Putting Feet First: Ensuring integrated foot care services for people living with diabetes and AQP going forward

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Every week, more than 100 people with diabetes in England have a lower-limb amputation (Holman et al, 2012).

This has a huge cost. Diabetes-related amputations are expensive and put a significant financial pressure on the NHS, costing up to £700 million per year (Kerr, 2012). And with a higher 5-year mortality rate than breast or prostate cancer (derived data in Moulik et al [2003] and from the Office of National Statistics [2012]), the human cost is incalculable. Living with foot disease can be painful, affect people's social lives and relationships, often results in discrimination and reduced independence through lack of mobility.

Yet up to 80% of diabetes-related amputations are preventable. This is why we at Diabetes UK are focusing on the issue with our Putting Feet First campaign (Diabetes UK, 2012), which aims to reduce diabetes-related amputations by half within 5 years. This is a complex campaign because there is no one single change that would bring the problem of preventable amputations to an end. The truth is that they are happening because of issues right across the care pathway, from routine foot checks, lack of awareness, through to decisions to amputate being made too early.

There are early signs that some things are getting better. The percentage of inpatients with diabetes getting foot checks in hospital has increased since last year (NHS Diabetes, 2013) and we hear anecdotally that more healthcare professionals in primary care are aware of the issue of diabetes-related amputation and so better-placed to act. But any progress is fragile, and unless careful, the variations in commissioning and the Any Qualified Provider (AQP) scheme for podiatry could fragment diabetic foot care further. Careful co-ordination and monitoring is needed to ensure AQP is implemented in the right way.

We welcome the decision to exclude wound management services for people with diabetes from the AQP core podiatry service specification (supply2health, 2012), making it clear that anyone assessed as having increased risk feet (ie not low risk) needs to be looked after by podiatrists working within Foot Protection (FPT) and/or multidisciplinary foot care teams (MDfT). This reflects the fact that someone with diabetes who has a wound on their foot is automatically at higher risk of amputation. But we are concerned that this message is getting lost. The podiatrist can provide care from the point of diagnosis through the care pathway and is central to referral and liaison with other professionals. In many areas, the podiatrist is the FPT commissioned as the diabetes element of community podiatry services. But awareness about the importance of the FPT is low and its profile needs raising. We are also worried about the way that some emerging Clinical Commissioning Groups (CCGs) have used this flexibility to open up the whole pathway to competition. This has the potential for confusion, high cost and ultimately for harm to patients by threatening the integration so central to the pathway (Diabetes UK, 2012).

The guidance (supply2health, 2012) recognises that the annual foot check recommended by the National Institute for Health and Care Excellence (NICE, 2004a; 2013; Diabetes UK, 2013) needs to be provided within primary care, as these checks are the starting point for early identification of problems. If someone is at high risk, but not identified as such, then they will get poor care no matter how good the rest of the pathway is. We still hear stories about supposed foot checks where the person has not even been asked to take their shoes off. There is increased awareness about the importance of good quality foot checks and we need to make sure progress is not put at risk by opening this out to services not co-ordinated within the integrated pathway.

As well as ensuring CCGs do not extend AQP to cover aspects of care it is not suited for, the nature

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of AQP means we need to be vigilant around protecting the integrated nature of diabetic foot care services that are so important to the health and wellbeing of people with diabetes. Specifically, that there are clear lines of communication between the AQP podiatry service, general practice, members of the foot protection team (FPT) and multidisciplinary foot care team (MDfT), with all cases of foot ulceration and other newly presenting disease being referred for urgent assessment by the MDfT within 24 hours. CCGs need to ensure that FPT and MDfT services exist. Timely treatment is of the essence to reduce risk of amputation. AQP services must not be commissioned at the expense of quick access the expertise of FPTs and MDfTs within the integrated diabetic foot care pathway.

This integration needs to be coupled with a focus on giving people with diabetes information to help them to take control of their care. If they are getting services from AQP providers, they should be told what the service does and does not provide, what other services they should be accessing and contact telephone numbers for emergencies. They should also be told their risk level and the standards of care they should expect (NICE, 2004a; b; 2013), while those at increased risk should understand they are entitled to expert assessment and treatment from the FPT or MDfT as appropriate.

It is also vital that all healthcare professionals in the care pathway have the right knowledge levels. This means the local NHS needs to ensure that any AQP services, delivered to people with diabetes at low risk, have good communication links and the skills necessary to ensure national quality standards are met. It is positive that greater emphasis is being placed on prevention and increasing access to podiatry care for those with diabetes who find it difficult to care for their own feet, such as those with poor sight, memory or mobility difficulties. But it is essential that people with diabetes do not think that this replaces their annual foot review.

Ultimately, this is about local health teams working together in a structured way to deliver quality care. This is what will ensure that people with diabetes get the foot care they need from someone they can be confident is able to deliver it well. At the moment, too many people are not being quickly referred to FPTs and MDfTs and if we could improve this then we could prevent many of amputations. We need to make sure that AQP is implemented in a way that makes sure it is part of the solution, not an added problem.

Diabetes UK (2013) has produced a summary to help ensure that AQP implementation does not put existing diabetic foot care services or people with diabetes at risk. Living with type 1 or type 2 diabetes is hard enough, without having the added stress of navigating a complex myriad of different organisations providing different bits of the care pathway. Therefore, everyone has a role to play in making people with diabetes aware of what foot care they should expect and who to get it from. We are all working towards the same thing: services being commissioned in a way that helps foster an environment where people with diabetes receive good care across the care pathway so that the high rate of preventable amputations is brought to an end. As such, Diabetes UK will be watching the situation develop and holding local NHS organisations to account if standards of care are seen to be falling. ■

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