Any qualified provider: One man's choice, another man's inequality?

Louise Stuart MBE

Alistair McInnes

Louise Stuart MBE is a Consultant Podiatrist, Manchester; Alistair McInnes is Senior Lecturer, University of Brighton, Brighton.

Secretary of State for Health Andrew Lansley continues to push the passage of the 2011 Health and Social Care Bill through Parliament. The Bill has been identified as pivotal for the modernisation of the NHS. Clinical Commissioning Groups (CCGs), Strategic Health Authority boundary changes and other cost-saving strategies – including staff re-profiling – are already well under way, changing the landscape of the NHS ahead of the Bill being enacted. However, there are further structural changes required by the Bill in order to reduce the NHS' expensive bureaucracy and increase clinician involvement in the commissioning of services. These include engaging the private sector in the provision of NHS care in ways that may have unintended consequences – that is, by adversely impacting patient care and outcomes in both the short and long term.

It is sometimes difficult for commentators to disentangle the cost saving initiatives from the policy reform agenda, and this may inevitably translate into the same confusion for those charged with managing and implementing change. The White Paper *Equity and Excellence: Liberating the NHS* (Department of Health [DH], 2010a), and the consultation document *Liberating the NHS: Greater Choice and Control* (DH, 2010b), both suggest that the way forward for the NHS is to ensure greater choices in their care for patients. Subsequently, in July 2011, the authors of *Operational Guidance to the NHS on Extending Patient Choice of Provider* (DH, 2011) coined the phased "any qualified provider" (AQP).

The NHS Supply2Health website provides information for commissioners and members of the public about the AQP services. It is expected that the introduction of competition to the NHS will drive up quality, empower patients and meet the *Quality, Innovation, Productivity and Prevention* (DH, 2010c) challenge. The services that have been identified by the volunteer PCT clusters and emerging CCGs for the first phase of AQP include adult podiatry services, and are defined in the *Podiatry: Any Qualified Provider Implementation Pack* (DH, 2012) as follows:

> ***"... the scope of practice obtained at graduation including the treatment of patients with biphasic peripheral pulses as a minimum determined by Doppler ultrasound; eighty percent (80%) peripheral sensation based on mononfilament assessment and excluding any comorbidities requiring immuno-suppressant medication including Anti-TNF and people with diabetes assessed under NICE Clinical Guideline 10 as at Increased Risk or above."***

The podiatry implementation pack indicates that people with diabetes at low risk of ulceration are eligible for treatment under AQP services. An important aspect of the service specification is referral and signposting to specialist services when ulcer risk increases. Compliance and achievement of this part of the specification is the critical factor for the success of the entire scheme, in terms of the patient experience and clinical outcomes.

Integrated podiatry services have a key role to play both in the multidisciplinary diabetic foot team (MDT) and in the foot protection team (FPT) as recommended by NICE (2004; 2011a). NICE (2011b) diabetes in adults quality standard states: "people with diabetes or at risk of foot ulceration receive regular review by an FPT in accordance with NICE guidance, and those with a foot problem requiring urgent medical attention are referred and treated by an MDT in 24 hours."

"... the major concern is that completely different organisations providing podiatry care in isolation from the multidisciplinary diabetic foot team may lead to increasingly fragmented care with suboptimal outcomes for people with diabetes."

We, as many of must be, are worried at the lack of capacity that our own services have to meet current demand. Furthermore, there is a national shortfall of up to 50% of the required number of podiatrists to meet the requirements of NICE guidance (2004).

AQP organisations are required under the services contract to include provision for podiatry for people with diabetes. However, there is a worrying and confusing statement in the implementation pack (DH, 2012) that reads: "Treatment of patients assessed as low current risk may include wound care to include grades 0–1 on the Wagner Scale or equivalent and/or wounds not healed after 4 weeks".

As people at low-risk of ulceration are (by definition) unlikely to present with a wound, why include wound care in the implementation pack? Is there an intention to include other at risk categories? Furthermore, the Wagner scale as a measure of wound severity has mostly been superseded by the Texas classification system (Lavery et al, 1996); why is the former being used when all services – NHS or AQP should be using the same systems for the purposes of audit.

While this may appear to be a minor gripe, the major concern is that completely different organisations providing podiatry care in isolation from the MDT may lead to increasingly fragmented care with suboptimal outcomes for people with diabetes. There is a current model for provision of diabetic foot care via Foot Protection Teams in primary and community care settings in the NHS. These can be cost-effective and, where there are robust shared-care pathways and excellent communication channels to the MDT, improve outcomes. However, if there are anticipated AQP podiatry providers from the private sector engaging with diabetes patients with foot ulcers, then the monitoring of quality care, the monitoring of contracts and the resulting complex referral pathways can only be detrimental to the provision of care that our patients deserve. The CCGs will require further contracts (i.e. service level agreements) for podiatry input to the MDTs and have to monitor patient movement from AQP podiatry to the integrated care services of a MDT.

Conclusion

The recent important publication on the recorded incidence of amputation of the lower limb and foot in England (Holman et al, 2012) has drawn national media attention to the ten-fold variation in both major and minor amputations across the 151 primary care trusts in England. One of the conclusions made by Holman and colleagues is that the variations may reflect generic differences in local healthcare delivery. This is clearly an unacceptable situation for people with diabetes and highlights the urgent need for improvements in diabetic foot care services. We consider that the AQP initiative and localisation agenda will offer little confidence that the current variability in service will improve. ■

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