NSW Health

Leading Better Value Care

High risk foot services

Organisational models

This summary document provides decision-makers with options to improve care in different service delivery settings. Building on *Access to high risk foot services: Clinical priorities (2020)* which describes *what* to improve, the focus here is on *how* to improve care. These documents are informed by research evidence about best clinical care, current service delivery models and experiential evidence from clinicians and patients.

IMPROVING KEY PRIORITY AREAS

Referral and triage

- Establish agreed referral criteria and clinical-decision support
- Develop clear intake criteria for urgent and non-urgent cases
- Establish dedicated time for the coordinator to triage new referrals
- Develop and document pathways for hospital and emergency department avoidance, and access to ED when the high risk foot service is unavailable

Multidisciplinary care

- Involve a senior physician, a senior podiatrist and a nurse/credentialled diabetes educator. In rural services the role of senior physician may be fulfilled by an upskilled nurse practitioner working with a consulting physician
- Active involvement of team members in clinics and case conferences
- Establish and document rapid access referral pathways to vascular and orthopaedic surgical consultations and wound care

Footwear and orthotics

- Provide access to onsite pressure offloading modalities
- Develop an online pathway for prescription of footwear and footwear modifications and total contact casting
- Direct referrals to EnableNSW
- Provide patient education about the use of devices

Coordination of ongoing care

- Use phone, face-to-face, electronic or letter handover to ongoing care providers to ensure continuity of care
- Send wound management documentation to ongoing care providers
- On discharge, provide advice on the prevention of ulcer recurrence
- Routinely include management plans, including footwear needs, in discharge communications (within five days of discharge)

IMPROVING THE OVERALL PATIENT JOURNEY

- Maintain strong communication and connections across primary care and community-based services
- Support self-management using a personalised, goal-oriented approach
- Collect and monitor data through audit and feedback processes
- Use telehealth to support access to multidisciplinary care
- Provide access to an Aboriginal podiatrist, health worker or health practitioner (such as Healthy Deadly Feet workforce)
- Refer to follow-up services that reflect ongoing care requirements and comorbidities
- Establish a shared care model or step-down clinic post patient discharge
- Collect and act upon patient reported experience and outcome measures (PROMIS-29 and Cardiff Wound Impact Schedule)

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OPTIONS FOR ORGANISATIONAL CONFIGURATIONS

High risk foot services are defined by minimum and best practice standards. A specialised, coordinated, multidisciplinary approach is delivered to manage time-critical high risk foot complications. Patient care is coordinated to focus on the identification and management of complications to minimise hospitalisation or the need for surgical intervention. There are two key service types which vary the composition of the team.

Regardless of which service type is selected, there are common elements of care:

- Referral and intake criteria for triage and prioritisation
- A coordinated interdisciplinary team care approach
- Pressure offloading, prescribed footwear and footwear modifications
- Individualised management planning, including diabetes management
- Pathways to support access and continuity of care across settings
- Shared care model or step-down clinic post discharge
- Culturally responsive services for Aboriginal people, which may include outreach services in some local health districts. In these services, there should be access to an established Aboriginal workforce, such as the Healthy Deadly Feet team.

Option 1: Medical led high risk foot service

Minimum staffing includes a senior physician (such as an endocrinologist) and a senior podiatrist with expertise in high risk foot care, with access to nurse consultation.

This model is well suited to services with access to dedicated specialist care, particularly in metropolitan and larger sites. These services may provide care to regional or smaller sites through telehealth.

Why choose this model?

- optimises coordination of care through physical co-location of team members
- maximises benefits of multidisciplinary care
- ensures availability of specialist care when required

If you choose this, then...

- consider the physical space required to provide optimal interdisciplinary care
- assess capacity to provide telehealth services to smaller sites across the LHD or district boundaries

Option 2: Allied health (podiatry)/Nurse led high risk foot service

Minimum staffing includes a senior podiatrist with expertise in high risk foot care, who has access to senior medical, surgical and nurse consultation. In rural sites, access to medical consultation may be an upskilled general practitioner or a nurse practitioner with an advanced scope of practice (with access to a consulting physician).

These services may be enhanced through the provision of telehealth to access care and/or expertise from a senior clinician, connecting patients who may not otherwise be able to access a high risk foot service.

Why choose this model?

- if access to dedicated specialist medical or surgical services is not available
- in larger geographical areas, smaller sites can provide care closer home
- can minimise travel time for patients

If you choose this, then...

- ensure pathways are established to access specialist medical and surgical consultations, as required
- establish processes for effective communication using standardised tools
- assess readiness to provide telehealth

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