear. If the current system doesn’t change, Philip Taylor said, the consequences will be serious, and might include:

- A further degeneration in the quality of footwear in the NHS, a likelihood that is generally accepted.
- People with disabilities will be further disadvantaged and disenchanted with the NHS.
- There will be a continuing decline in the skills of the people involved with the industry.
- Disabled people will not receive the footwear they require in the future.

However, if the system does change, orthotists will be better trained, and disabled people can begin to feel confident about themselves and their appearance. It will be possible, Philip Taylor said, to create a skilled and profitable industry capable of guaranteeing the supply of good quality footwear in the future.

**The patients’ perspective**

Two clear themes to emerge from the Conference so far were the dissatisfaction of many patients with the current level of orthotic service they received, and a need to allow more direct contact between patients and the skilled people making their footwear.

From these points of view, the experiences of the Conference’s two guest orthopaedic footwear users were particularly relevant to delegates.
Sheila Kendall-Edgecombe has had 31 pairs of orthopaedic shoes since 1990, 18 of which were paid for by the NHS, and 13 by herself. All the NHS shoes were unusable for any period of time, she said, whereas only one of the pairs she paid for was unsuitable.

Sheila Kendall-Edgecombe describes her experience of made-to-measure footwear

At one point she became so desperate, she recalled, that she even tried making her own shoes. As other speakers had pointed out, the waste of resources for the NHS is considerable. However, the damage to patients’ quality of living also needs to be part of the equation. This includes “restriction of movement and opportunities, pain, frustration, despair, depression, further damage and ill health due to this neglect,” she said, asking, “How has this happened?”

Sheila felt that the core problem lay in NHS commissioning, where companies cut corners in skill and quality to be able to compete with the lowest tenders.

Orthotists and shoe makers needed to work more closely together. “Orthotists should know far more about shoe making, and orthopaedic shoe makers should know far more about orthotics,” she said.

Melvyn Flacks told delegates he suffers from the condition Charcot-Marie-Tooth disease, an inherited disorder, and has had to wear orthopaedic footwear since he was 12 years old, more than 50 years ago.
Paul Marchant had polio at the age of three months old, when he contracted it during the epidemic of 1944, and was at the Conference representing the British Polio Fellowship.

One way to improve the service, Paul feels, would be to allow greater contact between the patient and the person making them their shoes. “That’s how it used to be in the old days,” he said, “you used to go and see a guy and you would have a fitting, you would go in a room, he would do a bit of tweaking, come back, ‘try that’, go away, come back, and then you would have your appliance within a week or two.

“Now it is telephone calls, make an appointment, go to the clinic, tell them what’s wrong, make notes, you go back a fortnight later, they’ve altered it but it’s still not right.”
His early experiences of NHS orthotic provision were poor, and caused him a great deal of pain, and to miss many hours of school because of his frequent hospital appointments.

When he was 15 years old, he told the Conference, he was moved to a different hospital, where he encountered a particularly difficult appliance officer he dubbed ‘The Dragon.’ After many adjustments the shoes she provided were still unwearable. None-the-less, she insisted he leave the hospital wearing them.

Paul hopes that the Shoes Made for Walking Conference will lead to greater choice for patients. “You’ve got a choice,” he said, “you can either go to this orthotics company or that orthotics company, you choose which one you want to go to and just deal with them direct.”

And would Paul want patients to carry a footwear voucher scheme with them? “I think that is a good idea,” he said.

Mervyn Flacks describes the pain of poorly fitted footwear

“I remember sitting down on the floor in the corridor, out of her sight, and changing my shoes,” he recalled, “I was crying with pain, and I never went back.”
Anne Bontoft manages the Orthotics Service for Northern Lincolnshire and Goole Hospitals NHS Trust, and is also a qualified occupational therapist with a particular interest in Rheumatology.

Anne was keen to emphasise that there are already improvements and changes in her Trust. “We’ve got a really rigorous service specification,” she said, “so that when patients come and GPs refer in, they’re able to see exactly what the service offers, what types of services we’ve got, what products we provide, and also what we don’t provide.”

As well as direct GP referrals in to the Service, cutting out the delays and cost involved with referral through consultants, Anne’s Trust also allows multidisciplinary referral, “so if the patient comes in for physiotherapy, they can be referred from the physiotherapist into Orthotics,” she said.

The link between orthotists and footwear manufacturers can be problematic, she feels. “The orthotists like to have a link with the factory,” she said, “it’s a difficult one, because there is a conflict between purchasing from particular companies, it doesn’t necessarily offer best value when you know you can
Following the intervention of a concerned GP, he was referred to an independent, skilled shoe maker who extensively photographed and measured his feet before making lasts. The shoes made were a vast improvement on anything he had received from the health service. “This was the first time the person making the shoes had ever looked at my feet,” he said.

After a series of skilled shoe makers, who Melvyn dealt with directly with his hospital’s approval, responsibility for making his shoes was assumed by a major company holding an NHS contract. “It soon became obvious that the new company did not want such difficult jobs,” he told the Conference, “they took an increasingly long time to make me a pair of shoes because it had to fit in with their mass production.”

Melvyn then saw an advertisement for Philip Taylor’s shoe making business, The Cordwainer, and after a home visit paid for a pair of made-to-measure boots, which he needed for a trip to Australia; these boots could not be leather, as he was planning to go white water rafting whilst he was there, and leather boots would have been ruined. “For the first time in my life I put on a comfortable pair of boots and had the ability to walk pain free,” he said, “fifteen years later I am still wearing that pair of shoes.”

After some haggling with his hospital he persuaded them to pay Philip Taylor to make his shoes for him in the future.

“In my experience, difficult cases of orthopaedic footwear cannot be manufactured successfully unless the person making the shoes has direct contact with the patient,” Melvyn said, “even a qualified orthotist with many years of experience cannot communicate all the necessary information for shoes to be made to the actual shoe maker.”

Orthotic Services: the NHS perspective

Although the Conference heard many examples of the shortfalls in Orthotic Service provision, and there was general agreement that the current approach to providing orthopaedic footwear needed to change, there were also examples of individual hospitals and Trusts that were flexible in the way that they provided orthotic support to their patients.

Anne Bontoft is the Orthotic Services manager for the North Lincolnshire and Goole Hospitals NHS Trust, and already allows patients with more complex needs to liaise directly with her contracted supplier. “If we’ve got somebody who’s really problematic, and we’re struggling with some shoes,” she said, “we would allow that patient to go into the factory, and actually go and talk to the technicians.”
In her presentation, Anne talked about the history of orthotic services within the NHS, and described the different types of stock, modular and bespoke footwear available through the service.

NHS commissioning is a major factor, she said, and in a PCT there might be up to three different commissioners. The best way to commission services remains an important consideration.

Anne finished her presentation by asking if there could be different ways of funding the manufacture of bespoke orthopaedic footwear, and through this to allow greater flexibility and choice in the provision of made-to-measure shoes.

Prescription charges, personal health budgets and a shared responsibility for funding bespoke footwear were possibilities that might be considered further, she said.

**A role for design**

The Conference’s speakers had explored the needs of clinicians and manufacturers, the economics of orthotic services and the patient experience, but the fundamental quandary remained the same – how can the NHS supply bespoke footwear that improves the quality of its patients’ lives both through better functionality and through better appearance?

The important role that design can play in this process was explored by the Conference’s final contributors, Tom Cassidy, Professor of Design at the University of Leeds, and Dr Robert Chien Chung Chen, the Group Leader of the User Centred Design Studio in the Faculty of Art and Design at De Monfort University in Leicester.

Professor Cassidy discussed the increasing importance of the ‘baby boomers’ generation, who now held more than 60% of all savings - and who are the only growing age segment - in the UK. By 2020 there will be 130 million people aged 50 or over across the European Union, and in the UK over 50% of all adults will be over 50 years old, he said.

In the UK the estimated annual purchasing power of disabled people is between £40 and £50 billion, emphasising the economic as well as medical case for improving the choice available to service users.

After giving some examples of good design that radically improved both the aesthetic appearance and functionality of objects such as wheelchairs, Professor Cassidy discussed two current footwear development projects:

- A student footwear design project at the University of Central Lancashire (UCLan) in Preston, which is sponsored by the Helen Hamlyn Centre at the Royal College of Art and the Arthritis Research Council.
Orthotist Stephen Mottram from Ossur UK put the case for his profession to delegates with an impromptu address towards the end of the Conference. Stephen started his career in industry, but did move into the NHS. “Patient safety is paramount in everything we do,” he said, “as well as patient needs.”

As the link between the patient, the manufacturer and the purchasing Trust, the clinician is in a unique position, working to balance the differing priorities of these influencers to achieve the best outcome for the patient within the resources and products available. Nobody goes to work to do a bad job, Stephen said, but the relative pressures on the service must be taken into account when making choices for patients, the vast majority of who are satisfied with their treatment. Some of the problems lay, he felt, in the fact that one of the service model drivers is based around spend rather than improved outcomes.

Annual orthotic costs are around £200 million, Stephen pointed out, a figure that could be reduced to approximately £160 million with improved administration. These cost savings should be reinvested to bring improvements in patient care, he said, which will reduce social care and society costs at the ratio of £4 to every £1 spent.
Two project proposals coming from the Hong Kong Polytechnic University, the first for the development of optimally fitting orthotic inner soles for patients with diabetic foot, and the second for the development of a multi-functional monitoring and warning system for footwear.

The technology exists to improve the orthotic service available to patients, and Professor Cassidy finished his part of the presentation by looking at some of the orthopaedic software that is available, that can scan and match feet, lasts and foot casts. They can also match the scanned lasts with a range of different styles, or create a new design to the customer’s requirements.

Dr Robert Chien Chung Chen then described the development of a universal rocker-bar for Gout foot disorder. Gout is a disease that affects three people out of every 1,000 in the UK, and is categorised by an accumulation of uric acid crystals around joints, tendons and other tissues. Joints can be progressively damaged by the disease, and orthopaedic footwear with an assistive rocker bar is the only non-medical way of dealing with the disease.

Dr Chen and Professor Cassidy’s challenge was to design a built-in rocker bar system for orthopaedic footwear that would allow users to move away from the unsightly products currently on offer.

Working with a researcher trained by the Taiwan Footwear Rsearch Institute, the team adopted a foot measuring system based on the Orthopaedic Standard BS-5943, and C&J Clarks International’s system, which is commonly used in fitting trials.

After experimenting with rocker bar angles and adjustable heel-strike cuts, a range of trial sandals were manufactured. Tests enabled the team to identify the optimum-rocker bar angle, that offers suitable to-spring in the forepart of a Gout patient’s footwear, and makes walking and standing comfortable and pain-free.

The finished product was the first example of a hidden rocker bar construction, which showed the best way to improve the appearance, strength and comfort of orthopaedic rocker-bar shoes for those Gout patients with foot or joint disorders. As such, it aids patients’ psychological rehabilitation, Dr Chen said, as well as alleviating their physical disorder.

**Shoes made for walking: brainstorming the best way to improve orthotic and orthopaedic services**

The Conference was drawn to a close by CPD4 Health Innovation Director Elaine McNichol, who facilitated a lively brainstorming session encouraging delegates to identify their ‘wish lists’ of changes that might improve the orthotic services available to patients in the NHS.

A number of people felt that funding should follow the patient. Individual budgets, they felt, would mean the money went with the patient, and that the patient would be the decision maker, able to go to the service and products that they wanted.
Delegates brainstorm their ‘wish lists’ to improve orthotic services

One table of delegates felt a preventative service would be productive, and might stop some of the more complex problems before they had really developed. More education, information and prevention, they said.

Specialised orthotic departments were also on delegates’ wish lists, where multidisciplinary teams could include orthotists and manufacturers. Other delegates felt these teams should be capable of producing a shoe in which every feature was prescription.

Some people felt that new technologies were not being used enough, and that scanning and CAD-CAM technologies needed refining so that they offered the patient the best service possible.

More cross over between the retail sector and the NHS, enabling people with minor issues to cater for these through their high street shoe suppliers.

Many of the ideas delegates proposed included making access to orthotic services easier for patients, part of which might include de-medicalising the service with easier to understand terminology and service names.
On a similar note, another table felt it would be good if the orthotist treating the patient was also the craftsperson responsible for making their shoes, which is a model that is far more common in Germany. This would mean that there was more direct communication between the patient (or customer) and the specialist shoe maker.

On a practical level, some delegates felt that CAD-Cam impressions should supplement foot mouldings and casts, as it was not always possible to read a cast accurately, and providing the shoe maker with the CAD-cam images would be a way of combining art and science to create ideal footwear.

More partnership working between orthotists, manufacturers, the NHS and patients would lead to valuable improvements, some delegates believed.

After asking all delegates for their feelings, Elaine asked each table in the Conference to identify one important change they would like to see happening, a ‘BHAG’, or Big Hairy Audacious Goal.

One table’s goal was to get the entire population of the UK into appropriate, problem free footwear.
Another table wanted to blend high street and specialist footwear so that they met in the middle. This would mean there was a much wider choice of specialist footwear, they said, and the retail side would become far more conscious of foot health.

Another table had two goals. The first was that orthotic services should be measured on the outcomes they achieve, not the costs, and the second was to recognise that the real waste in the system is NHS duplication and bureaucracy.

Change the perception of footwear psychology, another table of delegates felt, and an infinite budget. Design choice for patients, make the industry more appealing, and look for alternatives to the traditional concept of shoes.

See before you buy, another table said, calling for patients and customers to be provided with computer generated images of their footwear before they actually pay for them.

From a patient’s point of view the goal would be to walk away with a pair of well fitting, pain free and stylish shoes, one table felt, and from the manufacturer’s perspective the goal should be to provide patients with a rapid and successful service.

Another table summed up the whole Conference succinctly. “Happy feet, happy patients”, they said.

“Happy feet, happy patients”