THE VALUE OF PASCOM-10 FOR PODIATRY A QUARTER OF A CENTURY ON

THE IMPACT THAT CAME OUT OF THE BLUE!

Following on from Anthony Maher's article in last month's *Podiatry Now*, David Tollafield reflects on the history of PASCOM-10

When I qualified, local anaesthetic was introduced for the first time on our course in 1978. It took another two years before the Medicines Act 1968 was modified and local anaesthetic was truly accessible as a legal medicine for the profession. These were exciting times and the profession was split initially, many holding unfounded fears. As chiropody metamorphosed into podiatry, the search for improved status naturally led to degree courses.

Podiatry today is less recognisable from the chiropody of my early career; we strive for evidence and many excellent papers present robust material to challenge older recycled theories. Today, the idea of suggesting evidence through benign and fallacious statements such as, 'In my experience!' carries less weight, not least because of the likely inaccuracy of our memory, let alone paucity of clinical records. Maintaining a clinical record relates to audit; a framework of data assembled into meaningful reports. Audit does not mean that scientific hypotheses can be proven; data must be collected to represent accurate activity. The larger the dataset the more helpful such data become. In context data can provide supporting material for further analysis. The value brought by predetermined data collection (datasets) can be raised if captured pro-actively and set against agreed criteria. These criteria have been built by our profession into the system known as PASCOM-10.

If I reflect on the years since PASCOM-10[1] was established, I count sixteen; nationally we now have robust online data for six years (2010-16). Where PASCOM-10 has been cited, annual anonymised reports and past papers are accessible to the public.[2] At the time of writing (June 2016) we have 254 users recording 75,000 patients for a total of nearly 400,000 events and 77,000 episodes of care. This is impressive as no specialty allied health profession can boast such a large number of voluntary recordings with such credible data capture. During the period 2010 to now, the system has been refined, but, as with any product, ongoing work is essential. Based on our broad podiatric community in 2008-9 we were able to expand beyond podiatric surgery to six key domains of clinical activity.

PASCOM-10 can now be implemented for nail surgery; MSK for biomechanics; at risk – wound management and tissue viability for specialists in diabetics and vascular care; and general podiatry for all non-specialist areas. We have even established a section to record therapeutic injections.

PASCOM dates back to 1992 when the very the first version was reported; a crude database which only looked at a narrow range of surgical procedures[3] between 1988-1992 (Table 1).

The system was developed from an in-house project backed and funded by Nene College in Northampton. Only two audit projects had preceded this work in podiatric surgery.[4, 5]

Clearly the increase in numbers of metatarsal osteotomies seen in Table 1, much as nail surgery, was a remarkable advance for the profession. These changes in practice cannot be taken lightly. Laxton[6] published one of the most powerful supportive arguments for podiatrists providing nail surgery based on effective outcome. This provided an independent unbiased report comparing outcomes between traditional medicine (GPs) and surgeons versus podiatrists. The inclusion of hammer toe surgery however showed less variation in outcome; the methodology used for hammer toe surgery comparison might be considered weak.[5]

In 1997, Walsall Community Trust adopted the crude method of reporting from Northampton and created an in-house style database using Microsoft™ Access and run from CD-ROMs. The system was branded as PASCOM, a mnemonic for; podiatry – audit – surgery – clinical and outcome.

The next stage was to try the system out as an intranet system within the local NHS Trust. Saving data could be tricky with disks, and easily lost or corrupted if copied incorrectly; indeed, this can still happen with spreadsheets. We had to have

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Procedure	1988-1993	2010-2016	Change
Amputation whole / partial lesser digit	31	53	+22
Arthrodesis proximal IPJ (external wire fixation)	18	98	+80
Arthroplasty distal or proximal IPJ lesser toes	118	88	-30
Osteotomy first ray or hallux	11	371	+360
Calcaneal spur resection	2*	0	-2
Capsulotomy (MTPJ)	1	7	+6
Cheilectomy (dorsal first MTPJ)	6	16	+10
Keller excisional arthroplasty; mixed or as sole procedure	12	27	+15
Lesser metatarsal osteomy	10	90	+80
Metatarsal cuneiform exostectomy	1	reclassified	-
Neurectomy	15	83	+68
Osteotripsy	9	2	-7
Nail excisioin (winograd)	2	34	+32
Tendon Lengthening (not Achilles or ankle tendons)	6	20	+14
Phenolisation of nail matrices	57	104	+47
Medial first metatarsal exostectomy (silvers)	4	5	+1
Subungal exostectomy	13	7	-6
Digital syndactyly	2	1	-1
Excision verrucae or foreign body	32	reclassified	-
**Now withdrawn from author's podiatric surgery practice*			

Table 1. Earliest data incorporated into the precursor to the PASCOM style audit shows 19 different procedures. Source Tollafield DR, Parmar DG (1994).

This report formed the progenitor for PASCOM-10. The data recorded from P-10 is taken from 239 currently coded activities expanded from the original 19 codes (1994). Data for all codes can be found in annual reports and is open for public view at www.pascom-10.com. Procedures illustrated were performed at Northampton General Hospital between 1987-1993 and at the Manor Hospital and Spire Little Aston Hospital 2010-2016 by the author or his team.

a better system – faster and more reliable, more responsive and without the errors of lost data or corruption.

The Society adopted PASCOM in 2000, which morphed into PASCOM-2000. By 2005, Walsall Community Trust relinquished the unmarketed product to The Society of Chiropodists and Podiatrists free of charge. The working party started to build on the system initially as 'invasive surgery', but keen MSK podiatrists wanted a wider framework. Attempting to achieve cross party agreement for all areas created a big challenge, but by May 2010 we were ready to launch and rebrand PASCOM-10. PASCOM-10 now includes two distinctive pathways for invasive and non-invasive treatment .

The Society's support has been unparalleled in terms of their long-term investment. PASCOM-10 outstrips anything we had last century because it can be used anywhere in the world and accessed instantly. I appreciate many will say: 'but it has better use to you as a podiatric surgeon, and it is biased toward that group of users': that may have been true once, but no longer. PASCOM, or P-10, to give it its' shorter name, would not have worked initially if it had not been robustly bench tested in a single speciality.

Papers and reports addressing PASCOM-10 data have built up over time. There is some disappointment however. For all the effort and careful preparation for a wholly free membership system, it has not unfortunately been engaged by all podiatrists. Free training programmes, and now online registration, have made joining easier, but numbers outside of podiatric surgery remain disappointing. So why are so many not engaged?

The old cherry often run out as an excuse is; 'I do not have time, what with all the other things I have to do!' or 'I am not allowed to use it' (for various reasons), often hiding behind the coat-tails of governance and even confidentiality, argued, more by the uninitiated than those seeking to attain qualitative responsibility.

Collection of clinical and outcome data is a personal achievement, not specifically organisation based. Data and records of activity suggest a profile of individual activity; the HCPC require that we collect reflective information for their own 'random' appraisal. The speed with which PASCOM-10 can generate a range of evidence to satisfy their requirements is highly attractive.

SO WHAT CAN PASCOM OFFER PODIATRISTS?

How many nail surgeries are performed each year? How many podiatrists give injections? What is the demography of our practices? What are the top five medical conditions and what are the top five podiatric conditions that we treat? These are what I consider to be 'gross' rather than 'net' data.

'Net' data is extrapolated from gross data. Number crunching is quick and easy to form basic activity reports. From gross data we might want to see the percentage of risk, a neat feature placed within the general podiatry domain. Providing data shows activity and therefore how busy we are in specific areas. Effectiveness comes from a sense of outcome; visual analogue pain change; MOXFQ pre and post scoring in the key domains of pain, social impact and mobility.

CONCLUSION

The podiatric surgeons (fewer than 100 individuals) have hammered down the key ingredients of outcome measurement but 8000 podiatrists can access the system; consider the impact if we had 2000 podiatrists alone? This would provide the basis upon which national policy could be made. Audit taken from a large bank of data could allow us to make a better case in political circles both for educational support and inclusion in preventative health care programmes.

It must be remembered as a general rule; 'If you do not write something of merit down it does not exist. If you fail to publish something of merit no one will ever know. A profession that fails in this regard will forever remain in obscurity'. Does Jones et al[7] statement of a 'basic podiatrist' not resonate with apathy? This was the view of one interviewee:

'Does the job ok, but doesn't really learn from each patient, who just ticks over.'

ACKNOWLEDGEMENTS

A long list of people has shaped the inception of PASCOM-10 over the course of development and it is right that some should be named for their impact and contribution. Without

doubt the success of the project would not have seen the light of day without their belief in the long-term benefits and confidence in me.

Gavin Rudge (Former audit officer Walsall Community Health), Pam Sabine (former Chair of Council), Ralph Graham (former Chair of Council), David Gould (former Director of Finance), Peter Graham, Christopher Hunt & Graham Howell (former Chairs of the Professional Practice Committee), Joanna Brown (former Chief Executive Society of Chiropodists & Podiatrists), Linda Merriman (former Head of School Northampton). Alan Borthwick (Editor in Chief, JFAR) and Ian Reilly (Member of the Committee of the Directorate of Podiatric Surgery). Members of all the working parties since 1997 and current committee; especially Anthony Maher and Matt Fitzpatrick (Current Chair of PASCOM-10 & Provost of the College of Podiatry). ■

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