Initial learnings from AQP in podiatry: Where are the threats to service sustainability coming from?

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In January 2013, the NHS Commissioning Board (NHSCB) supported the first meeting of the Integrated Clinical Commissioning Network (ICCN) in Leeds, where two senior managers reinforced the benefit of partnership working with clinicians to ensure that effective, safe, and innovative services can thrive. As Director of Commissioning Support Strategy and Market Development at the NHSCB, Bob Ricketts is responsible for promoting patient choice and the Any Qualified Provider (AQP) agenda. He presented a message at that meeting that we need to hear. His assertion that even more radical change is required was delivered to Clinical Commissioning Groups (CCGs) as a last-chance warning for commissioning to make the large-scale transformational changes that will see many traditional hospital-based services delivered in the community.

Mr Ricketts' assertion that the market must work for the benefit of patients and communities, not professions or services, highlighted his belief that there are behaviours among those working within the system that need to change. Failure to address this could be as harmful as any threats that new providers may bring into the system. If new providers demonstrate the same power-based positions that currently exist within some areas of the NHS, they will fail to deliver the changes that are needed. Protecting and developing one element of the foot care pathway based on personal clinical interest and perverse incentives creates as much weakness in the prevention and management of foot disease in diabetes as the introduction of new providers does.

I was able to ask Mr Ricketts what learning has come from the first phase of AQP and how will that be applied to the next stage? He is confident that the process works, with evidence of several hundred additional providers creating choice for patients, audiology was his key example area. An evaluation process is ongoing, with an initial review due in March 2013, to assess whether the implementation packs are being widely used and whether the intended aim of driving up quality is being achieved. There will not be a second phase for AQP, it will next become one of the procurement options for CCGs.

So the question has to be asked: "Do we think bringing additional providers into the market place is always bad?" If we adopt this position, should we not challenge ourselves and ask whether this view is based on self-interest, or on what will most benefit the patient? As a past manager of a podiatric surgery service, I have seen how professional protectionism works to the detriment of patients and positive change, so I can understand why NHS managers would want to challenge any professional resistance.

Certainty, commissioners could not have been more enthusiastic to include podiatry as one of the three AQP choices. Eighteen commissioning clusters identified that they wished to improve competition for foot care services in England, involving populations of more than 18.2 million people. The majority used the implementation pack service specification (Department of Health, 2012) in its entirety, which – as has been discussed in the pages of *The Diabetic Foot Journal* previously (Stuart and McInnes, 2012) – had many areas of confusion, contradiction, and error.

It would be wrong of me not to disclose that I was part of a group that contributed to that initial document. The motive for selecting podiatry can only be known by local decision makers. However, doubts must arise about this decision being based on a desire for plurality or a concern over local quality. I am left contemplating that some organisations may have used this opportunity to review and restructure their existing podiatry service within a different financial framework.

The national specification primarily provides a level of prevention and foot care that is not commonly commissioned at present. In most

cases, this does not require a redistribution of resource, but new money and that just does not make sense in the current financial climate. The real danger of having an enhanced AQP foot care service for those at low risk of active diabetic foot disease is not the introduction of new providers, but the loss of resource from the existing specialist services that make up both community foot protection teams and hospital-based multidisciplinary teams – and these are already under significant pressure. Podiatry is seeing the downgrading of specialist staff and redundancies, even in areas of high amputation rates. The pathway of care is only as strong as the sum of all its parts.

I have heard first-hand how the introduction of the AQP service specification, even without any new providers, has changed immensely the ability to provide the level of community podiatry required for safe and effective care. Community services are accepting AQP referrals that would previously have been rejected at triage. This work is being paid at AQP tariff as additional work, but the tariff does not cover costs and service budgets have been reduced based on anticipated volumes of AQP work. Podiatry services are left needing to earn back, through AQP, the money that has come from the block contract to run their services and this is done at the expense of patients who need access to specialist services. AQP is resulting in a two-tier system of care, whereby people at lower risk of ulceration are given higher priority than those with greater clinical need.

So has commissioner interest in AQP podiatry increased the choices for pati in this area of health policy was supposed to encourage? A review of approved providers on the NHS Supply2Health website (*www.supply2health.nhs.uk*) would not suggest this to be the case, with the current providers dominating.

So why has AQP podiatry not appealed to more independent and corporate organisations? The Society of Chiropodists and Podiatrists is clear that the applications process – particularly aspects of IT systems establishment, such as N3 connection (*n3.nhs.uk*) and compliance with the Information Governance Toolkit (*www.igt.connectingforhealth.nhs.uk*) – have been a block in engaging small business.

On a larger scale, AQP would appear to be ideal for large private health companies such as Connect Physical Health, which currently has substantial NHS contracts and provides more than 3 000 referrals per week in 10 PCTs, employing 200 staff including 130 clinicians. This company completed several ITT applications and, in all cases, their bids were successful. Connect Physical Health's CEO, Andrew Walton, provided me with this quote: "I am surprised that some other providers have been able to deliver a service of reasonable standard as we have an intimate understanding of both podiatry and delivering value for money in community NHS services. On further analysis, the price would not meet the costs calculated that are required to ensure a safe and effective service and, therefore, this company has withdrawn from the process."

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Many podiatry managers have done incredible jobs to put together the most detailed and professional tender applications, in a bid to retain their own services. However, they continue to be caught under a heavy cloud, where commissioning motives and threats from new providers remain unclear. Sadly, this type of competitive process requires a commercial distance between providers and commissioners, which impacts on previously positive relationships and produces behaviours that are not always patient-centred. Where the outcome of AQP is increased choice to one group at the expense of another that has an increased clinical risk, this inequity must be challenged. This type of clinical direction does not seem to fit with anything that the NHSCB were indicating at the ICCN, or with the recommendations that the Francis Report (2013) has provided. We cannot be quiet about these changes.

There are some examples of sensible commissioning where the specification has been limited to partial/total toenail avulsion procedures only. There is a sound rationale behind this level of specification as these procedures are also provided in secondary care, minor injuries units, and GP practices, all at higher costs.

If AQP is being used as an opportunity to reopen the debate on the provision of nail and foot care by the NHS, it is clear that the debate has not been won. The risk to the stability of the entire diabetic foot care pathway must be seen as very real. The input and innovation of all involved will be needed to preserve those services we know to improve outcomes. Our patients are our best advocates and their feedback on the impact of AQP on podiatry must be encouraged.

There has been a recent, and brief, opportunity to review the national AQP specification on podiatry, which no longer makes reference to the care of those with diabetes (Supply2Health, 2012). However, during this process, four organisations have ignored the national specification and opened up the whole community specialist service to AQP – including the foot protect teams. The Wirral, Merseyside even have a year-of-care tariff for those at high risk of foot ulceration of £350.88 (Supply2Health, 2013), which would indicate some very detailed knowledge and costing of services. Should this tariff prove to be insufficient – as has been the case with the lower risk groups – services and people with diabetes will be put at great risk. ■

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