

**COMMUNITY HEALTH, TRANSITIONAL AND
SUPPORT SERVICES-
ALLIED HEALTH SERVICES -
PODIATRY FOR PEOPLE WITH AT-RISK / HIGH-RISK
FEET
TIER LEVEL THREE
SERVICE SPECIFICATION**

STATUS:

MANDATORY

It is compulsory to use this nationwide service specification when purchasing this service.

Review History	Date
Published on NSFL	October 2011
Working Party Review: of the Podiatry for People At-Risk / High-Risk Feet Dec (2003) tier three service specification	October 2011
Administrative Review to align reference to new tier one Community Health Transitional and Support Services and tier two Allied Health Services service specifications.	April 2013
Consideration for next Service Specification Review	within five years

Note: Contact the Service Specification Programme Manager, National Health Board Business Unit, Ministry of Health to discuss proposed amendments to the service specifications and guidance in developing new or updating and revising existing service specifications.

Nationwide Service Framework Library web site <http://www.nsfl.health.govt.nz>

**COMMUNITY HEALTH, TRANSITIONAL AND SUPPORT SERVICES -
ALLIED HEALTH SERVICES –
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TIER LEVEL THREE
SERVICE SPECIFICATION
AH01006**

This tier three service specification for Podiatry for People with At - Risk / High Risk Feet (the Service) must be used in conjunction with the tier two Allied Health Services (non-inpatient) service specification under the tier one Community Health, Transitional and Support Services service specification.

The Service is also linked to the following tier two Specialist Medical and Surgical services service specifications: General Medical Services, General Surgical Services, and Diabetes Services.

Background

Effective, well integrated and timely podiatric intervention in diabetic and other limb disease is a major factor in the reduction of amputations, the prevention of other complications and the improvement in the quality of an individual's life.

Diabetes is a major cause of lower-extremity amputation in New Zealand. Education and careful daily foot inspection by the individual, early referral for medical review and early treatment of potentially damaging foot lesions have been shown to reduce the need for amputation by up to 80 percent.¹

The diabetic foot² remains one of the major costs associated with diabetes. Approximately 85 percent of lower limb amputations related to diabetes are preceded by a foot ulcer or episode of trauma and 90 percent of foot ulcers occur in individuals with sensory neuropathy. Earlier intervention with podiatric evaluation and treatment of the at-risk foot combined with high-risk foot clinics in secondary health care services and immediate access to multidisciplinary foot clinics have been shown to reduce lower limb amputation rates.

1. Service Definition

The Service provides specialist podiatry services for an individual (the Individual) with diabetic feet and at-risk / high-risk feet including, for example, those with rheumatologic disorders, or severe peripheral arterial disease. The Service includes post discharge services and is provided to maintain mobility and help prevent ulceration and possible amputation.

The Service is provided in an outpatient or community setting to Disability Support Services clients and Personal Health individuals that meet the referral criteria. . Allocation for the provision of these services is based on the level of the Individual's disability and the capacity to benefit.

Podiatry services work with primary health care, secondary health care specialist services, providers of diabetes care and education, and Māori and Pacific people health care providers that provide facilitation or support for Individuals with diabetes and their families and whānau.

¹ Simmons, D, Scott, D, Kenealy, T, Scragg, R. Foot care among diabetic patients in South Auckland. New Zealand Medical Journal. 1995. Vol 108. P106-108.

² See Appendix C and D

2. Exclusions

This service specification excludes:

- non specialist primary health podiatry treatment services in the community.
- podiatry services funded by Accident Compensation Corporation Act 2001.

3. Service Objectives

3.1 General

The Service objectives are to:

- decrease the barriers to accessing high quality care for Māori, Pacific and other high risk groups
- develop and provide a patient-centred, integrated model of care for the prevention and treatment of at-risk / high-risk foot problems in community and hospital settings
- ensure that health practitioners including General Practitioners (GPs), practice nurses and diabetes Clinical Nurse Specialists, and Nurse Practitioners have the knowledge and skills to identify foot problems early and understand the pathway for their management.
- improve the quality of diabetes podiatry care for Individuals and support their treatment plan agreed by the Individual and their primary / secondary health care provider
- develop the self-management capability of Individuals by promoting independence with foot care
- provide high quality podiatry services based on established professional standards and codes of practice
- ensure podiatry services for the Individuals in the DHB catchment are comprehensive, appropriate and accessible
- reduce the incidence of unplanned hospital admissions and / or amputations for diabetes-related complications
- improve the lower limb health of all individuals with diabetes with particular emphasis on Māori and Pacific people
- foster a comprehensive understanding of the epidemiology and extent of foot disease in the local district and region; and
- establish and enhance Māori health gains by ensuring services are linked with primary care services, general practice, community providers and Māori providers.

3.2. Māori Health

Refer to the tier one Specialist Medical and Surgical Services and tier two Diabetes service specifications, as appropriate.

4. Service Users

The Service is provided to eligible Individuals with at-risk and high-risk foot complications..

5. Access

5.1 Referral

Referrals to the Services may be from primary podiatry services; general practice, secondary diabetes services, Māori / Pacific peoples' health care workers, community health nurses or other services

Referrals for individuals with diabetes may also be initiated from foot screening undertaken at the time of the diabetes Annual Review, using the New Zealand Guidelines Group *Primary care guidelines for the management of core aspects of diabetes – Diabetic foot screening (2000)*.

5.2 Entry Criteria

Eligible³ Individuals with advanced foot disease who meet the specified entry criteria (refer Appendix C) include Individuals with:

- peripheral neuropathy
- peripheral neuropathy and musculoskeletal deformity
- renal failure / dialysis
- ulceration or pre-ulcerative states
- previous history of amputation / ulceration
- peripheral arterial disease.

5.3 Exit Criteria

Individuals will be discharged to their primary health care practitioner:

- when they have completed the planned intervention, or reached a level of care where further intervention can be maintained and monitored by their General Practitioner, practice nurse, Nurse Practitioner or other health practitioner.
- if they have declined treatment.

5.4 Timeframes

Individuals who have been referred to the Service should be offered an appointment within the timeframes below:

- Urgent - *within 1 week.*
- Semi-urgent - *within 4 weeks.*
- Routine - *within 12 weeks.*

6. Service Components

Components of the specialist podiatry service include:

- screening for identification of risk categories
- assessment of foot health status
- palliative podiatry services to help maintain the health of Individuals' lower limbs and feet

³ Eligibility criteria: - Not all people who are referred or present to the Service are eligible for publicly funded services. Refer to website: <http://www.moh.govt.nz/eligibility> for more eligibility information

- provision of specialist podiatry care surgical and/ or non-surgical treatment for eligible Individuals described within this service specification
- clinical advice and support to primary health care providers to ensure they have the knowledge and skills to identify foot problems early and understand the pathway for their management
- effective communication with the Individual, their GP and referrers
- assistance for Individuals to attend their podiatry appointments
- and, where appropriate, follow protocols for referral to other health specialty services.

6.1 Service Delivery Processes

6.1.1 Treatment Plan

After the Individual's first appointment, the referrer should receive written treatment plan from the provider if the episode of care is to extend past one appointment.

Within three weeks of the completion of the episode of care, the Service should provide a report of treatment and follow-up care required, including further referrals, to the Individuals and their GPs, with a copy to the referrer.

6.1.2 Maintaining electronic records

Where possible, the provider will share the Individual's notes with the Primary Care Team using a patient management information system.

An electronic record must be maintained with a register of Individuals with diabetes receiving diabetes podiatry care. Core information about each episode of care and the results must be recorded in the electronic record (refer Appendix A). Summary information must be reported to the Local Diabetes Team (LDT) or equivalent service (refer Appendix B).

6.2 Settings

The Service may be delivered in any setting that is most appropriate in order to achieve the best possible health outcomes and coverage for the population served.

6.3 Pacific Health

Podiatry services must contribute to current Pacific health diabetes initiatives to improve Pacific peoples' access to services and to reduce the incidence and impact of diabetes in Pacific communities within New Zealand.

6.4 Key Inputs

Podiatrists employed to implement this Service:

- require the Bachelor of Health Sciences in Podiatry, or other qualification as recognised by the Podiatrist Registration Board
- must be registered with the Podiatrist Registration Board
- hold a current Annual Practising Certificate.

7. Service Linkages

The costs of these linkages below are not included in the price of this Service; however the costs of liaison and linkages with these services are included in the Purchase Unit price.

The linkages include, but are not limited to the following:

Service Provider	Nature of Linkage	Accountabilities
General Practitioner (GP), Nurse Practitioner or other primary health carers	Referral and consultation	Assessment, treatment and intervention that supports seamless service delivery and continuity of care.
Specialist Hospital Services: <ul style="list-style-type: none"> • cardiology • dermatology • endocrinology • gastroenterology • general surgery • geriatric medicine / gerontology • haematology • internal medicine • neurology • obstetrics • oral health • orthopaedic • paediatric services • pharmacology • podiatry services • psychiatric care • psychosocial care • radiology • renal medicine • respiratory medicine • specialist emergency service • vascular surgery 	Referral and consultation	Obtain expert clinical consultation and referral services that support continuity of care.
Other Allied Health services, eg, podiatry, orthotics, dietetics	Referral and consultation	Assessment, treatment and intervention that supports seamless service delivery, continuity of care and improved diabetes management.
Local diabetes teams	Collaboration	Provision of information and participation contributing to service planning and delivery
Community organisations and services	Facilitate Service access and participation	Provision of information and services that supports seamless service delivery and continuity of care
Social services, home help	Referral and consultation	Assessment, treatment and intervention that supports seamless service delivery and continuity of care.
Disability Support Services	Referral and liaison	Assessment, treatment and intervention that supports seamless service delivery and continuity of care.
Long term supports for chronic health conditions	Referral and consultation	Assessment of needs and arrangements for provision of support services to enable families to best manage the individual's diabetes and ensure family function is maintained.
Community Nurse	Referral and consultation	Assessment, treatment and intervention that supports seamless service delivery and continuity of care.

Service Provider	Nature of Linkage	Accountabilities
Māori, iwi and Māori communities	Facilitate Service access and participation	Liaison with local iwi and communities to ensure culturally appropriateness and accessibility to services.
Pacific and new migrant Community Health Workers	Facilitate Service access and participation	Liaison with local communities, community leaders, churches, temples, mosques etc.

8. Quality Requirements

8.1 General

The Service must comply with the Provider Quality Standards described in the Operational Policy Framework or, as applicable, Crown Funding Agreement Variations, contracts or service level agreements.

8.2 Efficiency

Assistance provided by the provider for Individuals to attend their podiatry appointments may include:

- active recall systems
- providing information to the Individual about transport options
- working with other health care providers to encourage and aid attendance
- inviting the attendance of support Individuals (eg, family or whānau)
- providing access to interpreters.

If an Individual fails to attend a podiatry appointment, contact with them should be made, reasons for non-attendance discussed, strategies to aid attendance agreed, and the Individual offered another appointment.

If this is not successful, or if the Individual fails to attend the second appointment without a reasonable explanation, then their GP should be advised within two weeks. Specialists, nurses, Pacific or Māori health care providers providing support for the person may also be informed, if appropriate, within the context of the Health Information Privacy Code (1994).

8.3 Acceptability

Instruments and equipment used for injection or penetration of the skin or mucous membrane are to be single-use only, or if the item is designed for multi-use, it is to be cleaned and sterilised prior to re-use following AS/NZS 4815:2001 guidelines.

9. Purchase Units and Reporting Requirements

Purchase Units are defined in the joint DHB and Ministry's Nationwide Service Framework Purchase Unit Data Dictionary. The following Purchase Unit applies to this Service:

PU Code	PU Description	PU Definition	Unit of Measure	Unit of Measure Definition	National collections / payment systems
AH01006	Podiatry	Specialist podiatry services provided in an outpatient or community setting for people with at risk high/ risk feet.	Contact	The number of face to face contacts between a health professional and client or group of clients, for the provision of clinical services/interventions described in the services specification. A contact is equivalent to a visit. A contact excludes: phone consultations, discussions between health professionals about a client's care, and where the sole purpose of the contact is provision of supplies or consumables. Where a service is provided to a group of people simultaneously by one health professional it will be counted as one contact, one event.	Non Admitting Patient Collection (NNPAC) Contract Management System (CMS) (as per contract)

The Service must comply with the requirements of national data collections where available.

9.1.1 Additional Reporting Requirements

Reporting table

Reporting by PHO	Reporting by DHB	Reporting to LDT or equivalent service Frequency	Reporting to LDT or equivalent service Date
N/A	Data reporting via NNPAC	Annually	by 20 th July

9.1.2 Annual Reporting Requirements to Local Diabetes Teams or equivalent service

The Service must provide an annual report to DHB, PHO and/or Local Diabetes Team (or equivalent service) as a basis for its Annual Report on diabetes and diabetes services in the area by 20th July.

The report must include:

- general issues / highlights and concerns such as service uptake, amputation rates etc
- a review of the provision, management and utilisation of diabetes podiatry services for Māori and Pacific people
- the information required in Appendix B and
- provision of a 12-monthly outline of plans / intentions for the coming 12 months, aimed at addressing the opportunities and concerns identified.

10. Service planning

As further podiatry services are developed it is important to ensure the appropriate level of care is provided for the assessed level of risk. A guide for the implementation of targeted podiatry services is provided in Appendix D.

APPENDIX A: MINIMUM DIABETES PODIATRY DATASET

NHI	
Sex	
Date of birth	
Ethnic origin	
Domicile	
Referral source	
Name of podiatrist	
Date person enrolled in podiatry service	
Date of procedure	
Type of diabetes	
Date of diagnosis of diabetes	
Categorisation of risk	
CVD Risk	
Hb1AC	
Type of procedure	
Site of procedure	
Location of clinic or setting where procedure was delivered	
Date of discharge from service	

APPENDIX B: AGGREGATED PODIATRY SERVICE DATA TO BE REPORTED TO THE DISTRICT HEALTH BOARD

	Number Receiving Podiatry	Number of referrals at risk and high risk podiatry	Number of referrals received for active foot disease	Number of DNAs	Number of first assessment treatments	Number of follow up treatments	Referrals for orthopaedic review	Referrals for vascular review	Referrals other secondary services	Referrals for orthotic services	Referrals to smoking cessation	Referrals to Māori/Pacific health providers
Māori												
Pacific Island												
Other												
Asian												

Key
DNA: Did not attend

APPENDIX C: RISK CRITERIA FOR DIABETES PODIATRY SERVICES

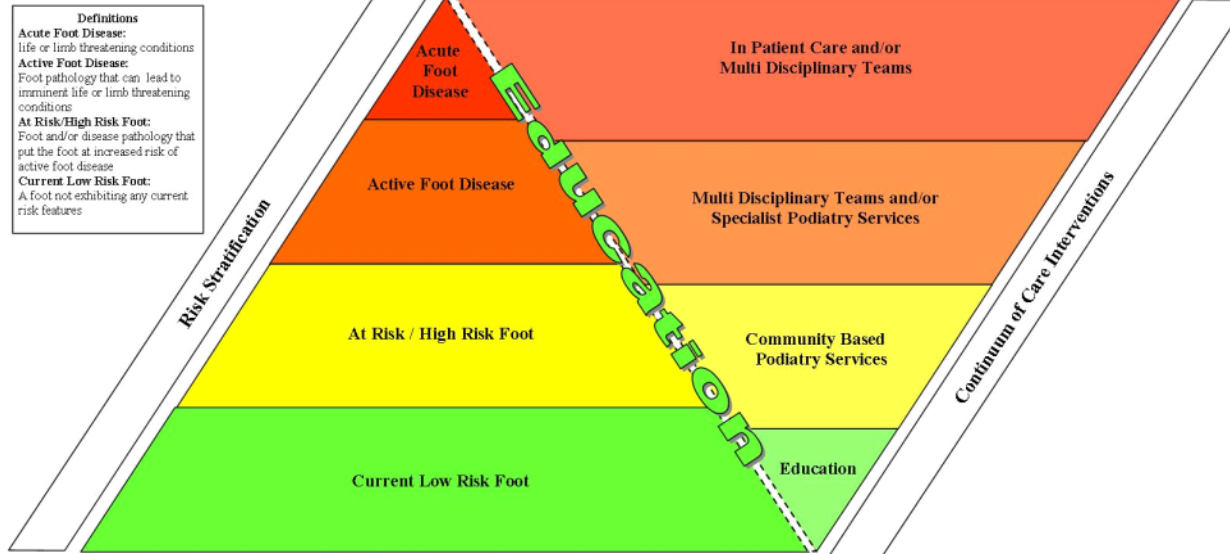
Podiatry Referral Criteria for the at- risk and high-risk foot	Podiatry Referral Criteria for active foot complications <small>*Requires urgent referral</small>	Referral Criteria for advanced foot complications <small>**Requires immediate referral to hospital services.</small>
<ul style="list-style-type: none"> • Previous diabetic foot ulceration (and no current ulceration) • Previous history of amputation • Neuropathy with musculoskeletal deformity and pre ulcerative lesions • Absent or pulses or other signs of peripheral arterial disease or a history of previous vascular surgery • Nail infections or suspected subungual ulceration in the presence of neuropathy and/or peripheral arterial disease • End stage renal failure • Neuropathic foot with absence of protective sensation (patient cannot detect the 10g monofilament at 1 or more testing sites) and/or reduced vibration sensation with Biothesiometer threshold >25V, absent tuning fork 128 	<ul style="list-style-type: none"> • *Current ulceration • *Peripheral Arterial Disease, ABI at 0.5-0.8 with pre-ulcerated or ulcerated lesion • *Charcot's neuroarthropathy • *Neuropathic or neuro-ischaemic that have not demonstrated significant measurable improvement(30-40%) within 4 weeks of treatment • *Ulcers presenting at >grade 2 or indolent Grade 1 	<p>**Diabetic Ulcerations with associated signs of:</p> <ul style="list-style-type: none"> • Cellulitis • Systemic symptoms of infection • Infection not responding to oral antibiotic therapy • Radiological or clinical evidence of bone involvement • Critical ischemia

Other risk factors for increased incidence of foot ulceration:

- Elevated HbA1c/poor glycaemic control
- Nephropathy
- Retinopathy/Visual Impairment
- Smoking
- Long standing diabetes
- Reduced perception of risk; and
- Mental health history.

APPENDIX D: MODEL FOR THE MULTI-PROFESSIONAL MANAGEMENT OF THE AT RISK FOOT

Model for the multi-professional management of the at risk foot



NB The transverse lines in the two triangles do not align reflecting the reality of possible clinical overlap between the risk strata and care intervention categories.

This model is underpinned by robust disease specific screening programmes that identify risk categories and ensure timely referral to the appropriate level of service. In broad terms discrimination for access to service is based on level of disability and the capacity to benefit. Referral criteria for disease specific foot complications will be based on current national, international guidelines and clinical priority assessment criteria .